Novice counsellors' skill development:

An investigation of weeping events

Polyxeni Georgiadou

Department of Educational and Counselling Psychology

McGill University, Montreal

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Ph.D. in Counselling Psychology

Your file Votre référence
ISBN: 0-612-88476-7
Our file Notre référence
ISBN: 0-612-88476-7

Table of Contents

List of Tables

List of Figures

Abstract

Using session events from nine dyads (counsellors-in-training and their clients), the present study examined how counsellors-in-training react to client weeping events. Trainees' reactions were observed across three different phases of psychotherapy (early, middle, and late) in order to investigate whether there were important changes in counsellors' reactions across time. Two studies - using distinct but complementary methodological perspectives - were employed for this investigation.

Results from the first, quantitative analysis indicated that, during weeping events, trainees adopted a mainly warm and empathic attitude towards their clients. To a lesser degree, they adopted an exploratory stance by working with clients' thoughts, feelings, and behaviours. Finally, they demonstrated almost no negative attitudes that would be characterized by a defensive or judgmental style. A further important finding from this analysis was that therapist attitudes and behaviours did not significantly change across the three phases of psychotherapy.

A finer-grained, qualitative examination using discovery-oriented methodology indicated that changes in trainees' behaviours and attitudes over time were discernible. Therapists became more focused on the present, learned to balance their focus on clients' cognitions as well as emotions, and used a variety of interventions to do so. Throughout all three phases, they were found to adopt an empathic and accepting attitude towards their clients. Trainees were also found to become more active and solution-oriented in the last phase of therapy. In terms of the quality of trainees' tasks, some commonalities were found between tasks judged positively and negatively regardless of time, however, no clear pattern of quality of tasks was found across the three phases.

Résumé

À partir des événements de session de neuf dyades (conseillers en formation et leurs clients), la présente étude nous a permis d'examiner la façon dont les conseillers en formation réagissent aux épisodes de pleurs de leurs clients. Ces réactions ont été observées pendant trois phases différentes de psychothérapie (début, milieu et fin) en vue de déterminer s'il y a eu des changements importants dans les réactions des conseillers avec le temps. Deux études, utilisant des méthodologies distinctes, mais complémentaires, ont été employées pour cette investigation.

Les résultats de la première analyse quantitative ont révélé que, pendant les épisodes de pleurs de leurs clients, les stagiaires ont adopté une attitude essentiellement chaleureuse et empathique envers eux. À un degré moindre, ils ont adopté une attitude exploratoire en travaillant avec les pensées, les sentiments et les comportements de leurs clients. Finalement, il n'y a presque pas eu d'attitudes négatives qui seraient caractérisées par un style défensif ou critique. Un autre résultat important de cette analyse a été le fait que les attitudes et les comportements des thérapeutes n'ont pas changé de façon importante pendant les trois phases de la psychothérapie.

Un examen qualitatif de ces événements, avec une méthodologie axée sur la découverte, a révélé qu'à ce niveau plus fin de granularité, des changements dans les comportements et les attitudes des stagiaires étaient discernables avec le temps. Les thérapeutes se sont davantage concentrés sur le présent, ils ont appris à prêter attention, de façon équilibrée, aux aspects cognitifs et aux émotions de leurs clients et ils ont utilisé divers types d'interventions à cet égard. Pendant les trois phases, ils ont adopté une attitude d'empathie et d'acceptation envers leurs clients. Cet examen a également révélé que les stagiaires étaient plus actifs et davantage orientés vers les solutions au cours de la dernière phase de la thérapie. Pour ce qui est de la qualité des tâches des stagiaires, certaines tendances communes ont été relevées entre différentes catégories qui définissent les niveaux de qualité. Toutefois, aucun changement sur le plan du développement n'a été relevé dans la qualité des événements.

Acknowledgments

One of the very important lessons I learned writing this dissertation is that as much as it is a long and lonely process, it has also allowed me to appreciate that it is a special blessing to have people in your life that you can count on. I have a lot of such people to thank, dispersed in different continents and cities.

First of all, I would like to thank my parents, Andrew and Elpida Georgiades, and my brother Savvas for their constant support and endless patience. I want to express my love and gratitude for the fact that they always tried to understand and respect my dreams and aspirations, allowing me to follow a passion that started early in my life.

I would like to thank all the professors and the administrative staff of the department, particularly Diane Bernier, who helped me, from the beginning of my stay in Canada, to feel at home so far away from home.

I would like to thank the members of both my research groups, Nick Gazzola, Irene Petsopoulis, Kieron Rogan, and Alexia Jaouich and Jennifer Jansen for their commitment and professionalism. I always had great admiration for their quality of work and their unwillingness to look for simple answers. I want to thank Shigeru Iwakabe and Anna Lenkovskaya for their unexpected—but much needed and appreciated—help. Thanks to Manny, Martha, and the group of Masters' students who helped me in the initial stages of this work. Some people have been particularly special to me, and I would like to take some extra time to thank them. First of all, special thanks and gratitude to Kieron for his assistance from the beginning to the end of this process. Kieron, I am very grateful for everything you have done; for being an editor, a consultant and a constant source of support. I want to express my love and gratitude for my friend Ken Mah for being the best

long distance consultant I could ever wish for. Ken, thank you for always being there for me, patient and willing to help. I want to especially thank Irene for always being willing to help and for always seeing the light at the end of the tunnel.

I want to express my gratitude to the members of my advisory committee: Ted Maroun, Marilyn Fitzpatrick, and Michael Hoover for their insights, guidance, and valuable contributions for the completion of this dissertation. Special thanks to Marilyn Fitzpatrick for following me from the beginning steps of this process and for making herself available so readily. I want to thank my co-supervisor, Jack DeStefano for his valuable input, and his keen attention to details. Both have added to the quality of the end product. His patience and guidance in times of need was much appreciated.

And last but not least, I want to express my sincere gratitude to my principal supervisor, Anastassios Stalikas for his constant help in developing and organizing this dissertation. His help was instrumental in teaching me how to think like a researcher, and how to use this lens in my clinical work. Under his supervision, my capacity for critical thinking and my appreciation for the scientific endeavor grew stronger. His firm, demanding, and knowledgeable guidance made this challenging project easier.

Thank you, Anastassios.

Prefatory Note - Contribution to Knowledge

The first contribution that this study makes to the field of psychotherapy research and to psychotherapy training lies in the fact that it is the first study to examine trainees' reactions to specific and significant moments in psychotherapy. Furthermore, this study examines how these reactions change over time as a result of experience and training. Thus, the findings of this study allow researchers and educators to closely follow the changes observed in trainees' behaviours and attitudes across time.

A second important contribution of this study is that it provides information about very specific aspects of trainees' behaviours when reacting to client weeping. The results indicate that trainees adopt an empathic stance towards their clients very early in the counselling. This is consonant with one of the goals of training, which are to teach trainees empathy and the facilitative conditions in order to develop a good therapeutic relationship. A third contribution relates to trainees' behaviours and how they evolve across training. The findings of this study indicate that by the last phase of their training, trainees become more flexible in the use of skills and learn to generally follow the steps that are suggested by researchers on client weeping.

Another significant contribution relates to the quality of trainees' reactions to client weeping. Common characteristics of the quality (or appropriateness) of trainees' tasks were found between different events, irrespective of phase of therapy, clearly demonstrating the *ingredients* of what constitutes quality of tasks. However, there was no clear pattern in the development of the quality of therapists' reactions across time, which suggests that although trainees in general know what to do, they do not master those skills in a stable manner that progresses positively through the stages. This finding has

important implications for training in that it suggests counsellors' conceptualization skills are not yet adequately developed by the end of the first year of training. Another finding that emerged from the data is that in the last phase of therapy, trainees became more active, although this was not necessarily an indication of an improved quality of the trainees' work.

