eCOMMONS

Loyola University Chicago
Loyola eCommons

Master's Theses | Theses and Dissertations

1994

Assessing the Inner Experiences of Experienced Therapists Using Cued Recall

June C. Parks
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses

Part of the Education Commons

Recommended Citation

Parks, June C., "Assessing the Inner Experiences of Experienced Therapists Using Cued Recall" (1994). *Master's Theses*. 3967.
https://ecommons.luc.edu/luc_theses/3967

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master's Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License.
Copyright © 1994 June C. Parks

LOYOLA UNIVERSITY CHICAGO

ASSESSING THE INNER EXPERIENCES OF EXPERIENCED THERAPISTS USING CUED RECALL

A THESIS SUBMITTED TO

THE GRADUATE SCHOOL

IN CANDIDACY FOR THE DEGREE OF

MASTER OF ARTS

DEPARTMENT OF COUNSELING AND EDUCATIONAL PSYCHOLOGY

BY

JUNE C. PARKS

CHICAGO, ILLINOIS

MAY 1994

Copyright by June C. Parks, 1994
All rights reserved

ACKNOWLEDGMENTS

I would like to acknowledge Dr. Marilyn Susman, director of this thesis, and Dr. Martha Ellen Wynne for their assistance and guidance in this endeavor. In addition, I thank my husband for his support.

TABLE OF CONTENTS

ACKNOWLEDGMENTS iii

LIST OF TABLES v

Chapter

I. INTRODUCTION 1

Purpose of Study 3

II. REVIEW OF RELATED LITERATURE 6

Psychotherapy Research 6
Process and Outcome Research 11
Response Modes 12
Inner Experiences 20
Intentions 22
Measurement of Intentions 23
Cued Recall 28
Preliminary Study 29
Summary 31

III. METHOD 32

Participants 32
Instrument 33
Procedures 34
Coding Procedures 35

IV. RESULTS 37

V. DISCUSSION 41

Limitations 43
Implications 44

REFERENCES 46

VITA 51

LIST OF TABLES

Table

1. Percentage Use of Therapists' Inner Experiences Across Categories 39

CHAPTER I

INTRODUCTION

Psychotherapy process researchers have devoted much attention to describing and understanding the events that occur during therapy sessions. One method of comprehending these occurrences is through the study of inner experiences. Inner experiences have been classified as cognitive processes, such as thoughts, feelings, perceptions and rationales. This includes metacognitions, internal dialogue, self-talk and intentions (Hill & O'Grady, 1985; Morran, Kurpius & Brack, 1989). Research indicates that the inner experiences of practicing therapists are frequently related to tasks such as focusing on clients, formulating hypotheses, promoting change and developing interventions (Hill, 1982; Hill, 1990; Hill & O'Grady, 1985; Kivlighan, 1989). However, due to the subjective and often complex nature of inner experiences, researchers have found it difficult to measure these internal processes.

The investigation of response modes is a frequently used method of characterizing verbal behavior in therapy. For this reason, it has been regularly employed to examine therapists' inner experiences (Goodman & Dooley, 1976; Hill, 1978; Russell & Stiles, 1979). In this procedure, therapists provide statements that depict their inner

experiences. Researchers classify these verbal statements using response modes which define what has been said. Inferences are then made regarding therapists' inner experiences during sessions, based on the categorization of the response modes.

Unfortunately, the examination of inner experiences using response modes is a complex task. This is due, in part, to the variability of the English language. It is difficult to identify the precise and exact words to illustrate therapists' inner experiences. Researchers have therefore developed numerous response mode categories to describe therapists' verbal behaviors. Presently, there is no one universal response mode categorization system that concisely classifies the verbal behaviors of therapists. Therefore, various systems remain and are used to identify therapists' verbalizations.

In addition to the exploration of response modes, the study of intentions has been frequently used to measure therapists' internal processes. Intentions are a specific type of inner experience and have received much attention in process research (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988; Hill & O'Grady, 1985; Hill, Thompson, Cogar, & Denman, 1993). Intentions appear to provide a more concrete method for observing therapists' inner experiences. Therefore, researchers have conducted numerous studies investigating therapists' intentions during sessions (Hill,

1982; Hill, 1990; Hill & O'Grady, 1985; Kivlighan, 1989). Results indicate that intentions are purposeful and rational. Further, findings show that intentions are a significant and influential element in the therapeutic process.

Purpose of this Study

This exploratory study examines practicing therapists' inner experiences during actual therapy sessions. Cued recall, a frequently used procedure of ascertaining therapists' inner experiences, is employed to aid in the recall of therapists' memories (Hill & O'Grady, 1985; Morran et al., 1989). It is also believed that a cued recall method will increase the number of inner experiences produced by therapists.

The purpose of this study is to expand upon previous research on therapists' inner experiences. Past studies have evaluated inner experiences by focusing on the use of intentions by therapists. Therapists' responses have been coded using intentional lists. These findings on intentions have provided insight into one aspect of therapists' inner experiences.

In this study, it is hypothesized that therapists' inner experiences are broader and more rich than that of intentions alone. It is asserted that the examination of intentions does not capture all components of therapists' internal experiences. Therefore, in contrast to previous

studies, an intentional and a non-intentional coding scale will be used to measure therapists' inner experiences. It is believed that by employing this method, thoughts, feelings, perceptions and rationales not ordinarily captured on intentions lists will be observed. Further, a more accurate measure of therapists' inner experiences will be obtained.

The experienced therapists participating in this study are expected to predominately use intentions in their interactions with clients. The use of intentions is a conceptually complex task emphasized in the teaching and supervision of therapists (Hill & O'Grady, 1985). Intentions are beneficial because they help therapists comprehend what is occurring during therapy sessions. However, while intentional use is predicted, other inner experiences are also anticipated to occur. These relevant internal processes will be coded and analyzed using a non-intentional list.

The first coding schema used to categorize inner experiences in this study is the Therapist Intentions List. This instrument was developed by Hill & O'Grady (1985) to examine the pantheoretical intentions used by therapists. In recent studies, this list has been revised in an attempt to increase accuracy in the measurement of therapists' intentions (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988). This revised version is used in the present

study. The second schema used is the Novice Therapists Pre-Intentional Coding Scale (Rezek, Susman, Wynne, Birringer, & Gaubatz, 1994). This scale examines the variety of non-intentional inner experiences of therapists.

In chapter II of this thesis, related literature on therapists' inner experiences will be explored. Then, in chapter III, the methodology employed in this study will be examined. Results of therapists' inner experiences will be presented in chapter IV with a discussion of these findings being addressed in chapter V.

