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The self-presentational view of psychotherapy challenges current assumptions about the benefits of high levels of clients' openness in therapy (A. E. Kelly, 2000). The author responds to questions about whether clients' discretion really is linked to favorable therapy process ratings and outcomes. She also addresses problems that may emerge if readers apply a narrow definition of self-presentation as a form of deliberate manipulation, rather than the intended definition of consciously or unconsciously showing oneself to be a particular kind of person for audiences. A brief review of the evidence on the role of audience feedback in self-concept change is offered, along with suggestions for explaining self-concept change to clients.

Is clients' discretion really associated with favorable therapy process ratings and outcomes? What role does therapists' feedback play in clients' self-concept change? What are the implications of the proposed view of psychotherapy (A. E. Kelly, 2000), in terms of both what clients should reveal in therapy and how self-concept change takes place? These are three of the central questions that emerge from the commentaries from leading researchers in counseling/clinical psychology (Hill, Gelso, & Mohr, 2000) and social psychology (Arkin & Hermann, 2000). As one might expect given their different areas of expertise, the researchers focused on different parts of the article. Hill et al. (2000) fixed on the findings from a subset of the section on clients' openness in psychotherapy. They disagreed with the conclusion that clients' discretion is associated with positive therapy process ratings and outcomes and with the stated implications of the proposed self-presentational view for therapy. These disagreements concern the implications seemed to stem from their use of the term self-presentation as it has been narrowly defined, rather than as it was used in the article. In contrast, Arkin and Hermann (2000) agreed with my premises for challenging traditional notions of psychotherapy and focused most of their suggestions on the section on self-presentation research. They argued that, given current findings on self-presentation (see, e.g., Tice, 1992) and action identification (Vallacher & Wegner, 1987), the implications for self-concept change in therapy may be both further reaching and more complex than I originally indicated. My primary goal in this rejoinder is to clarify my meanings in A. E. Kelly (2000), especially concerning how the term self-presentation was used and the corresponding implications for self-concept change.

Reply to Hill, Gelso, and Mohr (2000)

The empirical work of Hill and her colleagues (e.g., Regan & Hill, 1992) has played a critical role in helping scientists to understand better the dynamics of psychotherapy, especially covert processes. Without this empirical foundation, the proposed self-presentational view of psychotherapy—which challenges the heart of current assumptions about the importance of clients' openness in psychotherapy—could not have been advanced at this time. However, Hill et al. (2000) and I have offered very different interpretations of these and other findings; in the following paragraphs, I explain how these differences can be resolved.

Clients' Concealment and Therapy Outcomes/Process Ratings

In a review of her own research, Hill (1992) concluded that "clients often hide negative reactions; and when the therapists are aware of negative reactions, there may be negative effects on the therapy" (p. 689). In my review of the literature, I agreed with this conclusion and added evidence to support the claim that many clients keep secrets from therapists. However, Hill et al. (2000) challenged this claim by suggesting that "clients hide very little in therapy" (p. 495). Their comment raises the interesting question, What is a high rate of secret keeping in therapy?

Many of the same facts that I used to illustrate that clients often hide their negative reactions and keep secrets from their therapists were recast by Hill et al. (2000) to mean that clients are quite open with their therapists. It might seem as though they were interpreting the proverbial glass as half full in cases where I seemed to be interpreting the glass as half empty. In particular, they stated that "over half of clients did not keep any secrets from their therapists (54% in Hill et al., 1993; 60% in Kelly, 1998)" (p. 495). It must be clarified that in the A. E. Kelly (1998) study, 40.6% of the clients said they were keeping relevant secrets. When the keepers of irrelevant secrets were included, a total of 60% of the clients in the A. E. Kelly (1998) sample reported that they were keeping secrets...
from their therapists. Moreover, this percentage is likely to be an underestimate of actual secret-keeping because, as Hill et al. (2000) pointed out later in their commentary, people may not be completely honest when filling out surveys. Nevertheless, the question of whether 60% is a high or low percentage of secret-keepers in a given sample is subject to interpretation. I contend that it is a high percentage of secret-keepers, given that virtually all of the clients in the A. E. Kelly (1998) study indicated that they perceived that the therapists expected full disclosure from them.

