Clinical interview as a behavioral antecedent of self concept

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The University of Montana

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THE CLINICAL INTERVIEW AS A BEHAVIORAL ANTECEDENT OF SELF CONCEPT

By

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1974

Approved by:

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Date

May 28, 1974
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# TABLE OF CONTENTS

**LIST OF TABLES** ................................................................. iv

**Chapter**

1. **INTRODUCTION** ............................................................. 1  
   CONCEPT OF SELF .............................................................. 1  
   CONCEPT OF SELF AS A SITUATIONALLY DEPENDENT TRAIT ................. 3  
   SELF PERCEPTION AND RESULTANT ATTRIBUTION OF ATTITUDES .......... 7  
   DEFINITION OF SELF CONCEPT ........................................ 9

2. **HYPOTHESES** .............................................................. 11

3. **METHOD** ................................................................. 15  
   SUBJECTS .............................................................................. 15  
   PRE-TESTING AND ASSIGNMENTS ......................................... 15  
   TREATMENT PROCEDURES .................................................. 16  
   FOLLOW-UP TESTING .......................................................... 18

4. **RESULTS** ................................................................. 19

5. **DISCUSSION** ............................................................... 23

6. **SUMMARY** ................................................................. 28

**BIBLIOGRAPHY** ............................................................. 31

**APPENDIXES** ............................................................... 35  
   A. SELF-RATING SCALE .................................................... 35  
   B. INSTRUCTION SHEETS .................................................. 40  
   C. CLINICAL INTERVIEW FORM ........................................... 44  
   D. DEBRIEFING HANDOUT .................................................. 49
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Summary of Factorial Analysis of Pre-Manipulation Variance</td>
<td>19</td>
</tr>
<tr>
<td>2.</td>
<td>Summary of Factorial Analysis of Self-Concept Scores</td>
<td>20</td>
</tr>
<tr>
<td>3.</td>
<td>Summary of Analysis of Repeated Measures</td>
<td>21</td>
</tr>
</tbody>
</table>
Chapter 1

INTRODUCTION

The vast body of literature dealing with the self concept ranges from diverse theoretical statements to research on child development, delinquency, aging, mental illness, interpersonal attraction, career choice, self-consistency, self-esteem and self-presentation to name but a few (Gordon and Gergen, 1968 and Wylie, 1968). Drawing these various sources together in a coherent manner is, in the studied opinion of experts, a near impossibility at this point in time. In light of this, the scope of the general review of the area presented in this paper will be limited to 1) a brief review of theoretical development, 2) a somewhat more detailed look at those areas of theory and research most closely related to the task at hand, and 3) the provision of a working definition of the concept to be used for the purposes of the present research.

CONCEPT OF SELF

Usages of the term "self" are widespread in the literature of psychology and can be roughly classified under two major categories: 1) those referring to the self as agent and
2) those referring to the self as the object of the person's own knowledge and evaluations. The latter is often referred to as the self concept.

The first formal theory of self was formulated around the turn of the century and was based mainly on the work of James and Mead. The theory was constructed on the following basic assumptions: 1) that all men are capable of conscious experience, 2) that all such experience is divisible into two major categories; self and not-self, 3) that a person's experiences of self are primarily reflections of the ways in which others experience him, 4) that over a period of time a unified gestalt or core of self-relevant experiences develops and influences subsequent behaviors on the part of the individual, 5) that the most important type of self experience is evaluative in nature, and 6) that in the gradual development of the concept of self the individual strives toward the end point of consistency.

There are several contemporary theories of personality that include self concept or self-esteem as a significant variable. The neo-Freudians--particularly Sullivan, Horney and Fromm--were highly attentive to the importance of the self concept but tended to treat it as a separate topic rather than one central to their own theories. Adler, on the other hand, assigned the concept of self a major role in his writings but was more concerned with its therapeutic than with its theoretical implications. The work of such ego psychologists as
Erickson and Jacobson was clearly, though again tangentially, related to self concept. Finally, self-psychologists, such as Rogers, along with phenomenologists in general are deeply concerned with both the general nature of subjective behavior and with the individual's acceptance of his experiences.

CONCEPT OF SELF AS A SITUATIONALLY DEPENDENT TRAIT

There are, according to social psychologist Kenneth Gergen, two basic theoretical approaches to the issue of personality in general and, more specifically, to the area of self concept. The first well-entrenched point of view deals with personality "traits" as inner, essential aspects of man--as relatively unchanging basic substances. The second, on the other hand, defines personality in terms of outward appearance--as an ever changing mask or, more correctly, series of masks adopted in any given situation out of social necessity.

The vast majority of the existing literature has stemmed from the first of these orientations. In correlating a given subject's self-descriptive "personality assessment" scores with other behaviors in which the subject engages, the underlying assumption has generally been that such scores represent relatively stable underlying traits or dispositions of the subject which will be predictably and consistently reflected behaviorally over a wide range of situations.

