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The Development of a Self-Esteem Protocol for Adults

Steven D. Mauro
Andrews University

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The development of a self-esteem protocol for adults

Mauro, Steven Dale, Ph.D.

Andrews University, 1987

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THE DEVELOPMENT OF A SELF-ESTEEM PROTOCOL FOR ADULTS

A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
Steven D. Mauro

May 1987
THE DEVELOPMENT OF A SELF-ESTEEM PROTOCOL FOR ADULTS

A dissertation presented
in partial fulfillment of the requirements
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Steven D. Mauro

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ABSTRACT

THE DEVELOPMENT OF A SELF-ESTEEM PROTOCOL FOR ADULTS

by

Steven D. Mauro

Chairman: Jerome Thayer
ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University
School of Education

Title: THE DEVELOPMENT OF A SELF-ESTEEM PROTOCOL FOR ADULTS

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Date completed: May 1987

Problem

Counseling researchers and practitioners studying the self-esteem construct have had difficulty conducting consistent assessments. Varying approaches have led to ambiguous findings and inconsistent client assessments. There was a primary need for combining a clearly defined self-esteem construct with accepted methods of assessing clients. The instrument containing the combined assessment techniques was identified as the Self Esteem Protocol.
Methods

The preliminary phase of research consisted of developing 60 items for the Protocol by combining Maslow's self-esteem construct with acceptable assessment techniques. The items combined techniques by using a structured interview, test scores, and counselor observations. Six professional counselors previewed the items and made recommendations which facilitated Protocol development.

Protocol evaluations were conducted with 128 members of the American Psychological Association, Division of Counseling Psychology. The 128 evaluators comprised three successive, random samples of 19, 58, and 51, respectively.

Results

Three assessment techniques were effectively combined in the Protocol. Evaluations from the first sample indicated that 27 items were appropriate for the study. Evaluations from the second sample indicated that the 27 items were appropriate for study in combination with client information. Evaluations from the third sample indicated that counselors could use the Protocol to estimate a client's self-esteem. The third sample also provided information about the Protocol's potential utility with various types of counselors. Protocol validity was based on evaluator agreement about Protocol usage.

Conclusions

This study was able to overcome validity hurdles by uniting theory and practice. Evaluation data demonstrated that the
self-esteem construct was effectively utilized in the Protocol. The construct used in the Protocol does not represent all possibilities of self-esteem but rather commonalties accepted by the evaluators and consonant with theory.
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CHAPTER I

SELF ESTEEM

Introduction

Self-esteem holds special interest for many different types of people. For example, teachers believe it affects some students' learning patterns. Psychologists believe it reflects social adjustments and emotional stability among clients. Parents, pastors, advertisers, employers, and others believe self-esteem can influence the choices and behaviors of those they serve.

Self-esteem is a special quality which helps people understand and influence one another. Leaders need self-esteem. Those who lack it also lack the confidence they need for being satisfied with themselves and satisfied with the people that they lead. People with high levels of self-esteem tend to achieve success in life.

Counseling psychologists are especially interested in the self-esteem of their clients. Psychologists have this interest because they realize that self-esteem is related to the client's total development. Self-esteem represents the adjustment and social interactions of the client. The counseling psychologist frequently attempts to understand the client's development as it relates to the client's goal of increased self-esteem.
Statement of the Problem

Professional counselors and researchers have criticized self-esteem evaluation. Criticism has focused on the lack of clarity about how evaluations should be conducted. Disagreement between practitioners and researchers about evaluation techniques have also led to problems. Counselors tended to use informal interview methods and researchers preferred to use psychometric instruments (Wells & Marwell, 1976).

Coopersmith (1967) distinguished between neo-Freudian and phenomenological approaches to self-esteem and noted the lack of clarity about measurement. To resolve this, Coopersmith devised and tested a psychological Protocol to evaluate the self-esteem of children. Coopersmith's procedures, which also combined interview and test techniques, were an improvement over Maslow's (1940) approach. The Protocol approach was identified as an appropriate method of studying the self-esteem construct.

Much of the problem confronting researchers in the area of self-esteem has dealt with basic differences between accepted research procedures and humanistic approaches. For example, Maslow (1970) suggested that the problem to be studied should dictate the methods that would be used in any study. In principle, most researchers would agree with Maslow. Unfortunately, however, Maslow's suggestions for studying human problems did not always conform to standard research procedures. Further difficulties were noted by Maddi and Costa (1972) who suggested that the purely empirical approach to personality studies was unable to grasp adequately the holistic aspects of the
human being. Self-esteem as a personality construct was considered subject to the difficulties surrounding personality study.

The fundamental differences between the rigors of empirical study and the arguments of humanistic thought were confronted in this research. The struggle to pursue simultaneously these two diverse lines was justified in terms of continued interest in self-esteem studies and self-esteem counseling. Wylie (1974) noted the abundance of studies related to self-constructs. A practical approach was recommended which would combine the methods of empirical study while retaining the self-esteem values found in humanistic literature. The challenge lay in carefully defining self-esteem and in finding ways to measure it which were acceptable in the professional community.

Maslow (1970) was critical of scientists who were limited by traditional empirical methods. Their research weaknesses, he contended, sprang from their tendency to define problems in terms of their methods. His recommendation was that human problems should define the methods used in each study. In principle, this argument is basically acceptable. Its difficulty, however, lies in the results it generates. For example, when the problems are not studied with traditional methods, the studies are difficult to replicate and to pursue in ongoing research.

The theoretical model offered by Maslow (1970) was considered appropriate for this study. Maslow offered a fairly acceptable explanation of how self-esteem was acquired. From a theoretical standpoint, Maslow explained the roots and development of self-esteem. Maslow's theory has met a common-sense acceptance in numerous books on human development. In contrast, Maslow's theory has been difficult to
study because of the research challenges which confront the investigation of his model.

This study was undertaken in an attempt to utilize a combination of suggestions as outlined in the literature. The decision to do so was justified in terms of continued interest in self-esteem research and in the field of counseling psychology (Atkinson, Atkinson, & Hilgard, 1983; Coopersmith, 1967; Maslow, 1970; Wylie, 1974).

Purpose of Research

This study purposed to develop an instrument which could meet the recommendations of the literature regarding self-esteem evaluation. The research attempted to provide a new configuration for evaluating adult self-esteem. The effort focused on combining a number of existing techniques. The combination of techniques is referred to as a Protocol (Hinsie & Campbell, 1970). Counseling psychologists have used differing methods to evaluate adult self-esteem. The various approaches to these evaluations resulted in research findings which were somewhat vague (Wylie, 1974). In contrast, this dissertation attempted to provide counseling psychologists with a viable means of improving the consistency of self-esteem evaluations. It was anticipated that counseling clients would receive improved services as a result of a Protocol.

Questions to be answered

The challenge of developing a Protocol prompted three questions which guided the study. The questions were based on needs for improved self-esteem measurement. They were also designed to address
the self-esteem measurement problems and to operate within the theoreti-
cal constraints of this research. The following were studied:

1. Could assessment techniques be effectively combined in a Protocol
   for evaluating adult self-esteem?

2. Could a sample of counseling psychologists agree on the basic
   structure of a clinical Protocol designed to evaluate adult self-
esteeem?

3. To what extent would counseling psychologists agree on the valid-
   ity of the self-esteem Protocol?

These questions were addressed at each stage of the research.

Each step of the research produced specific information which in part
answered each of the three questions. Searching for answers was a
developmental process. Each stage of research produced a level of
information regarding each question. Research procedures were
designed to answer each question within its appropriate scope.

Theoretical framework

Abraham Maslow's theory of motivation (1970) provided the theo-
retical framework underlying the construct of self-esteem. Other
writers influenced the technical development of this study through
their criticisms of previous research and self-esteem instruments.
Maslow's theory which addressed self-esteem prompted this study.

Maslow believed that a fully functioning person progressed
through several stages. The stages were also called levels of need.
These levels were identified as physiological, safety, belongingness,
self-esteem, cognitive needs, aesthetic needs, and self-actualization.
The stages or levels of need represented basic levels of motivation.
Each need served to motivate the client. The stages were considered developmental such that they were mastered on a sequential and progressive basis (Maslow, 1940; 1970).

According to Maslow's theory, one's development through the stages was a natural consequence of having the succession of needs met. When the client's physiological and safety needs were met he automatically sought affiliation, belongingness, love, and support (Maslow, 1970).

When the client's belongingness need was satisfied, he had pleasant sensations. These sensations were the source of comfort and confidence which promote self-esteem. The desire for belongingness prompts people to affiliate in groups such as churches, clubs, service organizations, fraternities, and others (Maslow, 1970).

Maslow suggested that if the client had his physiological, safety, and belongingness needs met, the client would discover the need for self-esteem. This was the client's need to value himself. The client needed to appreciate himself and to know his intrinsic value. This value was often discovered and expressed in the world of work. Achievement in the workplace and achievements in school stimulated and reinforced many clients. Positive self-esteem helped the person continue and grow in his achievements (Maslow, 1970).

According to Maslow's original model, the stage of self-esteem was followed by self-actualization. Self-actualization enabled the client to resolve difficulties and conflicts. It also represented a stage of confidence. Confidence was something which could inspire other people. It was also a quality which led one to transcend problems and to resolve inner difficulties and stresses. In his revised
model, Maslow added two other stages between self-esteem and self-actualization. The additions were the needs for knowledge and for aesthetics (Maslow, 1970).

It should be noted that self-esteem and the attending results preceded the stage of actualization. Self-esteem was very important for mastering identity questions. According to Maslow, all people had identity questions. The identity issues were resolved if there was a sense of self-esteem, knowledge, and aesthetics. Self-esteem was necessary for making ongoing adjustments and for achieving personal success (Maslow, 1970).

Importance of Research

A Protocol accepted by counseling psychologists would represent a major step toward solving problems surrounding self-esteem evaluations. The practical value of this was its potential benefit for both counseling psychologists and clients.

Clients and counselors often select self-esteem as a counseling goal. Counselors typically seek to facilitate the client's self-esteem. This is pursued in counseling from a number of perspectives. Counselors believe that clients can potentially improve self-esteem by pursuing a number of other goals. The client goals in counseling often include desired improvements in the areas of physical comfort, pleasure, rest, exercise, and stimulation.

Counselors frequently want clients to have a sense of belongingness. People need to know that they belong to a supportive group. Clients need supportive family members who will stand by them under all circumstances. When people do not receive the support they need
from others, they often become discouraged and have personal problems which are fairly complex. Lack of interpersonal support results in low self-esteem.

The Protocol seeks to help counselors work with clients to acquire and develop positive self-esteem. Such a Protocol could be used in the counseling meetings. The counseling psychologist often evaluates the client's self-esteem at the onset of counseling. Typically, the counselor has difficulty evaluating the client's self-esteem because of the inadequate methods of evaluating it. For example, the counselor has no way of knowing precisely what level of self-esteem the client possesses. So the counselor spends numerous hours trying to evaluate self-esteem without a clearly defined evaluation procedure. The Protocol approach, in contrast, is pursued to help the counselor and client reduce counseling hours by implementing assessment proceedings.

Assumptions

It was assumed that counseling psychologists are qualified to evaluate a client's self-esteem. Psychologists who work in counseling with clients who are pursuing self-esteem goals use techniques which they acquire in professional training. These techniques include evaluating the client's self-report, observing the client's non-verbal behavior, and evaluating the client's test scores. Professional psychologists who acquire these skills are typically interested in counseling psychology as a discipline and therefore join the APA Division of Counseling Psychology. It was therefore assumed that individuals in this APA division are qualified to participate in this research.
Limitations

The study was limited by several practical features of the research. For example, it was understood at the outset that the study could develop an instrument to a stage which would answer the research questions. It was also known that future questions would need to be answered. It was believed that this study could develop an instrument to the extent that a level of practical validity could be demonstrated on the instrument.

The study did not statistically generalize its findings to a given counselor population. Rather, it was believed that a group of counseling psychologists could be found who would be willing to help evaluate various stages in the development of the instrument. As such, the evaluations which supported the development of the instrument should be considered as not statistically generalizable to a specific counselor population.

It was known that counselors varied in their approaches to working with clients. The limitation imposed by this variability resulted in a limited availability of participating counselors. Another impediment was the reluctance of some counselors to participate in self-esteem research. To this extent, counselor participation was viewed as a limitation.

An instrument evaluating self-esteem should be based on theory and practice, thus affording construct validity. At the present, instrument applications for specific counselor types treating client types is not established. The self-esteem construct retained would not reflect all possibilities for how self-esteem could be defined and evaluated. Rather, features of the retained construct reflect...
commonalties approved by a sample of counseling psychologists. An instrument developed in this context could be limited if psychologists willing to evaluate it, by their own self-selection, introduced a bias for the instrument.

**Definitions**

Self-esteem is defined as the client's evaluation of himself. This study sought to combine the client's affective, cognitive, and behavioral responses. For example, a client makes judgments about his worth based on feelings and interpersonal information related to behavioral interactions (Christensen, 1981; Coopersmith, 1967; Epstein, 1982; Fleming & Courtney, 1984; Greeson, 1981; Lowry, 1973; Wells & Marwell, 1976).

The self-esteem Protocol is a specific combination of assessment items and techniques which provide a comprehensive appraisal of the adult client's self-esteem. The Protocol techniques were selected from recognized psychological assessment procedures, the uses of which were supported by the literature (Choca, 1980; Dailey, 1971; Gynther & Gynther, 1976; Pruyser, 1979; Thorne, 1955).

**Outline**

The following overview provides an outline for the material presented in the dissertation:

Chapter I presents the background information for the study.

Chapter II provides an overview from the literature which guided this research.

Chapter III outlines the methods used to develop the Protocol.
This includes procedures for the use of subjects and their evaluation tasks.

Chapter IV identifies the findings of each stage of research. It also demonstrates the use of the findings for answering the research questions.

Chapter V summarizes the study and recommends continued research efforts which are needed.
CHAPTER II

REVIEW OF LITERATURE

Introduction

This chapter addresses itself to several important questions which surround the study of self-esteem. The questions represent core issues of self-esteem as treated by counseling psychologists. This study is best understood in the context of counseling psychology as it responds to the needs of clients. Counselors who approach self-esteem from a theoretical basis typically ask questions such as these:

1. What contributions have self-esteem studies made to the field of psychology?
2. Why have counseling psychologists been interested in the study of self-esteem?
3. What deficiencies exist in self-esteem instruments such that this study is warranted?
4. How has Maslow's theory contributed to an understanding of self-esteem?
5. How did Maslow's concepts develop over the years?
6. How have psychologists attempted to resolve the validity problems associated with the self-esteem construct?
7. What specific recommendations in the literature are relevant to this study?
These questions and the answers to them provide the outline of this chapter.

Questions About Self-Esteem Studies and Some Proposed Answers

What contributions have self-esteem studies made to the field of psychology?

Briefly stated, self-esteem studies have contributed to psychology in the following ways:

1. Improved the growing body of knowledge about the self (Wells & Harwell, 1976; Wylie, 1974)
2. Clarified the understanding of the self-esteem construct (Wells & Harwell, 1976; Wylie, 1974)
3. Provided information on psycho-social development and emotional well-being (Atkinson, Atkinson & Hilgard, 1983; Epstein, 1982)
4. Improved services provided for counseling clients (Gergen, 1971; Greeson, 1981; Narramore, 1978; Patterson, 1973; Raimy, 1971)
5. Increased the understanding of the human personality (Arndt, 1974; Coopersmith, 1967, 1984; Wells & Marwell, 1976)

Self-esteem as a psychological construct has been studied in the context of psycho-social development and emotional well-being (Atkinson et. al., 1983; Branden, 1980, 1981; Coopersmith, 1967; Epstein, 1982; Gergen, 1971; Lowen, 1985; Rosenberg, 1979; Wells & Marwell, 1976). Self-esteem has been linked to psychological well-being for some time (Allport, 1977; Maslow, 1940; Thorne, 1955; Vaughn, 1952).

Self-esteem has also been linked to the self-concept (Coopersmith, 1967; Epstein, 1982; Fleming & Courtney, 1984; Gergen,

Narramore (1978) linked self-esteem to one's feelings of worth, competence, security, and sense of being loved. Fleming and Courtney (1984) suggested that self-esteem was the evaluating aspect of the self-concept, that self-concept subsumed self-esteem. This position of self-concept subsuming self-esteem was taken from Gergen (1971).

Raimy (1971) suggested that the self-concept consisted of all the conclusions made about one's self. He also believed the self-concept was a cognitive object which served as one regulator of behavior. He viewed the self-esteem as one measure of psycho-social adjustment over time. He also viewed self-esteem as being the mechanism which either approved or disapproved the self. Bedeian (1977) suggested that self-esteem was an evaluation of one's overall worth as a person. Fleming and Courtney (1984) considered self-esteem to have multi-dimensional properties which reflected on the general self-concept.

As early as 1890 William James wrote that self-esteem was a ratio of success to pretensions, "the ratio of our actualities to our supposed potentialities" (cited in Coopersmith, 1967, p. 29). This allowed the individual to compare himself to others and to take stock of his material possessions in determining his worth as an individual. It was also thought that self-esteem was derived from the opinions of others and how those opinions were perceived.

Why have counseling psychologists been interested in the study of self-esteem?

Counseling psychology has had a vested interest in self-esteem to the extent that improved self-esteem has been a goal in psychotherapy.
(Branden, 1980; Branden, 1981; Chiang and Maslow, 1977; Raimy, 1971). Maslow (Chiang & Maslow, 1977) reported that the psychoanalysis he took from Karen Horney was most valuable in his process of self-discovery. Greeson (1981) suggested that the self-report of clients in psychotherapy can be translated into a psycholinguistic index for estimating self-esteem. Raimy (1971) also suggested that successful counseling results in improved self-esteem. Patterson (1973) credited Dollard and Miller with efforts to improve self-esteem through psychotherapy and thus to alleviate neuroses. Existential therapy was thought to strengthen self-esteem to guard against anxiety. Patterson (1973) endorsed the counseling of Wolpe, Rogers, Thorne, and Kanfer and Phillips as facilitating self-esteem.

Osipow (1973) cited Super, Ginzburg, Holland, Hoppock, and Roe for their work on different theories of vocational development. They were also counselors and counselor educators. Although their work was done independently, they accorded self-esteem and self-concept major roles in the individual's vocational development.

Erikson (1959) quoted Sigmund Freud as stating that man's great aims of adjusting were "to work and to love." The Freudian construct of the ego represented an early attempt to account for psycho-social differences. The ego, Freud believed, represented man's innate and acquired ability to make choices and to distinguish himself from others. In essence, the ego accounted for differences among people regarding their levels of success apart from intelligence and physical strength. As such, the ego can be construed as the self-social variable which explains interpersonal adjustments.
Other counselors who had a neo-Freudian approach to self-esteem included Harry Stack Sullivan, Karen Horney, and Alfred Adler. Sullivan accepted Meade's position about the social self-esteem and anxiety of the individual who sought to guard against loss of self-esteem. Coopersmith (1967) commented on the work of Karen Horney, summarizing that she "focuses on interpersonal processes and on ways of warding off self-demeaning feeling" (p. 32). He concluded that Adler's antecedents for self-esteem include adequacies and appropriate parental support of the growing child.

Coopersmith (1967) explored contributions of Fromm, Rogers, and Allport, noting that they contributed to a potentially extended theory of self-esteem. He agreed with Fromm that social isolation tended to deter healthy self-esteem. Rogers encouraged positive self-perceptions which allow the client to expand and to adjust to the external world.

Counselors have typically promoted respectful, accepting, and concerned treatment to express esteem or love. These expressions have been considered essential for the acquisition of self-esteem. From this aspect, self-esteem has reflected what others have given to the self. The more these affectionate expressions are received, the greater the likelihood of favorable self-esteem (Coopersmith, 1967, p. 40).

Values and aspirations have contributed to self-esteem but the relationships have lacked clarity. Aspirations and self-esteem in combination have received little research. It has been thought that persons with low self-esteem have lower aspirations than do their counterparts with high self-esteem (Coopersmith, 1967).
Counselors have observed that the manner of responding to poten­
tially demeaning experiences varies from one client to the next. One
person acquires personal insight and inner strength from a particular
experience while another person is humiliated and haunted by the same
event. The ability to ward off humiliating perceptions is frequently
called defensiveness. There is evidence that different social classes
characteristically use different defense mechanisms to fend off humil­
iating perceptions and/or anxiety (Coopersmith, 1967, p. 43).

Coopersmith attempted to clarify distinctions between subjective
self-esteem and behavioral self-esteem as it related to interpersonal
popularity. The behavioral self-esteem was an overt, outgoing style
which apparently had extrovertive qualities. It was found that this
extrovertive "behavioral self-esteem" was the determiner of social
popularity and the "subjective self-esteem" was not particularly
associated with popularity. The issue of subjective versus behavioral
self-esteem has puzzled counselors (Coopersmith, 1967, p. 49).

It was presumed that persons with high subjective self-esteem
approached tasks and social situations with both confidence and the
belief that they were completely acceptable. This inner reference of
self-trust formed a consistent orientation and perceptual constancy.
The constancy took the form of courage to pursue ideals and dreams
(Coopersmith, 1967).

In what ways are existing self-esteem
instruments deficient such that
this study is warranted?

As important as self-esteem is to psychological well-being and to
psychotherapy, research in the area has met with difficulty
Wylie (1974) suggested that self-esteem research has floundered on the rocks of inadequate instrumentation. To accommodate the fluctuations of self-esteem, which also cause reliability problems for the instruments, it was suggested that measurement efforts incorporate more than one method of evaluation (Fleming & Courtney, 1984; Wells & Marwell, 1976).

Two quotes from Wylie (1974) illustrate research challenges to self-esteem studies.

Beginning in the 1940s, there was a widespread resurgence of interest in the self-concept in psychology and related disciplines; and this interest was reflected in part in a wide variety of personality theories. The last decade has seen no important refinements or elaborations of any of these early theories, but there have been two main "new" influences in the area of personality study: existentialism and Skinnerian behaviorism.... As it happens, neither of these has been concerned with contributing to a scientific psychology of personality which makes use of self-referent constructs. That is, existentialists have employed self-referent constructs, but they have deliberately avoided scientifically useful clarification of terms and propositions. In fact, they have taken considerable pains to derogate the potential applicability of the scientific attitude and method to the study of personality. By contrast, Skinnerians have stressed the importance of the scientific approach, but they have argued vigorously against the scientific utility of introducing any constructs, including, of course, self-referent constructs. As I discuss below, the continuing primitive state of formal theories involving self-referent constructs has much to do with the degree of adequacy of methodology in researches relevant to the self-concept (p. 316).

Although a great many instruments have been used only once or twice, the last decade has seen considerable validity-relevant work on a few instruments. Some of this work has commendably applied certain relevant technologies such as item analysis, factor analysis, and controls for response set. But no one instrument intended to measure self-concept variables has been developed by the process of beginning with close attention to stating rigorous conceptual definitions; and followed, finally, by the application of all appropriate modern procedures for refining a
purported index of a construct and establishing its con-
struct validity. Two especially noteworthy shortcomings
characterize even the most thoroughly studied instruments:
lack of clarity in the establishment of the basic construct
definitions, and failure to apply multitrait-multimethod
analyses and other techniques for establishing discriminant
validity. Part of the difficulty stems from inadequate
delineation of the constructs by personality theorists (p.
325).

The following comments by Crandall (1980) have also shed light
on the problems surrounding self-esteem research.

The approach one decides to use to measure self-esteem
reflects assumptions which are in themselves testable. For
instance, a general assumption is that self-reports are
valuable. The extent to which they are should be tested by
correlating self-reports with behavior and other criteria.
Self-reports involve certain givens no matter what format
is used; forced-choice scales, Likert scales, and Guttman
scales all have a direct self-report factor in common. In
addition each scaling method involves different procedures
which can be tested for their effect on self-reports (p.
46).

Most important, but still ignored for all types of
measurement, are the specific items (whether adjectives,
phrases, etc.) which make up the scales (p. 47).

