The Effects of Feedback Self-Consistency, Therapist Status, and Attitudes Toward Therapy on Reactions to Personality Feedback

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Abstract

Reactions to interpersonal feedback may depend upon characteristics of the feedback and the feedback source. The effects of experimentally manipulated personality feedback, emailed to participants ostensibly by a therapist, on degree of acceptance of the feedback were examined. Consistent with Self-Verification Theory (Swann, 1987), self-consistent feedback was more readily accepted than self-inconsistent feedback. Furthermore, main effects were found for therapist status and attitudes toward therapy. Significant interactions showed that high status therapists and positive client attitudes increased acceptance of self-inconsistent feedback, effects that were only partially mediated by perceptions of therapist competence. Results suggest that participants may be susceptible to change or to self-fulfilling prophecy effects.

KEYWORDS: Identity, Self-, Self-Concept

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Social psychologists and people in general seem to have an inherent curiosity about the nature of the self. The self-concept has been assessed in a variety of ways, with its cognitive, affective, motivational and behavioral properties now well documented (see Brown, 1998). Research on the self in an interpersonal context has demonstrated that people often prefer to have others see them as they see themselves; that is, people seek verification of their identities in the responses of other people (e.g., Swann, 1987). There may be both epistemic reasons (i.e., to maintain a sense of coherence) and pragmatic reasons (i.e., to allow for smoother interactions with others) for attempting to maintain consistency between self-views and others' views (Swann, Rentfrow, & Guinn, 2003). In order to maintain such consistency, people are theorized to seek feedback from others that is self-consistent (e.g., Swann, 1987). People are also more likely to notice consistent feedback over inconsistent feedback and to interpret ambiguous feedback in line with their own self-conceptions (Swann, 1983; Swann & Read, 1981).

Sometimes, however, people find themselves in the position of receiving self-inconsistent feedback; according to self-verification theory, people are likely to reject such feedback (e.g., Swann & Ely, 1984; Swann & Hill, 1982). Nevertheless, there are some situations in which self-change is promoted and self-inconsistent feedback is meant to be taken seriously and scrutinized. In particular, the therapeutic clinic is a context for such change, often set in motion by the delivery of self-inconsistent feedback (e.g., Young, Klosko, & Weishaar, 2003). However, self-verification theory suggests—and has demonstrated (e.g., Giesler, Josephs, & Swann, 1996)—that those in need of therapeutic change (i.e., depressed people) may show a preference for negative feedback over positive feedback. The clinical implications of such a finding are clear:

clients with negative self-conceptions may be resistant to therapists' attempts to generate positive therapeutic change. As such, Swann (1997) has suggested a number of strategies that therapists might use to counter their clients' self-verification strivings. However, to our minds, the context of therapy itself would seem to invite people to be open to reassessing their self-views (unless of course they are ordered to participate in therapy). Indeed, in this setting, there may be a greater willingness to accept self-inconsistent feedback, although other factors, like therapists' status and clients' attitudes toward therapy, may moderate this acceptance.

The significant impact of source cues (such as status, competence, credibility, power, attractiveness, etc.) on message acceptance is well documented in the social influence literature (e.g., Berger, Fisek, Norman, & Zelditch, 1977; Cialdini, Petty, & Cacioppo, 1981; Eagly & Chaiken, 1993; Hovland & Weiss, 1952). However, these factors have generally not been experimentally manipulated with regard to evaluation of self-relevant feedback. One exception is found in the research literature on behavioral confirmation of interpersonal expectations (see Snyder & Stukas, 1999). Here, people have been demonstrated to confirm the randomly assigned (and therefore often erroneous) expectations of their interaction partners, particularly when these partners have greater power (e.g., Copeland, 1994; Snyder & Kiviniemi, 2001). People may be motivated to yield to the expectations others hold for them when they are in lower power positions, perhaps feeling that such behavior will enable them to receive greater rewards from the higher power person (e.g., Copeland, 1994). In the therapeutic context, a number of studies (e.g., Claiborn & Schmidt, 1977; McKee & Smouse, 1983) have found that the status of a therapist may have a substantial effect on the client's perception of him or her as an effective agent of psychological change (e.g., Scheid, 1976). High status therapists are a case in point of expert power (French & Raven, 1959), suggesting that they will be perceived as more credible and

competent than low status therapists. In support of this contention, Binderman, Fretz, Scott and Abrams (1972) found that highly credible therapists (i.e., counselors with doctorates) were able to evoke greater acceptance of self-inconsistent personality feedback from participants (as compared to low credibility sources—counseling practicum students).

Different clients may also react to feedback from therapists in different ways. Clients' pre-existing attitudes toward therapy may reflect the degree of legitimate power that they grant to therapists in general (e.g., French & Raven, 1959). These attitudes may influence latitudes of acceptance and rejection for *any* feedback from therapists, but perhaps especially for discrepant self-inconsistent feedback (e.g., Sherif & Sherif, 1967). Sibicky and Dovidio (1986) noted that many people have negative attitudes toward therapy, perhaps stemming from the social stigma attached to receiving psychological help (e.g., Link & Phelan, 2001). Such negative attitudes, underscored by negative beliefs about the efficacy of therapy and the competence of therapists, can work against a therapist's attempts to create change in his or her client by undermining the validity of the therapist's role as a change agent (e.g., Kerr, Olson, Claiborn, Bauers-Gruenler, & Paolo, 1983). As such, attitudes toward therapy should be functionally similar, although orthogonal, to therapist status, which also may influence beliefs about competence, as a predictor of the acceptance or rejection of feedback.