More important than the question of what percentage of clients keep secrets from their therapists is the question, What happens when clients keep secrets that they believe are relevant to their treatment? Hill et al. (2000) disagreed with the interpretation of the results from the A. E. Kelly (1998) study, which was that clients’ keeping relevant secrets in therapy predicted their having fewer symptoms. Hill et al. described the findings from the A. E. Kelly (1998) study as showing no correlation between relevant secret-keeping and current symptomatology (r = -.11). However, they noted that the relationship between these two variables became statistically significant (standardized β = -.40) after a multiple regression analysis controlled for social desirability and self-concealment scores.

How should those findings from the A. E. Kelly (1998) study be interpreted? For the sake of simplicity, the social desirability scores are not included in this explanation because relevant secret-keeping was a statistically significant predictor of lower symptomatology scores, even when the multiple regression analysis controlled only for self-concealment scores. Self-concealment refers to one’s general tendency or disposition to keep secrets, whereas relevant secret-keeping refers to clients’ keeping particular relevant secrets from their therapists. Self-concealment scores were used as a covariate in the multiple regression analysis that tested whether relevant secret-keeping predicted less symptomatology because previous research has shown that people with higher self-concealment scores tend to report more symptomatology (see, e.g., Larson & Chastain, 1990). Indeed, there was a positive zero-order correlation between clients’ self-concealment and symptomatology scores (r = .37) in the A. E. Kelly (1998) study. As one might expect, there was also a positive zero-order correlation between the clients’ self-concealment scores and relevant secret-keeping (r = .42). Yet the multiple regression analysis showed that the two variables predicted symptomatology scores in opposite directions: Keeping a relevant secret predicted lower symptomatology (standardized β = -.32), whereas higher self-concealment was linked with greater symptomatology (standardized β = .50). The way to think about these findings is that for clients who were at the same level of self-concealment, the ones who reported keeping relevant secrets from their therapists had lower symptomatology scores than those who reported that they were not keeping any. Put another way, when clients’ general tendencies to keep secrets (a personality variable) were taken into account, keeping particular relevant secrets (a therapy process variable) emerged as an important predictor of symptomatology. However, researchers will need to replicate the results from this one study before feeling confident about this pattern.

In addition to these specific disagreements, Hill et al. (2000) contradicted my broader conclusion that there is a link between clients’ discretion and positive therapy process ratings. They cited one study with statistically significant results that supported their challenge (Wright, Ingraham, Chemtob, & Perez-Arce, 1985). Wright et al. (1985) showed that the more that members of a group therapy class withheld from other group members and the group leaders, the less satisfied they were with the group sessions. However, the reader should be alerted to the fact that the two first authors (i.e., Wright and Ingraham) were the two group leaders in that study and had hypothesized that the participants would report less satisfaction in group meetings in which the participants held things back. Their methodology involved obtaining weekly feedback on the things withheld during the therapy and satisfaction with the sessions from the 15 graduate students enrolled in their group therapy course. As conscientious group leaders, the authors used this weekly feedback to try to enhance the subsequent sessions. Thus, because of the possible demands on the students to fulfill their instructors’ expectations, these findings would need to be replicated in studies where the demand characteristics are less prominent before researchers could conclude that concealment in group therapy is associated with less satisfaction with the sessions.

Hill et al. (2000) also expressed several general concerns about the methodological limitations of the clinical studies cited in A. E. Kelly (2000). They indicated that the studies varied in their methodologies, settings, time frames, and kinds of participants used. However, the fact that there are consistent patterns in the findings across the different settings and samples provides even stronger support for the proposed self-presentational view of psychotherapy. Theories are supposed to explain and integrate observations across different settings. Once a pattern of findings emerges from a number of studies, such as the pattern that I have described between clients’ discretion and favorable therapy outcomes/ process ratings, researchers should try to offer a theoretical explanation for it. Hopefully, the theory will encourage other researchers to follow up with tests of the hypotheses from it, so that the theory may be revised over time.

Applying Different Definitions of Self-Presentation

There were several places where Hill et al. (2000) interpreted the implications of the proposed self-presentational view in ways that were different from how they were intended. These misinterpretations seem to stem from Hill et al.’s construing self-presentation in the narrow manner as a form of deliberate manipulation, as other psychotherapy researchers might do. It is important to note, however, that I used the broader definition of self-presentation, which means to show oneself (either consciously or unconsciously) to be a particular kind of person for various audiences (see, e.g., Schlenker, 1986).