Theoretically, self-esteem is directly tapped only by
asking people how much they like themselves. However,
dimensions of self-esteem emerge when people are asked
about their responses to different aspects of themselves:
physical, mental, moral, in school, with people, at work,
etc. Two basic theoretical points arise with regard to
these various dimensions. First, some important dimensions
for each unique individual may not be included...; that is,
different people may derive esteem from widely differing
sources. By letting people define their own dimensions,
these important but perhaps unique sources of esteem can be
tapped. Second, perhaps a gain in our precision of meas-
uring overall self-esteem can be accomplished by weighting
sub-areas according to importance rather then by just com-
bining them additively; this also takes into account
individual differences in sources of esteem (p. 47).

Both these points seem worth considering, but so far
neither has been empirically validated. Although two
scales presented here--one by Miskimins, the other by
Sherwood--allow individuals to define some rating scales
for themselves, neither author has reported any gain in
validity from these personal items. Weighting items by
importance to self-concept is also theoretically appealing. Here again, however, there is no convincing evidence that added validity is gained by this sophistication. The Sherwood Scale also includes this possibility, but the only real support for weighting has come from three studies with the Secord and Jourard physical esteem scale (p. 47).

The fact that specific operationalizations of these two theoretical refinements of simple additive scales have not proved useful does not mean that they will not prove so in the future. In our current state of research, development of basic items is probably most important; however, eventually the frontier of improvements in measurement will probably involve added sophistication in techniques (p. 48).

How has Maslow’s theory contributed to an understanding of self-esteem?

Maslow’s theory of motivation suggests that human motivation follows a pattern of need-fulfillment (Lowry, 1973). His theory, as it appeared in 1943, was built upon five loosely defined constructs: physiological needs, safety needs, love/belonging needs, esteem needs, and self-actualization. These constructs were prepotent, meaning that each ascending need was dependent upon the fulfillment of the construct which immediately preceded it.

Maslow’s theory has appealed to common sense. It has been compatible with other theories of development and has been popularly accepted by many college teachers. The problem it contained, however, was the poorly defined self-esteem construct. Maslow’s concept of self-esteem remained vague for several reasons. (1) It sprang from his notions about dominance among the monkeys he observed. (2) His thinking was influenced by his professional culture which promoted strict behaviorism and existentialism. Behaviorism suggested that self-esteem did not exist since it could not be measured, and existentialism criticized self-conceptualization definitions. (3) World War
II disrupted Maslow's research environment. Following the War, he began his work on self-actualization. (4) A premature death ended his studies before his constructs could be embellished (Lowry, 1973).

Maslow's theory that physiological, safety, and love needs were bases of self-esteem provided a useful model for this study. For example, a Protocol designed to measure self-esteem could also attempt to account for other determinants such as physiological, safety, and love needs. In a practical sense, the counseling psychologist attempts to determine if the client's physiological, safety, and love needs are being met so that self-esteem can be experienced. The counselor realizes that self-esteem can only be developed as the other needs are met. Maslow (1940) and Coopersmith (1967) also utilized these concepts in their self-esteem studies.

How did Maslow's concepts develop over the years?

Lowry (1973) presented a progression of papers which illustrated the development of Maslow's motivation theory. In 1936 Maslow wrote two papers for the *Journal of Genetic Psychology*. They reported his observations of monkeys. One study was conducted at the Primate Laboratory at the University of Wisconsin and the other was conducted at the Vilas Park Zoo in Madison, Wisconsin. Maslow found that dominance was an important determinant of social and sexual behavior among monkeys. He also noted that dominance could be present among either males or females and that the dominance could be temporarily abrogated during periods of intense play. The importance of dominance was seen as a determiner of food consumption, sexual activities, and submission.
by others. For example, the dominant monkey mounted other monkeys but did not allow them to mount him or her.

In 1937, Maslow distinguished between dominance behavior and dominance feeling. Dominance behavior consisted of overt social interactions which caused another person to accept a subordinate role. Dominance behavior appeared to reside on a continuum of extremes with one end representing little control and the other representing a great deal of control and domination. Dominance behavior often resulted in dominance status (Lowry, 1973).

 Dominance feeling was Maslow's construct which he later reconceptualized as self-esteem. Dominance feeling was defined as a combination of self-confidence, self-esteem, a high regard for the self, consciousness of a general sense of superiority, mastery, strength of character, and a certainty about being able to handle other people (Lowry, 1973).

The low dominance person, in contrast, generally referred to himself as lacking in self-confidence, self-esteem, and possibly strength of character. Others with low dominance feelings or the absence of dominance feelings reported general inferiority, shame, weakness, or a feeling of being beneath others. They frequently reported shyness, timidity, a sense of unworthiness, self-consciousness, and a reluctance to be with others. It was thought that persons with low dominance feelings had been subjected to humiliation or failure or traumatic experiences which blocked their dominance feelings (Lowry, 1973).

Maslow was also able to identify a relationship between dominance feeling and dominance status. He noted that dominance
feeling often determined dominance status and that dominance status could produce feelings of dominance. Maslow also believed that in interpersonal encounters between two people, one person would attain a dominant status while the other person would have a subordinate status. Groups of people also demonstrated dominance which resulted in a hierarchy of persons or a pecking order of status levels. At this time, Maslow was making generalizations about people even though his actual data were from animal research. He also identified problems of relying on social status or social dominance as a method of achieving dominance feelings. Maslow observed people who achieved dominance behavior but did not achieve dominance feelings. He assumed that the person had achieved a level of compensation. The individual compensated for lack of dominance feeling by producing dominance behavior which resulted in dominance status. It was thought that these subjects felt weak but wished to appear strong. It was also thought they cloaked their inferiority or lack of dominance feeling with a facade of dominance behavior. So it appeared that the dominance behavior was largely a facade for weakness and that the dominance behavior did not reflect genuine feelings of dominance (Lowry, 1973).

Maslow tried not to confuse the subject's craving for dominance feelings with true dominance feelings. For example, a subject who was craving dominance feelings and dominance status made statements about desires such as "I wish I could be self-confident." Maslow did not fully develop the concept of dominance craving in his 1937 paper. He
was able, however, to specify that he had observed the craving for dominance as a possible imitator for true dominance. He also admitted that it was difficult to clarify and identify the pure craving for dominance. He noted that individuals crave specific symbols of dominance such as health, a new car, or a new house (Lowry, 1973).

Maslow indicated his recognition of the need to understand the role of dominance within the context of the total personality. He studied four traits among his subjects. The traits were dominance, activity, sociability, and sexual drive. He observed that some of these traits were present in his subjects in varying degrees and in varying combinations within individual subjects. For example, one subject possessed all four traits, while others possessed only one or two. He also observed that there was a relationship between behavior and the inner state. He noted that feelings affected behavior. He acknowledged the role of culture in combination with personality and dominance. He was not able to specify the role of culture upon dominance nor the role of personality with dominance. He acknowledged that culture, personality, and dominance affected each other in the presentations the subjects made (Lowry, 1973).

In 1939 Maslow published an article entitled "Dominance, Personality, and Social Behavior in Women." This was printed in the Journal of Social Psychology. In this article, Maslow defined dominance feeling as ego level. He considered it to be an evaluation of the self. This evaluation of the self was identified in what the subject was saying about herself. The subjects were 130 college women who participated in an intensive interview. High dominance feeling empirically involved good self-confidence, self-assurance,
high evaluation of the self, feelings of general capability or superiority, and a lack of shyness, timidity, self-consciousness, or embarrassment (Lowry, 1973).

Low dominance feeling was seen as deficiencies of self-confidence, self-assurance, and self-esteem; instead there are extensive feelings of general and specific inferiority, shyness, timidity, fearfulness, and self-consciousness. People with such feelings were easily embarrassed, blushed frequently, were generally silent, and tended to be incapable of normal easy-going social relationships or forward behavior (Lowry, 1973).

Dominance status was considered to be a social relationship. It was an expression of social position with respect to other people. A person with dominance status dominated others overtly in behavior or implicitly and emotionally. The person who was dominated was said to be subordinate (Lowry, 1973).

Dominance behavior was different from dominance feeling. Dominance behavior was the process of one behaving in a manner that controlled, guided, or influenced other people. In evaluating this work Maslow made some very candid and interesting admissions of research problems. First, he identified the problem of theoretical difficulty and construct definition. He also noted that dominance feeling and dominance behavior would change together. For example, when the subject's dominance feeling increased, her dominance behavior also increased (Lowry, 1973).

Maslow had difficulty predicting or describing just how those changes would occur. He also noted the importance of cultural pressures and social norms. He recognized that dominance feeling would
be subject to both cultural pressures and social norms in establishing the importance of the differences between inner and outer personality. Maslow's point was that behavioral explanations of personality were inadequate (Lowry, 1973).

In 1940 the Journal of Social Psychology published Maslow's article, "A Test for Dominance Feeling (self-esteem) in College Women." Two years later the same journal published another Maslow article entitled "Self Esteem (Dominance Feeling) and Sexuality in Women." Maslow was changing his emphasis from dominance feeling to self-esteem. Following this 1940 article, Maslow referred to dominance feeling as self-esteem (Lowry, 1973).

In his 1940 article, "A Test for Dominance Feeling," Maslow stated that he was looking for human equivalence of infra-human primate behavior. Though his original studies were with monkeys, he subsequently sought to observe similar behaviors among people. In 1943 Maslow again published for the Journal of Social Psychology. This article was entitled "The Authoritarian Character Structure." The article was a response to World War II Nazi atrocities (Lowry, 1973).

The next major article also appeared in 1943, in the Psychological Review. This article was entitled "A Theory of Human Motivation." The essence of Maslow's motivation theory was two-fold. The first part represented five different sets of goals. These sets were identified as physiological, safety, love, esteem, and self-actualization. The other part of this theory entailed the upward thrust which moved a person from lower-level needs to the higher
needs. These needs were also identified as motives, goals, developmental levels, drives, and motivations. This hierarchy was described as being prepotent. This means that a lower-level goal must be satisfied before the subsequently higher-level need could be satisfied. As the lower need was met, the next higher-level need was simultaneously experienced (Lowry, 1973).

In 1950 Maslow printed an article entitled "Self-Actualizing People: A Study of Psychological Health." Again, these studies were quite subjective. The study was based on his analysis of 25 people whom he interviewed. Nineteen historical figures were also analyzed from a biographical perspective. These people were individuals such as Lincoln, Jefferson, Einstein, Spinoza, Beethoven, Freud, Albert Schweitzer, and others (Lowry, 1973).

Abraham Maslow is best remembered for his theory of development and for his contributions to humanistic psychology. Both his model of development and his humanistic contributions focus on fulfillment. The model defines fulfillment in terms of self-actualization, an ongoing striving for success and intrinsic enrichments. Maslow gave earnest attention to the discovery of persons who achieved such successes and enrichments. His work with self-actualization is important to this dissertation because self-esteem is considered a precursor of self-actualization. Maslow's theory states that the client does not achieve fulfillment without first acquiring self-esteem. An understanding of Maslow's approach to self-actualization enriches this study because it illustrates the projected outcomes of self-esteem.
Maslow described self-actualizing people as having efficient perceptions of reality and being comfortable in their relations to it. Self-actualizing people accepted themselves, others, and nature. They had the ability to be spontaneous. Self-actualizing people had the ability to focus on problems outside themselves. They have the need for privacy and detachment. They were characterized by personal autonomy and could make personal decisions independently of their culture and environment. They seemed to have continued freshness of appreciation. They had a mystic experience which was identified as powerful and driving emotions. They could identify with other human beings with a brotherly attitude. They had deeper and more profound interpersonal relationships than did most other adults. They had a democratic character structure which meant they recognized the dignity of other human beings and they respected the differing opinions of others. They seemed to be able to distinguish their goals in contrast to the means of achieving goals. They had a philosophical and unhostile sense of humor and were creative (Lowry, 1973).

The self-actualized people had a firm foundation of personal values. They accepted the nature of themselves. They understood the nature of their social life and the nature of their physical reality. The self-actualizers seemed to have accepting values. They accepted life as it was, accepted themselves as they were, and were able to distinguish the difference between the ideal and the real. They also seemed to be gifted in accepting the stress between what was ideal and what was status quo (Lowry, 1973).
How have psychologists attempted to resolve the validity problems associated with the self-esteem construct?

Maslow (1940) developed a test of self-esteem using female college students as subjects. He obtained the test items by refining a series of interview questions which he asked his subjects. Both verbal and non-verbal responses given by the subjects were recorded. His notes on each subject comprised a Protocol for evaluating the subject's self-esteem.

Maslow's (1940) research utilized a self-esteem Protocol for each subject. Although his efforts were less than well-refined, he used a multi-method procedure in pursuing construct validity. He combined three methods: the subject's self-report, the interviewer's observations, and the subject's test score. Coopersmith (1967) also combined the subject's self-report and test scores with the interviewer's observations which resulted in a self-esteem Protocol.

Coopersmith (1967) reported studies with fifth-grade children. His subjects took various inventories and projective tests and participated in several "experimental situations and interviews all of which established differences in individual responses" and which in turn revealed "characteristically different ways of approaching, perceiving, and responding to environmental stimulation" (p. 46).

Coopersmith (1967) tested his subjects for creative expression using the Draw-A-Person Test, the Unusual Uses Test, and the Circles Test. His findings suggested that persons with high self-esteem were predictably higher in creativity scores than subjects with low self-esteem. He also accepted the work of Ernst Kris to help confirm the relationship between self-esteem and creativity. Kris apparently
found that secure individuals allowed their subconscious activities to provide creative resources (p. 59).

Subjects were identified as having either high, medium, or low self-esteem. It was then noted that persons with a particular level of self-esteem would categorically respond to self, others, and objects in ways which categorically differed from their counterparts with a different level of self-esteem (Coopersmith, 1967).

The low self-esteem subject predictably expressed notes of depression or pessimism. This type of person was likely to respond, "I don't see much reason for others to like me." In contrast, someone with high self-esteem was likely to acknowledge, "I consider myself valuable and at least as good as others." The subject with moderate self-esteem tended to include positive self-statements that were more moderate in terms of self-appraisals, competence, significance, and expectations than were those of his or her high self-esteem counterparts (Coopersmith, 1967, p. 47).

Coopersmith (1967) observed that his subjects demonstrated pervasive and remarkable differences in terms of their levels of self-esteem. He identified subjects as having either high, low, or medium self-esteem. These categorical levels of self-esteem reflected notable differences in the way a person experienced the world and carried out social interactions. High self-esteem seems to allow one the freedom to present ideas freely and forthrightly and without self-anxiety, withdrawal, and preoccupation with inner problems. The person with medium self-esteem apparently lacked the freedom to present him or herself with the same confidence as his or her counterpart.
with high self-esteem. The person with low self-esteem was characterized by poor achievement, anxiety, and frustration. Coopersmith (1967) attempted to integrate a number of theoretical positions and noted four antecedents which contributed to the development of self-esteem. The first antecedent to self-esteem was the treatment one received from the significant others in life. Respectful accepting and concerned treatment promoted healthy self-esteem. A second antecedent which contributed to healthy self-esteem was one's history of successes. The third antecedent was the individual's ability to interpret experiences in accord with his or her values and desires. And lastly, the individual developed a response set for responding to demeaning experiences. Personal equilibrium was maintained by the ability to defend the self-esteem and thus ward off anxiety.

Coopersmith (1967) defined self-esteem as a personal judgment of one's worthiness. This judgment was evident in the attitudes one held about oneself. The attitudes were verbalized and behaviorally demonstrated. Self-esteem was associated with personal satisfaction, decision-making skills, independence, and overall success in life. Coopersmith (1967) postulated that self-esteem was the product of early childhood development including parent-child interactions and social background.

What specific recommendations have been made relevant to this research?

The development of the self-esteem Protocol in this research was guided by numerous recommendations found in new literature. Many of
these recommendations have been applicable for other psychological assessments as well. The suggestions are listed as follows.


2. Self-esteem evaluation should distinguish between emotional, cognitive, and behavioral aspects of the construct (Coopersmith, 1967; Crandall, 1980; Wells & Marwell, 1976; Wylie, 1974).

3. A qualified interviewer must make observations about the subject's self-report and behaviors. The observations provide valuable information which also guides the evaluation of self-esteem. Observations shed light on the subject's defensiveness and emotional states which also affect the self-esteem (Coopersmith, 1967; Crandall, 1980; Wells & Marwell, 1976; Wylie, 1974).


5. Acceptable test instruments are essential both for measuring self-esteem and for conducting self-esteem research (Crandall, 1980; Fleming & Courtney, 1984; Wells & Marwell, 1976; Wylie,
Wylie (1974) and Crandall (1980) described instruments and their adequacies in detail.

6. The Protocol should combine evaluation methods so as to provide for a coherent and effective assessment of self-esteem (Choca, 1980; Coopersmith, 1967; Dailey, 1971; Maslow, 1940; Wells & Marwell, 1976; Wylie, 1974).

Additionally, much has been written regarding the strengths and weaknesses of using paper-and-pencil tests alone to measure self-esteem (Coopersmith, 1967; Crandall, 1980; Wells & Marwell, 1976; Wylie, 1974). The researcher found three existing instruments which appeared to have potential for use in combination with the Protocol. The Self-Esteem Inventory, the IPAT Anxiety Scale, and the Adjective Check List could be used in combination with a structured counseling interview. The researcher used these instruments with clients prior to conducting this study.

The Self-Esteem Inventory was suggested by Bedian (1976; 1977), Bedian & Zmud (1977), Bedian, Teague, & Zmud (1977), Coopersmith (1984), Crandall (1980), Simon (1973), Spatz & Johnston (1973). Coopersmith (1984) incorporated concepts which are compatible with Maslow's model. For example, this Inventory contains items which explore the client's support system such as the family. This also serves to cross-reference similar items in the proposed self-esteem Protocol. The Self-Esteem Inventory has been studied by a number of investigators.

The IPAT Anxiety Scale (Self-Analysis Form) incorporated the anxiety items from the Sixteen Personality Factor Questionnaire (Krug et al., 1976). The Anxiety Scale appears to have potential value for
Protocol evaluations and has been investigated by a number of other researchers (Bach, 1973; Bendig, 1959; Bonney, 1967; Bull & Strongman, 1971; Cattell, 1973; Fisher & Kramer, 1963; Gynther & Gynther, 1976; Horne, 1974; Klusman, 1975; Krug & Henry, 1974; Strassberg, 1973; Wohl & Hyman, 1959).

The Adjective Check List was suggested for self-esteem research because of its ability to reflect supportive information about the client's self-esteem (Crandall, 1980; Gough & Heilbrun, 1980). Its scales have inferred clinical information about the client's self-confidence, inter-personal needs, counseling readiness, creativity, and cognitive style. Gordon Allport (1977) suggested that stable clients have realistic perceptions and integrated pursuits as reflected by adjective check lists, and that these have been validated with the Minnesota Multi-phasic Personality Inventory. Other researchers also recommended the use of the Adjective Check List (Block & Thomas, 1955; Evans, 1971; Goldman & Mendelsohn, 1969; Gough, 1979; Gough, Lazzari, & Fioravanti, 1978; Heilbrun, 1959; Heilbrun & Sullivan, 1962; Kitchen, 1972; Scarr, 1966; Trent, Fernandez-Marin & Maldonado-Sierra, 1960; Williams & Bennett, 1975; Williams & Williams, 1980; Ziegler, 1973).

Psychologists tend to prefer different instruments in terms of their capacity to answer specific questions about a particular client. It appears that the Self-Esteem Inventory, the IPAT Anxiety Scale, and the Adjective Check List could be used in part of the self-esteem Protocol. Ultimate decisions about which instruments to combine into the Protocol would require further research.
Summary of Chapter II

This chapter has identified several questions which the dissertation needed to consider. Answers to the questions were provided from the literature. It was shown that self-esteem study has a vital role in the field of psychology. Counseling psychologists have found self-esteem to be an important concern of their clients. Deficiencies of construct clarity and validity in existing instruments indicate that this study was warranted. Maslow's theory of motivation offered a hierarchy of needs which lead to self-esteem. His construct of self-esteem was not clearly developed due to understandable reasons. Both Maslow (1940) and Coopersmith (1967) found ways to confront the challenge of validity in their research endeavors. They both utilized a Protocol approach, combining assessment techniques. Recommendations from the literature were provided for improving Protocol research on self-esteem using combined techniques.

The following chapters illustrate how the recommendations from the literature were used in this study.
CHAPTER III

METHODS OF PROTOCOL DEVELOPMENT

Introduction

This chapter presents a description of the methods which were employed to develop the self-esteem Protocol. The purpose of the research was to develop a Protocol which counseling psychologists could use in evaluating the self-esteem of their adult clients. To accomplish this goal, the researcher first developed a pool of items. The items were then studied by submitting them to counseling psychologists for a series of evaluations. The evaluations were conducted in four separate stages of research. The third and fourth stages contained the same items but the evaluation tasks differed.

The evaluators analyzed the items in each stage and their evaluations were used to guide the stages of research that followed. Evaluation procedures were designed to assist the researcher in solving the research questions using the evaluators' analyses about the strengths and weaknesses of the items. The following outline indicates the format followed in this chapter:

1. Sequential Stages of Research
2. Operational Aspects of the Sequential Stages
3. The Population
4. Use of Evaluators to Solve Research Questions
5. The Draft Protocol Stage of Research
Sequential Stages of Research

The study was characterized by four sequential stages of research. The research began with the formation of the Draft Protocol. The second instrument studied was the Pilot Protocol. The third and fourth instruments were called the Field and Final Protocols, respectively. Each successive stage was developed employing the evaluations which the previous stage received. Each stage was also characterized as having a unique purpose in the development of the Protocol.

The Draft Protocol was designed to obtain initial feedback from professional counselors regarding the possible use of such an instrument. The Draft stage was intended to discover some degree of response and acceptance or rejection from counselors. The responses
of these counselors gave an indication of reactions which could be expected from potential subjects. These reactions were relevant to their willingness to participate, their evaluation of the items, tasks they would perform, and instructions they would follow.

The Pilot Protocol was designed to obtain an evaluation of the items which were employed following the study of the Draft Protocol. The Pilot Protocol sought to obtain initial answers to the research questions. Evaluations obtained from the psychologists provided the first stage of information for solving the research questions. This stage of research also provided information about the use of the evaluation procedures and the instructions to evaluators.

The Field Protocol represented the third stage of research. This stage was designed to test the decision of the researcher to retain the items which were selected from the Pilot Protocol. Twenty-seven items in the Pilot Protocol appeared to be appropriate for continued study. These items were placed in the Field Protocol. The purpose of the Field Protocol was to verify the usefulness of the 27 items.

The Final Protocol was designed to use the items in a hypothetical counseling case. Hypothetical client responses were provided in the spaces which followed the items on the Protocol. Evaluators were asked to judge the Protocol in terms of the client's responses and the structure of the Protocol.

Operational Aspects of the Sequential Stages

The Protocol began with a draft which was submitted to six professional counselors. (A description of these counselors and their qualifications is provided in Appendix A.) The six counselors were
selected to serve as informal critics of the proposed Protocol system. The criteria for selecting the counselors included their professional standing in the community and their availability to be interviewed by the researcher.

The task of the counselors was to read the Protocol items and make recommendations. Their recommendations were used to prepare the Protocol for the next stage of study. The suggestions made by these counselors comprised the first stage of Protocol development. The Protocol which was submitted to these counselors was referred to as the Draft Protocol. The draft contained the following 60 items:

PART I Record the client's responses

**Question A (Feelings)**

Are you satisfied with your feelings, in terms of:

1. Your comfort and relaxation without the aid of medicine, drugs, or alcohol? 
2. Your feelings of being secure and safe?
3. Your feelings of closeness or love with your Mate? Children? Parents? Other relatives? Peers?
4. Your feelings about your choices and responsibilities in life?

**Question B (Behaviors)**

Have your behaviors obtained the results you wanted, in terms of:

5. Comfort and relaxation without the aid of medicine, drugs, or alcohol?
6. Security and safety?
8. What you wanted to accomplish in life?

**Question C (Beliefs about the future)**

Do you believe you can get what you want, in terms of:

9. Comfort and relaxation without the aid of medicine, drugs, or alcohol?
10. Security and safety?
11. Having closeness and love with your
Mate? _____ Children? _____ Parents? _____ Other
relatives? _____ Peers? _____
12. What you will accomplish in life? _____

PART II Record your observations

Section A

Note the physical and linguistic aspects of the "Client's Responses." Underline the adjectives which specify some detail that you see, hear, or feel from the client.