A number of studies have randomly assigned participants to receive interpersonal feedback, manipulating a variety of independent variables to find that people tend to prefer self-consistent feedback (e.g., Jussim, Coleman, & Nassau, 1989; Moreland & Sweeney, 1984; Morling & Epstein, 1997; Swann & Read, 1981; Swann & Schroeder, 1995), though none of these studies made reference to the clinical context. In the current study, we focus, like Binderman et al. (1972), on the acceptance or rejection of personality feedback transmitted to

participants from a high status or low status therapist. Updating our methods to the twenty-first century (and making use of recent trends toward on-line therapy), we delivered our feedback by email. Participants were randomly assigned to receive self-inconsistent or self-consistent feedback and simply returned their evaluation of the feedback to us by email. We hypothesized that, overall, participants would be more willing to accept self-consistent feedback than self-inconsistent feedback from a therapist. Acceptance of the latter was hypothesized to be moderated by both the status of the therapist and the participant's attitude towards therapy. In other words, we predicted that participants would be more willing to accept self-inconsistent feedback when it came from a high status, rather than a low status, therapist and that participants with positive attitudes toward therapy would be more willing to accept self-inconsistent feedback than participants with negative attitudes toward therapy.

Method

Participants

A total of 373 Australian students, from a metropolitan university and from a variety of disciplines, who had signed up on a registry of potential research participants were approached via email and invited to participate in the study. Of these potential participants, 224 did not respond to our email, indicating their decision not to participate. A further 29 participants agreed to participate and completed the initial personality measures, but subsequently did not respond to the feedback; after two days with no response, these participants were sent a debriefing email. This left a total sample of 120 participants who were entered into a lottery for an AU$50 prize. Of these 120 participants, 78 were female (M = 19 years, SD = 2.34) and 42 were male (M = 21 years, SD = 3.42); their ages ranged from 17 to 38 years. The overall response rate was 40% (149 agreements / 373 emails sent).

Materials

Attitudes towards Psychotherapy and Psychotherapists Scale. We measured each participant's general attitude towards therapy with the Attitudes towards Psychotherapy and Psychotherapists Scale (APPS; Goldstein, 1971). The APPS consists of 25 items, with each item responded to on a 7-point scale, ranging from 1 (strongly agree) to 7 (strongly disagree). For example, "Psychologists are not very much help in solving people's problems." Responses to each item were averaged together to form a scale with high scores indicating a negative attitude (twelve items required reverse scoring). Scores ranged from 2.12 to 6.72 (M = 3.61, SD = 0.72). For the current study, the APPS was found to have solid internal consistency (Cronbach's alpha = .85); the scale has previously been demonstrated to have a test-retest reliability of r = .87 (Goldstein, 1971). For the purpose of analysis and to eliminate positive skew, a median split was performed at an APPS score of 3.52.

Shortened Eysenck Personality Inventory. To gain a measure of participants' self-concepts, we used the shortened version of the Eysenck Personality Inventory (EPI; Eysenck & Sybil, 1964) to determine whether they saw themselves as extraverted or introverted. The shortened version of the EPI consists of 12 yes-no items, with affirmative responses indicating extraversion for 6 items and introversion for the other 6 items. For example, "Are you mostly quiet when you are around other people?" All items were scored in the direction of extraversion, and were summed to create a total scale score for each participant (range 0 to 12, M = 6.53, SD = 2.79). For the current study, the shortened version of the EPI was found to have a reliability coefficient of KR-20 = .85.

Participants also completed 3 free response and 9 yes-no "filler" items (interspersed among the 12 EPI items) to give greater credibility to both the test and the feedback that they

were to receive regarding their test results. For example, “Please describe how you to tend to interact with people.” These items were not analyzed.

Design

Participants were randomly assigned to two independent variables, each with 2 levels: therapist status (high or low) and feedback type (self-consistent or self-inconsistent). Attitude towards therapy was also included as an independent variable and was measured as a pre-existing individual difference with 2 levels, positive and negative (as determined by a median split on the APPS). As such, the investigation possessed 8 conditions. The principal dependent variable of interest was a participant's willingness to accept the feedback provided to them by the therapist.

Procedure

Potential participants were approached via e-mail with an informed consent form, which outlined the potential risks, benefits, and ethical requirements of the study, along with a cover story, which described the study as a trial of a new Australian on-line counseling service. Participants were told that they would be e-mailed a personality test that, once completed, would be assessed by a clinical psychologist. Participants were sent the APPS and the “Freeman Personality Test” (i.e., the shortened EPI plus filler items) and asked to e-mail their responses back to the experimenter. Once the completed tests were received, a personality type (either introverted or extraverted) was determined for each participant based on his or her scores on the EPI, using the midpoint of the scale to separate the two groups; this procedure resulted in 77 extraverts and 43 introverts. As soon as participants were classified, they were e-mailed feedback regarding their results. After responding to the feedback, participants were immediately sent a debriefing email.

Feedback Manipulation. Participants were randomly assigned to receive either self-consistent or self-inconsistent feedback from the therapist. Consistency of feedback was determined with regard to each participant's EPI classification. Therefore, extravert and introvert feedback passages were constructed and served variously as either consistent or inconsistent feedback. The descriptors used in the extravert and introvert feedback were obtained directly from the descriptions of extraversion and introversion provided by Eysenck and Eysenck (1985; p. 50). To make certain that our feedback was uniformly positive, we chose introvert and extravert adjectives from the stable (as opposed to unstable) side of Eysenck and Eysenck's neuroticism personality dimension. Thus, the extravert feedback described the participant as "sociable, talkative, lively, and outgoing…with an easygoing approach to life" and as one who had provided "strong, decisive, and authoritative" responses to the questionnaire. Conversely, the introvert feedback described the participant as "thoughtful, peaceful, passive, and reliable…with an even-tempered approach to life" and as one who had provided "relaxed, sincere, and discreet" responses to the questionnaire.