CHAPTER II

REVIEW OF RELATED LITERATURE

Psychotherapy Research

The examination of psychotherapists' inner experiences and intentions is founded in psychotherapy process research. The objective of process research is to describe and investigate the actions, interactions and state of mind of therapists and clients during therapy sessions (Shoham-Salomon, 1990). "Counseling involves a two-way process of influencing that is defined by the respective role of each participant" (Highlen & Hill, 1984, p. 383).

Incidents during therapy sessions occur on various levels. Some events are overt, social exchanges that occur between clients and therapists (Hill & Corbett, 1993).

Numerous studies have examined these overt interactions. Friedlander & Phillips (1984) investigated topic introduction and participants' compliance to that topic. Through this investigation, researchers attempted to define the interactive discourse between clients and therapists. Results indicated that during the early stages of therapy, both clients and therapists exert great effort to define the scope of the problem. Additionally, both strive to delegate responsibility for directing verbal interactio

In another study, patterns of response modes were examined to detect complementary or symmetrical interactions between clients and therapists (Heatherington, 1988). Findings suggested that complementary or symmetrical interactions could be identified by outside observers.

However, researchers have discovered that overt, observable behaviors do not always provide comprehensive information regarding events during therapy sessions. Events during sessions are often covert, intrapersonal reactions between clients and therapists (Martin, 1991). Complete awareness of these covert occurrences can provide additional insight into therapy events.

Research examining the subjective experiences of therapists has been conducted in the area of cognitive psychology. One of the first studies on cognitive events in therapy was performed by Kagan (cited in Martin, Martin, Meyer & Slemon, 1986). Kagan created Interpersonal Process Recall (IPR), a complex system for training therapists. Using the IPR technique, clients and therapists view videotapes of recently completed therapy sessions. They then provide recollections of their internal cognitive and affective experiences.

More recently, Martin et al. (1986) examined cognitive variables with respect to therapist effectiveness. Results indicated that therapists frequently use internal, cognitive intentions to assist clients in joining new and old memory

information, to regulate clients' personal thoughts and feelings, to aid in clients' reflection on new information and to encourage retrieval of pertinent details in memory. The identification of these and other cognitive behaviors provide important information regarding events that occur during therapy.

Because of the importance of understanding both overt and covert behaviors in therapy, Hill (1982) asserts that the first of three objectives in process research is to describe what is happening in the therapy session. The observation of all therapy events allows researchers to identify similarities or differences in treatments, as well as to confirm the use of specific treatment procedures.

The second goal of process research is to observe change in clients' within session behaviors (Hill, 1982). These changes provide beneficial information as to how clients function outside of the therapy setting. Further, this gives therapists a first hand awareness of clients' maladaptive behaviors or present problems. With this knowledge, therapists are better able to formulate effective treatment plans and interventions.

Finally, process research strives to connect process with outcome to better understand how client change occurs in therapy (Hill, 1982). In this pursuit, change process research has become a valuable tool for evaluating the total therapy process. Change process reduces the dichotomy

between process and outcome, and helps to relate these two variables.

Greenberg (1986) contends that change process can be clearly understood only after examining both beginning and end points of therapy, as well as the events that occur between these two points. The focus of change process is to classify and predict, over the entire length of therapy, the effects of these processes that produce therapeutic change.

In investigating change process in therapy, three levels of process must be examined (Greenberg, 1986). They are: (1) speech acts, which represent how one person interacts with another through the use of language or actions; (2) episodes, meaningful units during therapeutic interactions designed to achieve intermediate objectives; and (3) relationship, specific qualities or implicit understandings, used to describe the ongoing therapeutic relationship.

Further, three levels of outcome must be examined in evaluating the process of change in therapy (Greenberg, 1986). They are: (1) immediate outcomes, which are changes that occurs in the session as a result of specific interventions; (2) intermediate outcomes, such as intermediary changes in target attitudes and behaviors; and (3) final outcomes, which occur at the end of treatment and represent ultimate change.

Studies examining process research have evolved over the past 20 years. Early studies utilized research conditions where psychotherapeutic treatments were give to experimental groups, but not to control groups. (Bergin, 1971). For example, Smith & Glass (1977) conducted a meta-analysis on 375 studies of treated and untreated groups of clients. This study examined approximately 25,000 experimental and 25,000 control subjects. Results indicated that therapy clients showed approximately 75% more improvement, in contrast to untreated individuals.

However, these first studies in process research attained modestly positive results. These less than encouraging findings have been attributed to many factors. One of these factors is the lack of specificity in describing the nature of therapy. The experimental/control research paradigms did not explore the various events that occur during therapy sessions. This omitted aspect may be partially responsible for the average results attained (Orlinsky & Howard, 1986).

More recent studies in process research have focused on within-session variables, as well as changes that occur within therapy (Greenberg, 1986; Hill, 1982). To better understand this process, researchers have focused on therapist response modes and cognitive processes (Elliott, 1985; Hill, 1978; Hill, 1982; Hill, 1990; Hill & O'Grady, 1985; Martin et al., 1986). This shift from examining what

therapists do in sessions, to investigating the messages behind their actions, illustrates the significance of studying the inner experiences and intentions of therapists.

<u>Process and Outcome Research</u>

Numerous studies have identified the relationship between process and outcome research. The focus of these studies is to determine what makes psychotherapy effectively therapeutic. In addition, process and outcome research explores procedures for accomplishing this goal. In these studies, process variables are described as all observable events that occur between clients and therapists as they work together therapeutically (Orlinsky & Howard, 1986). Process research is concerned with behaviors within the therapy session and measures changes that occur during treatment. This definition of process includes all actual events that occur during therapy sessions, as observed by participants or non-participants.

In contrast, outcome research is related to behaviors occurring outside of the session (Greenberg & Pinsof, 1986). Generally, outcome is measured as changes that occur between pre-therapy and post-therapy assessments (Hill & Corbett, 1993). Additionally, outcome refers to changes that occur as a consequence of the process of therapy.

Therefore, process research strives to link process with outcome to determine how client change occurs. By observing changes throughout therapy, process and outcome

research converge and provide a continual measure of progress and growth.

Response Modes

The irregularities, variations and complexities found within the English language often make it difficult to understand occurrences during therapy sessions. Therefore, because of the subjective and often unclear, nature of process research, great importance has been placed on the study of verbal behaviors. The study of verbal behaviors provide a means of identifying events during therapy sessions. Therapists' response modes are a useful method of classifying the various types of therapist verbalizations (Elliott, 1985; Hill, 1978).