13. Breathing: Nervous Tense Relaxed Comfortable
14. Eyes: Nervous Tense Relaxed Comfortable
15. Forehead: Nervous Tense Relaxed Comfortable
17. Lips: Nervous Tense Relaxed Comfortable
18. Skin: Nervous Tense Relaxed Comfortable
19. Voice tone: Nervous Tense Relaxed Comfortable
20. Language usage: Nervous Tense Relaxed Comfortable

Section B

Appraise the client's defensiveness and/or social desirability facade. Use a letter (A,P,R) to grade the client's willingness to discuss self and others.
A=Active Willingness, P=Passive willingness, R=Refusal/inability

22. Faults/wrongs/failure of others _____
23. Faults/wrongs/failures of self _____
24. Positive qualities/successes of others _____
25. Positive qualities/successes of self _____
26. His/her responsibility for circumstances in life _____

Section C

Check (✓) the following client behaviors demonstrated during the interview.
27. Seeks extra help from therapist _____
28. Cries/sniffles/chokes up _____
29. Fidgets excessively _____
30. Looks around, easily distracted _____
31. Rocking or shifting movements _____
32. Slumps/droops in chair _____
33. Wrings hands _____
34. Changes story when confronted _____
35. Dramatizes self-report _____
36. Refuses to cooperate _____
37. Refuses to accept responsibility _____
38. Makes threats _____

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PART III Indicate your use of test information

Check (✓) the kinds of test scores you would use to evaluate the client's self-esteem.

41. Self-esteem scales
42. Self-concept scales
43. Social desirability scales
44. Anxiety scales
45. Defensiveness scales
46. Social adjustment scales
47. Achievement needs scales
48. Dominance needs scales
49. Order needs scales
50. Affiliation needs scales
51. Counseling readiness scales
52. Self-control scales
53. Self-confidence scales
54. Ideal self scales
55. Self-criticism scales
56. Self-nurturing scales
57. Self-inhibiting scales
58. Emotional stability scales
59. I would not use a test score
60. Others (please list)

The instrument used in the second stage of Protocol development was referred to as the Pilot Protocol. The Pilot Protocol was formed on the basis of the suggestions made by the counselors who reviewed the Draft Protocol. The Pilot Protocol was reduced to 50 items. The counselors who discussed the Draft provided numerous criticisms regarding the Protocol. The changes focused on item clarity, instructions to evaluators, directions for counselor administration, and directions for each section of the Protocol. (A copy of the Pilot Protocol is included in Appendix B.) Ten items from the Draft were removed to form the Pilot Protocol of 50 items. The removal of 10 items was based on suggestions made by the counselors.

The Pilot Protocol was used in a survey mailing to 70 counseling psychologists. The evaluators were selected from a mailing list of 1,000 members in the APA Division of Counseling Psychology. The
sampling procedures for the evaluators is discussed further in the Pilot Protocol section of this chapter (p. 67). Nineteen psychologists chose to participate in the study. Their evaluations were provided in the evaluation tasks which accompanied the Protocol items. After their evaluations were analyzed, the number of items was reduced in order to formulate the Field Protocol.

The item pool was reduced from 50 to 27 to form the Field Protocol. Twenty-three items were discarded from the Pilot Protocol because they were perceived as inadequate by the evaluators who participated in the pilot study. Other modifications were made regarding instructions to evaluators, instructions for counselor administration, and directions for each section of the Protocol. The Field Protocol items were determined from the pilot stage (see Appendix C). The wording of the items was basically the same in both the Pilot and Field Protocols.

The findings of the Field Protocol suggested that all 27 items could be justifiably retained for the Final Protocol. Each item was analyzed in terms of the tasks which the evaluators performed. Evaluation totals were compiled which indicated the evaluators' opinions regarding the strengths and weaknesses of the Protocol items. The charts which summarized the evaluator responses are provided in Chapter 4.

The findings of the Field Protocol suggested that the Final Protocol could remain unchanged. To answer adequately the research questions and to try for construct validity, the Final Protocol contained hypothetical client answers. It can be noted from Appendices B and C that the Pilot and Field Protocols contained evaluation
tasks. In contrast, the Final Protocol did not contain evaluation tasks. Rather, the evaluation tasks were provided on a survey form which accompanied the Protocol. The Final Protocol contained hypothetical client responses which the evaluators were to judge.Evaluator responses were recorded on the evaluation survey which they returned to the researcher. The evaluations were analyzed and their evaluations comprised the ending of the data collection. The findings of each stage of Protocol development became the basis of chapter 4 of this dissertation. It should be noted that each stage produced a set of answers to the research questions. The questions which were selected also represented the practical aspects of the need for construct validity.

The evaluators analyzed the Protocol items at each stage of Protocol development. The researcher provided evaluation tasks for the evaluators. The evaluation tasks were outlined for the evaluators on the Protocol pages and adjacent to the Protocol items. This format was used in the first three stages of Protocol development. The Final Protocol was analyzed by evaluators on their evaluation surveys which accompanied the Protocol. Examples of these evaluation tasks may be found in Appendices B, C, and E, which contain the Pilot Protocol, the Field Protocol, and the Evaluation Survey. It should be understood that the term "final" did not refer to a permanent termination of research regarding all aspects of the self-esteem Protocol. Rather, this study was completed with a stage of research simply referred to as the final stage. Final simply indicates the conclusion of this particular study.
The Population

The study was undertaken to develop an instrument for use by counseling psychologists. Because professional counselors would be using the Protocol, it was thought that they were best qualified to evaluate its development. Professional counseling psychologists were identified in the American Psychological Association, Division of Counseling Psychology. A randomized sample of 1,000 potential evaluators belonging to the Division of Counseling Psychology was obtained from the American Psychological Association. Members on the list were randomly distributed throughout the mailing regions in the United States. The members' names and addresses were printed on gummed labels.

Counseling psychologists are qualified to administer psychological test instruments. The instruments are typically administered in the context of three assessment techniques which are used by counseling psychologists. The techniques include the administration and interpretation of test instruments, elicitation of the client's self-report (interviewing techniques), and observing the client during the counseling session. These techniques were employed in the Protocol and were considered the common ground which linked the Protocol to the counseling psychologists.

Numerous counseling psychologists have published professional works regarding self-esteem. This constituted another reason for using counseling psychologists in the study.
Use of Evaluators to Solve Research Questions

Counseling psychologists belonging to the American Psychological Association (APA) were randomly selected to participate in the study. APA members in the Division of Counseling Psychology were sent mailing packets which requested their evaluations of the Protocols. The evaluations which the evaluators returned were used to help answer the research questions about the development of the Protocol.

The evaluators were required to complete evaluation tasks which were included with the Protocols they studied. The tasks were determined by the information which was needed at each stage of research. The information needed by each stage was indicated by the purpose of that stage. The Final stage was unique in that it did not employ evaluation tasks in the same manner which the previous stages did. The Final stage asked the evaluators to answer seven questions about the Protocol they received. The first six questions used multiple choice responses. The seventh question asked the evaluators to indicate which part of the Protocol they preferred and for additional comments if necessary.

The counseling psychologists were used as evaluators to answer the following research questions:

1. Could assessment techniques be effectively combined in a Protocol for evaluating adult self-esteem?

2. Could a sample of counseling psychologists agree on the basic structure of a clinical Protocol designed to evaluate adult self-esteem?

3. To what extent would counseling psychologists agree on the validity of the self-esteem Protocol?
At each stage of research the three research questions were used as criteria to guide the formation of the evaluation tasks. The counseling psychologists, serving as evaluators, completed the evaluation tasks. These tasks provided an evaluator analysis of each item. On the Draft Protocol the counselors provided face-to-face criticism. The Draft Protocol counselors did not perform written tasks.

The Draft Protocol Stage of Research

Item selection procedures

The items which comprised the Protocol were constructed around a general criteria. The criteria were as follows:

1. The items constructed were guided by published recommendations as outlined in Chapter 2. These recommendations influenced the content of the items.

2. The actual methods of evaluating clients were also guided by the literature. Evaluation methods include the client's self-report and test scores in combination with the counselor's observations. Part I of the Protocol used the assessment technique which employed the client's self-report. Part II in the Protocol developed items which assisted counselors to make observations regarding the client's self-report. Finally, Part III presented items representing test options which would be available for use in the assessment.

Criteria A and B combined, the union of theory and practice, provide the basis for construct validity.
Item selection: Recommendations in the literature regarding item content

The recommendations of the literature guided both the definition of self-esteem and the formation of the Protocol items. The following recommendations were identified in the literature:

1. Self-esteem evaluation should be sensitive to the individual's development (Coopersmith, 1967; Maslow, 1970).

2. Self-esteem evaluation should distinguish between emotional, cognitive, and behavioral aspects of the construct (Wells & Marwell, 1976; Wylie, 1974).

3. A qualified interviewer must make observations about the subject's self-report and behaviors. The observations provide valuable information which also guide the evaluation of self-esteem. Observations shed light on the subject's defensiveness and emotional states which also affect self-esteem (Coopersmith, 1967; Wylie, 1974).

4. Discomfort from stressors and anxiety also affect self-esteem. They too should be considered in the evaluation (Atkinson et al., 1983; Branden, 1980; Lowen, 1983).


6. The Protocol should combine evaluation methods so as to provide for a coherent and effective assessment of self-esteem (Maslow, 1940; Wells & Marwell, 1976).
Item selection: Assessment techniques used by counseling psychologists

Counseling psychologists utilize three basic assessment techniques: the client's self-report, the client's test scores, and the counselor's observations of the client. These three techniques were used in the Protocol and divided the Protocol into three separate sections. As in other psychological evaluations, the Protocol required the counseling psychologist to interpret the findings of the combined techniques. Each technique was presented in a distinct section within the Protocol.

Following the suggestions of Wells & Marwell (1976), the Protocol employed the client's self-report as an assessment technique. The first basic assessment technique in the Protocol was the client's self report. It was decided that the self report should be structured. The structure was imposed to provide Protocols with guidance and predictability so as to afford unity in the interpretation and administration of the Protocol.

The second basic assessment technique was found in the Part II of the Protocol, the counselor's observations. These observations were presented in the Protocol in the form of items which the counselor checked. These items were not presented to the client during self-esteem evaluations. In contrast, the counselor observations were to be marked while the client was answering the questions in Part I. This required the counselor to be very alert regarding the client's responses. Part II of the Protocol assisted the counselor in documenting and evaluating the implicit counseling information available in the self-report.
The literature (Wells & Marwell, 1976) recognized that the counselor's observations were essential for raising the level of self-esteem evaluations above previous levels of simple pencil-and-paper tests. It was also known that counselors have typically utilized their observations as informal techniques. The Protocol simply formalized and utilized a technique which had been left somewhat unpredictable among self-esteem evaluations.

The third technique which counseling psychologists have relied upon consisted of client test scores. Psychologists have used test scores to identify and respond to various psychological constructs. For example, anxiety has been studied as a construct and has been identified with various psychological tests. The literature (Robinson & Shaver, 1980) presented tests which were designed to measure self-esteem as a construct. Robinson and Shaver (1980) also showed the strengths and weaknesses of numerous instruments which measured various aspects of self-esteem as well as other constructs which were related to self-esteem.

The researcher, under consultation with the counselors who reviewed the Draft Protocol, elected to present topical items in Part III. This meant that the items in Part III represented general types of scales which could be used to assist the counselor in the self-esteem evaluation. It was thought that these items would be strengthened by the use of generic names as opposed to specific titles. For example, instead of using a specific test title such as the IPAT Anxiety Scale, the item simply stated "anxiety scale." This allowed the counselors to select the scale which would be most helpful to a particular client.
Item selection: Rationale supporting each item

The items in Parts I, II, and III were initially written by the researcher. They were organized into the Draft Protocol which was then submitted to criticism by professional counselors who agreed to review it and to critique it verbally. The items which were dropped due to weak evaluations are indicated as such. The changes in the wording of the items may be found by comparing the Draft Protocol with the Pilot Protocol. Following the formation of the Pilot Protocol, the basic wording of the items remained unchanged.

Part I Client's Self-report

Items 1-4 were designed to assist the counselor in identifying the client's feelings of satisfaction about some important areas. Maslow considered that the client's satisfaction about his physical comfort, security, and belongingness indicated the client's basis of self-esteem. Items 1-4 utilized Maslow's theory to operationalize the measurement of the self-esteem construct. Items 1-4 follow.

Part I Record the client's responses

Question A (Feelings)

"Are you satisfied with your feelings, in terms of . . . ."

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? ____
2. Being secure and safe? ____
4. Your choices and responsibilities in life? ____

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol is considered an essential feature of physiological need. The item was in the Protocol because a large
number of evaluators considered it highly functional in the measurement of self-esteem. The information regarding the evaluations to all the items is available in Chapter 4.

2. The client's satisfaction with his feelings of being secure and safe was also considered an essential item. In terms of Maslow's theory, security and safety promote feelings of self-esteem.

3. The client's satisfaction with his feelings of closeness or love with his mate, children, parents, other relatives, and peers is essential in understanding his self-esteem. In a practical sense, this represented the client's support group. Nearly all writers and researchers in the field of self-esteem considered that a strong, positive support group facilitated the client's self-esteem (Coopersmith, 1967; Maslow, 1970; Wells & Marwell, 1976).

4. The fourth item, "your choices and responsibilities in life," asks the client to evaluate his satisfaction with his feelings about his options. This question is important because it gave valuable information about the client's perceptions and motivation.

The Section B question dealt with the client's conceptions of his behaviors. This section asks the client to analyze his own behaviors in terms of getting what he wanted. In Items 5-7, Maslow's hierarchy of physiological security and belongingness needs was implemented.

The eighth question, though somewhat different from Maslow's specific hierarchy, was certainly consistent with his writings. It would
appear that Items 1-4 and Items 5-8 were somewhat repetitive. The
distinction, however, is that the first four items evaluated the
client's feelings and the second group evaluated his behaviors.

**Question B (Behaviors)**

"Have your behaviors obtained results you wanted, in terms of . . .

5. Comfort and relaxation without the aid of medicine, drugs, or alcohol? _____
7. Closeness and love from your Mate? _____
   Children? _____ Parents? _____ Other relatives? _____ Peers?
8. What you wanted to accomplish in life? _____

5. The fifth item, "Have your behaviors obtained results you
   wanted, in terms of comfort and relaxation without the aid
   of medicine, drugs, or alcohol" resembled Maslow's require-
   ment for physiological needs. This question requires the
   client to analyze his own behavior. Maslow did not specify
   that clients distinguish between their feelings and behav-
   iors, but other writers suggested such specification (Wells
   & Marwell, 1976). The Protocol at this point attempts to
   help the client identify various areas of self-esteem. The
   client's beliefs about his behavior are suggestive of one
   facet of his self-esteem. The client who reports satisfac-
   tion with his behaviors regarding comfort and relaxation
   without the aid of medicine, drugs, or alcohol is also
   suggesting personal competence with his physiological
   needs. This item helps the counselor understand the
   client's ability to find comfort without chemical support.
   A chemical dependence undermines the self-esteem of many
   clients and becomes a false sense of esteem and security.
6. Item 6 paralleled Maslow's level of safety needs. The item asks the client to rate his behaviors in terms of achieving security and safety. The question is designed to help the client distinguish behavioral patterns relevant to acquiring self-esteem. This is an important distinction.

7. This item requires the client to consider his own behaviors in terms of his closeness and love from his mate, children, parents, other relatives, and peers. This item also parallels Maslow's model. For Maslow and others the client's behavior in terms of his support network has been a critical area of self-esteem.

8. The eighth item represented concerns that Maslow implied but did not directly express in his model. The implications were present in Maslow's other writings. The client was required by this item to consider his behavior in terms of what he wanted to accomplish in life. This item gave the client the opportunity to compare what he had achieved with what he had wanted to achieve.

The Section C question asked the client for information regarding his beliefs about the future, using Items 9-12. These four questions represented an effort to explore the client's expectations. Critics (Wells & Marwell, 1976) of self-esteem research have suggested that evaluations should distinguish between the client's feelings, behaviors, and beliefs. Items 9 through 12 represent the third effort to make this distinction. Items 9-12 follow.
**Question C (Beliefs about the future)**

Do you believe you can get what you want, in terms of:

9. Comfort and relaxation without the aid of medicine, drugs, or alcohol? _____
10. Security and safety? _____
12. What you will accomplish in life? _____

9. The ninth item required the client to express his beliefs about his comfort and relaxation. Clients who believe that they need medicine, drugs, or alcohol in order to be comfortable tend to have self-esteem difficulties related to what is being ingested. The researcher realized that this item could present some difficulty in terms of being accepted by evaluators. This item was later eliminated because of suggestions by evaluators.

10. Item 10 asked the client to evaluate his beliefs about his security and safety. This item again assisted the client in distinguishing his beliefs about himself. It was also consistent with Maslow's theory. The item was considered redundant by the researcher but was included in the event that the evaluators would approve of it. It was later eliminated by the evaluators.

11. Item 11 asked the client to evaluate his beliefs about his closeness and love which he experienced with relatives and peers. The item was included because it was consistent with Maslow's model and other criticisms. Prior to evaluation, it was considered unnecessary for the Protocol's
success but was included in an effort to be consistent with the model.

12. Item 12 was included because it was consistent with the theory and could potentially provide insight into the client's expectations. In self-esteem evaluation it is important to determine what the client expects to accomplish because such expectations help to identify self-esteem. The evaluators indicated that this item should be left in the Protocol.

Part II Counselor's observations

Part II of the Protocol was designed to give the counselor a standard format for recording observations about the client. These observations are important because they provide additional information about the client's statements. For example, clients tend to use facades and to present defensiveness when discussing difficult topics. Discomfort and defensiveness can be observed in the client's voice tone, non-verbal behavior, and extraneous comments. Items 13-21 attempted to identify behavioral indications of discomfort, which assist the measurement of self-esteem. Items 13-21 follow.

PART II Record your observations

Section A

Note the physical and linguistic aspects of the client's responses. Underline the adjectives which specify some detail that you see, hear or feel from the client.

13. Breathing: Nervous Tense Relaxed Comfortable
14. Eyes: Nervous Tense Relaxed Comfortable
15. Forehead: Nervous Tense Relaxed Comfortable
17. Lips: Nervous Tense Relaxed Comfortable
18. Skin: Nervous Tense Relaxed Comfortable
20. Language usage: Nervous Tense Relaxed Comfortable

13. Item 13 was designed to identify discomfort in the client's presentation. Many times a client is observed to be breathing nervously while presenting self-esteem information. Counselors who observe the client breathing tensely typically conclude that the client is nervous about the topics being discussed.

14. Item 14 was included because clients who discuss difficult self-esteem topics frequently look around and present eye movements which suggest discomfort. It should be noted that this item is similar to item 30. Item 14 was included because the researcher knew that the discrimination of the evaluators would be indicated in screening unnecessary items.

15. Item 15 sought to identify nervousness in the visual appearance of the client's forehead. Frequently, a nervous client has a furrowed brow which is sometimes associated with fear. This item was known to be weak in the Draft Protocol and was eliminated during the pilot study.

16. Item 16 was included to provide the counselor with another indication of client discomfort. A clenched jaw often indicates nervousness on the part of the client. This item was considered weak at the outset of study and was eliminated during the process of evaluation.

17. Tension in the lips is frequently indicative of a client who is having difficulty. For this reason, Item 17 was
included. It was also known that this item would potentially be considered redundant by the evaluators. It too was eliminated during the process of evaluation which occurred in the pilot study.

18. Item 18 was included to provide an additional visual criteria for client nervousness. Skin color and/or skin tone typically reflect nervousness among clients. For example, a nervous client sometimes presents redness in the neck or face. Other clients sometimes present paleness in the face or hands. This item was redundant and was eliminated in the pilot study.

19. Voice tone typically reflects some degree of nervousness or comfort. Comfort during the client's self-report helps to informally validate the client who states that he is comfortable with his relationships and other developmental experiences. For example, the client who says that he is comfortable but speaks with a nervous voice typically invalidates his self-report with his own manner of presentation. This item was reorganized into the Protocol following the positive evaluation it received during the pilot study. It became Item 11 in the field and final studies.

20. Item 20, which sought to evaluate the client's language usage, was presented on the grounds that it would assist in the validation of the client's self-report. It was repetitive to the extent that it had close similarity to the pre-
vious item as well as to Items 22-26 of the Draft Protocol. This item was eliminated during the pilot study.

21. Counselors typically observe the client's posture and body movements during counseling meetings. Such movements as reflected in this item provide the counselor with cues regarding nervousness or comfort. These cues also help the counselor to understand the client's self-report. Item 21 was also redundant of both previous and subsequent items. It was eliminated by the evaluators.

Section B of Part II, Items 22-26, were included to identify the client's defensiveness or social desirability facade. These five items were modified into two items in the Pilot Protocol, Items 16 and 17. Item 16 remained and was renumbered Item 12 in successive stages of study. Hence, Draft Items 22-26 were reduced to one in the field and final Protocols. Defensiveness and facades end to be lowest among high self-esteem people. For this reason, these items entered the Protocol. Items 22-26 follow.

Section B

Appraise the client's defensiveness and/or social desirability facade. Use a letter (A,P,R) to grade the client's willingness to discuss self and others.

A=Active willingness, P=Passive willingness, R=Refusal/inability

22. Faults/wrongs/failure of others _____
23. Faults/wrongs/failures of self _____
24. Positive qualities/successes of others _____
25. Positive qualities/successes of self _____
26. His/her responsibility for circumstances in life _____

22. Item 22 sought to appraise the client's defensiveness and/or social desirability facade. The particular defensiveness aspect was represented in the client's attributed
willingness to discuss the faults or wrongs or failures of other people. Defensiveness and social desirability facades typically reflect moderate or low self-esteem. In contrast, people with high self-esteem are not typically prompted to be defensive and extensively present facades.

23. Item 23 was included to identify defensiveness or a facade related to a focus on one's past failures. Again, people with high self-esteem typically do not spend time talking about their past failures. A client who would do this would not be one presenting typically high self-esteem.

24. Item 24, in contrast, sought to identify the client's willingness to present positive information about other people. Clients with high self-esteem do not have difficulty talking about the quality and successes of others.

25. The client with high self-esteem is willing to discuss his own successes when given the appropriate opportunity. Item 25 was included to identify a person's willingness to acknowledge his own positive qualities and successes.

26. Item 26 was included to identify the client's willingness to express responsibility for his own circumstances in life. Clients with low self-esteem and clients with moderate self-esteem frequently have difficulty taking responsibility for their difficulties and challenges. This item was included to help estimate the client's defensiveness.

Part II Section C, Items 27-40, allows the counselor to identify the client's interview behaviors which potentially indicate self-esteem difficulties. These items represent some possible indications
that the client is experiencing difficult emotions during the self-esteem evaluation. Items 27-40 follow.

Section C
Check (✓) the following client behaviors demonstrated during the interview.

27. Seeks extra help from therapist
28. Cries/sniffs/chokes up
29. Fidgets excessively
30. Looks around, easily distracted
31. Rocking or shifting movements
32. Slumps/droops in chair
33. Wrings hands
34. Changes story when confronted
35. Dramatizes self report
36. Refuses to cooperate
37. Refuses to accept responsibility
38. Makes threats
39. Expresses distrust for the therapist
40. Expresses anger/disgust for the therapist

27. When a client seeks extra help from the therapist (Item 27), it is considered that the client is demonstrating a dependency need. This is frequently seen among counseling clients. It is also an indication that the client is missing needed support.

28. Crying was included on the grounds that it represents anxiety, stress, or depression, any of which impeded the client's self-esteem. For example, when a client cries while discussing a particular item, the counselor understands that the client has difficulty with that topic.

29. The client who fidgets excessively is typically one who is uncomfortable. This discomfort is another indicator of potential difficulties with self-esteem because it is prompted by the discussion of self-esteem issues. Item 29
is obviously repetitive of other items in the draft. It was eliminated by the evaluators.

30. Counselors are concerned about clients who are easily distracted during the counseling meetings (Item 30). For example, if the client has difficulty paying attention to the counselor, it appears that the client is not prepared to concentrate on the self-esteem evaluation.