Finally, a heuristic model that describes different aspects of trainees' reactions to weeping, across phases was extrapolated from the findings. This model, which provides a preliminary map for analyzing trainees' behaviours in moments of client weeping, has important implications for training, and for research in areas related to counsellor training and development.

CHAPTER 1

INTRODUCTION

It has been established that psychotherapy is effective (Smith, Glass, & Miller, 1980; Strupp, Butler, & Rosser, 1988). Estimating the treatment effects of psychotherapy, Smith, Glass, and Miller (1980) reported that the average client undergoing psychotherapy is better off than 80% of the untreated sample.

Psychotherapy's effectiveness and the increased use of its services have led to the inclusion of psychotherapy in the public health care system (Ogles, Anderson, & Lunnen, 1999). While this being a positive step, it has increased the pressure on practitioners to provide efficient and cost-effective services (Egan, 1994). The pressure to make psychotherapy cost-effective increases the need for research focused on training and development.

The field of psychotherapy training has evolved, since its beginning with the early work of Freud and later Rogers, into systematic methods of training. Over time, two main directions have emerged in training: training models and manualized training. Training models incorporated specific guidelines and practices intended to teach and to train novice therapists[1]. Treatment manuals were developed by different schools to systematically describe and teach therapeutic methods of intervening. With regard to the former, three training models, all based on Rogerian theory, are the most widely used and researched training methods. Two of these models aim primarily to teach the facilitative conditions

[1] Consistent with the literature (e.g., Brammer, Shostrom, & Abrego, 1989), the terms "counselling", "therapy", and "psychotherapy" will be used interchangeably throughout this document. The same applies for the terms "trainees", "novice counsellors", "counsellors-in-training" and "therapists" (unless otherwise specified).

(FC) developed by Rogers (1961), while the focus of the third model is primarily on teaching specific microskills (Ivey, 1971; Kagan, Krathwohl, & Miller, 1963; Truax & Carkhuff 1967). Along with the different training methods, a number of models describing novice counsellors' development through training were developed and tested (Stoltenberg, 1981).

Research in the area of training is mainly directed towards two main domains: (a) Counselling microskills, and (b) specific aspects of counsellor development such as self-efficacy or role identity. The focus of the present study falls in the former domain of research, namely on skill development.

Examining either of the above areas, researchers have used whole sessions or a number of sessions as their unit of study. Although this line of research has been very important and fruitful, it can yield only a general picture of trainees' behaviour and their development in training. Also, the examination of whole sessions or completed therapies assumes that all moments in psychotherapy are equivalent and of equal importance. To date, none of the studies in the area of counsellor training and development has examined trainees' behaviours at a micro level, that is, in specific moments or events of psychotherapy. The examination of specific events in psychotherapy is a relatively new trend in psychotherapy research. This trend developed after the realization that not all moments in psychotherapy have the same value (Rice & Greenberg, 1984).

Consistent with the preceding trend, the aim of this study is to open a new field of investigation in the area of counsellor training and development and to examine trainees' reactions to specific events and how these reactions change across time as trainees acquire more experience.

One category of psychotherapy events that is considered, by all therapies to be an important curative factor, is emotional expression events (e.g., Frank, Hoehn-Saric, Imber, Liberman, & Stone, 1978; Greenberg & Safran, 1987, 1989; Mahoney, 1991; Purzner, 1988). While emotional expression is important, some researchers discuss that research in the area needs to address an important problem. Greenberg and Safran (1984) postulate that when emotional expression events in psychotherapy are researched, they tend to be collapsed and examined as if all types of emotional expression are the same or have the same effects. They further argue that "it is important not to adopt a uniformity assumption around affect and change but rather to recognize that affect functions in a variety of different ways in psychotherapy and change" (p.577). They urge researchers to distinguish between various types of emotional change processes when examining different change events rather than classifying all emotional processes under a general label of "emotions." Thus, when examining therapists' reactions to specific types of emotional expression events, researchers will be able to differentiate what type of therapists' reaction is therapeutic for what type of emotional expression event.

Since research in the area of emotional expression events in psychotherapy in general is still developing and is very limited in the area of counsellor training and development (Nutt-Williams, Judge, Hill, & Hoffman, 1997), this dissertation aims to combine the two areas for the first time, and examine a specific type of emotional expression event, namely weeping[2]. There are very few studies examining weeping events in psychotherapy (Greenberg, 1999; Labott, Elliott, & Eason, 1992), and no studies examining how trainees react to client weeping.

---

[2] The terms "weeping" and "crying" have been used interchangeably by different studies. Since both terms are given similar definitions, only the term "weeping" will be used in the present study.

Weeping in psychotherapy is a complex behaviour because it results from an emotional state associated with different emotions, such as sadness and distress (Greenberg, 1999). It is a particularly difficult behaviour for novice therapists to react to, because it implies that trainees are willing to deal with their own emotional reactions to clients' emotional expressions (Greenberg & Paivio, 1997). Furthermore, it has been found that trainees tend to become overwhelmed when clients express emotions in the session (Nutt-Williams, et al., 1997). Since weeping is associated with moments of client intense vulnerability (Greenberg, 1999), it is important to examine how trainees respond to such moments in psychotherapy.

The present study will examine how counsellors-in-training react to client weeping, and how the manner in which they react during those moments, changes over one year of training. To examine therapist reactions, weeping events from sessions of novice counsellors will be examined, and this will be done over three phases of psychotherapy (early, middle, and late).

Section II of this dissertation reviews literature in the area of counsellor training and development. Models and research on therapist training and development will be discussed. Views from both traditional and contemporary theories on the importance of emotional expression and particularly weeping will be presented, and empirical research in the area will be examined. Additionally, the two areas of counsellor training/ development and client weeping events will be linked, and the importance of examining the two areas in tandem will be presented. Finally, the research questions of this study will be presented.

Section III explains the procedures and the methodologies used for the analysis of the data. Section IV presents the results of the study and the answers to the research questions posed. Section V discusses the findings of the study with regard to the existing research and literature presented in Section II. Additionally, implications of these findings for training will be presented. Finally, limitations of this dissertation will be examined and suggestions for future research will be presented.

II. LITERATURE REVIEW

Brief History of Counsellor Training

Formal psychotherapy training dates back to the beginning of the 20th century. Starting with Freud in the early 1900's, an important component of psychoanalytic training was personal psychoanalysis for the psychoanalysts-in-training, the objective being to "refine" the psychoanalytic instrument—the psychoanalyst—by resolving his or her own unconscious conflicts and countertransference issues (Strupp, Butler, & Rosser, 1988). Training consisted of extensive knowledge of, and strict allegiance to the theoretical model, and required close mentoring by a supervisor. The techniques used for training were those used for treatment (Matarazzo & Garner, 1992). The clinical research on training in psychoanalysis does not often report systematic studies or empirical evidence, rendering any conclusions for the effectiveness of psychoanalytic methods of training difficult, if not impossible (Strupp, Butler, & Rosser, 1988; Ogles, Anderson & Lunnen, 1999).

More systematic training approaches began with Rogers in the 1940s. Rogers used tape recorders in the psychotherapy sessions with his clients, and later analysed these audiotapes with members of his research team. Rogers' main principle in training was to help therapists acquire the specific skills basic to effective work. He considered these skills - empathy, genuineness, active listening, and unconditional positive regard - to be necessary and sufficient conditions, and named them "facilitative conditions" (Rogers, 1957, 1961). In the 1960s, published research on how to teach and supervise psychotherapy started to emerge (Matarazzo, Wiens, & Saslow, 1966). The first studies were based on an examination of Rogers' facilitative conditions, and on the development

of models designed to teach these conditions to students through instruction and supervision.