A response mode is a verbal action that identifies an interpersonal relationship between the communicator and recipient (Stiles, 1978). Response modes indicate the significant features of these interpersonal relationships. They are commonly used in process research because of their ability to describe the therapeutic relationship, without altering the content of the communication (Stiles, 1979).

There are numerous response mode category systems that classify the verbal behaviors of therapists and clients (Goodman & Dooley, 1976; Hill, 1978; Russell & Stiles, 1979). One reason for the existence of various categories is the lack of universal theoretical understanding regarding response modes. Therefore, in pursuit of clarity,

researchers have developed numerous systems in hopes of capturing all elements of verbal behaviors that occur in therapy.

Goodman & Dooley (1976) identified six response categories that were used to classify helping styles, to classify interactions between clients and therapists and to define the therapeutic relationship. First, the researchers identified six types of helping intentions: (1) gathering information; (2) guiding another's behavior; (3) providing interpersonal space; (4) explaining or classifying another's behavior; (5) expressing empathy and; (6) revealing one's personal condition. They then described these intentions in terms of responses modes used by therapists. These response modes were: (1) question, frequently used to gather information; (2) advisement, overt statements used to change another's behavior or attitude; (3) silence, overt latencies between speakers or within response modes; (4) interpretation, statements that go beyond the other person's overt statements and provide new meaning for behaviors, feelings and cognitions; (5) reflection or paraphrase, a summary of another's verbal and nonverbal communication; (6) disclosure, statements that reveal a hidden aspect of the speaker's feelings thoughts and experiences.

In more recent studies examining these response modes, Elliott, Barker, Caskey & Pistrang (1982) discovered that

interpretation and advisement were the most helpful response modes. Questioning was found to be the least useful.

Hill (1978) created a counselor response category system, incorporating elements from existing response mode systems. This schema contains 17 categories. They include: (1) minimal encourager, short phrases that illustrate agreement or understanding; (2) approval-reassurance, to provide emotional support and reinforcement; (3) structuring; (4) information, to supply facts, data or resources; (5) direct guidance, advice or suggestions offered by therapists to clients; (6) closed questions, questions used to invoke limited yes or no information from clients; (7) open questions, inquiries that require clarification or exploration, but do not limit clients' responses; (8) restatement, repeating clients' statement; (9) reflection, restatement of clients' verbalizations, including references to clients' feelings; (10) nonverbal referent, questions regarding clients' non-verbal behavior; (11) interpretation; (12) confrontation, statements that challenge the clients' awareness and highlights discrepancies in the clients' statements; (13) self-disclosure, therapists' use of themselves as instruments, or the sharing of personal information about therapists; (14) silence; (15) friendly discussion; (16) criticism; and (17) unclassifiable. High agreement levels for all 17 therapist verbal response categories were found. The researcher concluded that this

category system was able to identify the diversity in therapists' responses within sessions.

A later study examining these therapist response modes, found interpretation, approval, paraphrase and self-disclosure to be the most helpful (Hill et al, 1988). Open question, confrontation and information were moderately useful. Direct guidance and closed question were found to be least beneficial.

The existence of numerous response mode categories compelled Stiles (1979) to create an integrated and descriptive framework. In this study, a taxonomy was developed, based on three principles of classification that define and relate response modes. The three principles were source of experience, frame of reference and focus. Source of experience refers to the experience of the person whose viewpoint is being expressed. Frame of reference signifies the viewpoint of the person making the utterance. Finally, focus examines whether or not the speaker implicitly understands the other person's experience, or frame of reference. The taxonomy also distinguishes eight response modes. They are: (1) disclosure; (2) question; (3) edification; (4) acknowledgment; (5) advisement; (6) interpretations; (7) confirmation/disconfirmation; and (8) reflection.

Further recognizing the need to integrate various systems of verbal behaviors, Russell & Stiles (1979) created

a framework from which to compare and contrast categorization schemes. In this study, a 3 x 2 topology method was used to examine verbal interactions in psychotherapy. The three language categories consisted of content, intersubjective and extralinguistic. Content categories describe the semantic content of words or word groups. Intersubjective categories identify the implied syntactical, and other, relationships between communicator and recipient. In contrast to content categories, intersubjective categories can often be defined without reference to the semantic content of the communication. Finally, extralinguistic categories describe vocal noises that do not make up language. These include pitch, amplitude and other vocal noises that are associated with language behavior. Further, extralinguistic categories are classified without reference to semantic intent of syntactical structure. Extralinguistic categories have been used to examine emotional and motivational states.

Sectioning across these language categories are two unique coding strategies. The first is classical strategies which describes the characteristics of the communication. The second is pragmatic strategies which identifies characteristics of the communicator, such as inner state, or intentions.

Difficulties in comparing response modes systems have been attributed to contrasting labels, measurement

assumptions and rating methods used in the various category systems. Elliott, Hill, Stiles, Friedlander, Mahrer & Margison (1987) evaluated seven sets of actual therapy sessions to determine a common set of primary response modes. Six established response mode systems were used to determine frequently occurring response modes. The results indicated that a common set of response modes occurs universally between the six response mode systems. They are: (1) question; (2) advisement; (3) information, (4) reflections; (5) interpretation; and (6) self-disclosure. While all six systems measured these primary modes, the modes were defined somewhat differently within each category system. In addition, researchers concluded that no one system was clearly superior over the other response modes category systems.

In examining 1100 research studies on outcome in psychotherapy, Orlinsky & Howard (1986) identified seven response modes that affect client outcome. The first is interpretation. An interpretation is defined as an explanatory statement used to clarify the meaning of an action or experience. Interpretations are consistently found to be effective (Hill, 1992). They appear to be more constructive when of moderate depth and associated with specific interpersonal problems facing the client. However, other researchers assert that it is difficult to determine the potential positive or negative affects of

interpretations. Therefore, it is assumed that other significant factors increase or decrease the impact of interpretations on client outcome (Orlinsky & Howard, 1986).

The second element is confrontation, or giving feedback (Orlinsky & Howard, 1986). The goal of confrontation is to generate insight. Confrontation can occur through feedback from therapist to client or through the use of techniques, that are designed to promote confrontation. Present process-outcome studies indicate high success when the response mode confrontation is used as an intervention.

The third response mode explored in outcome research is exploration or questions (Orlinsky & Howard, 1986). Therapists will frequently use questions as a method of gathering information. In addition, questions are used to assist in clients' exploration of their experiences.