31. Item 31, rocking or shifting movements, is considered another aspect of distractability. As such, the item was repetitive and was removed after the pilot study.

32. Clients who slump or droop in their chair (Item 32) fail to present the energy and intensity associated with strong self-esteem. The slumping and drooping behaviors are considered to be associated with lack of energy or enthusiasm, and even some depression.

33. The client who wrings his hands while presenting his own self-esteem report is typically uncomfortable with the discussion. Item 33 was included for this reason, but since the item was repetitive of other items, it was removed following the pilot study.

34. Counselors consider that clients who change their stories (Item 34) when confronted may be presenting vacillation and ambivalence. Vacillation and ambivalence are contraindications of strong self-esteem.
36. Item 36, "refuses to cooperate," was included as an item which replicated others in the Protocol. As such, it was considered unnecessary by the evaluators. Item 36 was useful to the researcher to the extent that it indicated that the evaluators were performing their tasks appropriately. It was eliminated after the pilot study.

37. Clients who refuse to accept responsibility for their choices and actions (Item 37) also indicate a lack of self-esteem. Self-esteem, in contrast, is associated with a mature willingness to accept responsibility.

38. A client who "makes threats" was included to identify inappropriate hostility (Item 38). It is understood from Maslow's theory that people with self-esteem are typically able to make appropriate adjustments without undue hostility.

39. Item 39 was included to check evaluator discrimination. It was very similar to the previous item. As such, it was discarded after the evaluation done in the pilot study.

40. Item 40, and the last in Part II, identified the client's anger or disgust for the therapist. It added another dimension to understanding the client's hostility.

PART III Counselor's use of test information

Items 41-60 comprised PART III of the Protocol. The final section represented an opportunity for the counselor to combine test scores with observations and the client's self-report. Wells & Marwell (1976) suggested a need to make such a combination. For this
reason, scales were included as a third area of the Protocol. PART III represented generic scales which could guide yet not limit the counselor's selections. Items 41-60 follow.

**PART III Indicate your use of test information**

Check (✓) the kinds of test scores you would use to evaluate the client's self-esteem

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<td>41. Self-esteem scales</td>
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<td>43. Social desirability scales</td>
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<td>58. Emotional stability scales</td>
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<td>59. I would not use a test score</td>
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<td>60. Others (Please list.)</td>
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41. Self-esteem scales (Item 41) provide test information about the client's self-esteem. This information is, of course, limited by the characteristics of the test chosen. The information found by the self-esteem scale is to be combined with the other information in the Protocol and utilized by the counselor. It is understood that no one question or test score could totally limit or determine the outcomes of the evaluation. This is consonant with other forms of psychological evaluation which combine similar techniques.
42. The self-concept is identified as a construct which some counselors want to test in the self-esteem evaluation. The distinction between the self-esteem and the self-concept is largely theoretical. The distinctions between the constructs are sought by numerous researchers. Item 42 was considered necessary by the evaluators in both the pilot and field studies.

43. Social desirability refers to the construct which is present in the client who is trying to favorably impress others with a false sense of self-esteem. Social desirability contaminates the self-esteem appraisal to the extent that the counselor can confuse the client's actual self-esteem with the self-esteem which the client is trying to present. Item 43 was removed subsequent to the pilot study.

44. It is recommended that anxiety be considered as a tested construct in the self-esteem evaluation. Although the self-esteem evaluation did not seek to accentuate anxiety, it is thought that a measure of anxiety could be helpful for understanding the client's self-esteem. Item 44 passed the evaluation which was conducted during the pilot study and remained in the Protocol through the final stage.

45. Defensiveness scales could potentially assist in the self-esteem evaluations. It was realized that such scales would assist in validating the counselor's observations in Part II of the Protocol. Item 45 was somewhat redundant and was removed during the pilot study.
The researcher chose to plant eight bogus items to check evaluator discrimination. This was done to determine whether evaluators critically reviewed the items sent to them. Items 39, 46, 47, 49, 51, 55, 56, and 57 were used by the researcher in checking evaluator discrimination. All eight items were removed due to the weak evaluations they received from evaluators. Thus the items did not appear in the field and final studies.

46. Item 46, social adjustment scales, was not necessary for the Protocol. It was used to check evaluator discrimination. The researcher inserted this item in hopes of discovering the evaluators' discrimination. The item was removed because of the evaluations during the pilot study.

47. Achievement needs scales were listed to check the evaluators' discrimination. Item 47 was considered unnecessary by the researcher and that opinion was validated by the findings of the pilot study, after which the item was dropped.

48. Dominance needs scales (Item 48) are similar to self-esteem scales to the extent that the client's dominance represents his desire to compete and to succeed. This item was considered unnecessary by the evaluators.

49. Order needs scales were considered unnecessary by the researcher prior to the evaluations. Item 49 was inserted as a means of identifying the evaluators' discrimination. It was dropped subsequent to the pilot study.

50. Affiliation needs (Item 50) can be helpful to the discerning counselor in determining whether the client's
self-esteem is supported by adequate affiliation. For example, it is known that clients with strong self-esteem typically have good support networks and successfully affiliate with others. The evaluators, however, considered the item unnecessary, and it was dropped after the pilot study.

51. Counseling readiness scales (Item 51) were considered unnecessary by the researcher. This item was used to identify the evaluators' discrimination. It was discarded during the pilot study.

52. It was thought that a self-control scale could potentially assist counselors in reviewing the client's self-esteem. The evaluators did not support this opinion, and Item 52 was dropped during the pilot study.

53. Self-confidence is associated with self-esteem. It is thought that a measure of self-confidence would be helpful in understanding the client's self-esteem. The evaluators agreed with this position, and Item 53 was retained.

54. Wells and Harwell (1976) suggested that self-esteem could be viewed as the difference between the real self and the ideal self. As such, the ideal-self scale helps the client understand his level of self-esteem. Self-esteem is also considered a function of the differences between the ideal self and the real self as perceived by the client. The evaluators agreed with this position, and Item 54 was retained.
55. Self-criticism scales (Item 55) were included as another means of identifying evaluator discrimination. The item was dropped at the end of the pilot study.

56. Self-nurturance scales (Item 56) were included to assist with evaluator discrimination checks. The item was dropped after the pilot study.

57. Self-inhibiting scales (Item 57) sought to identify evaluator discrimination. The evaluators considered it unnecessary, and it was dropped as a result of the pilot study.

58. The need for an emotional stability scale (Item 58) was suggested by the literature (Robinson & Shaver, 1980). It is thought that clients with strong self-esteem also have a positive degree of emotional stability. The evaluators in the pilot study agreed, and Item 58 was retained.

59. Item 59 was included to indicate whether the evaluators wanted to avoid the use of test scores. The evaluators considered the item unnecessary, indicating that test scores should be included as one dimension of the Protocol.

60. Item 60 allowed the evaluators to list other scales which they would prefer using. The item was dropped because the evaluators considered it unnecessary and because no other scales were demanded.

Evaluation of criticism of the draft

It should be noted that the Draft Protocol began with 60 items. Based on the recommendations made by the six counselors who met with the researcher and reviewed the Draft, the Protocol was reduced to 50 items. (The specific criticisms of the Draft are outlined in Appen-
Draft items 1-8 and 27-60 were left unchanged and placed in the Pilot Protocol, except for Draft Item 59 which was dropped.

The other Draft items, 9-26, were reworded and reorganized into Pilot Protocol items 9-17. These changes account for the ten items which were lost between the draft and pilot studies. The Pilot Protocol items which resulted from the draft study appear as follows.

PART I Record the client's responses

Question A (Feelings)

Are you satisfied with your feelings, in terms of:

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? _____
2. Feelings of being secure and safe? _____
4. Feelings about your choices and responsibilities in life? _____

Question B (Behaviors)

Have your behaviors obtained the results you wanted, in terms of:

5. Comfort and relaxation without the aid of medicine, drugs or alcohol? _____
8. What you wanted to accomplish in life? _____

Question C (Beliefs) Read the following instructions to the Client:

Briefly answer the two remaining questions.

9. What do you expect to accomplish during the next five years? _____

PART II Record your observations of the client.
Section A

Instructions: Try to observe client's covert messages about his/her feelings. Check (✓) client's nonverbal cues which suggest discomfort. For example, if the client's breathing seems to be uncomfortable when he answers item #3, you would check (✓) the #3 box on the "Breathing" line below the matrix.

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<td>15. Voice and tone:</td>
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Section B

Instructions: Try to identify the client's defensiveness and social desirability facade.

16. Did you get the impression that the client was: Highly Defensive, Moderately Defensive, Slightly Defensive, or Not Defensive. (Underline your estimate of the client's defensiveness.)

17. Did the client seem to have social desirability facade about some items which you discussed? If so, which items?

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Section C

Check (✓) the following client behaviors demonstrated during the interview.

18. ____ Seeks extra help from therapist
19. ____ Cries/sniffles/chokes up
20. ____ Fidgets excessively
21. ____ Looks around, easily distracted
22. ____ Rocking or shifting movements
23. ____ Slumps/droops in chair
24. ____ Wrings hands
25. ____ Changes story when confronted
26. ____ Dramatizes self report
27. ____ Refuses to cooperate
28. ____ Refuses to accept responsibility
29. ____ Makes threats
30. ____ Expressed distrust for the therapist
31. ____ Expresses anger/disgust for the therapist
PART III Record the client's test scores on the lines provided.

Selection of scales is left to the counselor's discretion.

32. Self-esteem scales _____
33. Self-concept scales _____
34. Social desirability scales _____
35. Anxiety scales _____
36. Defensiveness scales _____
37. Social adjustment scales _____
38. Achievement needs scales _____
39. Dominance needs scales _____
40. Order needs scales _____
41. Affiliation needs scales _____
42. Counseling readiness scales _____
43. Self-control scales _____
44. Self-confidence scales _____
45. Ideal self scales _____
46. Self-criticism scales _____
47. Self-nurturing scales _____
48. Self-inhibiting scales _____
49. Emotional stability scales _____
50. Others (Please list.) _____

TASK III Your further suggestions and criticisms would be most helpful. Feel free to write them on the back of this page.

The Pilot Protocol Stage of Research

The 50 items which were retained after the Draft study became the Pilot Protocol. These items were sent to the counseling psychologists in the first mailing. The evaluations submitted by the Pilot group of psychologists resulted in a reduction in the number of items.

A randomized listing of potential evaluators

Evaluator selection was conducted on three separate occasions. Each Protocol, the Pilot, the Field, and the Final, was sent to a group chosen by a process of random selection. The evaluators were members of the American Psychological Association, Division of...
Counseling Psychology. The researcher obtained a list of 1,000 APA counseling psychologists from the APA computer division.

The names and addresses of these potential evaluators were printed on gummed labels. The list contained groups from geographical regions throughout the United States. The selection procedures used by the researcher provided possibilities for the use of equal numbers of evaluators in all mailing regions throughout the USA.

Use of evaluators to solve research questions

On the Pilot Protocol the evaluators completed two tasks so as to provide double assessment of each item. TASK I was designed to assess the potential of each item in terms of its function in the self-esteem evaluation. TASK II was designed to indicate a level of priority as perceived by the evaluators. The evaluators were asked to indicate which items were considered highly functional, moderately functional, slightly functional, and not functional. Functional was defined as the property of the item which caused the item to be helpful in the self-esteem evaluation. For example, it would be not functional to ask the client, "Has anyone ever called you a jerk?" In contrast, a functional item would provide a high quality of information about the client's sources of self-esteem feelings, beliefs, or behaviors. In TASK II the evaluators were asked to identify levels of priority among the items. This was done by designating a group of 12 items that could be eliminated first, then 12 that could be eliminated next, and then a final group of 12 items that would be eliminated. TASK III was optional in the Pilot Protocol and asked evaluators for written suggestions.
Sampling procedures

Evaluator selection for studying the Pilot Protocol proceeded as follows:

1. The first 42 names were drawn from the 42 pages of the list using the fourth label on each page. The additional 28 names were on the labels in the fourth from the end position of each page. The final 28 were evenly spaced throughout the 42 pages of the total list.

2. A total of 70 labels were removed from the list and attached to mailing packets which were sent to the counseling psychologists.

3. Each evaluator received a 9 x 12 manila mailing packet. Upon opening the packets the evaluators found first the cover letter along with a $1 bill. The cover letter introduced the evaluators to the request for research participation. The evaluators were asked to proceed with their evaluation instructions which introduced the Protocol. The Protocol began with a yellow page containing instructions for evaluators. The second page contained directions for counselor administration. Pages 3-5 of the Protocol contained the items to be evaluated as well as the three evaluation tasks. The mailing packets also contained a self-addressed, stamped, white, business envelope. The cover letter asked evaluators to complete the evaluation tasks and return the Protocol with their evaluations.

4. A letter of invitation was included in the mailing packet. A total of 21 counseling psychologists chose to participate at the Pilot stage of research. Two evaluators were removed due to
their response errors. Nineteen psychologists participated in successfully evaluating the Pilot Protocol. This sample size was adequate due to the purposes of the pilot study. The group was large enough to provide an adequate response to the researcher's request for initial information about the adequacy of the Protocol. This sample allowed the researcher to continue studying the Protocol and to present it to a larger sample. The adequacy of the total returns, 128, was sufficient for the purposes of this study.

5. TASK I was an evaluation activity performed by the evaluators. Evaluator tasks are included in Appendix B. The evaluators were asked to determine how functional each item was. There were four categories regarding the functional value of each item. Each item was to be judged as one of the four following categories: highly functional, moderately functional, slightly functional, disfunctional. The evaluators were asked to check the appropriate column in TASK I which indicated their evaluation of the functional level of each item. Detailed instructions were provided for each evaluator task.

6. The evaluators were asked to perform a second evaluation service which was entitled TASK II. Each evaluator was to identify the 12 weakest items and check them as the first group that could be eliminated from the Protocol. This was an indication of which items the evaluator considered to be potentially unnecessary. It also indicated the evaluators' perceptions of which items would be retained in the Protocol. The evaluator was to screen the items three times indicating three different groups of items.
which could be eliminated in a prioritized manner. Careful instructions were given the evaluators for completing TASK II.

7. TASK III was designed to collect further suggestions from the evaluators. They were given the opportunity to write their comments on the back page of the Protocol. It was expected that few evaluators would provide much written information after completing the previous two tasks.

8. In hopes of increasing the number of evaluators who would participate, the researcher provided an opportunity for the evaluators to receive a research bibliography from this study. Evaluators wanting the bibliography were given the opportunity to check a box indicating this preference.

9. Several of the evaluators wrote criticisms of the Protocol. Their criticisms are presented in Chapter 4.

   The findings from this stage are presented in Table 1 of Chapter 4. The findings were used to prepare the survey materials which were used at the Field stage of the research.

   The evaluator responses to the Pilot Protocol were tallied and presented in a summary chart which is included in Chapter 4. Each item was evaluated by the researcher in terms of the evaluators' responses indicating their appraisals of each item. Of the 50 items, 27 passed the dual criteria which included a satisfactory rating imposed by the researcher on both TASK I and TASK II of the Protocol. The evaluators' responses which they wrote in TASK III also guided the researcher's interpretation of their TASK I and TASK II evaluations.
A rigid application of the criteria would have removed 32 items from the Pilot Protocol. It would also have reduced the strength of the Protocol's Part II Section C by eliminating 10 of 14 items from the section which both the literature and the Draft Protocol counselors stated was very important. To resolve this tension the researcher selected nine marginally close items, 5, 10, 15, 19, 21, 23, 25, 26, and 31 to remain in the Protocol. The Protocol which emerged at the end of the Pilot evaluation appears as follows:

PART I

TASK I

Section A (Feelings)

"Are you satisfied with your feelings, in terms of . . . ."

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? _____
2. Being secure and safe? ______
4. Choices and responsibilities in life? _____

Section B (Behaviors)

"Have your behaviors obtained the results you wanted, in terms of . . . ."

5. Comfort and relaxation without the aid of medicine, drugs or alcohol? ______
6. Security and safety? ______
8. What you wanted to accomplish in life? ______

Section C (Beliefs) Read the following instructions to the client: "Briefly answer the two remaining questions."

9. What do you expect to accomplish during the next five years? ______
PART II

TASK I

Section A

The client's voice and tone may suggest discomfort when discussing specific items. Check (✓) the items #1-10 from the previous page which elicited discomfort in the client's voice and tone.

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<td>11. Voice and Tone</td>
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Section B

Try to identify the client's defensiveness.

12. Did you get the impression that the client was:
   Highly Defensive, Moderately Defensive, Slightly Defensive,
   or Not Defensive. (Underline your estimate of the clients' defensiveness.)

Section C

Check (✓) the following client behaviors demonstrated during the interview.

13. _____ Seeks extra help from therapist
14. _____ Cries/sniffles/chokes up
15. _____ Looks around, easily distracted
16. _____ Slumps/droops in chair
17. _____ Changes story when confronted
18. _____ Dramatizes self report
19. _____ Refuses to accept responsibility
20. _____ Makes threats
21. _____ Expresses anger/disgust for the therapist
PART III Record the client's test scores on the lines provided. Selection of scales is left to the counselor's discretion.

22. ______ Self-esteem scales
23. ______ Self-concept scales
24. ______ Anxiety scales
25. ______ Self-confidence scale
26. ______ Emotional stability scales
27. ______ Ideal self scale

The Field Protocol Stage of Research

The subsequent Protocol, the Field Protocol, contained 27 items. This meant that the Pilot Protocol lost 23 items as a result of the subjects' evaluations. The 27 items remaining after the pilot study are the same ones which remained in the Protocol during the subsequent stages of research. The items which were discarded may be found by comparing the Pilot Protocol to the Field Protocol. The Pilot and Field Protocols are provided in Appendices B and C. Pilot Items 1-10, 15, 16, 18, 19, 21, 23, 25, 26, 28, 29, 31-33, 35, 44, 45, and 49 were retained and were studied throughout the remaining stages of the research.

Use of evaluators to solve research questions

The counseling psychologists serving as evaluators for the Field Protocol evaluated the items with two tasks also. The first task remained the same as TASK I on the Pilot Protocol. TASK II, however, simply asked the evaluators to circle items they believed were unnecessary. A TASK III was designed to find out what types of counselors were considered to be benefited by the Protocol. The evaluators were also asked in TASK III to indicate the section of the Protocol they believed to be most helpful.
**Sampling procedures**

The following paragraphs describe the sampling procedures which were used to collect information about the Field Protocol.

1. First, 126 counseling psychologists were invited to participate in the survey which was conducted on the Field Protocol. Their names were drawn from the randomized list of mailing labels provided by the American Psychological Association.

2. The names of the individuals who were invited to serve as evaluators were drawn from the list in the following manner: (a) Three names from each page of the list were drawn. (b) The first three names on the second column of each page were selected. Since there were 42 pages, a total of 126 names were drawn; 58 psychologists chose to participate in the study. This group returned the Field Protocol with sufficient evaluation. A sample size of 58 was fully adequate for preparing the Protocol for the next stage of study. At this point, the researcher had collected 70 evaluations of the Protocol. The evaluators of the Field Protocol confirmed the evaluations which were provided in the previous stage of study.

3. The names and addresses for each evaluator were removed from the randomized listing previously described. The Field Study used identical sampling procedures as did the pilot study aside from the following changes.

A. TASK II on the Field Protocol asked the evaluators to identify items which they considered unnecessary. The instructions for evaluators stated, "It is important that you do this to indicate which items could be eliminated
from the Protocol without impairing its effectiveness."

Three pages were used to outline the 27 Protocol items. On each page, and following the items, TASK II was presented. On each page the evaluators were asked to circle the items they considered unnecessary for self-esteem appraisal.

B. TASK III asked the client to answer two brief questions. One question asked the evaluators to indicate how helpful the Protocol might be to various kinds of counselors. Their opinion was to be indicated by circling one of following four sets of initials: VH, MH, SH, or NH (VH=Very Helpful, MH=Moderately Helpful, SH=Slightly Helpful, NH=Not Helpful). This question was designed to ascertain some level of agreement about the perceived usefulness of the Protocol.

C. TASK III asked a second question. "Do you prefer certain parts of the Protocol over others? If so, which ones do you prefer?" The purpose of this question was to identify some agreement among evaluators about the structure of the Protocol.

D. The front page of the Field Protocol was blue, the back page was cream colored, and the middle three pages were yellow. The colors were selected in order to ease the visual concentration of the evaluators. The pages were also color-coded in hopes of increasing psychologist participation.
The findings of the Field Protocol study were used to guide the final study.

The Final Protocol Stage of Research

Use of evaluators to solve research questions

The Final Protocol took the approach of presenting client information to the evaluators. The three samples of the final Protocols are located in Appendices E, F, and G. The stimuli presented came in the form of hypothetical client information on the self-esteem Protocol. This was in contrast to previous Protocols which had asked evaluators to judge unused items. This required some analysis and critical thinking of the evaluator. The evaluator was required to conceptualize how the Protocol would be used with any client plus the evaluation of the hypothetical client's self-esteem. The Final Protocol evaluation survey asked evaluators to judge Protocol sections which contained client information. The client responses were hypothetical. Three final Protocols were used with three sets of 30 evaluators. The 30 evaluators in each group received one of the three Protocols. A total of 90 counseling psychologists received the three Protocols.

The rationale for the hypothetical responses was developed by the researcher. The hypothetical responses represented fairly typical responses which counseling psychologists hear from their clients. The purpose of implementing such responses on the Protocols was to give the evaluators appropriate stimuli. From a research perspective, the value of the hypothetical responses was their ability to...
elicit a counseling psychologist's estimate of the client's self-esteem.

The theoretical underpinnings of the hypothetical responses were consistent with the criteria previously identified. For example, the responses on all three Protocols were typical of clients who were evaluated for self-esteem. Clients who have wanted counseling for self-esteem have at least some degree of inconsistency. The hypothetical responses were designed to be somewhat inconsistent. Three different Protocols were used to determine whether different client profiles could evoke different evaluations. The researcher varied the client profiles by altering each of the three parts within the three Protocols. Two parts of each Protocol contained inconsistent client information. One part of each Protocol contained consistent information. Protocol #1 had a consistent Part II. Protocol #2 had a consistent Part III. Protocol #3 had a consistent Part I.

Hypothetical Client #1 presented wide ranging responses on Parts I and III of the Protocol. The self-report statements had a wide range of numbers. The lowest number was one and the highest number was nine. The client, for example, expressed a low level of satisfaction about his ex-wife; he also reported a high level of satisfaction with his peers. These differences as well as differences from other responses made Part I of the Protocol seem somewhat inconsistent.

The hypothetical test scores on the first Protocol were also wide ranging. The test scores were inconsistent to the extent that the Ideal Self Scale contained a 61 percentile. In contrast, the Self-Esteem Scale contained a 92 percentile and the Self-Concept
Scale provided a 78 percentile. When a client had some varying scores such as these, counselors have tended to doubt the client's high self-esteem score. It should be noted that some counselors tend to disregard test scores altogether.

Because Parts I and III of the first hypothetical Protocol provided inconsistent responses, they are considered similar. Part II of this Protocol, in contrast to Parts I and III, provided some fairly consistent responses. For example, in Section A of Part II, the counselor checked the majority of items as representing the client's discomfort in voice and tone. Section B indicated that the counselor viewed the client as highly defensive. Section C indicated that during the interview the client sought extra help from the therapist, looked around and was easily distracted, slumped in his chair, changed his story when confronted, dramatized his self-report, and refused to accept responsibility.

Hypothetical Client #1 was considered to have inconsistent responses for the following reasons: He claimed that prior to his divorce he was happily married. He also stated that he got along great with everybody. These were responses to Item 10. His responses to Item 9 indicated that he intended to get a Master's degree in Psychology, remarry, and stay in touch with his two-year-old son. The inconsistencies at this point appeared to lie in his perception of his past marriage. The past marriage was considered happy until the divorce. This suggested that he lacked insight regarding his responsibility for the divorce. His desire to remarry and stay in touch with his son and get a Master's degree have the
potential of being somewhat contradictory. The goals appeared to be ideal, but the probability of all of them occurring would be influenced by other factors. The employment prospects for the Master's degree in Psychology were not included in the list of five-year goals. Something was missing in the client's planning. This too suggested an inconsistent client.

