The Development of Novice Counselors' Inner Experiences, Counseling Self-Efficacy, and Skills

Pamela Rezek
Loyola University Chicago

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LOYOLA UNIVERSITY CHICAGO

THE DEVELOPMENT OF NOVICE COUNSELORS' INNER EXPERIENCES, COUNSELING SELF-EFFICACY, AND SKILLS

A DISSERTATION SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL IN CANDIDACY FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

DEPARTMENT OF COUNSELING AND EDUCATIONAL PSYCHOLOGY

BY

PAMELA REZEK

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Dedicated to my husband and best friend, Jim, whose encouragement, sensitivity, and devotion have been my foundation during seven years of graduate school; and to my mom, brother, and extended family for their constancy and reassuring support.
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CHAPTER I

INTRODUCTION

The study of psychotherapists' intentions or rationales for their interventions is rooted in the process research literature, the global goals of which have been to determine outcomes or success of psychotherapy and to understand how change occurs. Initially, research focused on comparing the success or outcome of receiving versus not receiving psychotherapeutic treatment (Bergin, 1971; Bergin & Lambert, 1978; Eysenck, 1952; Smith & Glass, 1977) and later concentrated on within-session variables that might illuminate how change occurs in therapy (Elliott, James, Reimschuessel, Cislo, & Sack, 1985; Greenberg, 1986; Hill, 1982; Llewelyn, 1988; VandenBos, 1986). Therapist response modes became a particular focus as researchers developed means for categorizing various types of therapist verbalizations (Elliott, 1985; Hill, 1978). Simultaneously, researchers became interested in the cognitive processes that were assumed to accompany therapist behaviors (Elliott, 1985; Hill, 1982; Hill, 1990; Hill & O'Grady, 1985; Martin, Martin, Meyer, & Slemon, 1986).

In a recent review of the historical development of process research, Hill and Corbett (1993) described process research as the study of within session client and thera-
pist behaviors, both overt and covert, as well as the interaction between the client and the therapist. The authors highlighted the drive to integrate cognitive theory with process research, based on the premise that cognitions mediate behaviors and thus are legitimate targets of analysis and intervention.

The move in research from a focus on therapists' overt behaviors to their covert activities in sessions highlights the importance of understanding therapists' rationales or intentions for particular interventions. Given the significance of intentionality as a variable operating in the therapeutic process of change, understanding the nature and development of intentions seems critical to the training of psychotherapists.

The notion of intention implies both an awareness and purposeful utilization of internal, subjective cognitions. Yet literature suggests that novice counselors, those in the beginning phases of training, are self-conscious, anxious, uncomfortable, insecure, have difficulty relaxing, lack confidence and insight (Flapan, 1984; Friedlander, Dye, Costello, & Kobos, 1984; Ralph, 1980; Sansbury, 1982; Stoltenberg, 1981; Watkins, 1990), and at the same time are attempting to learn basic, concrete counseling skills (Grater, 1985; Sansbury, 1982). The image of novice counselors is not one of individuals who are confident in their ability to perform skills, and who simultaneously and
instinctively analyze their rationale for and choose the most effective intervention for a particular client at any given moment in a therapy session. Instead, their cognitive state seems paradoxical to that conducive to having and being aware of intentions for behaviors. In fact, research seems to indicate that novice counselors have few intentional thoughts. Borders, Fong-Beyette, and Cron (1988) found that much of counseling students' cognitions were characterized by self-doubt, self-scrutiny, and minimal awareness of the interaction between client and therapist, and that intentionality and self-instruction are not instinctive processing practices for beginning counseling students. Based on their study of student-counselors' self-talk or internal dialogue, Kurpius, Benjamin, and Morran (1985) suggested that learning how to collect client information is more important than learning what client information to collect. With regard to intentions, this study also may suggest that teaching novice counselors how to think is as critical as teaching them concrete response modes. Kivlighan (1989) suggested that research should focus on detecting changes due to training that may be more subtle than, but related to, the use of intentions.

In addition, the portrayal of novice counselors as anxious, self-doubting, self-critical, and lacking in confidence may suggest that they are plagued by low self-efficacy. Self-efficacy refers to the belief that one can
successfully perform a given behavior (Bandura, 1977). Also, self-efficacy beliefs are posited as powerful determinants of behavior and behavior change (Bandura, 1977; Lent, Brown, & Larkin, 1984, 1986). Studies have indicated that self-efficacy is an important factor in performance in general (Bandura, 1977) and in learning and performing counseling skills specifically (Johnson, Baker, Kopala, Kiselica, & Thompson III, 1989; Larson, Suzuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992; Munson, Stadulis, & Munson, 1986; Munson, Zoerink, & Stadulis, 1986). The relationship between self-efficacy and intentionality in novice counselors has not been examined; however, taken together, the literature on self-efficacy, therapist intentions, and counselor development implies that low self-efficacy may be counterproductive to performing counseling skills, including the ability to formulate intentions for interventions with clients.

Need For the Study

The importance of therapist intentions in psychotherapy and of the effect of self-efficacy on performance both highlight the significance of the development of intentionality and self-efficacy, and the effects of self-efficacy on intentionality, as critical training issues. Insight into the nature and development of novice counselors' intentions could enhance how new therapists are trained. The literature suggests, however, that the explo-
ration of intentions in novice therapists should be expanded to include more rudimentary forms of thought because beginning counselors often do not exhibit awareness and use of formal rationales for their behaviors. In addition, understanding how self-efficacy affects the development of the ability to be aware of and use intentions could further benefit training. With this in mind, this study will examine the nature and development of intentionality by exploring the inner experiences of novice therapists as they implement basic counseling skills. In addition, this paper will examine the level of and change in self-efficacy, and the relationship between inner experiences and self-efficacy in novice counselors enrolled in a one-semester basic counseling skills course.

Organization of the Study

This study is organized under five major headings. Chapter I introduces the research problem, as well as the importance and purpose of the study. A review of the literature and research relevant to the study is presented in Chapter II, including a review of intentions in general, the measurement of intentions, experienced and novice counselor intentions, internal processes related to intentions, developmental characteristics of novice counselors, and self-efficacy as it pertains to novice counselor development. The specific research questions also are presented in Chapter II. The methodology of the study is presented
in Chapter III, including a description of the participants, the treatment, measures, procedures, and an overview of the statistical analyses appropriate to each research question or hypothesis. The analyses performed and the results obtained are presented in Chapter IV. Chapter V provides further discussion of the results and of the implications for training and future research.
CHAPTER II
REVIEW OF THE RELEVANT LITERATURE

The study of psychotherapists' intentions or rationales for their interventions is rooted in the process research literature, the global goals of which have been to determine outcomes or success of psychotherapy and to understand how change occurs. As therapist response modes became a particular focus of process research (Elliott, 1985; Hill, 1978), investigators also became interested in the cognitive processes that were assumed to accompany therapist behaviors (Elliott, 1985; Hill, 1982; Hill, 1990; Hill & O'Grady, 1985; Martin, Martin, Meyer, & Slemon, 1986). Thus, cognitive theory was integrated with process research as investigators began to focus on therapists' covert, within-session activities and how those activities mediate therapists' overt behaviors (Hill & Corbett, 1993).

Of the covert activities studied, therapists' intentions have been identified as a significant variable operating in the therapeutic process of change. Research primarily has focused on the intentions of experienced therapists' (Gelso, Hill, & Kivlighan, 1991; Hill & O'Grady, 1985; Horvath, Marx, & Kamann, 1990). Although interest in the intentions of novice counselors recently
has developed, some research suggests that novice counselors have few intentional thoughts (Borders, Fong-Beyette, & Cron, 1988; Kivlighan, 1989). Novice counselors' difficulty in performing the activities necessary to formulate intentions for interventions with clients may be due to a variety of developmental factors, including low self-efficacy related to the performance of counseling skills. This chapter will review the literature and research relevant to experienced and novice counselor intentions and internal processes, and to self-efficacy as it pertains to the development of intentionality in novice counselors.

**Intentions**

In a review of recent developments in process research, Hill (1992) highlighted the Process Model as a representation of the continual within session interaction between therapist and client overt and covert behaviors. Hill's Process Model consists of a therapist's formulated intention for a desired impact, based on theory, clinical observation, and diagnostic conceptualization, the therapist's corresponding response mode, the client's internal reaction to the intervention, and the client's corresponding response.

Hill and O'Grady (1985) defined intentions as "a therapist's rationale for selecting a specific behavior, response mode, technique, or intervention to use with a
client at any given moment within the session" (p. 3). Intentions are the cognitive counterpart to therapists' within session behaviors; they represent the covert reasons therapists have for a particular overt technique, response, or intervention. Therapist interventions are not simply a series of behaviors; rather, intentions are an integral element of interventions. Implicitly, intentions embody therapists' goals for an intervention (Hill, 1990; Hill & O'Grady, 1985). Spiegel and Hill (1989) advocated for definitions of interventions to include therapists' intent, and not simply judges' ratings of the response or effect. The construct of intentions is critical because it illuminates an essential aspect of therapists' internal processing while with clients. Intentions represent the therapist's awareness of goals, both short and long term, and they provide moment-by-moment direction for the therapy session.

Measurement of Intentions

Measuring intentions is challenging because of their covert nature. Typically, measurement is a two-part process that involves recording intentions and later rating them; however, the methods for accomplishing both tasks vary widely. Most studies have relied on therapists' post-session recollections of intentions from videotaped or audiotaped meetings with clients. For example, Hill and O'Grady (1985) used transcripts of sessions and a checklist
of intentions from which the therapist would mark an unlimited number of relevant intentions that corresponded to each of the subject's speaking turns. A disadvantage of this method is that the intention-recall procedure took place 1-2 months after the actual session. In a second study (Hill & O'Grady, 1985), therapists reviewed an audio-taped session within 24 hours after the actual session and recorded their intentions for each speaking turn, again using an intention checklist. In two separate studies, an analogue and a counseling study, Elliott (1979) used tape-assisted recall to cue clients' perceptions of their helpers' intentions using a free-response method rather than a pre-existing intention list. In a later study (Elliott, 1985), counselors were asked to identify their intentions for particular responses using the list of intentions developed in the 1979 study. The disadvantage of studies using a preexisting checklist is that the range of intentions recorded by therapist-subjects may be limited. The use of a free-response method, however, allows for an unrestricted range of intentions to be recorded.

Hill (1992) identified current difficulties with the measurement of intentions, primarily the absence of reliability indicators for existing measures. Hill argued that test-retest indicators of reliability are merely measures of a therapist's memory of their intentions. In addition, Hill asserts that inter-rater reliability indicators are
problematic because they constitute subjective judges' ratings of originally subjective therapist thoughts and introduce the risk of reinterpreting therapists' recollections. Having therapists rate their own intentions using an existing list, however, presents the same problem in reverse; therapists are subjectively interpreting categories of intentions, perhaps differently than was intended by the measure's developer.

**Experienced Counselor Intentions**

Hill and O'Grady (1985) presented a theoretical model describing the role of intentions in the therapy process. According to this model, therapists take in vast amounts of data -- about the presenting problem, client behaviors, therapist reactions, environment, postulations -- and process the data in "an incredibly quick and sophisticated manner" (p.4). Using the data, knowledge, and training, therapists formulate goals or intentions for what they want to achieve, and these intentions influence their choice of intervention from moment to moment within the session. Following an intervention, the client's response becomes new data with which the therapist again begins the cycle of formulating and acting on intentions. In one study (Hill & O'Grady, 1985), the most frequently used intentions were to promote insight, clarify a statement, identify or intensify feelings, and foster change. Regardless of which intentions are more frequently used, research suggests that
intentions of experienced therapists seem to be as well-formulated, complex, reflexive, and refined as Hill and O'Grady's (1985) model proposes.

Horvath et al. (1990) examined clients' understanding of their therapists' intentions and found that intentions related to client feelings and acceptance of responsibility were most often correctly understood by clients. In a study exploring the relationships among counselor intentions, transference, client insight, and session quality, Gelso et al. (1991) found that clients' negative transference, as rated by counselors, was positively related to counselor intentions having to do with the relationship and interaction between client and therapist and with facilitating client exploration of behaviors and feelings. Negative transference was inversely related to counselor intentions having to do with structuring the session or directing client behavior change. These results provide support for the depiction of experienced therapists as being able to monitor client reactions and adjust their in-session goals, and thus their intentions for their interventions, according to the moment-to-moment status of clients.

Novice Counselor Intentions

The study of the intentions of novice therapists is limited. Of this research, little has been done to describe the content and nature of novice counselors' intentions. Also,
the existing research lacks cohesion and therefore addresses the topic of novice intentions in a somewhat disconnected manner. For example, Kivlighan and Angelone (1991) examined the relationship between novice counselor intention use and helpee introversion. They found that higher helpee social introversion corresponded to more frequent use of the "cognitions" (to identify irrational cognitions) and "challenge" (to shake up, test, or question client patterns) intentions and less frequent use of the "support" (to provide supportive environment), "relationship" (to maintain smooth therapeutic relationship), and "therapist needs" (to defend therapist or alleviate anxiety) intentions.

Kivlighan (1989) compared the change in intentions between graduate students receiving interpersonal-dynamic training and those receiving no training, over one semester, and found that students who received training increased their use of "explore" (cognitions, behaviors, feelings) intentions and decreased their use of "assessment" (get information, focus, clarify) intentions over the semester. Kivlighan suggested that research should focus on detecting changes due to training that may be more subtle than, but related to, the use of intentions.

The purpose of a study by Kelly, Hall, and Miller (1989) was to test the validity of counselor intentions as a construct that positively affects counseling outcome.
They examined the effects of counselor intentions on single-session outcome by comparing the clarity of masters and doctoral level counseling students' intentions with ratings by counselors and clients of session value and power, and with ratings by two judges of counselor performance. Intentions that reflected a distinct knowledge of the objective pursued through the intervention were identified as having high clarity. Results indicated that intention clarity was positively associated with favorable outcome as rated by judges and clients, but no association was found between intention clarity and counselor ratings of outcome. Based on these findings, the authors concluded that "it is clearly desirable for counselors to know what their intentions are in making interventions" (p. 160), thus affirming counselor intention as a construct that positively affects counseling outcome.

Several cautions must be noted in interpreting this study, however. First, intentions were operationalized as clarity of objective rather than type of objective. Second, participants were "relatively inexperienced" (p. 159) masters and doctoral level counseling students with a range of 1-6 and an average of 2 prior practicum experiences. Although in itself the participants' experience level is not problematic, the researchers specifically prompted subjects for their intentions for each intervention via stimulated recall, and research has suggested that inexper-
enced counselors may be pre-intentional. Finally, no information was reported about the intentions that were rated as having low clarity. Quite possibly, the low-clarity intentions may have resembled the less formulated and purposeful inner experiences that can be expected from relatively novice counselors.

Although research has attempted to examine novice counselor intentions in relation to other variables (i.e. helpee introversion, training, and outcome), it has not produced a clear description of novices' covert, cognitive activities while with clients. Instead, the existing research has assumed that novice counselors have intentions without clearly establishing that novice counselor cognitive activities have developed to the same level as that of experienced therapists. In fact, some research has indicated that novice counselors have few intentional thoughts (Borders et al., 1988).

Internal Processes

Although few studies explicitly have examined intentions of novice counselors, many researchers have explored areas related to intentions, including internal dialogue, cognitive processing, and countertransference. These topics are similar to intentions because they represent covert, internal processes rather than externally observable activities.
Counselor Internal Dialogue

Internal dialogue has been explored in the novice therapist literature as a construct that may be closely related to intentionality. Morran, Kurpius, and Brack (1989) explored the content and structure of naturally-occurring counselor self-talk with the goals of further understanding within-session counselor thoughts and defining categories of self-talk content. Using both experienced counselors and trainees, the researchers found that client-focused questions, summarizations, inferences for hypotheses, and self-instructions were the four most frequent thought categories. In addition, Morran et al. (1989) presented a two-dimensional scaling solution based on their data. The first dimension consists of attending (self-monitoring and behavior observations) and assessing (i.e. self-doubt, positive and corrective self-feedback, relationship assessment) behaviors at one pole and information-seeking (i.e. client-focused questions) at the other pole. The second dimension consists of integrative understanding (i.e. inferences, hypotheses, summarizations, associations) at one extreme and intervention planning (i.e. self-instruction) at the other end. Unfortunately, the researchers did not examine possible differences in thoughts between experienced and novice counselors.

Kurpius et al. (1985) compared the internal dialogue and hypothesis formulations of students in four training
conditions: 1) cognitive self-instruction, 2) clinical hypothesis knowledge, 3) a combination of cognitive self-instruction and clinical hypothesis knowledge, and 4) no training. Internal dialogue was measured using scores on a thought-listing procedure in which subjects received points for thoughts reflecting clinical hypothesis knowledge and self-instruction strategies. Results showed that students in cognitive self-instruction and combined training conditions performed better on both the thought-listing and hypothesis formulation measures than did students in the clinical hypothesis knowledge and no training conditions. Based on these results, the researchers suggested that learning how to collect client information is more important than learning what client information to collect, and that the latter occurs as students learn how to collect information. With regard to intentions, this study also may suggest that teaching novice counselors how to think is more critical than teaching them concrete response modes and, further, that learning response modes may occur as students learn to process information and formulate intentions.

Morran (1986) examined the association between three specific types of internal dialogue -- task facilitative, task distractive, and clinical hypothesis formulation -- and counselor performance, as measured by client ratings of satisfaction and judges' ratings of the counselors' clini-
cal hypotheses and session quality. Facilitative self-talk was operationalized as the frequency of thoughts focused on understanding and guiding client behavior and task distractive self-talk was measured as the frequency of thoughts focused on the counselor's own feelings of anxiety and inadequacy. Of the 40 subjects, 14 were graduate students in a counseling laboratory course, 13 were graduate students with at least one practica experience, and 13 were professional counselors in community agencies. With the effects of level of experience and education removed, results of multiple regression techniques showed that only quality of hypothesis formulation was predictive of performance. Morran (1986) noted that the formulation of clinical hypotheses involves many cognitive processes. Given the absence of a relationship between the frequency of facilitative and distractive self-talk and counselor performance, the author also suggested that the quality rather than the quantity of counselors' internal dialogue may be a better predictor of performance and a more useful variable to study. One implication of this result is that inner experiences of therapists are difficult to tap and to measure, particularly the smaller units of thought that lead to more global conceptualizations. By removing the variable of experience level that may mediate between internal dialogue and performance, however, this study may have forfeited valuable information about the differences
between novice and experienced counselors' self-talk and thus information about how more global conceptualizations are formulated.

Cognitions and Cognitive Processes

Martin (1984) advised that direct examination of the cognitive processes occurring during counseling must have its place in the study of counseling outcomes. Martin proposed a model that represented the interactions between therapist and client, including cognitive and behavioral components. His "cognitive mediational paradigm" was based on the premise that both client and counselor are cognitively active and that this activity mediates between behavioral interactions and outcome or client change.

Defining cognitive processes. Cognitive processing refers to cognitive activities on a variety of levels. Hillerbrand (1989) stressed the importance of student-counselor acquisition of metacognitive skills, or knowledge about cognitive processes. He highlighted Anderson's (1982) differentiation between declarative and procedural knowledge.

Anderson (1982) outlined two stages of cognitive skill development: declarative and procedural. The declarative stage is marked by the reception and encoding of instruction and information about a particular skill, which then can be interpreted behaviorally. In the procedural stage, knowledge about the skill is transformed into knowledge
about how to apply the skill without intervening interpretive or rehearsal activities. In essence, a skill becomes less deliberately and more automatically applied.

Hillerbrand (1989) emphasized the importance of applying theories of metacognition to training and of the acquisition of procedural skills, particularly within a group supervision modality. Self-monitoring of cognitive processes is one area in which Hillerbrand suggested that change should occur over the course of training in counseling.