Another response mode frequently used by therapists is support and encouragement. Research on support has yielded modestly positive findings, leading researchers to conclude that while support may sometimes be beneficial, it does not seem to be consistently influential (Orlinsky & Howard, 1986).

An additional response mode is advice giving (Orlinsky & Howard, 1986). Research has yielded conflicting results regarding advice giving. While Elliott et al. (1982) found advice giving, as perceived by therapists and clients, to be significantly related to outcome evaluations, other studies

found no relationship between therapist advice and client outcome (Staples, Sloane, Whipple, Cristol & Yorkston, 1976). Therefore, it is concluded that too few findings exist to accurately determine the strengths or weaknesses of advice giving (Orlinsky & Howard, 1986).

A further response mode is reflection (Orlinsky & Howard, 1986). Reflections are defined as a technique of restatement used by therapists to verify their understanding of clients' statements. Additionally, reflections are used to clarify clients' meaning and to assist in the exploration of specific client experiences. A few studies have examined the affects of reflection on outcome. Elliott et al. (1982) found no significant relationship between reflection, as reported by therapists and clients, to outcome. Reflections are viewed as neither helpful nor harmful and is therefore considered a poor intervention in terms of creating significant therapeutic results (Orlinsky & Howard, 1986).

Therapist self-disclosure is the final response mode (Orlinsky & Howard, 1986). Various studies have examined the utility of self-disclosure. Elliott et al. (1982) measured self-disclosure from the perspective of both clients and therapists, in regard to therapeutic outcome. No significant findings were attained. However, a significantly positive relationship was found between self-disclosure and outcome, as evaluated by therapists only. These findings have lead researchers to conclude that self-

disclosure, while occasionally helpful, is generally not a strong therapeutic intervention (Orlinsky & Howard, 1986).

Inner Experiences

Among the various areas explored in process research, inner experiences is one that has received significant attention. Inner experiences are the thoughts, feelings, perceptions and rationales that may or may not exist within therapists' awareness (Hill & O'Grady, 1985; Hill & Corbett, 1993). Further, inner experiences include internal processing such as metacognitions, intentions and therapists' self-talk. Examining these internal experiences can provide valuable information about therapy sessions and client outcome.

Morran et al. (1989) explored therapists' inner dialogue as it affects the therapy process. Important information was obtained regarding therapists' inner experiences. Thirty-eight novice and experienced therapists were asked to report their thoughts during therapy sessions. These self-reported thoughts were then independently categorized by the researchers. The categories included: (1) behavioral observations, thoughts directed to clients' overt behavior; (2) client-focused questions, thoughts questioning the clients or their situations; (3) summarizations, thoughts that analyze and integrate clients' stories; (4) associations, thoughts relating clients' experiences to those of others; (5) inferences or

hypotheses, thoughts, hunches and assumptions about clients, which go beyond what clients have expressed; (6) relationship assessment, thoughts regarding the client-therapist relationship or the therapeutic process; (7) self-instruction, self-directed thoughts made by therapists to take a specific course of action, intervention or therapeutic technique; (8) anxiety or self-doubt, thoughts of uncertainty, confusion, apprehension or lack of confidence; (9) corrective self-feedback, thoughts identifying specific therapist performance problems, but also recognizing the possibility of corrective actions; (10) positive self-feedback, self-reinforcing thoughts that acknowledge positive elements of therapists' performance; (11) reaction to client, emotional thoughts that therapists have toward clients; (12) self-questions, thoughts in the form of questions that therapists are directing toward themselves; (13) external, thoughts not directly related to the therapist, client or the therapeutic relationship; and (14) self-monitoring, thoughts expressing therapists' self-awareness that is not directly related to their performance. Results indicated four thought processes therapists engage in and which characterize 60% of all thoughts categorized. They were: (1) summarizations; (2) client-focused questions; (3) inferences or hypotheses; and (4) self-instructions.

Because of the subjective nature of inner experiences, it is often difficult to measure these events. More

concrete methods, such as the study of intentions, have been employed to provide a comprehensive examination of the inner processes of therapists.

Intentions

More studies in process research are examining the reasons behind therapists' behaviors; thus, the importance of intentions becomes apparent. Intentions are cognitive elements and provide covert reasons and goals for interventions (Hill, 1990; Hill & O'Grady, 1985). Therapists process an enormous amount of information ranging from the presenting problem, the therapy setting, the client's behaviors, and the therapist's reactions. Through training and experiences, therapists incorporate this information to form intentions as to what they want to achieve during the session.

Hill and O'Grady (1985) define 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 refer to the reasons why therapists do what they do, in contrast to interventions and techniques which refer to the behaviors of therapists.

Several studies have investigated therapists' techniques and interventions to better understand how these factors relate to therapists' intentions. Hill (1992) outlined 9 categories of therapist verbal techniques. They

are: (1) approval; (2) information; (3) direct guidance; (4) closed question; (5) open question; (6) paraphrase; (7) interpretation (8) confrontation and (9) self-disclosure. Studies examining therapists' techniques provide practical information as to how therapists' intentions positively or negatively impact client outcome. With this knowledge the goal of providing effective psychological treatment can be achieved.

Intentions also influence therapists' choice of interventions. Interventions are defined as specific tasks, including techniques, introduced by therapists in response to problems presented by clients (Orlinsky & Howard, 1986). Additionally, interventions are specific procedures deliberately made by therapists, clients or both. It is asserted that interventions comprise the most prominent and intentional component of therapy (Orlinsky & Howard, 1986).

Measurement of Intentions

The measurement of intentions is a complex task, due to its covert element. Most studies have measured therapists' intentions through therapists' post-session recollections of their intentions after viewing a videotape or audiotape of the session (Caskey, Barker & Elliott, 1984; Elliott, Barker Caskey & Pistrang, 1982; Heppner, Rosenberg & Hedgespeth, 1992; Hill & O'Grady, 1985).