One can infer that Hill et al. (2000) were applying a narrow definition of self-presentation when they stated that they disagreed with the claim that clients conceal things from their therapists primarily for self-presentational reasons. My actual claim was that “one obvious reason for this concealment is that clients want their therapists to have favorable impressions of them” (A. E. Kelly, 2000, p. 476). I also noted that “clients cannot avoid trying to construct desirable images of themselves in the presence of their therapists—it happens automatically, much like communication itself” (A. E. Kelly, 2000, p. 477). Hence, to state that clients have primarily self-presentational motives seems to miss the point that
self-presentation is an inherent part of interpersonal communication. Furthermore, as indicated in the article (A. E. Kelly 2000), even though self-presentational motives are always likely to exist in the therapy relationship, clients may have additional motives for why they conceal information from their therapists. For example, they may not reveal details surrounding their previous sexual experiences because they fear that the therapists might weigh those details too heavily in developing their treatment plans. As such, Hill et al.'s observation that what clients "do conceal involves many different kinds of information that are hidden for many different reasons" (p. 495) is consistent with the proposed self-presentational view.

Their use of a narrow definition of self-presentation may also explain why Hill et al. (2000) thought that I vacillated on the presentational view. Given that other readers too may wonder about the recommendations, they are summarized as follows: Instead of suggesting that clients deliberately should hide information from their therapists to make a good impression, I noted that clients do conceal information as part of either conscious or unconscious attempts to construct desirable images before the therapists. There is evidence that such discretion does not necessarily undermine their treatment (and it may even enhance their treatment). In those cases where clients believe that their therapists could not view them favorably after hearing particularly heinous revelations, I suggested that it is acceptable for clients to discuss themes as opposed to details of those revelations. At the same time, there may be some clients who enter therapy with very negative self-views surrounding specific transgressions or humiliating events and who may come to believe that their therapists would still have favorable impressions of them even if the therapists knew about these events. "Such clients might benefit immensely from telling the therapists about these events and then hearing the therapists' challenges of their negative self-views surrounding the events" (A. E. Kelly, 2000, p. 486). Rather than my suggesting that clients show only positive self-images to their therapists, I proposed that it is acceptable for clients to use some discretion based on their perceptions of the therapists' responses (A. E. Kelly, 2000).

Reply to Arkin and Hermann (2000)

Arkin and Hermann (2000) agreed with the premises of the proposed self-presentational view and elaborated on the implications of the proposed view. In the following paragraphs, I address what role therapists' feedback plays in bringing about self-concept change and why clients sometimes might find it useful to reveal the themes as opposed to the details of their problems.

Role of Therapists' Feedback

Arkin and Hermann (2000) noted that the research from the self-presentation literature, much of which I cited, has demonstrated that no audience feedback is needed for people to shift their self-beliefs in the direction of their self-presentations. The mere presence of an audience was enough for the participants to experience this carryover effect, or internalization of their self-presentations, in several experiments (e.g., Tice, 1992). Thus, according to Arkin and Hermann, the role of the therapists and their feedback in clients' self-concept change might have been overemphasized in the article (A. E. Kelly, 2000). They suggested that it is really what clients self-present that seems to be critical—with or without feedback from the therapists.

Real versus imagined feedback. I agree that clients' self-concept change can occur without actual feedback from their therapists and indicated as much when I said that the real or imagined feedback is what counts (A. E. Kelly, 2000). Likewise, I avoided claiming that therapists' feedback was a necessary condition for clients' self-concept change. It is theoretically possible for a client to benefit from therapy when the therapist says nothing because the client could develop some important insights merely by imagining the feedback from the therapist.

This distinction between real and imagined feedback has implications for qualifying my suggestion that clients may benefit from presenting themselves to their therapists in a manner that is believable to themselves and their therapists (A. E. Kelly, 2000). It would have been more precise for me to say that self-concept change should be enhanced when the clients find their self-presentations to be believable and when they think that their therapists find them to be believable. It really should not matter for clients' self-concept change whether the therapists do in fact find the clients' self-presentations to be believable. Nevertheless, there is still a good, separate argument for the suggestion that clients' self-presentations should be believable to their therapists. This argument comes from the evidence that extremely positively biased self-perceptions are not associated with favorable mental health (see Taylor & Brown, 1994). Having therapists find the self-presentations believable is likely to provide some indication that the clients' self-presentations are not too extreme or maladaptive, even if the therapists' actually believing the self-presentations may not be crucial for clients' self-concept change.

Therapists' feedback is important. Arkin and Hermann's (2000) comments appropriately called attention to the importance of clients' own behaviors and perceptions (i.e., self-presentations) in the self-concept change process. As yet, the relative contributions to self-concept change of the self-presentations and the corresponding feedback are not known. I identified both factors as important to self-concept change in the proposed self-presentational view of psychotherapy because this view provides a parsimonious yet comprehensive accounting for the evidence.