Hiebert's (1987) differentiation between cognitive process and cognitive structure nicely encompasses what is typically referred to by researchers as cognitive processing. Hiebert (p. 3) defined cognitive process as a person's "moment-by-moment thinking" that occurs throughout the day, and cognitive structure as the framework or schema people use to organize and understand those thoughts.

Metacognitive skills. Much of the research on novice counselor internal processes has focused on what Hiebert (1987) referred to as cognitive structure. Martin et al. (1986) conducted a study to collect data regarding all the cognitive and behavioral client and counselor components of the cognitive mediational paradigm. Results indicated that the most frequent therapist intentions were directed towards helping clients make cognitive connections and to monitor their thoughts and feelings. Interestingly, the
three novice counselors rated themselves as working harder than did the four experienced counselors. The authors attributed this result to the more automatic processing capabilities of experienced therapists. This interpretation seemed to be corroborated by results from a later study (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989) in which experienced counselors appeared to draw on their more extensive knowledge and schemata in conceptualizing clients, whereas novices seemed to require more client-specific concepts in addition to their general knowledge of the counseling process. A 1987 study (Martin, Martin, & Slemon) supported results of the 1986 study (Martin et al.), both of which suggested that the cognitive processes represented in the cognitive mediational paradigm seem related to counselor and client perceptions of counseling, "but in a rather unobvious" (p. 259) or unpredictable manner.

Cummings, Hallberg, Martin, Slemon, and Hiebert (1990) explored the differences in conceptualizations between novice and expert counselors and found that the experts more consistently used general schemata, used more social-interpersonal-interactional concepts, and initially used more family background and current relationship concepts in viewing clients than did novice counselors. This study seems to support Hill and O'Grady's (1985) model of intention use which portrays experienced therapists as having
the ability to process and synthesize large amounts of complex data, including current information about the client and pre-existing schemata, and to use it to formulate goals based on perceptions of clients.

In a study exploring the association of experience to client conceptualization, a type of cognitive activity that influences the counseling process, Hirsch and Stone (1983) found that students with more experience appeared to form earlier conceptualizations of clients and asked questions more related to those conceptualizations as compared to students with less experience. In exploring the connection between problem structure -- the degree to which information is clear and recognizable -- and cognitive processing that leads to diagnosis, Hillerbrand and Claiborn (1990) found that diagnostic reasoning was affected by problem structure for both novice and expert counselors. Although novices and experts did not differ in their diagnostic reasoning, expert therapists rated themselves as more knowledgeable and confident in their reasoning skills, and more clearly conceptualized cases than did novice counselors.

In a study of conceptual level and hypothesis formulation, Holloway and Wolleat (1980) found that, while conceptual level was associated with quality and clarity of hypothesis formulation, conceptual level was not related to amount of clinical experience. This result may suggest
that quality rather than quantity of training is most important in the development of novices' cognitive abilities.

Claiborn and Dixon (1982) compared the effects on trainees' conceptual skills of two types of supervision: instruction and feedback. Students who received written feedback on their performance on an initial 15 minute role play exhibited more specific goal formulation and more generalization of their skills across contexts (different client problems) than did students who received written instruction. Also, those who received feedback rated their supervision as more effective than did those who received instruction. These results suggest that training in conceptualizing and other cognitive processes may be more effective when in the form of personalized and evaluative feedback that is relevant to a trainee's experience rather than in the form of impersonal, nonevaluative instruction on behavioral goals. Mallinckrodt and Nelson (1991) examined the relationship between counselor training level -- novice, advanced training, and experienced -- and the components of developing a working alliance. Results showed the greatest differences between training levels in the ability to develop overall treatment goals, a component the authors suggested may require more sophisticated cognitive capabilities typical of experienced therapists.

In a study that examined the relationship between
conceptual level and counselor trainee behavior Goldberg (1974) found that trainees with conceptual styles characterized as concrete, externally oriented, and either authority-dependent or oppositional exhibited more directive verbal behavior, were more controlling, and asked more fact-seeking questions. Trainees who possessed conceptual styles that were more abstract, cognitively complex and flexible, more accepting, and more mutual as opposed to authoritative were more open to accepting and supporting client perspectives, were less controlling, responded more to client affect, and asked more open-ended questions that facilitated client exploration of feelings. Based on these results, Goldberg (1974) posed several considerations relevant to training, including the possibility of teaching trainees to think and conceptualize differently, and the prospect of focusing training on the development of cognitive processing rather than on the development of specific behavioral skills.

Content of cognitions. Some of the research on cognitive activities has focused on the content of therapists' thoughts, or what Hiebert (1987) referred to as "cognitive process" (p.3). Dole and Others (1981) developed a coding system and manual for describing the retrospective inner thoughts and experiences of therapists during counseling. The coding system allows therapists' retrospections to be classified along the following six dimensions: time (past,
present, or future), place (in-session or out-of-session), focus (client, counselor, relationship, or supervisor), locus (external/observable behavior or internal/covert), professional or personal orientation, and mode (neutral, planning, positive, or negative). Using this coding system, Borders (1989) examined the range of in-session cognitions across various ego levels of first-year practicum students. Results indicated that cognitions did not differ across ego levels. Interestingly, however, students with higher ego levels had fewer negative thoughts about themselves and their clients than did students at lower ego levels.

Borders, Fong, and Neimeyer (1986) investigated the effects of level of ego development and level of experience on the structural complexity and content of counseling students' perceptions of clients. No significant relationships were found between ego level or level of experience and the degree to which perceptions were differentiated and integrated. A trend was noted, however, in the relationship between ego level and content of students' perceptions of clients, such that students at higher ego levels tended to be more aware of the interactive process of therapy than students at lower ego levels. This trend suggests that research should focus on describing and quantifying the content of novices' thoughts rather than on more metacognitive features of thought, such as structure and com-
plexity.

Regan and Hill (1992) examined the content of unspoken thoughts of doctoral level counseling students, with 1-13 years of experience, in conducting brief therapy and found that the thoughts were more often negative than positive and more often related to emotion and clinical hypothesizing than to behaviors or cognitions. Conclusions about the content of the students' thoughts are hindered, however, by the wide range of experience; students with 10-13 years of experience may be no longer classified as "novice."

The purpose of another related case study (Borders et al., 1988) was to examine the range of counseling students' in-session cognitions using an unstructured, open-ended, and unsimulated method. Results indicated that much of the student's cognitions were characterized by self-doubt, self-scrutiny, and minimal awareness of the interaction between client and therapist. Based on their results, the researchers concluded that intentionality and self-instruction are not instinctive processing practices for beginning counseling students and further suggested that novice therapists may have few intentional thoughts.

Countertransference

Countertransference, the therapist's own affective reactions activated by the client or the therapy, also has been studied as a component of therapists' internal pro-
cesses. Normandin and Bouchard (1993) asserted that, although the cognitive component of therapists' inner experiences has been studied relatively recently, the study of the affective component of therapists' inner experiences has been sparse, if not absent. Normandin and Bouchard (1993) described three types of countertransference that serve three primary functions: 1) a rational or objective, observing function, 2) a reactive function as a defense against anxiety, and 3) a reflective and interpretive function. The development of their Countertransference Rating System (CRS) was based on these distinctions between types of countertransference, with the implication that the reactive category represents the most primitive type of countertransference and the reflective category the most advanced and sophisticated. Reflective countertransference encompasses peripheral and stable awareness of the inner experience, elaboration and understanding of the thought or feeling, and formulation of an intervention with an intention to take action; movement through all four stages represents a complete cycle.

Normandin and Bouchard (1993) tested the use of their rating system by examining the effects of theoretical orientation and experience on type of countertransference. With regard to experience level, the authors hypothesized that expert therapists, those with 10 or more years of experience, and novice therapists, those with one year of
experience, would differ in the proportion of the three types of countertransference. Specifically, they expected experts to be more reflective and less reactive. Overall, 12% of all therapists' countertransference was of the objective-observational type, 19% was reactive, and 69% was reflective. Contrary to expectations, however, novice therapists were significantly more reflective and less reactive than expert therapists, with less that 12% of all the experts and 24% of the novices completing a reflective cycle of awareness, reflection, elaboration, and intention formulation. The authors speculated that novices are specifically taught to maintain an open attitude about clients and that the experts may have had more courage to risk acknowledging periodic lapses in objectivity.

Robbins and Jolkovski (1987) examined the utility of a model that contends that countertransference feelings must be managed so that they do not produce non-therapeutic counselor behaviors and interfere with the counseling process. Using doctoral students of various levels, the researchers found support for their hypothesis that counselors with higher awareness of countertransference feelings exhibit less acting-out behavior, as defined by higher engagement, particularly when they have a theoretical framework in place for processing these feelings, as compared to counselors with low awareness of countertransference feelings. Although the authors cited several
methodological weaknesses of their study, they contend the results support their model of awareness and management of countertransference feelings.

Based on the premise that awareness of countertransference feelings has a positive effect on the therapeutic process, Peabody and Gelso (1982) explored the relationships among self-reported countertransference feelings, empathic ability, and countertransference behavior, defined as withdrawal of personal involvement, of 22 male doctoral counseling students. Results indicated that students who rated themselves as more open to countertransference feelings were rated as having more empathic ability than students who reported being less open to countertransference feelings. The authors suggested that the interaction of the awareness of internal processes and empathic ability may mediate how countertransference feelings and behaviors are managed. The results of these studies suggest that awareness and cognitive processing of a counselor's internal responses are highly important to the counseling process.

Significance of Internal Processes

Therapists' awareness of their inner experiences is essential for guiding their own behavior, understanding the client, and maximizing the benefits of therapy, in general. Bandura (1956) asserted the importance of therapist awareness of internal processes, specifically those related to
anxiety. Such insight would enable a therapist to consciously monitor behavior that might be influenced by the anxiety or other internal states and, therefore, enhance a session's therapeutic benefit to the client. In an article on the function of supervision, Mollon (1989) highlighted the importance of a counselor's ability to be receptive to and reflective on the process of therapy and to utilize internal reactions to better understand the self, the client, and the therapeutic process. Attention to and understanding of their own inner experiences helps therapists prevent misuses of countertransference (Gelso & Carter, 1985).

In a review (Baker, Daniels, & Greeley, 1990) of three major counselor training programs, Interpersonal Process Recall (IPR) was identified as unique because of its emphasis on counselor awareness of inner experiences. Developed by Kagan, the focus of IPR is to teach students of counseling to become aware of and attend to their internal processes, including thoughts, feelings, goals, impressions, and bodily sensations, and to use this insight to facilitate client and counselor development. Reviewing video- and audiotapes of counselor-client interactions and recalling inner experiences represents a primary component of IPR. Based on the premise that the anxiety experienced by novice counselors interfered with their ability to attend to and utilize inner experiences, IPR attempts to
reduce anxiety by facilitating stimulation and discussion of counselor affect, particularly anxiety.

Clearly, internal processes impact therapy, and awareness of these processes helps ensure that therapist behaviors are beneficial rather than detrimental to therapy. Research on the internal processes of novice counselors indicates that they differ from experts in some important ways. First, research on novice counselor metacognitive skills suggests that they tend to lack metacognitive or structural skills necessary to process information in a reflexive, integrative, holistic, complex, abstract, and goal-oriented manner. With regard to cognitive content, research indicates that novice counselors are less aware of their actions and thoughts, are more negative and self-denigrating, and have limited awareness of the interactive process. In sum, novice counselors appear to possess limited internal processing skills essential to formulating intentions for their interventions.

Developmental Characteristics of Novices

The literature on models of therapist development typically portrays beginning therapists as anxious, unre-laxed, self-conscious, insecure, and lacking confidence (Flapan, 1984; Friedlander et al., 1984; Ralph, 1980; Stoltenberg, 1981; Watkins, 1990). In addition, they often are intent on performing specific behavioral skills (Grater, 1985; Sansbury, 1982). These portrayals are
corroborated by research which suggests that novice counselors are less able to integrate and utilize immediate and pre-existing information than experienced therapists (Cummings et al., 1990; Martin et al., 1986; Martin et al., 1989). In addition, research suggests that students' cognitions often are plagued by self-doubt, self-scrutiny, and minimal awareness of the interaction between client and therapist, and that intentionality and self-instruction are not intuitive processing practices for beginning counseling students (Borders et al., 1988).

Tracey, Hays, Malone, and Herman (1988) examined differences in counselor response types across three levels of experience and found that novices were less immediate than advanced counseling students and experienced therapists. Also, novice and advanced counseling students were less flexible in their choice of responses, an index the authors attributed to the greater ability of experienced counselors to spontaneously strategize to meet the here-and-now demands of the interaction.

Finally, Hale and Stoltenberg (1988) found that self-focus and anxiety were positively correlated in novice counselors being taped and evaluated. Although the correlation does not allow for the conclusion that increased self-focus leads to increased anxiety or vice versa, the authors presented the possibility that self-focus and anxiety may be reciprocally related such that increased
self-focus may precipitate anxiety, which in turn may trigger additional self-focus.

Based on the portrayal of novice therapists in the developmental literature, increased self-focus might be expected to take the form of negative self-evaluations, and doubts about skills and the ability to perform counseling functions. In fact, much of the research on novice counselors has linked anxiety to various internal processes, including self-assessments. Using physiological and self-report measures of anxiety, Bowman, Roberts, and Giesen (1978) and Bowman and Roberts (1979) established the existence of anxiety in masters level counseling students conducting a 10 minute role play with a confederate client. More importantly, results of the study also indicated that subjects’ anticipation or expectations of the counseling interview increased their anxiety. Dodge (1982) referred to supervisee anxiety as the result of a desire to be competent and to receive approval from others, which suggests that self-worth as a counselor is contingent upon external sources.

In a study to explore the clinical implications of problem-solving self-perceptions, Heppner, Reeder, and Larson (1983) compared self-perceived effective and ineffective problem solvers on a variety of content and process-oriented cognitive variables. Results indicated that subjects with self-perceived problem solving effect-
iveness had more positive self-concepts, were more consistent in and certain of their self-perceptions, were less self-critical, and were more likely to engage in and enjoy cognitive activity than were those with self-perceived problem-solving ineffectiveness. Aside from the clinical implications for problem-solving reported in the study, the results suggest that counseling trainees who perceive themselves as less effective problem-solvers or helpers, and thus are more self-critical and have more consistently negative self-perceptions, actually may inhibit their ability to be effective helpers. Hazler and Hipple (1981) found that beginning masters level counseling students who received two hours of training in counseling imagery, or mental practice, had higher self-confidence and were better able to be self-observational than their peers who received no training in mental practice.

Other research has linked anxiety to the performance of cognitive processes. For example, Kelly et al. (1989) found that self-reported counselor anxiety was associated with unfavorable ratings of sessions by counselors and with lower clarity of intentions. The researchers suggested that in-session anxiety may inhibit counselors' ability to perform certain cognitive functions. Yulis and Kiesler (1968) studied the effects of anxiety on countertransference, as measured by personal involvement. They found that counseling students with low anxiety exhibited more
personal involvement, evidenced in their choice of responses to taped clients, than did students with higher anxiety.

The premise of a study conducted by Bandura (1956) was the importance of insight into therapist anxiety. Bandura asserted that, if unattended, anxiety may be manifested by questions, premature interpretations, value judgments, or overuse of reassurance, all of which could inhibit the therapist's ability to respond therapeutically to a client. Bandura studied the relationship between anxiety, competence, and insight in professional psychotherapists and found that therapists with higher anxiety levels were rated as less competent than therapists with lower levels of anxiety. No relationship was found, however, between insight and competence. Although no causal relationship can be determined between anxiety and competence, the coexistence of the two variables seem inherent in the construct of self-efficacy.

In addition to lacking some of the cognitive skills related to awareness and formulation of intentions, research and literature strongly suggests that novice counselors' inner experiences are characterized by anxiety and self-deprecating thoughts. The content of their thoughts seems to be that of a negative self-assessment, such as low self-confidence, low self-worth, and negative expectations and self-perceptions. In essence, these characteristics
may be reflective of low self-efficacy in novice counselors.

Self-Efficacy

Self-efficacy refers to the belief that one can successfully perform a given behavior (Bandura, 1977). Bandura (1977) distinguished between outcome expectancy, the belief that a certain behavior will lead to a particular outcome, and efficacy expectation, the belief in one's ability to successfully perform a given behavior necessary to reach an outcome. Bandura (1977, 1982) identified four sources of information people use to estimate their self-efficacy: 1) previous experience of performance mastery and accomplishment, 2) vicarious experience through modeling and observation of others successfully performing the desired behavior, 3) persuasion and encouragement from others, and 4) emotional arousal such as stress or fear. Experience of moderate arousal is likely to have a beneficial effect on performance, whereas emotional arousal experienced as intensely negative is likely to inhibit performance. In addition, negative self-evaluation can be a source of motivation to decrease the discrepancy between performance and the desired standard by modulating behavior. Self-efficacy expectations are posited as powerful determinants of behavior and behavior change (Bandura, 1977). For example, research findings indicated that high self-efficacy was related to higher academic performance.
(Lent et al., 1984, 1986). Once enhanced, self-efficacy tends to generalize to other areas of performance (Bandura, 1977, 1982).

Moe and Zeiss (1982) explored the extension of Bandura’s concept of self-efficacy by developing a measure to assess self-efficacy expectations for social skills. Results supported the preliminary utility of extending the concept of self-efficacy into the realm of social skills, and for identifying and intervening in areas of low self-efficacy. The study has implications for targeting counselor training towards identified areas of low self-efficacy in interacting with clients.

Self-efficacy beliefs and their effects on performance also have been examined with regard to counselor development. Munson et al. (1986) compared two types of training, microskills and mental practice, on the development of self-efficacy and competence in attending and responding skills in therapeutic recreators. They found that students in both training groups demonstrated significant increases in self-efficacy due to training as compared to the wait-control group; students in the two training groups perceived themselves as capable of performing more skills and as having greater competence than students in the control group. In a similar study (Munson et al., 1986) examining self-efficacy specific to decision-making counseling skills in recreation therapists, students in microskills and
mental practice training groups again perceived themselves as more competent and as capable of performing more skills at posttest than did the control group. Although no differences in self-efficacy were found between the two training groups, results from both studies suggest that training in general will improve counselor self-efficacy.

Similarly, Rudolf, Manning, and Sewell (1983) examined the effects of clinical experience on students self-efficacy in working with stutterers and found that students who received clinical training experienced a significant increase in self-efficacy, whereas students who received no training or client contact showed no significant increase in self-efficacy over a one semester period. Also, students who received clinical training had higher pre-training self-efficacy than students who received no training, a difference that was presumed by the authors to be due to the former group's higher program status and previous didactic instruction. Interestingly, students' self-efficacy was negatively correlated to supervisors' ratings of clinical ability; thus, as students' beliefs in their ability to perform clinical skills increased, their supervisors' perceptions of their clinical abilities decreased.

Sipps, Sugden, and Faiver (1988) examined the relationship between counseling students' year in training and their perceived ability in competent verbal responding. Regardless of year in training, a relationship was found
between response type and self-efficacy expectations such that students had lower self-efficacy for responses with a higher difficulty level (as hierarchically arranged by Hill, Charles, and Reed, 1981). As would be expected, results showed that students in their third and fourth year of training had higher perceptions of competence in responding than students in their first and second year. Interestingly, however, first year students also had higher verbal responding self-efficacy than second year students; thus, second year students had the lowest self-efficacy regarding their competence for verbal responding, perhaps indicating that first year students don’t yet know what they don’t know. This study is limited by the degree of simulation involved; students viewed a videotape and were asked to pretend they were a counselor and to choose responses from a restricted list of categorized responses.