Contemporary Psychotherapy Training

Concurrently with the beginning of research in the area of counsellor training, a number of training programs were developed by different theoretical orientations. All these programs have focused predominantly on basic interviewing skills for novice therapists and placed a secondary role on higher-order counselling skills, such as case conceptualization, or timing (Russell, Crimmings, & Lent, 1984). From all the training models developed, those that were based on a Rogerian conceptualization of therapy have received the most research attention (Stein & Lambert, 1995). These programs are: (a) Human Resource Training/ Human Resource Development (HRT/HRD), by Truax & Carkhuff (1967), (b) Interpersonal Process Recall (IPR), by Kagan, Krathwohl, and Miller (1963), and (c) Microcounseling (MC), by Ivey (1971). One reason for the special attention these models received is the clearly articulated techniques and programs for teaching counselling skills they offer. These three programs and their emphasis on training in regards to client weeping will be briefly discussed below.

Training Models

Human Resource Training/ Human Resource Development (HRT/HRD)

Truax and Carkhuff (1967) developed a didactic-experiential training program designed to teach skills for relationship building. Originally developed to train Rogerian counsellors, the HRT/HRD was based on Rogers' facilitative conditions (FC) of empathic understanding, unconditional positive regard, and genuineness as ingredients in the

helping relationship (Rogers, Gendlin, Kiesler, & Truax, 1967). The training program focused on the development and use of specific measures of the facilitative conditions, particularly empathy, and incorporated social learning theory, behavior modification, and programmed instruction in their training models. The creators of this training model believed that counsellors needed to acquire, through a deep understanding of the facilitative conditions, a therapeutic attitude that would enable them to deal with all and any therapeutic situation. The model does not deal directly with specific moments, but postulates that the different skills learned are useful regardless of the situation, and training was considered successful when the student was able to communicate the same FC in their personal lives as in the therapy setting, and therefore grow and develop both as a therapist and as an individual.

In conclusion, the aim of the HRT/HRD model, was to teach novice counsellors: (a) basic facilitative conditions in the therapeutic interaction, and (b) sensitivity to their own and their clients' emotional processes. As will later be discussed, applying this knowledge to moments of client weeping is considered one of the therapeutic ingredients in order to deal effectively with client weeping (Greenberg, Rice, & Elliott, 1993). Therefore, it is expected that if counselling students are being successfully trained in this model, they will develop the basic tools that are considered necessary, for reacting appropriately to client weeping.

Interpersonal Process Recall (IPR)

Kagan, Krathwohl, and Miller (1963) developed IPR based on Bloom's (1954) method for teacher training. Bloom audiotaped classroom discussions and later replayed those discussions to teachers and students in order to stimulate the recollection of

classroom events. He found that this method provided a mirror of the teachers' behaviour, stimulated deeper discussion, and highlighted weaknesses in the discussion structure. The IPR system of training is based on the theory that beginning counsellors miss parts of the interview because they have performance anxiety and are preoccupied with making a good impression. Thus, Kagan's IPR model (1984) aims to help students - through the recall process - to remember thoughts, feelings, goals, aspirations, bodily sensations, and other covert processes. The goal of this process is to further help trainees attend to these events in the session and, eventually, to use the resultant awareness to foster growth in the client and in themselves.

The goals of IPR are similar to those of HRT/HRD. At the end of training, novice counsellors are expected to be able to communicate the facilitative conditions, and to further be able to: (a) study their own interpersonal behaviour, including becoming more attuned to their own sensations, feelings and thoughts, and (b) become aware of the importance of the therapeutic relationship. Although this model, similarly to HRT/HRD, does not address specific moments in therapy, its emphasis on trainees' awareness of their own emotional processes and on the therapeutic interaction, is considered important in order to teach effective reactions to client weeping (Greenberg & Paivio, 1997). Therefore, both IPR and HRT/HRD help trainees to acquire the personal knowledge and interview skills needed to react to weeping appropriately.

Microcounseling (MC)

Based on Allen's (1967) model for teaching, Ivey (1971) developed a model rooted in social-learning theory. Suggesting that experiential learning is not necessary, Ivey

emphasized the teaching of positive facilitative behaviors with individually operationalized skills. The method of MC (a) identifies clearly delineated discrete behaviors, such as attending, reflection of feeling, or self-disclosure; (b) teaches these behaviors systematically, one at a time and; (c) once each skill is mastered, integrates them. The procedure is designed to teach one skill at a time, and is based on the belief that client-counsellor interactions can be analysed and learned as single helping units before they are gradually integrated into meaningful therapeutic constructs. One of the major goals of this approach is to teach students to develop flexibility in generating multiple responses and thus to develop "intentionality," which is the ability to approach a problem from different vantage points, thereby calling on different skills (Ivey, 1971).

Within the MC approach, students are expected to know how to communicate the facilitative conditions, to be multiculturally sensitive, and to start developing case conceptualization skills. At the same time they are expected to be comfortable with the specific microskills hierarchy which includes various counsellor response types (e.g., reflections, interpretations).

Summary of the Three Training Models

Examining the three training models we would expect to find changes in trainees' development in a number of areas. One such change might be observed in trainees' ability to communicate the facilitative conditions, such as empathy, acceptance, and approval in different situations in therapy. Another change might arguably be related to the way trainees perceive themselves in the therapeutic interaction. Since one of the foci of the training models is for trainees to become progressively more aware of their own emotional processes, it could be expected that the more experienced they become in

recognizing their own emotional processes, the more comfortable they would feel in their role as counsellors, and the more confident they would feel in responding to difficult moments in therapy. Another possible change might be in therapists' abilities to communicate different microskills more effectively. For example, it is possible that progressively, they could become better able to construct a "good" interpretation. Finally, as a consequence of all the above changes, we might also expect to find a change in their abilities to do more exploratory work in the session. For example, they should be better able to understand client issues, help clients work with their feelings (e.g., recognize and understand them), and further explore problematic behaviours.

All training models recognize that psychotherapy is an ever-changing process. Thus, they attempt to teach students how to be sensitive and to attend flexibly to changes in the clients, themselves, and the therapeutic interaction. It follows therefore, that successful training and learning allows new counsellors to apply their knowledge and skillfulness to specific events such as weeping.

Stages in Therapy

The training models presented above, although sensitive to different changes that take place in the process of therapy, are not prescriptive as to specific steps or stages in therapy. Hill and O'Brien (1999) on the other hand among other training textbooks (e.g., Egan, 1994, 1998), suggest different stages for the psychotherapy process and propose specific techniques at each stage that was designed to facilitate learning for trainees. These authors state that psychotherapy progresses through three stages. First, (a) in the exploration stage the goal is to help clients explore their thoughts, feelings, and behaviours. Therapists need to encourage clients to tell their stories, and to be able to

establish rapport and develop a therapeutic relationship with their clients. This is the stage of getting to know the clients and of gathering information about their lives. Second, (b) in the insight stage, the aim is to help clients understand their thoughts, feelings and behaviours. The therapists' role is to collaborate with clients to achieve understanding of their dynamics and their manner of perpetuating their problems. Maintaining the therapeutic relationship is continued in this stage. Third, (c) in the action stage the aim is to help clients decide what actions to take based on their new understanding. In this stage, therapists need to help their clients make decisions. In other words, according to Hill and O'Brien, we would expect that there would be changes in trainees' behaviours across stages in psychotherapy, thereby introducing time (or phase of therapy), as a variable that influences trainees' behaviours. For this reason, stage or phase of therapy was considered an important variable, and included in the present study.

Research in the Area of Models of Training

In the foregoing, the goals of the major training models were presented. In the following section, the effectiveness of these models as training methods will be discussed.

All three models were developed by pioneers in this training mode and each program emphasizes different skills (Baker, Daniels, & Greeley, 1990). Carkhuff's HRT/HRD emphasized the importance of high levels of the core facilitative conditions in the supervisory relationship, and the transferring of those conditions in the therapy session. Kagan's IPR model introduced learning through discovery, while Ivey's MC model emphasized the importance of teaching specific microskills (Baker, et al., 1990). A meta-analytic review of hundreds of studies resulted in conclusive findings concerning two of these models (HRT/HRD and MC). Despite methodological flaws (such as the

failure, at times, to provide adequate no-treatment control conditions, or the absence of pre-test data), the research led to favorable conclusions about the effectiveness of the HRT/HRD and MC training programs (Baker, et al., 1990). Results based exclusively on studies examining IPR are more inconclusive.

