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Social influence in counseling: Counselor expertness and aggressiveness on client self-esteem

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SOCIAL INFLUENCE IN COUNSELING: COUNSELOR EXPERTNESS AND AGGRESSIVENESS ON CLIENT SELF-ESTEEM

A Thesis

Presented to the

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College, San Bernardino

In Partial Fulfillment of

the Requirements for the Degree

Master of Science

in

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ABSTRACT

This counseling analogue investigation examined the effects of a counselor's perceived expertness and verbal aggressive style on client self-esteem. Sixty undergraduate subjects were randomly assigned to one of four experimental conditions representing high and low levels of counselor credibility, and counselor aggressive or nonaggressive therapeutic style. Each participant completed two pencil and paper measures of self-esteem at pretest and posttest intervals spaced one week apart. The experimental treatment consisted of a videotaped therapeutic message where a counselor who was introduced as being either an expert or an inexpert presented either an aggressive or nonaggressive style. The results indicated that both expertness and aggressive style act to effect levels of self-esteem. The highest levels of post-treatment esteem were obtained when the counselor perceived to be an expert presented a nonaggressive style, and when the same counselor perceived to be an inexpert presented an aggressive style.

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INTRODUCTION

Psychological research has indicated that many, if not all human relationships involve persons attempting to influence each other, and that much of the influence can be exerted either inadvertently or deliberately. In the counseling relationship purposeful influence is common when therapists attempt to alter clients' attitudes, behaviors, values, or views of the world (Corrigan, Dell, Lewis, and Schmidt, 1980; Haley, 1963; Watzlawick, 1974).

Frank (1961) wrote that

> attempts to enhance a person's feelings of well being are usually labelled treatment, and every society trains some of its members to apply this form of influence. Treatment always involves a personal relationship between healer and sufferer. Certain types of therapy rely primarily on the healer's ability to mobilize healing forces in the sufferer by psychological means. These forms of treatment may be generically termed psychotherapy (p. 1).

Using this perspective, Frank explored the commonalities of diverse forms of healing such as placebo effects in medical and psychological treatment, religious healing, thought reform, miracle cures, and the traditional mental hospital. In his chapter on the experimental studies of persuasion, Frank was one of the earliest investigators to apply the results of social psychological research to understanding the psychotherapy process.

Later, Goldstein, Heller, and Sechrest (1966) wrote more

extensively about psychotherapy research by extrapolating ideas from social psychology. Working under the supposition that a client must experience a certain degree of attraction to the therapst in order for the therapist's influence attempts to be successful, these authors propose that "patient attraction to the therapist may increase by cognitive dissonance induced by patient exposure to information discrepant with resistive behavior" (p. 112). Stated otherwise, attraction to the therapist is increased when cognitive dissonance is aroused and channeled in directions that place the therapist and therapeutic participation in favorable light.

As a means of testing this hypothesis, Goldstein, et al. suggest implementing what they term the "credible plant". Basing their hypothesis on the "non-clinical" work of a number of investigators (i.e. Hovland, Janis, and Kelley, 1953; Kulp, 1934; Haiman, 1949), Goldstein et al. suggest that a therapist's assertations are more likely to be accepted if he or she is viewed by the client as having credibility. The "credible plant", therefore, involves channeling dissonance reduction attempts by directly manipulating the therapist's perceived credibility.

These propositions apparently stimulated Strong (1968) to write what would soon become a landmark paper on counseling as an interpersonal influence process. Based on Festinger's (1957) theory of cognitive dissonance, Strong indicated that counselor's attempts to change clients' be-

havior or opinions would precipitate dissonance in clients. Zimbardo (1960) summarized the theory as follows:

> Dissonance theory assures a basic tendency toward consistency of cognitions about oneself and about the environment. When two or more cognitive elements are psychologically inconsistent, dissonance is created. Dissonance is defined as a psychological tensions having drive characteristics. Thus, the existence of dissonance is accompanied by psychological discomfort and when dissonance arises, attempts are made to reduce it (p. 86).

The theory, therefore, suggests that dissonance will be aroused in an individual when he communicates his opinion to someone holding a contrary opinion. The degree of dissonance is directly related to both the perceived discrepancy between the two opinions, and the intensity of the relationship between the individuals involved. Thus, the greater the perceived discrepancy, the greater the dissonance, and the greater the pressure to reduce it.

In the counseling relationship the common theoretical implication is that when client A is attracted to therapist B and yet nonreceptive to B's influence attempts (or opinions) a degree of client dissonance is thus created (Goldstein, Heller, and Sechrest, 1966). According to Festinger's theory, which was operationalized by Strong (1968), there are five major dissonance reduction avenues that are possible: (a) The person may change one or more of the cognitions that are involved in the dissonant relationship; (b) add new cognitive elements that are consonant with his or her own opinion; (c) discredit the communicator and thus reduce the

importance of the communicator's assertions; (d) change the communicator's opinion to be more consistant with his or her own or, (e) decrease the subjective importance of the cognitions involved. In the latter reduction avenue a client may have his initial contact with a therapis primarily as a result of pressure from a significant other. In th1s case a client may view participation in therapy as less stressful and therefore less dissonance arousing than a reinstatement of the pressure from the significant other.

The avenue chosen for dissonance reduction is largely dependent upon the circumstances of the influence attempt. If, however, the communicator cannot be discredited, the issue of importance cannot be devalued, counterpersuasion cannot be exerted, and there is no social support available, then an individual's cognitive change is said to be the result of a communicator's influence attempts. According to dissonance theory, however, the lessening of client dissonance because of acceptance of the communicator's position is possible only when other avenues of dissonance reduction are controlled (Strong, 1968).

A review of the literature that is concerned with controlling avenues of dissonance reduction in therapeutic settings shows that a great deal of attention has been paid to a counselor's perceived characteristics. To examine dissonance reduction through discrediting the communicator a therapist's perceived credibility has been varied in a number of studies

(Strong and Schmidt, 1970; Strong and Matross, 1973; Greenberg, 1969). Credibility, as defined by Hovland, Janis, and Kelley (1953, p. 21), has two components ... "(1) the extent to which a communicator is perceived to be a source of valid assertions (his expertness), and (2) the degree of confidence in the communicator's intent to communicate the assertions he considers most valid (his trustworthiness)". Having reviewed and conducted a number of investigations, Hovland et al. conclude that there is sufficient documentation to indicate that the reactions to a communication are significantly affected by the communicator's credibility.