For example, Gergen (1965) demonstrated that the types of self-presentations that participants performed and the feedback that they received affected their self-perceptions. As described in the article (A. E. Kelly, 2000), the participants in Gergen's study were instructed either to present themselves accurately or to try to make a good impression during an interview. They either received reflective reinforcement (e.g., "very good," "yes, I would agree") or did not receive such feedback. As one might expect, the participants who had been instructed to try to make a good impression during the interview became even more positive in their self-descriptions following the interview than those who had been instructed to be accurate. More important for the present argument, participants in the reflective-reinforcement condition described themselves significantly more positively following the interview than did participants in the no-feedback condition, demonstrating that feedback was important in changing self-perceptions (Gergen, 1965).
Those findings from the laboratory converge with a number of clinical observations. For instance, G. A. Kelly (1955) observed that as long as he could give feedback that helped his psychotherapy patients see their old problems in new ways, then they would show improvement in their psychological functioning. Likewise, Elliot (1985) found that clients rated therapists' feedback that gave them a new perspective on their problems as the most helpful form of intervention. Also, in a review of brief therapy techniques, Hill (1992) discovered that interpretations made by the therapists (i.e., therapists' feedback) stood out as the most consistently helpful technique. Finally, in a study that assessed internalization in psychotherapy, clients came to incorporate in their self-views the favorable opinions that they believed their therapists had about them (Quintana & Meara, 1990).

Any theory of psychotherapy should account for the interactional nature of the relationship between the therapist and client, including the feedback from the therapist (Strong, 1987). Even though clients keep some undesirable information from their therapists, they also tend to disclose their problems such as feelings of low self-esteem and depression (see, e.g., A. E. Kelly, Kahn, & Coulter, 1996). Because the clients are performing so many negative self-presentations to an important audience, one might expect that they would emerge from therapy worse off than if they had received no treatment. However, researchers using meta-analytic techniques (see, e.g., Smith, Glass, & Miller, 1980) have shown that the average treated therapy client is better off than 80% of the comparable untreated clients (i.e., those on a waiting list for treatment). Why do clients fare so well in therapy despite their many negative self-presentations? I have argued that it is the real or imagined favorable feedback from the therapists, along with corresponding favorable changes in the clients' self-presentations, that can explain how clients come to experience positive self-concept change (A. E. Kelly, 2000).

In sum, there is evidence that therapists' feedback (whether real or imagined) plays an important role in clients' improvement, and any theory of psychotherapy should take that evidence into account. Although Arkin and Hermann (2000) have downplayed the role of therapists' feedback, their comments inspire the interesting future research question, What is the relative contribution of the clients' self-presentations and the therapists' feedback to self-concept change? 

Explaining Self-Concept Change

Arkin and Hermann's (2000) suggestion that therapists may help their clients by explaining the processes that shape self-concept change was an excellent one, and I wish to extend their discussion. As they recommended, therapists may explain to their clients that what the clients tell others about themselves is likely to become an important part of who they are; the therapists may further engage their clients in role plays (as many already do) to facilitate positive self-presentations. I suggest that therapists also may explain that the people with whom the clients interact, including their therapists, can affect how the clients describe themselves. In one study, clients presented themselves differently to four different counselors, leaving the four counselors with different impressions of the same clients (Fuller & Hill, 1985).

In addition, therapists may explain that publicly committing oneself to an identity seems to be an important part of self-concept change. Researchers have demonstrated that the presence of an audience is a crucial element of internalizing one's self-presentations (Baumeister & Tice, 1984; Schlenker, Dlugolecki, & Doherty, 1994; Tice, 1992). Once people claim to be particular kinds of persons to others, they obligate themselves to behaving consistently with those identities (Schlenker et al., 1994). If people try to present themselves differently from their previous self-presentations, they may face the very negative consequences of being seen as unreliable, flighty, hypocritical, or self-deluding, or as liars. People's peers tend to give them feedback that constrains them to being consistent with their previous identities (see, e.g., Swann, 1996). This feedback (whether real or imagined) is likely to be important in influencing one's self-perceptions, given that naturalistic studies have shown that how people think that others perceive them is substantially linked to how they see themselves (Shrauger & Schoeneman, 1979). Hence, therapists may explain that it is the motive to be consistent with one's prior self-presentations—and with the corresponding feedback from others—that may cause clients to be affected by their own self-descriptions. Such an explanation could be especially useful to clients who indiscriminately reveal the details of their problems to their co-workers, family, and friends (see A. E. Kelly & McKillop, 1996).