Hypothetical Client #1 was represented in a Protocol that was inconsistent. The inconsistencies were, of course, provided by the researcher who was attempting to present a typical client. The researcher also attempted to present to the subjects a Protocol which would be difficult to interpret. This difficulty represented typical difficulties which counselors have encountered when attempting to interpret the self-esteem of clients with inconsistencies.

Thirty evaluators received copies of the Protocol containing responses from Hypothetical Client #1. The evaluators were instructed to complete an evaluation survey regarding their analysis of Protocol #1. They received a cover letter with the research materials which were mailed to them. Sampling was conducted in terms of the procedures which were previously outlined for the Final Protocol. The responses for the evaluators who analyzed Hypothetical Client #1 are presented in Chapter 6.

Hypothetical Client #2 was somewhat different from Client #1. This hypothetical client presented inconsistencies in Parts I and II of the Protocol. In contrast, Part III of the Protocol contained fairly stable test scores. The researcher provided differing Protocols, varying the sections of the Protocols which were
inconsistent, in order to study potential differences among the responses of differing evaluator groups.

The self-report responses of Client #2 were fairly wide ranging. The scores ranged from a low score of 1 to a high score of 9. The client felt fairly dissatisfied with her feelings about her mate yet suggested that her feelings about her peers were highly satisfactory. This represented a remarkable inconsistency in the client's feelings. A client of this nature is difficult to evaluate in previous self-esteem evaluations.

The counselor's observations on Part II of the second hypothetical client were also somewhat vague or inconsistent. For example, only half of the items listed in Section A were checked as providing discomfort in the voice and tone. Section B reported that the counselor considered the client to be moderately defensive. Finally, in Section C it was reported that the client sought extra help from the therapist, cried, slumped in her chair, and dramatized her self-report. Section C contained only 4 of a possible of 11 interview behaviors.

Parts I and II of the second hypothetical client's Protocol were difficult to interpret due to a lack of consistency. In this sense, Parts I and II were similar. Part III of this Protocol was different in that its items contained fairly even or consistent test scores. For example, the percentile scores for these scales suggested that the client had a moderate degree of emotional stability, self-concept, self-confidence, and self-esteem. At the same time, the anxiety scale contained a 62nd percentile, which was also moderate.
The hypothetical responses for this second Protocol were formulated to present a female client who was in counseling for self-esteem and for specific life changes. For example, she wanted to improve her love life, get a promotion at work, quit worrying about her parents' approval, and possibly relocate. These goals represented her expectations for herself during the next five years. The goals were also responses to Item 9.

The hypothetical response to Item 10 suggested that she was living with a boyfriend who was unfaithful to her. She, in contrast, was still faithful to him. At the same time, her parents were critical of her. She reported that she was succeeding as an engineer and expected her company to possibly promote and relocate her. She also said that her friends respected her. These responses were inconsistent. They also represented typical inconsistencies that many people have lived with and inconsistencies which have prompted individuals to seek self-esteem counseling.

Thirty counseling psychologists received the Protocol containing the responses for the second hypothetical client. The Protocol is included in Appendix F and is designated as Hypothetical Client #2. The evaluators' responses were recorded on a summary chart and provided in Chapter 4. Their responses were returned to the researcher on the evaluation survey which was sent them with the Protocol they reviewed.

Hypothetical Client #3 was considered to be inconsistent in Parts II and III of the Protocol. This Protocol represented a hypothetical client who was somewhat difficult to interpret in terms of his test scores in Part III and the counselor's observations in
Part II of the Protocol. For example, the counselor indicated in Section A of Part II that the client presented discomfort in his voice and tone on 5 of the 10 previous items. The counselor considered the client moderately defensive. Four of the nine client behaviors were checked by the counselor. Those behaviors were as follows: the client sought extra help from the therapist, slumped in his chair, dramatized his self-report, and refused to accept responsibility.

Because the hypothetical client presented this type of profile on Parts II and III of the Protocol, he was considered inconsistent. Part I of the Protocol was different than Parts II and III. The client responses for Part I were fairly homogeneous. For example, the client indicated that he was moderately dissatisfied with his feelings of security and closeness with his children, parents, relatives, peers, and with his responsibilities in life. His discomfort seemed to reside in his physical relaxation and with his wife.

He explained his responses to the previous items by providing additional information at Items 9 and 10. He expected to improve his marriage, get a job, and improve his health during the next five years. He indicated that his wife nagged him about his unemployment. She threatened to leave if he did not work. He complained that he was too weak to work due to back pain and indicated that his family and friends were critical of him.

These responses were used in the third Protocol in order to elicit evaluator responses regarding a fairly inconsistent client. The client's inconsistencies were probably most evident in Parts II and
III of the Protocol. For example, the client scored a 90th percentile on the self-esteem scale. At the same time, he scored an 88th percentile on the anxiety scale. He also scored a 36th percentile on the emotional stability scale. The inconsistency indicated here is that the self-esteem score would be difficult to rely on due to the elevated anxiety score and lowered emotional-stability score. These inconsistencies were also paralleled by the inconsistent observations which were checked by the counselor in Items 11 through 19. The client would be difficult to evaluate in one self-esteem interview in which the client interacted directly with the counselor.

**Sampling procedures**

The Final stage was sent to 90 psychologists, 51 of whom chose to participate in the study. Three groups of 30 each received Protocols. The total of 51 represented evaluators in all three groups: 19 from the first group, 18 from the second, and 14 from the third.

The procedures for conducting the Final stage are outlined as follows:

1. The 27 items identified as justifiable for continued research following the Pilot Protocol continued to be used through the Field and Final stages of the research. Two major changes occurred in the Final stage. The evaluation tasks which were presented to the evaluators and the hypothetical Protocol answers constituted the major changes. Both changes were made to facilitate the validation work which would be needed in
answering the research questions. The research questions also
guided the formation of the evaluators' tasks.

2. The researcher used the previously described randomized listing
to obtain names and addresses of potential evaluators. Selection procedures were consistent with those already discussed.
Mailing packets containing the cover letter and other materials were also used as was described.

3. Evaluators responded using the following evaluation survey:

1. Can you estimate the client's self-esteem by using the client's responses, counselor's observations, and test scores as combined in the Protocol? (Circle your response as follows.)

   Definitely Yes     Probably Yes     Undecided
   Definitely No     Probably No

Note: For questions 2-6, circle the appropriate letters to indicate your response. (VH=Very Helpful, MH=Moderately Helpful, SH=Slightly Helpful, NH=Not Helpful)

2. How Helpful was the Protocol's basic structure for estimating the client's self-esteem? VH MH SH NH

3. How Helpful was the structure of Part I (client's responses) of the Protocol for estimating the client's self-esteem? VH MH SH NH

4. How Helpful was the structure of Part II (counselor's observations) of the Protocol for estimating the client's self-esteem? VH MH SH NH

5. How Helpful was the structure of Part III (test scores) of the Protocol for estimating the client's self-esteem? VH MH SH NH

6. How Helpful might this Protocol format be to various types of counselors?

   A. Counselors like yourself: VH MH SH NH
   B. Marriage/Family counselors: VH MH SH NH
   C. Beginning/Student counselors: VH MH SH NH
   D. Humanists: VH MH SH NH
   E. Behaviorists: VH MH SH NH
4. The first six of the seven questions provided forced choice responses. This was done to identify categorical levels of evaluator agreement about the Protocol. The final question allowed the evaluators to present additional information which would be helpful in interpreting their previous responses.

5. Directions for counselor administration were attached as a last page for each Protocol. These directions remained the same for all three groups. The directions were attached to the back to avoid distracting the evaluators from their work. 6. The evaluators were asked to return their evaluation surveys in the enclosed business envelope. Fifty-one of the 90 psychologists who received mailing packets participated in the study. The size of this sample, 51 psychologists, was adequate to arrive at a satisfactory level of credibility regarding the evaluators' responses. This sample, in combination with the previous samples, elevated the total sample size to 128. This size group was fully adequate to determine answers to the research questions as outlined in the study.

7. It was then necessary to distinguish between the evaluation surveys returned from three different groups of evaluators. To identify the evaluator group associated with a particular evaluation survey, three different colors of evaluation surveys were duplicated. The first group of 30 evaluators received the
Protocol containing hypothetical responses for Client #1. This first group of evaluators received beige-colored evaluation survey forms.

The second group of evaluators received Protocols bearing the second set of hypothetical client responses. This group of evaluators received blue evaluation forms. The third group of evaluators, who received Protocols with the third set of hypothetical responses, received salmon-colored evaluation forms.

Summary

This chapter has provided the information describing the procedures used to develop the Protocol. The chapter began with a review of the research goals. The goals consisted of developing a Protocol in harmony with answers to research questions which were framed at the outset of research.

The findings of each stage of Protocol research provided indications for determining the research procedures at the following stage of research. Thus, the findings of the Draft Protocol determined the content and format of the Pilot Protocol study. Next, the findings of the Pilot study provided guidance for the Field study. Finally, the information obtained in the Field study provided the information which was needed to conduct the Final Protocol study.

The chapter also described the population and the sample. It should be understood that the research did not attempt to infer information about a population. Rather, the population was discussed in reference to the development and potential utility of the Protocol. The Protocol was studied in terms of its usefulness to
counseling psychologists; therefore, they were used as evaluators. The evaluators were randomly sampled from the American Psychological Association, Division of Counseling Psychology.

The major portion of the chapter focused on the actual methods of Protocol development. Those methods included item selection, sequential stages of research, use of evaluators, sampling procedures, and analysis of evaluator responses. Each of these methods was fully addressed in a subsection within the chapter.

Chapter 4, which follows, identifies the information which was found at each stage of research. Each stage produced a set of findings. The findings were the answers to the research questions. It should be noted that the findings were inextricably bound up in the methods used to gather information about the Protocol. These findings constitute the basis of the chapter which follows.
CHAPTER IV

RESEARCH FINDINGS

Introduction

This chapter provides a description of the research findings. The material in this chapter is also presented to answer the following research questions:

1. Could assessment techniques be effectively combined in a Protocol for evaluating adult self-esteem?
2. Could a sample of counseling psychologists agree on the basic structure of a clinical Protocol designed to evaluate adult self-esteem?
3. To what extent would counseling psychologists agree on the validity of the Self Esteem Protocol?

The answers to the questions were found in a step-by-step process. In a practical sense, this meant the answers were pursued in a developmental process. At each step of the research, the questions were studied and subsequent research stages provided additional information for each question.

Chapter 4 discusses the findings which distinguished each stage of Protocol development. The items used in the Protocols passed through the different stages of development. This chapter also describes the evaluation of the Protocol at each stage of the research.
The findings are presented in the following outline:

1. Background Information
2. The Draft Stage
3. The Pilot Study
4. The Field Study
5. The Final Study
6. The Summary of Research Findings

**Background Information**

Chapter 3 emphasized the developmental nature of the study. For example, the research was conducted in sequential stages. The second stage could not be conducted until the first stage had been completed and analyzed. Likewise, the third and fourth stages could not be conducted until the stages preceding them had also been completed.

The first step was referred to as the Draft stage. The second, third, and final steps were referred to as the Pilot, Field, and Final stages, respectively. The first three stages were conducted with Protocols which contained both Protocol items and evaluation tasks to be completed by evaluators who participated in the study. The Final Protocol differed in that it contained supplied hypothetical client information. The Final stage evaluators provided feedback by answering questions on the Evaluation Survey form which accompanied the Protocol.

**The Draft Stage**

The Draft Protocol was the focus of study in the first stage of research. The evaluation procedures consisted of six interviews held with professional counselors. Their responses to the Protocol were
recorded and evaluated. Their feedback was used by modifying the Protocol before sending it to the first group of evaluators. The purpose of the Draft stage was to provide guidance for the researcher at the outset of the study. It was also intended to provide indications of potential acceptance or rejection which the researcher could expect from evaluators who would be participating in the study.

The counselors who reviewed the Draft Protocol provided valuable criticism regarding the proposed study. The criticisms, as outlined in Appendix A, resulted in the removal of 10 items, improvements of instructions to evaluators, and improvements in the evaluation tasks. The informal findings at this stage regarding the research questions appear as follows:

1. The counselors agreed with the combination of techniques as utilized in the Protocol. They believed the basic techniques were fundamental to counseling psychologists and to self-esteem evaluation. These counselors insisted that the techniques be refined as outlined in the Protocol items. This recommendation was fulfilled to the extent that the items, the instructions, and the evaluation tasks were improved.

2. The Protocol's basic structure was approved by the counselors. These critics agreed that the Protocol could potentially improve existing techniques for evaluating adult self-esteem. The counselors also indicated that they typically preferred interview methods of evaluating self-esteem, as opposed to the Protocol method. Two counselors expressed reservations about the Protocol's ability to improve self-esteem measurement. Three
counselors noted potential heuristic value in the Protocol approach.

3. The six counselors all agreed that the evaluation methods as presented in the Draft Protocol needed simplification. The simplification was accomplished by clarifying the instructions to evaluators. There was general agreement that clear-cut evaluation procedures would be needed to arrive at a valid Protocol. In response to the counselors' suggestions, the Protocol was simplified by rewording and reorganizing Items 9-26. Items 9-12 were reorganized into two items. Items 13-21 were reorganized into five. Items 22-26 were also modified and reduced to two items. Item 59 was dropped, reducing the total number of items to 50. The instructions and evaluation procedures were also simplified to enhance clarification.

The Pilot Study

The Pilot study formed the second stage of Protocol development. This stage began with 50 items and ended with 27. The Pilot stage was designed to obtain an evaluation of the items which were studied following the Draft Protocol. Twenty-three items were removed from the Pilot Protocol, leaving 27 to be investigated in the next stage.

The pilot study data were collected with the Pilot Protocol which contained evaluation columns, TASK I and TASK II. The Pilot Protocol is presented in Appendix B.

Table 1 contains the evaluations indicating which items were appropriate for continued study. Dual retention criteria used by the researcher for identifying agreement among evaluators follows:
### Table 1

**DATA TOTALS FROM THE PILOT STUDY**

\((n = 19)\)

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**Evaluator Response Key**

* TASK I: HF = Highly Functional  MF = Moderately Functional  SF = Slightly Functional  D = Disfunctional

** TASK II: C = Items to be eliminated in first group of twelve.  B = Items to be eliminated in second group of twelve.  A = Items to be eliminated in third group of twelve.

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1. Any item appropriate for continued study would need a minimum of five evaluators checking it as highly functional in TASK I. These evaluations may be found in Table 1 under the "HF" column. This column in the table contains the total evaluator responses indicating which items they checked as highly functional.

2. TASK II supplied a second criterion. Items were removed for having four or more "Type C" responses from the evaluators. The TASK II "C" category indicated that the evaluator was checking an item which could be eliminated in the first group of 12 items considered to be least useful for the Protocol.

A review of TASK II instructions for evaluators were as follows: "Reconstruct the Protocol by marking three groups of 12 items each. Check Column C to show which group of 12 items you would eliminate first if you were to reduce the size of the Protocol. Then check Column B to show which 12 items you would eliminate next. And finally, check Column A to show which 12 items would be eliminated last . . ." This task identified items considered least necessary in terms of the Column C responses. Appendix B presents TASK II in the Pilot Protocol.

A rigid application of the two retention criteria would have removed 32 items from the Pilot Protocol. It would also have reduced the strength of the Protocol's Part II, Section C, by eliminating 10 of 14 items from the section which both the literature and the Draft Protocol counselors stated as very important. To resolve this tension, nine marginally close items, 5, 10, 15, 19, 21, 23, 25, 26, and 31, were selected to remain in the Protocol for the next stage of study. Evaluations indicated 18 of the 50 items were marginally
close to the criteria. Nine of the 18 were selected for further study. A total of 32 items would have been lost had the criteria been rigidly enforced. The Draft Protocol introduced eight items to be used as discrimination checks. The items were developed by the researcher to be tangential to but unnecessary for self-esteem evaluation. The Pilot Protocol carried the eight items numbered 30, 37, 38, 40, 42, 46, 47, and 48. The pilot study evaluators demonstrated good discrimination by their evaluations showing the weaknesses of the discrimination items. Weak evaluations appropriately led to the removal of the discrimination items. Twenty-seven items were selected for continued study as a result of the evaluations obtained on the Pilot Protocol. The items selected from the Pilot study—Items 1-10, 15, 16, 18, 19, 21, 23, 25, 26, 28, 29, 31-33, 35, 44, 45, and 49—were retained and utilized in the subsequent stage, the field study. The 27 items are presented with their evaluation percentages in Table 2.

The responses provided by evaluators indicated that the research questions, at this stage of research, were answered as follows:

1. Evaluators accepted the basic combination of assessment techniques as provided in the Protocol. At this point, it was still understood by the researcher that the evaluation process would need simplification.

2. The evaluators tended to agree on the basic structure of the Protocol. The structure of the Protocol was defined by the items which comprised it. The response patterns indicate that there was noticeable agreement among evaluators regarding which items were functional and which should be eliminated.
### TABLE 2
PERCENTAGES SUMMARIZING THE PILOT STUDY DATA, TASKS I AND II 
ON ITEMS RETAINED FOR CONTINUED STUDY  
(n = 19)

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**TASK I**

"Functional" percentages combine Highly Functional, Moderately Functional, and Slightly Functional evaluations per item.

"Disfunctional" percentages represent Disfunctional evaluations per item.

**TASK II**

"Least Necessary" percentages represent category C evaluations per item.
3. Agreement among evaluators was estimated on individual items in terms of evaluator responses on TASKS I and II. The evaluators demonstrated good discrimination assigning appropriate evaluations to the eight discrimination items. Discrimination Items 30, 37, 38, 40, 42, 46, 47, and 48 were removed from the Protocol subsequent to the pilot study.

It should be noted that the items can be viewed as functional in terms of the responses given by the evaluators. More than two thirds of the evaluators considered each item to be slightly to highly functional, and less than one quarter of the evaluators considered each item to be disfunctional. Less than 30 percent of the evaluators considered each item to be least necessary.

The Field Study

Table 3 reports data from the field study which evaluated the 27 items identified in the pilot study as appropriate for continued research. The purpose of the field study was to test the decision of the researcher regarding the retention of the items identified for continued study upon completion of the pilot stage. The field study would also provide assurance that the items were ready to be studied in a Protocol containing client information. The field study was important to the extent that it would confirm and clarify various aspects of the Protocol. Field study data totals and percentages for TASKS I and II are provided in Table 3.

A review of Table 3 indicates that more than three-fourths of all evaluators considered each item to be functional. It should also be understood that this evaluation includes combined functional
TABLE 3
FIELD STUDY EVALUATOR RESPONSE TOTALS, TASKS I AND II
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</tr>
<tr>
<td>23</td>
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<td>29</td>
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<td>25</td>
<td>43</td>
<td>21</td>
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<td>09</td>
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</tr>
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<td>14</td>
<td>24</td>
<td>47</td>
<td>81</td>
<td>5</td>
</tr>
</tbody>
</table>

Evaluator Response Key

**TASK I:**
- **HF** = Highly Functional
- **MF** = Moderately Functional
- **SF** = Slightly Functional
- **F** = Functional
- **D** = Disfunctional

*F combines Highly, Moderately, and Slightly Functional responses.

**TASK II:** Total evaluators who circled each item as unnecessary.
responses which were marked Highly Functional, Moderately Functional, or Slightly Functional.

Less than one-fourth of all of the Field evaluators considered any one item to be disfunctional. This means that all 27 items were considered functional by a considerable majority of the evaluators.

Fewer than one-third of the evaluators considered any one item to be unnecessary. This means that all 27 items were considered necessary by two-thirds or more of the evaluators.

Table 4 reports evaluator response totals from two questions addressed in TASK III of the field study. Responses to the first question, "How helpful might this Protocol be to various kinds of counselors?" indicated that a majority of evaluators considered the Protocol helpful for nearly all types listed. It should be understood that the helpful evaluation combined evaluator responses marked Very Helpful, Moderately Helpful, and Slightly Helpful.

Seventy-one percent of the evaluators considered the Protocol to be helpful for counselors like themselves; 81% of the evaluators considered the Protocol to be helpful for marriage/family counselors; 84% thought it would be helpful for beginning/student counselors; 86%, that it would be helpful for humanists; 60% believed the Protocol helpful for behaviorists; 50% considered it helpful for psychoanalysts; 84% said it would be helpful for clinical social workers; 83% considered it helpful for high-school counselors; and, finally, 64% considered the Protocol helpful for psychiatrists.

The second question in TASK III, "Do you prefer certain parts of the Protocol over others?" was left unanswered by 69% of the evaluators. Only 18 evaluators answered the question, and 8 of them
indicated preferences for more than one Protocol part. Although no certainty was found in preferences for Protocol parts, Part I was preferred most frequently, and Part II was preferred more often than Part III.

The field study was able to answer the research questions as follows:

1. **The basic assessment techniques were retained in the combination originally devised.** The items which employed techniques such as the client's self-report, counselor observations, and test scores were considered functional by a large majority of evaluators. Less than one-fourth of all evaluators considered any item to be disfunctional.

2. **The evaluators agreed to the basic structure of the Protocol as evidenced by the response percentages in Table 3.** The evaluator responses indicated that the researcher could retain all 27 items for continued study. Justification for retaining the items was based on the evaluations each item received. Specifically, evaluator agreement was based on the fact that more than three-fourths of all evaluators considered each item to be functional, less than one-fourth considered any one item to be disfunctional, and less than one-third considered any one item to be unnecessary.

3. **Tentative agreement about the validity of the Protocol may be presumed by studying the data percentages in Table 3.** The perceived agreement was determined by the response patterns which indicate, for example, how many evaluators thought that each item was functional, disfunctional, or unnecessary. A strong,
three-fourths majority considered each item to be functional. Small minorities of less than one-fourth and one-third, respectively, considered any one item to be either dysfunctional or unnecessary.

TASK III of the Protocol provided additional information about the usefulness of the Protocol for specific types of counselors. For example, the responses to Question 1 suggested that a large majority considered that the Protocol could be helpful for counselors like themselves. There was strong agreement that the Protocol could be helpful for the following types of counselors: marriage/family, beginning/student, humanists, clinical social workers, and high-school counselors.

The Final Study

The last stage of research conducted was referred to as the Final study. The last Protocol was called "Final" only to indicate the terminus of the dissertation. It was understood that the Protocol developed at this stage would need ongoing studies. The Final study was able to determine that the sampled counseling psychologists agreed on the usage of the Protocol. Confirmation of the validity of the Protocol was available in the last stage of research.

The Protocol employed the 27 items which were found acceptable in the two previous stages of research. Evaluation was conducted with the Evaluation Surveys which accompanied the Protocol sent to evaluators. These surveys were studied by the researcher to obtain answers to the research questions.
The Final Protocol differed from the previous stage of study in that it contained hypothetical client information. The researcher formulated typical client answers to questions in Part I of the Protocol. In Part II of the Protocol, the researcher provided counselor observations for Items 11-21. The researcher also provided percentile scores on the six scales in Items 22-27.

Ninety psychologists were randomly assigned to three groups of 30 each. Three different hypothetical client Protocols were mailed, one to each of the three groups. This was done to discover whether major differences in response patterns could be found. The differences would indicate whether client responses would affect evaluator responses.

The first client Protocol contained Parts I, II, and III, and each part contained hypothetical client information. Parts I and III of the first Protocol presented inconsistent and varying client information, and Part II contained consistent information. For example, in Part I the client was answering with a wide range of numbers. His responses varied from one through nine. This represents considerable inconsistency. His test scores in Part III of the Protocol ranged from a 37 percentile to a 92 percentile, again representing inconsistent scores. In contrast, the items in Part II of the Protocol were fairly consistent; demonstrating discomfort in the voice tone, high defensiveness, and numerous behavioral items such as changing his story when confronted, dramatizing his self-report, refusing to accept responsibility, seeking extra help from the therapist, and other behavioral indicators which were consistent with the discomfort and high defensiveness.
In a similar manner, the other two Protocols also contained two inconsistent parts and one consistent part. The second Protocol contained consistent scores in Part III, and the third Protocol contained consistent responses in Part I. The three varying Protocols provided three evaluation trials to determine whether the Protocols could evoke differing responses between evaluation groups.