Thus, Strong (1968) suggested that clients' perceptions of counselors as sources of valid assertions would be influenced by

> (a) objective evidence of specialized training such as diplomas, certificates, and titles, (b) behavioral evidence of expertness such as rational and knowledgeable arguments and confidence in presentation, and (c) reputation as an expert (p. 216).

Using this perspective, Strong went on to review the relevant literature concerning the effects of perceived expertness and concluded that "a communicator's perceived expertness controls the extent to which his discrepant communications will lead to opinion change rather than to his own disparagement" (p. 218). Further, if these suppositions are useful ones for describing the therapeutic arena as a social influence process, then by extrapolation from social psychological research counselors' ability to influence their clients in

helpful ways may be effected by their clients' perceptions of them as being an expert.

Alternative Social Influence Paradigms

Psychotherapy has typically been conceptulized as a social reinforcement process. Having its roots in verbal conditioning research (Krasner, 1958, 1965), the reinforcement model indicates that a client's interactions are significantly influenced by a therapist's dispensation of social reinforcements. In a broad sense this paradigm has been tied to a diversity of therapeutic madalities including modeling (Bandura, 1965), social learning (Rotter, 1954), and client centered therapy (Rogers, 1957). Using selected client verbalizations and behaviors as reinforced actions, each of these therapeutic approaches uses the therapist as a reinforcing agent (Gillis and Patrick, 1980).

Although this view of therapeutic interaction is common, Haley (1963) has offered an alternative. He views interpersonal interactions in general, and psychotherapy in particular, as arenas of competition. According to Haley, both therapist and client struggle for control of the therapeutic relationship; a client uses his symptoms and a therapist a host of intervention techniques.

As one may surmise, and as several investigators have noted (Frank, 1972; Gillis, 1979), the psychotherapy process has become quite bewildering. With ever evolving systems of therapeutic approaches and techniques, there appear to be few

commonalities between such diverse therapies as nude encounters, Gestalt therapies, and the traditional Freudian approach. What is currently termed a "social influence" approach to psychotherapy, then, is an attempt to apply social psychological concepts to the identification of the ingredients common to all psychotherapy systems. Specifically relevant to this investigation are such variables as a therapist's reputational and behavioral characteristics and their effects on clients' attitude change regarding self-esteem.

Credibility Structuring

In attempting to structure reputational cues, counselors' attributed experience and status have been the focus of several investigations (Brooks, 1974; Clairborn and Schmidt, 1977; Friedenberg and Gillis, 1977, 1980; Greenberg, 1969; Hartley, 1969; Price and Iverson, 1969; Spiegal, 1976). Frequently, therapists who are heard on audiotapes, viewed on videotapes, or seen in interviews are introduced to subjects as either experienced or inexperienced. Typically, such cues range from Ph.D level clinicians with national recognition to undergraduate students. Although the manner in which credibility cues have been manipulated has shown some consistency, the dependent variables among these studies have differed widely. Most studies have employed some sort of scale that measures perceived expertness.

In one study, Price and Iverson (1969) manipulated a

therapist's perceived status by way of a credibility structuring orientation. The results indicated that counselors who are ascribed high status are more favorably received by others upon initial contact. Similarly, Scheid (1976) investigated the relative effects of counselor behavior and found that counselors who are introduced as having greater experience and higher status are viewed as more comfortable and competent than those introduced as having less experience and lower status. Further, it is notable that Hartley (1969) found that differences resulting from credibility manipulations via introductions resulted in differences that lasted throughout ten group sessions. It appears, then, that information regarding a counselor's status can reliably affect the perceived expertness of that counselor.

Although the literature concerning a counselor's perceived expertness has indicated that subjects can be reliably structured on this variable, the outcome effects that are associated with such manipulations have received much less attention. In two separate studies, extrapolating from social psychological research that is concerned with changing attitudes, Friedenberg and Gillis (1977, 1980) presented college student subjects with a counterattitudinal message that was designed to raise levels of self-esteem. This message was a videotaped segment that was presented under conditions of either high or low credibility. The

content of the message consisted of Ellis' (1962) suggestions regarding those irrational ideas that sustain emotional disturbances. On all dependent measures of self-esteem Freidenberg and Gillis found that in both studies subjects viewing the videotape under high credibility conditions had a significant increase in levels of self-esteem over subjects in low credibility conditions. Although these are among the first studies that have examined therapeutic outcome as a function of therapist credibility, the Freidenberg and Gillis findings are generally supportive of the position that psychotherapy clients are susceptible to social influence.

Given these findings the implication that positive therapeutic effects are associated with structuring clients' perceptions of the status and/or credibility of a therapist is given support. Lacking in the literature, however, are studies that investigate the conditions under which perceived expertness is effective regardless of the presence of other, more direct, social psychological variables. Specifically, unknown are the therapeutic effects that are associated with a counselor's actual behavior when he/she is perceived to be either an expert or an inexpert.

Therapist Behavioral Characteristics

While it has been widely believed that therapists should present empathic responses, research has indicated that not all clients prefer such styles of interaction. In a study of communication styles in counseling relationships, Reisman

and Yamokoski (1974) found that clients neither expected nor preferred psychotherapists to behave empathically, rather, they preferred these individuals to act in an expository, advice-giving manner.

Further, in examining clients' preferences for counselor response styles, Venzor, Gillis, and Beal (1976) found that clients showed no differential preferences for empathic responding over advice-giving or interrogative responding. These authors suggest that clients find acceptable a wide range of response styles, and that empathic understanding of a problem seems not to matter a great deal.

Similarly, Davis (1971), attempting to assess the adequacy of Haley's (1963) view of psychotherapy as an arena of competition, investigated a therapist's interview behavior according to either a social reinforcement of a competitive program. Under the social reinforcement condition interviewers responded to the interviewee's remarks with approval or agreement. Under the competitive condition, however, interviewers expressed disagreement or disbelief at these remarks. Davis' measure of the effects of the two conditions consisted of the frequency of the subjects' requests for further interaction with the interviewer. As predicted by Haley's model, subjects sought verbal exchanges significantly more often with those interviewers who responded unfavorable to their remarks. Davis concluded that his findings supported Haley's proposition that clients attempt to control

the situation by seeking positive evaluations from the interviewer. If, however, such evaluations are withheld, as in Davis' investigation, clients continue to seek opportunities to persuade the interviewer to alter his assessment. Such a change in assessment presumably indicates that the therapist has lost some of his verbal advantage. Gillis and Patrick (1980), using paradigm similar to that of Davis, failed to replicate his findings. They did report, however, no evidence of psychiatric patients preferring an empathic style to a competitive one.

