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**Self-Concept, Schematic Processing and Change
in Perceptual-Processing Experiential Therapy**

**A thesis submitted to the Faculty of Graduate Studies
in partial fulfilment of the requirements
for the degree of**

Master of Arts

Sharon M. Day

**Graduate Programme in Psychology
York University
North York, Ontario**

December 1994



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Change in Perceptual-Processing
Experiential Therapy**

by
Sharon M. Day

a thesis submitted to the Faculty of Graduate Studies of York
University in partial fulfillment of the requirements for the degree
of

MASTER OF ARTS

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Abstract

The purpose of the present research was to determine the degree of relationship between pre-treatment to post-treatment changes in clients' self-schemata and level of self-concept, and to explore, both quantitatively and descriptively, the processes involved in the development of self-schemata in the context of the perceptual-processing method of experiential therapy (Toukmanian, 1990).

The study was constructed in two parts. Part I focused on the examination of change in self-concept and self-schemata, from the standpoint of clients' in-therapy process and final outcome. As was hypothesized, participants who received perceptual-processing experiential therapy improved on measures of self-concept and self-schemata to a significantly greater degree than participants who received skills training. Correspondingly, clients with the greatest in-therapy gains in perceptual-processing tended to have greater pre-treatment to post-treatment gains on the measures of self-concept and perceptual congruence. These results provided tentative support for the conception of change specified by the perceptual-processing therapeutic approach (Toukmanian, 1992) that self-schemata become more elaborate and flexible as a result of therapy, and that clients who engage in more complex processing operations are

more likely to show improvement in self-concept and increased flexibility of self-schemata.

In Part II, a descriptive analysis was conducted on one client's experience of a segment of therapy that was identified by her as therapeutically significant, in light of Toukmanian's (1992) model of therapy. The results of this analysis provided support for the proposed model. First, the event that the client described as most meaningful to her was found to be the same segment of therapy that had been described as high processing in terms of Toukmanian's model of perceptual-processing (1992). Secondly, the client was able to identify elements of her in-therapy experience that were conceptually relevant to the taxonomy proposed by the model.

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Self-Concept, Schematic Processing and Change in Perceptual-Processing Experiential Therapy

Current psychotherapy process research encompasses two divergent methodologies (Rennie & Toukmanian, 1992) which may be described as qualitative and quantitative methods. Quantitative approaches are based on the traditional positivist-empiricist model of scientific study that assumes the existence of an objective reality independent of the observer. Since the dawn of science, as we know it, that assumption has been challenged by thinkers who are of the opinion that reality is socially constructed and that there cannot be a truly value-free enquiry into any aspect of human nature (Danziger, 1993; Gergen, 1982; Harré, 1984; Mead, 1962; Shweder & Miller, 1985). For example, according to Gergen, the traditional positivist-empiricist approach, with its emphasis on verification, falsification and finding causal relationships in an objective world, has given rise to a misguided understanding of self-concept as a unified, stable and enduring entity, as opposed to the more plausible conception of a fluid sense of self.

Qualitative approaches assume furthermore that the element of study in human science cannot be sifted out of the observer-participant relationship. Thus, the most profitable method of enquiry is one that centres on

descriptive explanations of meaning in a particular context.

At the present time, there is some debate over the viability of incorporating the two methodologies into one framework of study, particularly when methodology is viewed as logic of justification (Smith & Heshusius, 1986).

However, it can also be argued that there is room for compatibility, primarily when methodology is envisioned in terms of technique, rather than logic of justification (Rennie & Toukmanian, 1992; Smith & Heshusius, 1986). In this vein, Toukmanian (1992) recommends the combination of qualitative and quantitative methods for a comprehensive analysis of the psychotherapy process. Thus, the present study was an attempt to investigate, both quantitatively and qualitatively, the effects of a brief psychotherapy on the process of change in clients' self-concept and schematic structures.

Review of the Literature on The Self in Psychotherapy

Curiosity about the nature of "self" throughout the history of psychology has created a rich theoretical and empirical knowledge-base within which the notion of self-concept has developed. As a result, this construct has been conceptualized and dealt with in the literature in a variety of ways.

From the realm of social constructionism, whose adherents focus on the social embeddedness of human knowledge, both phenomenological and behaviourist conceptions of "the self-concept" are criticized for stripping the self of its sociohistorical context (Gergen, 1985; Shweder & Miller, 1985). For example, the behaviourist proposition that the self is an abstract and non-observable notion, not worthy of theoretical formulation, is denounced for its reductionist approach to human nature that ignores the very essence of the object of study. Phenomenologists, with their focus on internal processes, are criticized for ignoring social and historical determinants of conceptualizations of self.

Two similar social constructionist views of self-concept are presented by Mead (1962) and Harré (1984). Mead contends that the self is an emergent that arises out of the symbolic activity of language. In his theory, the social

meaning inherent in communication at the level of gestures between non-human animals (the "conversation of gestures") is seen as the precursor to the development of a self-concept in humans. Having acquired sufficient neurological equipment, the human animal is able to make a "significant gesture"--a reflexive gesture that occurs when the performer takes on the role of the other to whom the gesture is being made. The self-concept arises in children when they are able to take on the role of the "generalized other", or all of the other players in, for example, an organized game (1962).

Rom Harré (1984) contends that knowledge in general is acquired through the process of making analogous inferences. For example, in our society, we conceptualize time in terms of movement, such as a parade of soldiers marching in a band; hence the expression "time marches on". Harré views self-concept as a particular type of analogous inference, acquired when an individual observes and uses socially favoured models for self-ascription. By this, he means that children observe the way people interact in the social realm and, in particular, how information is ascribed to participants in the social conversation. Over time, they model their internal dialogue on the basis of this external interaction, ascribing bits of information to themselves, just as they witnessed information being ascribed to various

participants in the social conversation. Hence, each person's self-concept, learned via observations of ascription practices in the public conversation, is a theory about personal being that is extracted from and analogous to one's theory of social being.

Both Mead and Harré contend that the self-concept develops by virtue of social interaction in a broader sense than is considered by theorists like Sullivan who propose that the development of the self-concept is mediated by early relationships with significant others (Greenberg & Mitchell, 1983). Furthermore, they maintain that the both empiricist and phenomenological views are too limiting for a comprehensive understanding of human nature. Hence, the social constructionist paradigm presents an interesting and contrasting vantage point from which to consider the views of psychotherapy theorists concerned with conceptualization of the "self".

Self-Concept and Theories of Psychotherapy

In traditional psychoanalytic theory, the self-concept has not been a matter of concern per se. Instead, Freud and his followers have focused on the personality in general, expressing it as a system of three dynamic forces, in conflict with one another. The human struggle to seek pleasure and to avoid pain is believed to be controlled by interactions of instinct (the Id), the moral precepts of

society (the SuperEgo), and the dictates of reality (the Ego) (Fancher, 1990). Because these internal structures are for the most part unconscious, the self can never be known directly in Freud's model, but must be inferred through analytical interpretation. Moreover, the aim of Freudian psychodynamic therapy is insight into one's unconscious conflicts and motives, as opposed to changing one's self-representations.

In contrast, for many neo-Freudians, self-representation has become integral to theories of human functioning. Object relations theory focuses on development of representations of self and object. The self is characterized as an "amalgam of innumerable experiences with early caretakers, prototypically the mother" (Lukton, 1992, p. 154). In H. S. Sullivan's programme, self-concept is a particular organization of experience within an individual's personality that is based on the appraisals of significant others (Greenberg & Mitchell, 1983).

Similarly, in Rogers' phenomenological theory of psychotherapy, wherein the focus is on the dynamic organizational capacities of the self, the self-concept is seen to reflect the process of formulating a view of oneself that develops as the individual interacts with his or her environment and acquires an ability to symbolize new facets of experience (Rogers, 1980). It acts to motivate behaviour

(Keen, 1992) and is manifest in the views people have of themselves and of themselves in relation to others (Fitts & Hamner, 1969).

Not all post-Freudian theories of psychotherapy have put a great deal of emphasis on the self, however. Behaviourist theory forgot the self entirely in its emphasis on empirically testable objective qualities of human nature, as, for the most part, has cognitive-behaviourist theory which focuses on cognitions as internal behaviours (Dobson & Block, 1988). Furthermore, it has only been relatively recently that clinical cognitive theory has emphasized self-concept change as a goal of therapy (Beck, Steer & Epstein, 1992; Epstein, 1980; Möller, Kotzé & Sieberhagen, 1993).

Thus, the self-concept has been conceptualized in a variety of ways within the context of psychotherapy theory. While in some theories it has been largely ignored, in favour of warring unconscious agencies or observable and testable behaviours, in others it has been credited as the seat of healthy versus abnormal functioning.

Self-Schemata and Theories of Psychotherapy

There is a growing interest in the multi-dimensional nature of the self in clinical cognitive psychology (Higgins, 1987; Nurius & Majerus, 1988; Ryff, 1991). Furthermore, as cognitive psychology continues to advance in affiliation with information processing theory, it is

becoming increasingly evident that the concept of self must be reformulated to take into account the processing of information about the self, the manner in which this information is organized and represented, and its potential for therapeutic reorganization.

Recently, the "self" has been treated in the literature as a cognitive prototype or a system of schematic knowledge structures composed of an array of self-representations (Mahoney, 1990) or collection of entities (Young, 1988) that serve to process and integrate a wide range of information about the individual (Markus & Sentis, 1982). Like the conceptualization of self-concept, this view maintains that self-schemata develop with experience and that they become increasingly differentiated as the individual interacts with his or her environment (Lewis, 1992; Markus & Sentis, 1982).