The hypothetical client information was provided in order to give the evaluators an application of the Protocol. The previous stages were seeking evaluation of the Protocol items. As such, the Pilot and Field stages were reviewing and refining the basic assessment techniques as presented in the Protocol items. The final study, in contrast, was seeking information about the application of the Protocol. The last stage was intended to examine the actual use of the Protocol as illustrated with hypothetical clients. Evaluator responses also helped to determine the construct validity of the Protocol. Table 5 reports the data for the three groups used in the final study. Both raw data and percentages are reported for Questions 1-5 of the Evaluation Survey.

Fifty-three percent of all evaluators indicated they could estimate the client's self-esteem using the Protocol they received. This 53% was found by adding Definitely Yes and Probably Yes responses for the combined groups of evaluators. Fifty-three percent of Group I, 50% of Group II, and 57% of Group III responded that they could use the Protocol to estimate self-esteem. Similar response patterns among the three groups suggest that responses were not varied due to differing Protocol parts from one group to the next.
## TABLE 5

**EVALUATION SURVEY**

**FINAL SURVEY RESPONSES, QUESTIONS 1-5**

<table>
<thead>
<tr>
<th>Group</th>
<th>(n = 19)</th>
<th>Group</th>
<th>(n = 18)</th>
<th>Group</th>
<th>(n = 14)</th>
<th>Combined Groups</th>
<th>(n = 51)</th>
</tr>
</thead>
</table>

### 1. Can you estimate the client's self-esteem by using the client's responses, counselor's observations, and test scores as combined in the Protocol?

<table>
<thead>
<tr>
<th>Evaluator Responses</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Combined Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitly Yes</td>
<td>2 11</td>
<td>0 00</td>
<td>0 00</td>
<td>2 04</td>
</tr>
<tr>
<td>Probably Yes</td>
<td>8 42</td>
<td>9 50</td>
<td>8 57</td>
<td>25 49</td>
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<tr>
<td>Undecided</td>
<td>3 16</td>
<td>3 17</td>
<td>2 14</td>
<td>8 16</td>
</tr>
<tr>
<td>Probably No</td>
<td>6 32</td>
<td>6 33</td>
<td>3 21</td>
<td>15 29</td>
</tr>
<tr>
<td>Definitely No</td>
<td>0 00</td>
<td>0 00</td>
<td>0 00</td>
<td>0 00</td>
</tr>
</tbody>
</table>

### 2. How helpful was the Protocol's basic structure for estimating the client's self-esteem?

<table>
<thead>
<tr>
<th>Evaluator Responses</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Combined Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Helpful (VH)</td>
<td>1 03</td>
<td>1 06</td>
<td>2 14</td>
<td>4 08</td>
</tr>
<tr>
<td>Moderately Helpful (MH)</td>
<td>11 58</td>
<td>6 33</td>
<td>7 50</td>
<td>24 47</td>
</tr>
<tr>
<td>Slightly Helpful (SH)</td>
<td>6 32</td>
<td>8 44</td>
<td>4 29</td>
<td>18 35</td>
</tr>
<tr>
<td>Not Helpful (NH)</td>
<td>1 03</td>
<td>3 17</td>
<td>1 07</td>
<td>5 10</td>
</tr>
</tbody>
</table>

### 3. How helpful was the structure of Part I (client's responses) of the Protocol for estimating the client's self-esteem?

<table>
<thead>
<tr>
<th>Evaluator Responses</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Combined Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Helpful (VH)</td>
<td>3 16</td>
<td>1 06</td>
<td>2 14</td>
<td>6 12</td>
</tr>
<tr>
<td>Moderately Helpful (MH)</td>
<td>6 32</td>
<td>6 33</td>
<td>7 50</td>
<td>19 37</td>
</tr>
<tr>
<td>Slightly Helpful (SH)</td>
<td>8 42</td>
<td>9 50</td>
<td>4 29</td>
<td>21 41</td>
</tr>
<tr>
<td>Not Helpful (NH)</td>
<td>2 11</td>
<td>2 11</td>
<td>1 07</td>
<td>5 10</td>
</tr>
</tbody>
</table>

### 4. How helpful was the structure of Part II (Counselor's observations) of the Protocol for estimating the client's self-esteem?

<table>
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<tr>
<th>Evaluator Responses</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Combined Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Helpful (VH)</td>
<td>7 37</td>
<td>1 06</td>
<td>1 07</td>
<td>9 18</td>
</tr>
<tr>
<td>Moderately Helpful (MH)</td>
<td>5 26</td>
<td>6 33</td>
<td>5 36</td>
<td>16 31</td>
</tr>
<tr>
<td>Slightly Helpful (SH)</td>
<td>4 21</td>
<td>8 44</td>
<td>5 36</td>
<td>17 33</td>
</tr>
<tr>
<td>Not Helpful (NH)</td>
<td>3 16</td>
<td>3 17</td>
<td>2 14</td>
<td>8 16</td>
</tr>
</tbody>
</table>

### 5. How helpful was the structure of Part III (test scores) of the Protocol for estimating the client's self-esteem?

<table>
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<tr>
<th>Evaluator Responses</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Combined Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Helpful (VH)</td>
<td>2 11</td>
<td>1 06</td>
<td>1 07</td>
<td>4 08</td>
</tr>
<tr>
<td>Moderately Helpful (MH)</td>
<td>5 26</td>
<td>4 22</td>
<td>2 14</td>
<td>11 22</td>
</tr>
<tr>
<td>Slightly Helpful (SH)</td>
<td>6 32</td>
<td>10 56</td>
<td>3 21</td>
<td>19 37</td>
</tr>
<tr>
<td>Not Helpful (NH)</td>
<td>6 32</td>
<td>3 17</td>
<td>8 57</td>
<td>17 33</td>
</tr>
</tbody>
</table>
Responses to the first question, "Can you estimate the client's self-esteem...?" are understood in context with the responses to two other questions. The second question, "How helpful was the Protocol's basic structure for estimating the client's self-esteem?" and the sixth question, "How helpful might this Protocol format be to various types of counselors?" sought information which was relevant to the first question. For example, an evaluator could have had difficulty estimating the self-esteem of a client he could not meet. The same evaluator could have considered the Protocol's basic structure to be helpful for estimating the client's self-esteem. This evaluator also could have considered the Protocol's format to be helpful for a number of different counselors.

Ninety percent of all evaluators considered the Protocol's basic structure helpful. This represents a combination of Very Helpful, Moderately Helpful, and Slightly Helpful responses. Ninety-five percent of Group I, 83% of Group II, and 93% of Group III indicated the basic structure was helpful. The perceived helpfulness of the Protocol's basic structure did not seem to be affected by the different inconsistent parts of the Protocols.

Ninety percent of all evaluators considered Part I to be helpful. Ninety percent of Group I, 89% of Group II, and 93% of Group III considered Part I helpful. The perceived helpfulness of the Protocol's Part I did not seem to be affected by the different inconsistent parts of the Protocols.

Eighty-two percent of all evaluators considered Part II to be helpful. Eighty-four percent of Group I, 83% of Group II, and 79% of Group III considered Part II helpful. The perceived helpfulness of
the Protocol's Part II did not seem to be affected by the different inconsistent parts of the Protocols.

Sixty-seven percent of all evaluators considered Part III of the Protocol to be helpful. Sixty-nine percent of Group I, 84% of Group II, and 42% of Group III considered the Protocol's Part III helpful. The scores were widely spread in response to this evaluation question. It is possible that the varying Protocol contents resulted in varying response percentages from the evaluators. This possibility would arise from the fact that the Group II evaluators considered Part III to be helpful more frequently than did evaluators in the other groups. It should also be noted that Group II evaluators were sent Protocols containing a consistent Part III. It is also possible that evaluators relied on test scores less than they relied on the client's remarks and counselor observations.

It is believed that evaluator responses to the question, "Can you estimate the client's self-esteem by using the client's responses, counselor's observations, and tests scores as combined in the Protocol?" were influenced by the absence of the client. Evaluator responses were limited by the hypothetical client information provided on the Protocols. Some evaluators commented in writing regarding the difficulty of evaluating a client's self-esteem without meeting the client. Other researchers (Crandall, 1980; Wells & Marwell, 1976; and Wylie, 1974) have drawn similar conclusions about the absence of the client.

The sixth question of the Evaluation Survey asked how helpful the Protocol format would be to various types of counselors. Evaluators
estimated the helpfulness of the Protocol for nine different counselor types. Evaluator responses to this question are reported in Table 6.

Seventy-two percent of all evaluators thought the Protocol format to be helpful for counselors like themselves. Helpful again refers to the combined responses of Very Helpful, Moderately Helpful, and Slightly Helpful. Seventy-nine percent of Group I, 56% of Group II, and 85% of Group III considered the Protocol helpful for counselors like themselves.

Eighty-four percent of all evaluators, 90% of Group I, 78% of Group II, and 85% of Group III believed the Protocol format to be helpful for marriage/family counselors.

Eighty percent of all evaluators, 63% of Group I, 88% of Group II, and 93% of Group III judged the Protocol format helpful for beginning/student counselors.

Seventy-four percent of all evaluators, 80% of Group I, 73% of Group II, and 71% of Group III considered the Protocol format helpful for humanists.

Sixty-seven percent of all evaluators, 68% of Group I, 56% of Group II, and 78% of Group III thought the Protocol format helpful for behaviorists.

Sixty-three percent of all evaluators, 74% of Group I, 61% of Group II, and 50% of Group III felt the Protocol format helpful for psychoanalytics.

Eighty-one percent of all evaluators, 79% of Group I, 78% of Group II, and 85% of Group III regarded the Protocol format helpful for clinical social workers.
TABLE 6
EVALUATION SURVEY

<table>
<thead>
<tr>
<th>Group I (n = 19)</th>
<th>Group II (n = 18)</th>
<th>Group III (n = 18)</th>
<th>Combined Groups (n = 51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Pct</td>
<td>N</td>
<td>Pct</td>
</tr>
<tr>
<td>-------</td>
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<tr>
<td><strong>6. How helpful might this Protocol format be to various types of counselors?</strong></td>
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<tr>
<td>Evaluator Responses</td>
<td>Group I</td>
<td>Group II</td>
<td>Group III</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>A. Counselors like yourself:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(VH)</td>
<td>1</td>
<td>05</td>
<td>1</td>
</tr>
<tr>
<td>(MH)</td>
<td>8</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>(SH)</td>
<td>6</td>
<td>32</td>
<td>5</td>
</tr>
<tr>
<td>(NH)</td>
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<td>8</td>
</tr>
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<td><strong>B. Marriage/Family counselors:</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(VH)</td>
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<td>11</td>
<td>2</td>
</tr>
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<td>(MH)</td>
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<tr>
<td>(NH)</td>
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<td><strong>C. Beginning/Student counselors:</strong></td>
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<td></td>
</tr>
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<td>(MH)</td>
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</tr>
<tr>
<td>(NH)</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td><strong>E. Behaviorists:</strong></td>
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</tr>
<tr>
<td>(VH)</td>
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<td>05</td>
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</tr>
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<td>(MH)</td>
<td>4</td>
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</tr>
<tr>
<td>(SH)</td>
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<td><strong>F. Psychoanalysts:</strong></td>
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</tr>
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</tr>
<tr>
<td>(MH)</td>
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</tr>
<tr>
<td>(SH)</td>
<td>10</td>
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<td><strong>G. Clinical Social Workers:</strong></td>
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</tr>
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<td><strong>H. High-School Counselors:</strong></td>
<td></td>
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</tr>
<tr>
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<td>(MH)</td>
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<td>(NH)</td>
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<td>4</td>
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<td><strong>I. Psychiatrists:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(VH)</td>
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<td>05</td>
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</tr>
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<td>(MH)</td>
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</tr>
<tr>
<td>(NH)</td>
<td>5</td>
<td>26</td>
<td>9</td>
</tr>
</tbody>
</table>
Sixty-eight percent of all evaluators, 79% of Group I, 45% of Group II, and 85% of Group III classified the Protocol format helpful for high school counselors.

Fifty-seven percent of all evaluators, 68% of Group I, 40% of Group II, and 64% of Group III considered the Protocol format helpful for psychiatrists.

An overview of all evaluations to the sixth question, "How helpful might this Protocol format be to various types of counselors?" provides the following information. First, the Protocol format was believed beneficial by a majority of evaluators for all counselor types listed. Secondly, Groups I, II, and III of the evaluators produced similar response patterns on only three types of counselors; marriage/family counselors, humanists, and clinical social workers. For most other types of counselors, the evaluator responses varied regarding the helpfulness of the Protocol format. For example, helpful responses for "counselors like yourself" ranged from 56% to 85%. Helpful responses for "beginning/student counselors" ranged from 63% to 93%; for "behaviorists" from 56% to 78%; for "psychoanalyticists" from 50% to 74%; for "high school counselors" from 55% to 85%; and lastly, for "psychiatrists" from 40% to 68%.

A brief overview of the response percentages suggests that evaluators held varying opinions about the professional applicability of the Protocol. This is observable from the differences of response percentages among the listed counselor types. On five types, there was a 20 point difference among response percentages. Group II gave the lowest percentage of helpful responses on five of the nine counselor types. It is possible that with only a consistent Part
III, Group II considered the Protocol to have less counselor utility than did the other groups.

Table 7 summarizes evaluator responses to the seventh question of the Evaluation Survey, "Do you prefer certain parts of the Protocol over others? If so, which ones?" Two-thirds of the evaluators did not express a preference among Protocol parts. Of the preferences indicated, 25% favored Part I, while 24% and 2% favored Parts II and III, respectively. A total of eight evaluators, four in Group I, one in Group II, and three in Group III, indicated more than one preference among Protocol parts. Some evaluators indicated preferences for sub-sections of Parts I and II. A possible weakness would exist in making much of the percentages since eight evaluators indicated preferences

<table>
<thead>
<tr>
<th>Evaluator Responses</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Combined Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Pct</td>
<td>N</td>
<td>Pct</td>
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<tr>
<td>Part I</td>
<td>5</td>
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<td>17</td>
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<td>7</td>
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<td>06</td>
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<tr>
<td>Part III</td>
<td>1</td>
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<td>00</td>
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<tr>
<td>No preference</td>
<td>11</td>
<td>58</td>
<td>15</td>
<td>83</td>
</tr>
</tbody>
</table>

TABLE 7
EVALUATION SURVEY
FINAL STUDY RESPONSES, QUESTION 7

Group I (n = 19) Group II (n = 18) Group III (n = 14) Combined Groups (n = 51)
for more than one Protocol part, and since 67% of the evaluators expressed no preference.

The Summary of Research Findings

The four stages of research—draft, pilot, field, and final—have provided answers to the research questions which prompted the study. This chapter provided supporting information which was used to answer the research questions. In review, the questions and answers are as follows:

1. Could assessment techniques be effectively combined in a Protocol for evaluating adult self-esteem?

   Three basic assessment techniques, the client's self-report, the counselor's observations, and the test scores were effectively combined in a Protocol for evaluating adult self-esteem.

2. Could a sample of counseling psychologists agree on the basic structure of a clinical Protocol designed to evaluate adult self-esteem?

   The counseling psychologists sampled agreed on the usefulness of the basic structure of the Protocol designed to evaluate adult self-esteem. It should be noted that the basic structure was considered helpful by the majority of evaluators.

3. To what extent would counseling psychologists agree on the validity of Self-Esteem Protocol?

   The extent to which counseling psychologists agreed on the validity of the Self Esteem Protocol was primarily answered in their response that they could estimate the hypothetical
client's self-esteem using the Protocol they received. The Protocol validity was also supported by findings which indicated the evaluators considered the Protocol's basic structure and parts to be helpful for evaluating self-esteem.

A summary of the dissertation and a discussion of recommendations regarding future studies is presented in Chapter 5.
CHAPTER V

SUMMARY AND RECOMMENDATIONS

The study focused on the need for developing improved methods of self-esteem evaluation. The method selected by the researcher for improving such evaluation consisted of combining existing techniques and using recommendations found in the literature. The specific combination of these techniques and methods was referred to as the Self-Esteem Protocol. Evaluation techniques in the Protocol combined the client's self-report and test scores with the counselor's observations.

The dissertation sprang from an interest in criticism which self-esteem studies have received. Regardless of the problems which self-esteem studies have encountered, the topic has remained quite popular and professional counselors and researchers continue to find relevance in pursuing such study. Criticism has focused on the lack of clarity regarding how the evaluations should be conducted. Numerous psychometric instruments have been designed and studied for evaluating the self-esteem of counseling clients.

The studies have been influenced to a large extent by humanistic psychology as utilized by both clients and professional counselors. The roots of humanistic approaches are found in the writings of noted researchers such as Abraham Maslow. Maslow (1970) argued that the purely empirical approach to personality research was unable to grasp
the holistic aspects of human experience. Self-esteem was considered a personality construct and was thus subject to the difficulties inherent in personality study.

The researcher selected the model of human development and motivation presented by Abraham Maslow (1970). This model indicated that a person acquires self-esteem as other needs are met. For example, the client must first resolve physiological needs, needs for security, and needs for love and support before self-esteem can be experienced. The Self-Esteem Protocol incorporated these concepts in specific items designed to elicit a client's self-report.

The research was designed to meet the recommendations of the literature by developing an instrument which could respond to the criticisms of previous self-esteem studies. The research attempted to provide a new system for evaluating self-esteem. The professionals who would be using the instrument would typically be counseling psychologists, and the recipients of such services would be clients seeking self-esteem counseling. It was also anticipated that such clients would profit from improved services subsequent to the development of a Self-Esteem Protocol.

The research was designed to address three fundamental questions regarding a Protocol approach to self-esteem measurement. The research questions guiding the study were as follows:

1. Could assessment techniques be effectively combined in a Protocol for evaluating adult self-esteem?

2. Could a sample of counseling psychologists agree on the basic structure of a clinical Protocol designed to evaluate self-esteem?
3. To what extent would counseling psychologists agree on the validity of the Self-Esteem Protocol?

It was assumed that counseling psychologists would be qualified to evaluate a client's self-esteem. It was also assumed that such psychologists would be capable of evaluating an instrument which would be used to evaluate the client's self-esteem. The techniques which counseling psychologists typically use include evaluating the client's self-report, observing the client's non-verbal behavior, and evaluating the client's test scores. Professional psychologists who conduct professional counseling are typically interested in joining the American Psychological Association, Division of Counseling Psychology. It was, therefore, assumed that members of the APA, Division of Counseling Psychology would be qualified to participate in this study. Individuals in this APA Division were invited to evaluate various Protocol developments as represented in the Self-Esteem Protocols which were sent them.

It was realized from the start that the study could develop an instrument to a stage which would answer the research questions. Questions which would arise out of the study were also expected. It was anticipated that this study could develop an instrument to the extent that a level of practical validity could be demonstrated for the Protocol.

The study was conducted in four sequential stages of research. In the first stage, the researcher developed a series of items using the criticisms of the literature as well as the recommendations for future study and the theoretical model provided by Abraham Maslow (1970). The first stage of research used an instrument referred to

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as the Draft Protocol. The Draft Protocol was presented to six professional counselors who provided the researcher with verbal comments about the utility of such research which the researcher proposed. The six separate dialogues which the researcher conducted with these informal evaluators resulted in a number of changes to the instrument.

Subsequent to the interviews with counselors, a second stage of research was conducted using the criticisms and suggestions of the professional counselors who met with the researcher. The second stage of research utilized the Pilot Protocol which was mailed to 70 members of the APA Division of Counseling Psychology. The Pilot Protocol was used to refine specific elements of the study, most notably the length and format of the Protocol as evaluated by the 19 individuals participating in the pilot stage of research. The pilot stage was used to obtain initial information about the viability of continued study with the Protocol. For example, the information obtained in the pilot stage indicated that numerous items were considered to be either unnecessary or of little consequence to the Protocol. The pilot study reduced the size of the Protocol from 50 items to 27.

The third stage of the study was referred to as the field study, which utilized the Field Protocol. One hundred twenty-six psychologists were randomly selected and mailed the Protocols, 58 of which were returned. The Field Protocol consisted of the 27 items which were found to be functional and useful in the pilot stage of research. The field study was used to prepare the Protocol for sub-
sequent study which would involve a specific application of the Protocol.

The final stage of research utilized the Final Protocol. Ninety psychologists were randomly selected and mailed Protocols, 51 of which were returned. This Protocol evaluation differed from the first two stages to the extent that it no longer asked the evaluators to simply evaluate the items. The Evaluation Survey used with the Final Protocol asked the evaluators to evaluate the information which was provided with the Protocol items. The Final Protocol contained hypothetical client information. More specifically, the items contained statements and responses provided by a hypothetical client as well as the counselor's observations about that hypothetical client. Hypothetical test scores were also provided in the Final Protocol.

A total of 128 counseling psychologists participated in the study. These individuals were randomly selected from the American Psychological Association, Division of Counseling Psychology. The 128 who participated in the study represented less than one half of the 286 members of this division who were invited to participate. Numerous refusals were returned to the researcher indicating that those invited did not consider themselves to be either qualified or interested to evaluate the Protocol. The 128 counseling psychologists who did participate indicated that they had adequate understanding of the Protocol, although various questions did persist about it.

The pilot and field studies employed evaluation tasks which led some evaluators to question the researcher's intentions. The intentions had purposely not been communicated to the evaluators. The
researcher received numerous questions from evaluators regarding the purpose of the evaluation tasks and the use of subsequent findings. The evaluators in the final stage were given specific client information on their Protocols, and their tasks differed from those of the first two stages.

The final stage of research was used to determine a level of practical validity regarding the Protocol as it would relate to subsequent research. For example, participants in the final stage indicated that they could estimate a client's self-esteem using the Protocol. This indicated that the Protocol was able to convey the information evaluators needed for estimating a level of self-esteem.

The challenges for evaluators were considerable because they were not accustomed to evaluating self-esteem without meeting the client. Evaluators were to determine whether the Protocol by itself could represent the client's self-esteem. This approach was somewhat contrary to that of most psychologists who insist on meeting the client before estimating his self-esteem.

The research questions were answered as follows:

1. Could assessment techniques be effectively combined in a Protocol for evaluating adult self-esteem?

Three basic assessment techniques—the client's self-report, the counselor's observations, and the test scores were effectively combined in a Protocol for evaluating adult self-esteem.

2. Could a sample of counseling psychologists agree on the basic structure of a clinical Protocol designed to evaluate adult self-esteem?
The counseling psychologists sampled agreed on the usefulness of the basic structure of the Protocol designed to evaluate adult self-esteem. It should be noted that the basic structure agreed to was considered moderately to slightly helpful by the majority of the evaluators. It should also be noted that neither the literature nor the evaluators suggested other methods or structures for developing an instrument which could evaluate self-esteem.

3. To what extent would counseling psychologists agree on the validity of the Self-Esteem Protocol?

The extent to which counseling psychologists agreed on the validity of this Self-Esteem Protocol was primarily answered in their responses that they could estimate the hypothetical client's self-esteem using the Protocol they received.

The research was successful to the extent that each level of study provided specific answers to the research challenges. For example, at the draft stage, counselors warned of resistance which other counselors would present for evaluating the Protocol. At the pilot stage, it became evident that numerous items would need to be removed and evaluation procedures on the Protocol would also need to be improved for counselors to evaluate it. At the field stage, the researcher was able to obtain a degree of certainty about the items which would measure the combination of techniques as well as the basic structure of the Protocol. The acceptance of the techniques and the basic structure would also relate to future estimates of validity. In the final stage of study, the researcher was able to
estimate the successful combination of assessment techniques as well as the usefulness of the basic structure of the Protocol.

Based on the participation of 128 participants evaluating the Protocol, it was estimated that a satisfactory level of agreement was reached regarding the validity of the Protocol. It should be noted that in the final stage the evaluators received three different Protocols containing hypothetical client information. One group of evaluators was sent the Protocol of one hypothetical client, the second group of evaluators received a second hypothetical client Protocol, and the remaining evaluators received a third set of hypothetical client Protocol information.