Hill & O'Grady (1985) investigated experienced therapists' use of intentions. In this study, a

pantheoretical, non-mutually exclusive list of 19 therapists' intentions was developed and used to assess one counseling psychologist's intentions across 20 therapy sessions. These intentions were: (1) set limits in regard to structuring the session and establishing objectives; (2) get information, to find out specific facts about client history and functioning; (3) give information, to educate and correct misperceptions; (4) support, to provide a warm environment; (5) focus or change the subject in order to get client back on track; (6) clarify, to provide or solicit more elaboration; (7) hope, to communicate the expectation that change is possible and likely to transpire;(8) cathart, to promote the alleviation of tension or unhappy feelings; (9) cognitions, to identify maladaptive and illogical thoughts, beliefs and attitudes; (10) behaviors, to recognize and provide feedback concerning clients' maladaptive behaviors, as well as the consequences of their behaviors; (11) self-control, to gain proficiency over thoughts, feelings and behaviors and to aid in clients' recognition of appropriate internal functioning; (12) feelings, to identify acceptable feelings and encourage clients' awareness of underlying affect; (13) insight, to promote clients' understanding of hidden reasons, dynamics or unconscious motivations for cognitions, feelings and behaviors; (14) change, to create new and more adaptive skills, behaviors and cognitions; (15) reinforce change, to

provide positive feedback concerning behavioral, cognitive or affective attempts at change and to increase the probability that these changes will be maintained; (16) resistance, to overcome barriers, and to progress; (17) challenge, to confront clients' current state by challenging beliefs, feelings and behaviors; (18) relationship, to reconcile obstacles as they occur in the therapeutic relationship in an effort to create an effective therapeutic alliance; and (19) therapist needs, to promote feelings of superiority at the client's expense. Transcripts of therapy sessions and a checklist of these 19 intentions were provided to the therapist. The therapist was then asked to select pertinent intentions that coincided with each of her responses. The most frequently used intentions corresponded to the therapist's stated theoretical orientation, leading researchers to conclude that a profile of intentions can provide useful information regarding therapists' theoretical orientation.

In the second part of this study (Hill & O'Grady, 1985), researchers investigated the applicability of this intentional list across various theoretical orientations. Therapists used the same 19 category intention list to identify the intentions of each of their responses after listening to an audio tape of an actual session. Results indicated that therapists from various theoretical orientations use intentions in unique and predicable ways.

For example, psychoanalytic therapists were found to use more feelings and insight whereas behavioral therapists employed more change, set limits and reinforce change. These findings coincide with the techniques associated with these two orientations.

In subsequent studies, this list of 19 therapist's intentions was organized into eight clusters (Hill et al., 1988). This revision was made to provide a more complete representation of therapists' intentions that frequently occur in therapy and should be explored in future research. The eight categories are: (1) set limits; (2) assess (get information, focus and clarify); (3) support (support, instill hope and reinforce change); (4) education (give information); (5) explore (identify and intensify cognitions, behaviors, and feelings); (6) restructure (insight, resistance and challenge); (7) change; and (8) miscellaneous (relationship, cathart, self-control and therapist needs).

Elliott (1979) has also investigated therapists' intentions. Video tapes were used to prompt clients' memories of specific segments of their therapy sessions. Clients were then asked to provide free responses regarding the intentions of their therapists. The intention variables measured were: (1) guiding client; (2) reassuring client; (3) communicating understanding of client's message; (4) explaining client; (5) gathering information; and (6) using

self to help client. Results indicated a moderate but significant finding that clients were able to predict the intentions of their therapists.

In another study that measured intentions, therapists were asked to classify their intentions during therapy sessions in order to examine helpful and non-helpful events during therapy (Elliott, 1985). Therapists' intentions consisted of: (1) gather information, open questions; (2) gather information, closed question; (3) guide in session; (4) advise client; (5) communicate understanding of client's message; (6) explain client to client; (7) reassure client; (8) disagree with client, (9) share self with client and (10) give general information. The results found communicating understanding, explaining client to client and reassuring client to be the most predominate helpful intentions, according to the therapists.

In a study examining non-intentional behaviors of therapists, Rezek et al. (1994) developed a Novice Therapist Pre-Intentional Coding Scale. The schema was designed to examine the variety of non-intentional inner experiences encountered by therapists. The categories consisted of: (1) the-rapist self-awareness (of emotions, behaviors, or cognitions); (2) therapist self-direction (of emotions, behaviors or cognitions); (3) therapist self-evaluation, the assessment of therapists' in-session behaviors along a continuum that includes criticism, self-corrective feedback

and praise; (4) therapist awareness of client's (emotions, behaviors, or cognitions); (5) client situational-interpersonal status, observations and questions about client's life that are relevant to issues presented by client; (6) hypothesizing/formulating, therapists' higher-order thoughts pertaining to clients; (7) client evaluation, evaluations concerning client or individuals in client's life; (8) setting/situational evaluation, thoughts referring to the therapy situation; (9) relational/process, thoughts referring to the interaction between therapist and client; and (10) tangential focus, blatantly tangential thoughts that represent a shift in the therapist's perspective.

Cued Recall

Therapists' intentions have been frequently measured through the use of video or audio tapes that is reviewed immediately following therapy sessions. The advent of audio recording made it possible for researchers to examine actual moment-by-moment therapy events without having to rely on observers' reports which could be biased or inaccurate (Hill & Corbett, 1993). Typically, the tape is stopped after every statement made by therapists. Therapists then provide their intentions which correspond to the employed intervention.

Kagan's IPR technique extensively uses cued recall to explore cognitive and affective experiences (cited in Hill, 1992). Researchers have expanded this technique to include

the investigation of therapists' intentions and behaviors, as well as clients' perceptions (Elliott, 1979, 1985; Hill & O'Grady, 1985).

This method of tape assisted recall has been useful in examining clients' inner experiences and intentions. Cued recall can access a larger variety of clients' in-session experiences than can be attained through other methods, such as free recall. With more examples of inner experiences, researchers can better identify and define the subjective processes of therapists.

Preliminary Study

In a preliminary study, using the same methodology and data presented in this study, researchers examined cued and free recall methods in an attempt to assess therapists' inner experiences (Susman, Wynne, Rezek, Martin, Katz & Ries, 1992). Therapists were interviewed following therapy sessions and asked to provide free responses regarding their thoughts, feelings and rationales after each intervention based on their recollection of dialogue from the first five minutes; the most significant event; and the last five minutes. Follow up interviews were conducted two weeks later with the same therapists. Therapists were cued by pre-recorded audio tapes of the first five minutes, the most significant event and the last five minutes of the session. Therapists were asked to provide their inner experiences.

Inner experiences from the cued and free recall methods were analyzed using two coding scales. The first was the revised Hill & O'Grady intention list, designed to identify the intentions used by therapists (Hill et al, 1988). The second scale was a supplementary list developed to capture the non-intentional inner experiences of therapists (Susman, et al., 1992). The categories included: (1) therapist self-awareness (emotional, behavioral and cognitive); (2) therapist self-direction (emotional, behavior and cognitive); (3) therapist awareness of client (emotional, behavioral and cognitive); (4) self-evaluating, therapists' positive or negative evaluation of themselves; (5) client evaluation; (6) situational evaluation, therapists' awareness of the therapy situation; (8) hypothesizing-formulating, higher order thoughts outside of clients' awareness; (9) general knowledge external to therapy session; and (10) garbage can.