The current use of the term *schema*, as the principle cognitive structure in perception, originated with Bartlett (Neisser, 1976). Bartlett credited the idea to his colleague Sir Henry Head, who was studying storage of past responses in the central nervous system. Head chose the term "schemata" to describe organized groups of reactions that were instrumental in shaping present behaviours (Bartlett, 1958, p. 146). More recently, Neisser has further defined and contextualized schema within the realm of perception:

A schema is that portion of the entire perceptual cycle which is internal to the perceiver, modifiable by experience, and somehow specific to what is being perceived. The schema accepts information as it becomes available at sensory surfaces and is changed by that information; it directs movements and exploratory activities that make more information available, by which it is further modified (1976, p. 54).

Within Beck's cognitive model of therapy, schemata are viewed as "the underlying cognitive structures that organize the client's experience and that can form the basis for the individual instances of bias or distortion" (p. 275, DeRubeis & Beck, 1988). These "core beliefs" are not directly accessible to awareness. They exist as if-then propositions at a deeper level which can only be discerned by examining people's patterns of thoughts and behaviours, and they can change over time as they are challenged by new experience (Hollon & Beck, 1979; Beck & Greenberg, 1984; DeRubeis & Beck, 1988; Beck & Weishaar, 1989).

Critics have argued that the conceptualization of schemata in cognitive therapy is at variance with cognitive psychology theory (Hoffart, 1993; Safran, 1990) and that it should be redefined to encompass interpersonal factors

(e.g., the therapeutic relationship), as well as intrapersonal factors (e.g., domains of the self, and the standpoints from which the self is viewed) (Higgins, 1987; Nurius & Majerus, 1988; Ryff, 1991; Safran, 1990). Three reformulations of self-schemata in terms of these criticisms have arisen from the following perspectives: 1) self as consisting of interacting cognitive subsystems, 2) self-concept as a constellation of self-schemata, and 3) self-discrepancy theory.

Interacting Cognitive Subsystems. In a recent review, Teasdale (1993) argues that the current usage of cognitive constructs (such as self-schemata) in clinical cognitive psychology, although closer to the formulations of cognitive science than the earlier Beckian employment of these constructs, remain fuzzy due to everyday usage in treatment and research. To counter this problem, Teasdale proposes the use of Barnard's (1985, cited in Teasdale, 1993) "interacting cognitive subsystems" (ICS) approach to cognitive therapy, in which different domains of experience are presumed to be represented by qualitatively different mental codes. He explains:

Each type of information is processed by its own specialised processing subsystem. ...Information processing involves the transfer of information between subsystems and its transformation from one

mental code to another. ICS proposes mental codes related to two levels of meaning, a specific and a more generic level (p. 344).

Teasdale states that meaning at the specific level of "discrete concepts" is represented by patterns of "propositional code", and that meaning at this level is quite easily expressed and understood, because of the fairly direct relationship between language used to describe a concept and the concept itself. An example would be the sentence "The telephone is ringing".

Teasdale further suggests that meaning at the more generic and holistic level, that is not readily expressed in language, is represented by patterns of "implicational code". Representations at this level of meaning are highly abstracted and thematic. They are derived from salient non-verbal features of an event and represent implicit inter-relationships among elemental schemata. Communication at this generic level of meaning tends to be indirect, through emotion, and/or in the form of poetry or storytelling.

Although Teasdale does not refer specifically to either the self-concept or self-schemata, it appears from the examples he provides that a notion of self is implicated in both psychopathology and change. In particular, the self appears to be represented at the more holistic, generic

level of meaning. At this level, meaning is derived from a pattern created by sensory information and components of the lower level discrete meaning. "It is the total pattern that determines high level meaning and the emotional response" (p. 350). In this case, Teasdale's is referring to depression as the emotional response and he asserts that it is caused by a particular pattern of sensory information and discrete meanings, as opposed to negative cognitions only.

In order to alleviate a depressive episode, he feels that therapy must be aimed at the generic level of meaning, and focused on replacing the associated implicational code with more adaptive alternative higher order meanings. With respect to the exact mechanisms of change, however, Teasdale is not very clear. He suggests that change could occur by methods of traditional cognitive therapy, in such a way that the newly incorporated thoughts and images "would replace the schematic models related to themes of helplessness and hopelessness that would otherwise maintain depression" (p. 349). He also suggests that sensory-based therapies, such as Gestalt therapy can be effective in creating adaptive high order meanings, his main point being that alleviation of depressive symptoms requires change at the holistic level of meaning, and not just at the specific level (i.e., negative cognitions).

Self-Concept as a Constellation of Self-schemata.

Although self-schemata are viewed as the "core elements" making up the self-concept in personality and social psychology, Nurius and Majerus (1988) note that the relationship between these two constructs has not been recognized in the psychotherapy literature. Drawing from the information processing literature on priming and activation theory, these authors propose three dimensions of self representation that they believe would bridge this gap: "accessibility", "possible selves" and "elaboration".

The term accessibility is used in the information processing paradigm to imply that only a subset of schemata is activated in working memory at any particular moment. Accordingly, Nurius and Majerus (1988) argue that a distinction needs to be made between a person's "global self concept", the stable pool of self-schemata that potentially can be activated, and his or her "working self-concept", the set of self-schemata that, at any given moment in time, are activated, or accessed, and made available for information processing.

"Possible selves" refers to the inconsistencies in the accessibility of different schemata that occur across different situations. The authors suggest that such inconsistencies may explain current contradictory views of the self as both stable and fluid. Any stability that does

exist in the global self-concept would not necessarily be reflected in schemata that are accessed for the processing of self-relevant information in a particular situation (i.e., the working self-concept).

Finally, consistent with the notion of elaboration in models of schematic processing, the authors suggest that schemata that are the most elaborated are also the most accessible and influential in meaning making. For example, a view of self that is complex and well differentiated will be difficult to change.

Thus, Nurius and Majerus' (1988) depiction of the self-concept suggests that the "self" is made up of a relatively stable pool of schemata, organized into constellations of information that vary in their amounts of differentiation, elaboration and accessibility. This leads them to speculate on a specific therapeutic approach. Instead of focusing on changing the content of current self-perceptions, Nurius and Majerus recommend that treatment interventions be focused on the development and elaboration of newer and more functional schemata.

Self-Discrepancy Theory. Another example of a broader model, that bridges the gap between the self-concept and self-schemata, comes from self-discrepancy theory (Higgins, 1987; Strauman & Higgins, 1987). Higgins' model draws on Freud's (1923/1961) notion of SuperEgo, Mead's (1934)

generalized other, Kelly's (1955) theory of personal constructs and Rogers' (1961) idealized self. From the standpoint of this diverse background, self-discrepancy theory purports that the self is made up of two cognitive dimensions: standpoints on the self and domains of the self.

Higgins maintains that there are two standpoints from which the self is viewed: (1) own or "myself as I see me", and (2) other or "myself as I believe significant others see me". He further suggests three domains of self: (1) actual or "the attributes I believe myself to possess", (2) ideal or "the attributes that I would like to possess", and 3) ought or "the attributes that I believe I should possess". Together, the two standpoints and three domains form six possible self-states: own/actual, own/ideal, own/ought, other/actual, other/ideal, and other/ought.

These self-states may be considered one example of multiple selves along the lines suggested by Nurius and Majerus (1988). According to Higgins, the self-concept is represented by the own/actual and other/actual self-states, while the remaining four self-states, which Higgins calls "self-guides", are internally generated standards that vary somewhat in relation to the individual. What is important in self-discrepancy theory is people's motivation "to reach a condition where our self-concept matches our personally relevant self-guides" (p. 321).

In this model, automatic activation of discrepancies between the self-concept and a self-guide are believed to be the cause of particular forms of emotional discomfort. Preliminary studies indicate, for example, that actual versus ideal discrepancies are linked to dejection type emotions, such as sadness, whereas actual versus ought discrepancies correlate with agitation type emotions, such as fear (Higgins, 1987; Strauman & Higgins, 1987).

There does not appear to be any research on the change processes associated with self-discrepancy theory. Higgins suggests three examples of how self-discrepancies might change in therapy. These include (1) changing clients' behaviours to make their self-concept more consistent with their self-guides, (2) changing clients' negative cognitions so that self-guides become more consistent with their concept of self, and (3) decreasing the accessibility of self-discrepancies, through reduced exposure to discrepancy evoking situations. He suggests that change is accomplished in each of these cases by existing therapy modalities: behavioural, cognitive and psychodynamic therapies in the first case, cognitive and psychodynamic therapies in the second case, and behavioural and cognitive therapies in the third case.

In sum, the preceding review suggests that the self may be conceptualized as a hierarchically organized system of

constellations of information which are processed via mental codes (or schemata) relevant to particular domains of experience and standpoints on the self. This self-system may be fairly stable in its entirety (e.g., "global self-concept"), but subsets of the system (e.g., "the working self-concept", "self-states") may be accessible for processing at any moment. The relative accessibility of these subsystems depend upon elaboration and previous access. Thus, the most elaborate and often used subsystem will be immediately activated in any given event, thereby influencing the processing of new information in that event.

It would also seem that psychopathology, within these integrative approaches, is related to the accessibility of dysfunctional schemata, whether caused by discrepancies between various self-states, or representations of the self that may have once served a purpose, but are no longer useful. However, research describing change processes and approaches to psychotherapy within these modalities, is limited. Thus, the following section describes some of the current and past psychotherapy research in the areas of self-schema and self-concept change in general.

Change in the Self in Psychotherapy Research

Research conducted from the vantage points of the perspectives reviewed earlier (self-concept and self-schemata) share the common view that the "self" is strongly

implicated in people's perceptions and judgements about themselves, others, and situations, as well as in their psychological adjustment and ability to function well in their environment (e.g., Fitts & Hamner, 1969; Ingram & Kendall, 1986; Linville, 1985; Winfrey & Goldfried, 1986). Psychiatric patients have been found, for example, to have self-concepts that are more negative, variable, deviant, conflicted and confused and less certain than members of the general population (Fitts & Hamner, 1969).