Status Manipulation. The status manipulation was achieved by providing participants with a randomly assigned description of the therapist who had supposedly provided them with their personality assessment, which portrayed the therapist as either high or low status by focusing on educational and professional achievements, as well as clinical experience. These descriptions were based on previous work investigating the effects of therapist status (e.g., Claiborn & Schmidt, 1977; Lasky & Salomone, 1977; McCarthy, 1982; Scheid, 1976), where status was also manipulated according to clinical experience, education levels and professional achievements. So, for example, the high status therapist was described as having "been a practicing psychologist for 29 years" and as "past president" of an association of clinical

psychologists—“one of the highest honors a psychologist can receive”, whereas the low status therapist was described as having “been a practicing psychologist for 3 months”, “working part-time as a counselor”, and “seeking to develop some clinical skills and experience.” The written description of the therapist was presented directly before the actual feedback.

Dependent Variables

Once participants had read the feedback provided by the therapist, they were asked to complete a response to feedback form, which contained two primary subscales: a feedback acceptance subscale and a feedback positivity subscale. The items on these subscales were constructed by the researchers for this study. Thus, the validity of these items is untested, although we believe that their face validity is high.

Feedback Acceptance Subscale. To assess participants' willingness to accept the feedback provided, we devised three items, responded to on a seven point rating scale, ranging from 1 (strongly agree) to 7 (strongly disagree): "I think that the assessment is an accurate representation of my personality", "I accept this assessment of my personality", and "I reject this assessment of my personality" (reversed scored). These three items were averaged to form a single composite variable that measured participants’ overall willingness to accept the feedback provided by the therapist (Cronbach’s alpha = 0.97).

Feedback Positivity Subscale. To determine how positively (or negatively) participants saw the feedback, we devised two items, again responded to on a seven point rating scale, ranging from 1 (strongly agree) to 7 (strongly disagree): "The feedback provided was of a positive nature" and "The feedback provided was of a negative nature" (reversed scored). These two items (r = .66) were averaged to form a composite variable that measured participants' overall perceptions of feedback positivity.

The response to feedback form also contained 2 additional items, including one item designed to serve as a manipulation check for beliefs about the therapist's competence (as derived from our status manipulation). The other item focused on participants' prior self-certainty about their self-concept. All items were answered on the same 7-point rating scale, ranging from 1 (strongly agree) to 7 (strongly disagree). Once participants completed the response to feedback form, they were asked to e-mail it back to the experimenter.

Results

A Precaution: Positivity of the Feedback

Previous research (e.g., Anderson, 1968; Stukas & Snyder, 2002) has demonstrated that, in general, extraversion tends to be rated more positively than introversion. To avoid creating a bias in our study, such that the effect of our manipulation of self-consistency on feedback acceptance was overwhelmed by the positive or negative nature of the feedback, we drafted the personality feedback messages to be equivalently positive. Nevertheless, it was essential to test whether there were empirical differences in ratings of positivity of the feedback. Therefore, we conducted a 2 (participant personality type: extravert or introvert) x 2 (feedback type: self-consistent or self-inconsistent) ANOVA on the positivity subscale from the Response to Feedback form. The ANOVA revealed no significant interaction effect between personality type and feedback type (the central test of this concern) and no main effects for either participant personality type or feedback type on these positivity ratings. A hierarchical multiple regression analysis using the continuous Eysenck Personality Inventory and a two-level variable representing feedback type also results in no main effects or interactions when predicting feedback positivity.

Feedback Acceptance

In our main analysis, we investigated the influence of the type of feedback provided (self-consistent or self-inconsistent), the status of the therapist giving the feedback (high or low), and the attitude towards therapy (positive or negative) of the participant receiving the feedback on the feedback acceptance scale. However, data collected on this scale proved to be negatively skewed (indicating greater overall acceptance of our feedback). Based on advice from Tabachnick and Fidell (1996), we decided to reflect and square root the data in order to counter the negative skew. Once this procedure was conducted, the feedback acceptance data were normally distributed. For ease of interpretation, untransformed means and standard deviations are reported in text and tables, though all inferential tests were conducted on transformed scores.

To test our hypotheses, a 2 (therapist status: high or low) x 2 (attitude: positive or negative) x 2 (feedback type: self-consistent or self-inconsistent) ANOVA was conducted on the feedback acceptance scale scores. Main effects of all three independent variables were found on acceptance of feedback. Thus, the ANOVA revealed a significant effect of therapist status, $F(1, 112) = 34.70$, $p < .001$, eta-squared = .24, such that feedback given by the high status therapist ($M = 5.46$, $SD = 1.25$) was more accepted than feedback given by the low status therapist ($M = 4.21$, $SD = 2.07$). ANOVA results also revealed a significant main effect for attitude, $F(1, 112) = 54.42$, $p < .001$, eta-squared = .33, such that participants with positive attitudes toward therapy ($M = 5.58$, $SD = 1.53$) were more willing to accept the feedback provided than participants with negative attitudes toward therapy ($M = 4.13$, $SD = 1.80$). Finally, the ANOVA revealed a main effect for feedback type, $F(1, 112) = 54.06$, $p < .001$, eta-squared = .33, such that self-consistent feedback ($M = 5.61$, SD = 1.03) was more accepted than self-inconsistent feedback ($M = 4.06$, SD = 2.10). Table 1 provides the untransformed mean feedback acceptance ratings across each of the 8 experimental conditions.