In analyzing the cued recall method, therapists' used intentional inner experiences 74% of the time. The supplementary list captured the remaining 26% of the inner experiences of these therapists. For the free recall data, therapists' used intentions 53.2% of the time and other inner experiences 43.8% of the time. In both free and cued recall methods, therapists used more intentional inner experiences than non-intentional inner experiences. The most frequently used intentions were assess, explore and

restructure. On the supplementary lists, the most frequently used categories were therapist evaluation of therapeutic situation and therapist awareness of client (emotional, behavioral or cognitive).

Summary

Prior studies have used cued recall methods to investigate intentions in attempt to understand therapists' inner experiences. However, this study asserts that therapists' inner experiences encompasses more than just intentions. Therefore, in contrast to the majority of other studies examining inner experiences, two coding scales will be used to examine therapists' internal processes. One is an intentional scale, the other a non-intentional scale. By using both scales, it is hoped that therapists' thoughts, feelings and rationales following each intervention with clients, will be more accurately captured and provide a clearer depiction of therapists' inner experiences.

CHAPTER III

METHOD

Participants

A list of 1400 licensed psychologists in the Chicago and surrounding Cook County area comprised the initial sampling frame. This number was reduced to 1216 names due to the unavailability of 196 psychologists, who had either relocated, were no longer employed, or were deceased. One-third of the remaining 1216 names were randomly selected and comprised the final sampling frame. Several mailings and telephone calls were made to these 845 psychologists. After extensive attempts to obtain participants, 23 therapists (2.72%) agreed, in principle, to take part in this study. Twenty therapists actually were interviewed and complete data were obtained from 15 therapists. Therapists received no compensation for their participation in this study.

Therapists (12 women and 3 men) ranged in age from 39 - 60 years (M = 49.07, SD = 6.27). All therapists were in full-time or part-time private practices. Years of post-doctoral clinical experience ranged from 3 - 29 years (M = 12.29, SD = 6.79). Therapists identified their theoretical orientations as either systems, cognitive-behavioral, analytic or an integrated mixture of these three methods.

Clients were selected from therapists' private practices. All clients completed informed consent forms and their identities were unknown to the researchers.

Instrument

A three part interview protocol was created for this study. Part I examined the client/therapist relationship. Part II investigated therapists' recall and inner experiences during the first five minutes, the most significant episode, and the last five minutes of the sessions. These three time segments correspond to primacy, saliency and recency effects (Elliott, 1983). Finally, Part III analyzed contextual elements of the therapy sessions. This study focuses on data obtained from the follow up interview held two weeks later and used audio taped segments of the first five minutes, most significant event and last five minutes.

Five graduate counseling students at Loyola University Chicago (1 male and 4 females) served as interviewers. All interviewers memorized the protocol and were fully trained to establish procedural consistency across interviews. This protocol was then field-tested using practicing psychotherapists as subjects before actual data were collected. Throughout this process, extensive revisions were made to the protocol.

Procedures

On the day of a therapist's session, an interviewer arrived at the therapist's office, prior to the session, to set up audio recording equipment. The interviewer then left the therapist's office and the session was conducted. The interviewer returned following the session and asked the therapist to complete Part I of the three part interview protocol. Next, the therapist was asked to recall verbatim the dialogue between the client and him/herself with regard to the first five minutes, the most significant episode and the last five minutes of the session. The therapist's responses were written down by the interviewer. The interviewer then read back the therapist's words and asked the therapist to provide his/her inner experiences for each intervention. These inner experiences were also recorded. Finally, Part III of the interview and a demographic questionnaire were administered.

Following this interview, audio tapes were made which contained the three time segments from the original recording of the session. The most significant event was identified on the tape by the therapist's response on the protocol. The taped segments of the first five minutes, the most significant episode and the last five minutes began with the client's statement and ended after the therapist's response.

Two weeks following the data collection, the interviewer returned to complete the follow-up portion of

the interview. In contrast to the first interview, where the therapist used free recall to recount inner experiences during the sessions, the therapist was now cued by the pre-recorded audio tape of the first five minutes, most significant episodes and last five minutes of the session. These three designated time segments were from 5-8 minutes in length. After listening to the audio tape, the therapist was asked to describe his/her thoughts, feelings and rationales prior to each intervention. The responses were recorded verbatim by the interviewer. These inner experiences were coded and analyzed.

Coding Procedures

The inner experiences were divided into discrete thought units by two graduate counseling students who attained overall simple interrater agreement of 90%. Disagreements were resolved through discussion.

These thought units were then coded by two different graduate students using the revised Hill & O'Grady Therapist Intentional List (Hill et al, 1988). This instrument is designed to identify intentions used by therapists. A ninth category (PCAT) was created to classify any thought units that fell outside the realm of the intentions list. The inner experiences in the ninth category then were coded using the Novice Therapist Pre-Intentional Coding Scale (Rezek et al., 1994). This instrument examines the diverse,

non-intentional inner experiences encountered by experienced and novice therapists.

Transcripts were randomly assigned to the two raters. Final coding decisions were reached through discussion and resolution. Resolution was used in coding inner experiences because independent agreement did not reach 80%.

The two raters received six hours of training on the Hill & O'Grady revised intentional list (Hill et al., 1988) and 21 hours of group training on the Pre-Intentional Coding Scale (Rezek, 1994). Training involved independently coding training transcripts, discussing disagreements, and resolving and defining categories on the coding scales. Training on both scales continued until coding agreement stabilized between 65-70%.

Simple interrater agreement of 73% was attained on the intentional list and 64% on the non-intentional list. Scott's π was used to calculate reliability. Results indicated a value of .63 on the intentional list and .59 on the non-intentional list.

CHAPTER IV

RESULTS

To increase comparability of how therapists used coding categories across subjects, all frequency data were transformed into percentages. These percentages were attained by dividing each participant's frequency of use of a given category by the total number of thought units in the participant's transcript. The eight Hill intentions categories were then collapsed into a single mean percentage of use.