Friedlander, Keller, Peca-Baker, and Olk (1986) found that trainee self-efficacy was not affected by role conflict, defined as the presence of a discrepancy between a counselor’s intended action and a supervisor’s recommended action. Further, results showed inverse relationships between performance, anxiety, and self-efficacy; increased performance was related to increased self-efficacy and decreased anxiety, whereas decreased performance was related to decreased self-efficacy and increased anxiety.

Johnson et al. (1989) explored the relationship be-
etween counseling efficacy and performance in a natural training environment over an eight week period. Fifty master's level students enrolled in a counseling skills course were divided into low and high efficacy groups based on their scores on a self-efficacy scale specific to counseling skills. Aside from demonstrating large individual differences in initial levels of self-efficacy, results also indicated that differences in self-efficacy between the low and high groups persisted from pre-training to posttraining. Based on this persistence of self-efficacy, the authors suggested that self-efficacy may be a more stable trait that is less malleable to standard skills training and may require more robust or repeated challenge to self-perceptions. After the first four weeks of training, however, the low self-efficacy group continued to show gains in self-efficacy whereas the high group had not; this suggests that the low group eventually may have equalled the high group in self-efficacy had the study been extended beyond eight weeks.

Finally, Larson et al. (1992) conducted a series of studies aimed at developing a reliable and valid measure of counseling trainees' judgments of and expectations for successful counseling. The resulting measure, the Counseling Self-Estimate Inventory (COSE), is comprised of five dimensions: 1) microskills execution; 2) attention to process; 3) dealing with difficult client behaviors; 4)
behaving in a culturally competent way; and 5) being aware of one’s values. Internal consistency and test-retest reliability, as well as convergent, discriminant, and criterion validity were established. In addition, the researchers found that perceptions of counseling self-efficacy "increased dramatically from the beginning to the end of a semester" (p. 118) for 9 out of 10 practicum students; however, conclusions from this result are limited by the small sample size. An advantage of the COSE over other counseling self-efficacy measures is its established reliability and validity and identification of an underlying factor structure (Larson et al., 1992). Further, the inventory seems to capture dimensions that go beyond basic counseling microskills and that reflect critical abilities relevant to providing more comprehensively effective therapy, such as the attention to process and awareness of one’s own world view and cultural issues. In fact, these more advanced skills may be components of or related to a therapist’s ability to execute cognitive skills essential to providing effective therapy, such as internal awareness and the formulation and use of intentions.

In general, research indicates that counselors with less experience tend to perceive themselves as less able to successfully perform various counseling skills than counselors with more experience. In addition, low self-efficacy beliefs may inhibit their ability to perform those
skills. Skill training, however, appears to be an effective means of increasing counselor self-efficacy.

Overview and Research Questions of the Study

Although literature suggests that intentions are a critical and influential component in the therapeutic process, research seems to indicate that novice counselors have few intentional thoughts. Instead, their "intentions" are more akin to unformulated and haphazard inner experiences and less like the purposeful rationales of experienced therapists. Further, their cognitions are dominated by the self-scrutiny and self-doubt that may be reflective of low self-efficacy. Together, the research and literature on novice counselors' internal processes and self-efficacy has implications for a possible relationship between counseling self-efficacy and inner experiences. Writing on the cognitive significance and influence of self-efficacy, Bandura (1982) asserted that knowledge alone is not sufficient to successfully perform a skill. Instead, the process of knowledge put into action is mediated by self-focused thoughts. The implications of these observations are that training for novice therapists may need to focus as much on teaching students how to think, both about their clients and about themselves, as on how to behave. In addition, training may need to focus on increasing novice counselors' sense of self-efficacy specific to counseling skills, with the goal of improving their
ability to perform both cognitive skills and basic, overt microskills. Such changes or emphases in training, however, should be grounded in solid models of the development of counselor inner experiences, including intentionality and self-efficacy. The first step in creating a developmental model is an adequate, qualitatively specific description of the content and quality of novice counselors' inner experiences.

The main purpose of this study is to explore the nature of novice counselor inner experiences using master's level students enrolled in a one-semester counseling skills course. Specifically, the nature or quality of students' inner experiences are expected to change over the 12-week period. For example, the inner experiences may become less self-focused, more client focused, more self-directive, less self-critical, less reflective of anxiety and self-doubt, and more reflective of hypothesis formulation about the client at the end of the semester as compared to the beginning of the semester.

A secondary purpose of the study is to examine the change in novice therapists' counseling self-efficacy over the semester using the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). The level of students' self-efficacy at the end of the 12-week period is expected to be higher than their self-efficacy at the beginning of the semester, particularly in the microskills dimension. Fur-
ther, this study will explore the relationship between inner experiences and self-efficacy. Specifically, changes in self-efficacy are expected to be related to changes in the quality of students' inner experiences. For example, increases in self-efficacy may be related to increases in cognitions that are client-focused, self-directive, and more reflective of hypothesis formulation about the client, and to decreases in cognitions that are self-focused, self-critical, and reflective of anxiety and self-doubt.

In addition, this study will investigate the relationship between self-efficacy and performance of counseling skills, as measured by peer and instructor ratings, as well as the relationship between inner experiences and performance. Ratings of skills are expected to increase over the semester and these increases are hypothesized to correspond both to increases in self-efficacy and to changes in the quality of students' inner experiences.

The research hypotheses being explored in this study are as follows:

1. A change in the quality of inner experiences will be found between the beginning and end of the semester.

2. A change in self-efficacy will be found between the beginning and end of the semester.

3. A relationship will be found between changes in quality of inner experiences and changes in level
of self-efficacy.

4. A relationship will be found between change in self-efficacy and change in skill ratings.

5. A relationship will be found between change in the quality of inner experiences and change in skill ratings.
CHAPTER III

METHOD

Participants

The data for this study was generated as a part of the routine instructional design of a pre-practicum counseling skills course. Thirty-one master's level students enrolled in four sections of this course agreed to participate in the study by giving written consent to have information generated through the course used as data for this study (see Appendix A for consent form). Prior to requesting consent, students were told that the purpose of the study was to investigate novice counselor development and that participation was voluntary. In addition, students were provided with a detailed description of the particular course requirement that generated the majority of the information used as data for this research (see Appendix B). Students choosing not to participate in the study were expected to fulfill the requirements of the course; however, their data did not become part of the study. Only one student did not consent to participate.

At the end of the data collection phase, complete data was available for 24 of the 31 students who consented to participate; these 24 students, therefore, were included as
participants in the research. All data was confidential and students identified themselves by the last four digits of their social security number rather than their name in completing all forms.

Participants completed a demographic form during the first class meeting (see Appendix C). Demographic information was available for 23 of the 24 participants and is presented in Table 1. Twenty of the participants were female and three were male. Participants ranged in age from 21 to 35; the average age was 25.3. Eighteen participants identified themselves as Caucasian and five did not indicate their race. Nineteen of the participants were first year students enrolled in a two-year community counseling, school counseling, or closely related program. Although only one participant had previous experience in formal counseling, 16 participants indicated having had previous informal counseling experience, including camp counselor, resident assistant in a dormitory, group facilitator, or psychology technician. Five participants indicated having had no previous counseling experience. Four participants indicated having had previous coursework or training in basic counseling skills prior to taking the skills course in which they were currently enrolled.

Instruments

The Counseling Self-Estimate Inventory (COSE)

The COSE (Larson et al., 1992) was administered to
**TABLE 1**

**Demographic Information For Participants**

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**Note:** Numbers represent frequencies unless specified otherwise (n = 24).
participants in the first and last classes of the semester (see Appendix D). The instrument was designed to measure counselor trainees’ perceptions of and expectancies for successfully performing counseling activities during a counseling session. The COSE consists of 37 items subsumed under five dimensions: 1) microskills execution, which represents basic microcounseling skills typically taught in prepracticum courses; 2) attention to process, which seems to represent the synthesis of basic counseling skills; 3) dealing with difficult client behaviors, for example, lack of motivation, suicidality, silence, and alcoholism; 4) behaving in a culturally competent way, which represents items related to working with clients of different cultural, ethnic, or social groups; and 5) being aware of how one responds to clients, which represents items regarding counselors’ manner, biases, values, and personal life, and which will be referred to throughout this study as "self-management." Overall, the COSE was reported by Larson et al. (1992) as being internally consistent (coefficient $a = .93$). Internal consistency coefficients for each of the five dimensions were reported as follows: microcounseling skills (.88), process (.87), difficult client behaviors (.80), cultural competence (.78), and self-management (.62). Test-retest reliability over a 3-week period, using a 30-item short form of the COSE, was reported as $r = .87$ for the total inventory, $r = .68$ for microskills, $r = .74$ for
process, \( r = .80 \) for difficult client behaviors, \( r = .71 \) for cultural competence, and \( r = .83 \) for self-management.

**Skill Ratings**

A skill rating form was developed as a measure of counseling skill performance. Items for the measure were culled from various sources and chosen for their relevance to the skills and concepts typically taught in this and most prepracticum microcounseling courses. Four of the nine items -- Here and Now, Topic Centrality, Voice Quality, and Impact -- were taken from the Revised Response Empathy Scale (Elliott, Filipovich, Harrigan, Gaynor, Reimschuessel, & Zapadka, 1982). Four additional items were developed to represent what many sources (Carkhuff, 1987; Hackney & Cormier, 1988; Ivey & Authier, 1978) consider to be critical and basic counseling skills: Nonverbal Attending (i.e. eye contact, body movements, and posture), Rapport, Empathic Understanding, and Genuineness. A final item, "Helpfulness," was added as a general indicator of how helpful the therapist was to the client. All nine items were placed on a 7-point Likert scale as follows: 1=never, 2=infrequently, 3=sometimes, 4=equally present and absent, 5=often, 6=very often, and 7=always. Four versions of the rating scale, containing identical items, were developed to be completed by the client, the therapist, the instructor, and the observers or peers (see Appendix E).
The Novice Therapist Pre-Intentional Coding Scale

The Novice Therapist Pre-Intentional Coding Scale was developed specifically for this study to reflect the variety of inner experiences of novice counselors. Initial development of the coding scale was data-driven, using transcripts and recorded inner experiences from an earlier pilot study conducted by this author. The initial version of the scale was amended during training of coders for the present study, utilizing transcripts from participants' second and third videotaped role plays. Changes in the initial scale were made to incorporate increased representation of the idiosyncrasies of novice counselors' inner experiences. Changes included the addition of codes and refinement in definitions of existing codes. One of the changes, the division of a self-evaluation category, was guided by the corrective self-feedback classification identified by Morran, et al. (1989).

The final version of The Novice Therapist Pre-Intentional Coding Scale includes the following 20 coding categories, subsumed under ten major content headings: 1) Therapist Self-Awareness (of emotion, behavior, or cognition); 2) Therapist Self-Direction (emotional, behavioral, or cognitive); 3) Therapist Self-Evaluation (criticism, praise, or corrective self-feedback); 4) Therapist Awareness of Client (emotion, behavior, cognition, or situational-interpersonal status); 5) Hypothesizing-
Formulating; 6) Client Evaluation; 7) Awareness of the Setting/Situation; 8) Awareness of the Relationship-Process; 9) Tangential Focus (pertaining to client or to therapist); and 10) Uncodable. A manual for the use of the coding scale, including a detailed description of the category definitions and an extensive list of prototypical examples of each of the 20 categories, is shown in Appendix F.

The Treatment

The counseling skills course in which the participants were enrolled as students served as the treatment for this research. Each of the four sections of the course was taught by a different instructor. The four instructors, however, were supervised by one person, the Director of Clinical Training, and the design, content, and schedule was identical for all four sections of the course. A detailed syllabus of the course is shown in Appendix G.

The course was designed to provide entry level counseling students an overview of the counseling process and an understanding of the basic skills needed by a person in a helping role. The course objectives included the development of: 1) an understanding of the counseling process; 2) specific skills, such as attending, and facilitative and empathic responding; 3) the ability to formulate and appropriately test hypotheses about a given case; 4) greater self-awareness and sensitivity to others; and 5) a sense of
personal adequacy in human interactions.

The format of the course was a combination of lecture and classroom practice activities, with an emphasis on the latter. Students also received practice assignments outside of class. Readings were assigned from two textbooks: Counseling Strategies and Interventions by Hackney and Cormier (1988) and Improving Therapeutic Communication by Hammond, Hepworth, and Smith (1977). Specific topics addressed in the course included an overview of the counseling process, attending and listening, responding empathically, advanced accurate empathy, probes, structuring and problem clarification, focusing, immediacy, confrontation, and termination.

To meet course requirements, students were expected to conduct four in-class videotaped role plays. Following a taping day, students were required to transcribe verbatim their role play as a therapist and to record their internal processes during the role play. Transcriptions were due three days following the taping day. The information generated through this particular course requirement provided the bulk of the data for the present study; therefore, the videotaping and transcribing procedures are described in greater detail in the "Procedures" section of this chapter.

In addition, students were expected to maintain a weekly journal chronicling their personal growth and devel-
opment throughout the semester. Students were responsible for weekly assigned readings, regular class attendance, and appropriate ethical behavior. Students were expected to write one ten page paper from the perspective of a member of a client population of their own choosing (i.e. as if they were a person with alcoholism or depression). Finally, outside of class, students were required to audiotape two 10 minute counseling sessions and three 30 minute counseling sessions, the latter conducted with the same client. Students were told they could ask friends or family to role play a client. The audiotapes were submitted to the instructor for review and feedback.

Procedures

Videotaping Role Plays

As part of the routine instructional design of the counseling skills course, students videotaped and transcribed four in-class role plays which took place on the third, sixth, ninth, and twelfth weeks of the semester. Video equipment was provided and taping was done sequentially, without rewinding the tape, so that a record was kept of each students' four taping sessions.

On taping days, each student secured a partner and was expected to role play both a "client" and a "therapist." Each role play was approximately 5-8 minutes in length. Immediately following each role play, the "client," "therapist," instructor, and observers (class members not in-
involved in the role play) completed their respective skill rating forms and returned them to the instructor. Ratings were available for ratees to view during the next class meeting. Videotaped role plays were not discussed at this time, but were reviewed as a class the following week as part of the course design. A detailed description of the videotaping procedure was provided to students and is shown in Appendix B.

**Transcribing Videotaped Role Plays**

As part of the course requirements, students transcribed their own role play as therapist on transcription sheets provided (see Appendix H). On the left side of the sheet, under "Record Dialogue," students transcribed verbatim every statement made by themselves as therapist, and by their "client," indicating each statement as such by a "C" for client and "T" for therapist. On the right side of the form, under "Inner Experiences," students were asked to record, as closely as they could recall, their inner experiences at the time that they made each intervention or statement as a therapist. Therapist inner experiences were defined as the thoughts, feelings, and rationales at any given moment within the session with a client. In other words, they were asked to record their inner experiences (thoughts, feelings, rationales) as they were at the time of the role play, rather than processed, after-the-fact thoughts, feelings, and rationales. Examples of transcrip-
tions and inner experiences were provided to students (see Appendix I).

To help facilitate the recall of actual inner experiences as they occurred in the role play, students were expected to transcribe their tape and turn it in to a central location by 4:00 p.m. on the fourth day after a taping session (with the exception of the Wednesday class, which turned their transcripts in by 4:00 p.m. on the fifth day after taping due to the interruption of the weekend). The transcriptions with inner experience recordings were copied and returned to the instructors so that comments could be made and the transcripts returned to students for review. A detailed description of the transcription procedure was provided to students and is shown in Appendix B.

**Coding Transcripts**

**Preparation for coding.** Using the written transcripts of the first and fourth role plays, two trained doctoral level students independently divided the recorded inner experiences into separate thought units. This process was referred to as unitization (Genest & Turk, 1981, p. 252). Unitization of the participants' recorded thoughts ensured that subsequent raters coded identical units. Also, unitization was necessary for converting coding category frequencies into a meaningful scale common to all subjects; for each transcript, the frequency of occurrence of a coding category would be divided by the total number of
units for that transcript, obtaining a percentage of category occurrence.

Rules for unitizing were developed and sample unitizations are presented in Table 2. Complete thought units were defined as sentences or phrases that retained their meaning and substance when separated from a preceding and succeeding thought. Typically, sentence structure and punctuation were used as cues for separating thoughts. Thoughts often were divided at periods, commas, semicolons, and dashes (---), provided that the units created by the division contained a subject or noun and a verb, and therefore retained their structure and meaning. Also, divisions at punctuation were made only if the units created by the division represented a shift in content, rather than simply a restatement of the same content in an immediately preceding thought unit. Two ideas were left together if they were connected by the word "and" or by dashes, unless the thought segment following the word "and" or the dashes added new meaning and retained its structure. Thought segments following the words "because" and "so" were treated as explanations of the thought segment immediately preceding the words "because" and "so;" therefore, two thought segments connected by the words "because" and "so" typically were retained as one unit.

For each transcript, the unitizing coders compared their independently derived unitizations and recorded the
TABLE 2*

Sample Unitizations

Feeling nervous/ -- trying to make (client) relax./
I should not be doing this./ It's way off the point./
She has such a painful expression on her face/ -- it's hard to make eye contact/ -- maybe if I shift positions a little./
She seems nervous/ -- She's talking about feeling weird and strange/ -- I need to know more./
I felt uncertain about how I should start our session./ I also felt like I didn't even know what I was doing./
I mumbled./ I need to speak up./ I am struggling with my words./
I could tell she was not happy or comfortable,/ so I tried to make her feel better about being and talking with me./
She is having a hard time expressing herself./ I waited until I understood her frustration./
He is telling me the meat of the problem./ I felt good/ because he felt comfortable enough to tell me more specific details of his frustration./ It sounds like he might be nervous/ because he is repeating his words.../...also sounds angry./
Maybe he is jealous because of this new man at work?/ Deal with the more apparent feelings now./
I am understanding more of where her anger and frustration stem from./ I understand why she is in the state she's in./
I felt the need to rephrase/ because there was a lull in the discussion./
I was a little bit nervous about ending our session/ because I didn’t know how./ I was relieved to finish./
Try to pretend you’re on the line again./ That should help me to focus on her, instead of me./ I should stop smiling now./ I'm probably trying to reassure myself./

*Unitizations are indicated by a slash (/).
number of units on which they disagreed. Through subsequent discussion, they reached 100% agreement on unitizations, numbered each unit sequentially, and recorded the final number of units for each transcript. For each transcript, simple agreement was obtained by dividing the number of units on which the coders initially agreed prior to discussion by the total number of units derived after discussion (agreement before discussion/total number of units after discussion). The two coders' mean simple agreement for all transcripts is presented in chapter 4.

Training in the use of the coding scale. Eight masters and doctoral level students, not inclusive of the unitizers, were trained to use The Novice Therapist Pre-Intentional Coding Scale. Training consisted of coding training transcripts, discussion of disagreements, and refinement and clarification of category definitions. First, the eight raters were trained in the use of the coding scale as a whole group for four 2-hour sessions on four consecutive weeks. Raters were given 2-4 transcripts per week to code independently. Then, raters met as a group to compare their codes for each unit and to discuss disagreements. Thus, they received eight hours of group training in addition to the time they spent independently coding transcripts. A second phase of training included eight more hours of training over a period of three weeks, in two groups of four. During this time, the composition
of the two groups of four raters was varied to help ensure conformity and agreement among all eight raters, and to prevent deviation between the two groups in interpretation of the coding scale.

After training in two groups of four, the eight raters were divided into four groups of two. This final phase of training took place over a period of two weeks and consisted of one 2-hour meeting and one 3-hour meeting. Again, practice transcripts were coded independently and the process of comparing codes, discussion, and resolution was conducted within the dyads. In total, the eight raters received 21 hours of training in addition to independent coding time.