HRT/HRD and MC show strong research support for their effectiveness. Specifically, with respect to the core facilitative conditions, it was found that both HRT/HRD and MC were effective in teaching empathy and communication skills (Toukmanian & Rennie, 1975; Russell, Crimmings, & Lent, 1984). Similar results were reported in other studies: Training models can help trainees acquire and use basic microskills (Alberts & Edelstein, 1990). Alberts and Edelstein (1990), in their review of studies on training, reported that training is effective in teaching more complex verbal repertoires (such as conceptualization skills), and trainees manage to maintain those skills across time and generalize them across clients and settings. The authors concluded that training is important in learning therapeutic skills. Given the evidence supporting the effectiveness of training, one would expect similar gains in basic and conceptualization skill acquisition in regards to the events in question; weeping events. A change in counsellor reactions to client weeping over time would indicate that trainees were able to apply their general skills in these specific moments, which would demonstrate the development of flexibility in their knowledge and skills.

Development of Therapists-in-Training.

Examining existing research on the development of therapists-in-training, no studies were found that examined trainees' reactions to specific, significant moments in psychotherapy—such as weeping—or how these reactions change across time. Rather,

previous examinations of trainee development have concentrated mainly on general concepts, such as cognitive development, self-efficacy, or discrete microskills (e.g., reflections, interpretations, etc.). The focus in those areas allowed researchers to follow the changes of trainees' development from different angles that provided a general picture of their development. For this reason, those studies of trainee development will be presented next, in order to provide guidelines regarding changes that trainees in the present sample might be expected to have experienced.

Developmental Models of Training

The different developmental training models describe a number of stages that trainees go through which indicate their increased level of maturity and expertise. One of the most influential models of therapists' development is Stoltenberg's "Counselor Complexity Model" (1981) which describes counsellor cognitive development during training. According to this model, trainees are individuals embarking on a course of development that will culminate in the emergence of their counsellor identity. This final point constitutes the integration of skills, theory, and a more complete awareness of self and others. Stoltenberg's (1981) model posits four levels of counsellor development:

1. Trainees attempt to define external boundaries and discover where counselling techniques end and where the personality of the counsellor begins. They begin to understand how to express themselves through techniques, while their counsellor identity begins to develop. Trainees at this stage need instruction, interpretation, support, awareness training, and exemplification.
2. A dependency-autonomy conflict develops. Trainees attempt to find themselves,

but still experience strong dependency needs. Self-awareness increases, while at the same time there is an oscillation between over-confidence in skills and being overwhelmed by the increased responsibility. This results in a fluctuation of motivation about doing counselling work.

3. There is an increased sense of personal counsellor identity and professional self confidence, and trainees need less guidance. They feel competent, while at the same time they are aware of their needs. Their overall motivation is more stable.

4. Trainees develop into master counsellors. They are capable of independent practice due to the development of adequate awareness of their own personal limitations. They reach a point of purposeful interdependence with others.

Stoltenberg's model appears to be a model of mastery of skills. He does not suggest how long trainees tend to stay at any of the stages, which implies that there are clear individual differences in counsellor development. Another important suggestion from Stoltenberg's work is that trainees do change through training, both in their application of counselling skills and in their levels of maturation as counsellors. Trainees' increased level of maturation was further validated by a later study, that led to the conclusion that as the level of experience increases, there are qualitative changes in the conceptual development of trainees (McNeil, Stoltenberg, & Pierce, 1985).

A second developmental model, proposed by Hill, Charles, and Reed (1981) focuses on a further aspect of trainee development, namely, role identity. These authors suggest that students progress from a general state of over-involvement with the clients' problems to a state of being able to keep a distance from the client and develop their own style. Specifically, the authors suggest that trainees progress through four stages in their

personal and professional development along a continuum of relative growth. Thus, trainees:

1. At first experience sympathy towards their clients: they feel over-invested in counselling and responsible for their clients.

2. Develop a "counsellor stance" by adopting the "right way" they learned.

3. Are exposed to many orientations, clients and supervisors, and they are in transition. They experience disruption and anxiety when they have to re-adapt previously learned skills. At this point they may become atheoretical and adopt the stance of "whatever works."

4. They develop an integrated personal style, where techniques and theories are integrated into a consistent personal style and they now know how to act appropriately for a particular situation and client.

The authors report that, in terms of counselling skills, trainees report changes in more abstract and less operational and higher order abilities, such as timing, appropriateness of an intervention, ability to conceptualize client's dynamics, planning treatment strategies, methods of working with resistant and defensive clients, and ideas about when and how to terminate (Hill, Charles, & Reed, 1981). Although the sample in the above study was comprised of trainees at a doctoral level of training, its conclusions are parallel to the ones by Stoltenberg (1981), namely that trainees progress through different levels of maturation, and face different challenges during that process.

Counsellor intentions

Several researchers report finding a change in counsellor intentions over the course of training, a finding that is seen as indicating counsellor cognitive development

(Fong, Border, Ethington, & Pitts, 1997; Kivlighan 1989). Fong and her colleagues (1997) state that trainees change significantly in their use of different patterns of intentions, suggesting that training resulted in a change in cognition. Results from that study provide initial empirical evidence that small incremental gains in counsellor cognitive functioning occur over the course of a master's training program.

Counselling skill effectiveness

Using measures of counselling performance, it was found that after training, a greater proportion of more complex counsellor responses were used by students and the effectiveness of those responses had significantly changed from ineffective to effective (Fong, et al, 1997; Thompson, 1986). At the same time, these studies suggest that despite the changes and their maturity in the way they approach their clients, trainees need to focus more on the conceptualization of the case (how to think about a client), rather than on skill development (what to do) (Fong, et al, 1997; Thompson, 1986).

Counsellor self-efficacy

Research in the area of counsellor self-efficacy indicates that individual counsellor perceptions of self-efficacy change across developmental levels, and the degree of counsellor self-efficacy increases with training and experience (Larson et al., 1992; Sipps, Sugden & Favier, 1988).

Counsellor self-efficacy is a concept that - although not extensively researched - is nevertheless informative about changes throughout training (Leach, Stoltenberg, McNeil, & Eichenfield, 1997). Self-efficacy is a construct initially introduced by Bandura (1977, 1982, 1986a, 1989). Extending Bandura's construct to counselling, counsellor's self-

efficacy is defined as "one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p.180). Thus, in a study on trainee's development through a master's level pre-practicum in counselling, it was found that counselling self-efficacy increased over the process of the didactic course (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989). Furthermore, Larson and her colleagues (1992) found that beginning practicum students had significantly lower self-efficacy scores than master's-level counsellors and professional psychologists. It therefore appears that novice trainees initially have low appraisals about their capabilities to effectively counsel a client, but their appraisals increased over the course of training. Although self-efficacy is not directly examined in the present study, knowledge about trainees' change in this area over time provides a more thorough picture of their development and adds to the expectations from their behaviours and attitudes in their sessions. These expectations stem from existing research that indicates that counsellor self-efficacy is positively related to performance (Larson & Daniels, 1998). Therefore, it may be expected that trainees with better in-session performance have higher levels of self-efficacy.