These studies of response style preference suggest one reason why so many diverse forms of psychotherapy claim success. That subjects, as a group, show no specific preferences for therapist responses indicates that they are willing to accept a wide range of approaches regardless of a therpist's theoretical orientation. Based on these investigations it seems plausible to hypothesize that a therapist's verbal aggressiveness fails to alienate a client in ways that had previously been thought.

Particularly relevant in terms of demonstrating the success of therapy are insturments that measure self-esteem. According to Murry and Jacobson (1971) diminished self-respect is characteristic of many persons who seek psychotherpay, and enhancement of esteem is typically viewed as a major goal of treatment (Butler, 1966). As has been noted, manipulating a therpaist's perceived status or experience via

introductions has been shown to have positive effects on various therapy outcome measures, particularly self-esteem (Friedenberg and Gillis, 1977, 1980). Given these results the case for social influence in counseling, particularly in relationshop to credibility structuring, is made quite compelling. Further, although successful therapy outcomes in association with a therapist's warmth in treatment is legion (Truax and Carkhuff, 1967; Truax and Mitchell, 1971), there is evidence to suggest that the lack of this characteristic fails to alienate clients in ways that had previously been thought certain (Gillis and Patrick, 1980; Davis, 1971). Based on these investigations the supposition that a therapist's perceived credibility is powerful to the degree that it carries its positive effect regardless of response style characteristics is the purpose of the present investigation.

The following hypotheses were tested in this study: (a) clients' increased self-esteem will be significantly related to a thertapist's perceived expertness, (b) There will be no difference in levels of self-esteem as a result of a therapist's verbal aggressive style, and (c) These two variables will not significantly interact to effect self-esteem.

METHOD

Subjects

The subjects for this study were 60 undergraduate college students who were enrolled in various psychology courses at California State College, San Bernardino.

Instruments

Two instruments that measure self-esteem were used in this study: 1) The Rosenberg Self-Esteem Scale (Rosenberg, 1965; Appendix A) and 2) The Tennessee Self-Concept Scale (Wylie, 1974; Appendix B). Although many self-esteem measuring instruments are available to researchers, the above two were chosen for this study for two reasons: 1) Of particular importance to most research projects is their employment of similar dependent measures that allow for comparability across investigations. Both the Rosenberg and Tennessee Scales have been widely used as dependent measures. Thus, their inclusion in this investigation allows for an ease of comparison across studies. 2) Both scales have been subjected to considerable validity testing. The results have repeatedly demonstrated that both scales successfully measure self-esteem as a self referent attitude and as observed behaviorally by others.

The Rosenberg Scale consists of five positive and five

negative self referent items, each rated on a four point scale ranging from "strongly agree" to "strongly disagree". The scoring procedure is on an item-by-item basis; a score of one on any single item indicates low self-esteem and a score of four high esteem. The total score could thus range from 10 to 40, increasing with level of self-esteem.

Rosenberg's (1965) validity studies of this scale consisted of associating subjects' self-esteem scores with other indicators of their psychological functioning. Specifically, Rosenberg found significant chi-square relationships between hospital nurses' judgment of subjects' depressive affect and level of self-esteem, and, between subjects' subjective appraisal of "feelings of unhappiness" and esteem ratings. Further, other significant relationships were found between esteem ratings and psychophysiological indicators, peer group reputation, interpersonal attitudes, self criticism, and leadership involvement. In short, Rosenberg found the scale to be a valid indicator of one's positive or negative attitude toward a particular object, namely, the self.

The Tennessee Self-Concept Scale, one of the most frequently used measures of self-esteem, consists of 100 items that are rated by a subject on a five point scale. To avoid subjects acquiring a response set, one half of the items describe positive characteristics and the other half negative characteristics. Ninety of the items are scored for esteem, the remaining 10, taken from the MMPI L-Scale, serve as a

brief validity scale. Scores can range from 90 to 450, increasing with level of esteem.

The validity of the Tennessee Scale has been supported by the work of several investigators (Fitts, 1964; Rentz and White, 1967; Williams and Cole, 1968). Fitts (1964) compared normals with psychiatric patients and found significant differences on various personality measures and personality changes under particular conditions. Rentz and White (1967) found high correlations between college student subjects' self-ratings on a semantic-differential and Tennessee scores. Further, Williams and Cole (1968), evaluating the relationship between school achievement and self-concept, found significant relationships between reading and mathematics scores and adolescents' self-concept as measured by the Tennessee scale. It seems, then, that this instrument accurately performs the function for which it was designed, specifically, measuring levels of self-esteem.

Counterattitudinal (Therapeutic) Message

Two eight-minute videotapes, similar to those used by Friedenberg and Gillis (1977, 1980), were developed to depict a therapist's aggressive or nonaggressive style while delivering a therapeutic message. The content of each tape consisted of Ellis' (1962) suggestions regarding those irrational ideas that sustain emotional disturbances (Appendix C). Several of these irrational beliefs were described followed by remarks that included the persuasive

message that the listener was a better person than he/she gave himself/herself credit for being and that he/she should change accordingly. The speaker was a mature, distinguished-looking 41 year old male speaking in an informative and authoritative manner.

For purposes of defining both aggressive and nonaggressive presentation styles the characteristics of each mode were expected to differ in terms of varying degrees of volume, forcefulness and tone of voice used, and in facial expressions and eye contact. In developing a construct definition of aggressiveness the intent of the speaker was to present a style that manifested a vigorous and controlling pursuit of the goal of raising levels of self-esteem (Chaplin, 1975). Although the nonaggressive presentation style was also interpreted as having an effect on self-esteem, it lacked the controlling vigor that characterized the aggressive style. More specifically, the aggressive style was characterized by the speaker presenting a firm, controlling, and frequently loud tone of voice, and nonverbal behavior that included few eye contacts and smiles. The nonaggressive style, however, differed by way of the speaker presenting a non-controlling, passive, warm, and mild tone of voice and showing more eye contact and softer facial expressions than were evident in the aggressive style. For purposes of this study, then, aggressive style was defined as the intent to control a person to the degree of raising their

level of self-esteem. This definition is operationalized through the use of a therapist's verbal and nonverbal cues.