Throughout the training process, simple agreement was monitored to obtain preliminary indications of how consistently the coding scale was being applied and, thus, a rudimentary indication of reliability of the scale. Scott's Index of Inter-coder Agreement ($\pi$; 1955), one indicator of reliability, was chosen to obtain inter-rater agreement based on raters initial codes. Scott's $\pi$ was chosen because of it's appropriateness for nominal data being coded by pairs of raters using a scale with a large number of categories. The index accounts for the number of categories in the scale and the frequency with which each category is used, and therefore produces a more accurate estimate of chance agreement and of "the extent to which
coding reliability exceeds chance" (Scott, 1955, p. 323). The training plan was to attain inter-rater agreement of .80, necessitating achievement of simple agreement of approximately 85%. In the event this was not possible, the plan was to obtain agreement by resolution; however, the decision regarding the procedure for obtaining final codes was not to be made until the coding of the data had begun and simple agreement could be monitored. Training continued until coding agreement stabilized at an average of 68% for the four pairs of raters.

Coding of units. The unitized transcripts were coded by the eight trained raters, who remained in the pairs in which they were trained, using The Novice Therapist Pre-Intentional Coding Scale. A total of 48 transcripts were coded, 24 of which were first transcripts generated at the beginning of the semester (Time 1) and 24 of which were fourth transcripts generated at the end of the semester (Time 2). Information identifying the transcripts as the first or fourth were removed so raters were blind to the order of the transcripts. Assignment of first and fourth transcripts was random.

Twelve of the 48 transcripts were randomly assigned to each of the four dyads. In the event that preliminary calculations of simple agreement were adequate to attain acceptable inter-rater agreement once coding began, transcripts were divided within the pairs such that only a
percentage of each pair's transcripts initially were coded by both members of the pair. For each dyad, therefore, a randomly selected subsample of four of the 12 transcripts were coded by both members of the dyad, although the members were blind to which four transcripts were being cross-coded. This subsample, comprising 33% of the total sample of transcripts, was necessary to calculate an estimate of the reliability of the coding scale (Scott, 1955). The remaining eight transcripts for each dyad were divided and randomly assigned to the members of the dyad, so that individual raters coded four different transcripts. In sum, each member of all four dyads initially coded a total of eight transcripts -- four different transcripts than those received by their partners and four mutual transcripts -- and each dyad coded a total of 12 transcripts.

Coding was conducted at a central location in one day, over a six hour period, to prevent divergence between dyads in the interpretation of the coding scale, and to minimize distractions and maximize the focus on the coding process. All eight raters received and independently coded their first, randomly-assigned transcript. Raters were provided with a coding form (Appendix J) on which to record the code they assigned to each unit. As raters completed each transcript, they reported to a "checker," an individual assigned to their coding pair who determined whether the transcript was to be individually coded or cross-coded with
the other member of the pair. If the transcript was to be coded individually, raters were given the next transcript assigned to them and instructed to continue coding. If the transcript was to be cross-coded, raters were instructed to wait until their partner had completed the same transcript and the two raters’ codes were checked for disagreements. Disagreements were marked for the pair and simple agreement was recorded. The pair of raters then convened to discuss and resolve their disagreements for the purpose of obtaining agreement on a final code for those particular units, and thereby attaining 100% agreement on the cross-coded transcripts. Final codes were recorded on the original voting forms.

After all cross-coded transcripts were completed, simple agreement was tabulated for the four pairs. Because the simple agreement was not adequate enough to attain satisfactory inter-rater agreement, the decision was made to attain final codes on all 48 transcripts by a discussion and resolution process. This meant that each member of a dyad needed to code an additional four transcripts that already had been coded by their partner.

The discussion and resolution phase of the coding process was carried out in the same manner as the initial phase. As members of each dyad completed a transcript, they reported to a "checker" who compared the codes of both members and noted disagreements. The raters then convened
to discuss and resolve their disagreements and recorded final codes on the original coding forms. The final codes, derived by this discussion and resolution process, were used in subsequent analyses.

Analysis of the Data

This is an exploratory, descriptive study using a within-subjects, repeated-measures design. Descriptive statistics, such as frequencies, percentages, and means, when appropriate, are reported in Chapter 4. The first hypothesis of this study is that a change in the quality of inner experiences would be found between the beginning and end of the semester. Change in quality of students' inner experiences was determined by comparing the percent of units in each inner experience category of The Novice Therapist Pre-Intentional Coding Scale from the first to the last videotaped role plays. The significance of the change in percent of units in each category was determined using a repeated-measures multivariate analysis of variance (MANOVA).

The second hypothesis is that a significant difference in self-efficacy would be found between the beginning and end of the semester. Students' self-efficacy scores for the first and last weeks of class, as measured by the COSE, were evaluated for statistically significant differences using a paired t-test, and change in factor scores on the COSE were assessed using a repeated-measures MANOVA.
The third hypothesis is that a relationship exists between changes in the quality of inner experiences and changes in level of self-efficacy. This relationship was explored by correlating differences in percent of inner experience categories to differences in self-efficacy using a Pearson product-moment correlation. Also, a discriminant function analysis was conducted to examine further a possible relationship between self-efficacy and inner experiences, specifically the ability of inner experiences to discriminate between groups of participants based on self-efficacy scores.

The fourth hypothesis is that a relationship exists between change in self-efficacy and change in skill ratings. This relationship was examined by correlating change in self-efficacy with change in level of counseling skill performance, as measured by skill ratings, using a Pearson product-moment correlation.

The fifth hypothesis is that a relationship would be found between the change in quality of inner experiences and the change in skill level. This relationship was investigated by comparing the change in percent of units in each category of the Novice Therapist Pre-Intentional Coding Scale with change in skill ratings using a Pearson product-moment correlation.
CHAPTER IV
RESULTS

This chapter describes the data analysis and the results of these analyses. The variables of interest are novice counselors' inner experiences, self-efficacy, and counseling skill ratings obtained from instructors, "clients," peers, and the novices' themselves. Measurement of these variables for this project occurred at two different times in the semester: Time 1, the third week of the semester; and Time 2, the twelfth week of the semester. The data was collected from all participants at both times, making this a within-subjects, repeated measures design.

Inner Experiences

Transcript Units

Two trained doctoral students coders independently unitized the recorded inner experiences into discreet thought units. For each transcript, simple agreement was obtained by dividing the number of units on which the coders initially agreed prior to discussion by the total number of units derived after discussion (agreement before discussion/total number of units after discussion). Percent agreement ranged from 74-100%, with a mean simple agreement of 92% for all transcripts.
The total number of units for each transcript varied widely among the participants, ranging from six to 106. At Time 1, the mean number of units for all participants was 47.1, and the mean number of units at Time 2 was 38.2.

Analysis of Inner Experience Categories

Type and frequency of inner experiences were assessed using the Novice Therapist Pre-Intentional Coding Scale (see Appendix F). Raters assigned one of 20 codes, representing the inner experience categories, to each thought unit on all transcripts.

Coding agreement. In the initial phase of coding, a subsample of 33% of the transcripts were cross-coded by the pairs of raters to provide a means for assessing the consistency with which the coding scale was being applied and, thus, an indication of the reliability of the scale. Simple agreement on this subsample of transcripts was 60%, yielding an Inter-coder Agreement (Scott, 1955) of .545, and necessitating the attainment of final codes by discussion and resolution. Agreement on the pairs’ initial codes before resolution was monitored throughout the entire coding process, yielding an average of 61% agreement for all 48 transcripts.

Type and occurrence of inner experiences. Using the final codes derived from the discussion and resolution process, frequency of occurrence was tabulated for each of the 20 categories, for both Time 1 and Time 2. Then,
percentages were calculated, dividing the frequency of each category by the total number of units for that transcript. All subsequent analyses used these percentages. Percent of occurrence ranged from 0-14.1% at Time 1 and from 0-12.7% at Time 2. Percent of occurrence for individual codes at Time 1 and Time 2 are presented in Table 3.

A 2 X 20 (Time X Coding Category) within-subjects, repeated-measures MANOVA was performed to explore the first hypothesis that a change in the quality of inner experiences would be found between the videotaped role plays at Time 1 and Time 2. The results of this analysis indicated no significant differences in types of inner experiences between Time 1 and Time 2, multivariate F(19,5)=1.55, p=.33. This result most likely was due to the large number of categories being analyzed (20) relative to the number of cases (24). The following categories, therefore, were rationally collapsed based on similarity of content: 1) therapist self-awareness of emotion, cognition, and behavior; 2) emotional, cognitive, and behavioral therapist self-direction; 3) therapist self-evaluation, including criticism, praise, and corrective self-feedback; and 4) tangential focus, including situational focus, tangential focus on client or therapist information, and uncodable units. This reduced the number of categories to 11, including the four collapsed categories and seven remaining individual categories.
TABLE 3

Percent Occurrence of Novice Therapists' Inner Experiences

At Time 1 and Time 2: 20 Individual Categories

<table>
<thead>
<tr>
<th>Inner Experience Category</th>
<th>% at Time 1</th>
<th>% at Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Self-Awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>6.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Cognitive</td>
<td>11.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Behavioral</td>
<td>14.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Therapist Self-Direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Cognitive</td>
<td>1.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Behavioral</td>
<td>10.7</td>
<td>5.6</td>
</tr>
<tr>
<td>Therapist Self-Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticism</td>
<td>2.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Praise</td>
<td>2.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Corrective self-feedback</td>
<td>7.4</td>
<td>5.7</td>
</tr>
<tr>
<td>Awareness of Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotion</td>
<td>4.7</td>
<td>12.7</td>
</tr>
<tr>
<td>Cognition</td>
<td>3.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Behavior</td>
<td>8.6</td>
<td>12.1</td>
</tr>
<tr>
<td>Situational-Interpersonal Status</td>
<td>4.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Hypothesizing-Formulating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>About Client</td>
<td>0.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Client Evaluation</td>
<td>2.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Awareness of Setting-Situation</td>
<td>6.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Awareness of Process/Client-Therapist Relation</td>
<td>6.0</td>
<td>5.3</td>
</tr>
<tr>
<td>Tangential Focus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Information</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Therapist Information</td>
<td>7.2</td>
<td>6.0</td>
</tr>
<tr>
<td>Uncodable Thought Units</td>
<td>0.7</td>
<td>0.7</td>
</tr>
</tbody>
</table>
A 2 X 11 (Time X Revised Coding Category) repeated-measures MANOVA on the revised grouping of categories produced a significant effect for time, $F(11,13)=3.84$, $p=.012$. Posthoc tests for mean differences indicated a significant increase from Time 1 to Time 2 in the occurrence of the following inner experience categories: therapist awareness of client emotion, $F(1,23)=17.66$, $p=.0001$; therapist awareness of client cognition, $F(1,23)=12.22$, $p=.002$; therapist awareness of client situational-interpersonal status, $F(1,23)=9.02$, $p=.006$ and, therapist hypothesizing-formulating about client, $F(1,23)=5.02$, $p=.035$. Participants reflected more about clients' emotions, clients' cognitions, and clients' problems or interpersonal situations, and hypothesized more about clients at Time 2 than at Time 1. Posthoc tests indicated a significant decrease from Time 1 to Time 2 in the occurrence of therapist self-awareness, $F(1,23)=19.26$, $p=.0001$, and therapist self-direction, $F(1,23)=7.79$, $p=.01$. Participants reflected less about themselves, including their within-session emotions, cognitions, and behaviors, and they directed themselves to initiate a new emotion, cognition, or behavior less often at Time 2 than at Time 1. These results are presented in Table 4.

Self-Efficacy

The Counseling Self-Estimate Inventory (COSE; Larson, et al., 1992), an instrument designed to measure counselor
TABLE 4
Percent Occurrence of Novice Therapists' Inner Experiences
At Time 1 and Time 2: Collapsed Categories

<table>
<thead>
<tr>
<th>Inner Experience Category</th>
<th>% at Time 1</th>
<th>% at Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Self-Awareness</td>
<td>31.9</td>
<td>15.5*</td>
</tr>
<tr>
<td>(emotional, cognitive, behavioral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist Self-Direction</td>
<td>12.5</td>
<td>6.9*</td>
</tr>
<tr>
<td>(emotional, cognitive, behavioral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist Self-Evaluation</td>
<td>11.5</td>
<td>9.6</td>
</tr>
<tr>
<td>(criticism, praise, corrective self-feedback)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangential Focus</td>
<td>14.4</td>
<td>10.9</td>
</tr>
<tr>
<td>(tangential client or therapist information, physical setting of session, uncodable thought units)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness of Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotion</td>
<td>4.7</td>
<td>12.7**</td>
</tr>
<tr>
<td>Cognition</td>
<td>3.3</td>
<td>8.0**</td>
</tr>
<tr>
<td>Behavior</td>
<td>8.6</td>
<td>12.1</td>
</tr>
<tr>
<td>Situational-Interpersonal Status</td>
<td>4.1</td>
<td>12.6**</td>
</tr>
<tr>
<td>Hypothesizing-Formulating About Client</td>
<td>0.7</td>
<td>2.6***</td>
</tr>
<tr>
<td>Client Evaluation</td>
<td>2.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Awareness of Process/Client-Therapist Relationship</td>
<td>6.0</td>
<td>5.3</td>
</tr>
</tbody>
</table>

* significant decrease from Time 1, p<.01.
** significant increase from Time 1, p<.01.
*** significant increase from Time 1, p<.05.
trainees' perceptions of and expectancies for successfully performing counseling activities during a counseling session, was administered to participants in the first and last weeks of the semester. The COSE incorporates the following five dimensions: 1) microskills execution, which represents basic microcounseling skills typically taught in prepracticum courses; 2) attention to process, which represents the synthesis of basic counseling skills; 3) dealing with difficult client behaviors, for example, lack of motivation, suicidality, silence, and alcoholism; 4) behaving in a culturally competent way, which represents items related to working with clients of different cultural, ethnic, or social groups; and 5) what is referred to for the present study as "self-management," which seems to represent items regarding behaving in a nonjudgmental, respectful, and non-abrupt manner towards the client, advice-giving, and managing personal conflicts so they do not interfere with counseling abilities.

Reliability of the COSE

Item-total correlations on the scores from the first administration of the COSE demonstrated the instrument to be internally consistent (coefficient α = .87). Item-total correlations on the scores from the second administration produced similar results (coefficient α = .93). These results are consistent with previously reported reliability estimates for the COSE (Larson et al., 1992).
**Analysis of Self-Efficacy**

At the beginning of the semester, scores on the COSE ranged from 102 to 175, with a mean of 141.58. At the end of the semester, scores ranged from 74-195, with a mean of 159.62. A dependent t-test was performed to examine the second hypothesis that a significant difference would be found between self-efficacy scores at the beginning and end of the semester. Results of the t-test indicated a significant increase in self-efficacy from the first to last administration of the COSE, t(23) = -2.96, p = .01 (see Table 5). Participants' expectancies for and perceptions of their abilities to perform counseling skills, in general, increased over the 12-week counseling skills training period.

A 2 X 5 (Time X Factors of the COSE) MANOVA was performed to further explore the change in counseling self-efficacy over the semester. Although the results of the MANOVA were insignificant, F(5,19) = 1.70, p = .18, univariate tests produced significant results for four out of the five self-efficacy factors. Participants' scores on the following four dimensions increased significantly from Time 1 to Time 2: 1) microskills, F(1,23) = 6.15, p = .021; 2) attention to process, F(1,23) = 7.08, p = .014; 3) dealing with difficult client behaviors, F(1,23) = 10.20, p = .004; and 4) behaving in a culturally competent way, F(1,23) = 4.87, p = .038. These results indicate that participants' self-efficacy for
TABLE 5

Means and Standard Deviations For Scores on the COSE at the Beginning and End of the Semester

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Test</td>
<td>141.58</td>
<td>18.08</td>
</tr>
<tr>
<td>Posttest</td>
<td>159.62</td>
<td>24.71</td>
</tr>
</tbody>
</table>

Note: Means differ significantly, p=.01.

TABLE 6

Means For Scores on the Five Factors of the COSE

<table>
<thead>
<tr>
<th>SELF-EFFICACY FACTORS</th>
<th>PRE-TEST</th>
<th>POSTTEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microcounseling Skills</td>
<td>49.42</td>
<td>53.83*</td>
</tr>
<tr>
<td>Attention to Process</td>
<td>37.04</td>
<td>42.87*</td>
</tr>
<tr>
<td>Dealing w/Difficult Client Behaviors</td>
<td>22.29</td>
<td>27.17**</td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>17.17</td>
<td>19.04*</td>
</tr>
<tr>
<td>Self-Management</td>
<td>15.67</td>
<td>16.71</td>
</tr>
</tbody>
</table>

Note: * Significant increase, p < .05.  
    ** Significant increase, p < .01.
successfully performing microcounseling skills, attending to the process of counseling, handling difficult client behaviors, and behaving competently regarding culture increased over the semester. Participants' self-efficacy for self-management, however, did not change from Time 1 to Time 2, \( F(1,23)=1.85, p=.19 \). These results are presented in Table 6.

Relationships Between Inner Experiences and Self-Efficacy

Correlations Between Inner Experiences and Self-Efficacy Scores

To investigate the third hypothesis of this study, that a relationship would be found between change in occurrence of inner experiences and change in self-efficacy, change scores were computed for those variables with significant Time 1 and Time 2 differences and then correlated with one another. Change scores were computed, therefore, for the following inner experience and self-efficacy variables: therapist self-awareness; therapist self-direction; awareness of client emotion; awareness of client cognition; awareness of client situational-interpersonal status; hypothesizing about the client; change in total self-efficacy scores; and change in the self-efficacy scores specific to microskills, attention to process, dealing with difficult client behaviors, and behaving in a culturally competent manner.

No correlations were found between change in the six
inner experience variables entered into the analysis and change in total self-efficacy scores (see Table 7). Also, no correlations were found between change in inner experiences and change in the four self-efficacy factors entered into the analysis, as presented in Table 8.

**Discriminating Between Self-Efficacy Groups on the Basis of Occurrence of Inner Experiences**

A stepwise discriminant function analysis was performed to further explore the relationship between counseling self-efficacy and inner experiences at Time 2. Participants' scores on the COSE at the end of the semester were tri-partitioned, creating high, medium, and low self-efficacy groups. Occurrence of inner experience categories were entered into the analysis as predictors of membership in the three self-efficacy groups.

The discriminant analysis yielded two functions. The first function was significant, chi-square(14)=25.91, p=.03, and had an eigenvalue over 1.0 (eigenvalue=1.79). The first function was comprised of the following seven inner experience categories: awareness of client behavior, awareness of client cognition, therapists' awareness of their own cognition, awareness of client emotion, tangential focus on therapist information, awareness of the counseling situation, and therapists' behavioral self-direction. The components of the first function, along with factor loadings, are presented in Table 9. The second
<table>
<thead>
<tr>
<th>INNER EXPERIENCES</th>
<th>SELF-EFFICACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Self-Awareness</td>
<td>.05</td>
</tr>
<tr>
<td>Therapist Self-Direction</td>
<td>.05</td>
</tr>
<tr>
<td>Awareness of Client Emotion</td>
<td>.02</td>
</tr>
<tr>
<td>Awareness of Client Cognition</td>
<td>.14</td>
</tr>
<tr>
<td>Awareness of Client Situation</td>
<td>-.06</td>
</tr>
<tr>
<td>Hypothesizing About Client</td>
<td>.08</td>
</tr>
<tr>
<td>INNER EXPERIENCES</td>
<td>Microskills</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Therapist Self-Awareness</td>
<td>-.23</td>
</tr>
<tr>
<td>Therapist Self-Direction</td>
<td>.04</td>
</tr>
<tr>
<td>Awareness of Client Emotion</td>
<td>.16</td>
</tr>
<tr>
<td>Awareness of Client Cognition</td>
<td>.09</td>
</tr>
<tr>
<td>Awareness of Client Situation</td>
<td>-.02</td>
</tr>
<tr>
<td>Hypothesizing About Client</td>
<td>.16</td>
</tr>
<tr>
<td>INNER EXPERIENCE CATEGORY</td>
<td>FACTOR LOADING</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Therapist Self-Awareness of Cognition</td>
<td>.60</td>
</tr>
<tr>
<td>Therapist Behavioral Self-Direction</td>
<td>.42</td>
</tr>
<tr>
<td>Therapist Awareness of Client Emotion</td>
<td>.84</td>
</tr>
<tr>
<td>Therapist Awareness of Client Cognition</td>
<td>.91</td>
</tr>
<tr>
<td>Therapist Awareness of Client Behavior</td>
<td>-.58</td>
</tr>
<tr>
<td>Therapist Awareness of Counseling Situation</td>
<td>.65</td>
</tr>
<tr>
<td>Tangential Focus on Therapist Information</td>
<td>.99</td>
</tr>
</tbody>
</table>
function, which yielded an eigenvalue of less than 1.0, was not significant.