We also found a significant two-way interaction between therapist status and feedback type, $F(1, 112) = 56.96$, $p < .001$, eta-squared = .34. Figure 1 provides a graphical representation of this effect. To further investigate this significant two-way interaction, simple effects were calculated and revealed that self-inconsistent feedback was more accepted when it came from a high status therapist ($M = 5.53$, $SD = 1.38$) than a low status therapist ($M = 2.59$, $SD = 1.60$), $t(112) = 9.55$, $p < .001$. Acceptance of self-consistent feedback was not significantly different based on whether the feedback came from a high status therapist ($M = 5.39$, $SD = 1.12$) or a low status therapist ($M = 5.82$, $SD = 0.90$), $t(112) = 1.17$, $p > .05$. Thus, the nature of this interaction was such that self-inconsistent feedback was more willingly accepted when it came from a high, rather than a low, status therapist.

A further significant two-way interaction was found between attitude and feedback type, $F(1, 112) = 4.36$, $p = .039$, eta-squared = .04. Figure 2 shows this interaction graphically. To investigate this significant two-way interaction, simple effects were again calculated. These demonstrated a spreading interaction: although participants with positive attitudes toward therapy were more likely to accept feedback overall, the difference in acceptance ratings for those with different attitudes was greater for inconsistent feedback. Thus, participants with positive attitudes towards therapy ($M = 6.10$, $SD = .82$) accepted self-consistent feedback more willingly than did participants with negative attitudes toward therapy ($M = 5.18$, $SD = 1.01$), $t(112) = 3.73$, $p < .001$—and participants with positive attitudes towards therapy ($M = 5.10$, $SD = 1.87$) also accepted self-inconsistent feedback more willingly than did participants with negative attitudes towards therapy ($M = 3.02$, $SD = 1.79$), $t(112) = 6.72$, $p < .001$.

The third possible two-way interaction, between status and attitude, was statistically non-significant, $F(1, 112) = 1.84$, $p > .05$, eta-squared = .02, as was the potential three-way

interaction between status, attitude and feedback type, $F(1, 112) = .01$, $p > .05$, eta-squared = .00. We recognize that by dichotomizing scales, we have lost potentially valuable information for the sake of using ANOVA and presenting our results more simply. Therefore, all analyses were also run with continuous versions of the EPI and the APPS (with the latter transformed using a logarithmic transformation to reduce skew) using hierarchical multiple regression. These results demonstrated the same significant effects on feedback acceptance.

Therapist Competence

As part of the Response to Feedback Scale, we also assessed participants' perceptions of the competence of the therapist with a single item, "I feel that the psychologist who assessed me was competent" (answered on a 7-point scale, with higher scores meaning greater competence; we applied a reflect and square root transformation to these scores to eliminate negative skew). See Table 2 for the untransformed means and standard deviations. Although this item was originally conceived to be a check on the therapist status manipulation, we decided to examine it as a dependent variable instead given its likely relationship to client attitudes as well as therapist status. Therefore, a 2 (therapist status: high or low) x 2 (attitude: positive or negative) x 2 (feedback type: self-consistent or self-inconsistent) ANOVA was conducted on this therapist competence item.

Results demonstrated a main effect for therapist status, $F(1, 112) = 14.03$, $p < .001$, eta-squared = .11, such that the mean competence rating for the high status therapist ($M = 5.78$, $SD = 1.28$) was significantly higher than for the low status therapist ($M = 4.88$, $SD = 1.75$). This main effect provides validation for the experimental status manipulation, as we expected our manipulation of therapists' experience and achievements to directly influence perceptions of competence. However, our analysis also revealed that participants with positive attitudes toward

therapy (*M* = 5.81, *SD* = 1.44) provided significantly higher therapist competence ratings than participants with negative attitudes toward therapy (*M* = 4.89, *SD* = 1.60), *F*(1, 112) = 14.14, *p* < .001, eta-squared = .11. A smaller difference in the mean therapist competence ratings given by participants receiving self-consistent (*M* =5.55, *SD* = 1.27) and self-inconsistent (*M* = 5.12, *SD* = 1.82) feedback was found to be non-significant, *F*(1, 112) = 2.19, *p* >.05, eta-squared = .03.

Additionally, a significant interaction between status and feedback, *F*(1, 112) = 6.14, *p* = .015, eta-squared = .10, was also revealed. Please see Figure 3 for a graphical representation of this interaction. To further investigate this significant two-way interaction, simple effects were calculated and revealed that, when providing self-inconsistent feedback, high status therapists were seen as more competent (*M* = 5.97, *SD* = 1.22) than low status therapists (*M* = 4.27, *SD* = 1.98), *t*(112) = 4.42, *p* < .001. When providing self-consistent feedback, therapists were seen as equally competent whether they were portrayed as high status (*M* = 5.60, *SD* = 1.33) or as low status (*M* = 5.50, *SD* = 1.22), *t*(112) = 0.89, *p* > .05. Thus, this interaction of status and feedback type follows the same pattern as in the analysis of feedback acceptance ratings—inconsistent feedback leads therapists of lower status to be deemed less competent than therapists of higher status, but consistent feedback leads to equivalent ratings of competence for therapists from both status conditions.