Revealing Themes Versus Heinous Details

I suggested that it is acceptable for clients to focus on general themes of their problems when the the details of their problems seem too terrible or humiliating for them to imagine that their therapists still would view them favorably after a revelation of those details (A. E. Kelly, 2000). However, Arkin and Hermann (2000) noted that themes, as compared with specific behaviors, have greater implications for one's identity (Vallacher & Wegner, 1987). They cogently argued that a focus on themes could encourage clients to experience a generalized sense of shame, as opposed to a feeling of guilt, and that guilt can be adaptive in inducing clients to change their behaviors, whereas shame can prompt a maladaptive effort to change the self. As a solution to the dilemma surrounding negative disclosures, Arkin and Hermann indicated that it may be better to describe the event fully, but in a neutral, factual manner. This would allow the opportunity for client and therapist, when necessary, to reframe the client's understanding of specific events and help negate the tendency to move to broader, self-oriented levels of thinking and characterizing of the self. (p. 503)

Their suggestion certainly is reasonable for clients who can imagine that their therapists would view them favorably after a description of negative events. Moreover, it captures what many therapists, including psychoanalysts and cognitive—behavioral therapists, already do. However, my recommendation specifically targets those times when the client cannot imagine that the therapist would view him or her favorably after a revelation. I agree with Arkin and Hermann (2000) that it can be beneficial for a client to reveal behaviors like "I sometimes slam the door or stomp out" (p. 503), but these behaviors almost certainly would not be in the category of acts that
most clients would fear revealing to their therapists. In A. E. Kelly (2000), I used the example of the man who hit his wife with a bat one time because when people do such terrible things, those few acts often come to define them. The same is likely to be true for very humiliating details, such as those in the infamous Starr Report (Starr, 1998), which was criticized for its gratuitous provision of sexual details: “According to Ms. Lewinsky, she performed oral sex on the President on nine occasions... On one occasion, the President inserted a cigar into her vagina” (p. 5). I speculate that a client who feels burdened by similarly humiliating details could indicate something like “we had sexual contact” and could discuss her feelings about the events to let the therapist know what impact those events had on her. This option might be preferable to revealing the details and then imagining the undesirable themes that the therapist is developing about her. Of course, one must keep in mind that it is possible for a client to want the therapist to hear such sexual details because she anticipates that she will be seen in a desirable way (e.g., as playful or adventurous woman). My recommendation to focus on themes as opposed to details does not apply to such cases.

Support for my argument that a few noteworthy acts can be linked directly to their broader undesirable themes comes from evidence (see Mischel & Peake, 1982) that people judge others to have consistent traits, such as self-centeredness or conscientiousness, by stringing together their highly prototypical behaviors (i.e., behaviors that are representative of their broader categories). If a therapist hears that a client has beaten his wife on the back with a bat, the client might imagine that the therapist will weigh that detail heavily in evaluating that client’s overall personality. This perception is likely to be accurate, too, given that Regan and Hill (1992) found that therapists formed very negative clinical conjectures about their clients, conjectures that they then hid from the clients. In addition, research has shown that therapists’ perceptions of a target person are consistently less favorable than laypersons’ perceptions, whether that person is a client or nonclient (see Willis, 1978). It should not be surprising that clinicians form such negative opinions, given that they are trained to use the Diagnostic and Statistical Manual (DSM; see American Psychiatric Association, 1994), which lists behaviors that qualify their patients to have various disorders.

My suggestion about clients’ generating their own themes involves their creating relatively desirable themes, as opposed to the undesirable themes (e.g., having feelings of being self-centered) described by Arkin and Herrmann (2000). For example, the man who hit his wife might say, “I am a person committed to dealing with my issues of rage,” as opposed to “I am a despicable wife-beater who has no place in society.” If the client reveals the detail of hitting his wife, he might imagine getting feedback from the therapist that supports the more desirable wife-beater label. Moreover, therapists are probably more apt to empathize with and like their clients if the clients can focus on their feelings of rage, frustration, hurt, and helplessness, rather than if the clients describe heinous acts in a detached way. Empathy has been found to play an important role in clients’ improvement (see Beutler, Machado, & Neufeldt, 1994), and clients who are more well liked by their therapists tend to show more progress in therapy (see, e.g., Stoler, 1963).