Personality, in other words, is viewed as that which gives
rise to behavior. In contrast to this historically accepted point of view, however, recent studies have indicated that such self ratings and descriptions (and, by implication, their underlying "traits") are highly susceptible to at least temporary modification.

A series of studies concerned with reported attitude changes as a function of role playing (Janis and King, 1954 and King and Janis, 1956) laid the groundwork for subsequent research (Jones, Gergen and Davis, 1962 and Jones, Gergen and Jones, 1963) which indicated that the way in which a person defines himself is, in many cases, greatly influenced by his motivation in a given situation. A more recent study by Gergen and Taylor (1969) demonstrated a predictable, quantitative effect on self-reported feelings of esteem as a function of perceived situational task demands.

Goffman (1959) has dealt at length within a theoretical framework with the "self-convincing" effects of situationally specific presentation of self especially where such presentation takes place in the presence of others, and experimental investigation by Gergen (1965) lends support to these hypotheses. This work demonstrated a marked increase in reported private self-image as a result of the requested presentation of a highly positive public self-image in the presence of a perceived authority figure.

The first of the aforementioned theoretical approaches, then, emphasizes the role of personality as a determinant of
social behavior while the second places its emphasis on the extent to which one's social behavior might reflexively influence his personality. In Gergen's opinion, the resolution to this seeming paradox might best be approached on the basis of differential intensity or strength of attitudinal dispositions. To this end he cited the argument offered by Campbell (1963) in which he conjectured that, using an example directly related to concept of self, a person whose feelings of self-esteem were strong or intense would tend to vacillate with respect to those feelings very little from one situation to another while a person in whom feelings of self-esteem were fragile at best might well be expected to display a good deal less consistency in the face of situational variation.

Gergen further posited that, in addition to the "strength of disposition" factor, we might also give serious consideration to the possibility of a multifaceted conceptualization of the nature of personality. Again with specific reference to the self concept. Gergen would say that although a person might generally feel high regard for self, there would most certainly exist for him situations in which he would feel much less positive about himself.

William James once described the person with a divided sense of self as a "sick soul" who was to be pitied and, if possible, redeemed. This point of view was based on the aforementioned assumption, pervasive in our cultural
heritage, that a unified sense of self is good and that inconsistency is bad. However, James also noted, with respect to a man's public identity, that "a man has as many different social selves as there are distinct groups of persons about whose opinion he cares."

In much the same vein, turn of the century sociologist Charles Horton Cooley (1902) emphasized the importance of social or interactive determinants in the formation of "self-feeling." It was his contention that one's ideas of self are largely constructed on the basis of social experience via "imagining how ourselves...appear in the minds of persons we look up to."

Cooley referred to this socially oriented concept of self as the "looking-glass" self--one that reflected the imagined appraisals of others. Any "sensitive man," he wrote, "in the presence of an impressive personality, tends to become, for the time, his interpretation of what the other thinks he is."

In Gergen's opinion, this parade of public selves in fact constitutes the private self. "Once donned," he wrote "the mask becomes reality." From this theoretical standpoint the mask which one wears; the role which one plays out within a given situational setting, effectively defines the self, both public and private, within the context of that setting.
SELF PERCEPTION AND RESULTANT ATTRIBUTION OF ATTITUDES

The relationship between attitudes or beliefs and behavior has historically been an important area of social-psychological research. Pervasive in most theoretical considerations of this relationship has been an implicit assumption of causality whereby one's behavior is not only assumed to be consistent with those beliefs and attitudes to which one adheres but is further felt to be a direct consequence of the same.

In the opinion of psychologist Daryl Bem (1967), however, the actual direction of causality may be reversed. He feels that those statements typically thought of as comprising the "traits," "beliefs" and "attitudes" which are felt to give rise to observed behaviors may, in fact, be under the partial control of those behaviors. Approached from this point of view, then, attitudes and beliefs are conceived of as functions of behavioral phenomena.

Self-perception, a product of social interaction, has been defined as an individual's ability to respond differentially to his own behavior. Self-descriptive verbalizations, including the above mentioned statements of attitude and belief, are a common behavioral example of this self-perceptive process.
Due to the unique nature of the self-descriptive learning process (via which one is taught to label private stimuli on the basis of observed public responses or events) self-descriptive statements may continue to fall under the control of those events which the training community made use of in inferring private stimuli. If, for example, an individual is taught to describe his feelings, attitudes, and beliefs on the basis of others' observations of his reactions to external stimuli, then he might later continue to base many, if not all, self-descriptive attitudinal statements on 1) self observation of overt behavior and 2) the external stimulus conditions in effect at any given point in time.