Counsellors' in-session emotions

In terms of the feelings that trainees experience in their sessions, Nutt-Williams, Judge, Hill, and Hoffman (1997) found that trainees become progressively less anxious and more adept at managing countertransference reactions (i.e., strong feelings about clients). Furthermore, while trainees generally demonstrated adequate skills and developmental growth, these authors found that trainees experienced a range of positive and negative feelings, and at times, these feelings interfered with their ability to provide

maximally effective counselling. According to supervisor evaluations, counsellors could become over-involved or avoidant when dealing with strong emotions (Nutt-Williams et al., 1997). This particular point is very important for the purposes of this study. Based on the above findings, and considering what we know about trainees' changes both from the training models and from the developmental models (Hill et al., 1981; Stoltenberg, 1981), it is probable that trainees' emotions will be especially pertinent to the ways they react to moments of client weeping in psychotherapy.

Client emotional expression and trainees' reactions to clients' emotions are greatly under-examined in the field. Strong emotions in psychotherapy are generally not thoroughly examined (Mahrer, Fairweather, Passey, Gingras, & Boulet, 1999). In the area of training, the study by Nutt-Williams and her colleagues (1997) is the only study on trainees' reactions to clients' emotional expressions, and it does not distinguish between types of emotional expression. It is important to examine whether trainees have different reactions to different types of emotional expressions. This would both enrich what we know about trainees' identity role development and facilitate further training in the area.

Although the above findings concerning trainees' reaction to client emotions may appear to contradict results that report increased counsellor self-efficacy, a fine differentiation needs to be noted. It appears that, although trainees generally develop greater self-efficacy through training, when they deal with client strong emotional experiences they experience emotional reactions that may obstruct their therapeutic work. Weeping is a client emotional expression that could provoke emotional reactions from beginner trainees, as has been noted by Nutt-Williams and her colleagues (1997). The findings of that study indicate that the learning of discrete counselling skills is not always

enough to help counsellors-in-training deal with "significant" moments in counselling, and further implies that the ability to deal effectively with client strong emotions comes with developmental growth and experience.

Working alliance

Research into trainees' ability to develop a working alliance has yielded inconsistent findings. In an analysis of 25 studies, Stein & Lambert (1984) found that experienced counsellors were more effective than less experienced counsellors in retaining clients in treatment, suggesting that they more effectively build a working alliance with their clients. Supporting this interpretation, Mallinckrodt and Nelson (1991) found that counsellors' experience level was predictive of clients' ratings of the goal (an aspect of the alliance that reflects agreement as to the aims of therapy) and the task component (an aspect reflecting agreement concerning therapeutic activities), with more experienced counsellors establishing stronger alliance. However, in the bond component of the working alliance (the aspect of the client-therapist relationship that reflects positive affective attachment between the two individuals) no significant differences were found among different levels of training. This suggests that although development of a therapeutic bond is not significantly affected by level of therapist experience, less experienced therapists are less capable of focusing on setting goals, and on setting tasks towards achieving these goals. Two other studies, however, have yielded findings that suggest counsellor experience level is <u>not</u> predictive of client-rated alliance (Dunkle & Friedlander, 1996; Kivlighan, Patton, and Foote, 1998).

The two sets of studies presented above, clearly contradict each other. The present study - although not specifically focused on client and therapist working alliance - will examine the therapeutic tasks and conditions present in significant therapeutic moments. Findings of the present study may thus provide support for one of the two positions, and aid in clarification of that debate.

Training Models and Trainee Development – Summary

Above, research and theory on models of counsellor training and development were reviewed. The first general conclusion is that several different methods of training are effective in teaching trainees both basic microskills and facilitative conditions. A second conclusion is that novice counsellors do not develop evenly across training (e.g., skills, identity, timing, or conceptualization). For example, it was found that trainees change in their intentions and in the effectiveness of their interventions, but it can take longer for them to learn more complex types of interventions and for counselling self-efficacy to increase.

A third finding relates to how counsellors' ability to form an alliance changes over time. According to some studies, in early stages of their training, student counsellors are found to develop the bond component of the working alliance—an indication that the training in the facilitative conditions is successful—but their ability to develop the task and goal component of the working alliance improves with training and experience. This finding leads us to conclude that the ability to be empathic and to effectively use microskills is developed early on in training, but perhaps the ability to conceptualize, set goals and develop tasks to reach these goals develops only with higher levels of

experience and training. As stated above, there is some controversy in this area, and perhaps the present study will, indirectly, shed some light on the debate.

Another important finding in the area of trainee development was that in the first stages of training, counsellors become overwhelmed when dealing with clients' emotions. The implications of this finding are significant both for training and for trainee development. It is important for trainee's to learn how to recognize and deal with their own emotional reactions in order to feel more comfortable in their role as counsellors, to mature in their conceptualization of their clients, and to become more effective in the way they react to different client emotions.

The present study will examine specific in-session events in therapy in order to counteract the "uniformity myth" (Kiesler, 1966), wherein all processes of psychotherapy are considered to have the same meaning at any moment in the session. Instead the present research seeks to find what type of therapy is best for what type of client with what type of problem (Paul, 1969). Answers to these questions will provide significant information in several areas: (a) How trainees react to a specific type of client emotional expression, namely weeping; (b) how trainees react to weeping in specific phases in therapy; (c) how these reactions change across time; and (d) which of these reactions are appropriate for specific clients in specific situations (i.e., quality of trainees' reactions).

The importance of examining therapist reactions to specific moments in psychotherapy has been established in this dissertation. Next, the rationale for choosing to examine client weeping as an important event, will be developed. It will be argued that weeping is a type of emotional expression that is considered important by most schools of therapy. Furthermore, weeping is a manifestation of different types of emotions, and so

this type of emotional expression is more complex than many others. This, along with findings that indicate trainees tend to become overwhelmed by clients' emotional expressions, leads to the conclusion that an examination of novice therapists' reactions to client weeping is a particularly interesting area of research which will have a number of training implications.

Emotions and Emotional Expression

In psychotherapy, emotional awareness is considered to enhance the way we evaluate our needs, desires, goals, and concerns. Emotions are indicative of the way we conduct our lives and how we relate to the environment (e.g., Greenberg & Paivio, 1997; Labott, Elliott, & Eason, 1992). Emotions and emotional expression are considered by most therapies to be one of the curative factors in psychotherapy, a basic motivational source for people to seek psychotherapy and an important step for therapeutic change to occur. In general, psychotherapy research indicates that episodes of emotional intensity are frequently associated with significant psychological change (e.g., Mahoney & Eiseman, 1989; Purzner, 1988; Rice and Greenberg, 1984). In many major therapeutic approaches the awareness of one's emotions, the arousal of these emotions, and in turn, the reorganization of this awareness into new cognitive schemata are considered critical for therapeutic change to occur.

Complicating matters, theorists disagree on a commonly accepted definition of emotions. However, it is generally accepted that three fundamental components constitute an emotion: Emotional expression, experience, and arousal. To differentiate these three components, the definitions by Kennedy-Moore and Watson (1999) will be used.

Emotional arousal is "the physiological aspect of emotional responses," while emotional experience is "the subjective, felt sense of emotional responses." What constitutes emotional expression is "the observable verbal and nonverbal behaviours that communicate and/or symbolize emotional experience. Emotional expression can occur with or without self-awareness, it is at least somewhat controllable, and it can involve varying degrees of deliberate intent" (p. xv). The emotional component that is of interest in this study is emotional expression, since weeping refers to an observable client behaviour.

Research on Emotional Expression in Psychotherapy

Despite the large number of theorists and clinicians that have addressed the significance of emotional expression in psychotherapy, until recently, only a small number of studies examined client emotional expression (Hill, 1990). Earlier studies on catharsis demonstrated that emotional discharge was beneficial (Nichols & Zax, 1977). Additionally, Bohart (1977) found that expression of emotion along with cognitive processing produced the most significant outcome. The results from Bohart's (1977) study are in agreement those of Pierce, Nichols, and DuBrin (1983) which suggested that although catharsis and emotional expression in general are therapeutic, it is the quality and not necessarily the quantity, that makes catharsis therapeutic.