Table 1 shows the distribution of percentage use of the intentional and non-intentional categories. Therapists identified intentional inner experiences 71.92% of the time. The three largest intentional categories were assess (24.41%), support (14.25%), and explore (12.51%). These categories accounted for 51.17% of all intentional categories used. Utilization of the remaining five intentional categories were fairly evenly distributed. Intentional categories infrequently used were change (3.80%), set limits (1.13%) and educate (1.01%).

Items that fell in the ninth category (PCAT) were non-intentional and coded using the Novice Therapist Pre-intentional Coding Scale (Rezek et al., 1994). 28.08% of

all inner experiences employed by therapists were non-intentional. Therapists used 12 categories from the pre-intentional list (Rezek et al., 1994). They were: (1) therapist self-awareness of emotion; (2) therapist self-awareness of cognition; (3) therapist self-awareness of behavior; (4) therapist awareness of client's emotion; (5) therapist awareness of client's cognition; (6) therapist awareness of client's behavior; (7) client situational and interpersonal status; (8) hypothesizing-formulating; (9) client evaluation; (10) setting/situation; (11) tangential focus, pertaining to client; and (12) uncodable.

Of the 28.08% of all non-intentional categories used, the four largest categories were hypothesizing/formulating (20.42%), therapist awareness of client's behaviors (13.72%), therapist awareness of client's emotions (12.81%), and therapist awareness of client's cognition (12.51%). These non-intentional categories comprised 59.46% of all non-intentional categories used by therapists. Non-intentional categories infrequently used were client evaluation (2.30%), setting/situation (0.09%), and self-evaluation (0.00%).

Table 1

Percentage Use of Therapists' Inner Experiences Across Categories

	Mean	**Standard Dev.**
Intentional		
Set Limits	1.13	1.60
Assess	24.41	10.61
Support	14.25	8.03
Education	1.01	1.83
Explore	12.51	6.52
Restructure	8.28	5.94
Change	3.80	6.37
Miscellaneous	6.53	6.63
Total	71.92	14.85
Non-Intentional	28.08	16.76
Non-Intentional		
Therapist Emotion	5.61	8.41
Therapist Cogn.	8.66	9.55
Therapist Behav.	6.39	10.02
Client Emotion	12.81	9.16

Table 1 (continued)

	Mean	**Standard Dev.**
Client Cognition	12.51	13.96
Client Behavior	13.72	13.85
Client Situation	8.91	7.90
Hypothesizing	20.42	37.85
Client Evaluation	2.30	4.85
Setting/Sit.	0.09	0.31
Tangential Focus	6.08	10.06
Uncodable	2.19	5.73

CHAPTER V

DISCUSSION

Experienced therapists tended to utilize more intentional responses (71.92%) than non-intentional responses (28.08%). The most frequently used intentions were to assess (24.41%), support (14.25%) and explore (12.51%). Of the non-intentional inner experiences, the most frequently used categories were hypothesizing (20.42%), therapist awareness of client's behavior (13.72%), therapist awareness of client's emotion (12.81%) and therapist awareness of client's cognition (12.51%).

While the present study reported a large number of intentions under the categories of assess, support and explore, the other intentions were fairly evenly distributed across the five remaining intentional categories. They were restructure (8.28%), miscellaneous (6.53%), change (3.80%), set limits (1.13%) and educate (1.01%).

Further, intentions such as assessing, supporting and exploring, reflect experienced therapists' desire to focus and understand clients' issues and presenting problems. After absorbing this information, therapists are then better able to assist clients and develop intentions for interventions.

Interestingly, the most frequently used intentions in this study are somewhat passive in that they do not overtly promote change in the client's presenting problems. Instead these intentions are designed to gain information about clients and to encourage positive therapeutic alliances. More active therapists' intentions such as educate, and promote change occurred only 1.01% and 3.80% of the time, respectively.

These findings differ slightly from the intentions of experienced therapists reported in the Hill & O'Grady (1985) study. In this research, the most frequently used intentions were insight, behaviors, feelings, change, challenge and self-control. These intentions fall under the revised coding scale categories of explore, restructure, change and miscellaneous. While explore frequently occurred in both studies, change and miscellaneous were observed less often in the present study.

In another study using the revised Hill & O'Grady list, results indicated that the most helpful intentions, as indicated by clients and therapists, were exploring feelings and behaviors (Hill et al., 1988). Further, moderate ratings were given to support and restructure. In comparison to the present study, explore and support were also found to be frequently used intentions. While restructuring was used less often, it also occurred at an average level.

Of the 28.08% non-intentional inner experiences of practicing therapists, the category most used by experienced therapists was hypothesizing. Hypothesizing is conceptually similar to the development of intentions. Thus, it seems appropriate that therapists used this non-intentional category more frequently than any other. Further, the regular use of non-intentional categories such as therapist awareness of clients' behaviors, emotions and cognitions reflects experienced therapists' use of inner speech to synthesize information about clients.

Prior research suggests that non-intentional behaviors are less conceptually complex than intentional behaviors. (Rezek et al., 1994). One such category is tangential focus. Out of the 28.08% of the time that non-intentions were reported, 2.19% of therapists' non-intentional inner experiences were tangential and unrelated to therapy sessions.

The data from this study suggests that while therapists appear to develop intentions for their interventions and utilize complex inner experiences in therapy sessions, the use of less developed inner experiences is demonstrated. These less complex inner experiences should not be ignored in future research investigating the inner experiences of therapists.

Limitations

One limitation of the present study is the small sample

size used. Many therapists contacted chose not to participate due to reasons related to time, fear that audio taping would interfere with the therapy process and unwillingness of clients to have their sessions taped. Therefore, because of the small number of participants, it is difficult to generalize the present findings.

Further, in conducting the follow-up interview, two weeks transpired from the initial therapy session. Although therapists were cued by audio tapes to assist in the recall of their inner experiences, this passage of time may have negatively impacted upon the accurate recall of therapists' inner experiences. Therapists' responses, two weeks later, may have reflected their present inner experiences upon listening to the audio tapes and not their original inner experiences at the time of the session. A shorter time frame may have provided more conclusive results.

Implications

This study suggests that therapists' inner experiences are broader than what is captured on intentions lists. It is important to recognize that conceptually simpler non-intentions such as therapist self-awareness and tangential focus do occur as experienced therapists conduct sessions. Their existence, while slight, appears to play a role in therapy sessions. It would be interesting to discover how these small but present, non-intentional inner experiences positively or negatively affect the therapeutic process.

Although these conceptually less advanced inner experiences are often observed to occur with novice therapists and can be reduced though training, they do not disappear. This study suggests that the presence of non-intentional inner experience could provide beneficial information about therapy events.