Several studies have demonstrated that an individual's belief and attitude statements can, in fact, be manipulated by inducing him to play a role, deliver a persuasive communication, or otherwise engage in behavior implying personal endorsement of a particular attitudinal standpoint (Brehm & Cohen, 1962; King and Janis, 1956). More recent investigation into the nature of these "self-persuasive" phenomena suggest that an individual tends to base subsequent attitudes and beliefs on self-observed behaviors to the extent that these are emitted under circumstances that have, in the past, set the occasion for telling the truth (Bem, 1956; 1966).
DEFINITION OF SELF CONCEPT

The working definition of self concept to be used for the purposes of this study is derived from the definition of "self-esteem" proposed by Stanley Coopersmith (1967) in The Antecedents of Self-Esteem. Coopersmith defined self-esteem in general, as "feelings of personal worth" and, for the more demanding purposes of behavioral research, as "evaluative attitudes towards the self."

According to Coopersmith, "The object of observation and appraisal, which we shall call the person, differs from the self, which consists of the abstractions formed about that object. The bases for the abstractions are the individual's observations of his own behavior and the way other individuals respond to his attitudes, appearance, and performance."

This conceptualization of self-esteem (or of self concept, the two terms to be used interchangeably from this point forward) appears to have a threefold advantage for the purposes of the present study:

1) by placing the study of self concept within the general province of attitude studies, this approach enables the writer to draw upon the existing literature of attitude formation, changes, and consequences in both the formulation of hypotheses and interpretation of results;

2) Coopersmith's emphasis on the concept of self as an abstraction based on "the individual's observations of his
own behavior" is theoretically in keeping with the Bemian notion of self-perception presented in the foregoing section;

3) this formulation keeps the definitional approach consistent with the dependent variable to be employed in that the "self-esteem scales" which will constitute that measure in the current study were, in fact, directly derived from those developed by Coopersmith in his investigations into the antecedents of self-esteem in adolescents.
Chapter 2

HYPOTHESES

Gergen (1965) noted, in an article reporting the results of experimental manipulation of reported self concept as a function of "presentation of self," that "...it would be interesting to know whether such changes (in reported self concept) are likely to occur when the role being played is self-deprecating rather than self-enhancing." It would seem that, perhaps in part out of necessity, the clinical "intake" interview utilized in many large mental hygiene centers and psychiatric out-patient clinics for purposes of screening and referral might well constitute such a potentially "self-deprecating" situation. As such the intake interview might, in and of itself, be expected to result in a decrement in self concept.

Several recent areas of research seem to have some bearing on this notion. Rosenthal (1966), in his discussion of experimenter bias, pointed out that the expectations or perceived expectations of others can be highly influential in shaping social conduct and this has been found to be particularly true where the "others" represent figures of authority within the interpersonal context. In keeping with this now
widely accepted concept, Gergen and Wishnow (1965) found that the perceived \textit{personality} of others had a significant effect on the manner in which a person presented himself in their presence. More to the immediate point, Miller, Doob, Butler and Marlowe (1965), demonstrated that students would markedly alter self-evaluations in order to conform to the perceived expectations of professional psychologists and Morse and Gergen (1970) found evidence that to the extent that one perceives another as a high status individual relative to oneself, one's concept of self tends to drop within that situational setting.

Moreover, there is some evidence to indicate that the abovementioned phenomena might tend to operate in an even more powerful manner if the population under consideration included a high proportion of individuals whose level of self-esteem was initially subnormal. Many studies, ranging over a period of years (Crandall and Bellugi, 1954; Block and Thomas, 1955; Hillson and Worcell, 1957; Leary, 1957; Pishkin and Thorne, 1968; Fox, Markhus, Stillman, Harrow and Hallowell, 1969; Miskimins, Wilson, Braucht and Berry, 1971), have shown low self concept to be associated with various forms of maladjustment and neuroticism. In addition, in at least two studies involving counter-attitudinal role-playing (Crawford and Gergen, 1966; Gergen and Gordon, in press), low self-regarding persons were most influenced by this temporary adoption of
role as evidenced by post treatment changes in reported attitudes.

One might well posit on the basis of 1) the pervasiveness of low self concept among client populations (i.e. the "maladjusted and neurotic"), 2) the apparent high degree of maleability among individuals with a low concept of self and 3) the strong self-persuasive effects of perceived expectations and/or authorativeness of others on such easily swayed individuals, that potential clients' attitudes about self might well suffer from the largely negative presentation of self within a clinical interview setting.

This notion, moreover, lends itself to a theoretical formulation of self-perception and resultant self-attribute a la Bem. The Bemian theory states, in effect, that "I behave as if I believe in certain things, therefore I must in fact be a person who does believe in these things." Restated in terms of the current line of reasoning, this statement might take the following form: "I have indicated by my verbal behavior during a clinical interview, and in the presence of an authority in the field of mental illness, that I have a low opinion of myself--therefore I must, in fact, hold such an opinion."