Different patterns of perceptual organization, that occur in the development of the self-concept, have also been found to correspond to different clinical disturbances (Guidano, 1987) as, for example, in post-traumatic stress disorders where negative images of the self as weak, helpless, needy, frightened and out of control are prevalent (Young, 1988).

Both self-concept and self-schemata have been shown to change as a result of therapy (Hamburg, 1988; Toukmanian & Grech, 1991). Change in self-concept has been conceived of as "a reorganization of the patterns of attitude toward oneself" (Guidano, 1987, p. 220) which comes about through the conscious elaboration of information about the self that is already represented in some way. It has been demonstrated that positive change in self-concept is often accompanied by freedom of movement and self-expression

(Hamburg, 1988). In follow-up studies lasting from 3 months to 5 years, the self-concept has remained stable, or has continued to move in a positive direction (Morrison & Heeder, 1986; Pahkinen & Cabbie, 1990).

In a recent study, short-term group therapy was compared to social skills training for change in self-concept (measured in terms of self-image) and depression in a group of depressed adolescents (Fine, Forth & Gilbert, 1991). At post-test, the therapy group showed significantly greater improvement than the social skills training group on measures of depression and self-concept. At a 9-month follow-up, the therapy group gains were maintained and the social skills group caught up. Thus, it was suggested that both social skills training and short-term group therapy are effective in reducing levels of depression and elevating self-image in adolescents.

Evidence for change within a particular domain was demonstrated by Wadlington, Austin and Bitner (1992). They found an increase in math self-concept and decrease in anxiety in college students after systematic desensitization. Math self-concept was defined as competence and self-esteem in the area of mathematical skill.

In an attempt to define the predictors of increased self-concept in terms of interpersonal perceptions in group

therapy, Neimeyer, Harter and Alexander (1991) found that perceptions of other group members were associated significantly with improvement in self-concept, social adjustment and symptomatic distress (related to having survived incest), when measured at the beginning of therapy. When outcome measures were analyzed with later therapy sessions, however, perceptions of the therapist played a more significant role in determining self-concept change. Hence, Neimeyer et al. suggest that therapeutic change in self-concept is facilitated by a working alliance with the therapist (even within the context of group therapy).

These recent studies reinforce the notion that self-concept disturbances play a role in psychopathology and the importance of the therapeutic alliance in self-concept change, while providing tentative support for the multi-dimensional nature of self-concept.

According to self-schema theorists, schematic change occurs on a continuum from subtle differentiation to schematic restructuring. It leads to a change in mental representations of self and others, and may be seen as the goal of psychotherapy (Freeman, 1986; Showers, 1992; Stein, 1992). Resistance to change is viewed in terms of pre-existing schemata which serve to undermine change by rejecting schema-inconsistent information (Markus, 1977; Stein, 1992). Like the theoretical premise underlying

change in self-concept, reorganization of mental structures is viewed as the key component of change in self-schemata (Showers, 1992; Toukmanian, 1992).

Pace and Dixon (1993) studied the effects of a brief version of Beck's cognitive therapy, designed to access and alter the cognitive structures that underlie depression, on change in self-schemata and depressive symptoms. They found a significant decrease in depression and a decrease in depression related self-schemata, as measured by self-referent recall, which was not observed in the control group. However, it is unclear whether the method of therapy employed in this study affected schematic processing, or whether it merely led to changes in the products of this processing. The results are interesting anyway, in light of the (previously mentioned) association found between reduction in levels of depression and raised self-image (Fine, Forth & Gilbert, 1991).

In a recent review of the effects of cognitive therapies on agoraphobia, Hoffart (1993) found that results from studies of "cognitive therapies" that were not drawn from current models of cognitive psychology were difficult to interpret. However, in studies where the method of treatment was clearly derived from cognitive psychology (i.e., where the aim of therapy was schematic restructuring as opposed to a focus on changing the contents of schemata),

significant treatment effects were found in agoraphobia and panic disorder.

Therefore, it appears that schematic restructuring, the goal of therapy according to self-schema theorists, may or may not be addressed by a variety of treatment modalities within the general cognitive paradigm. Whether the treatment model being used leads to schematic reorganization, or merely to change in the products of self-schemata (e.g., cognitions) remains to be seen in further research.

Change in self-concept has begun to be studied from the perspective of self-concept as a system of self-schemata. Möller, Kotzé, and Sieberhagen (1993) explored the effects of rational-emotive therapy and subliminal stimulation (aimed at unconscious processes) on self-concept in a follow-up study. Self-concept was operationalized in terms of the Tennessee Self-Concept Scale (TSCS) as a positive view of oneself in a variety of domains. Subliminal stimulation was hypothetically assumed to access schemata at some non-conscious level. The results provided some support for an effect of subliminal stimulation on enhancement of self-concept, which continued to improve at follow-up, while there was no support for an effect of subliminal stimulation on irrational cognitions.

The results obtained by Möller et al. (1993), that

there was an effect of subliminal stimulation on self-concept, yet no effect of subliminal stimulation on irrational cognitions, seem contradictory from the clinical cognitive perspective. However, they might be explained in terms of the notion of working versus global self-concept, as proposed by Nurius and Majerus (1988). From this perspective, the constellations of schemata that are accessed during conscious awareness could be different from those accessed during non-conscious awareness. Thus, a more positive view of the self could have been obtained by accessing some generic constellation of self-schemata, without concomitant changes occurring in "irrational cognitions" that may be processed via different constellations of schemata.

Similarly, in terms of Teasdale's (1993) interacting cognitive subsystems approach, perhaps change in schemata at a broad generic level might have been facilitated through subliminal stimulation. Nevertheless, there is no evidence to show that subliminal stimulation does, in fact, access schemata at any level and this speculation merely acts to highlight the dearth of research addressing the relationship between schematic restructuring and self-concept change.

Given the recent interest in the integration of self-concept and self-schemata and the therapeutic focus on change in conceptualizations of self-in-the-world, two

challenges remain. First, as was mentioned, there is a need in psychotherapy research for more information regarding the specific kinds of processes underlying self-schema change and the assessment of this change as a measure of therapy outcome. Second, despite the commonly accepted view that people's self-concept/network of self-schemata evolve through experience, to date relatively little is known about the relationship between change in self-schema and change in self-concept occurring as a result of therapy.

The Present Study

The present study had two main objectives: (1) to determine the degree of relationship between pre- to post-treatment changes in clients' self-schemata and level of self-concept, and (2) to explore, both quantitatively and descriptively, the processes involved in the development of self-schemata in the context of the perceptual-processing method of experiential therapy (Toukmanian, 1990).

The Conceptual Framework

The study was contextualized within Toukmanian's (1986; 1992) schematic developmental model of perceptual organization and change, which was developed specifically to explicate the processes involved in client change in experientially oriented psychotherapy. The model is based on current research in the fields of information processing, experimental cognitive psychology and social cognition. It adheres to phenomenological and constructivist positions, which maintain that people are information seeking and goal oriented organisms, whose behaviour is determined by perceptually driven constructions of meaning about self and events in their environment.

This model's view of schemata is consistent with current research. Schemata, the basic units of the perceptual system, are regarded as "structures underlying people's internal or mnemonic representations of prior

experiences" (Toukmanian, 1992). Their function is to provide the person with "loosely organized frameworks for the anticipation of information specific to varying domains of experience" (p. 80). Early schemata are believed to be crude and undifferentiated. With exploration of the environment as the child develops, they become complex and hierarchical (Toukmanian, 1992).

The model posits two interactive components of perception: perceptual or schematic readiness and mode of processing. Perceptual readiness refers to the available network of schemata which, when activated, determines how an event is represented or perceived. The more differentiated and complex the schematic structures in relation to a domain (e.g., the self), the greater likelihood that more of the available information will be detected and processed in any given episode within that domain.

Mode of processing refers to the automated or controlled manner with which information is analyzed, through various kinds of mental operations (e.g., recognition, scanning, differentiation, evaluation) and transformed into an internal representation. Automated processing is a rapid, nonreflective analysis of salient features in an event. Controlled processing is a slower, more reflective and deliberate analysis (Shiffrin & Schneider, 1977) involving qualitatively different and more

complex mental operations, which when brought to bear on the information being processed, lead to a modification of schematic structures and hence, to changes in the event's construction and representation (Toukmanian, 1992).

In this model, psychological dysfunction, or maladaptive behaviours, are seen to be symptomatic of "an underlying perceptual system that is developmentally arrested and restricted in the kind of information that it can accept and the way in which this information is processed" (Toukmanian, 1990, p. 311). Particular emphasis is placed on perceptual dysfunctions associated with an individual's representations of self (self-schemata) and self-in-relation to the world. These representations play a crucial role in the construction of events in unique and personally meaningful ways. When invoked, they provide the individual with a rich source of autobiographical information for the construal of everyday life situations. Thus, self-schematic representations that are formulated primarily through an automated mode of processing would be divorced from the individual's situation-specific sense of the "I" and "me" and consequently would fail to perform an adaptive function.

The treatment approach derived from this model assumes that schematic change occurs when the processing of information is deliberately interrupted, and interventions

are applied that engage the client in the reprocessing of information through the enactment of more complex mental operations (Toukmanian, 1992). Thus, according to the postulates of this model, therapeutic interventions serve to facilitate self-exploration and the reprocessing of problematic events, such that different facets of experience are recalled, associated meanings are differentiated, and experience is reconstructed more fully "from a more complete and internally discerned data base" (Toukmanian, 1990, p. 313).