No further interactions were significant: attitude and feedback, *F*(1, 112) = .48, *p* > .05, eta-squared = .01, status and attitude, *F*(1, 112) = .01, *p* > .05, eta-squared = .00, or the three-way interaction between status, attitude and feedback type, *F*(1, 112) = 1.03, *p* > .05, eta-squared = .01. The same pattern of significant results was found when continuous variables were used in a hierarchical multiple regression analysis.

A Mediation Model

Given the similarity of the patterns of results for therapist competence and feedback acceptance (and the theoretical arguments linking the two), it seems possible that judgments of competence could mediate (or partially mediate) the effects of therapist status and/or client attitude toward therapy on feedback acceptance. The effects of feedback self-consistency are unlikely to be directly mediated by competence (given the absence of a main effect), but the interactive effect with therapist status could be mediated by perceptions of competence.

We followed the instructions provided by Baron and Kenny (1986) to test for mediation using linear regression analyses:

Step 1. We regressed our transformed acceptance scale on attitudes toward therapy (using the continuous version of the scale, which was positively skewed and therefore logarithmically transformed for this analysis), the dummy-coded therapist status variable, and an interaction term representing feedback consistency (created from the continuous EPI scores and the dummy-coded feedback type variable, which were entered on a previous step). Together, these three predictors explained 39% of the variance in feedback acceptance scores [$r^2 = 0.39$; $F(5, 113) = 14.72$, $p < .001$], with attitudes (beta = 0.43, $t = 5.78$, $p < .001$), the personality by feedback type interaction (beta = 0.79, $t = 2.67$, $p = .009$), and therapist status (beta = .24, $t = 3.25$, $p = .002$) all contributing significantly. On the final step in this analysis, the feedback type by status interaction term was added and also contributed significantly to the explanation of variance in feedback acceptance [beta = 1.04; r^2 change = .06; $F_{\text{increase}}(1, 112) = 12.11$, $p = .001$]. This brings the total variance accounted for to $r^2 = 0.45$.

Step 2. We regressed acceptance on the transformed competence measure. This single predictor (beta = 0.54, $t = 7.03$, $p < .001$) explained 30% of the variance in feedback acceptance scores [$r^2 = .295$].

Step 3. We regressed competence on our transformed attitude measure, personality by feedback interaction term (with main effects entered on the previous step), and therapist status. These three predictors explained 29% of the variance in competence scores [r^2 = 0.29; F(5, 113) = 9.32, p < .001], with attitudes (beta = 0.40, t = 5.02, p < .001) and therapist status (beta = .23, t = 2.88, p = .005) contributing significantly, but feedback type not significantly related to competence (beta = -0.17, t = -0.54, p = .59). On a second step in this analysis, the feedback type by status interaction term contributed significantly to the explanation of variance in perceptions of therapist competence [beta = 1.03; r^2 change = .06; F_{increase}(1, 112) = 10.05, p = .002].

Step 4. Given that all three of the previous analyses were significant (for all effects other than feedback type), the test of mediation was carried out by examining whether the significant effects of attitude toward therapy and therapist status on feedback acceptance scores went away (or were significantly reduced) when competence judgments were entered simultaneously as a predictor on the same step (e.g., Baron & Kenny, 1986). Surprisingly, this analysis revealed that judgments of competence mediated the effects of attitude toward therapy and therapist status on feedback acceptance in only a minor way, if at all. These predictors still explain a significant proportion of the variance in acceptance even when judgments of competence (beta = 0.33, t = 4.33, p < .001) are entered simultaneously: attitude beta = 0.29 (t = 3.79, p < .001)—a reduction of 0.14; personality by feedback interaction term beta = 0.85 (t = 3.08, p = .003)—an increase of 0.06; and status beta = 0.16 (t = 2.25, p = .03)—a reduction of .08. For this model, F(6, 112) = 17.15, p < .001; r^2 = .48.

To examine whether the significant interaction of feedback type and therapist status was mediated by judgments of competence, on the final step in the analysis, the interaction term was entered (this time with competence judgments controlled) and again appeared as a significant

predictor, beta = 0.75 (t = 2.50, p = .014)—a reduction of 0.29; r^2 change = .03, $F_{increase}(1, 111)$ = 6.25, p = .014. With all predictors in the model, the total variance accounted for was 50.7%.

Thus, although judgments of therapist competence may partially mediate the effects of therapist status, attitude toward therapy, and the interactive effect of status and feedback type, it seems clear that all three predictors still have their own direct effects on feedback acceptance. Additionally, the effect of feedback consistency itself was not mediated by judgments of therapist competence at all. Of course, none of this undercuts the importance of judgments of therapist competence in predicting feedback acceptance but only indicates that acceptance ratings may be multiply determined. To be sure, if one takes into account the fact that competence and acceptance were measured as part of the same scale, the partial mediation found here could be an artifact of measurement, suggesting even more strongly that therapist status and attitudes toward therapy influence feedback acceptance through some other (unmeasured) process in addition to any effect on judgments of competence.

Discussion

Our research was guided by theoretical predictions about how and whether therapist status and client attitudes would influence willingness to accept self-consistent and self-inconsistent feedback. Our results confirmed our central experimental hypotheses: a) participants were more willing to accept self-consistent than self-inconsistent feedback; b) participants were more willing to accept self-inconsistent feedback from a high status therapist than from a low status therapist; and c) participants with positive attitudes towards therapy were more willing to accept self-inconsistent feedback than participants with negative attitudes toward therapy. Additional exploratory analyses suggested that these effects were partially mediated by judgments of therapist competence, though direct effects were stronger than indirect (mediated) effects.