In order for the tapes to accurately reflect a therapist's aggressive or nonaggressive style, a semantic differential (Osgood, Suci, and Tannenbaum, 1957) was developed to test the differences between these styles (Appendix D). This instrument was administered to a group (n = 17) of undergraduate subjects who viewed both tapes and subsequently rated the presentation style using a series of bipolar adjectives. Each pair of words was rated on a seven point scale, a score of one indicating a nonaggressive style and a score of seven an aggressive style. The Ss were randomly divided into two groups with each group viewing either the aggressive or nonaggressive tape first. Although 11 pairs of adjectives comprised the semantic differential, only five were scored for presentation style. Thus, scores could range from seven to 35, increasing with level of aggressiveness. The results indicated that the two tapes differed significantly in the expected direction on aggressive style, $t(16) = 3.78$, $p<.001$.

Procedure

Session 1. Subjects participated in two experimental sessions that were spaced one week apart. In the first session all subjects were administered the Rosenberg Self- Esteem Scale and the Tennessee Self-Concept Scale and subsequently randomly assigned to one of four

experimental conditions. These data served as a measure of pre-treatment level of self-esteem. The experimental conditions were represented in a 2 x 2 factorial design which included high and low levels of communicator credibility (expertness) and aggressive or nonaggressive therapist presentation style.

Session 2. Following the one-week interval all subjects were involved in the experimental manipulation (viewing the taped therapeutic message). Subjects in the high expertise group(s) were structured on this variable by way of the following introduction:

> This talk will be presented by Dr. Andrew Martin, a distinguished psychologist in the area of human potential and personal growth. Dr. Martin received his Doctorate from Yale University in 1969. Since that time he has received many personal recognitions and awards for his work in helping people to improve themselves as individuals. He has led more than 50 personal growth workshops and seminars in 23 states in the past year alone (Friedenberg and Gillis, 1977, 1980).

Subjects in the nonexpert condition(s) received the following introduction:

"This talk will be presented by Andy Martin".

Since the semantic-differential had shown that the two tapes delineated either an aggressive or nonaggressive style, and it is of theoretical interest to know the outcome effects that are associated with such an approach, no further attempts were made to structure the subjects' perception of the therapist's presentation style.

After all subjects viewed the videotape they completed

both measures of self-esteem. These data served as a measure of the treatment effects (therapeutic message).

Data Analysis

The data were subjected to analysis using a 2 x 2 (expertness x aggressiveness) fixed model factorial analysis of covariance (ANCOVA) using pretest scores as the covariate (Winer, 1971; Campbell and Stanley, 1966). Selected comparisons between Means using the Rosenberg scale scores and the Tennessee scale scores were subsequently performed.

RESULTS

The first results to be considered are those describing the characteristics of the sample distribution of scores that were obtained by the Rosenberg and Tennessee scales. Table 1 presents the pretest and posttest means, standard deviations, and range of scores on both scales across all groups.

Table 1

Means, Standard Deviations, Ranges of Pre and Posttest Scores

	Pretest		Posttest*		Pretest	Posttest
Condition	M	SD	M	SD	Low-High	Low-High
E - A						
Rosenberg	31.4	5.4	33.6	4.4	24 - 40	26 - 40
Tennessee	347.4	40.8	356.4	45.6	269 - 401	279 - 421
E - NA						
Rosenberg	31.8	5.6	34.9	4.5	21 - 40	27 - 40
Tennessee	339.3	48.6	379.1	27.1	182 - 402	317 - 409
NE - A						
Rosenberg	34.2	3.1	35.3	3.1	28 - 40	29 - 40
Tennessee	364.8	42.3	371.4	35.4	281 - 430	332 - 444
NE - NA						
Rosenberg	33.0	3.9	33.4	4.3	26 - 39	28 - 40
Tennessee	348.9	36.9	361.4	37.7	280 - 406	313 - 431

Note: E = expert; NE = non-expert; A = aggressive; NA = Non-aggressive. *Adjusted means.

Table 2 presents the Pearson product-moment correlations between pretest and posttest scores both within the Rosenberg and Tennessee scales and between both dependent measures.

Table 2

Rosenberg Scale and Tennessee Scale Correlation Coefficients

Scale	Rosenberg Pretest	Tennessee Posttest
Rosenberg Posttest	.81	.79
Tennessee Pretest	.34	.65

Note: All $p < .005$; $N = 60$

The significant correlations resulting between the Rosenberg and Tennessee Scales provide evidence for convergent validity.

The principle analysis of the study involved the use of a 2 x 2 (expertness x aggressiveness) fixed model analysis of covariance using pretest scores as the covariate. This technique is advocated by Campbell and Stanley (1966; Winer, 1971) as a preferred alternative to the use of a posteriori t-tests to evaluate between-group change scores. Selected t-tests between the adjusted means of the non-expert aggressive and non-expert nonaggressive groups, and between the expert aggressive and non-expert aggressive groups were performed, respectively, on the Rosenberg and Tennessee scales.

For purposes of clarity the results of the two dependent measures will be considered separately. To check for signif-

icant differences on the pretest levels of self-esteem across the four groups a one-way ANOVA on the Rosenberg scale was performed. No statistically significant differences were found, $F < 1$, indicating that the pretest level of self-esteem was equal across all groups on this dependent measure.

The analysis of covariance (ANCOVA) on the Rosenberg scale posttest scores indicated that a statistically significant expertness by aggressive style interaction occurred, $F(1,55) = 6.13$, $p < .02$; but no significant main effects for either expertness, $F < 1$ or aggressive style, $F < 1$ resulted. To better understand the interaction effect selected t-tests were performed on the adjusted cell means. Only the nonexpert - aggressive and the nonexpert - nonaggressive groups showed that the former had a significantly higher mean level of post-treatment self-esteem, $t(55) = 2.02$, $p < .05$. The pattern of the adjusted means on the Rosenberg scale for all groups is shown in Figure 1.