By and large, results from several preliminary studies provide support for the central tenets of Toukmanian's (1992) model with regards to the structural and process related changes expected of clients receiving the perceptual-processing method of therapy. For example, there is some evidence showing that this treatment is effective in enhancing the complexity of clients' self and other relevant schemata and level of self-concept (Toukmanian, 1988; Toukmanian & Roese, 1989). It has also been found that clients process their experiences through the enactment of more complex mental operations in later than in earlier therapy sessions (Toukmanian, 1989; Zink, 1990), that "improved" clients are more likely to engage in internally differentiating, re-evaluating and integrating types of mental operations than "less improved" clients (Toukmanian &

Grech, 1991; Jackson, 1993), and that improvement in clients' processing ability during therapy is associated with increases in level of self-concept (Toukmanian & Grech, 1991).

However, as most of this research has been exploratory, there is a need for a larger scale empirical investigation to replicate these findings. Further, to date no qualitative studies have been carried out on the therapy experience of clients receiving the perceptual-processing method of experiential therapy. A descriptive analysis of clients' accounts of a significant event in therapy may prove to be useful in shedding some light on the processes that are postulated by the model as being crucial to therapeutic improvement. Information gleaned from such an analysis could contribute to the refinement of the model and suggest new avenues for psychotherapy process research. In light of these observations, this study was constructed in two parts.

Part I focused on the examination of change in self-concept and self-schemata, from the standpoint of clients' in-therapy process and final outcome. Based on earlier findings, concerning the effectiveness of the perceptual-processing method of experiential therapy, it was hypothesized that clients receiving this method of therapy would have greater pre- to post-treatment gains in level of

self-concept and complexity of self-schemata than participants in the control group. Furthermore, with the assumption that improvement in processing ability is related to therapy outcome, it was also hypothesized that clients who achieve greater improvement in processing during therapy would demonstrate significantly higher gains in self-concept and complexity of self-schemata than those who show less improvement.

In Part II, a descriptive analysis was conducted on one client's accounts of the experience of a segment of therapy that was identified by her as therapeutically significant, in light of Toukmanian's (1992) model of therapy.

Part I

Method

Participants

The study involved a total of 40 participants who were drawn from the client population of the Counselling and Development Centre (CDC) at York University. The treatment group consisted of 20 (2 male and 18 female) clients who volunteered to participate in brief individual psychotherapy based on the perceptual-processing method of experiential treatment. Clients' suitability for the research was established through an initial screening interview, based on the following inclusion criteria: (1) absence of thought disorder, suicidal ideation and history of psychiatric hospitalization, (2) a presenting problem that was of an interpersonal nature, and (3) no prior individual or group therapy experience. Individuals who met these criteria and who were willing to participate signed a consent form (Appendix A) after being given a detailed explanation of the nature of their involvement in the study.

The control group consisted of 20 (5 male and 15 female) volunteer participants involved in various self-help and skills training programmes at the CDC, who were not receiving any form of therapy at the time of data collection.

The therapists were advanced graduate students in Clinical Psychology who had at least one-year of applied internship experience. All therapists had specialized training in the perceptual-processing method of therapy.

Outcome Measures

The Tennessee Self-Concept Scale (TSCS). The Clinical and Research form of the TSCS (Fitts, 1965) was used to assess participants' level of self-concept. This is a self-administered inventory, consisting of 100 items. Each item is rated on a 5-point scale, ranging from "completely false" to "completely true". The scale produces a global self-concept score as well as eight sub-category scores, each depicting self-perception in a particular domain (e.g., physical self, moral-ethical self, etc.). Only the global score was used in this research.

The TSCS is standardized on a broad sample of people of varying ages, sex and socio-economic status. Test-retest reliability estimates on college student samples have ranged from .70 to .90 (Fitts, 1965). The available evidence supports the Scale's assumption that significant life events, such as psychotherapy, effect change in one's self-concept. The TSCS is widely used and is considered one of the better instruments for assessing global self-perceptions in both clinical and non-clinical populations (Buros, 1975; Suinn, 1972).

The Perceptual Congruence Score (PCS). This measure of self-schema change (Toukmanian, 1992) is derived from a two-step procedure. First, respondents are asked to rate, on a 5 point scale, a list of positive and negative adjectives, obtained from Gough and Heilbrun (1980), as to their degree of self-descriptiveness. Second, they are asked to rate each adjective as to its degree of interpersonal usefulness. An individual's perceptual congruence score is obtained by correlating the value of self-descriptiveness with degree of usefulness on each adjective across all adjectives.

The assumption underlying this measure is that when therapy is successful in facilitating change in clients' perceptions there will be a change in the value of the congruence score, a higher value reflecting a more flexible network of self-schemata, capable of accepting and integrating a wider range of information about the self (Toukmanian, 1992). There is some evidence showing that perceptual congruence is sensitive to changes in clients' view of self occurring as a result of therapy (Toukmanian & Roese, 1989).

Process Measure

Levels of Client Perceptual Processing (LCPP). The LCPP (Toukmanian, 1986) is a measure of client in-therapy level of perceptual functioning. This classification system, derived from the perceptual-processing model,

consists of seven discrete categories. Each category represents a particular kind of mental operation, ranging from simple to more complex, that is assumed to reflect the model's conception of automated and controlled processing. The categories are: I. Recognition/Undifferentiated Statements; II. Elaboration; III. Differentiation with External Focus; IV. Differentiation with Analytic Focus; V. Differentiation with Internal Focus; VI. Re-evaluation; VII. Integration. It is assumed that the former three categories reflect an underlying automated mode of processing, while the latter four indicate a more controlled mode of perceptual activity. An eighth category labelled "other" is used for client responses that cannot be classified in any of the seven processing categories. A more complete description of each category is given in Appendix B.

Audio-taped therapy sessions are transcribed for LCPP rating. Client responses are evaluated in two steps. In the first step, contextual units (i.e., everything said by the client between therapist interventions) are examined for shifts in the client's manner of perceptual processing. In the second step, the appropriate LCPP category label is assigned to these shifted segments, or scoring units (Toukmanian, 1989). Inter-rater reliability estimates from a variety of studies using Cohen's Kappa have ranged from

.37 to .78 (Brown, 1984; Jackson, 1993; Sinclair, 1990).

The LCPP has been found sensitive to changes in clients' processing over the course of therapy (Toukmanian, 1986; Zink, 1990). There is some evidence pointing to a relationship between clients' in-therapy manner of processing and therapy outcome on the Tennessee Self Concept Scale and the Perceptual Congruence score (Toukmanian & Grech, 1991). Furthermore, it has been shown (Shirley, 1983) that LCPP categories relate to conceptually relevant levels of the Experiencing Scale (Klein, Mathieu, Gendlin & Kiesler, 1970).

Procedure

Prior to any treatment, the TSCS and a set of adjectives drawn from Gough and Heilbrun's (1980) Adjective Check List (for the PCS) were administered to all participants. The treatment group received 60-minute weekly sessions of perceptual-processing therapy, lasting 10 to 14 weeks. The control group received an equivalent number of contact hours in self-help or skills training. Following the treatment period, all participants were re-administered the TSCS and the set of adjectives.

Data Extraction and Scoring for Process Analysis. Two audiotaped therapy sessions per client were selected for transcription. The first session was transcribed to serve as a baseline measure of clients' initial degree of

processing ability, and the other nine sessions were scrutinized, the one manifesting the greatest amount of high levels of processing was transcribed. An event manifesting a high degree of client processing was extracted from this transcription for rating on the LCPP. A segment of equivalent duration, and subject where possible, was then selected from the baseline transcript for LCPP rating (Zink, 1990).

High and low gain scores on the PCS and TSCS were established by first subtracting pre-test scores from post-test scores on each of these measures, and then taking half of a standard deviation of pre-treatment scores for the TSCS and .6 of a standard deviation for the PCS to split the groups.

In the case of the process measure, high processing was established, on each of the two rated sessions, as the proportion of the client's responses classified as Category IV, V, VI and VII on the LCPP. Difference scores were obtained by subtracting the proportions of high processing of the first session from the later session. The difference scores were split into high and low processing groups, using twice the standard deviation of the distribution of the initial session proportions.

These scores were obtained for 19 of the 20 clients in the treatment group. One client was eliminated because the

tapes of her early therapy sessions were not clear enough for transcription. Different cutoff points for the three scores were used (e.g., .5 x s.d., .6 x s.d. and 2 x s.d.) in order to provide a meaningful split, and also to obtain manageable numbers in a given cell.

Results

All statistical tests were carried out at York University, using SPSS Release 4 software.

Inter-rater Reliability

Events from both early and late therapy sessions were sampled to determine inter-rater reliability on the LCPP. Samples were taken on two different occasions, as the pool of clients increased. The overall absolute proportional agreement between the two judges on the first 140 scoring units sampled was .657 and the corresponding Kappa coefficient was .565. On the second sampling occasion, the overall absolute proportional agreement between the two judges on 108 scoring units was .755 with a corresponding Kappa coefficient of .679. These values reflect a high degree of inter-rater agreement ($p < .001$).

Preliminary Analyses

The data were first analyzed to verify assumptions of the general linear model, including normality of the distributions of process and outcome measures and homogeneity of variance between groups on the outcome measures. All variables were found to be normally distributed and the between group variance on the PCS and TSCS did not violate the assumption of homogeneity.

To ascertain comparability of groups on these measures

before treatment, a MANOVA test for simple effects was performed on the pre-test TSCS and PCS scores. No significant mean differences were found between the treatment and the control groups on either measure. The pre- and post-treatment means and standard deviations are presented in Table 1.