The implications of the establishment of such a behaviorally based and situationally reinforced negative concept of self within the therapeutic setting seem obvious in their potential for undercutting therapeutic progress. It was
the intention of the present study, then, to attempt to demonstrate a decremental effect on reported level of self concept as a function of participation in a clinical intake interview. The following hypotheses are made toward that end:

1) All experimental subjects participating in a clinical intake interview role-play situation will show a subsequent decrement in reported self concept as a function of the same.

2) Subjects given a "mentally ill" instructional set will show a greater decrement than will those given no such set.

3) Subjects in a "no interview" control group will show no such decrement on the basis of a test/retest comparison with no intervening interview.
Chapter 3

METHOD

SUBJECTS

The 60 subjects used in the study were undergraduate college students selected on a random basis from a lower level course in developmental psychology; 33 subjects were female and 27 male. All subjects received course credit for research participation.

PRE-TESTING AND ASSIGNMENTS

Early in the course a group testing session (hereafter to be referred to as the "pre-test") was conducted in the classroom by the regular instructor. None of the subsequent experimenters was present at this time. All students present on the day of administration completed a 58 item self concept scale based on Coopersmith's (1959) "self-esteem inventory."

The Coopersmith inventory has commonly been used to assess what is assumed to be one's basic level of self-esteem or self-concept (refer back to Definition of Self Concept, p. 10). The scale used in the present study was a modification of the Coopersmith scale and was designed by Morse and Gergen (1970) specifically to be used with college age populations.
The 58 items comprising the scale cover a wide variety of characteristics. Items appear in the form of self-descriptive sentences, such as, "I can make up my mind without too much trouble," "I get upset easily," "I'm proud of my work at college so far," etc. The respondent indicates relative agreement vs. disagreement with each statement on a six-point Likert scale ranging from "almost always true" to "almost never true" (see Appendix A).

Upon completion of pre-testing, 60 students were selected on a random basis from the total course enrollment and, again on a random basis, each of these was assigned to either 1) a Sick Set treatment group, 2) a No Set treatment group, or 3) a Control group. The number of subjects assigned to each of the three experimental groups was 20.

TREATMENT PROCEDURES

All subjects selected for participation in the study were contacted by telephone and asked to take part in a "pilot study" connected with the development of a new program for the "training of advanced graduate students" in the area of clinical psychology. For those subjects assigned to one of the two treatment groups, participation consisted of 1) an individual "clinical intake interview," 2) an individual "testing" session, and 3) a subsequent group testing session. Control group subjects participated in both individual and group testing sessions but were not interviewed.
All interviewing and testing took place at the Clinical Psychology Center of the University of Montana. As subjects came into the Center at a previously scheduled hour each was supplied with one of three Instruction Sheets (see Appendix B). The content of the same varied as a function of experimental group assignment.

**No Set Treatment Group:** Subjects assigned to the No Set treatment group were given an instruction sheet asking them to take part in a "typical clinical intake interview" for the purpose of training future clinicians in the art of effective interviewing techniques. They were given no specific instructional "set" with respect to the manner in which they would be expected to present themselves during the interview. Upon completion of the "intake interview," all subjects were given a series of individual "clinical" tests administered by an experimenter other than the interviewer. Included in these was the revised Coopersmith scale previously administered during pre-testing.

**Sick Set Treatment Group:** Subjects assigned to the Sick Set treatment group were specifically instructed to "role-play the part of an individual badly in need of immediate therapeutic treatment" during the course of the interview. With the exception of the introduction of this additional instructional "set," experimental conditions were the same throughout as were those described for the No Set treatment group.
Control Group: Subjects assigned to the Control group were instructed to remain in the waiting room until called and were informed that "due to fluctuations in the time required to administer individual tests" they might experience a 15 to 20 minute wait. After waiting for approximately 20 minutes these subjects were given the same series of individual "clinical" tests administered to both treatment groups.

FOLLOW-UP TESTING

One week after completion of the treatment procedures outlined above, a naive experimenter once more administered the 58 item revised Coopersmith scale to all 60 research subjects. This "follow-up" testing was accomplished in a group situation.

Upon completion of follow-up testing each subject was given a card crediting him or her with hours of research participation time earned and was personally thanked for his or her cooperation. This was accomplished on a one-to-one basis.

At this time each subject received a "debriefing handout" (see Appendix D) explaining the procedures and rationale underlying all experimental manipulations. Subjects were requested to read through the handout in the presence of the experimenter and to put to her outstanding questions, if any, regarding the same.
Chapter 4

RESULTS

The mean self concept score of subjects randomly assigned to the No Set treatment group was 254.87, the mean score of subjects assigned to the Sick Set treatment group 245.93, and the mean score of subjects assigned to the control group 257.40. A 1 x 3 analysis of variance (ANOVA) was performed on these pre-manipulation scores by group in order to insure that there were no significant differences between the groups prior to the experimental manipulation. A summary of the analysis is provided in Table 1.