Our results thus provided strong support for self-verification theory (e.g., Swann, 1987; Swann, Rentfrow, & Guinn, 2003), by demonstrating that participants were more willing to accept feedback that was consistent with their previously measured self-concepts, and less willing to accept feedback that was inconsistent with their self-concepts. However, our results also show that, in the face of self-inconsistent feedback, clients did not always choose to self-verify. Instead, under certain conditions, participants were more willing to accept self-inconsistent feedback. Specifically, we found that therapist status and client attitude toward therapy were significant moderators of the acceptance of self-inconsistent feedback, after one takes into account the finding that self-verifying feedback is generally preferred by clients. These findings provide more support for the role of source factors, like status (e.g., Binderman et al., 1972; Hovland & Weiss, 1952), and attitudinal factors, like discrepancy from one's own views (e.g., Sherif & Sherif, 1967), in determining message acceptance.

Researchers have become increasingly sensitive to the complex social variables that may moderate interpersonal processes, including those that deal with the negotiation of interpersonal expectations and identities (e.g., Snyder & Stukas, 1999; Swann, Bosson, & Pelham, 2002). Our study is consistent with research on the behavioral confirmation of interpersonal expectations that shows that participants are more likely to adapt to the interpersonal expectations of higher power others than to disconfirm them, which occurs more frequently when participants interact with others with lower power (e.g., Copeland, 1994; Snyder & Kiviniemi, 2001). In our case, participants may have felt that high status therapists were more likely to be right about them, which may have been made easier by the generally positive tone of both our feedback messages and the tendency for participants to interpret ambiguous feedback as consistent (e.g., Swann & Read, 1981). They were more likely to accept any feedback (consistent or inconsistent) from high

status therapists than from low status therapists, though the contrast is larger for self-inconsistent feedback (perhaps because a low status therapist may lead participants to be somewhat more vigilant for errors).

Researchers are also becoming aware of the pragmatic choices that people may make when deciding whether and when to confront others' erroneous perceptions of them (e.g., Miller, Rothblum, Felicio, & Brand, 1995; Stukas & Snyder, 2002). Our study followed these trends in the search for moderators and mediators of interpersonal processes by focusing on a person-centered variable that might influence responses to interpersonal feedback (see Swann & Ely, 1984, for a similar use of participants' self-certainty about their own characteristics[1]). Specifically, we felt that participants' own attitudes toward therapy might dictate their reactions to feedback received from a therapist. Negative attitudes toward therapy and therapists did lead to greater rejection of feedback (even consistent feedback) than positive attitudes, though again the effect was stronger for self-inconsistent feedback. Participants with negative attitudes may have been more ready to reject feedback, and to judge feedback as containing self-inconsistent information or errors. Conversely, participants with positive attitudes may have been more willing to interpret feedback in line with their self-concepts and to accept even feedback that we deemed inconsistent. Thus, attitudes toward the sender of feedback or context for feedback may create states of readiness that determine in advance how people respond to feedback, perhaps through such processes as selective attention and interpretation (e.g., Fiske & Neuberg, 1990). However, it is important to note that most of our participants held positive attitudes toward therapy (i.e., the distribution on the APPS was significantly skewed). As such, we do not know how those with truly negative attitudes toward therapy would respond to our feedback. Nevertheless, although there are some occasions when those with negative attitudes might be

required to consent to therapy, we believe that our sample may resemble the population of participants who actually seek therapy, given that those who choose to attend therapy (or to participate in research of this kind) are likely to do so because they hold at least moderately positive expectations about its usefulness.

We also felt that attitudes might influence reactions to feedback by their impact on judgments of therapist competence. However, although it seems logical that our status manipulation and our measure of participant attitude toward therapy might have affected feedback acceptance through their influence on judgments of therapist competence, we found that such judgments only partially mediated these effects. Therefore, although judgments of therapist competence were indeed affected by therapist status and pre-existing attitudes toward therapy, such judgments were not sufficient to fully explain the impact that status and attitudes had on reactions to feedback. Pending a replication with a better measure of therapist competence (i.e., more than a single item), we can only suggest that status and attitudes also influence reactions to feedback (especially self-inconsistent feedback) through some other mechanism, perhaps by guiding selective attention and interpretation, as we have already suggested.

Our results, though consistent with past research, should not be taken without a grain of salt. We chose a very minimal operationalization of the therapeutic context, one that allowed us to manipulate both therapist status and feedback without concern for the potential influence of other variables normally found in this setting (e.g., dynamics of an actual interaction, appearance of the therapist and therapist's office, actual psychopathology of clients). We also used a very short measure to assess participants' self-concepts. This reductionist approach worked well from both a practical and an ethical standpoint, when doing research in the real setting might prove more difficult. Therefore, readers are cautioned about generalizing our findings to the types of

interpersonal processes that occur in actual therapeutic sessions (with participants who have chosen to attend therapy rather than with student volunteers), where other factors may also influence reactions to therapeutic feedback. Finally, although we found that participants were willing to accept self-inconsistent feedback, it is unclear whether this represented a lasting change in their self-concepts. Given our minimal operationalization of the therapeutic context, it is perhaps likely that participants reverted back to their old self-conceptions shortly after completing the study -- however we did not include a second administration of the EPI to test this hypothesis. Given that lasting self-concept change is a key aim of therapy, and as most therapists will attest, often a difficult and long-term task (Beck, Freeman, & Davis, 2003), this question deserves further attention.