The first function indicated a clear separation among the low, medium, and high self-efficacy groups, as presented in Table 10. The low self-efficacy group had a group centroid of .72, the medium self-efficacy group had a group centroid of -1.76, and the high self-efficacy group had a group centroid of 1.04. Group classification results were computed as a measure of the ability of the first function to discriminate between the three self-efficacy groups. Overall, the function correctly classified 79.2% of all group members. Discrimination was high for the medium and high self-efficacy groups. Correct classification percentages for the three individual groups are presented in Table 11. Eighty-seven and one-half percent of the members in both the high and medium self-efficacy groups were correctly classified, and 62.5% of the members in the low self-efficacy group were correctly classified.

Skill Ratings

Novice therapists' counseling skills were assessed by rating forms completed by instructors, clients, observers, and the therapists themselves. Raters assessed therapists' skills using a 7-point scale (1=never, 7=always) on the following dimensions: non-verbal attending, voice quality, rapport, empathic understanding, genuineness, topic centrality, here and now focus, impact, and helpfulness.
**TABLE 10**

**Group Means/Centroids For the First Function**

<table>
<thead>
<tr>
<th>GROUP</th>
<th>MEAN/CENTROID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>.72</td>
</tr>
<tr>
<td>Medium</td>
<td>-1.76</td>
</tr>
<tr>
<td>High</td>
<td>1.04</td>
</tr>
</tbody>
</table>

**TABLE 11**

**Percent of Group Members Correctly Classified**

<table>
<thead>
<tr>
<th>GROUPS</th>
<th># OF CASES</th>
<th>% PREDICTED GROUP MEMBERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Low</td>
<td>8</td>
<td>62.5*</td>
</tr>
<tr>
<td>Medium</td>
<td>8</td>
<td>0.0</td>
</tr>
<tr>
<td>High</td>
<td>8</td>
<td>12.5</td>
</tr>
</tbody>
</table>

*Note: *Percent of grouped cases correctly classified.
Ratings were completed immediately following the role plays at Time 1 and Time 2.

**Reliability of Rating Forms**

Item-total correlations showed that all four versions of the skill rating form were internally consistent, both at Time 1 and Time 2. Results of these reliability analyses are as follows: 1) instructor rating form at Time 1, coefficient α=.90, and at Time 2, coefficient α=.84; 2) client rating form at Time 1, coefficient α=.93, and at Time 2, coefficient α=.89; 3) observer rating form at Time 1, coefficient α=.96, and at Time 2, coefficient α=.94; and 4) therapist rating form at Time 1, coefficient α=.91, and at Time 2, coefficient α=.92.

**Differences in Skill Ratings From Time 1 to Time 2**

A 2 X 4 (Time X Type of Rating) MANOVA conducted to examine the differences in skill ratings from Time 1 to Time 2 yielded a significant effect for time, $F(4,20)=23.58$, $p=.0001$. In addition, univariate tests performed on mean ratings at Time 1 and Time 2 produced significant results for all four sets of ratings. The ratings of novice therapists' skills by instructors, $F(1,23)=103.13$, $p=.0001$, clients, $F(1,23)=6.93$, $p=.015$, observers, $F(1,23)=12.67$, $p=.002$, and therapists, $F(1,23)=9.87$, $p=.005$, all increased significantly from Time 1 to Time 2. Means are reported in Table 12.
### TABLE 12

**Mean Ratings By Instructors, Clients, Observers, and Therapists**

<table>
<thead>
<tr>
<th>RATINGS</th>
<th>TIME 1</th>
<th>TIME 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor</td>
<td>40.2</td>
<td>53.8**</td>
</tr>
<tr>
<td>Client</td>
<td>52.6</td>
<td>57.8*</td>
</tr>
<tr>
<td>Observer</td>
<td>51.5</td>
<td>55.3**</td>
</tr>
<tr>
<td>Therapist</td>
<td>47.7</td>
<td>52.3**</td>
</tr>
</tbody>
</table>

**Note:**  
*Significant increase, p < .05.**  
**Significant increase, p < .01.
Correlations Between Skill Ratings and Self-Efficacy

To examine the fourth hypothesis of this study, that a relationship would be found between change in skill ratings and change in self-efficacy, change scores were computed for all four skill ratings and then correlated with change in total self-efficacy scores and change in scores on the four self-efficacy factors for which significant differences between Time 1 and Time 2 were found.

No correlations were found between change in total self-efficacy scores and change in any of the four skill ratings. Correlations were found, however, between change in skill ratings and change in individual self-efficacy factors. First, change in client ratings were negatively correlated with change in self-efficacy for microskills, \( r = -.45, p < .01 \). This result suggests that an increase in clients’ ratings of their therapists’ skills was associated with a decrease in therapists’ perceptions of their abilities to successfully perform basic microcounseling skills. In addition, the change in therapists’ ratings was positively correlated with the change in self-efficacy scores regarding dealing with difficult client behaviors, \( r = .41, p < .05 \). This correlation indicates that the increase in therapists’ ratings of their own skills was related to the increase in their expectancies for successfully dealing with difficult client behaviors. Correlations between change in self-efficacy and change in skill ratings are
Correlations Between Skill Ratings and Inner Experiences

To test the fifth hypothesis of this study, that a relationship would be found between change in occurrence of inner experiences and change in skill ratings, change scores for all four skill ratings were correlated with change scores for the six inner experience categories exhibiting a significant difference between Time 1 and Time 2. Change in instructors' ratings was positively correlated with change in hypothesizing about clients, $r = .51$, $p < .01$, indicating that the increase in instructors' ratings of therapists' skills was associated with the increase in the occurrence of novices' hypothesizing about clients. In addition, the change in therapists' awareness of clients' emotions was positively correlated both with the change in clients' ratings, $r = .51$, $p < .01$, and the change in observers' ratings, $r = .44$, $p < .05$. This suggests that the increase in both clients' and observers' ratings of therapists' skills was associated with the increase in novices' awareness of their clients' emotions. Correlations between change in inner experiences and change in skill ratings are presented in Table 14.

Summary

Analysis on the 20 individual inner experience categories produced insignificant results. Analysis on the revised grouping of inner experiences, collapsing
<table>
<thead>
<tr>
<th>SELF-EFFICACY</th>
<th>Instructor</th>
<th>Client</th>
<th>Therapist</th>
<th>Observer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td>.19</td>
<td>.39</td>
<td>.33</td>
<td>-.31</td>
</tr>
<tr>
<td>Microcounseling Skills</td>
<td>.28</td>
<td>-.45**</td>
<td>.40</td>
<td>-.06</td>
</tr>
<tr>
<td>Attention to Process</td>
<td>.10</td>
<td>-.35</td>
<td>.13</td>
<td>-.43</td>
</tr>
<tr>
<td>Dealing w/Difficult Client Behaviors</td>
<td>.13</td>
<td>-.29</td>
<td>.41*</td>
<td>-.34</td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>-.08</td>
<td>-.36</td>
<td>.35</td>
<td>-.18</td>
</tr>
</tbody>
</table>

Note: *Significant, p < .05.
**Significant, p < .01.
<table>
<thead>
<tr>
<th>INNER EXPERIENCES</th>
<th>Instructors</th>
<th>Clients</th>
<th>Observers</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Self-Awareness</td>
<td>.02</td>
<td>.00</td>
<td>-.32</td>
<td>-.57</td>
</tr>
<tr>
<td>Therapist Self-Direction</td>
<td>-.29</td>
<td>.02</td>
<td>-.05</td>
<td>.40</td>
</tr>
<tr>
<td>Awareness of Client Emotion</td>
<td>.02</td>
<td>-.08</td>
<td>.31</td>
<td>.06</td>
</tr>
<tr>
<td>Awareness of Client Cognition</td>
<td>.21</td>
<td>.51**</td>
<td>.44*</td>
<td>.13</td>
</tr>
<tr>
<td>Awareness of Client Situation</td>
<td>.08</td>
<td>.16</td>
<td>.10</td>
<td>.30</td>
</tr>
<tr>
<td>Hypothesizing About Client</td>
<td>.51**</td>
<td>-.16</td>
<td>.13</td>
<td>.07</td>
</tr>
</tbody>
</table>

Note: *Significant, p < .05.
**Significant, p < .01.
categories with similar content, however, showed an increase in the occurrence of therapist awareness of client emotion, cognition, and situational-interpersonal status, and of hypothesizing, and a decrease in the occurrence of therapist self-awareness and self-direction from Time 1 to Time 2.

Total self-efficacy scores also increased from Time 1 to Time 2. When broken down further, results showed a significant increase from Time 1 to Time 2 in self-efficacy specific to microskills, attention to process, dealing with difficult client behaviors, and behaving in a culturally competent manner. Correlational analysis revealed no significant correlation between change in total self-efficacy scores and change in the occurrence of the six inner experience categories for which a significant difference from Time 1 to Time 2 was noted. Furthermore, no correlations were found between change in inner experiences and change in the four self-efficacy factors for which a significant change from Time 1 to Time 2 was noted. A combination of seven inner experience categories -- awareness of client behavior, awareness of client cognition, therapists' awareness of their own cognition, awareness of client emotion, tangential focus on therapist information, awareness of the counseling situation, and therapists' behavioral self-direction -- were effective, however, in correctly classifying 79.2% of members in low,
medium, and high self-efficacy groups.

Lastly, analyses showed significant increases from Time 1 to Time 2 in all four types of skill ratings. Although no correlations were found between change in total self-efficacy scores and change in any of the four skill ratings, correlational analyses indicated a positive correlation between an increase in novice therapists' ratings and an increase in self-efficacy for dealing with difficult client behaviors, and a negative correlation between an increase in client ratings and an increase in self-efficacy for microskills. In addition, correlational analyses yielded significant correlations between change in inner experiences and change in skill ratings. Positive correlations were found between an increase in instructors' ratings and an increase in the occurrence of hypothesizing about clients, and between an increase in novice therapists' awareness of clients' emotions and an increase in both clients' and observers' ratings.
Summary of the Project

Therapist intentionality has been discussed in the literature as an important factor operating in the therapeutic process of change. Experienced therapists purposefully employ their internal, subjective cognitions to formulate moment-by-moment goals and to guide their interventions during therapy sessions with clients. Little is known, however, about the nature of novice counselors' thought processes and how they develop the sophisticated ability to be intentional. Although research has attempted to qualitatively describe novice counselors' cognitive processes (Borders et al., 1988; Morran et al., 1989), few studies have examined change in those cognitions over time with training. Furthermore, much of the existing research simply has assumed that novice counselors have intentions (Kelly et al., 1989; Kivlighan, 1989; Kivlighan & Angelone, 1991). The literature suggests, in fact, that novice counselors have few intentional thoughts and that the exploration of intentions in novices should be expanded to include more rudimentary forms of thought (Borders et al., 1988; Kivlighan, 1989).
In addition, novice counselors have been described as anxious, self-conscious, insecure, and lacking in confidence and insight. These characteristics may suggest that novice counselors are plagued by low self-efficacy and, perhaps more importantly, these attributes may inhibit the formulation of intentional thoughts. Insight into the development of novice counselors’ intentions and self-efficacy, and a possible relationship between self-efficacy and intentionality, could enhance our understanding of the dynamics of the training process. Understanding the nature of novices’ thought processes, how their cognitions change with training, and how cognitions may be related to self-efficacy, may guide the content and technique of training novice therapists.

With this in mind, this study explored the nature and development of the inner experiences of novice counselors enrolled in a one-semester, masters level counseling skills course. A significant portion of this project involved the development and refinement of a coding scale that would adequately represent the full range of novice counselors’ inner experiences. To this end, development of categories for the coding scale was data-driven, and the initial version of the scale was tested and revised in an earlier pilot study conducted by this author. The scale was refined further during training of coders for the present study, resulting in the final version of the Novice Thera-
pist Pre-Intentional Coding Scale. Type and frequency of inner experiences were measured using this scale, and because participants' inner experiences were assessed at both the beginning and end of the semester, change in the quality and quantity of inner experiences over time with training could be evaluated.

In addition, this study examined the change in counseling self-efficacy and counseling skills. Counseling self-efficacy was measured by the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992), and counseling skills were assessed by rating forms completed by instructors, classmates serving as clients and observers, and by the student-therapists themselves. The measurement of counseling self-efficacy and skills provided an opportunity to explore possible relationships between change in inner experiences, change in self-efficacy, and change in skill ratings. Inner experiences, self-efficacy, and skills were assessed on 24 participants, a relatively large subject pool by process research standards.

Measurement of these variables occurred at the beginning (Time 1) and end (Time 2) of the semester, making this a within-subjects, repeated measures design. Five research questions were proposed for this study: 1) a change in the quality of inner experiences would be found between Time 1 and Time 2; 2) a change in self-efficacy would be found between Time 1 and Time 2; 3) a relationship would be found
between change in quality of inner experiences and change in level of self-efficacy; 4) a relationship would be found between change in level of self-efficacy and change in skill ratings; and 5) a relationship would be found between change in quality of inner experiences and change in skill ratings.

Discussion of Results

Inner Experiences

Inter-Coder Agreement. To assess type of inner experiences, four pairs of raters assigned one of 20 codes from the Novice Therapist Pre-Intentional Coding Scale to each thought unit on all transcripts. Among pairs of raters, attaining a sufficient level of simple agreement (80%) to achieve an acceptable inter-coder agreement, adjusted for chance agreement, proved to be a difficult task. After 21 hours of intensive training, simple agreement stabilized at an average of 68% for the four pairs of raters. After the initial phase of coding 33% of the transcripts used as data for the study, simple agreement was 60%, yielding an Inter-coder Agreement (Scott, 1955) of .545. An average of 61% simple agreement was obtained on all 48 transcripts.

Several authors have noted the difficulty with achieving acceptable reliability in research involving the measurement and analysis of verbatim transcriptions of cognitive processes. Genest and Turk (1981) cited the idiosyncratic nature of such data as a major problem in making
comparisons across individuals. The method employed in the present study of unitizing transcripts was mentioned by Genest and Turk as one possibility for handling this type of data. The problem with "chunking," or unitizing, is that reliability of coding is likely to decrease because raters are making many more discriminations than if they were to make global judgments of the transcripts (Genest & Turk, 1981, p. 252).

Other authors have attributed the difficulty in achieving inter-rater reliability to the idiosyncratic nature of verbatim transcriptions of cognitive processes (Gelso et al., 1991; Hill, 1992; Hill & O’Grady, 1985). Dole et al. (1981) remarked that, because thought characteristics are particular to each individual, efforts to consistently categorize thoughts of many individuals are unrealistic, "like those of the inventor of a perpetual motion machine" (p. 16). Indeed, during the training process for this study, each new transcript presented unique thought characteristics and coding challenges, making consistent coding of thought units across many participants difficult, and confirming the observation made by previous authors.

**Change In Quality of Inner Experiences.** The analysis performed on all 20 inner experience categories individually revealed no significant differences in quality of inner experiences between the beginning and end of the
semester. This result, however, is likely attributable to the large number of categories (20) being analyzed relative to the small number of participants (24). Thirteen of the categories were condensed into four categories based on similarity of content, such that self-awareness of emotion, cognition, and behavior were subsumed under therapist self-awareness; emotional, cognitive, and behavioral self-direction were subsumed under therapist self-direction; criticism, praise, and corrective self-feedback were subsumed under therapist self-evaluation; and focus on the role play situation, focus on tangential therapist and client information, and units not fitting any category (i.e. one-word units) were subsumed under tangential focus. This reduced the number of categories to 11, including the four collapsed categories and the seven remaining individual categories.

Analysis of the revised coding categories revealed a significant effect for time for six of the inner experience categories. In general, participants had more thoughts indicating an awareness of clients' emotions, cognitions, and problem-interpersonal situations, and had more thoughts indicating the presence of hypothesizing about clients at the end of the semester than at the beginning of the semester. Participants experienced less thoughts about their own within-session emotions, cognitions, and behaviors, and cognitively directed themselves to initiate a new emotion,
cognition, or behavior less often at the end of the semester than at the beginning of the semester. Together, these results suggest that, in general, the participants in this study became less self-focused and more client-focused over just one semester of training.

The higher occurrence of therapist self-awareness at the beginning versus the end of the semester may support results of a study characterizing novice counselors as self-scrutinizing (Borders et al., 1988). The decrease in participants' self-direction, in combination with the increase in awareness of and hypothesizing about clients, may represent what Anderson (1982) referred to as a progression from the declarative to the procedural stage. In essence, this progression signifies that skills become less deliberately and more instinctively applied. The increase in client awareness parallels the results of Kivlighan (1989), who found that graduate students who received training increased their use of intentions embodying exploration of client cognitions, behaviors, and feelings. Kivlighan (1989) recommended, however, that research should attempt to detect changes due to training that are more subtle than, but related to, the use of intentions. In addition, the increase in hypothesizing about clients seems to corroborate results of a study which found that students receiving training in cognitive self-instruction and clinical hypothesis knowledge performed better on clinical
hypothesis measures than students who received no training (Kurpius et al., 1985). The increase in the occurrence of client awareness and hypothesizing, even over one semester of training, may represent the acquisition of the initial skills necessary to formulate intentions, skills that include the awareness and processing of client information (Hill & O'Grady, 1985).

Self-Efficacy

As expected, participants' beliefs in their abilities to perform counseling skills, in general, increased from the beginning to the end of the semester. The significant difference in total self-efficacy scores between Time 1 and Time 2 supports results of several other studies citing increases in counseling self-efficacy due to training (Larson et al., 1992; Munson, Stadulis, et al., 1986; Munson, Zoerink, et al., 1986; Rudolf et al., 1983). In addition, the increase in self-efficacy may indicate that skill training is an effective means of increasing counselor self-efficacy.

Additional analysis of the five factors of the COSE further clarified the change in participants expectancies for performing more specific counseling skills. Participants' showed an increase from the beginning to the end of the semester in their estimates of their abilities to perform microcounseling skills, to attend to the process of therapy, to deal with difficult client behaviors, and to
behave in a culturally competent manner. Participants' perceptions of their abilities for self-management -- being nonjudgmental and respectful, and managing personal conflicts -- did not increase over the semester. The increase in participants' self-efficacy for performing the specific skills represented by the COSE factors may be a direct result of training targeted at those skills.

The increase in beliefs in their abilities to perform the skills represented by the factors also may be reflective of changes in constructs related to self-efficacy. Constructs such as lack of confidence, anxiety, and self-doubt often are attributed to novice therapists (Borders et al., 1988; Flapan, 1984; Friedlander et al., 1984; Ralph, 1980; Stoltenberg, 1981; Watkins, 1990). The increase in self-efficacy in this study may indicate that, even over one semester of training, novice counselors become more confident, less anxious, and less self-doubting.