Analysis of the Tennessee scale resulted in a similar pattern of findings that were indicated by the Rosenberg scale. A one-way analysis of variance (ANOVA) on the Tennessee pretest scores showed that there was no statistically significant difference between pre-treatment levels of self-esteem across the four groups, $F < 1$. The ANCOVA that was performed on the post-treatment levels of esteem showed that a significant expertness by aggressive style interaction $F(1,55) = 5.10$, $p < .03$, but no significant main effect for

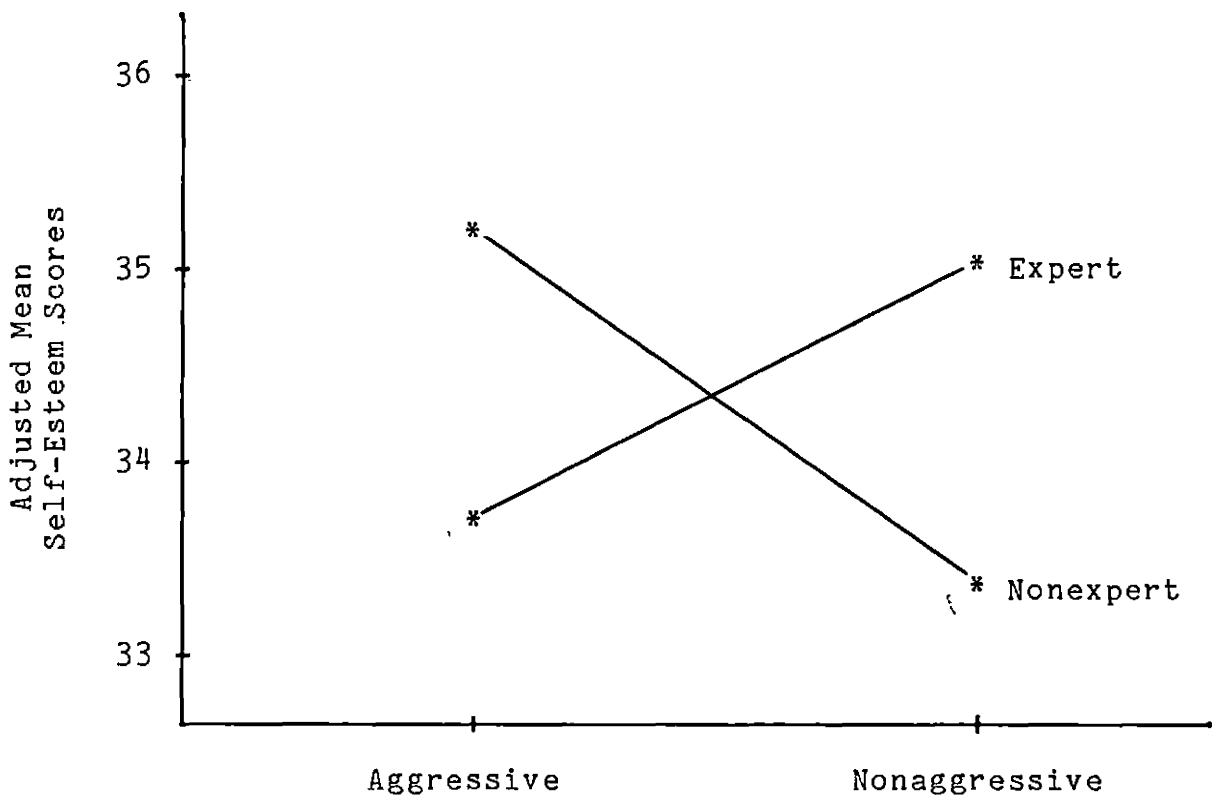

Figure 1. Rosenberg Scale Adjusted Means for the Four Groups.

either expertness, $F < 1$, or aggressive style, $F < 1$, occurred. A selected t-test between the adjusted means of the expert - aggressive and expert - nonaggressive groups indicated that the latter group had a significantly higher post-treatment level of self-esteem, $t(55) = 2.23$, $p < .05$. Figure 2 summarizes graphically the adjusted means that were obtained from the four groups.