TABLE 1
SUMMARY OF FACTORIAL ANALYSIS OF PRE-MANIPULATION VARIANCE

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Subjects</td>
<td>1089</td>
<td>2</td>
<td>545</td>
<td>0.82</td>
</tr>
<tr>
<td>Within Subjects</td>
<td>27986</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29075</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The demonstrated lack of significant differences in pre-manipulation scores ($F = 0.82, df = 2/42, n.s.$) confirms initial subject homogeneity.
Fifteen subjects were assigned to each of the three experimental conditions (No Set treatment, Sick Set treatment and Control). This figure represents a decrease in originally anticipated number of subjects per treatment group due to scheduling problems on the part of potential subjects. An additional 15 subjects who were not able to schedule the time required for interviewing and testing in the Clinic did agree to come in for a group follow-up test session and these constituted an additional control group composed of subjects who did not experience either the 15 to 20 minute "waiting period" or the intervening post-manipulation self concept measure.

A 3 x 3 ANOVA was performed on the raw self concept scores of the three original experimental conditions and a summary of this analysis is provided in Table 2.

**TABLE 2**

**SUMMARY OF FACTORIAL ANALYSIS OF SELF CONCEPT SCORES**

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Subjects</td>
<td>67336</td>
<td>44</td>
<td>1855.00</td>
<td>1.22</td>
</tr>
<tr>
<td>Experimental Conditions</td>
<td>3710</td>
<td>2</td>
<td>1855.00</td>
<td>1.22</td>
</tr>
<tr>
<td>Error</td>
<td>63626</td>
<td>42</td>
<td>1514.90</td>
<td>1.22</td>
</tr>
<tr>
<td>Within Subjects</td>
<td>9859</td>
<td>90</td>
<td>721.00</td>
<td>7.73</td>
</tr>
<tr>
<td>Repeated Measures</td>
<td>1442</td>
<td>2</td>
<td>721.00</td>
<td>7.73</td>
</tr>
<tr>
<td>Error</td>
<td>7838</td>
<td>84</td>
<td>93.31</td>
<td>7.73</td>
</tr>
<tr>
<td>Interaction</td>
<td>579</td>
<td>4</td>
<td>144.75</td>
<td>1.55</td>
</tr>
<tr>
<td>Total</td>
<td>77195</td>
<td>134</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The overall interaction analysis was not significant \((F = 1.55, df = 4/84, \text{n.s.})\) lending no support for the hypothesis that those subjects participating in a clinical intake interview "role-play" situation will display a subsequent decrement in self concept scores as a function of the same. The repeated measures variable did yield a significant \(F\) ratio \((F = 7.73, df = 2/84, p .001)\). In an attempt to gain more specific information as to the source of this variance a series of \(F\) tests for simple effects (Bruning and Klinkk, 1968, pp. 117-123) were run. The results are summarized in Table 3.

**TABLE 3**

**SUMMARY OF ANALYSIS OF REPEATED MEASURES**

<table>
<thead>
<tr>
<th>Experimental Group</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>(F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Set</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>0.05</td>
</tr>
<tr>
<td>Sick Set</td>
<td>929</td>
<td>2</td>
<td>464.50</td>
<td>4.99</td>
</tr>
<tr>
<td>Control</td>
<td>1080</td>
<td>2</td>
<td>540</td>
<td>5.79</td>
</tr>
</tbody>
</table>

The general tendency of self concept scores to increase across repeated measures regardless of experimental condition was found to be significant for both the Sick Set \((F = 4.99, \text{df} = 2/84, p .01)\) and Control \((F = 5.79, \text{df} = 2/84, p .005)\) groups. Significance was, however, not demonstrated with respect to the No Set group \((F = .05, \text{df} = 2/84, \text{n.s.})\). On the basis of these results pre-test and follow-up data from
the previously described additional control group was submitted to an analysis of variance. Results of this analysis indicated, in accordance with the generally noted trend, a significant increase in scores upon retesting ($F = 5.30$, $df = 1/14$, $p < .05$) with no intervening experimental manipulation and with no intervening exposure to the Clinic setting. The demonstrated instability of test scores in both control groups contradicts the experimental hypothesis that control subjects would display no significant test/retest differences in reported self concept scores.
Chapter 5

DISCUSSION

The hypothesized decrement in reported self concept subsequent to role-play participation in a clinical interview situation was not supported by experimental results. A secondary hypothesis of test/retest stability of self concept ratings in control group subjects was also contradicted by the results.

In treatment groups, post-manipulation self concept scores increased as compared to pre-manipulation scores. In control groups, retest performance indicated a similar increase in reported self concept in comparison with previously established "baseline" measures. This incremental tendency demonstrated across repeated measures regardless of experimental condition was, moreover, statistically significant in all groups with the exception of the No Set treatment group.