The pre- and post-test scores on the TSCS and PCS, for each of the treatment and control groups, were correlated to check their redundancy of measures. It can be seen from Table 2 that there was a significant, but moderate, relationship between these two measures. When correlations were calculated for each group separately (see Table 3), the relationship between the two measures continued to be moderately high for the control group. The treatment group, however, evidenced a much stronger relationship between the measures of self-concept and flexibility of self-schemata.

The percent of shared variance at pre-test was 43% for the control group and 53% for the treatment group; at post-test it was 26% for the control group and 68% for the treatment group.

Table 1**Means and Standard Deviations for Outcome Measures**

Measure	Treatment		Control	
	M	SD	M	SD
TSCS				
Pre	311.050	41.413	312.450	35.611
Post	338.650	46.381	316.300	42.835
PCS				
Pre	.403	.282	.392	.309
Post	.632	.214	.449	.321

Table 2

**Pearson Product Moment Correlations on Pre and Post-Test TSCS
and PCS Scores (N=40)**

	TSCS (Pre)	TSCS (Post)	PCS (Pre)	PCS (Post)
TSCS (Pre)	1.000	.804*	.689*	.539*
TSCS (Post)		1.000	.471*	.652*
PCS (Pre)			1.000	.762*
TSCS (Post)				1.000

***p < .01, 2-tailed**

Table 3

**Pearson Product Moment Correlations on Pre and Post-Test TSCS
and PCS Scores for Each Group**

Control Group

	TSCS (Pre)	TSCS (Post)	PCS (Pre)	PCS (Post)
TSCS (Pre)	1.000	.901**	.657**	.524*
TSCS (Post)		1.000	.522*	.511*
PCS (Pre)			1.000	.863**
TSCS (Post)				1.000

Treatment Group

	TSCS (Pre)	TSCS (Post)	PCS (Pre)	PCS (Post)
TSCS (Pre)	1.000	.784**	.730**	.695**
TSCS (Post)		1.000	.444*	.823**
PCS (Pre)			1.000	.723**
TSCS (Post)				1.000

*p < .05, 2-tailed

**p < .01, 2-tailed

Testing the Hypotheses

The first hypothesis, that pre- to post-treatment gains on the TSCS and PCS would be significantly higher for the treatment than for the control group, was tested by a repeated measures MANOVA. An initial Wilk's Test for multivariate analysis yielded a significant group by time interaction for the two outcome measures, combined [$F(2,37)=5.34, p < .05$]. Subsequent ANOVAs on each of the measures revealed significant group by time interaction effects for the PCS [$F(1,38)=9.14, p < .05$], and for the TSCS [$F(1,38)=9.14, p < .05$]. Significant main effects were also found for time, but not for group (see Table 4). In view of these findings, post-hoc tests for simple effects were conducted on the data.

The results of these univariate analyses are reported in Table 5. It can be seen that there was a significant pre-test to post-test gain for the treatment group on the TSCS [$F(1,38)=25.20, p < .001$] and the PCS [$F(1,38)=32.17, p < .001$]. There was, however, no effect for time on either measures for the control group. These findings support the effectiveness of the perceptual-processing method of therapy in enhancing clients' level of self-concept and development of self-schemata.

Table 4

Summary of Repeated Measures MANOVA

Source of Variability	Wilks Lambda	SS	df	MS	F
Group					
	.967		2		.637
TSCS		2194.51	1	2194.51	.690
PCS		.188	1	.188	1.294
Error					
			37		
TSCS		120926.98	38	3182.29	
PCS		5.528	38	.145	
Pre-Post					
	.596		2		12.522**
TSCS		4945.51	1	4945.51	16.359**
PCS		.409	1	.409	24.979**
GroupXPre-Post					
	.776		2		5.34*
TSCS		2820.31	1	2820.31	9.33*
PCS		.150	1	.150	9.13*
Error					
			38		
TSCS		11487.68	38	302.31	
PCS		.622	38	.016	

* $p < .01$

** $p < .001$

Table 5

Simple Effects: Univariate Tests of Group by Time

Source	DF	Hypoth. MS	Error MS	F
Treatment Group				
by Time				
PCS	(1,38)	.527	.016	32.169*
TSCS	(1,38)	7617.600	302.307	25.198*
Control Group				
by Time				
PCS	(1,38)	.032	.016	1.950
TSCS	(1,38)	148.225	302.307	.490

*p < .001

Fisher's Exact Test of Probability was used to test the second hypothesis that improvement in level of processing would be associated with greater gains at therapy outcome. As previously mentioned, these analyses were conducted on 19 clients. Clients with high and low processing on the LCPP, and with high and low outcome on the TSCS and the PCS, were identified following the procedure described in the Method section. As Table 6 shows, 10 of the 19 clients exhibited high gains on both the LCPP and the TSCS and 9 of the 19 clients exhibited high gains on both the LCPP and the PCS.

The associations between the Levels of Client Perceptual-Processing and each of the two outcome measures was found to be significant ($p < .05$, one-tailed), lending support for the hypothesis that clients' who achieve greater improvement in processing during therapy would demonstrate significantly higher gains in self-concept and complexity of self-schemata than those who show less improvement.

Table 6

Association Between Gains on Process Measure and Gains on Outcome Measures

Outcome Measures	LCPP	
	Low-Gains (on Categories IV, V, VI and VII)	High-Gains
TSCS *		
Low (n=8)	5	3
High (n=11)	1	10
PCS *		
Low (n=9)	5	4
High (n=10)	1	9
* $p < .05$, 1-tailed		

Discussion

The main objective of Part I of this research project was to determine the degree of relationship between clients' in-therapy process and final outcome. Overall, the results were as expected. Participants who received perceptual-processing experiential therapy improved on measures of self-concept and self-schemata to a significantly greater degree than participants who received skills training. These results are particularly telling, given that the control group was not strictly a no-treatment control group. They support the view, advanced in Toukmanian's (1992) model, that self-schemata become more elaborate and flexible, and that change occurs in general perceptions of self, as a result of therapy.

Similarly, the finding that clients with the greatest in-therapy gains in perceptual-processing tended to have greater pre- to post-treatment gains on the measures of self-concept and perceptual congruence was also consistent with expectations. These results provide tentative support for the conception of change specified by the perceptual-processing therapeutic approach, that clients who engage in more complex processing operations are more likely to show improvement in level of self-concept and increase in flexibility of self-schemata.

These results further strengthen two suppositions held in the recent psychotherapy literature. The first is that the client's perception of self is implicated in a variety of psychological disorders (Guidano, 1987; Linville, 1985; Winfrey & Goldfried, 1986) and therefore, change in the perception of self is a useful aim of psychotherapy. Secondly, therapy that focuses on change in the processing of information, or schematic reorganization, is more likely to bring about change in clients' perception of self than therapy that focuses on changing the content of self-schemata (Hoffart, 1993).

Finally, the moderately high correlation found between the TSCS and PCS is indicative of an association between change in self-concept and the reorganization of self-schemata. Given that this correlation is not extremely high, it is evident that these measures are conceptually related, but that each is tapping a different aspect of a construct--self-perception--that cuts across both measures. Furthermore, if the TSCS and PCS were in fact measuring the same construct, then the correlations should be equivalent between the treatment and control groups. The finding that the correlations, shown in Table 3, were moderately high for both groups at pre-test, but were quite disparate for the two groups at post-test, provides further support for the assumption that the two constructs being measured are

related, yet not the same. The shared variance at post-test for the treatment group (68%) was much higher than the control group (26%). This suggests, as proposed by the model, that clients develop more elaborate and flexible self-schemata that are capable of integrating more information about the self, thereby potentially broadening and integrating their overall view of self--hence, the high association between these two constructs.

If we accept Nurius and Majerus' (1988) model of self-concept as a "global" pool of self-schemata, only a portion of which are available for processing at any given time in the form of a "working" self-concept, the correlation found in the present study is due to the fact that the list of adjectives presented to clients for derivation of the Perceptual Congruence Score accessed a set of self-schemata that made up their "working" self-concept. Additionally, the Tennessee Self-Concept Scale, due to its comprehensive sampling in a variety of domains, was able to gather a wider range of information, representing the clients' global self-concept. The multi-dimensionality of the self, evidenced in these and other theories (Higgins, 1987; Teasdale, 1993) support the view that the self-concept is a global entity, made up of a large pool of self-schemata that are accessed from a variety of domains.

Two considerations remain for future work on this

project. First, as the sample of rated sessions for the process analysis was small, no conclusive statements can be made about the relationship between processing operations and improved self-concept and perceptual congruence. A full-scale study with a larger sample of clients and rated sessions would be needed to add further support to these results.

Secondly, the Perceptual Congruence Score is a relatively new measure that purports to assess structural changes occurring in clients' self-schemata. Although it proved to be sensitive to such changes in the present study, its validity remains tentative pending further investigation.

Part II

In Part II of the present research, one client's experience of a significant event in therapy was examined from the standpoint of Toukmanian's (1986) model of perceptual processing. The main purpose of this exploration was (a) to determine whether or not the course of the client's processing in this event was characterized by the kinds of information processing operations that are specified by this model as being crucial to therapeutic improvement, and (b) to ascertain if the client was aware of the processing operations, as defined by the LCPP, that she was engaged in during therapy.

Description of Procedure

The client, who will be identified as "Pat", was a member of the group of 20 clients involved in Part I of the research. A session from the late phase of therapy (session 11) was targeted for study. Within 20 hours of this session, a judge used the LCPP to locate on the audiotape a segment of the client's dialogue that demonstrated high level of processing (Category V, or above). Within 24 hours of this therapy session, an Interpersonal Process Recall (IPR) interview was conducted with the client by an experienced IPR interviewer (David Rennie).