It should be realized that some clients are more difficult to evaluate in terms of self-esteem than are others. The client with moderate self-esteem typically fluctuates between ongoing doubts as well as periodic peaks of success. This individual's beliefs and feelings about himself are somewhat inconsistent in his counseling presentations. A client whose self-esteem would be considered high, and one whose self-esteem would be considered low typically present predictable patterns of either success or failure. The inconsistent client, with moderate self-esteem is, therefore, the most difficult to evaluate with certainty regarding his self-esteem.

The Final Protocols, which the last group of evaluators received, each contained inconsistent self-esteem information from hypothetical clients. This presented the evaluators with a double challenge. First, the evaluator was not able to meet the client and directly evaluate the client, and thus, had to rely on the information reported in the Protocol. Secondly, the evaluator was required
to estimate the self-esteem of a Protocol which contained inconsistent counseling information. These challenges made it difficult for the evaluators to estimate the client's self-esteem. It is possible that these combined challenges prevented some evaluators from responding positively to the Protocol. This explanation could also account for some negative responses on the Evaluation Surveys.

A number of questions exist which should be answered in further studies. The questions are as follows:

1. To what extent does this Protocol provide improvement over other self-esteem instruments?
2. What criteria would be used to determine the value of the Protocol for improving self-esteem evaluation over other instruments?
3. What types of clients are best served with this type of Protocol, and what type of clients would not be well served by it?
4. To what extent would counseling psychologists accept and utilize the Protocol?
5. To what extent does the Protocol assist the counselor in organizing the self-esteem evaluation?

This study developed and evaluated a new configuration of existing self-esteem evaluation techniques. Because the approach is new, it is possible that evaluator understanding of the Protocol was less than ideal. Evaluators provided some initial resistance to it, which was expected. The resistance may have resulted from inexperience in Protocol usage, the absence of a client, and the Protocol's departure
from typical self-esteem evaluations. Traditional approaches have been typically subjective and inconsistent from one counselor to the next. The Protocol provides a format which improves self-esteem evaluation, though it cannot fully replicate all dynamics of counseling evaluations.

The research was able to successfully address criticism in the literature of self-esteem study. For example, the dissertation demonstrated the use of the multi-method approach to studying self-esteem. It also approached the construct with a clear-cut application of Maslow's (1970) theory regarding self-esteem. The application of the theory strengthened the use and interpretation of the construct. The fact that the Protocol items have been refined through the research process strengthens the argument of their validity. The research also provided a method of conducting consistent self-esteem evaluations. The Protocol method as presented in the dissertation represents an approach to self-esteem evaluation which has considerable potential for providing the consistency demanded by the critics. To this end, the dissertation has contributed a model for understanding self-esteem in the context of counseling psychology.

This research has provided a significant stimulus for future study. The dissertation has generated a number of questions which invite future research. For example, the dissertation was able to establish a valid measurement approach for self-esteem and to demonstrate its application. The research findings are open to future challenge because the study can be replicated. The questions listed
as arising from this research are evidence of the need for ongoing study in this area.

The study developed an instrument which has strong potential for making future heuristic contributions. For example, five groups of counselors were identified in the study as receiving potential benefit from using the Protocol. Findings indicate that a majority of final stage evaluators considered that counselors like themselves, marriage/family counselors, beginning/student counselors, humanists, behaviorists, psychoanalytics, clinical social workers, high school counselors, and psychiatrists could benefit by using the Protocol. It would appear that numerous counselors are interested in self-esteem evaluation and would appreciate training in the use of the Protocol. Future studies using these groups of counselors would also be fruitful.

The literature provided extensive documentation of validity problems related to self-esteem study. A major endeavor in this study was to overcome validity hurdles by uniting theory and practice. Maslow's (1970) theory provided a basis of developing the items, and practitioners evaluated them. The evaluation data demonstrate that the self-esteem construct was effectively utilized in the Protocol. Evidence of this was provided by the final study data. The construct used in the Protocol does not represent all possibilities of self-esteem but rather commonalties accepted by the evaluators and consonant with theory.
Appendix A

The Draft Protocol was reviewed and discussed by six professional counselors working in Berrien County, Michigan. These six were selected by the researcher because of their credentials and their geographical location. Their availability was influenced by their proximity to the researcher's location. These individuals were also well known to the researcher, and the researcher had considerable confidence in each of them. The following paragraphs briefly outline the credentials of each counselor.

Frederick Sulier has a full-time private practice in counseling and clinical psychology. He earned the doctorate in counseling psychology at Western Michigan University. He is also chief psychologist in the clinic, Psychology Associates, P.C. Sulier is a fairly conservative behaviorist who prefers rational emotive therapy as a counseling approach. Sulier's opinion of the research was that it could be done given specific precautions and limitations. Sulier was willing to acknowledge that the research could make a contribution to the field given the previously determined limitations of the study.

Kenneth Acheson holds a Ph.D. in Clinical Psychology from Rosemead School of Psychology. He has been a full-time professional psychologist for approximately ten years. He also conducted professional supervision meetings which the researcher attended. As a Christian psychologist, Acheson has a strong interest in the services
which counselors can provide to improve the quality of life as well as the self-concepts of counseling clients. He also has a strong background in the practice of neuro-linguistic therapy. His perceptions of the Draft Protocol were that it could be eventually refined and thus improve self-esteem evaluations. He immediately identified the heuristic value of the protocol.

Frederick Kosinsky is a counseling psychology professor at Andrews University and is in practice in the University Medical Center. He began his career as a high school counselor some 15 years ago. Since that time, he earned a doctorate in counseling psychology from Purdue University and began practicing at the professional level. Dr. Kosinsky spent considerable time reflecting on the Protocol and discussing it with the researcher. A major concern Kosinsky expressed was that this research would be extremely tedious.

Dennis McFarland is a limited license psychologist practicing in Psychology Associates. He practices counseling and clinical psychology under the supervision of Frederick Sulier. McFarland holds a Master's degree in Clinical Psychology from Central Michigan University. He has been a full-time professional counseling psychologist for approximately seven years. His reaction to the Protocol was that the research could be done and could potentially improve self-esteem evaluations. He also pointed out the strong tendency of professional counselors to use techniques with which they are most comfortable.

Robert Ferguson is a full-time professional counselor working at Child and Family Services of Southwestern Michigan. Ferguson holds two master's degrees. One degree is in counseling from St. Francis
University and the other is a M. Div. from the Nazarene Seminary. He has been known to the researcher for a number of years and has taken doctoral courses in counseling psychology with the researcher. Ferguson expressed considerable interest in the research and hopes to conduct research which would include the self-concept variable. He was optimistic regarding the potential of this research as it could relate to other research and counseling endeavors.

Charles Rubel is the Director of the Child and Family Services of Southwestern Michigan. He holds a Master's degree in clinical social work from The Ohio State University. He also taught in the School of Medicine, Clinical Psychiatry Department, at Cincinnati University. Rubel has a strong background in family therapy and has served at Child and Family Services as the Director for approximately ten years. His reaction to the protocol was guardedly favorable. Rubel provided the family therapy training for the researcher.

The following outline provides a combined listing of the criticisms to the Draft Protocol as given by the foregoing counselors. Their remarks have been combined in a single listing to reduce duplication.

1. One counselor stated, "All these client statements (Items 1-12) represent the client's beliefs. I don't believe you can justify separating the items into groups for feelings, beliefs, and behaviors. Everything the client tells you is from his/her belief system. The nonverbal observations (cringing, crying, eye-contact, etc.) are behavioral evidences of feeling states. And this is based on rational emotive theory."
2. Four counselors stated that clinicians would be unwilling to take the time to respond to a mailed survey which used the Protocol. They also feared that such resistance would impede completion of this dissertation.

3. Three counselors had difficulty understanding the directions for TASK II. They expressed beliefs about TASK II meeting with resistance among survey participants. They also considered the items to be verbose and redundant.

4. Another counselor made the following comments, "First of all, you have to assume that the Protocol won't hurt the client. Then you have to accept the fact that clients often misidentify their feelings. They're not sure exactly what their self-esteem is. The assessment scales at the end of the Protocol are probably unnecessary for the skilled therapist."

5. Two counselors wanted clarifications in the directions for evaluators. They stated that the directions should state that all 60 items could be marked Highly Functional if the evaluator believed them to be such. They also stated that TASK II should remind the evaluators to classify all 60 items.

6. One counselor made the following suggestions to improve the quality of the research instrument.

   A. Re-organize your instructions for TASK II. Employ the following concepts. The new directions would read:

      "Reconstruct the Protocol items into 4 groups of 15 items each. Show which group of 15 items you would eliminate first if you were to reduce the size of the Protocol. Then show which 15 items you would eliminate next. And finally, show which 15 items would be eliminated last. This will leave 15 items remaining."
Check (√) Column C to show the first 15 you would remove. Check (√) Column B to show the second 15 you would drop. Check (✓) Column A to show the third group of 15 to drop.

B. Drop TASK III. Evaluators won't be bothered by it. They also may trash your paper if they think they have to write something.

C. Add a 13th item to be asked of the client in Part I. It should read as follows: "I'm interested in your beliefs about your relationships. Help me understand why you feel the way you do about your __________ (mate/children/relatives/peers)."

D. Part I Section A should be reduced to the following:

Instructions: Try to observe client's covert messages about his/her feelings. Check (✓) the client's nonverbal cues which suggest discomfort. For example, if the client's breathing seems to be uncomfortable when he answers Item #3, you would check (✓) the #3 box on the "Breathing" line below in the matrix.

<table>
<thead>
<tr>
<th>Cues</th>
<th>Item 1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
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<th>7</th>
<th>8</th>
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<th>10</th>
<th>11</th>
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<th>13</th>
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<tbody>
<tr>
<td>14. Breathing</td>
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<td>15. Eyes</td>
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<td>16. Face</td>
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<td>17. Lips</td>
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<td>18. Voice tone</td>
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</table>

E. Part II Section B should be changed to the following:

Instructions: Try to identify the client's defensiveness and social desirability facade. Did you get the impression that the client was Highly Defensive, Moderately Defensive, Slightly Defensive, or Not Defensive. (Underline your estimate of the client's defensiveness.) Did the client seem to have a facade about the topics you discussed? If so, which ones?

7. Three counselors noted the heuristic value of the instrument.
Appendix B

Appendix B contains a copy of the Pilot Protocol. The original copies which were sent to evaluators were printed on colored pages. The first page was yellow, the second was blue, and the remaining were yellow. Different colored pages were used to contrast the contents of each page. It was thought that the differing colors would aid visual tasks of reading and identifying the various sections of the Protocols. It was also believed that the colors would assist in attracting the eyes of the evaluators.
INSTRUCTIONS FOR EVALUATORS
(Are outlined at each task)

TASK I. (Steps to be taken)

1. Read "Directions for Administering the Protocol" on the next page. This will help you know what the therapist is attempting.

2. Using the column marked TASK I, evaluate each item on the Protocol. In doing so, ask yourself, "How functional is this item for evaluating a client's self-esteem?"


4. Check (✓) the appropriate column next to each item. This indicates your evaluation of the item. Four columns are provided in the protocol and are marked Task I. Indicate your estimate of how well the item will function in the self-esteem assessment. Sample items are provided below the instructions for TASK II.

5. Use the following symbols to indicate your evaluation of each item. HF=Highly Functional, MF=Moderately Functional, SF=Slightly Functional, D=Disfunctional.

TASK II

Reconstruct the Protocol by marking 3 groups of 12 items each. Show which group of 12 items you would eliminate first if you were to reduce the size of the Protocol. Then show which 12 items you would eliminate next. And finally, show which 12 items would be eliminated last. This will leave 14 items remaining.

Check (✓) Column C to show the first 12 items you would remove.
Check (✓) Column B to show the second 12 you would drop.
Check (✓) Column A to show the third group of 12 to drop.

SAMPLE ITEMS illustrating TASK I and TASK II evaluations

<table>
<thead>
<tr>
<th>TASK I</th>
<th>TASK II</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF</td>
<td>MF</td>
</tr>
<tr>
<td>1.</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>

1. Are you satisfied with the intimacy you share with your mate? ____
2. Has anyone ever told you that you're a jerk? ____

TASK III
Feel free to assist with further suggestions on the back page of the Protocol. You may check the box at the end of the Protocol if you wish to receive a free copy of the research bibliography.
THE SELF ESTEEM PROTOCOL

Directions for Counselor Administration

1. Study the entire Protocol before administering.

2. Discuss ONLY items #1-10 with the client. DO NOT discuss items #11-50 when presenting items #1-10.

3. Interview the client using the questions provided in Part I of the Protocol (next page). Part I (items #1-10) presents several self-esteem questions. These questions appear in Part I, SECTIONS A, B, and C. SECTIONS A and B (items #1-8) have one set of instructions to the client. SECTION C (items #9-10) have a separate set of instructions for the client.

4. During the interview, use SECTION A/QUESTION to complete items #1-4. Use SECTION B/QUESTION to complete items #5-8. Finally, use SECTION C to facilitate self-disclosure about goals and relationships as presented in items #9 and 10.

5. While the client is answering items #1-10, carefully observe his/her mannerisms, language, and non-verbal messages. You will use these observations when you complete items #11-31 (Part II).

6. Ask the client to answer items #1-8 using a scale of one-to-ten. If the client wants to indicate his/her strongest possible "Yes!" the answer would be "10." If the client wants to give you the strongest possible "No!" he/she would answer "1." A client who is unsure of his/her feelings about an item could use a number close to the middle of the range, like 5 or 6. Write the client's numerical response on the line following each item.

7. Read the instructions aloud to the client. Instructions to the client appear above SECTION A/QUESTION and with SECTION C. The first instructions apply to both SECTIONS A and B. The second set applies to SECTION C only.

8. SECTION C (items #9 and 10) allows the client to express beliefs about both relationships and achievements. These two items may provide some indication of defensiveness and/or social desirability facades. While the client answers items #9 and 10 you can make brief notes about them.

9. Parts II and III provide you with further instructions.

10. Interpretation of the Protocol is left to the counselor's discretion.
PART I. Record the clients responses

Read the following instructions to the client.

"Answer the following questions using a scale of 1-10. When I read a question to you, for example, you will answer "1" to tell me your strongest possible "No." In contrast, you will answer "10" to report your strongest possible "Yes." If you're unsure or feel neutral about it, you can use a number close to the middle like 5 or 6.

Section A (Feelings)
Are you satisfied with your feelings, in terms of:

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<th>TASK I</th>
<th>TASK II</th>
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<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>1.</td>
<td>Comfort and relaxation without the aid of medicine, drugs, or alcohol? ____</td>
</tr>
<tr>
<td>2.</td>
<td>Being secure and safe? ____</td>
</tr>
<tr>
<td>4.</td>
<td>Your choices and responsibilities in life? ____</td>
</tr>
</tbody>
</table>

Section B (Behaviors)
Have your behaviors obtained results you wanted, in terms of:

<table>
<thead>
<tr>
<th>TASK I</th>
<th>TASK II</th>
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<tr>
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<tr>
<td>5.</td>
<td>Comfort and relaxation without the aid of medicine, drugs, or alcohol? ____</td>
</tr>
<tr>
<td>8.</td>
<td>What you wanted to accomplish in life? ____</td>
</tr>
</tbody>
</table>

Section C (Beliefs) Read the following instructions to the Client:
Briefly answer the two remaining questions.

<table>
<thead>
<tr>
<th>TASK I</th>
<th>TASK II</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>9.</td>
<td>What do you expect to accomplish during the next five years? ____</td>
</tr>
</tbody>
</table>
Part II. Record your observations of the client.
DO NOT DISCUSS THESE OBSERVATIONS WHEN RECORDING THEM!

SECTION A

Instructions: Try to observe the client’s covert messages about his/her feelings. Check (✓) the client’s nonverbal cues which suggest discomfort. For example, if the client’s breathing seems to be uncomfortable when he answers item #3, you would check (✓) the #3 box on the “Breathing” line below in the matrix.

<table>
<thead>
<tr>
<th>TASK I</th>
<th>TASK II</th>
<th>Cues</th>
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<tbody>
<tr>
<td></td>
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<td>Items</td>
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<tr>
<td>11.</td>
<td></td>
<td>11. Breathing</td>
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<tr>
<td>12.</td>
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<td>12. Eyes</td>
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<td>13.</td>
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<td>13. Face</td>
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<td>15.</td>
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<td>15. Voice and Tone</td>
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</table>

SECTION B

Instructions: Try to identify the client’s defensiveness and social desirability facade.

<table>
<thead>
<tr>
<th>TASK I</th>
<th>TASK II</th>
<th>Items</th>
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<tr>
<td></td>
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<td>Items</td>
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<tr>
<td>16.</td>
<td></td>
<td>16. Did you get the impression that the client was: Highly Defensive, Moderately Defensive, Slightly Defensive, or Not Defensive. (Underline your estimate of the client’s defensiveness.)</td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td>17. Did the client seem to have a social desirability facade about some items you discussed? If so, which items?</td>
</tr>
</tbody>
</table>

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### TASK I TASK II Section C

<table>
<thead>
<tr>
<th>HF</th>
<th>MF</th>
<th>SF</th>
<th>D</th>
<th>A</th>
<th>B</th>
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### PART III. Record the client's test scores on the lines provided.
Selection of scales is left to the counselor's discretion.

<table>
<thead>
<tr>
<th>TASK I</th>
<th>TASK II</th>
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</table>

### TASK III. Your further suggestions and criticism would be most helpful. Feel free to write them on the back of this page.

- [ ] Check this box if you wish to receive a free copy of the research bibliography. Then mail the Protocol with the enclosed envelope.

**THANK YOU FOR YOUR PARTICIPATION!**
Appendix C

Appendix C contains a copy of the Field Protocol which was sent to 126 members of the APA division of counseling psychology. The first page of the Protocol was blue, the next three pages were yellow, and the final page was creme in color. The pages were not printed on white paper in hopes of easing the readability of the Protocols.
INSTRUCTIONS FOR EVALUATORS
(Are outlined at each task)

TASK 1.

1. Using the grids marked TASK 1, evaluate each item on the Protocol. In doing so, ask yourself, "How functional is this item for evaluating the client's self-esteem?" You don't need to use it on your client. Simply indicate your opinion of the item as you see it.

2. Definitions: Functional refers to an item's effectiveness in facilitating the self-esteem assessment. Disfunctional items, in contrast, inhibit the self-esteem assessment.

3. Check (√) the appropriate column next to each item. This indicates your evaluation of the item. Four columns are provided in the protocol and are marked Task I. Indicate your estimate of how well the item will function in the self-esteem assessment. Sample items are provided.

4. Symbols: (to indicate your evaluation of each item.)
   HF=Highly Functional, MF=Moderately Functional, SF=Slightly Functional, D=Disfunctional.

SAMPLE ITEMS ILLUSTRATING TASK 1:

<table>
<thead>
<tr>
<th>A.</th>
<th>B.</th>
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<tbody>
<tr>
<td>HF</td>
<td>HF</td>
</tr>
</tbody>
</table>

A. Are you satisfied with the intimacy you share with your mate? 

B. Has anyone ever told you that you're a jerk?

5. "Directions for Administering the Protocol" on the last page describes how the counselor uses the Protocol.

TASK II

At the bottom of each page you are asked to circle unnecessary items. It is important that you do this to indicate which items could be eliminated from the Protocol without impairing its effectiveness.

TASK III Please answer a few questions at the end of the Protocol.
Part I. Read the following instructions to the client, then record his/her responses.

"Answer the following questions using a scale of 1-10. When I read a question to you, for example, you will answer "1" to tell me your strongest possible "No." In contrast, you will answer "10" to report your strongest possible "Yes." If you're unsure or feel neutral about it, you can use a number close to the middle like 5 or 6.

Section A/Question (Feelings)
"Are you satisfied with your feelings, in terms of..."

**TASK I**
1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? _____
2. Being secure and safe? _____
3. Closeness or love with your
   Mate? _____ Children? _____ Parents? _____
   Other relatives? _____ Peers? _____
4. Your choices and responsibilities in life? _____

Section B/Question (Behaviors)
"Have your behaviors obtained results you wanted, in terms of..."

**TASK I**
5. Comfort and relaxation without the aid of medicine, drugs, or alcohol? _____
7. Closeness and love from your
   Mate? _____ Children? _____ Parents? _____
   Other relatives? _____ Peers? _____
8. What you wanted to accomplish in life? _____

Section C (Beliefs) Read the following instructions to the Client:
"Briefly answer the two remaining questions."

**TASK I**
9. What do you expect to accomplish during the next five years? _____
10. Help me understand why you feel the way you do about
    your Mate? _____ Children? _____ Parents? _____
    Other relatives? _____ Peers? _____

**TASK II:** Circle the Items (1, 2, 3, 4, 5, 6, 7, 8, 9, 10) on this page which you consider unnecessary for self-esteem appraisal.
**Part II. Record your observations of the Client.**

**DO NOT DISCUSS THESE OBSERVATIONS WHEN RECORDING THEM!**

**Section A**

The client's voice and tone may suggest discomfort when discussing specific items. Check (✓) the items #1-10 from the previous page which elicited discomfort in the client's voice and tone.

<table>
<thead>
<tr>
<th>TASK I</th>
<th>Items</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
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<tbody>
<tr>
<td>11.</td>
<td>Voice &amp; Tone</td>
<td></td>
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</tbody>
</table>

**Section B**

Try to identify the client's defensiveness.

**TASK I**

12. Did you get the impression that the client was:
   - Highly Defensive, Moderately Defensive, Slightly Defensive, or Not Defensive. (Underline your estimate of the client's defensiveness.)

**Section C**

Check (✓) the following client behaviors demonstrated during the interview.

**TASK I**

<table>
<thead>
<tr>
<th>TASK I</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Seeks extra help from therapist</td>
</tr>
<tr>
<td>14.</td>
<td>Cries/sniffles/chokes up</td>
</tr>
<tr>
<td>15.</td>
<td>Looks around, easily distracted</td>
</tr>
<tr>
<td>16.</td>
<td>Slumps/рооps in chair</td>
</tr>
<tr>
<td>17.</td>
<td>Changes story when confronted</td>
</tr>
<tr>
<td>18.</td>
<td>Dramatizes self-report</td>
</tr>
<tr>
<td>19.</td>
<td>Refuses to accept responsibility</td>
</tr>
<tr>
<td>20.</td>
<td>Makes threats</td>
</tr>
<tr>
<td>21.</td>
<td>Expresses anger/disgust for the therapist</td>
</tr>
</tbody>
</table>

**TASK II:** Circle the Items (11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21) on this page which you consider unnecessary for self-esteem appraisal.
PART III. Record the client's test scores on the lines provided. Selection of scales is left to the counselor's discretion.

**TASK I**

<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>22</td>
<td>22.</td>
<td>Self-esteem scale</td>
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<tr>
<td>23</td>
<td></td>
<td>Self-concept scale</td>
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<td>24</td>
<td></td>
<td>Anxiety scale</td>
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<tr>
<td>25</td>
<td>25.</td>
<td>Self-confidence scale</td>
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<tr>
<td>26</td>
<td>26.</td>
<td>Emotional stability scale</td>
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<td>27</td>
<td>27.</td>
<td>Ideal self scale</td>
<td></td>
</tr>
</tbody>
</table>

**TASK II:** Circle the items (22, 23, 24, 25, 26, 27) on this page which you consider unnecessary for self-esteem appraisal.

**TASK III:** Please answer the following questions. The information is needed to understand the usefulness of the Protocol.

1. Indicate your opinion of how helpful this Protocol might be to various kinds of counselors. Circle the appropriate letters following each professional category.
   - VH = Very Helpful, MH = Moderately Helpful, SH = Slightly Helpful, NH = Not Helpful
   - 4. Counselors like yourself: VH MH SH NH
   - 5. Marriage/Family counselors: VH MH SH NH
   - 6. Beginning/Student counselors: VH MH SH NH
   - 7. Humanists: VH MH SH NH
   - 8. Behaviorists: VH MH SH NH
   - 9. Psychoanalyticists: VH MH SH NH
   - 10. Clinical social workers: VH MH SH NH
   - 11. High School counselors: VH MH SH NH
   - 12. Psychiatrists: VH MH SH NH

2. Do you prefer certain parts of the Protocol over others? If so, which ones do you prefer?

THANK YOU FOR YOUR PARTICIPATION!!!
THE SELF ESTEEM PROTOCOL

Directions for Counselor Administration

1. Study the entire Protocol before administering.

2. Discuss ONLY items 1-10 with the client. DO NOT discuss items 11-26 when presenting items 1-10. Items 1-5, 9-11 incorporate Maslow's hierarchy of needs. He suggested that physiological, security, and love needs precede self-esteem.