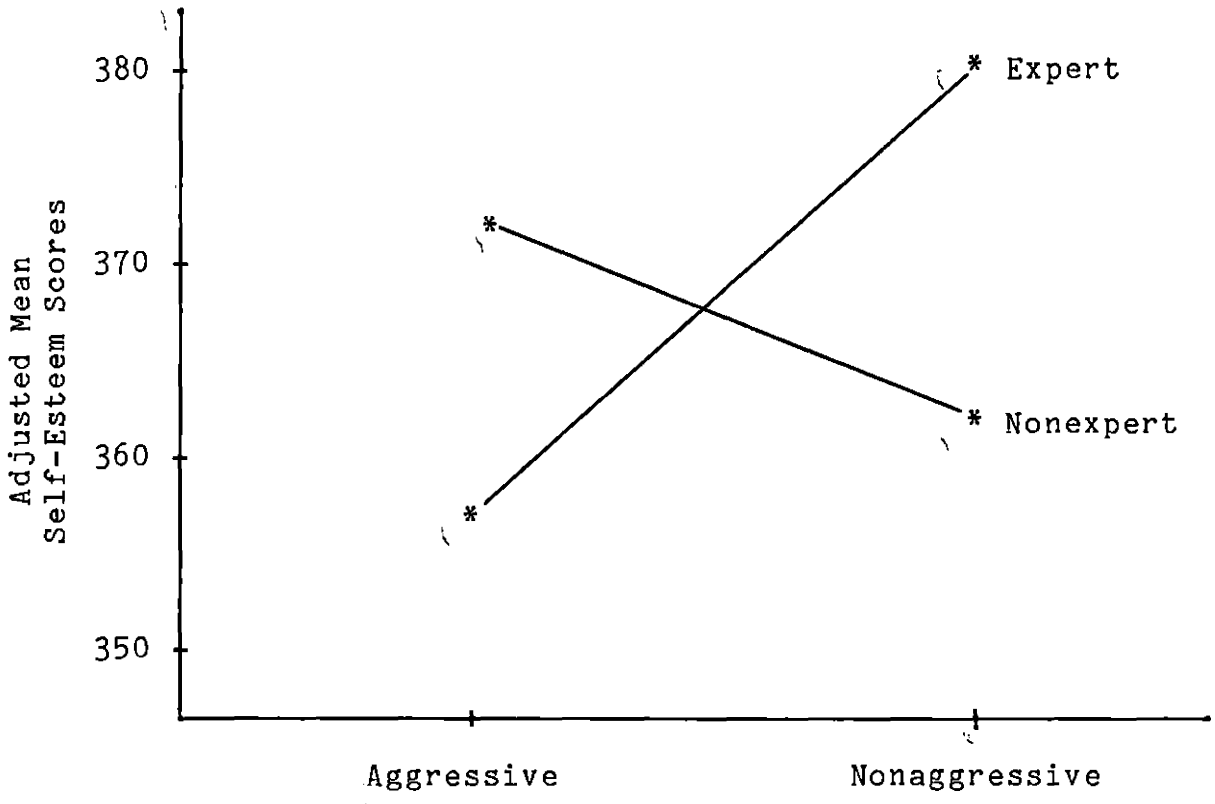

Figure 2. Tennessee Scale Adjusted Means for the Four Groups.

DISCUSSION

The present study was intended to serve as an examination of the effects of perceived counselor expertness and actual verbal aggressiveness on client self-esteem. Although the two dependent measures resulted in somewhat different findings in terms of statistically significant mean comparisons, the general pattern of results are highly similar. The findings that were obtained from the Rosenberg scale indicated that when the therapist was perceived to be a nonexpert the highest post-treatment level of self-esteem was established when he presented an aggressive style. When the results of the Tennessee scale are considered, the same positive therapeutic effects occur when the counselor is nonaggressive but is perceived to be an expert. Although the positive effects associated with perceived expertness that were found in this study are not novel, the unpredicted findings here were those of the aggressive style. The findings of this investigation indicate that if a counselor is perceived to be a nonexpert positive therapeutic effects are possible when an aggressive style is manifested. The implication of this finding is that when clients perceive a nonexpert counselor it is necessary for that counselor to exhibit some other trait. That is, if maximum therapeutic gain is to be expected. In the present investigation, then,

a counselor's perceived expertness and actual verbal aggressive style significantly interact to raise levels of self-esteem. Thus, the hypothesis of this study stating that credibility is the critical social influence variable that operates to raise levels of self-esteem cannot be supported.

Given these findings the indication that there are two sources of influence - expertness and aggressiveness - that function within the therapeutic setting is given support. Results here, however, suggest that if both of these influence variables operate simultaneously the positive effects that are associated with one are attenuated by the effects of the other. This is particularly true if the counselor is perceived to be an expert who is also verbally aggressive. It is tempting to suggest that subjects find a counselor with these characteristics overwhelming to a sufficient degree that they are unwilling to accept his/her intervention attempts.

Similar results were found, although perhaps for different reasons, with a counselor who is neither an expert nor verbally aggressive. With this finding it is possible that subjects viewed the counselor as being incompetent and therefore failed to accept the therapeutic message.

In terms of a theoretical base on which to build an explanation for these results, the present findings follow an outcome predicted by cognitive dissonance theory (Festinger, 1957). Very briefly, dissonance theory assumes that indivi-

duals seek consistency in their cognitions and when faced with discrepant information from another individual will seek to lower the resulting tension by one of the following methods: (a) Discrediting the communicator, (b) devaluating the importance of the issue, (c) attempt to change the communicator's opinion, (d) increase the importance of one's own opinion by adding cognitions to those already held or, (e) change one's opinion to that of the communicator.

The present study potentially created dissonance for the subjects by presenting them with information (therapeutic message) that possibly created discrepant cognitions with ones currently being held (attitude toward one's self). This logic implies that subjects in the expert - aggressive and nonexpert - nonaggressive conditions reduced dissonance by either (a) discrediting the communicator, (b) devaluating the importance of the issue or, (c) increasing the importance of their own opinion by adding cognitions to those already held. It seems likely, then, that subjects who were in the conditions that produced the highest amount of change in self-esteem (i.e. expert - nonaggressive and nonexpert - aggressive) chose to lower tension inducing dissonance by altering their self-concept attitudes to be more congruent with that of the communicator. In other words, two sources of power - expertness and aggressiveness - acting apart from each other were of sufficient strength to lower dissonance by changing subjects' attitudes to be more congruent with the therapeutic

message.

The results of this investigation, which employed a similar paradigm to that used by Friedenberg and Gillis (1977, 1980), are only marginally supportive of their findings. They are consistent in that a counter-attitudinal message aimed at increasing levels of self-esteem has proven effective. The conditions under which this effectiveness occurs, however, appear to be more complicated. In the Friedenberg and Gillis (1980) investigation credibility was found to positively effect self-esteem, and this finding was heightened when the counselor was reportedly a warm person. When a high status counselor was reportedly cold and distant the positive effects on self-esteem were somewhat attenuated. In all cases, however, regardless of attributed warmth the expert counselor had a greater effect on self- esteem. The results of the present investigation fail to support the positive effects of structuring for credibility alone. Although the Friedenberg and Gillis (1980) investigation involved attributing characteristics (warmth) to the counselor, the present study examined actual characteristics (aggressiveness). It is possible that if the counselor in the Friedenberg and Gillis study actually was either a warm or cold person, this characteristic combined with credibility structuring may have resulted in the two variables interacting to effect self-esteem.

Generalizing the results of this investigation to actual

therapeutic application warrants some important considerations. The subjects who participated in this investigation probably had a higher level of self-esteem than clients who are seeking psychological assistance and hence a lower potential for positive change. There is, however, some evidence that lower self-esteem renders clients more susceptible to social influence attempts (Friedenberg and Gillis, 1977). The attitude change technique that was used in the present investigation might thus be even more effective with actual clients.

One apparent limitation in generalizing the results of the present study to clinical practice involves the lack of direct client - counselor interaction. It may be that an aggressive therapist who directly interacts with a client would dissipate the positive effects that were produced by the same therapist via videotape.

Based on these positive findings, further investigation into the interpersonal influence characteristics of expertness and aggressiveness are suggested. While the possibilities of enhancing the effectiveness of psychotherapy by adapting selected social psychological techniques has only recently been suggested, the results of this investigation indicate that the expansion of empirical efforts in this direction are potentially rewarding.