Failure to obtain hypothesized results might well have been due to a basic error in the theory upon which the research was based and/or to shortcomings in research methodology. For the purposes of investigative speculation, however, the relative lack of increase in reported self concept demonstrated by No Set treatment subjects might be viewed as the equivalent of a post-manipulative decrease hypothesized under these experimental conditions. In other words, the apparently typical stability of pre vs. post-manipulation self concept ratings in
these subjects might be interpreted as the result of the predicted decrease confounded by the overall incremental trend.

If one tentatively accepts this interpretation of the results then the performance of this group can be viewed as lending at least partial support to the experimental hypothesis. Any entertainment of this interpretation, however, immediately poses a question as to why No Set treatment subjects demonstrated the hypothesized post-manipulation decrement in self concept while Sick Set subjects did not.

In an attempt to confront this question, two potentially relevant characteristics of the study at hand must be taken into account. First, the study deals with the effect on reported self concept of a situation involving the negative presentation of self whereas all studies cited previously were based on the effects of positive or of "neutral" self presentation.

It is possible that the largely self-deprecatory nature of the Sick Set clinical interview situation represented a perceived threat to participating subjects, one which they tended to counteract via subsequent compensatory statements. An individual who has recently been required to represent (and perhaps to temporarily perceive) himself as being "badly in need of immediate therapeutic intervention" might, if threatened by this situation, attempt to compensate for his response by subsequently representing himself as an extremely content, well-adjusted and self confident individual.
Secondly, the experimental design utilized requires all subjects to play a relatively difficult and demanding role for which most may have been completely unprepared in terms of experiential background and hence in terms of the ability to empathize with and/or understand the feelings of the acutely mentally disturbed individual. One would expect, moreover, that this would likely be the case under conditions of the highly structured role demands placed upon Sick Set subjects vs. the broader and less restrictive role definition provided the No Set group.

No Set subjects may well have been much less threatened by and accordingly more relaxed and at ease with their role requirements. The less structured nature of the No Set role-play instructions would, furthermore, seem to provide both 1) more leeway for the subject to interpret the role in a manner comfortable and acceptable to himself and 2) greater opportunity to base the chosen role on actual life experiences with a resultant increase in empathic involvement.

In the case of Sick Set subjects it would seem relatively easy and perhaps even unavoidable to divorce themselves emotionally from an imposed, repugnant, and/or totally foreign role. No Set subjects, conversely, might be expected to be "drawn in" to a role which they were much more instrumental in developing and with which they might more easily identify.

Much of the above speculation can be conceptually formulated in terms of J. W. Brehm's theory of psychological
reactance (1966). Briefly, this theory is based on the pre-
mise that

at any given point in time there exists a set of behaviors
in which an individual believes he is free to engage and
that any reduction or threatened reduction with respect to
that set of free behaviors arouses a motivational state of
'reactance' directed toward re-establishment of lost or

In other words, to the extent that you feel that your per-
ceived freedom of choice has been restricted, you will tend to
act in any way that will reinstate that freedom.

If an individual's behavioral repertoire in a given
sphere encompasses only behaviors X and Y, and if he is forced
to engage in X to the exclusion of Y, his consequent reaction
will be to avoid X and to act solely in accordance with Y in
an attempt to regain perceived freedom of choice. In terms
of this psychological reactance phenomenon, to the extent that
one presented a subject with a restrictive and highly struc-
tured role-play situation allowing for only extremely "sick"
behavior, one might expect a subsequent "reversal" effect
aimed at the re-establishment of threatened freedom via the
disavowal of any tendency toward mental "illness" or
instability.

On the other hand, if a subject is presented with a
relatively "loose" and non-structured role-play situation
allowing for a variety of behavioral interpretations, one
would not expect perceived freedom of choice to be threatened
and would not, therefore, expect the subsequent occurrence of
similar compensatory behaviors.
In light of the foregoing speculations, any further experimental investigation along these lines might benefit by the incorporation of several modifications in design. Ideally, subsequent research would be conducted within an authentic clinical setting with baseline measures established upon initial contact with prospective clients and retest measures obtained immediately following completion of existing intake or screening procedures. This would provide information derived directly from the locus of experimental inquiry and would, of course, eliminate all problems inherent in any role-play approach.

Short of this, the best approach would probably involve the development and utilization of a non-structured instructional set encouraging innovation on the part of subjects. Attention should be given to emphasizing the importance of the choice of a role with which one feels comfortable, which draws on past experience and with which one is able to identify emotionally. In either case--clinical setting or modified role-play--the instrument of measurement used should possess demonstrated test/retest stability over time with college age populations.
Chapter 6

SUMMARY

It has been suggested in previous studies that one's reported concept of self is a widely fluctuating variable, largely dependent on the specific situation within which an individual attempts to define self-oriented feelings. It was hypothesized in the present study that participation in a clinical "intake" interview situation with its characteristic emphasis on "unhealthy" symptomology would have a subsequent negative influence on feelings regarding self. Thus it was predicted that 1) all experimental subjects participating in a clinical interview role-play situation would show a subsequent decrement in reported self concept as a function of the same, and that 2) subjects in a "no interview" control group would show no such decrement.