The IPR is a qualitative methodology, or an approach to gaining access to clients' subjective experience of events

that occur during therapy (Rennie, 1990). It is a tape-assisted procedure in which the client is in charge of stopping the therapy tape at significant moments. The interviewer's task is to ask open ended questions that facilitate recall of what the client was thinking, feeling and/or experiencing at such moments.

The IPR procedure in this study consisted of two steps. In the first step, a non-directed inquiry was made into the client's recollection of the self-identified most significant event in the therapy session. The interviewer asked Pat to think back and consider whether anything significant had occurred at any particular period, during the session that she had previously identified as helpful. Once Pat identified a significant event, the interviewer isolated it, by replaying the tape until Pat was able to discern where the event began and ended.

In the second step, the interviewer replayed the segment of therapy tape that had been previously rated on the LCPP as high level of processing. A non-directed inquiry was made of Pat's experience of the event to see whether or not she was aware of and could describe the cognitive strategies, or processing operations, that she was engaged in during this segment of therapy. During the last half of this inquiry, the client was given broad hints about the perceptual-processing model and advised to step outside

of herself and look at her cognitive processes, versus her thoughts, or cognitions. The segment was then replayed and a directed inquiry was made as a way of "testing the limits" of the client's awareness of cognitive strategies in terms of the constructs of the perceptual-processing model.

Analysis

The analysis was carried out in two stages that correspond to the two steps of the IPR interview. In the first stage, a comparison was made between Pat's initial and spontaneous account of her experience in the self-identified most meaningful segment of therapy and the segment rated independently on the LCPP as high level of processing. In stage two, Pat's responses to the interviewer's probes were examined for her awareness of the cognitive strategies that she employed in the processing of the event during therapy. The descriptive analysis was carried out with the intention of ascertaining whether or not the client's account of her experience was in any way related to the postulates of the perceptual-processing model, as opposed to a purely hermeneutic analysis, which would have interpreted the client's explanations from a more open-ended position.

Stage One. As Pat listened to the first replay of the self-identified most significant therapy segment, she stopped the tape four times and made some comments about the previous section of tape. For the purposes of the present

research, these comments were scrutinized in light of LCPP ratings that were made on the original therapy transcript. These ratings are displayed on Table 7.

Table 7

LCPP Ratings of Client-Identified Segments of Tape

Therapy								
Tape	LCPP Category Ratings							
Segments:	I	II	III	IV	V	VI	VII	Totals
First	2	2	2	3	0	0	0	9
Second	3	3	0	5	1	2	0	14
Third	0	1	0	4	2	1	0	8
Fourth	2	7	6	2	4	2	2	25

Pat initially paused the therapy tape after a period where she had been describing her concerns about her ex-boyfriend and her personal safety, following the break-up of the relationship. During this therapy segment, she mentioned her worry that her ex-boyfriend might do some physical harm to himself, and that she would be left feeling quite guilty. Yet she did not want to take responsibility for her ex-boyfriend's behaviour and, therefore, she told the therapist that it would be best for her to stay away from her ex-boyfriend. The following is an excerpt from the IPR session, after Pat stopped the therapy tape:

I. this is the part where

P. let's see, that I realized that it wasn't what I thought, was in such a responsible way, but I didn't realize that it was because I was scared to death [I. I see] that he would, he would have this violent side, or could have, and at this point when we were talking, I was, I am and always have tried to keep, to dampen the fire so that I won't have a major confrontation. So this is the point where I thought, I started feeling, I think, "Holy shit!" I'm saying one thing, my reasons for doing that, which I wasn't even aware of, were altogether different.

I. So have we identified the point where it began,

where the realization began?

P. Yes. We have.

As can be seen from the transcript, Pat identified the previous section of the therapy tape that she and the interviewer had been listening to as the beginning of a significant event in the therapy session. In fact, this is precisely the spot where the LCPP rater independently marked the beginning of the segment of high processing. The concomitant LCPP ratings for the therapy session previous to this significant moment ranged from Category I through Category IV (see Table 7, LCPP ratings for First Segment). According to the perceptual-processing model, the appearance of the lower categories indicated that her construal of the experience was from an external frame of reference and her processing somewhat static and internally undifferentiated. The occurrence of Categories III and IV showed that she was beginning to analyze and differentiate between aspects of her experience, although not yet from an internal point of view.

The therapy tape was started again. In this next segment, Pat continued to explore her concerns about how her ex-boyfriend was handling the break-up and her desire not to be held responsible for his actions. She admitted to being somewhat afraid of him, and told the therapist that she had

enlisted the support of friends to keep her up-to-date on her ex-boyfriend's situation, in such a way that she would not have to deal with him personally. At Pat's next pause:

P. I know what's coming up, so. There's a realization here where I hesitate and I realize that [a friend] can't help me either. [I. uhmm] That's the talking and like, [therapist] is very, the way she asks you the question, you just stop, you almost like recap [I. umhmm] and think, "No, it's not going to work this way," and here, this is where I'm going, "No, he can't help me either." There's no [i. umhmm] so then, there's no-- there's nobody there, so I'm having another thought of, "What do I do? Who is there?" So, then I'm thinking of being some form of, not really being a detective, I guess it's another sense of fear, another stage of I'm in this thing alone! [I.-umm] I can't really even put a peace bond on him, because he doesn't respect those. I can't, and at that moment, I thought that, "I'm really alone with this guy. So now what am I going to do?" Those thoughts are with me.

Pat told the interviewer that in the previously heard segment of therapy she was on the verge of coming to a

"realization". Her fear of her former boyfriend was recalled along with the memory that she was all alone to deal with it. Thus, in the therapy session, she not only was analyzing the "facts" surrounding the situation, but also appeared to be turning inward in an attempt to explore the experience from an internal frame of reference and tentatively coming to a "realization" that her experience was one of fear and aloneness.

When looked at from the point of view of the perceptual-processing model, Pat's statements are compelling (see Table 7, LCPP ratings for Second Segment). Her LCPP ratings for both the previous and the following therapy segments include a large percentage of Category IV and above ratings. Both Category V (internally-differentiating) and Category VI (re-evaluating) are evident in both segments. The client's accounts of the experience were clearly compatible with the perceptual-processing model's description of the nature and progression of productive processing.

During the next segment of therapy, Pat explored the usefulness of having friends check up on her ex-boyfriend, in light of their inability to watch his every move. She discussed his previous aggressive behaviour, saying that she was concerned that he might become angry with her for leaving him, and this concern felt very "real" to her. At

Pat's third pause:

P. I may have realized because I'm saying it now, and this is for the whole process that I have, seeing [therapist]. It's where I said I'm aware that he will blame me, whereas before, I felt responsible and I took the guilt [I. umhmm] in order to correct it [I. umhmm] and now like, "Hey, this isn't my problem. Don't blame me for," like, this isn't a new stage or anything. It's just that the progress that I've made [I. ummm] since I've been here, it's good.

I. And in this moment you're saying sort of, remember yourself saying this.

P. Yes. I did. And I realized, yeah, I did realize not that that's a step in the right direction. I'm not responsible for whatever people do with their lives....understand.

I. Somehow it's different to say it to someone like [therapist].

P. Yes. Um, it's different to say it [I. as opposed to sort of thinking it]. Yes, because I always took the blame for everything. I was always the guilty one. It's different to be able to, because you've freed yourself. You can say, well, you're in a situation to deal with it, or you're not my

problem, or before, I would feel, "I don't want the situation," but I would never voice that. I was afraid that if I put my foot down and said no, I'd be rejected. This person would get mad at me, and now I'm realizing I deal with those things differently and I don't let them get inside me [I. Umhmm] like I used to.

- I. What I'm interested in [Pat] is, did this realization occur at this moment? Can you recall?
- P. It must have. Just by hearing what I said, probably I have been thinking about this, but when I just heard myself say that to [therapist] it must have, or I wouldn't have brought it out.

Here Pat was aware of a change in her view of self, or how she saw herself in relation to her former boyfriend. Previous to this, she had felt responsible for his behaviour but now was recognizing that it was not her problem. This change in the client's perception was reflected in the LCPP ratings (see Table 7, LCPP ratings for Third Segment), which showed that Pat's processing continued to be at high and productive levels.

The final pause came at the end of the significant moment in the therapy session, as identified by Pat. During the therapy session, she came to a realization that she felt

as if she was running scared, both from her ex-boyfriend and from a host of other worries. In this segment, she spelled out her economic worries, her fears, and her wish to be "protected" by someone. She concluded that she was in fact alone to deal with all of this, and ended the segment by taking a look at some potential coping strategies.

Due to technical difficulties, this section of the tape was inadvertently not covered in the IPR interview. This is unfortunate, because it was the only section that included LCPP Category VII ratings, integration (see Table 7, LCPP ratings for Fourth Segment). It is important to note, however, that the event that Pat chose as meaningful in therapy did include a segment where, according to the model, she integrated new material into her existing view of self.

Stage Two. During the second stage of the IPR interview, the LCPP-identified high process segment was replayed. As noted above, this fell within the client's self-identified significant segment. Whereas in stage one, the client was in charge of stopping the therapy tape, in stage two the interviewer paused the tape several times, asking probing questions, designed to elicit Pat's awareness of her cognitive processes during the bracketed therapy segment. The following excerpt occurred at the beginning of this stage of the IPR interview, after the interviewer replayed the segment of tape where Pat described her fears

of her ex-boyfriend's aggressiveness, and described herself as running scared:

I. Let's go down to the beginning of the moment. It seems like it started when [therapist] made her comment, the uh fire. That's when we sort of stopped the tape.

P. She said, like, I'm always trying to dampen the fire [I. right] to smooth things over [I. right]. It's not a major competition, and at that point I realized the reason I was doing that was because I was afraid of him.