APPENDIX A

ROSENBERG SELF-ESTEEM SCALE

For each item below circle the choice which indicates how you feel about yourself.

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

6) I take positive attitude toward myself.

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

9) I certainly feel useless at times.

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

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

1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

APPENDIX B

TENNESSEE SELF-CONCEPT SCALE

INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully; then select one of five responses below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

You will find these response numbers repeated at the bottom of each page to help you remember them.

	ANSWERS				
1. I have a healthy body.....	5	4	3	2	1
2. I am an attractive person.....	5	4	3	2	1
3. I consider myself a sloppy person.....	1	2	3	4	5
4. I am a decent sort of person.....	5	4	3	2	1
5. I am an honest person.....	5	4	3	2	1
6. I am a bad person.....	1	2	3	4	5
7. I am a cheerful person.....	5	4	3	2	1
8. I am a calm and easy going person.....	5	4	3	2	1
9. I am a nobody.....	1	2	3	4	5
10. I have a family that would always help me in any kind of trouble.....	5	4	3	2	1
11. I am a member of a happy family.....	5	4	3	2	1
12. My friends have no confidence in me.....	1	2	3	4	5
13. I am a friendly person.....	5	4	3	2	1
14. I am popular with men.....	5	4	3	2	1
15. I am not interested in what other people do.....	1	2	3	4	5
16. I do not always tell the truth.....	5	4	3	2	1
17. I get angry sometimes.....	5	4	3	2	1
18. I like to look nice and neat all the time.....	5	4	3	2	1
19. I am full of aches and pains.....	1	2	3	4	5
20. I am a sick person.....	1	2	3	4	5
21. I am a religious person.....	5	4	3	2	1

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

ANSWERS

22. I am a moral failure.....1 2 3 4 5

23. I am a morally weak person.....1 2 3 4 5

24. I have a lot of self-control.....5 4 3 2 1

25. I am a hateful person.....1 2 3 4 5

26. I am losing my mind.....1 2 3 4 5

27. I am an important person to my friends and family.5 4 3 2 1

28. I am not loved by my family.....1 2 3 4 5

29. I feel that my family doesn't trust me.....1 2 3 4 5

30. I am popular with women.....5 4 3 2 1

31. I am mad at the whole world.....1 2 3 4 5

32. I am hard to be friendly with.....1 2 3 4 5

33. Once in a while I think of things too bad to talk about.....5 4 3 2 1

34. Sometimes, when I am not feeling well, I am cross.5 4 3 2 1

35. I am neither too fat nor too thin.....5 4 3 2 1

36. I like my looks just the way they are.....5 4 3 2 1

37. I would like to change some parts of my body.....1 2 3 4 5

38. I am satisfied with my moral behavior.....5 4 3 2 1

39. I am satisfied with my relationship to God.....5 4 3 2 1

40. I ought to go to church more.....1 2 3 4 5

41. I am satisfied to be just what I am.....5 4 3 2 1

42. I am just as nice as I should be.....5 4 3 2 1

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

ANSWERS

43. I despise myself.....	1	2	3	4	5
44. I am satisfied with my family relationship.....	5	4	3	2	1
45. I understand my family as well as I should.....	5	4	3	2	1
46. I should trust my family more.....	1	2	3	4	5
47. I am as sociable as I want to be.....	5	4	3	2	1
48 I try to please others, but I don't overdo it.....	5	4	3	2	1
49. I am no good at all from a social standpoint.....	1	2	3	4	5
50. I do not like everyone I know.....	5	4	3	2	1
51. Once in a while, I laugh at a dirty joke.....	5	4	3	2	1
52. I am neither too tall nor too short.....	5	4	3	2	1
53. I don't feel as well as I should.....	1	2	3	4	5
54. I should have more sex appeal.....	1	2	3	4	5
55. I am as religious as I want to be.....	5	4	3	2	1
56. I wish I could be more trustworthy.....	1	2	3	4	5
57. I shouldn't tell so many lies.....	1	2	3	4	5
58. I am as smart as I want to be.....	5	4	3	2	1
59. I am not the person I would like to be.....	1	2	3	4	5
60. I wish I didn't give up as easily as I do.....	1	2	3	4	5
61. I treat my parents as well as I should (Use past tense if parents are not living.....	5	4	3	2	1
62. I am too sensitive to things my family say.....	1	2	3	4	5
63. I should love my family more.....	1	2	3	4	5

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

	ANSWERS				
64. I am satisfied with the way I treat other people..	5	4	3	2	1
65. I should be more polite to people.....	1	2	3	4	5
66. I ought to get along better with other people.....	1	2	3	4	5
67. I gossip a little at times.....	5	4	3	2	1
68. At times I feel like swearing.....	5	4	3	2	1
69. I take good care of myself physically.....	5	4	3	2	1
70. I try to be careful about my appearance.....	5	4	3	2	1
71. I often act like I am "all thumbs".....	1	2	3	4	5
72. I am true to my religion in my everyday life.....	5	4	3	2	1
73. I try to change when I know I'm doing things that are wrong.....	5	4	3	2	1
74. I sometimes do very bad things.....	1	2	3	4	5
75. I can always take care of myself in any situation.	5	4	3	2	1
76. I take the blame for things without getting mad...	5	4	3	2	1
77. I do things without thinking about them first.....	1	2	3	4	5
78. I try to play fair with my friends and family.....	5	4	3	2	1
79. I take a real interest in my family.....	5	4	3	2	1
80. I give in to my parents. (Use past tense if parents are not living).....	1	2	3	4	5
81. I try to understand the other fellow's point of view.....	5	4	3	2	1
82. I get along well with other people.....	5	4	3	2	1
83. I do not forgive others easily.....	1	2	3	4	5