These findings demonstrate the significance of examining emotional expression and lead us to conclude that identifying ways of dealing with in-session emotion will lead to therapeutic change. Research findings also leave a number of unanswered questions. Although studies using quantitative methodologies have indicated that there is a relationship between client emotional expression, in-session change events and long-term

outcome, it is still not known how this change occurs, or how client emotional expression alone leads to change. Furthermore, although there are some limited findings on the types of therapist interventions that facilitate emotional expression, further research in the area needs to take into account other variables that may concomitantly impact on the psychotherapy process (e.g., timing, context, individual differences) (Hill, et al., 1988). While client emotional expression with experienced therapists has been repeatedly examined, this area remains largely unexplored in regards to novice therapist.

Psychotherapy events research paradigm

The evolution of psychotherapy research has lead researchers to isolate and examine significant therapy events. In many regards, this is essentially a new research paradigm (e.g., Iwakabe, Rogan, & Stalikas, 2000; Mahrer & Nadler, 1986), and has many encouraging results. The aim of this "new paradigm" is to specify what client behaviours are set in motion by what therapist interventions at what particular points in therapy. Researchers argue that by being able to understand clients' operations in a certain context (e.g., a certain type of emotional expression), we will be able to transfer therapist's actions that were used in these contexts to other contexts, and therefore identify and use the essential ingredients for change. Thus, by examining patterns within and across therapists' behaviours, researchers will be able to link specific therapist's behaviours to treatment outcome (Greenberg, 1986; Henry, Schacht, & Strupp, 1986). Applying the knowledge of how trainees react to client weeping in the area of counsellor training would allow training programs to identify the strengths and weaknesses of novice counsellors and to train them in eliminating their weaknesses. This new perspective will

offer the tools to examine which therapist behaviours are more effective for what client behaviors under which type of circumstances (Weissmark & Giacomo, 1998).

In both quantitative and qualitative studies, a relationship has been found between client emotional expression and micro-outcomes (e.g., Clarke, 1989, 1996; Mackay, Barkham, & Stiles, 1998). Qualitative studies investigating clients' experience revealed that clients themselves found the expression of emotions helpful (e.g., Labott et al., 1992). This line of research indicates the importance of examining specific types of emotional expression events, in order to: (a) Broaden our knowledge for the therapeutic ingredients that are necessary for effective work, (b) learn to apply this knowledge to the field of counsellor training, and (c) teach trainees the most effective way to react to specific types of client emotional expression.

Weeping is considered to be one of the most common and complex behaviors in psychotherapy and yet has been largely neglected by psychotherapy research (Frey, 1985; Hill, 1990; Kottler, 1996). What follows is a presentation of different studies from a variety of disciplines, indicating the importance and the meaning of weeping in different areas of our lives.

Theories of Weeping

Like other types of emotional expression, weeping communicates that something significant is taking place within an individual. What makes weeping more complex than other emotions like laughter or anger, is that it is associated with different emotions, such as sadness and distress, and it can be the result of different degrees of arousal (Kottler, 1996).

Weeping in general, as a human behaviour has been examined from various viewpoints and has been interpreted in many different ways. Some theorists reduce weeping to its supposed physiological functions (Darwin, 1872; Frey, 1985), while others recognize that weeping could be caused by different psychological or social factors (e.g., Efran & Spangler, 1979; Labott & Martin, 1988).

Although Darwin (1872) considered tears as a more or less useless accompaniment to the contraction of the muscles around the eye, he did postulate that they could be helpful in bringing physiological relief from distress. More recently, the American biochemist Frey (1985), a pioneer of modern research on weeping with his focus on its biochemical aspects, proposed that the main function of weeping is the removal of toxic waste products released when people are distressed. Frey (1985) described that the balance of the body is altered when there are emotional disturbances (since stress alters the chemical balance of the body), which, in turn can affect emotional change. Thus, one of the major researchers in the area has established the role of weeping on restoring the emotional balance of the organism and affects one's mental state.

Psychoanalysts proposed several theories of weeping, all seeming to believe that a process of psychological homeostasis is maintained through weeping. For example, Heilbrunn (1955) argued that weeping symbolizes regression to an intrauterine state. He also postulated the symbolic extension of weeping from washing away painful irritants by tears to washing away painful states of the organism. Other psychoanalytic theories of weeping maintain that by releasing tears, an excessive buildup of emotions is avoided, and there is a draining off of the energy mobilized during distress. Expanding on Breuer and Freud's (1895/1955) belief regarding catharsis, Greenacre (1965) and Lofgren (1966)

theorized that when emotional stimuli build up tension to a point close to the limit that a person can tolerate, relief is obtained in different forms by a release of energy from various organs, including the eyes, by weeping.

Theorists on communication regarded weeping as a way of interacting with the environment. In this way of thinking, tears are seen as powerful signals that can be used as a form of communication with different meanings, used differently by men and women. Collins (1932) explained weeping as an outlet for nervous energy, where the purpose is to communicate a wish in order to attract attention and elicit sympathy. Kottler (1996) stated that weeping is uniquely used by humans as a method to mobilize help from others in emergencies.

In a therapeutic situation, according to some authors the client can use weeping in order to distract attention from critical issues and discourage the counsellor from exploring issues further (Kingsley & Wooster, 1987), a situation that can easily be missed by a novice therapist and thus important therapy material may be lost.

One of the most cited theories of weeping is Efran and Spangler's "Cognitive Model" theory (1979). According to these authors, weeping is an indication of an alteration of the person's cognitive schemata in order to fit data that they were previously struggling to make sense of. These authors postulate that the person is going through an arousal phase where tension is created, and when this tension decreases, then the person goes to a "recovery pattern," and it is then that tears occur, as a manifestation of the shift to recovery. Thus, tears are not part of different emotions (e.g., sadness, happiness, and anger), but rather part of the recovery from these emotions. In other words, when they occur in therapy, tears are a sign that something therapeutic or meaningful has occurred.

Thus, weeping is a meta-behaviour that appears as a result of different emotions, and helps achieve cognitive changes. In turn, it suggests that when confronted with weeping, it is important that therapists deal with both the cognitions and the accompanying emotions.

In terms of psychotherapy theory, some authors believe that tears occur spontaneously, but crying, as an event needs permission to continue (Kingsley & Wooster, 1987). If that permission is not given and the client withholds the free expression of tears, he or she may block a natural response, which can impede the healing process. While some suggest that "little weeping events" might be less helpful than larger weeping events (Perls, Hefferline, & Goodman, 1951), others argue that it is not the quantity but rather the quality of weeping that matters (Kennedy-Moore & Watson, 1999). This means that a "good cry" may be enough (Efran & Spangler, 1979), and most agree that weeping can be therapeutic only if there is a resolution of the issue at hand or a further cognitive exploration of the material.

For this study the definition of weeping put forward by Labott, Elliott, and Eason (1992) will be adopted: "Weeping consists of tears, sobbing (irregular respirations), and crying (vocalizations)" (p.49-50).

In the foregoing section, the importance of weeping - as viewed by biological researchers, experts in communication, and to some degree psychology theorists - was presented. In the section that follows, the importance of weeping to traditional and contemporary theorists of psychotherapy will be examined. This presentation clarifies the importance of studying weeping events in psychotherapy.

Weeping in Four Major Theoretical Approaches

As will be presented, all major theories of psychotherapy regard weeping in psychotherapy as important and some suggest that for weeping to be therapeutic, a cognitive exploration and processing of the emotions needs to follow.

Psychoanalysis and Psychodynamic therapies

At the initial stages of the development of his theory, Freud considered weeping as an important and necessary process for his patients, in order to drain off built up emotional energies and thus achieve catharsis (Bohart, 1980; Breuer & Freud, 1955; Kennedy-Moore & Watson, 1999; Nichols & Zax, 1977). Although he later abandoned the focus on catharsis, Freud's main goal was to encourage emotional expression in order to make conscious the unconscious traumatic feelings of the past. Emotions were considered a necessary "vehicle" for the patient to achieve insight. Therefore, emotional expression was necessary for a new cognitive understanding of the patient's unresolved issues. While it is not clear how Freud dealt with different types of emotional expression, he considered all types, including weeping, to be valuable material in order for change to occur. Furthermore, there are no writings known that explain in detail his views on training analysts to deal with patient weeping.