I. Right. Was there something about [therapist's] response that did that to you?

P. [pause] I don't um, the way she presented it, you mean? Whether that had something to do with it? [I. umm] Well it certainly graphed it to my mind. [I. graphed in what sense?] Well, just easy to picture. I pictured [I. yes] that [boyfriend] would be the fire, I would be the water. I would be the one keeping it smouldering rather than it igniting. I related to that and uh. ...I'm not sure what you're wanting of me or what you want to hear or what.

I. Well, what I am interested in is like, you came about a realization here, that you really are

afraid of him, and somehow the quality of that realization shifted.

- P. Became more intense you mean? [I. yes] You know that it, it happened, I tend to block this thing out for two reasons and I'm not just sure what they are. One is the reality that um, that I don't want to face the dangers that lie ahead. The other is that I'm blowing this out of proportion and it's unnecessary to feel this way.

As can be seen from this excerpt, at first Pat was unable to grasp what she was supposed to be doing in response to the interviewers non-directive probes. The IPR session continued along these lines, until the interviewer finally began to brief Pat on some of the underlying assumptions of the perceptual-processing model. At first this was done in a very general and somewhat vague manner, designed to focus the client on her cognitive strategies, but without giving her any of the language employed by the model.

After giving Pat this background information, the interviewer replayed the LCPP high-rated segment, and asked her whether she could now begin to make some kind of statement about what she thought she was doing in the therapy segment:

P. As I listen to that, I feel different today than I did. I was in a state of shock and I think it was an unnecessary state. I think that I am expecting something to happen. Un, because of things that have happened in the past. I see myself creating this whole scenario, things that, the way it's going to be. Maybe I fabricated something in my mind that's not going to be that way. I'm actually torturing myself, and putting myself through a lot of what ifs, and buts, maybes. I, I it sounds kind of silly to me to say, at that time it was real. I don't feel that anxiety that I did then. It sounds foolish. Certainly very self-destructive, how I felt there.

Thus, when asked to evaluate what she was doing in the therapy session, Pat responded in a self-critical manner. During the actual therapy session she had been feeling very anxious, but in the meantime her situation had changed and now she felt kind of foolish in hearing herself. Thus, from Pat's initial assessment, it would appear that she might not have been aware of her processing strategies during this sub-segment of the therapy session.

The interviewer responded by coaching Pat further in regards to the model:

I. Okay. If I said to you um, psychologists like to think that people engage in different kinds of cognitive processes, would that have any meaning to you? [P. by cognitive you mean...] thinking, mind [P. create a situation?]. Let me [brief pause]. For example, remembering would be one kind of process. Deliberating would be another kind of process.

P. Making situations that really isn't there, or elaborating, or concocting? Is that what you're sort of?

I. That would be getting, yes, then this is examples of what we would be doing. Okay? Cognitively, in our minds.

P. I'm not sure if you're saying that I have um, I accept I want something like this to happen, or I guess it's ... confusing here.

The interviewer tried a new strategy to set aside Pat's confusion. Telling her that he was more interested in her thought processes than her actual thoughts, he suggested that as she listened to the therapy tape, she should step outside of herself, and watch herself. After listening to a small portion of the previously played segment, where she was describing and projecting her ex-boyfriend's temper onto

potential reactions that he might have in the present situation, Pat took more of a third person stance in her report:

- P. I'm assuming that [boyfriend] is going to do something [I. um-hmm] and in assuming that he's going to do something, I'm already experiencing all of the feelings [I. um-hmm] that would go along if he actually was doing it, so I'm creating the scene inside.
- I. This is closer now, you see.
- P. I do that you know. Do we have to relate to this situation here? Is that what for me just to key into?
- I. No. If you want to elaborate, that's fine.
- P. We have a tendency--I have a tendency to do that. It's a form of attention seeking. You fabricate things in your mind and then you role play it. [um-hmm] I've done that a lot. It, it, I, I, um, for a long time. I've never thought about this before. But I have, or, or and not, it's mainly negative. Like, you're dying and everybody's coming to see you. It's always something that's negative and tragic. Always. Pretty much.
- I. Okay, sorry. What you're telling me is that what you've discovered here is something that is part

of your style, you have a tendency...Now, but I would also observe that um, you might be putting yourself down just a trifle, you know, in making these observations about yourself, because, what I want to do now is to go back and replay this again and I want you to now listen to it and ask yourself, 'Right. Let's take for granted that I'm doing that; is there anything else that I'm doing?'

Here, after it was suggested that she step outside of herself, Pat was able to report that in the therapy segment she was "assuming", "creating a scene" (internally) and "re-experiencing" feelings. After veering off-track, she was guided again by the interviewer to take another look at what she was doing in the therapy session.

The same small portion of tape was replayed, and the interviewer asked a more specific question:

I. This is what I'm interested in. When you would say, "If he could have been that way then, he can be that way again"--I think that is in fact what you are saying [P. um-hmm] yeah--what are you doing there?

P. Umm. I'm assuming that the characteristics are still going to be there. [I. of him?] Yeah. Do you

want to know what I'm doing with that? What? Why?

I. What are you doing there? You're doing something about him, aren't you?

P. Gee, yeah, what am I , ho-hoping that he's that way, or knowing that he hasn't changed. I'm judging him [I. yeah] and I'm assuming that he hasn't changed.

I. Yes, you're forming a conclusion.

P. That's right, based on the past.

I. Just let me push one more step. If you were to come up with a word to describe this kind of doing, what you are doing, what would that one word be?

P. ...Certainly judging this person pretty harshly.

I. Judging would be closer to what I would be looking for [P. yeah] like, if we're looking for a central word.

P. I would have to say if I take myself out of the situation, and look at it as if it was somebody else, I'd say the person is coming down pretty hard on this guy. Um, assuming a lot, judging him. Convicted [I. umm] without even giving him a chance, because I haven't really dealt with him personally through the stress. Now to see whether he has, whether in fact, what he does, or how he

feels...

- I. See, what you're doing now? Well, you're sort of questioning your motives. [P. um-hmm] Now would you, which is okay, to do that I mean, if that is something that you get out of this interaction with me [P. um-hmm] that's fine. That's not what I'm looking for.

Once again Pat reported that she was "judging" and "assuming". Again the interviewer cautioned Pat to listen to herself on the tape, asking herself "What am I really doing here"? The interviewer played a little more of the tape, where Pat was describing how she felt about the way her boyfriend might react to the break-up and, after the next pause, Pat responded to the question about what she was "really doing":

P. Judging him again.

- I. Good, Okay, judging has a moral sort of connotation to it. Can we let go of the morality and if so, what are you doing?

P. Assuming that I know what's going on with him and what he's going to do. Um, creating a situation that might not even exist? Um, certainly worrying about a lot of things also that might not happen. Um, I'm putting myself through an awful lot of

anxiety, fear, resentment.

Here, Pat was able to identify several qualities of her in-therapy experience of the replayed tape, including "judging", "assuming", and "creating".

The final pause occurred after an additional few minutes of tape was replayed. In this last therapy segment, pursuing her feelings about her ex-boyfriend's potential reactions, Pat said, on one hand, that she was uncertain about what was going to happen, while on the other hand, she anticipated that something was going to happen, due to his previous "track record".

During the IPR interview, Pat responded in a different way than she had previously. Rather than examine her cognitive processing, she reaffirmed the reality of the experiences that led her to have the feelings that she was experiencing in the therapy session:

P. What I'm saying from his track record, and um this fear that I have is there. It's real; he has been drinking; he has pulled me out of bed, down the hall, restricted me from doing something, so that part of the confrontation, there is a fear there from the past, and I have not been able to get rid of that fear yet. Like it's still [I. yes]. Do you understand what I'm saying? [I. yes, yes, yes]

Um, but its a fear in the past and there has been nothing happen in, um eight, nine, ten months or more that would indicate to me that he's going to get physical. [I. um-hmm] As a matter of fact its quite the contrary. There were times when I expected him to react differently than he has and he hasn't. He kept a low key. So it's probably unnecessary, maybe rather than feeling afraid...I don't know what to do. Be a little more confident in him? [I. mmmm] That's it, that he's going to deal with this thing. That he is a civil human being. [I. So] Give him a chance in my mind not to confront him, but giving up is so hard on...

I. Okay, what are you doing now?

P. I don't know. What am I doing? I'm putting myself down for being so hard on him. Or, what am I doing? Justifying how he feels. I'm putting myself down [I. um-hmm] taking the bla--no, mmm, feeling kind of bad that I created a situation that I didn't have to create [I. mmmmm].

Justifying myself, I don't know. [I. Are you doing all of these things?] I think so, but now a hundred percent convinced yet that I have, that uh, I'm not convinced that I can put to rest these feelings of anxiety, worry, um, my guard down.

I'm not ready to do that yet. [I. right]

Actually, right now, I'm very much in limbo as to what to do. [I. At this moment with me you mean?]

At this moment, what to think. I've just sort of now, um, put all these things out in the middle of the ball field and I'm not just sure what I want to do with them. Like, I can look at them in different ways now than--before, I was focused on all these bad things, all these single things, all these fears, angers that I had. I don't feel that way anymore. But I don't know what I feel.

This moment in therapy seemed to have been a very compelling one for Pat. Not able to identify her cognitive operations for this segment, she began to talk about qualities of the feelings she had been experiencing. Then she seemed to attempt to plunge into therapy within the IPR session. If this IPR session were being rated on the LCPP, the client appeared to be involved in a high level of processing here, becoming internally focused and engaging in re-evaluations.

In the IPR session, the interviewer then proceeded to tell Pat what she had just done in light of the perceptual-processing model, and to fill her in on the specific aspects of the model. After a brief discussion concerning the

importance of Pat's revelations in light of the perceptual-processing model, Pat agreed that the language of the model was germane to her experience of her thought processes, as they occurred in the therapy session. The IPR session ended there.