**Relationships Between Self-Efficacy and Inner Experiences**

Exploration of the relationships between change in the four self-efficacy factors and the six inner experience categories produced no significant results. One explanation may be that self-efficacy for performing behavioral skills is not associated with self-efficacy for performing cognitive skills, and thus the increase in participants' scores on the COSE were not related to any changes in the types of inner experiences.
Researchers have suggested that increased anxiety may be associated with increased self-focus (Hale & Stoltenberg, 1988) and inhibition in performing certain cognitive functions (Kelly et al., 1989), and that counseling trainees who perceive themselves as less effective problem-solvers or helpers are more self-critical (Heppner et al., 1983). The lack of significant correlations between self-efficacy and inner experiences in this study, however, does not provide support for a relationship between the types of inner experiences and the constructs closely related to self-efficacy.

In contrast, further exploration of the relationship between self-efficacy and inner experiences at the end of the semester showed that a combination of the following seven inner experience categories were effective in discriminating between participants who had been partitioned into low, medium, and high groups based on their self-efficacy scores: the occurrence of therapists' thoughts about clients' emotions, cognitions, and behaviors, about their own in-session cognitions and behavioral self-directions, about the role play situation, and about tangential information regarding themselves. In combination, these inner experiences correctly classified 79.2% of all participants into the three groups, and correctly classified 87.5% of the members in both the medium and high self-efficacy groups, and 62.5% of the members in the low self-
efficacy group. Although no conclusions about a causal relationship may be drawn, these results suggest that self-efficacy and the occurrence of certain types of inner experiences may, indeed, be related. Novice counselors who differ in their level of self-efficacy also may differ in their inner experiences.

**Skill Ratings**

Novice counselors' skills during the role plays at the beginning and end of the semester were rated by the instructors, clients, observers, and the therapists themselves. Skill ratings from all four sources were significantly higher at the end of the semester than at the beginning of the semester. Although the skill ratings from all four sources are subjective, these findings suggest that one semester of training focused on specific counseling skills may be effective in increasing novice counselors' observed skill level, as perceived by instructors, peers, and the participants themselves.

Interestingly, correlations were found between changes in skill ratings and changes in the self-efficacy factors. In general, the increase in skill ratings by clients was associated with a decrease in therapists' perceptions of their abilities to successfully perform microcounseling skills. Although clients viewed counseling skills as improving, therapists' beliefs in their abilities to perform those skills diminished. The increase in therapists'
ratings of their own skills, however, was associated with the increase in their perceptions of their skills for successfully dealing with difficult client behaviors; thus, as therapists' beliefs in their skills to deal with difficult client behaviors improved, their ratings of their own counseling skills also increased. The results of a study (Rudolph et al., 1983) suggesting an inverse relationship between trainees' counseling self-efficacy and instructors' evaluations of trainees' skills were not supported by the lack of correlation between participants' counseling self-efficacy and instructors' skill ratings in the present study; perhaps the frequent dissemination of feedback reduced the occurrence of a discrepancy between students' and instructors' perceptions of skills.

Correlations also were found between change in skill ratings and change in the occurrence of certain types of inner experiences. The increase in instructors' ratings of therapists' skills was associated with the increase in the occurrence of novices' hypothesizing about clients. In addition, the increase in both clients' and observers' ratings of therapists' skills was associated with the increase in novices' awareness of their clients' emotions. As novice therapists experienced an increase in their awareness of their clients' emotions and in the occurrence of more sophisticated thoughts about their clients, those rating their skills viewed the novice therapists' skills as
improving. Interestingly, while novices' awareness of clients' emotions and clients' ratings of novices' skills both increased, self-efficacy for performing microskills decreased. Although speculative, these results suggest that novices are unable to detect the development of more sophisticated counseling skills that can be observed by instructors, clients, and peers.

In addition, these results may suggest that novices experience both increases and decreases in self-efficacy as they proceed through various stages of skill development. At the beginning of training, when they have not acquired client-focused skills and they are more self-focused, their counseling self-efficacy is low. As novices acquire basic skills that improve their ability to focus on clients, their self-efficacy may increase. When they proceed to the next skill level, such as hypothesizing and awareness of client emotion, however, they are confronted with new, more sophisticated skills and their self-efficacy may decrease until the new skills are mastered. In sum, novices may experience higher self-efficacy when they feel they have mastered a skill, and lower self-efficacy when they are confronted with learning and performing a new, more complex skill that they have not yet mastered.

Implications For Training

In general, participants in this study became less self-focused and more client-focused over the one-semester
training period. Awareness of clients' emotions, cognitions, and problems or interpersonal situations, as well as higher-order, inferential thoughts about clients, accounted for novice therapists' increased focus on clients. This may suggest that training in basic counseling skills, even over one semester, is effective in teaching novice therapists the initial cognitive skills that will serve as building blocks for developing intentions. Novice therapists must learn to be aware of and gather information about clients' emotions, cognitions, behaviors, and presenting problems, and to synthesize the information, before they can begin to formulate within-session goals for clients and, thus, intentions for their moment-by-moment interventions with clients. Participants did not demonstrate an increase in the occurrence of awareness about the client-therapist interaction and the process of therapy, a skill that may be essential for developing intentions for and initiating interventions.

Although the skills course in which participants were enrolled was aimed at teaching basic counseling skills to novice counselors at the masters level, the course incorporated a variety of teaching tools rather than highlighting a particular training technique. The educational components of the course included readings from texts, brief lectures, role playing, audiotaping, transcribing videotapes and recording inner experiences, journaling, and
substantial verbal and written feedback. The course did not employ, however, specific techniques for training students how to think, for example, how to hypothesize or be aware of the client-therapist interaction. Training in these skills may have occurred tangentially, however, during the routine instructional design of the course. The course also did not focus on increasing students' level of counseling self-efficacy.

In a review of the relevant literature, Fuqua, Johnson, Anderson, and Newman (1984) underscored that the established importance of cognitive processes in counseling should be translated into better training procedures and that training in cognitive skills should be tailored to individual trainee needs. Even relatively early research suggested that training should focus on the development of cognitive skills rather than exclusively on the development and performance of specific behavioral counseling skills (Goldberg, 1974). Mollon (1989) asserted that the function of supervision was to "facilitate the trainee's capacity to think about the process of therapy -- on the assumption that technique grows out of this understanding" (p. 120). Feelings of anxiety, shame, incompetence, and grandiosity should be accepted as part of the training process, brought into the trainee's awareness, and utilized to understand the therapeutic process.

In a review (Baker et al., 1990) of three major coun-
selor training programs, Interpersonal Process Recall (IPR) was identified as unique because of its emphasis on counselor awareness of inner experiences. Developed by Kagan, the focus of IPR is to teach counseling students to become aware of and attend to their internal processes, including thoughts, feelings, goals, impressions, and bodily sensations, and to use this insight to facilitate client and counselor development. Reviewing video- and audiotapes of counselor-client interactions and recalling inner experiences represents a primary component of IPR. Based on the results of a meta-analysis of 24 studies related to counselor conceptual level, Holloway and Wampold (1986) asserted that training environments and course designs should be diverse and tailored to meet the differing needs of various types of thinkers, from concrete to abstract types.

Hillerbrand (1989) suggested that metacognitive and procedural skills be taught within a group supervision setting that incorporates practice, feedback, and collaborative learning. The interaction between other novices and one expert provides the opportunity to verbalize, and give and receive feedback on, their cognitive processes. In addition, Hillerbrand suggested that the interaction with other trainees provides motivation and encouragement and increases self-efficacy. In designing group supervision with a focus on acquisition of cognitive skills, Hillerbrand recommended that trainees be taught how to
articulate their cognitive processes, a component that was achieved in the present study by having participants record their inner experiences. Research also suggests that training in appropriate cognitive processing may be more effective when personal and evaluative feedback relevant to current behavior and developmental level is provided to novices, rather than impersonal and nonevaluative instruction on how to perform such skills in the future (Claiborn & Dixon, 1982).

The lack of association between change in inner experiences and increase in self-efficacy in this study is puzzling, given the connection between increased self-efficacy and increased performance described in the literature (Bandura, 1977, 1982; Lent et al., 1984, 1986). Hillerbrand (1989) suggested that peer interaction and observation may increase self-efficacy and the acquisition of skills.

Although increases in self-efficacy for performing certain counseling skills were related to increases in skill ratings by clients and therapists, increases in self-efficacy were not related to changes in any cognitive skills. This may suggest that self-efficacy has differing effects on the acquisition and performance of behavioral and cognitive skills. The findings also may suggest that the course in which participants were enrolled was more heavily weighted towards teaching procedural or behavioral
counseling skills rather than cognitive or metacognitive skills.

Clearly, novice therapists should be taught how to think within therapy sessions, rather than being taught exclusively how to perform behavioral skills. Training in cognitive skills could focus on the acquisition of skills related to and necessary for the development of within-session interventions and the intentions for those interventions, such as awareness of clients and the therapeutic relationship, synthesis of client information, hypothesis and inference about clients, awareness of clients' within-session reactions, and utilization of self-awareness to enhance the therapeutic relationship. Based on the literature and the results of this study, the ideal training condition seems to be one in which novice counselors are taught to articulate their inner experiences and cognitive processes, and are given feedback about their cognitions and how to improve their cognitive skills. Role plays, audiotapes, and videotapes are likely to be useful tools in producing and examining cognitions, and practicing cognitive skills. Group training may be particularly helpful because it provides opportunities for modeling, and giving and receiving feedback. Feedback should be immediate, personal, and tailored to individual students' needs and cognitive styles. Finally, training and coaching focused on increasing students' self-efficacy for performing spec-
ific cognitive skills in addition to behavioral skills may be effective in improving their actual performance of more sophisticated cognitive skills essential to goal formulation and implementation.

Limitations of the Study

Although this study was successful in categorizing and quantitatively analyzing the inner experiences of a relatively large number of participants by process research standards, the inability to obtain acceptable simple and adjusted inter-coder agreement on the coding of inner experiences is troubling. Previous literature strongly suggests that obtaining reliability in coding cognitive processes is complicated, if not unrealistic, due to the idiosyncrasies of individuals' cognitive processes. The difficulty in obtaining acceptable inter-coder agreement, however, also may be indicative of the need to train raters for more than 21 hours, or of characteristics of the scale that make it difficult to apply consistently. The solutions to these methodological problems, respectively, would be to train raters for a longer period of time, or to revise the scale so that it can be more consistently applied.

Although changes were noted in several variables, conclusions about the development of novice counselors' inner experiences and self-efficacy are limited by the brief time span of this study. Had the study been extended
for two semesters or longer, more changes in and relationships among the variables of interest may have been detected. In addition, the design of the study involved one treatment, the skills course, which was experienced by all participants, rather than incorporating different training models into the design. Assigning each section of the skills course to a different training model would have provided a means for comparing change in self-efficacy and inner experiences for participants who receive training that varies in focus or training techniques.

Finally, this study has taken a significant step in describing the nature and development of novice counselors' inner experiences and, therefore, has taken an essential step towards comparing novice and expert counselors' inner experiences in the future. The addition of an intention category to the Novice Therapist Pre-Intentional Coding Scale, however, may have provided information about whether or not novices' have any intentional thoughts similar to those of expert therapists.

Recommendations For Future Research

In a study exploring the relationship between type of counselor self-talk and performance, Morran (1986) noted that many cognitive processes are involved in formulating clinical hypotheses. This interpretation implies that future research on internal processing needs to focus on identifying and measuring smaller units of thought that may
be not only the building blocks of more global conceptualizations, but also the building blocks of the sophisticated, intentional thought characteristics of experienced therapists.

The importance of examining and describing the content of novices’ cognitions is supported by a trend in which more awareness of the interactive process was noted in students with higher ego levels (Borders et al., 1986). Fuqua et al. (1984) called for improved measures of covert, cognitive processes, but acknowledged the benefits of developing research around current measures that produce relevant, qualitatively valuable data.

In an article on the benefits of group supervision in cognitive skill acquisition, Hillerbrand (1989) suggested that future research examine the differences between expert and novice cognitive behavior in group settings, as well as the effects of group supervision and of verbalization of cognitive processes on skill acquisition.

In the future, research on novice counselors’ inner experiences and self-efficacy may benefit from conducting longitudinal and cross-sectional studies. Both types of studies would provide more information about the long-term development of novice counselors’ cognitive skills and their beliefs in those skills. Longitudinal studies lasting more than one semester would illuminate the development of inner experiences and self-efficacy by tracking one
group of students throughout several stages and years of training, whereas cross-sectional studies could provide similar information by examining the inner experiences and self-efficacy of different groups of students at various levels and stages of training.

To explore the effects of certain training techniques, educators and researchers could design counseling skills courses that target specific skills, such as developing cognitive skills or increasing counseling self-efficacy. Measures of variables of interest, such as intentions, cognitions, self-efficacy, and behavioral skills, could be administered to groups receiving different training conditions, thereby providing a means for comparing the effectiveness of specific types of training.

Continued research is necessary to fully understand the nature and development of novice therapists' inner experiences and the effect of self-efficacy on the development of skills, particularly cognitive skills. Once achieved, a thorough understanding of novices' cognitive abilities would allow for comparison to the cognitive skills of experienced therapists. Knowing how the cognitive skills of counselors at various levels of training and experience differ will help counselor educators guide the content and techniques of supervision.
APPENDIX A

INFORMED CONSENT FORM
APPENDIX A

INFORMED CONSENT FORM

My signature below indicates that I give permission for Loyola University of Chicago to use materials generated by me in the CEPS 420 Counseling Skills course, taken in the Fall semester of 1992, for purposes of research. The specific materials to be used are all videotapes, transcripts of the videotapes, and rating scales. I understand that, if I participate, all of my tapes and transcripts will become part of the data in their entirety. I understand that there are no anticipated risks associated with participating in this study and that my materials and responses in this research will be kept confidential. I also understand that my participation is voluntary. In addition, I understand that participating in this research in no way alters the quality or expectations of this course; that is, the design of the course is instructional, and so I will be expected to participate in all activities and meet all requirements regardless of whether or not I give consent to Loyola University of Chicago to use the materials described above.

With my signature below, I give Loyola University of Chicago permission to use all videotapes and transcripts generated in CEPS 420 Counseling Skills for research purposes.

______________________________
Signature

______________________________
Date
APPENDIX B

INSTRUCTIONS FOR VIDEOTAPING AND TRANSCRIBING
APPENDIX B

VIDEOTAPING AND TRANSCRIBING

Videotapes
1. You will be provided with a videotape.
2. You will videotape and transcribe a minimum of 4 in-class role plays (on the recorder provided in class), which will take place on the 3rd, 6th, 9th, and 12th weeks of the semester.
3. Taping should be done sequentially, so that you have a record of your progress between the first and last sessions. Thus, instead of rewinding your tape, you will begin taping each session at the end of the previous session.

Videotaping Sessions
1. On a taping day, each student will secure a partner and be expected to role play both a "client" and a "therapist."
2. Each role play will be approximately 5-8 minutes in length.
3. Immediately following your own role play (as both a "client" and a "therapist"), you will complete an observation sheet, as will your peers and the instructor. The rating sheets will be turned in to the instructor at the end of class.
4. The videotaped role plays will be viewed as a class the following week, at which time they will be discussed and feedback will be provided from the instructor and fellow classmates.

Transcript Due Dates
1. Transcribing videotapes is beneficial to novice counselors because it increases their awareness of their inner experiences, of why they say what they say, and of their skill level and areas in which to improve.
2. Ideally, transcriptions would be most effective if done immediately following videotaping, before any after-the-fact processing is done on the session; however, because this is not realistic for this class..........
3. Transcriptions of videotaped role plays are due 3 days after the taping session. So, transcripts are due Monday by 4:00 for classes held on Friday, and are due Friday by 4:00 for classes held on Wednesday.
4. Envelopes for transcripts are located on the bulletin board outside of Dr. Susman’s office on the 8th floor of Lewis Towers, Room 841. Please put your transcripts in the envelope corresponding to your section and instructor.
5. If you are unable to hand deliver your transcripts on these days, or if you are unable to give them to a classmate to be delivered on time, you may mail the transcripts, but they must be postmarked by the morning of the day they are due. They can be sent to:

Jill

c/o Marilyn Susman, Ph.D.
Dept. of Counseling and Educational Psychology
Loyola University of Chicago
820 N. Michigan Avenue
Chicago, IL 60611

How To Transcribe

1. You will be provided with forms on which to transcribe your videotapes (see handout for sample). On the left side, under "Record Dialogue," you will transcribe verbatim every statement made by you and your "client." Separate client and therapist statements by a blank line and preface each statement with a "C" or "T" indicating whether it was said by the "client" or the "therapist," respectively. See the examples on handout.

2. On the right side of the form, under "Inner Experiences," you will record, as closely as you can recall, your inner experiences at the time that you made each intervention (statement) as the "therapist." Therapist inner experiences are defined as the thoughts, feelings, and rationale at any given moment within the session with a client. In other words, you should record your inner experiences (thoughts, feelings, rationale) as they were at the time of the role play, not processed, after-the-fact thoughts, feelings, and rationale. We are particularly interested in your internal processing just prior to and during each of your interventions or statements. Examples of therapist inner experiences are on the handout.

3. It is okay to write rather than type your transcripts as long as you write neatly and legibly.

4. Feedback will be provided on your transcripts and returned to you.
APPENDIX C

DEMOGRAPHIC FORM
APPENDIX C

DEMOGRAPHIC FORM
Counseling Skills

1. Name ____________________________________________
2. Age ____________________________
3. Sex ____F   ____M
4. Race ____________________________
5. In what program are you enrolled? ____________________________

6. At what level are you in your program? ____________________________
7. Have you had any counseling experience prior to taking this course? ____YES   ____NO
   a. If yes, what type of counseling did you do? ____________________________

   b. For how long did you do this counseling? ____________

   c. Were you supervised during this counseling experience? ____YES   ____NO

   d. If yes, indicate what kind of supervision it was and how frequently you met:

      ____ Individual supervision ____ Group supervision

      Hours per week ____________

   e. If you were supervised, did you use (check all that apply):

      ____ Process notes   ____ Audiotape   ____ Videotape

8. Have you had any courses or training in basic counseling skills prior to taking this course? ____ YES   ____ NO
   a. If yes, list the type of course or training and the duration. ____________________________
APPENDIX D

COUNSELING SELF-ESTIMATE INVENTORY
APPENDIX D
COUNSELING SELF-ESTIMATE INVENTORY

This is not a test. There are no right or wrong answers. Rather, it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor. Do not respond with how you wish you could perform each item; rather, answer in a way that reflects your actual estimate of how you will perform as a counselor at the present time.

Below is a list of 37 statements. Read each statement and then indicate the extent to which you agree or disagree with that statement, using the following alternatives.