The hypothesized decrement was not confirmed nor was the secondary hypothesis of control group test/retest stability. All treatment and control groups, with the sole exception of a single treatment group who entered the interview situation with a relatively non-structured instructional set, demonstrated an incremental trend across repeated measures regardless of the presence or absence of intervening experimental manipulation.
Results obtained were discussed in the light of a possible "reversal" effect in keeping with Brehmian psychological reactance theory and indicated modifications in experimental design were outlined.


Gergen, K. J. and Taylor, M. G. "Role Playing and Modifying the Self Concept. Sociometry, in press.


NAME ____________________________________ TELEPHONE ________________

Below is a series of statements about yourself and about your relations with other people. Each is followed by six lines. Indicate how true each statement is of your feelings or behavior or the behavior of these other people (parents, teachers, etc.) by checking the appropriate line.

100% - True almost all of the time  80% - True about 80% of the time  60% - True about 60% of the time  40% - True about 40% of the time  20% - True about 20% of the time  0% - True almost none of the time

1. I spend a lot of time day-dreaming.
2. I often wish I were someone else.
3. My parents and I have a lot of fun together when I'm home from college.
4. There are lots of things about myself I'd change if I could.
5. I find it very hard to talk in front of a class.
6. I'm a lot of fun to be with.
7. Someone always has to tell me what to do.
8. I'm often sorry for the things I do.
9. My parents usually consider my feelings.
10. I'm doing the best work that I can in college.
11. I can usually take care of myself.
12. I would rather hang out with students who are younger than myself.
13. I like everyone I know.
NAME____________________________________

100%-TRUE ALMOST ALL OF THE TIME
80%-TRUE ABOUT 80% OF THE TIME
60%-TRUE ABOUT 60% OF THE TIME
40%-TRUE ABOUT 40% OF THE TIME
20%-TRUE ABOUT 20% OF THE TIME
0%-TRUE ALMOST NONE OF THE TIME

15. Things are all mixed up in my life.                           100%  80%  60%  40%  20%  0%

16. No one pays much attention to me at home.                   

17. I do as well at college as I'd like to.                     

18. I don't really like me.                                     

19. I don't like to be with other people.                       

20. I'm usually shy.                                           

21. I often feel ashamed of myself.                             

22. If I have something to say, I usually say it.               

23. My parents understand me.                                  

24. My professors make me feel I'm not good enough.             

25. I'm a failure.                                              

26. Most people are better liked than I.                        

27. I always know what to say to people.                        

28. Things usually don't bother me.                            

29. I always do the right thing.                                

30. I'm usually pretty sure of myself.                          

31. I'm easy to like.                                           

32. I never worry about anything.                              

______________________________________________________________
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<thead>
<tr>
<th>Statement</th>
<th>100%</th>
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<tr>
<td>33. I sometimes wish I were younger.</td>
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<td>34. I can make up my mind without too much trouble.</td>
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<td>35. I get upset easily.</td>
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<td>36. I'm proud of my work at college so far.</td>
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<td>37. It takes me a long time to get used to anything new.</td>
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<td>38. I'm popular with other students.</td>
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<td>39. I'm never unhAPPy.</td>
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<td>40. I give in very easily.</td>
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<td>41. I'm pretty happy.</td>
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<td>42. I think my parents expect too much of me.</td>
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<td>43. I like to be called on in class.</td>
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<td>44. It's pretty tough to be me.</td>
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<td>45. My classmates usually follow my ideas.</td>
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<td>46. I can make up my mind and stick to it.</td>
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<td>47. I'd like it if I could find someone who would tell me how to solve my personal problems.</td>
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<td>48. I have a low opinion of myself.</td>
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<td>49. Before I came to college there were many times when I felt like leaving home.</td>
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<td>Statement</td>
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<td>50. I get upset in some of my classes.</td>
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<td>51. I'm not as nice looking as most people.</td>
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<td>52. Other students pick on me very often.</td>
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<td>53. I always tell the truth.</td>
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<td>54. I don't care what happens to me.</td>
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<td>55. I get upset easily when I'm yelled at or reprimanded.</td>
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<td>56. I usually feel as though my parents are pushing me.</td>
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<td>57. I often get discouraged in school.</td>
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<td>58. I can't be depended on.</td>
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</table>
Instruction Sheet

Please be seated. In a few minutes an interviewer will contact you. He or she will be a graduate student in clinical psychology nearing the end of the professional training program offered here at the University. When you go into the office with the interviewer, we would like you to play the role of an individual who has voluntarily come into the clinic for the first time. Try to "put yourself into" the feelings dictated by the role.

The interviewer will conduct a typical clinical "intake" interview during the course of which he or she will ask a number of questions concerning your "personal" background, feelings, etc. Answer the questions within the context of the role.