Summary and Discussion

Two interesting results were apparent at the outset of this analysis. First, in terms of stage 1 of this (qualitative) part of the study, the segment that Pat selected as particularly meaningful contained the section that had been identified as high level processing on the LCPP in comparison with the rest of the therapy session. Second, when the LCPP ratings for this segment were considered sequentially, a pattern emerged. There appeared to be a progression from a concentration of lower LCPP processing categories (I, II and III) at the beginning of the segment to a high proportion of Category IV (differentiation with an analytic focus) in the middle, followed by a greater number of higher processing categories (V, VI and VII) towards the end of the segment.

It is obvious from Table 7 that this progression is not straightforward. However, there is certainly a pattern of higher concentrations of less complex processing strategies towards the beginning and more complex processing strategies towards the end of the segment, with the only integration

shifts found at the very end of the segment. Thus, the LCPP ratings for the event described as particularly meaningful by Pat showed a steady progression from a static and automated mode of processing to a more controlled, reflexive and deliberate manner of analysis, which led to a re-evaluation of the event (i.e., her relationship with her former boyfriend) and an emergence of a new perspective.

Both the importance placed on the identified segment of therapy by the client and her depiction of what she believed she was doing in that moment are consistent with the model's prediction of therapeutic change. The LCPP rater described the segment as particularly high quality in terms of complex processing operations, and without knowing this, the client identified this segment as a meaningful one for her. Furthermore, the client's description of the way she "hesitated" and "came to a realization" (re-evaluation) and her agreement with the interviewer that she had come to a "conclusion" (integration) are descriptive of the way therapeutic change unfolds, according to the perceptual-processing model. These observations suggest that there is a relationship between the cognitive strategies implied by the perceptual-processing model and the meaning that this client attributed to important events. Further, inasmuch as we can use the information gleaned from one client, these observations suggest that perceptual change occurs through

reschematization as implied by the model.

Near the end of the first stage of the IPR interview, Pat tried to re-engage in the therapy process. It is useful to note that this occurred when she was reviewing a high processing segment of therapy. One possibility for Pat's re-engagement in therapy, during the IPR interview, is that her re-evaluation was left unfinished in the therapy session, and that the exploration of this in-therapy moment during the IPR session could have acted as a priming agent for relevant schemata.

Another consideration is the therapeutic value of the IPR interview itself. Perhaps it has the potential for facilitating client engagement in complex processing operations. An unanswered question arising out of this speculation may be considered in future psychotherapy process research. What therapeutic benefits are there, if any, to having clients listen to and explore meaningful segments of their past therapy sessions?

Technical difficulties prevented a description of Pat's perception of the moment in therapy that was rated on the LCPP as Category VII (integration). According to the model, this type of processing should signal a new understanding of oneself, and/or ones self-in-the-world relations. It is assumed that a similar analysis in the future might shed some light on this missing bit of information.

Stage two of the analysis addressed the question of the extent to which the client was aware of the cognitive strategies that she had been engaged in during the therapy segment. The results indicated that the client was clearly aware of many of her processing operations, but that she did not conceptualize them in the same way as the model sees them, nor did she consider her cognitive processing strategies to be particularly important until this possibility was pointed out by the interviewer.

At first, she responded to his non-directive suggestion, to reflect on what she had been doing in the therapy session, by evaluating her statements, and implied thinking strategies in a negative way. However, over time, as the interviewer directed her to focus on her cognitive operations, the client became quite reflective about what she was doing cognitively in the therapy session, and was able to provide a variety of descriptive terms that were, for the most part, consistent with the associated LCPP ratings for the segment under study.

For example, when Pat described her in-therapy strategies as "assuming" and "creating", the associated LCPP ratings for that segment of therapy included Categories IV (analytic differentiating) and V (internal differentiating). Hence it is apparent that the client was able to identify, in her own language, many of the processes involved in her

attempts to make sense of her experiences in the movement towards change.

The primary difficulty encountered in this part of the current study was the client's uncertainty about what she was supposed to be doing. Finding ways to keep the client on track, without actually coming out and telling her what he wanted to hear, was an arduous task for the interviewer, (who commented later to the researcher that this was the most difficult IPR interview he had ever done) and it forces a tentative posture in the analysis and interpretation of the results. However, the client did begin to catch on to the task at hand, after some coaching from the interviewer around the idea of stepping outside herself and observing her own cognitive processes. What is important to note is that once she engaged in this reflexive process of observing herself (Rennie, 1990), she was able to generate appropriate qualitative terms about her cognitive processing, during therapy.

In conclusion, both Part I and Part II of the present study provide support for the tenets of the perceptual-processing model. It is evident, from Part I, that clients who engage in complex processing strategies during therapy tend to outperform clients whose perceptual processing remains less complex, on measures of self-concept and complexity of self-schemata. Part II provides support for

the model's assumptions about the way in which these processes unfold in therapy, according to one client's understanding of her perceptual-processing operations over the course of a meaningful therapeutic event. Further, it provides substance for the proposition that on some level at least, clients are aware of their cognitive processing operations.

Finally, this research project was an incorporation of two divergent methodologies--quantitative and qualitative--into one framework of study, as proposed by Toukmanian (1992). In this vein, it is seen as a more comprehensive analysis of the psychotherapy process than would otherwise be possible with only the quantitative analysis.

In particular, the qualitative part was an exploratory, pilot investigation. The results, while yielding support for the client's in-therapy engagement in and, to some degree, awareness of the processing operations specified by the perceptual-processing model, leave some unanswered questions. Three of these questions are considered for the purposes of future study.

First, to what degree was the clients' awareness of her processing operations influenced by the interviewer's directive probes? To begin to answer this question, future investigative efforts should be directed at refining the IPR procedure to generate an array of generic questions that

would reflect the categories of the perceptual-processing model, in a non-directive manner.

Second, although Pat was able to identify a significant moment in therapy very quickly, it took quite a while into the IPR interview before she was able to look at her cognitive processes from an objective standpoint. Considering the possibility that objectivity towards oneself might vary across people and time, it is suggested that future studies incorporate more than one client and a larger percentage of therapy sessions in order to broaden the scope of the investigation.

Third, to what extent was the client's perceptual-processing focused review of past in-therapy events useful in allowing her to become aware of (and make changes in) her self-perceptions? The IPR interview itself should be rated on the LCPP in order to ascertain whether change in complexity of perceptual processing is occurring in the IPR session.

These are important considerations for the enhancement of psychotherapy research, because they are geared towards a clearer depiction of the processes that are hoped to lead to in-therapy change in clients' self-perceptions and to clients' ability to be more effective in self-in-the-world relations.

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Appendices

Appendix A
CONSENT FORM

Having been informed of the research project, I, _____ (please print), agree to take part in this study conducted at the Counselling and Development Centre (CDC) of York University.

I understand that the purpose of the study is to explore the different ways with which counsellors facilitate the process of change in short-term counselling and that the project is being carried out under the supervision of Dr. S. Toukmanian who is affiliated with the CDC. My involvement in this research will consist of responding to six questionnaires (10-20 minutes each) at the beginning of my group counseling programme and then again shortly after the termination of the programme.

I understand that my responses to these questionnaires will be kept in strict confidence and will be used only for the purpose of this research. I am aware that all identifying information will be deleted from the materials and that my identification will not be known to the director of my group programme or to anyone who is involved in the data analysis of this research. Furthermore, I understand that feedback about my performance on these questionnaires will be available upon request.

I am also aware that I can withdraw my participation from the research at any time and still be able to continue my group counseling programme at the CDC.

Signature _____

Address _____

Tel # _____

Date _____

Appendix B

Categories of the LCPP Classification System*

- Category I:** *Recognition/Undifferentiated Statements.* The main characteristic of this category is that the client's response conveys a condensed or packaged view of a complex inter- or intrapersonal event. When discussing self, others, or situations the client uses abstract, superficial, and glib statements to label his or her recognition of a "problem." The manner of communicating is nonreflective, categorical, and static.
- Category II:** *Elaborations.* Responses placed in this category are detailed accounts of events. They represent a series of descriptive statements that serve to provide extended and often factual information about seemingly related incidents. The client talks as if he or she is an observer reporting on the who, what, where, and when of an experience.
- Category III:** *Differentiation with External Focus.* The client describes a thought or a feeling about self, others, or situations using external referents. Other generated standards, rules, guidelines, etc., and external sources of information form the basis of the explorations and interpretations of his or her experience of an event.
- Category IV:** *Differentiation with Analytic Focus.* The client explores and discriminates among various aspects of an experience in an objective and intellectual manner. He or she attends to internal as well as external sources of information and uses systematic logic to explain his or her perspective of an experience. The manner of communicating is reflective but tight and analytical.
- Category V:** *Differentiation with Internal Focus.* Statements placed in this category are characterized by the idiosyncratic manner with which the client expresses himself or herself. He or she focuses on and explores the implied meanings of an event and uses uniquely personal descriptors to delineate differentiated aspects of an experience.
- Category VI:** *Reevaluation.* Here the client is actively involved in exploring several interpretations of an experience in a focused and differentiated fashion. However, there is a quality of uncertainty or tentativeness in the client's manner of communicating. The general impression is that the client is engaged in weighing and appraising alternate constructions of an experience as if he or she is on the verge of "resolving" or coming to grips with a potentially more meaningful perspective.
- Category VII:** *Integration.* Responses placed in this category reflect a synthesis of previously differentiated and alternately constructed aspects of an experience. The client conveys a newly emerged perspective. He or she generates a broader but a more personal perceptual base to further explore and modify his or her view of self, and the world.
- Category VIII:** *Other.* Responses that cannot be classified in one of the above categories.

*from Toukmanian, 1986