KEY: 1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.
   1 2 3 4 5 6

2. When I initiate the end of a session I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.
   1 2 3 4 5 6

3. I am likely to impose my values on the client during the interview.
   1 2 3 4 5 6
KEY: 1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

4. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).
1 2 3 4 5 6

5. I am certain that my interpretation and confrontation responses will be concise and to the point.
1 2 3 4 5 6

6. I am worried that the wording of my responses like reflection of feeling, clarification, and probing may be confusing and hard to understand.
1 2 3 4 5 6

7. I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client's values, beliefs, etc.
1 2 3 4 5 6

8. I feel I will respond to the client in an appropriate length of time (neither interrupting the client or waiting too long to respond).
1 2 3 4 5 6

9. I am worried that the type of responses I use at a particular time, i.e., reflection of feeling, interpretation, etc., may not be the appropriate response.
1 2 3 4 5 6

10. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.
1 2 3 4 5 6

11. I feel confident that I will appear competent and earn the respect of my client.
1 2 3 4 5 6

12. I am confident that my interpretation and confrontation responses will be effective in that they will be validated by the client's immediate response.
1 2 3 4 5 6
KEY: 1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

13. I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.
   1 2 3 4 5 6

14. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.
   1 2 3 4 5 6

15. I feel that I have enough fundamental knowledge to do effective counseling.
   1 2 3 4 5 6

16. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.
   1 2 3 4 5 6

17. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.
   1 2 3 4 5 6

18. I am not sure that in a counseling relationship I will express myself in a way that is natural without deliberating over every response or action.
   1 2 3 4 5 6

19. I am afraid that I may not understand and properly determine probable meaning of the client's nonverbal behaviors.
   1 2 3 4 5 6

20. I am confident that I will know when to use open or close ended probes, and that these probes will reflect the concerns of the client and not be trivial.
   1 2 3 4 5 6

21. My assessments of client problems may not be as accurate as I would like them to be.
   1 2 3 4 5 6
22. I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy.
   1 2 3 4 5 6

23. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I'm afraid that they may not be effective in that they won't be validated by the client's immediate response.
   1 2 3 4 5 6

24. I do not feel I possess a large enough repertoire of techniques to deal with the different problems my client may present.
   1 2 3 4 5 6

25. I feel competent regarding my abilities to deal with crisis situations which may arise during the counseling sessions -- e.g., suicide, alcoholism, abuse, etc.
   1 2 3 4 5 6

26. I am uncomfortable about dealing with clients who appear unmotivated to work toward mutually determined goals.
   1 2 3 4 5 6

27. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.
   1 2 3 4 5 6

28. I am unsure as to how to deal with clients who appear noncommittal and indecisive.
   1 2 3 4 5 6

29. When working with ethnic minority clients I am confident that I will be able to bridge cultural differences in the counseling process.
   1 2 3 4 5 6

30. I will be an effective counselor with clients of a different social class.
   1 2 3 4 5 6
KEY: 1 = Strongly Disagree  
2 = Moderately Disagree  
3 = Slightly Disagree  
4 = Slightly Agree  
5 = Moderately Agree  
6 = Strongly Agree

31. I am worried that my interpretation and confrontation responses may not over time assist the client to be more specific in defining and clarifying the problem.  
1 2 3 4 5 6

32. I am confident that I will be able to conceptualize my client’s problems.  
1 2 3 4 5 6

33. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work toward.  
1 2 3 4 5 6

34. I am confident that I can assess my client’s readiness and commitment to change.  
1 2 3 4 5 6

35. I feel I may give advice.  
1 2 3 4 5 6

36. In working with culturally different clients I may have a difficult time viewing situations from their perspective.  
1 2 3 4 5 6

37. I am afraid that I may not be able to effectively relate to someone of lower socioeconomic status than me.  
1 2 3 4 5 6
APPENDIX E

CLIENT, THERAPIST, OBSERVER, AND INSTRUCTOR
SKILL RATING FORMS
APPENDIX E

"CLIENT" REFLECTIONS ON ROLE PLAY

1. SS# (last 4 digits)____________________
2. Are you rating as: _____therapist  _____client  _____observer
3. Date______________________________
4. Name of therapist____________________
5. Rate your "therapist" on the following skills (for this role play) using the scale below:
   1 = Never  5 = Often
   2 = Infrequently  6 = Very often
   3 = Sometimes  7 = Always
   4 = Equally present and absent

   A. **Non-verbal attending**: Did your therapist maintain good, varied eye contact and demonstrate natural, comfortable body movements and gestures?
      1 2 3 4 5 6 7

   B. **Voice quality**: Was your therapist's voice expressive, empathic, and appropriate to what you were expressing?
      1 2 3 4 5 6 7

   C. **Rapport**: Was your therapist able to establish rapport with you?
      1 2 3 4 5 6 7

   D. **Empathic understanding**: Did your therapist try to perceive the world as it appears to you?
      1 2 3 4 5 6 7

   E. **Genuineness**: Did your therapist’s responses appear to be spontaneous, sincere, and authentic or congruent with who they are?
      1 2 3 4 5 6 7

   F. **Topic centrality**: Did your therapist refer and respond to what was most important to you?
      1 2 3 4 5 6 7

   G. **Here and now**: Did your therapist refer to what you were experiencing at the current moment?
      1 2 3 4 5 6 7

   H. **Impact**: Did your therapist’s responses facilitate your exploring or bringing up new material?
      1 2 3 4 5 6 7

   I. **Helpfulness**: Do you feel your therapist was helpful to you?
      1 2 3 4 5 6 7
"THERAPIST" REFLECTIONS ON ROLE PLAY

1. Your SS# (last 4 digits)_______________________
2. Are you rating as: ____therapist ____client ____observer
3. Date_______________________________________
4. Name of client______________________________
5. Rate yourself on the following skills (for this role play) using the scale below:

1 = Never 5 = Often
2 = Infrequently 6 = Very often
3 = Sometimes 7 = Always
4 = Equally present and absent

A. **Non-verbal attending:** Did you maintain good, varied eye contact and demonstrate natural, comfortable body movements and gestures?
   1 2 3 4 5 6 7

B. **Voice quality:** Was your voice expressive, empathic, and appropriate to what the client was expressing?
   1 2 3 4 5 6 7

C. **Rapport:** Were you able to establish rapport with the client?
   1 2 3 4 5 6 7

D. **Empathic understanding:** Did you try to perceive the world as it appears to the client?
   1 2 3 4 5 6 7

E. **Genuineness:** Were your responses spontaneous, sincere, and authentic or congruent with who you are?
   1 2 3 4 5 6 7

F. **Topic centrality:** Did you refer and respond to what was most important to the client?
   1 2 3 4 5 6 7

G. **Here and now:** Did you refer to what the client was experiencing at the current moment?
   1 2 3 4 5 6 7

H. **Impact:** Did your responses facilitate the client’s exploring or bringing up new material?
   1 2 3 4 5 6 7

I. **Helpfulness:** Do you think you were helpful to the client?
   1 2 3 4 5 6 7
OBSERVER RATINGS OF "THERAPIST"

1. Your SS# (last 4 digits)

2. Are you rating as: __ therapist  __ client  __ observer

3. Date

4. Name of therapist

5. Rate the "therapist" on the following skills (for this role play) using the scale below:

   1 = Never  5 = Often
   2 = Infrequently  6 = Very often
   3 = Sometimes  7 = Always
   4 = Equally present and absent

A. **Non-verbal attending:** Did the therapist maintain good, varied eye contact and demonstrate natural, comfortable body movements and gestures?

   1 2 3 4 5 6 7

B. **Voice quality:** Was the therapist’s voice expressive, empathic, and appropriate to what the client was expressing?

   1 2 3 4 5 6 7

C. **Rapport:** Was the therapist able to establish rapport with the client?

   1 2 3 4 5 6 7

D. **Empathic understanding:** Did the therapist try to perceive the world as it appears to the client?

   1 2 3 4 5 6 7

E. **Genuineness:** Did the therapist’s responses appear to be spontaneous, sincere, and authentic or congruent with who they are?

   1 2 3 4 5 6 7

F. **Topic centrality:** Did the therapist refer and respond to what was most important to the client?

   1 2 3 4 5 6 7

G. **Here and now:** Did the therapist refer to what the client was experiencing at the current moment?

   1 2 3 4 5 6 7

H. **Impact:** Did the therapist’s responses facilitate the client’s exploring or bringing up new material?

   1 2 3 4 5 6 7

I. **Helpfulness:** Do you think the therapist was helpful to the client?

   1 2 3 4 5 6 7
INSTRUCTOR RATINGS OF THERAPIST

1. Instructor’s Name ________________________________
2. Date_______________________________________
3. Name of therapist______________________________
4. Rate the "therapist" on the following skills (for this role play) using the scale below:
   1 = Never 5 = Often
   2 = Infrequently 6 = Very often
   3 = Sometimes 7 = Always
   4 = Equally present and absent

A. Non-verbal attending: Did the therapist maintain good, varied eye contact and demonstrate natural, comfortable body movements and gestures?
   1 2 3 4 5 6 7

B. Voice quality: Was the therapist’s voice expressive, empathic, and appropriate to what the client was expressing?
   1 2 3 4 5 6 7

C. Rapport: Was the therapist able to establish rapport with the client?
   1 2 3 4 5 6 7

D. Empathic understanding: Did the therapist try to perceive the world as it appears to the client?
   1 2 3 4 5 6 7

E. Genuineness: Did the therapist’s responses appear to be spontaneous, sincere, and authentic or congruent with who they are?
   1 2 3 4 5 6 7

F. Topic centrality: Did the therapist refer and respond to what was most important to the client?
   1 2 3 4 5 6 7

G. Here and now: Did the therapist refer to what the client was experiencing at the current moment?
   1 2 3 4 5 6 7

H. Impact: Did the therapist’s responses facilitate the client’s exploring or bringing up new material?
   1 2 3 4 5 6 7

I. Helpfulness: Do you think the therapist was helpful to the client?
   1 2 3 4 5 6 7
APPENDIX F

NOVICE THERAPIST PRE-INTENTIONAL CODING SCALE
APPENDIX F

NOVICE THERAPIST PRE-INTENTIONAL CODING SCALE

FOCUS ON THERAPIST

Self-Awareness
Awareness or recognition of the therapist's within-session state; i.e. therapist's thought about therapist's own emotion, behavior, or cognition; usually in the present or past tense.

Inclusions:
* States that are in progress and therefore not clearly present or future, including "trying," "working on," and states of readiness (i.e. I'm trying to ____; I'm working on ____; I was ready to ____).
* Questions to self as a reflection on self-status (Why did I say that? When do I get to talk?).

Rules:
A. Therapist questions to self: code as Self-awareness (1,2,3):
   * 1 if question re: emotional status (Why am I so nervous?);
   * 2 if question re: cognitive activity (What is keeping me from focusing?);
   * 3 if question re: behavioral activity (What response can I make?)
B. Vague vs. specific rule:
   * If the second verb is specific (make a reflection statement, tell her I understand) and therefore helps define the first verb, code according to second verb;
   * If the second verb is vague (say something, do something), code according to first verb.
C. Therapist's repetition of client's words:
   * If therapist is thinking about what the client just said by way of repeating the client's exact words, code as therapist's awareness that client said something, which would be 10a.
1. **Emotional:** therapist's own emotional within session state, i.e. anxiety.

**Inclusions:**
* Worry, concern, bother.

**Rules:**
D. **Therapist emotion:** should be directly stated by therapist; don't infer it.

**Examples**
- I'm all wound up.
- I'm nervous.
- I feel more relaxed.
- I feel as nervous as she does.
- I'm trying to relax; why am I so nervous?
- I started to get a bit nervous.
- I was getting frustrated with my ineptness.
- I was frustrated.
- I was working on feeling more comfortable and relaxed.
- I felt comfortable.
- I was trying to relax.
- I was working on feeling comfortable.
- I'm a little anxious.
- I'm afraid to say the wrong thing.
- I am scared to address it.
- I was pretty nervous.
- I was a little nervous already.
- That scared me.

2. **Cognitive:** recognition of or thought/cognition about therapist's own within session cognitive state.

**Inclusions:**
* Conation words that may seem emotional, i.e. hope, want, desire, wish;
* "Understand," "focus," or "follow;"
* Attention, concentration, memory;
* Knowing/not knowing, sure/unsure, no idea;
* Confusion, doubt, suspicion.

**Note:** See Rule B.
* When a cognitive word precedes a behavior or affect word, the unit is coded as cognitive (2) if the behavioral or emotional verb is vague (not situationally specific, no specific target);
* If behavioral or emotional verb is specific, code as 1 or 3 (i.e. I was thinking about how nervous I felt).
Examples

• I don’t remember what I was going to say.
• My mind is drifting.
• I can’t think of what to say.
• This catches my attention.
• I have no idea what to say or where to go.
• I’m not following her.
• Why don’t I understand her?
• I’m trying to focus on him.
• I understand.
• Because I was stuck.
• I had a remote idea of how he was feeling.
• I was having a hard time picking up on her feelings.
• But that is what came to my mind.
• I had some sort of mental block.
• I had a hard time here.
• I felt like I half-way was following him.
• I was trying to concentrate.
• I was working on focusing on my client.
• Okay, I got that.
• I forgot something.
• That’s what I wanted to say. (b/c therapist underlined "wanted")
• I know that.
• I wish I could question.
• I don’t know either.
• I understand this completely.
• Something? You lost me -- what?
• I didn’t know what to say or do. (b/c vague behavior)
• I wasn’t sure.
• I can see how it was difficult. (b/c therapist’s personal reaction)
• I hope I can remember all this.
• I’m getting back on track. (b/c meaning of verb is vague)
• I hope I’m getting this right. (b/c meaning of verb is vague)
• I can’t remember what I was going to say.
• I hope I do okay.
• Okay, what’s a good connection here?
• I don’t know what else it could be.
• Here I debated between just allowing her to go on and further probing the uncomfortable feelings she was having.
• I was not quite sure how to react appropriately. (b/c 2nd verb is vague)
• I was concentrating on the client’s words and feelings.
• I found myself really focused in on her experiences.
• I’m lost.
• Lots of things are going through my head.
• I knew what I wanted to say during a particular situation.
• I’m just so confused.
• Wondering if I’m on track or way off of it.
• Still lost.
• I hope I’m close.
• What? I’m a little lost.
• I can’t think of the words I’m trying to express.
• So I decided that wasn’t it or she would’ve elaborated.
3. **Behavioral**: recognition of or thought/cognition about therapist's own within session behaviors or behavioral states, i.e. reference to body position, verbal behavior.

**Examples**
- My legs are crossed.
- I hope I'm not **letting** her talk too much.
- Why did I say that?
- I was going to say something here like "It must be frustrating that the fathers have caused fights between you and your husband."
- So... I stayed quiet.
- But how do I tie this together? (see Rule A)
- So the look of surprise came really naturally.
- So I took a chance that it was insulting.
- I was struggling with how I wanted to say it.
- I had a real hard time putting her feelings into words.
- I resorted to guessing.
- I kept on trying though.
- But still digging.
- Once again, I can't touch upon a specific feeling.
- I couldn't identify any feelings. Why??!!
- I was trying to have an open posture.
- Working on that sitting position again.
- How can I put this into a level 5 response?
- I said this the last time.
- Why did you put your hand under your chin? (see Rule A)
- When do I say something? (see Rule A)
- What do I say? (see Rule A)
- I wasn't too concerned about cutting in. (see Rule B)
- I wanted to work with him some more. (see Rule B)
- I was interested about listening to her story.
- I wonder if this sounds phony. (see Rule B)
- I hope I didn't distract her. (see Rule B)
- Okay paraphrase.
- What am I supposed to say?
- I have no idea what to say to her. (see Rule B)
- What am I going to say to her?
- I don't even think I said that intentionally.
- I asked for clarification.
- At this point I was ready to say something.
- I guess I was trying to stress positive things about her.
- Okay, so what am I supposed to do?
- How do I sum all this up?
**Self Direction**

Therapist's internal self-direction to initiate a new, specific action **within the session**; likely to focus on the **immediate** future, but not necessarily; likely to be focused on intervention planning and self-corrective behavior;

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**Inclusions:**

* An order to the self with no pronoun;
* Many statements that begin with "I need to ...", "I want to ...", "I should..."  

**Rules:**

**E. Therapist "needs":**

* A "need" to do something, which also can be read as "I should" do something, is distinguished from a "need" to get something from an external source (i.e. I need more information) and should be considered a Self-direction;
* Code as a 4 if expressed as a need to do something emotional (i.e. I need to relax), a 5 if expressed as a need to do something cognitive (i.e. I need to concentrate), a 6 if expressed as a need to do something behavioral (i.e. I need to interrupt);
* "Needs" not fitting this criteria (i.e. I need more information) should be coded as self-awareness (1,2,3).

**F. Awareness (1,2,3) vs. self-direction (4,5,6):**

* Code as self-direction if therapist has made an internal choice or decision to initiate a new, specific action within the session.

* A clear decision is indicated by commands to self or by words such as need to, going to, want to...
* No clear decision is indicated by words like trying to, working on, ready to, thinking about, debating whether......all of which indicate a pre-decision or pre-directional state.
4. **Emotional**: self-direction to initiate a new emotional state.

Examples
• Don’t be so nervous.
• Don’t be so anxious.
• Try to relax.
• Get comfortable.
• I need to relax and really get into this.
• Okay, relax.

5. **Cognitive**: direction to self to initiate a new cognitive state, i.e. re: attention, concentration, thought processes.

**Inclusions:**
* Focusing and following

Examples
• Stop thinking about yourself.
• Pay attention.
• I need to concentrate.
• Focus on the client.
• Get back to _____. (see Rule B)
• I need to concentrate.
• Think empathic.

6. **Behavioral**: direction to self to perform or initiate a new overt behavior, i.e. regarding body position, verbal behavior, use of counseling skills.

Examples
• I need to get some basic information.
• I want to find out more about this now.
• Okay, listen.
• I’ll ask about this later.
• I will reflect that next.
• I should uncross my legs.
• I better end now.
• I need to look comfortable.
• Lets really listen here.
• Show her that I’m interested.
• Attempt a level 5.
• Just listen and then clarify later.
• Let her talk.
• Stop saying good.
• Get the feeling. (see Rule B)
• Try and get her feelings. (see Rule B)
• I guess I should touch on both.
• I have to say something about her need for belongingness.
• Listen carefully to catch all this.
• I really felt I had to respond to that intensity.
• I need the right intensity, not cold or over-warm.
• I’ll let him keep talking and let him sort out the facts.
Self-Evaluation
Encompasses therapist’s evaluation of self and within session behaviors or skills along a continuum that includes criticism, self-corrective feedback, and praise, all of which are more strongly evaluative than simple self-awareness.

Inclusions:
* One word adjectives or expletives (i.e. "good" or "s---") without a clear self-reference that should be coded under 7a or 7b.

7a. Criticism: thoughts that clearly are harsh criticism, judgmental, self-deprecating or when therapist attacks personal self vs. evaluates their behavior; these are thoughts that are not productive or indicative of matured therapeutic skills, and are not useful in guiding future behavior.

Inclusions:
* Words that universally have a negative connotation, i.e. babbling

Examples
• That was a bad response. (b/c of use of word "bad")
• I was completely disappointed with myself.
• I didn’t help her at all and I did a lousy job.
• This sucked!
• That sounded dumb!
• Dumb!
• Just babbling.

7b. Praise: thoughts that clearly are complimentary and that reflect positive self-feedback, a pat on the back, or are celebrative.

Examples
• Good!.
• Good start.
• That was a nice level 5 response.
• I hit on that anger feeling.
• I clicked somewhat here.
• Okay, good start.
• Good level 3.
7c. **Corrective Self-feedback:** thoughts that reflect awareness of behavior plus subtle implication that therapist wants to do it differently next time, and thus the thoughts that are productive in that they can guide future behavior; represents monitoring of behavior; **therapist evaluates their behavior vs. their personal self.**

**Examples**
- I'm a little off on my thoughts.
- That's not what I wanted to say.
- I didn't like that last part.
- That didn't come out right.
- I wanted to say that differently.
- That was an understatement.
- "Easy;" this isn't really what I meant to say.
- But it's not really what I want to say.
- Okay, yes, but not a level 5.
- But I was still off.
- Not necessarily on the mark.
- I knew I was not completely right about "torn."
- I'm a little bit closer here.
- Too analytical looking.
- Oops, a question.
- It definitely did not come out right.
- There's a lot of vagueness here.
- Wrong word.
- I really haven't been able to do anything for her.
- I should've said family.
- But I thought I was trying for 4's and 5's.
FOCUS ON CLIENT

Awareness of Client
General awareness or observation of client's state, both in- and out-of-session, that is primarily observational (i.e. a simple reflection of what the client has already shown, shared, or said) vs. inferential.