In sum, Arkin and Herrmann’s (2000) recommendation to fully describe negative behaviors makes sense when clients are unduly burdened by their undesirable actions and when they perceive that the therapists can view them favorably after such a revelation. My recommendation concerns acts that clients perceive to be heinous or extremely humiliating; it takes into account the fact that the clients do censor their revelations—with no apparent ill effects.

**Encouraging Thought Suppression?**

Arkin and Herrmann’s (2000) final comment was that efforts to withhold information may have the ironic effect of enhancing the impact of that information on one’s self-concept. They cited research on the negative effects of thought suppression (see Wegner, 1994) and suggested that encouraging clients to withhold details might make those thoughts even more vivid, salient, and central. Hill et al. (2000), too, suggested that clients’ withholding information could cause them to miss out on the benefits of therapy and cited research on the negative effects of inhibiting information to support their claim (see Pennebaker, 1997).

I have two sets of responses to this point. First, I am advocating an overhauling of current expectations of very high levels of revelation in therapy. If clients can come to believe that it is not a requirement of therapy for them to reveal unseemly details about themselves, then there would be no need for them to suppress such details. I (A. E. Kelly, in press) make the following distinction between secrecy and privacy:

> Whereas privacy connotes the expectation of being free from unsanctioned intrusion, secrecy does not. Secrecy involves active attempts to prevent such intrusion or leaks, and the secret keeper exerts this energy, in part, because he or she perceives that other people may have some claim to the hidden information. (ms. p. 4)

It follows that if clients do not feel pressed for disclosure, then they could view these details as private, rather than as secrets that need to be suppressed.

Second, even if clients did choose to suppress some details, the evidence that those details would ironically become more significant is far from clear. Wegner and his colleagues have demonstrated that when people are given thoughts to suppress, they become more preoccupied with those thoughts than if they had not suppressed them (see, e.g., Wegner, Schneider, Carter, & White, 1987). However, one pair of experiments (A. E. Kelly & Kahn, 1994) showed that when participants were asked to suppress their own unwanted intrusive thoughts, they actually either became less preoccupied with the thoughts (Experiment 1) or did not experience any change in the frequency of the thoughts (Experiment 2). Also, the results from Pennebaker’s (1997) studies may not be relevant to the present discussion because those studies focused on revelations in confidential, anonymous settings (i.e., they were not designed to look at the effects of revealing to an important audience). The crux of my argument for why it is acceptable for clients to censor some particularly heinous details was that the perceived feedback from an important audience (i.e., their therapists) could have negative implications for their self-concepts.

**Conclusion**

The commentaries from these leading social and counseling/clinical psychologists were extremely valuable in calling attention...
to the points from my article (A. E. Kelly, 2000) that required clarification. It was interesting to see the different assumptions that the two sets of researchers brought to this discussion. Social psychologists such as Arkin and Herrmann are probably likely to accept the notion that the masks people wear when interacting with others are a very important part of who they are and will become. In contrast, Hill et al. (2000) seemed to reject much of the evidence that people’s self-concepts are influenced by what they show others when they said, “we believe that one of the most important things that can happen in therapy is for therapists to accept clients deeply for themselves as they are” (p. 498). Hill et al.’s comment also implies that self-concepts are more stable than they actually may be, given that research on the self suggests that people have multiple self-concepts over time (see Baumeister, 1998).

Perhaps the two sets of researchers have in common a sense of optimism about the psychotherapy process. Arkin and Herrmann (2000) recommended that clients fully describe their very negative behaviors so that their therapists can help them see their behaviors as separate from the broader implications of who they are. Likewise, Hill et al. (2000) seemed to suggest that therapists can and do truly hold their clients in high regard, even when the clients reveal heinous details. I have seemed somewhat less optimistic in suggesting that being judgmental is part of human nature and that clients are rightfully sensitive to the possibility that their therapists may form very negative clinical conjectures about them if the clients say truly heinous things about themselves (see Regan & Hill, 1992). The key message from my proposal is that, at its core, psychotherapy is an interpersonal endeavor that is not exempt from social processes that characterize normal discourse. In particular, people put on masks when interacting with others. These masks have important implications for how they perceive that others see them and for how they see themselves. I am optimistic that once this perspective is acknowledged, scientists can exploit what is known about self-presentation to enhance their understanding of psychotherapy and potentially increase its effectiveness.

References


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