In Alexander and French's theory (1946), the therapist has to help the patient go through different types of emotional experiences in order to deal with conflicts of the past. Thus, therapists need to encourage the expression of any form of emotion, including weeping, not as an end goal, but rather as the first step in the cognitive exploration of the transferential relationship with the therapist in a therapeutic environment that provides the

necessary conditions for a corrective emotional experience to occur (Yalom, 1995). Although Alexander and French did not speak explicitly of training, it is apparent that in their theory they considered weeping as an important therapeutic phenomenon (as any other type of emotional expression) that needs to be encouraged by therapists.

Wilhelm Reich (1949, 1960) with his theory called "Vegetotherapy", was the pioneer of modern cathartic psychotherapy who brought back the emphasis on catharsis in psychoanalytic therapy. Reich aimed for the sustained catharsis over a prolonged course of psychotherapy, rather than isolated dramatic abreactions (Pierce, Nichols, & DuBrin, 1983). Weeping was conceptualized as a consequence resulting from the expression of emotions; emotional experience and expression may lead to pain, rage or sobbing. Thus, weeping was a form of discharge that was considered a necessary part of the process in dealing with the painful emotions. Therefore, therapists were expected to be able to increase arousal level, which would result in the expression of powerful emotions.

Finally, Janov emphasized intense emotional expression that leads to a genuine emotional transformation, and achieved his therapeutic goals by developing a variety of emotional procedures (Janov, 1970). Emotional experience and expression seemed to be the end goal, and weeping is one such form of expression. Therefore, since the goal for therapists is to help the patients re-experience repressed painful emotions, it is apparent that weeping is considered an important therapeutic phenomenon.

From the psychoanalytic perspectives, an important commonality among the theories is the affirmation that emotional expression, including weeping, is an important therapeutic phenomenon. Some theories further state that, although important, emotional expression is not a sufficient condition for change to occur. It is expected to happen when

one experiences previously repressed emotions, and seems to be encouraged. However, it is only the first important step that signals the patient's readiness to deal with crucial issues, a step that needs to be followed by the "working through" of these emotions, and the intellectual analysis and understanding of one's conflicts.

Experiential and Humanistic Traditions

Weeping in Rogers' theory is described as a form of catharsis (but he does not use that term). Rogers believes that catharsis in psychotherapy is the opportunity to freely express oneself, and to gain emotional release from repressed feelings and attitudes. He claimed that therapeutic change involved fully experiencing feelings that had in the past been denied awareness or had been distorted. This free expression is helpful and constructive even if therapy does not go any further (Rogers, 1942). Therefore, for Rogers, the first step for therapeutic change is the free experience and expression of emotion that is followed with a cognitive awareness and understanding of this experience.

In Gestalt therapy, emotions and their expression are conceptualized as part of a basic organizational system that interacts with the organism and the environment to constitute the whole, or the *gestalt*, of what a person is. It is expected that the therapist will "use" emotional expression, including weeping to bring the client in touch with his or her bodily sensations. The final goal of therapy is to understand the meaning of the emotions and accept them (Greenberg & Safran, 1987; Mackewn, 1997), highlighting once more the significance of following weeping with a cognitive understanding and acceptance of the experience.

Behavioral, Cognitive, and Cognitive-Behavioral Approaches

The role of weeping in treatment is not described in the traditional behavioral therapies. It is expected to happen in therapy, as a reaction to the person's exposure to the traumatic or fearful situation he or she re-experiences in therapy (Greenberg & Safran, 1989). Weeping is mostly addressed by Ellis' Rational Emotive Therapy (RET) as a cathartic method of controlling intense and inappropriate emotions. Therapists can promote emotional experience and expression aimed at changing inappropriate feelings to appropriate ones, and to challenge the maladaptive beliefs and irrational thinking behind it (Greenberg & Safran, 1987). In Aaron Beck's (1976) cognitive theory, weeping is one type of emotional expression used to understand and modify people's cognitive schemes

Therefore, in the cognitive-behavioral approaches weeping is considered the means by which one can "get rid" of very intense emotions that can be disruptive. Cognitive behaviour therapists can use weeping to help the client deal with emotional distortions.

In this section the focus was placed on the way traditional theories understood and used weeping in therapy. In the next section, a focus will be placed on contemporary theories that address weeping more explicitly and more systematically than did many of the traditional theories.

Contemporary Theories

Greenberg (1999) stated that moments of weeping in therapy are related to extremely painful emotions such as deep hurt, despair, shame, anger, and bitterness or isolation from others. Furthermore, clients may be feeling shameful and "abnormal" for

experiencing such strong feelings, and as a result may be reluctant to reveal them out of fear of being overwhelmed by their own feelings or rejected by the therapist.

Greenberg and Paivio (1997) suggest that practitioners need to differentiate among different types of weeping that are associated with different types of emotions. They have developed *emotionally focused therapy* (EFT) with which they suggest some methodological steps to use when dealing with strong, painful emotions. EFT involves primarily allowing and accepting the primary adaptive, although painful emotion. Therapists adopt an attitude of acceptance and empathy while directing the clients to their bodily felt sense, and help them symbolize the meaning of their experience. The goal is to help the client accept his or her experience and to fully recognize and accept as understandable and human, intense emotions previously felt to be *abnormal* (Greenberg, Rice, & Elliott, 1993). This process of being with someone with the purpose of validating, "holding," and comforting the person without trying to solve their problem or make the pain disappear is a difficult one for therapists. The difficulty stems from the fact that therapists need to stay with the other's pain and suffering, to allow themselves to be touched by the other's feelings, while being in touch with their own evolving feelings. These moments of intense vulnerability can be difficult for novice therapists, since "they need to develop the capacity to allow themselves to be deeply touched by the suffering of others and not move away from the pain" (Greenberg & Paivio, 1997, p.169). The final step in EFT is cognitive exploration which takes place after the painful feelings are faced, and the client has entered into the process of "unraveling" the complex cognitive-affective sequences that underline the bad feelings.

This process of helping the client experience his or her emotions, accept them and explore them cognitively is a complex one. This is further complicated by the fact that people tend to consider weeping as a sign of weakness, embarrassing, or silly, and they feel uncomfortable crying, a reaction more frequently observed in men than women (Frey, 1985). The vast majority of clients are afraid to cry because they feel vulnerable in the face of these intense feelings. They are also afraid that if they allow themselves to weep, they may not be able to stop, and as a consequence they may be rejected by their therapists (Greenberg et al., 1993). Furthermore, for some theorists weeping represents an intense form of the expression of distress and/or sadness (Greenberg, 1999). In this state, the client surrenders to the experience and its expression, while at the same time, there might be interruption of the ongoing processing and temporary withdrawal (Greenberg, 1999). Such a state would make the cognitive processing and exploration of emotions a difficult endeavor. Additionally, contrary to other types of emotional expression such as anger or disgust, where it is much clearer for the organism how to react, the function of sadness and distress is not clear. This lack of a clear task can make novice therapists uncomfortable.

The general steps proposed by Greenberg and his colleagues, offer a systematic way of dealing with various types of emotional expressions, including weeping. Greenberg and his colleagues hold that, in dealing with weeping, therapists need to be empathic and to foster the basic facilitative conditions, so that the clients feel accepted and understood. Finally, echoing the more traditional theories, Greenberg and his colleagues state that weeping is therapeutic if accompanied by a cognitive exploration and processing of the emotional schemata underlying it. They also state that dealing with

client weeping in the early stages of training is a challenging process for beginners, due to the different levels of awareness required; awareness of the clients' and the therapists' processes.