Nevertheless, we see our results as consistent with self-verification studies that suggest that self-verification of negative identities may inhibit therapeutic change (e.g., Swann, 1997) and with clinical research that has found clients with negative attitudes toward therapy to be unwilling to change (e.g., Taylor, Adelman, & Kaser-Boyd, 1985). Indeed, our research also suggests that the process of therapy may be impeded by clients with negative attitudes or for therapists with lower status (especially if feedback is judged to be self-inconsistent). We hope that such problems can be overcome in the actual interactions that take place in real therapeutic sessions, and perhaps by training of therapists with an eye toward overcoming such problems. Indeed, another implication of our results that should not be overlooked is that clients may be willing to accept feedback of any kind (including perhaps erroneous or mistaken feedback) from high status therapists or if they have pre-existing positive attitudes toward therapy. Thus, more than ever, therapists must ensure that they use treatment and diagnostic options that have shown efficacy, to ensure that errors of clinical judgment are kept to a minimum.

In conclusion, our results suggest that clients may not be passive recipients of therapeutic feedback, but instead their willingness to accept feedback may be influenced by a variety of factors that are not directly part of the therapeutic interaction but exist prior to its inception. In this regard, therapist status and client attitudes towards therapy may play key roles in predicting reactions to therapeutic feedback. A particularly interesting avenue for future research may be to examine how clients with actual clinical disorders (e.g., anxiety disorders, eating disorders, personality disorders) respond to therapeutic feedback (e.g., Giesler et al., 1996), paying particular attention to the specific intra- and interpersonal characteristics of each disorder that may influence this response, as well as the actual social dynamics that occur in therapeutic sessions. Moreover, just as this study has examined the variables that influence feedback acceptance within a therapeutic context, future research may benefit from investigating how variables such as attitude, feedback consistency, and source status influence feedback acceptance across different contexts, such as in romantic relationships or the workplace.

Notes

[1]Although we recognized that self-certainty may play an important role in determining reactions to feedback (e.g., Swann & Ely, 1984), we felt that it was impractical to assess self-certainty when first measuring our participants' levels of extraversion or introversion. In particular, we felt that such measures, in the context of the relatively sparse information provided to our "therapists", might call attention to the inconsistent feedback and make it seem deceptive. As such, we chose to assess self-certainty retrospectively during the assessment of the therapist's feedback, recognizing that such measures might be compromised by the feedback itself. A single item asked participants "Before the assessment was given, I felt certain about the type of personality I had" (rated on a 7-point scale). When this item was entered as a covariate into the feedback acceptance analysis, all effects remained unchanged [and the covariate was nonsignificant, $F(1, 111) = 0.35$, $p = .56$]. This single-item measure was also uncorrelated with our feedback acceptance index, $r(120) = .07$, $p = .45$.

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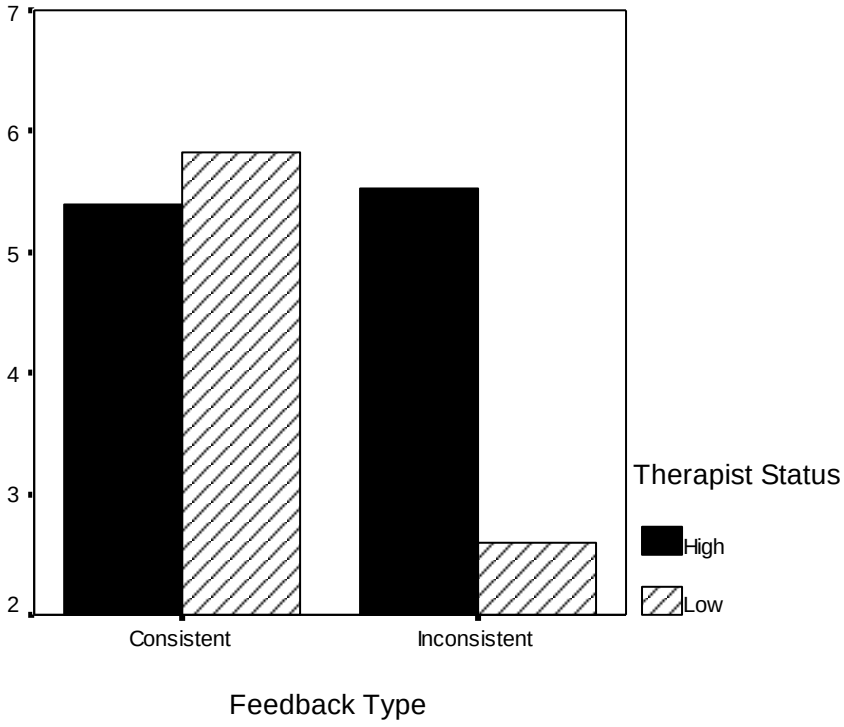
Figure Captions

Figure 1. Mean acceptance of feedback as a function of therapist status and feedback type.

Figure 2. Mean acceptance of feedback as a function of client attitude and feedback type.