Inclusions:
* Statements that begin with reference to therapist that are verbalisms ("I wonder if she" or "I think he")

Rules:
G. Questions re: client:
* Code as Awareness of Client
* 8 if question re: client emotion (What is he feeling?)
* 9 if question re: client cognition (What decision is he trying to make?)
* 10a if question re: client behavior (How long is he going to talk?)
* 10b if question re: client status that isn't re: emotion, cognition, behavior (re: client's interpersonal relationships, factual information, etc.)--see examples for this category.

H. Client "needs":
* Code as 9 if need is unspecified (He has a strong need in this area)
* If specified, code as 8 for emotional need (He needs to feel confident), 9 for cognitive need (He needs to make a decision), 10a for behavioral need (He needs to write his paper), 10b for an interpersonal need (He needs to please others).

Inclusions:
* Need specified as emotional
* Anxiety, worry, concern, bother

Examples
• She seems angry.
• I think he is bothered.
• He must have been scared to start his job.
• I wish he wasn’t so anxious.
• Guilty.
• Yeah, feeling a little guilty.
• She really doesn’t seem upset.
• Angry.
• I felt pride from her.
• So he was not expressing concern.
• In fact, I felt like she was dissatisfied with me.
• She wasn’t under pressure.
• Apprehensive, that’s it.
• She sounds sensitive.
• There’s the guilty feeling.
• Relaxed, that’s it.
• Sounds confident.
• Does he know how it feels to be made fun of? (see Rule G)
• What are the feelings?
• Where are the feelings?
• What is she feeling?
• God, she is so upset and lonely.
• What do I connect with how lonely she is?
• These are some pretty deep feelings.
• She is very upset.
• I could tell that was not the feeling by her hesitance.
• I sensed insecurity and fear.
• She felt betrayed.
• She was really angry at this point.
• Still angry here.
• Client got really upset here.
• I sensed a lot of anger and resentment toward her father.
• Maybe feeling a little guilty.
• Feeling a little uncomfortable.
• Feeling a little conflict.
• He admires the brother that has stayed Jewish Orthodox.
• It may not be urgent but you sound frustrated.
• He sounds a little distressed.
• Maybe she’s feeling competitive with her sisters.
• I could tell she would be upset by that type of comment.


Inclusions:
* Client’s hope, want, desire, wish
* Focus, follow, attention, memory, concentration
* Client’s "issues" as cognitive state
* Unspecified need (if specific, code accordingly as 8, 9, or 10a)
* Doubt, uncertainty, suspicion

**Note:** Refer to vague vs. specific Rule B.

**Examples**
- She wishes that didn’t happen.
- I don’t think he’s following me.
- The equality issue is important to her.
- That equality issue again.
- Female-equality issue.
- Equality issue again.
- I sensed that equality was really important.
- And I think she could sense it.
- She’s unsure.
- She sees it as natural.
- Why does she need this? (see Rule H)
- She’s doubtful and suspicious.
- Trying to justify to himself why he hasn’t dated Jewish girls.
- He keeps focusing on others.
- He’s trying to rationalize.
- He’s trying to justify why religion is important to him.
- A focus on others with little attention on "I".

10a. **Behavioral:** therapist’s awareness of client’s behavior or behavioral state.

**Note**
: Refer to Rule C.

*If therapist is thinking about what the client just said by way of repeating the client’s exact words, code as therapist’s awareness that client said something, which would be 10a.

**Examples**
- She’s talking fast.
- He really yelled at his wife yesterday.
- I realized that this was when she switched from her story to inner feelings about the story.
- She’ll let me know.
- Will she go on?
- Come on, tell me more. (b/c re: client behavior)
- Keep talking. (b/c re: client behavior)
- She’s trying so hard not to laugh.
- She’s talking really fast.
- Why does she keep nodding at me?
Feedback. ("She’s giving me feedback" is implied)
I feel like she is going to say something bad happened.
There is the "but."
It seems like she really needs to get this out. (see Rule H)
She really picked up on family.
She has mentioned it many times.
I think she really needs to talk about this issue more. (see Rule H)
She said beforehand "are you ready for this?"
Whoa--she went to meet the wife.
She needed to vent that. (see Rule H)
She mentioned a nephew and a daughter.
Her eyes were filling with tears.
I thought she was really talking about herself.
It seemed that she was contradicting herself.
She tries to sound as if she were objective about it.
She keeps switching.
What did it mean?
Your "turn to work with her." (see Rule C)

10b. Client Situational/Interpersonal Status: observations or questions/wonderings about the client’s life that are relevant to the issues being presented by the client, but don’t fit under categories 8, 9, & 10a because they are not an observation of client’s emotion, cognition, or behavior; also don’t fit under category 11 because thought is more specific and fact-based rather than broad and inferential; interpersonal includes other people and interpersonal situations (i.e. job)

Examples
- Is this the old or the new job?
- He has an issue with women.
- He has a need to please others.
- She’s not a child.
- Difficult--yea, it must have been.
- Her husband treats her poorly.
- They’re not fighting.
- Does she tell them that their pestering bothers her?
- So what’s the real problem?
- Anything like what? (see Rule G)
- Her coming to you for help or putting herself down?
- It seemed strange to me that the wife was so friendly.
- This is a really big thing.
- She must be pretty close with the family.
- Feels need to please mom. (see Rule H)
- A need to others (see Rule H)
### Hypothesizing/Formulating

11. **Hypothesizing/Formulating**: therapist's higher-order thoughts about client that are inferential and go clearly beyond the client's awareness to reflect patterns or underlying issues not clearly stated by or known to client; thought represents integrative understanding, summarization, association; not simply observational — observational + inferential; content + affect.

#### Rules:

I. Code 11 is reserved for hypothesizing about client's latent, more broad problems and underlying issues.
   * Inferences about what client has not said
   * Expressed as feelings connected to content
   * Exploration of client behavior based on underlying intrapsychic issues or emotions
   * Unit may be difficult to code because a mixture of codes are involved (i.e. 8, 9, 10a, 10b).

#### Examples
- He doesn't want to take the class because he's afraid to open up. He's angry because he allowed himself to be pressured into doing something he doesn't want to do.
- But then the fight between she and Paul didn't seem to be as important because she said and blablah.
- I thought she felt very strongly about it that she probably was a bit insulted along with the anger she felt with her father-in-law.
- I wondered if her father-in-law by helping and being nice if he tried to put a guilt trip on her and if that added to her anger.
- There are a couple of things here — deciding between the old and new job, and there's something else.
- Worried about how it reflects on her own self-image.
- Being lonely must be a significant issue for her.
- She is having a hard time letting go of him and his family.
- Her nonverbal behavior exhibits anxiety and unhappiness about her parents' separation.
- It must bother him or he wouldn't have brought it up and kept talking about it.
- He's confronted with a situation and going to have to make a decision that can't please everyone.
- Sounds like there's some resentment towards his mother; a little angry for having to play the game and for his mother setting the boundaries as far as when to be Jewish and when not.
- So religion is important to him.
- I could tell that the whole equality issue and not being underestimated or taken seriously because she was a woman was a real issue for her.
Client Evaluation

12. **Client evaluation:** evaluative thought re: client or people in client's world, that reflects the therapist's own opinion, value, judgment, and that wouldn't necessarily be therapeutic or helpful for the client and therefore may not be verbalized; ask yourself, "would this be sharing a personal opinion if verbalized?"

**Inclusions:**
* Negative or positive evaluation
* Statements that have clear implied criticism about client.

**Rules:**
J. Code #12 is used for thoughts that represent the therapist's personal reaction (opinion, judgment, value) -- either positive or negative -- to the client or to someone in the client's world (i.e. spouse, family, friends, boss)
* Ask yourself, "if verbalized, would this be sharing an opinion to the client?"
* This code supersedes other codes that might fit as well, such as 15 and 16

**Examples**
* I can't believe she quit her job.
* Her personality doesn't match her career.
* He (client) really treats her poorly.
* She made a bad choice.
* That's good that she wants to be considered an equal.
* Her friends don't sound nice.
* Equal—that's important.
* All she's doing is complaining.
* Okay, so you started it.
* But you did start it.
* Be quiet, ___, enough!
* So what!?
* Okay, enough.
* So is she less responsible than you?
* That was a big step.
* I was surprised that she considered her stepmom's defense as weird.
* When are you going to stop talking!
* More factors! UGH!
FOCUS ON SESSION

13. **Setting/Situation:** thoughts that refer to or reflect evaluation or awareness of the therapy situation, usually the physical environment; any reference to physical situation or parameters (i.e. time) supersedes reference to anything else.

**Inclusions:**
* Reference to time camera, chairs, session being over

**Rules:**
K. Any reference to physical environment or parameters of class/role play situation; this supersedes any other relevant codes.

**Examples**
- The time went so fast this time.
- These chairs aren't comfortable.
- This set-up isn't conducive to doing therapy.
- I feel uncomfortable in these chairs.
- I'm relieved it's over.
- I always feel so uncomfortable sitting in those chairs.
- Okay, time's up.
- Wrap it up? (b/c reference to time)
- I am glad it's over.
- Relief--it's over.
- It went so much faster this time.
- I was a little disappointed that the time was up.

14. **Relationship/Process** - thoughts that refer to the interaction between therapist and client, or reference to the therapeutic process as a whole; usually, neither client nor therapist is static or unaffected, and one's state is dependent on the other's; i.e. I felt uncomfortable when she snapped at me (14) vs. I felt uncomfortable with her (1), vs. She snapped at me (10).

**Inclusions:**
* References to process-as-whole as "this"
* References to "I" and "she/he," or "we"

**Examples**
- This will be hard.
- This isn't going like I think it should.
- This is a start.
• We’re off to a slow start.
• She misunderstood what I said.
• We keep interrupting each other.
• She ended up dealing with other feelings as a result of my mistake.
• What I said enabled her to express herself more.
• Where is this leading? ("this" refers to process)
• I realized it was okay to let the client tell their story to establish the basis for their feelings.
• We’ve got to concentrate.
• I don’t know if I can handle her reaction.
• The more she talked, the more lost I became.
• It’s hard.
• Just as I think I know what she’s saying, she changes.
• Is this a general concern addressing me as the counselor or is he worried about talking about religion because of what I discussed today as the client?
• Okay, so we are finally to the problem.
• We’re just getting to the issues after all those facts.
TANGENTIAL FOCUS

Thoughts that are blatantly tangential to the here-and-now focus of the session or to what the client is discussing, and that represent a shift or distraction from the client's experience/perspective.

15. Pertaining to Client: thoughts broadly related to the client that are blatantly tangential to the client's here-and-now focus.

Inclusions:
* Client
* Someone in client's life

Examples
Client: "I'm so angry at my father for making me get a job."
Therapist:
• I wonder what her father does for a living.
• I wish I knew how many siblings he has.
• He should just work in a restaurant.

16. Pertaining to Therapist: therapists' thoughts about self that are tangential to the client's immediate, here-and-now focus.

Inclusions:
* Neutral topics/general statements about the general public.

Examples
• I've been in that situation before.
• I like having choices, too.
• I know what I'd do in that situation.
• I like having choices too.
• I like being in a position like this.
• I guess I'd be like that too.
• God, it would really suck to feel like this.
• I had never counseled a client who got so emotionally involved.
• Something that I have never experienced yet.
• I agree.
• I think it's harder these days to stay traditional orthodox.
17. **Uncodable: use sparingly and only after deliberation!!**

**Inclusions:**
* One word units
* Units with no verb *and* where no verb can be easily implied

**Examples**
* Help! (no verb easily implied)
* Yeah, thank God!
APPENDIX G

COUNSELING SKILLS COURSE OUTLINE
APPENDIX G

CEPS 420: COUNSELING SKILLS
Course Outline

Loyola University of Chicago            Instructors: (the four
School of Education                        instructors were listed
Department of Counseling &              here)
    Educational Psychology

Introduction:

This course is designed to provide you with an overview of the counseling process and an understanding of the skills of a helping person. You will be given numerous opportunities to practice and develop these skills through classroom activities and outside assignments.

It is anticipated that you will also be involved in your own personal growth as the course progresses. You will be given opportunities to monitor and assess your growth through keeping a journal and through assigned exercises.

Course Objectives:

This course is intended to promote the following:

1. Understanding of the counseling process and the ability to describe it in some depth.

2. Mastery of specific competencies such as attending, responding facilitatively and empathically, etc.

3. Ability to formulate hypotheses about a given case and to test these appropriately in an interpersonal context.

4. The development of greater self-awareness and sensitivity to others.

5. The development of a sense of personal adequacy in human relationships.

Textbooks:

Students are expected to complete the assigned readings according to the schedule provided by the instructors. The following books have been ordered for the class:


In addition, each student must purchase a videotape for in class taping.

**Course Outline and Tentative Schedule:**

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<tr>
<th>Date</th>
<th>Topic</th>
<th>Assignment</th>
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<tbody>
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<td>Week 1</td>
<td>Introduction</td>
<td>H &amp; C - Ch. 1, 2 &amp; 3</td>
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<tr>
<td>8/31-9/4</td>
<td>Overview of the Counseling Process</td>
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<tr>
<td>Week 2</td>
<td>Attending &amp; Listening</td>
<td>Hammond et al.- Ch. 2 &amp; 4</td>
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<td>9/7-9/11</td>
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<tr>
<td>Week 3</td>
<td>Videotape Session</td>
<td>H &amp; C - Ch. 7</td>
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<td>9/14-9/18</td>
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<td>Week 4</td>
<td>Responding Empathically</td>
<td>Hammond et al.- Ch. 5</td>
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<td>9/21-9/25</td>
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<td>Week 5</td>
<td>Advanced Accurate Empathy</td>
<td>Hammond et al.- Ch. 6 Tape 1 Due</td>
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<td>Week 6</td>
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<td>Week 7</td>
<td>Probes</td>
<td>Tape 2 Due</td>
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<td>10/12-10/16</td>
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<td>Week 8</td>
<td>Structuring &amp; Problem Clarification</td>
<td>H &amp; C - Ch. 5 Tape 3 Due</td>
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<td>10/19-10/23</td>
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<td>Week 9</td>
<td>Videotape Session</td>
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<td>10/26-10/30</td>
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<td>Week 11</td>
<td>Focusing, Immediacy &amp; Confrontation</td>
<td>Hammond et al.- Ch. 9 &amp; 10 Tape 5 Due</td>
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<td>11/9-11/13</td>
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<td>Week 12</td>
<td>Videotape Session</td>
<td>H &amp; C - Ch. 9 Paper Due</td>
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<td>11/16-11/20</td>
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<td>11/23-11/29</td>
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Course Requirements:

1. **A personal journal**: Your journal will chronicle your personal growth and development throughout the semester. It should include your personal reflections on course reading material and on in class activities. In addition, any outside of class experiences where you were able to use counseling skills should be described. Your journal will be collected weekly and instructors will respond with appropriate feedback.

2. **Readings**: Assigned readings and exercises must be completed. You will be expected to attend class sessions prepared to discuss your thoughts and reactions to the readings.

3. **Process Recordings**: Four videotaped in-class role plays will be transcribed by students. Internal process prior to each intervention will be noted on forms provided. These will be collected three days following the taping day.

4. **Audiotapes**: Each student will audiotape five counseling sessions. Please note that the first two tapes are to be approximately 10 minutes in length. The final three tapes should be done with the same client and should be approximately 30 minutes in duration.

5. **Papers**: Students will complete one ten (10) page paper on one population of clients. The paper will reflect a working knowledge of this group based on your reading of five articles. However, your paper will be written from the perspective of a member of the group (i.e. as if you were an alcoholic, or suffering from depression). The paper must be done in APA style.

6. **Attendance**: Attendance and class participation will be taken into consideration in determining a final grade. Openness, contributions, commitment, and willingness to deal with issues is very important.

7. **Ethics**: Appropriate ethical behavior is expected including maintaining confidentiality.

Grading:
Grading will occur in consultation with each student and will assume successful completion of all course requirements. Self and peer competency checklists will help in determining the grade.
APPENDIX H

TRANSCRIPTION SHEET
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<th>Record Dialogue</th>
<th>Inner Experiences</th>
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APPENDIX I

SAMPLE INNER EXPERIENCES
### APPENDIX I

#### Sample Inner Experiences

<table>
<thead>
<tr>
<th>Record Dialogue</th>
<th>Inner Experiences</th>
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<tbody>
<tr>
<td><strong>EX 1:</strong> (T) Hi, Tony. How are you today?</td>
<td>This feels so unnatural. That sounded really meek. Why? I have to speak up.</td>
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<td>(C) Pretty good. Uh, I guess I feel a little bit stressed.</td>
<td>Enough of worrying about this. Now I have to pay attention.</td>
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<td><strong>EX 2:</strong> (T) It sounds like you're not sure you like the way she acts.</td>
<td>Acknowledging her feelings about friend and prompting her for more information.</td>
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<td>(C) There is a certain part of her I have always liked...</td>
<td>When she was describing the qualities she liked about her ex-friend, I was thinking I like that too in a person.</td>
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<td><strong>EX 3:</strong> (C) I guess I have (silence)... I guess I sort of wonder what... I hope that people can self-disclose a little bit...</td>
<td>He's uncomfortable...crossing his arms...closing up.Oops! I almost mirrored it. Stay open!</td>
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<td><strong>EX 4:</strong> (C) It is kind of getting to me a bit.</td>
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<td>(T) It seems like you are anxious and excited about what is to come, but a little bit nervous</td>
<td>I found it difficult to get focused on my client. There was too much &quot;stuff&quot; going on inside me. I felt</td>
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about whether you will get it all done, at the same time. A lot of different and mixed emotions going on.

anxious, so I think my manner was the same. I cut her off twice, assuming that I knew what she was going to say. I think "anxious" described me and not her.

**EX 5:** (T) Hi, how are you today? I have to remember to focus on feelings and not be judgmental. I’m extremely nervous. I have a lot to remember.
APPENDIX J

CODING FORM
# APPENDIX J

## Coding Form

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<th># Units</th>
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predisposition toward therapeutic communication.  

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**The Clinical Supervisor**, **6**, 49-69.


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**Journal of Counseling Psychology**, **30**, 537-545.

*Alberta


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Martin, J., Slemon, A. G., Hiebert, B., Hallberg, E. T., &


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VITA

The author, Pamela Rezek, was born in La Grange, Illinois.

Ms. Rezek graduated magna cum laude in May, 1983, from Hope College in Holland, Michigan, where she received a Bachelor of Arts degree in psychology and was elected a member of Phi Beta Kappa. She was employed as an Admissions Counselor at Hope College before embarking on her graduate education in 1987.

In May, 1989, Ms. Rezek received a Master of Arts in psychology from Wake Forest University, where she also received a Sigma Xi Research Award for her thesis research.

While attending Loyola University Chicago in the doctoral program in counseling psychology, Ms. Rezek was granted assistantships for three consecutive years and taught a masters' level counseling skills course for three semesters. She completed her internship in the Counseling Center at the University of Illinois at Chicago during her fourth year, and was awarded a dissertation fellowship during her fifth year, enabling her to complete the Doctor of Philosophy in May of 1994.
The dissertation submitted by Pamela Rezek has been read and approved by the following committee:

Dr. Marilyn Susman, Director
Assistant Professor, Counseling and Educational Psychology
Loyola University Chicago

Dr. Martha Ellen Wynne
Associate Professor, Counseling and Educational Psychology
Loyola University Chicago

Dr. Gloria J. Lewis
Associate Professor, Counseling and Educational Psychology
Loyola University Chicago

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

_4-8-94_
Date

[Signature]
Director's Signature