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

ANSWERS

84. I would rather win than lose in a game.....5 4 3 2 1

85. I feel good most of the time.....5 4 3 2 1

86. I do poorly in sports and games.....1 2 3 4 5

87. I am a poor sleeper.....1 2 3 4 5

88. I do what is right most of the time.....5 4 3 2 1

89. I sometimes use unfair means to get ahead.....1 2 3 4 5

90. I have trouble doing the things that are right....1 2 3 4 5

91. I solve my problems quite easily.....5 4 3 2 1

92. I change my mind a lot.....1 2 3 4 5

93. I try to run away from my problems.....1 2 3 4 5

94. I do my share of work at home.....5 4 3 2 1

95. I quarrel with my family.....1 2 3 4 5

96. I do not act like my family thinks I should.....1 2 3 4 5

97. I see good points in all the people I meet.....5 4 3 2 1

98. I do not feel at ease with other people.....1 2 3 4 5

99. I find it hard to talk with strangers.....1 2 3 4 5

100. Once in a while I put off until tomorrow what I ought to do today.....5 4 3 2 1

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

APPENDIX C: SELF-ESTEEM ENHANCEMENT TAPESCRIPT

Hello, my name is Andrew Martin and today I'd like to talk to you about some of the ideas we have that cause us to feel badly about ourselves. All of us have believed some things that we learned somewhere in our past; we feel very sure of these things and yet they have no rational basis and are very damaging to our emotional well-being. If we can become aware of some of these irrational ideas, we can discard them as inappropriate and be well on our way toward a more fair evaluation of our abilities and personal strengths.

The first irrational idea I would like to tell you about is the belief that it is absolutely necessary for an adult human being to be loved or approved of by every other person in his life. While it might be nice to be loved or approved of by all the people you come into contact with, the demand that they do creates nothing but problems. Nobody is perfect. To demand that everyone approve of you is unreasonable. Even if you could manage to get everyone currently to approve of you, you would have to worry all the time if the next person you meet will love you and how much and whether the love will last. It is impossible for you to be all things for all people and an attempt to do this would take virtually every minute of your time. You will spend so much time being what others want you to be that you will not be able to take care of your own wants and needs. Self-respect comes not from approval of others, but from liking yourself.

Idea number two that causes trouble is the notion that you should be thoroughly competent, adequate, and achieving in all possible respects if you are to consider yourself worthwhile. Nobody can be perfectly competent and masterful in all respects; most people cannot be truly outstanding even in a single major respect. To try to be quite successful is sane enough--there are, of course, advantages that come from being successful. But to demand of yourself that you succeed all of the time usually results in undue stress high blood pressure, and forcing yourself beyond your physical and emotional limits. Competition with others is all right, but to expect to always be number one is asking for unhappiness--there is always someone who is still better than you are. Being overly concerned with achievement normally results in becoming tremendously afraid to take chances, afraid of making mistakes, or afraid of failing at certain tasks. All of this is self-defeating and leads to an incomplete, unenjoyable life.

The third irrational idea we have is that it is awful and a catastrophy when things are not the way we would very much like them to be. We may be frustrated when things are not as we would like, but that is no reason for the long,

deep depression and anger we see in millions of people today. There is no reason why things should be different from the way they are, no matter how unfair or unfortunate the current situation is. It would be nice if things were different-- but reality is often unfair and unexplainable and it is not sensible for us to cry when we don't get everything we want out of life. Getting upset rarely helps us change things for the better. If we try, and cannot change things, we must be resigned to our fate and accept things the way they are. Instead of moaning, "oh my god, how terrible this situation is, I positively can't stand it" you should change your habit of making a catastrophy of things and instead say to yourself, "It's too bad I can't have things the way I want, but it won't kill me, now what can I do to make the best of this situation or change it to make it better?"

Another problem idea is that one should be dependent on others all the time and that you need someone stronger than yourself upon whom to rely. We do need others for some things, but that is no reason to increase our dependency. Let's be socially cooperative, but not act like slaves to others. The more you rely on others, the more you must go along with what they want to do. You lose your individuality and independence. And because others are doing things for you, you don't have a chance to learn by doing yourself. The more dependent you are, the more dependent you become. And if you depend on others for safety, and thereby avoid making any mistakes on your own, you lose the only real security there is in the world-- knowing that if you make a mistake, the world does not collapse and you are not worthless--you are merely a normal, fallible human being.

The last irrational idea that I want to discuss is one that holds that your past history is an all-important factor in your present behavior, that because something once strongly affected your life, it should always have the same effect. If you allow yourself to be too much affected by your past, you are committing the logical error of over-generalization. Just because something was true in some situations at one time, it does not mean it will be true for all situations for all time. It may have been true, for example, that you were not able to stand up for your rights against your parents or other adults in the past and thus had to be meek and obedient in order to preserve the peace and get some of the things you wanted. But that does not mean that now, 5, 10, or 15 years later, it is necessary to do those things to get your way. It is an "easy" solution to continue the ways of the past-- they are automatic and take little thought on your part. But these ways must not be always so easy as they seem on the surface. Over the short run it is easier to hide behind the excuse "I can't change" or "You can't teach an old dog new tricks," instead of looking at yourself and working hard to

change what you don't like about yourself. But if you don't try, you'll never know what could have been changed to make a happier life for yourself.

As far as we can tell, there is no certainty, perfection, nor absolute truth in the world. We must stop thinking of ourselves as incompetent, inferior, even "bad" people because we do not live up to unreachable goals, instead we must face up to our shortcomings, examine our strenghts, and apply ourselves to changes that will provide us with a fuller and happier life. In short, we can see ourselves as being much better as a person than we used to think we were. We can hold up our heads and try.

Thank you for listening. I hope this talk has been meaningful to you and will provide you with some ideas to think about.

APPENDIX D

SEMANTIC DIFFERENTIAL

Wise __ : __ : __ : __ : __ : __ : __ Foolish

Fair __ : __ : __ : __ : __ : __ : __ Unfair

Active __ : __ : __ : __ : __ : __ : __ Passive

Aggressive __ : __ : __ : __ : __ : __ : __ Non-Aggressive*

Lethargic __ : __ : __ : __ : __ : __ : __ Energetic*

Peaceful __ : __ : __ : __ : __ : __ : __ Belligerent*

Cool __ : __ : __ : __ : __ : __ : __ Warm*

Dirty __ : __ : __ : __ : __ : __ : __ Clean

Safe __ : __ : __ : __ : __ : __ : __ Dangerous*

Calm __ : __ : __ : __ : __ : __ : __ Enraged

Tense __ : __ : __ : __ : __ : __ : __ Relaxed

Cruel __ : __ : __ : __ : __ : __ : __ Kind

*Items scored for aggressive style

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