Further, this study raises questions concerning the development of therapists. Clearly, the high level of non-intentional responses that generally exists with novice therapists were not present in this study examining experienced therapists. However, what is the significance of the amount of non-intentional inner experiences found for these developed therapists? Are the levels of non-intentional inner experiences discovered in this study typical of developed and experienced therapists? Does the existence of these non-intentional inner experiences represent a lack of development or progress that could be reduced through additional training and supervision? These questions are all valid issues that should be addressed in future research examining the inner experiences of therapists.

REFERENCES

Bergin, A. E. (1971). The evaluation of therapeutic outcome. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change, New York: Wiley.

Caskey, N. H., Barker, C., & Elliott, R. (1984). Dual perspectives: Clients' and therapists' perceptions of therapist responses. Journal of Clinical Psychology, 23, 281-290.

Elliott, R. (1983). Fitting process research to the practicing psychotherapist. Psychotherapy: Theory, Research, and Practice, 20, 45-55.

Elliott, R. E. (1985). Helpful and nonhelpful events in brief counseling interview: An empirical taxonomy. Journal of Counseling Psychology, 32, 307-322.

Elliott, R., Barker, C. B., Caskey, N., & Pistrang, N. (1982). Differential helpfulness of counselor verbal response modes. Journal of Counseling Psychology, 29, 354-361.

Elliott, R., Hill, C. E., Stiles, W. B., Friedlander, M. L., Mahrer, A. R., & Margison, F. R. (1987). Primary therapist response modes: Comparison of six rating

systems. Journal of Consulting and Clinical Psychology, 55, 218-223.

Friedlandler, M. L., & Phillips, S. D. (1984). Stochastic process analysis of interactive discouse in early counseling interviews. Journal of Counseling Psychology, 31, 139-148.

Greenberg, L. S. (1986). Change process research. Journal of Consulting and Clinical Psychology, 54, 4-9.

Goodman, G., & Dooley, D., (1976). A framework for help-intended communication. Psychotherpay: Theory. Research and Practice, 13, 106-117.

Heppner, P. P., Rosenberg, J. I., & Hedgespeth, J. (1992). Three methods in measuring the therapeutic process: Clients' and counselors' constructions of the therapeutic process versus actual therapeutic events. Journal of Counseling Psychology, 39, 20-31.

Highlen, P.S., & Hill, C.E. (1984). Factors affecting client change in individual counseling: Current status and theoretical speculations. In S.D. Brown & R.W. Lent (Eds.), Handbook of Counseling Psychology, 334-396. New York: Wiley.

Hill, C. E. (1982). Counseling process research: Philosophical and methodological dilemmas. The Counseling Psychologist, 10, 7-19.

Hill, C. E. (1978). Development of a counselor verbal response category system. _Journal of Counseling Psychology_, _25_, 461-468.

Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. _Journal of Consulting and Clinical Psychology_, _58_, 288-294.

Hill, C, E. (1992). Research on therapist techniques in brief individual therapy: Implications for practitioners. _The Counseling Psychologist_, _20_, 689-711.

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. _Journal of Counseling Psychology_, _40_, 3-24.

Hill, C. E., & Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, K. E., Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. _Journal of Counseling Psychology_, _35_, 222-233.

Hill, C. E., & O'Grady, K. E. (1985). List of therapist intentions illustrated in a cast study and with therapists of varying theoretical orientations. _Journal of Counseling Psychology_, _32_, 3-22.

Hill, C. E., Thompson, B. J., Cogar, M. C., Denman, D. W., II. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each

other's covert processes. Journal of Counseling Psychology, 40, 278-287.

Kivlighan, D. M., Jr. (1989). Changes in counselor intentions and response modes and in client reactions and session evaluation after training. Journal of Counseling Psychology, 36, 471-476.

Martin, J. (1991). The perils of "process talk" in counseling and counselor education. The Counseling Psychologist, 19, 260-272.

Martin, J., Martin, W., Meyer, M., & Slemon, A. (1986). Empirical investigation of the cognitive mediational paradigm for research on counseling. Journal of Counseling Psychology, 33, 115-123.

Morran, D. K., Kurpius, D. J., Brack, G. (1989). Empirical investigation of counselor self-talk categories. Journal of Counseling Psychology, 36, 505-510.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherpay. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change, New York: Wiley.

Rezek, P. (1994). Inner experiences and self-efficacy of novice counselors. Unpublished doctoral dissertations, Loyola University Chicago, Chicago.

Russell, R. L., Stiles, W. B. (1979). Categories for classifying language in psychotherapy. Psychological Bulletin, 86, 404-419.

Stiles, W. B. (1978). Verbal response modes and dimensions of interpersonal roles: A method of discourse analysis. Journal of Personality and Social Psychology, 36, 693-703.

Smith, M. L. & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. American Psychologist, 32, 752-760.

Stiles, W. B. (1979). Verbal Response Modes and Psychotherapeutic technique. Psychiatry, 42, 19-62.

Susman, M., Wynne, M. E., Rezek, P., Martin, C., Katz, L., Ries, S. (1992). Assessing the inner processes of experienced and novice therapists: A comparison study. Unpublished manuscript.

VITA

The author, June C. Parks, was born in Chicago, Illinois. In September, 1983, Ms. Parks entered Northwestern University in Evanston, Illinois. She received her Bachelor of Arts degree in Psychology in June, 1987. While attending Northwestern University, Ms. Parks volunteered on the Northwestern Help Line as well as worked as a sleep lab technician.

In August, 1991, Ms. Parks began graduate studies at Loyola University Chicago. As a Loyola University student, she has worked at The Community House as a practicum counselor and volunteered at Grant Hospital of Chicago, conducting intake interviews and group therapy sessions.

Ms. Parks has been an active member of a research project at Loyola University, investigating psychotherapy process research. During the summer of 1993, she served as a research assistant for this project. Ms. Parks is a Master of Arts candidate for graduation in May, 1994.

APPROVAL SHEET

The thesis submitted by June C. Parks has been read and approved by the following committee:

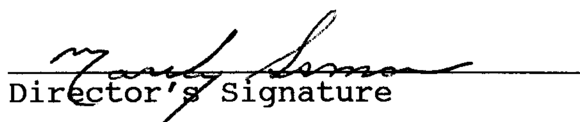
Dr. Marilyn Susman, Director
Associate Professor, Counseling and Educational Psychology
Loyola University Chicago

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

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

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts in Community Counseling.

3-30-94
Date


Director's Signature