Figure 3. Mean therapist competence ratings as a function of therapist status and feedback type.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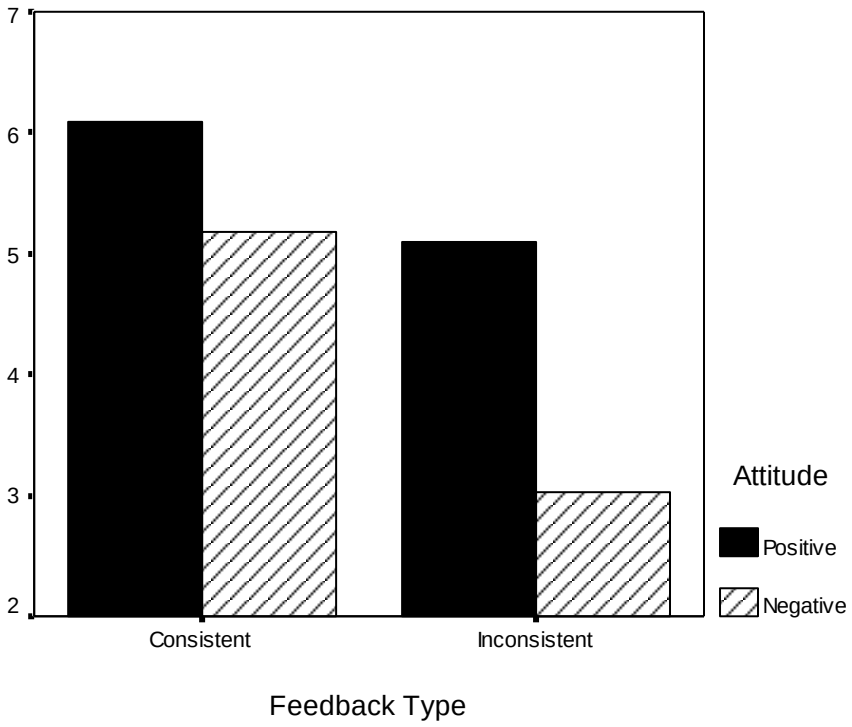
Consistent
Inconsistent
Feedback Type
Therapist Status
High
Low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Consistent
Inconsistent
Feedback Type
Attitude
Positive
Negative

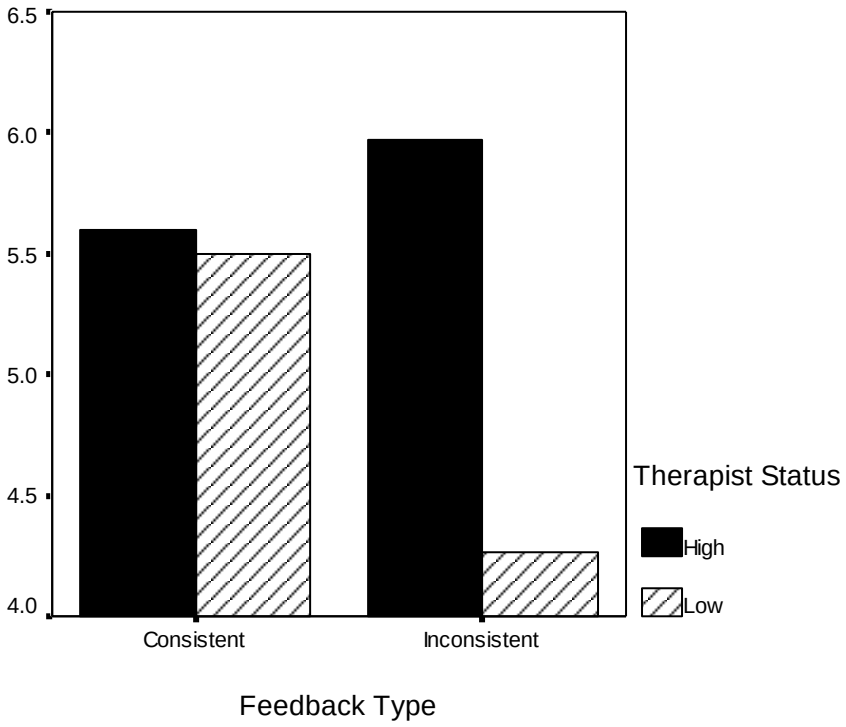
6.5
6.0
5.5
5.0
4.5
4.0
Consistent
Inconsistent
Feedback Type
Therapist Status
High
Low

Table 1.

Mean feedback acceptance ratings (untransformed scores) and standard deviations by condition.

Positive Attitude Toward Therapy		
Feedback Consistency	Therapist Status	
	High Status	Low Status
Self-Consistent	6.06 (0.93)	6.13 (0.76)
	n = 12	n = 16
Self-Inconsistent	6.42 (0.66)	3.60 (1.21)
	n = 16	n = 14
Negative Attitude Toward Therapy		
	High Status	Low Status
Self-Consistent	4.94 (1.02)	5.48 (0.94)
	n = 18	n = 14
Self-Inconsistent	4.52 (1.29)	1.71 (0.90)
	n = 14	n = 16

Note. Feedback Acceptance Ratings were an average of responses to three items, each rated on a scale of 1 to 7, with higher scores indicating greater acceptance.

Table 2.

Mean therapist competence ratings (untransformed scores) and standard deviations by condition.

Positive Attitude Toward Therapy		
Feedback Consistency	Therapist Status	
	High Status	Low Status
Self-Consistent	6.42 (0.79)	5.88 (1.26)
	n = 12	n = 16
Self-Inconsistent	6.19 (1.17)	4.79 (1.89)
	n = 16	n = 14
Negative Attitude Toward Therapy		
	High Status	Low Status
Self-Consistent	5.06 (1.35)	5.07 (1.07)
	n = 18	n = 14
Self-Inconsistent	5.71 (1.27)	3.81 (2.01)
	n = 14	n = 16

Note. Therapist Competence Ratings were a response to a single item, rated on a scale of 1 to 7, with higher scores indicating greater perceived competence.