Thank-you for your cooperation.
Instruction Sheet

Please be seated. In a few minutes an interviewer will contact you. He or she will be a graduate student in clinical psychology nearing the end of the professional training program offered here at the University. When you go into the office with the interviewer, we would like you to play the role of an individual who has voluntarily come into the clinic for the first time and who is badly in need of immediate therapeutic treatment. Try to "put yourself into" the feelings dictated by the role.

The interviewer will conduct a typical clinical "intake" interview during the course of which he or she will ask a number of questions concerning your "personal" background, feelings, etc. Answer the questions within the context of the role.

Thank you for your cooperation.
Instruction Sheet

Please be seated. You will be contacted shortly by an advanced student in psychology who is being trained in the administration of individual test batteries. He or she will give you a series of clinical "assessment" tests. Due to fluctuations in the time required to administer such tests, you may experience a 15 to 20 minute wait.

Thank you for your cooperation.
Clinical Interview Form

Presenting Complaints

Can you tell me briefly what problem(s) have brought you here to the clinic today?

____________________________________________________

When did the problem(s) first occur?

____________________________________________________

Was there any specific event preceding or triggering the problem(s)?

____________________________________________________

Which of the problems do you feel would be the most helpful for you to deal with here at the clinic? Why?

____________________________________________________

Have you considered or received other sources of help before coming to the clinic? At what time? From whom?

____________________________________________________

Family History

Full name and age?

____________________________________________________

Mother living? Good Health? Age? Occupation?

____________________________________________________

Father living? Good health? Age? Occupation?

____________________________________________________

Have you brothers and/or sisters? Ages?

____________________________________________________

How well would you say that you get along with your family?

____________________________________________________

Medical History

What medical diseases have you had?

____________________________________________________
Have you ever undergone surgery? For what purpose?

Have you ever had any accidents of any consequence?

When did you first begin to menstruate? Do you experience pain with menstruation? How severe? Are your periods generally regular or irregular?

**Psychosexual History**

Are you now or have you ever been married? Engaged?

Are you currently "going" with or living with anyone?

**Social History**

What year are you in school? How are you doing? What is your goal in school?

What is your major ambition in life as you see it at this point?

What is your current military status?

Do you have a criminal record?

Do you use drugs? Alcohol? If so, would you categorize yourself as an "occasional," "moderate" or "heavy" user?

What is your current economic situation?
Memory and Fund of Information

I would like you to commit the following street address to memory; I will ask you to recall it for me later. "615 Evans Avenue"

Please repeat the following number series after me; first forward, then backward. "2 5 4 6 1"

What is sand used for?

If the flag blows to the South, where is the wind coming from?

At what time of day is your shadow shortest?

Why does the moon look larger than the stars?

If your shadow points to the northeast, which way is the sun?

What is the street address I asked you to remember a few minutes ago?

Assessment of Current Mood

Can you tell me how you feel about yourself right now?

Which of the following describes your mood most of the time during the last few days?

___ sad ___ nervous
___ afraid ___ angry
___ depressed ___ dissatisfied
___ blue ___ unhappy
___ worried ___ hopeless

Have you experienced any of the following lately?

Loss of appetite? ______
Loss of weight? ______
Difficulty in sleeping? ______
Loss of energy? ______
Decreased interest in activities? _____
Inability to concentrate? _____
Recurrent thoughts of death or suicide? _____
Uncontrollable outbursts of crying? _____
Have you ever attempted suicide? If so, when, how?

If you had to sum up the "story of your life" for me in three or four sentences; what would they be?

Interviewer's Impression of S's Presentation of Self
"healthy" ___ ___ ___ ___ ___ "ill"
APPENDIX D
Debriefing Handout

The series of "clinical training" interviews and tests in which you have recently taken part was, in fact, designed to test a hypothesis concerning the effect of clinical "intake" interviews on the self concept of incoming clients. You were assigned to one of two experimental groups: 1) one in which you role-played an individual coming into the clinic for an initial interview after which you were administered a series of clinical tests or 2) one in which you role-played an individual coming into the clinic for an initial interview and "badly in need of immediate therapeutic treatment" after which you were administered a series of clinical tests or you were assigned to one of two control groups: 1) one in which you spent approximately 20 minutes in the waiting room of the Clinical Psychology Center after which you were administered a series of clinical tests or 2) one in which no intervening interviewing or testing took place.

The crucial data collected during the administration of the individual tests will be derived from the self concept scale administered at that time and identical to the one which you had previously completed in class. Your score on this earlier classroom test will be compared to that obtained in the clinical setting.

The major hypothesis of the study is that participation in a clinical "intake" interview will lower subsequent self
concept ratings. If you have any additional questions concerning experimental manipulations or rationale, feel free to discuss them with me now or to make an appointment to do so at a later date.

Please do not discuss the information contained in this handout with anyone participating in the study who has not as yet taken the final test or been provided with a copy of the debriefing handout. Thank you, again, for your cooperation.