3. Interview the client using the questions provided in Part I of the Protocol. Part I presents a self-esteem interview. The interview questions appear in Part I, SECTIONS A, B, and C. SECTIONS A and B (items 1-8) have one set of instructions to the client. SECTION C (items 9-10) have a separate set of instructions for the client.

4. During the interview, use SECTION A/QUESTION to complete items 1-4. Use SECTION B/QUESTION to complete items 5-8. Finally, use SECTION C to facilitate self-disclosure about goals and relationships as presented in items 9 and 10.

5. While the client is answering items 1-10, carefully observe his/her mannerisms, language, and non-verbal messages. You will use these observations when you complete items 15, 16.

6. Ask the client to answer items 1-8 using a scale of one-to-ten. If the client wants to indicate his/her strongest possible "Yes! the answer would be "10." If the client wants to give you the strongest possible "No!" he/she would answer "1." A client who is unsure of his/her feelings about an item could use a number close to the middle of the range, like 5 or 6. Write the client's numerical response on the line following each item.

7. Read the instructions aloud to the client. Instructions to the client appear above SECTION A/QUESTION and with SECTION C. The first instructions apply to both SECTIONS A and B. The second set applies to SECTION C only.

8. SECTION C (items 9 and 10) allows the client to express beliefs about both relationships and achievements. These two items may provide some indication of defensiveness and/or social desirability facades. While the client answers items 9 and 10 you can make brief notes about them.

9. Parts II and III provide you with further instructions.

10. Interpretation of the Protocol is left to the counselor's discretion.
Appendix D

Appendix D contains a copy of the cover letter which was sent to evaluators asking them to participate in the research. The letters were personalized so that each letter began with the heading, "Dear Dr. ___:" with the name of the recipient inserted.
Your evaluation is needed on the enclosed self-esteem protocol. You will be participating in a research project which we are pleased to share with you.

For years, self-esteem has fascinated practitioners and theoreticians alike. We believe we have identified an interesting approach to the study of self-esteem. And we hope you'll share a few minutes with us by participating in the study.

Your contribution, answering seven brief questions, can help us improve self-esteem research. Hopefully, the protocol will also have potential benefit for some types of counselors and practical benefits for clients.

The attached protocol contains a hypothetical set of client responses and test scores. It also contains some hypothetical counselor observations. The protocol's items have been developed in our research project. You are asked to read the protocol, estimate the client's self-esteem, and rate the value of the protocol format.

Please complete the EVALUATION SURVEY and return it in the enclosed envelope. You are welcome to keep the protocol. The one-dollar bill is an honorarium to express our appreciation for your participation in the study. If you cannot complete the EVALUATION SURVEY, please return it promptly.

Gratefully yours,

Steve Mauro, M.A. 
Jerome Thayer, Ph.D. 
Dissertation Chairman
Appendix E contains the first hypothetical client Protocol, which was used to collect data in the first group of evaluators in the final study. The Protocol contains hypothetical client information which was provided by the researcher in harmony with the methodology. The client information in Parts I and III of the Protocol contained wide-ranging responses and scores. Part II contained fairly uniform information. For example, Items 11-21 provided a consistent profile thus allowing for the Item 12 impression that the client was highly defensive. Evaluator estimates of both the hypothetical client's self-esteem and the utility of the Protocol were influenced by the varying client information.
THE SELF ESTEEM PROTOCOL

Part I. Read the following instructions to the client, then record his/her responses.

"Answer the following questions using a scale of 1-10. When I read a question to you, for example, you will answer "1" to tell me your strongest possible "No." In contrast, you will answer "10" to report your strongest possible "Yes." If you're unsure or feel neutral about it, you can use a number close to the middle like 5 or 6.

Section A/Question (Feelings)
"Are you satisfied with your feelings, in terms of..."

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? ______
2. Being secure and safe? ______
3. Closeness or love with your Mate? ______ Children? ______ Parents? ______ Other relatives? ______ Peers? ______
4. Your choices and responsibilities in life? ______

Section B/Question (Behaviors)
"Have your behaviors obtained results you wanted, in terms of..."

5. Comfort and relaxation without the aid of medicine, drugs, or alcohol? ______
6. Security and safety? ______
8. What you wanted to accomplish in life? ______

Section C (Beliefs) Read the following instructions to the Client:
"Briefly answer the two remaining questions."

9. What do you expect to accomplish during the next five years? ______
10. Help me understand why you feel the way you do about your Mate? ______ Parents? ______ Other relatives? ______ Peers? ______

Part II. Record your observations of the Client.

DO NOT DISCUSS THESE OBSERVATIONS WHEN RECORDING THEM!

Section A
The client's voice and tone may suggest discomfort when discussing specific items. Check (✓) the items #1-10 above which elicited discomfort in the client's voice and tone.

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<tr>
<th>Items</th>
<th>1</th>
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<th>10</th>
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<tr>
<td>Voice &amp; Tone</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td></td>
<td>✓</td>
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</tbody>
</table>
Section B

Try to identify the client's defensiveness.

12. Did you get the impression that the client was:

- Highly Defensive, Moderately Defensive, Slightly Defensive, or Not Defensive.

(Circle your estimate of the client's defensiveness.)

Section C

Check (✓) the following client behaviors demonstrated during the interview.

13. ✓ Seeks extra help from therapist
14. Cries/sniffles/chokes up
15. ✓ Looks around, easily distracted
16. ✓ Slumps/droops in chair
17. ✓ Changes story when confronted
18. ✓ Dramatizes self-report
19. ✓ Refuses to accept responsibility
20. ✓ Makes threats
21. Expresses anger/disgust for the therapist

PART III. Record the client's test scores on the lines provided.
Selection of scales is left to the counselor's discretion.

22. 92 Self-esteem scale
23. 72 Self-concept scale
24. 89 Anxiety scale
25. 83 Self-confidence scale
26. 37 Emotional stability scale
27. 61 Ideal self scale
THE SELF ESTEEM PROTOCOL

Directions for Counselor Administration

1. Study the entire Protocol before administering.

2. Discuss ONLY Items #1-10 with the client. DO NOT discuss Items #11-27 when presenting Items #1-10. Items #1-10 incorporate Maslow’s hierarchy of needs. He suggested that physiological, security, and love needs precede self-esteem.

3. Interview the client using the questions provided in Part I of the Protocol. Part I presents a self-esteem interview. The interview questions appear in Part I, SECTIONS A, B, and C. SECTIONS A and B (Items #1-8) have one set of instructions to the client. SECTION C (Items #9-10) have a separate set of instructions for the client.

4. During the Interview, use SECTION A/QUESTION to complete Items #1-4. Use SECTION B/QUESTION to complete Items #5-8. Finally, use SECTION C to facilitate self-disclosure about goals and relationships as presented in Items #9 and 10.

5. SECTION C (Items #9 and 10) allows the client to express beliefs about both relationships and achievements. These two Items may provide some indication of defensiveness and/or social desirability facades. While the client answers Items #9 and 10 you can make brief notes about them.

6. While the client is answering Items #1-10, carefully observe his/her mannerisms, language, and non-verbal messages. You will use these observations when you complete Items #11, 12.

7. Begin with Part I and read the instructions aloud to the client. Instructions to the client appear above SECTION A/QUESTION and with SECTION C. The first instructions apply to both SECTIONS A and B. The second set applies to SECTION C only.

8. Ask the client to answer Items #1-8 using a scale of one-to-ten. If the client wants to indicate his/her strongest possible “Yes!” the answer would be “10.” If the client wants to give you the strongest possible “No!” he/she would answer “1.” A client who is unsure of his/her feelings about an Item could use a number close to the middle of the range, like 5 or 6. Write the client’s numerical response on the line following each Item.

9. Parts II and III provide you with further instructions.
Appendix F

Appendix F contains the second hypothetical client Protocol which was used to collect data in the second group of final evaluators. The Protocol has consistent client information in Part III because the test scores provide a fairly uniform profile. The information in Parts I and II of the Protocol do not provide a uniform profile. The researcher designed this Protocol to present an inconsistent pattern of client information, as prescribed by the research methodology. The varying client information influenced the evaluators' estimations of both the client's self-esteem and the utility of the Protocol.
THE SELF ESTEEM PROTOCOL

Part I. Read the following instructions to the client, then record his/her responses.

"Answer the following questions using a scale of 1-10. When I read a question to you, for example, you will answer "1" to tell me your strongest possible "No." In contrast, you will answer "10" to report your strongest possible "Yes." If you're unsure or feel neutral about it, you can use a number close to the middle like 5 or 6.

Section A/Question (Feelings)
"Are you satisfied with your feelings, in terms of..."

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? 6
2. Being secure and safe? 3
3. Closeness or love with your Mate? Children? Parents? Other relatives? Peers?
4. Your choices and responsibilities in life? 9

Section B/Question (Behaviors)
"Have your behaviors obtained results you wanted, in terms of..."

5. Comfort and relaxation without the aid of medicine, drugs, or alcohol? 7
8. What you wanted to accomplish in life? 9

Section C (Beliefs) Read the following instructions to the Client:
"Briefly answer the two remaining questions."

9. What do you expect to accomplish during the next five years?
10. Help me understand why you feel the way you do about your Mate? Children? Other relatives? Peers?

DO NOT DISCUSS THESE OBSERVATIONS WHEN RECORDING THEM!

Section A
The client's voice and tone may suggest discomfort when discussing specific items. Check (✓) the items #1-10 above which elicited discomfort in the client's voice and tone.

<table>
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<th>Items</th>
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11. Voice & Tone
Section B

Try to identify the client's defensiveness.

12. Did you get the impression that the client was:
   Highly Defensive, Moderately Defensive, Slightly Defensive, or Not Defensive.
   (Circle your estimate of the client's defensiveness.)

Section C

Check (✓) the following client behaviors demonstrated during the interview.

13. ✓ Seeks extra help from therapist
14. ✓ Cries/sniffles/chokes up
15. ✓ Looks around, easily distracted
16. ✓ Slumps/droops in chair
17. ✓ Changes story when confronted
18. ✓ Dramatizes self-report
19. ___ Refuses to accept responsibility
20. ___ Makes threats
21. ___ Expresses anger/disgust for the therapist

PART III. Record the client's test scores on the lines provided.
Selection of scales is left to the counselor's discretion.

22. __________ Self-esteem scale
23. __________ Self-concept scale
24. __________ Anxiety scale
25. __________ Self-confidence scale
26. __________ Emotional stability scale
27. __________ Ideal self scale

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THE SELF ESTEEM PROTOCOL

Directions for Counselor Administration

1. Study the entire Protocol before administering.

2. Discuss ONLY Items #1-10 with the client. DO NOT discuss items #11-27 when presenting Items #1-10. Items #1-3, 5-7 incorporate Maslow's hierarchy of needs. He suggested that physiological, security, and love needs precede self-esteem.

3. Interview the client using the questions provided in Part I of the Protocol. Part I presents a self-esteem interview. The interview questions appear in Part I, SECTIONS A, B, and C. SECTIONS A and B (Items #1-8) have one set of instructions to the client. SECTION C (Items #9-10) have a separate set of instructions for the client.

4. During the interview, use SECTION A/QUESTION to complete Items #1-4. Use SECTION B/QUESTION to complete Items #5-8. Finally, use SECTION C to facilitate self-disclosure about goals and relationships as presented in Items #9 and 10.

5. SECTION C (Items #9 and 10) allows the client to express beliefs about both relationships and achievements. These two Items may provide some indication of defensiveness and/or social desirability facades. While the client answers Items #9 and 10 you can make brief notes about them.

6. While the client is answering items #1-10, carefully observe his/her mannerisms, language, and non-verbal messages. You will use these observations when you complete items #11, 12.

7. Begin with Part I and read the instructions aloud to the client. Instructions to the client appear above SECTION A/QUESTION and with SECTION C. The first set of instructions apply to both SECTIONS A and B. The second set applies to SECTION C only.

8. Ask the client to answer items #1-8 using a scale of one-to-ten. If the client wants to indicate his/her strongest possible "Yes!" the answer would be "10." If the client wants to give you the strongest possible "No!" he/she would answer "1." A client who is unsure of his/her feelings about an item could use a number close to the middle of the range, like 5 or 6. Write the client's numerical response on the line following each item.

9. Parts II and III provide you with further instructions.
Appendix G

Appendix G contains the third hypothetical client Protocol which was used to collect the data with the third group of final evaluators. The researcher provided the hypothetical client profile in harmony with the study methods. To this end the Protocol contained inconsistent client information in Parts II and III. Part I of the Protocol was considered consistent because the client's responses in Items 1-10 were consistent. The inconsistencies of the Protocol influenced the evaluators' estimates of both the client's self-esteem and the utility of the Protocol.
THE SELF ESTEEM PROTOCOL

Part I. Read the following Instructions to the client, then record his/her responses.

"Answer the following questions using a scale of 1-10. When I read a question to you, for example, you will answer "1" to tell me your strongest possible "No." In contrast, you will answer "10" to report your strongest possible "Yes." If you're unsure or feel neutral about it, you can use a number close to the middle like 5 or 6.

Section A/Question (Feelings)
"Are you satisfied with your feelings, in terms of..."

1. Comfort and relaxation without the aid of medicine, drugs, or alcohol? 2
2. Being secure and safe? 4
4. Your choices and responsibilities in life? 5

Section B/Question (Behaviors)
"Have your behaviors obtained results you wanted, in terms of..."

5. Comfort and relaxation without the aid of medicine, drugs, or alcohol? 2
8. What you wanted to accomplish in life? 4

Section C (Beliefs) Read the following Instructions to the Client:
"Briefly answer the two remaining questions."

9. What do you expect to accomplish during the next five years? [ ] Improve his marriage [ ] Improve his health
10. Help me understand why you feel the way you do about your Mate? [ ] Children? [ ] Parents? [ ] Other relatives? [ ] Peers? [ ]
   [ ] He's unhappy about his unemployment. He's threatened to leave if he doesn't work. He feels "too weak" to work due to his back pain. Says family and friends criticize him.

Part II. Record your observations of the Client.

DO NOT DISCUSS THESE OBSERVATIONS WHEN RECORDING THEM!

Section A

The client's voice and tone may suggest discomfort when discussing specific items. Check (√) the items #1-10 above which elicited discomfort in the client's voice and tone.

<table>
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<tr>
<th>Items</th>
<th>1</th>
<th>2</th>
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<th>7</th>
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11. Voice & Tone √ √ √ √ √
Section B

Try to identify the client's defensiveness.

12. Did you get the impression that the client was:
   - Highly Defensive, (Circle your estimate of the client's defensiveness.)
   - Moderately Defensive
   - Slightly Defensive
   - Not Defensive

Section C

Check (✓) the following client behaviors demonstrated during the interview.

13. Seeks extra help from therapist
14. Cries/snifflies/chokes up
15. Looks around, easily distracted
16. Slumps/droops in chair
17. Changes story when confronted
18. Dramatizes self-report
19. Refuses to accept responsibility
20. Makes threats
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PART III. Record the client's test scores on the lines provided.
Selection of scales is left to the counselor's discretion.

22. Self-esteem scale
23. Self-concept scale
24. Anxiety scale
25. Self-confidence scale
26. Emotional stability scale
27. Ideal self scale
THE SELF ESTEEM PROTOCOL

Directions for Counselor Administration

1. Study the entire Protocol before administering.

2. Discuss ONLY Items #1-10 with the client. DO NOT discuss items #11-27 when presenting Items #1-10. Items #1-3, 5-7 incorporate Maslow's hierarchy of needs. He suggested that physiological, security, and love needs precede self-esteem.

3. Interview the client using the questions provided in Part I of the Protocol. Part I presents a self-esteem interview. The interview questions appear in Part I, SECTIONS A, B, and C. SECTIONS A and B (Items #1-8) have one set of instructions to the client. SECTION C (Items #9-10) have a separate set of instructions for the client.

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5. SECTION C (Items #9 and 10) allows the client to express beliefs about both relationships and achievements. These two Items may provide some indication of defensiveness and/or social desirability facades. While the client answers Items #9 and #10 you can make brief notes about them.

6. While the client is answering Items #1-10, carefully observe his/her mannerisms, language, and non-verbal messages. You will use these observations when you complete Items #11, #12.

7. Begin with Part I and read the Instructions aloud to the client. Instructions to the client appear above SECTION A/QUESTION and with SECTION C. The first set of Instructions applies to both SECTIONS A and B. The second set applies only to SECTION C.

8. Ask the client to answer Items #1-8 using a scale of one-to-ten. If the client wants to indicate his/her strongest possible "Yes!" The answer would be "10." If the client wants to give you the strongest possible "No!" he/she would answer "1." A client who is unsure of his/her feelings about an item could use a number close to the middle of the range, like 5 or 6. Write the client's numerical response on the line following each item.

9. Parts II and III provide you with further instructions.
Appendix H

Appendix H contains a copy of the evaluation survey which was used in the final study. The evaluation form was printed on three different colors of paper, creme, blue, and salmon. The different colors coded each of three groups of evaluators. Group 1 of the evaluators returned creme colored surveys. The blue surveys were sent back by the Group 2 evaluators. The researcher received salmon colored surveys from Group 3. The differing colors assisted the process of distinguishing which evaluations were associated with each of the three Protocols.
EVALUATION SURVEY

Directions: First examine the protocol which contains client responses, counselor observations, and test scores. Then answer each of the questions on this page. (Instructions for counselor administration follow the protocol.)

1. Can you estimate the client's self-esteem by using the client's responses, counselor's observations, and test scores as combined in the Protocol? (Circle your response as follows.)

   Definitely Yes  Probably Yes  Undecided  Probably No  Definitely No

Note: For questions #2-6, circle the appropriate letters to indicate your response. (VH=Very Helpful, MH=Moderately Helpful, SH=Slightly Helpful, NH=Not Helpful)

2. How helpful was the Protocol's basic structure for estimating the client's self-esteem?
   VH  MH  SH  NH

3. How helpful was the structure of Part I (client's responses) of the Protocol for estimating the client's self-esteem?
   VH  MH  SH  NH

4. How helpful was the structure of Part II (counselor's observations) of the Protocol for estimating the client's self-esteem?
   VH  MH  SH  NH

5. How helpful was the structure of Part III (test scores) of the Protocol for estimating the client's self-esteem?
   VH  MH  SH  NH

6. How helpful might this protocol format be to various types of counselors?
   A. Counselors like yourself: VH  MH  SH  NH
   B. Marriage/Family counselors: VH  MH  SH  NH
   C. Beginning/Student counselors: VH  MH  SH  NH
   D. Humanists: VH  MH  SH  NH
   E. Behaviorists: VH  MH  SH  NH
   F. Psychoanalysts: VH  MH  SH  NH
   G. Clinical Social Workers: VH  MH  SH  NH
   H. High School counselors: VH  MH  SH  NH
   I. Psychiatrists: VH  MH  SH  NH

7. Do you prefer certain parts of the protocol over others? If so, which ones? (You may write on the back if necessary.)

Please return this survey. Thank you.
Directions: First examine the protocol which contains client responses, counselor observations, and test scores. Then answer each of the questions on this page. (Instructions for counselor administration follow the protocol.)

1. Can you estimate the client's self-esteem by using the client's responses, counselor's observations, and test scores as combined in the Protocol? (Circle your response as follows.)

   Definitely Yes  Probably Yes  Undecided  Probably No  Definitely No

Note: For questions #2-6, circle the appropriate letters to indicate your response. (VH=Very Helpful, MH=Moderately Helpful, SH=Slightly Helpful, NH=Not Helpful)

2. How helpful was the Protocol's basic structure for estimating the client's self-esteem?
   VH  MH  SH  NH

3. How helpful was the structure of Part I (client's responses) of the Protocol for estimating the client's self-esteem?
   VH  MH  SH  NH

4. How helpful was the structure of Part II (counselor's observations) of the Protocol for estimating the client's self-esteem?
   VH  MH  SH  NH

5. How helpful was the structure of Part III (test scores) of the Protocol for estimating the client's self-esteem?
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   A. Counselors like yourself: VH  MH  SH  NH
   B. Marriage/Family counselors: VH  MH  SH  NH
   C. Beginning/Student counselors: VH  MH  SH  NH
   D. Humanists: VH  MH  SH  NH
   E. Behaviorists: VH  MH  SH  NH
   F. Psychoanalysts: VH  MH  SH  NH
   G. Clinical Social Workers: VH  MH  SH  NH
   H. High School counselors: VH  MH  SH  NH
   I. Psychiatrists: VH  MH  SH  NH

7. Do you prefer certain parts of the protocol over others? If so, which ones? (You may write on the back if necessary.)

   Please return this survey. Thank you.
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Directions: First examine the protocol which contains client responses, counselor observations, and test scores. Then answer each of the questions on this page. (Instructions for counselor administration follow the protocol.)

1. Can you estimate the client's self-esteem by using the client's responses, counselor's observations, and test scores as combined in the Protocol? (Circle your response as follows.)
   - Definitely Yes
   - Probably Yes
   - Undecided
   - Probably No
   - Definitely No

Note: For questions #2-6, circle the appropriate letters to indicate your response. (VH=Very Helpful, MH=Moderately Helpful, SH=Slightly Helpful, NH=Not Helpful)

2. How helpful was the Protocol's basic structure for estimating the client's self-esteem?
   - VH
   - MH
   - SH
   - NH

3. How helpful was the structure of Part I (client's responses) of the Protocol for estimating the client's self-esteem?
   - VH
   - MH
   - SH
   - NH

4. How helpful was the structure of Part II (counselor's observations) of the Protocol for estimating the client's self-esteem?
   - VH
   - MH
   - SH
   - NH

5. How helpful was the structure of Part III (test scores) of the Protocol for estimating the client's self-esteem?
   - VH
   - MH
   - SH
   - NH

6. How helpful might this protocol format be to various types of counselors?
   - A. Counselors like yourself: VH
   - B. Marriage/Family counselors: VH
   - C. Beginning/Student counselors: VH
   - D. Humanists: VH
   - E. Behaviorists: VH
   - F. Psychoanalytic: VH
   - G. Clinical Social Workers: VH
   - H. High School counselors: VH
   - I. Psychiatrists: VH

7. Do you prefer certain parts of the protocol over others? If so, which ones? (You may write on the back if necessary.)

Please return this survey. Thank you.
REFERENCE LIST


Williams, J. E., & Bennett, S. M. (1975). The definition of sex stereotypes via the Adjective Check List. *Sex Roles, 1*, 327-337.


OBJECTIVE  Provide leadership in Human Resource areas

PROFESSIONAL EXPERIENCE

1986 -  Director, Human Resource Development
Life Care Centers/Tusculum College
Teaching Business/Marketing Research. Managing services related to Professional Development, Recruitment, Training, Employee Relations, Risk Management, and Benefits.

1982 -  Counseling/Organizational Psychologist
1986  Private Practice/Community Mental Health
Marketed Health Services. Provided services related to Psychological Assessment, Counseling, Employee Drug Rehab. Taught seminars in areas of Self Esteem, Statistics, Stress Management, Communication for Managers, and Divorce Recovery.

1980 -  Cardiac Rehabilitation Consultant/Intern Psychologist
1982  Center for Developmental Analysis/Private Practice
Provided educational and psychological services related to Cardiac Rehab, Psychological Assessment and Therapy, Residential Treatment, Stress Management, and Sports Psychology.

1975 -  Guidance Director/Teacher
1980  Ozark Academy/Niles Alternative High School
Provided services related to Teaching, Counseling, Career Development, Behavior Modification for cognitive and emotional impairments. Designed programs using community based organizations and resources.

PROFESSIONAL DEGREES AND LICENSES

Ph.D.  Counseling Psychology Andrews University 1987
M.A.  Education/Guidance Andrews University 1975
B.A.  English/Business Andrews University 1973

Licenses:  Psychological Practice/Teaching, (CA, MI) 1975-1987