Summary of Weeping in Psychotherapy

A review of the literature in the area of weeping indicates that is both an important and complex therapeutic phenomenon. There seems to be consensus among traditional and contemporary theorists that weeping can be therapeutic only in a climate of empathic understanding, that allows the client the free emotional expression needed for the cognitive exploration of the issues that led up to weeping.

While there is considerable theorizing with regard to the social or biological function of weeping, there is an absence of studies with regard to how trainees react to client weeping. A small number of studies of weeping in psychotherapy exist, and these will be reviewed to determine whether research confirms what theorists postulate as therapeutic when dealing with weeping events.

Research in the Area of Weeping in Psychotherapy

Research in the area of weeping in psychotherapy is very limited. Only three studies were found that have specifically examined weeping events. The first, conducted by Elliott (1983), was a case study aimed at examining significant events in psychotherapy. In this study, the client stated that the most therapeutic moment on therapy for her was a time in which she wept. Examining the event, Elliott reached the conclusion that four factors seem to have influenced the outcome of the event. First, the therapists' response at that critical moment of the client weeping was a *deep* reflection, a response

combining both reflection and interpretation that addressed one of the client's "core" issues. A second conclusion was that there was collaboration between the therapist and the client as they added to each other's response without being interruptive. Third, the therapist was sensitive to changes in the therapeutic process and in the client's behaviors. These shifts in the client's processes were indicators of the emotional shifts the client was experiencing. Fourth, the therapist was a facilitator who influenced the client in indirect ways, by example or through a dialectic process.

The second study, conducted by Labott, Elliott, and Eason (1992) was also a case study, and the first psychotherapy process study to specifically study a weeping event. The authors examined the major factors in the specific event that operated together to explain intense therapeutic weeping. They found that there were four such factors: (a) A level of unfinished emotionality that the client was experiencing, material that previously had not being fully expressed and integrated; (b) situational factors, since the client was in a state of stress and distress in her personal life; (c) the client's feeling of safety with the therapist; and (d) the client's ability to evaluate her memories and feelings concerning earlier traumatic events. In this study the authors concluded that the weeping helped the client to release tension and re-examine cognitions around events.

Labott, Elliott, and Eason (1992) concluded that weeping was an indication of feelings of distress the client was experiencing, confirming what had been previously presented by theorists, namely, that weeping is associated with different emotions, including distress. The conclusion that the client's feelings of safety enabled weeping validates the suggestion that in order for weeping to be therapeutic, clients need to feel

accepted and understood. Finally, the authors also validate the often stated importance of cognitive exploration in order for therapeutic change to occur.

Finally, the third study was conducted by Greenberg (1999). This study examined events of emotional pain and led to the development of a model of how to work with weeping. Results indicated that approaching the feeling and fully processing it emotionally led to a transformation process that appeared to involve different steps. The process Greenberg suggested follows a specific sequence of steps: First, painful feelings must be approached. Once the client is ready to allow and accept these feelings as part of him or herself, this process will result in the experience of the self as an agent rather than a passive victim of one's emotions. At that point the person is able to recognize and mobilize the need or the affective goal that is associated with the feeling, which will result in "an empowering of the organism to combat any dysfunctional beliefs that are embedded in the painful memories... This process results in an organism-like sense of relief and self-affirmation" (Greenberg, 1999, p.1472). Greenberg proposed this model of how to help clients through the process of weeping because his research showed that this process was therapeutic for his sample. He concluded that the experience, acceptance, and ownership of painful emotions is the first step toward the empowering force needed for relief from the painful emotions and experiences. He further argued that dealing with weeping therapeutically is a way to bring homeostasis to the organism from a physiological, emotional, and cognitive standpoint. His model offers a useful set of guidelines for therapists as they react appropriately to client weeping.

The studies discussed above suggest that therapeutic conditions and therapists' behaviours important for change to occur are the following: (a) The therapist delivers

deeper interventions while addressing the "core" issues of the client; (b) in a climate of empathy and acceptance there is a collaborative relationship between client and therapist; and (c) the therapist is not directive, but rather a "follower" of the client's processes. Finally, two additional components were addressed in all three studies: (a) The therapist was constantly aware of the client's processes, and (b) the therapists worked towards a cognitive exploration of the emotion and the emotional schemata underlying the weeping events. This existing research has begun to provide evidence of what therapists need to do when dealing with weeping in order to bring about therapeutic change.

As can be seen, research in the area is limited, and little has been written as to how to apply this knowledge in the area of counsellor training. Findings reviewed above lead to more questions and underline the point made by Vingerhoets, Cornelius, Van Heck, and Becht (2000) who state that "because the literature is full of unproved speculations about weeping and research on the phenomenon it is rather unsystematic and not theory driven, the time seems ripe for a more systematic and in-depth study of weeping" (p.361). This position is also shared by researchers in the area of psychotherapy process who state that weeping in psychotherapy has attracted minimal attention but merits further study (Hill, 1990). Thus, although overall there is a scarcity of research on weeping, especially in regards to training, the gap in the literature is particularly apparent.

Summary of the Literature Review

The foregoing review of the theories of psychotherapy has indicated that weeping is a type of emotional expression considered important by most therapies. Its importance is further emphasized by the fact that it is: (a) Associated with client change, and (b) associated with a number of different emotions. In order to effectively react to client

weeping, both the theory and research indicate that the therapist needs: (a) An attitude of empathic understanding and acceptance, (b) to allow the client experience his or her emotions, and (c) to help the client cognitively process this experience. We can also hypothesize that reacting to weeping could be a task particularly difficult for trainees since: (a) They tend to get overwhelmed when reacting to client emotions (Nutt-Williams et al., 1997), (b) they need to be aware and comfortable with their own emotional experiences, and (c) they need to allow the client to go though his or her experience without trying to change it or make it better (Greenberg & Paivio, 1997).

At the same time, from the area of counsellor training, we know that the first goal is to teach trainees how to be empathic, accepting and understanding of the clients' emotional experience, while the second goal is to teach different microskills that will help clients achieve cognitive and emotional exploration. Fulfilling these goals of training would theoretically mean trainees are "equipped" through their training to appropriately react to weeping.

Additionally, reviews of trainee developmental models added to our knowledge about how trainees achieve mastery of their skills and develop their professional identity. Models by Stoltenberg (1981) and Hill, Charles, and Reed (1981) were reviewed, and these stated that trainees in the first stages of training try to define their identity as counsellors, and that they may be over-invested in counselling and experience sympathy for their clients. From this we have strong indications that: (a) Trainees require the skills to react appropriately to weeping, and (b) they will have different types of emotional reactions to client weeping. Furthermore, novice counsellors are struggling with the development of their professional identities in ways that might increase their difficulty in

responding to strong client emotions. Based on this knowledge, and based on the importance of weeping in psychotherapy as a type of emotional expression, it is important to know how therapists-in-training react to moments of client weeping. Furthermore, since we know that trainees' reactions change as they develop, it is interesting to find out how their reactions to weeping change over one year of psychotherapy, during which time they were receiving training.

Purpose of the Present Study

A number of research questions emerge from the foregoing review of the field. The focus of the present study is to examine how trainees apply their general knowledge and skills to client weeping events. Given that there is a lack of convergence between the area of research on training and the area of emotion in psychotherapy, it will be important to find out if trainees manage to sustain an empathic attitude and maintain an adequate level of comfort with their clients during moments of client weeping. It is also important to know, what tasks they use, including both microskills and therapeutic techniques. Finally, it is particularly important to find out about how appropriately they use their therapeutic tasks. Examining these areas across different moments in therapy will also allow us to find out if and how trainees' tasks (behaviours) and style of communicating change across time. In order to address the above concerns two methodological perspectives will be employed in two studies. The goal of using these two perspectives is to provide a more comprehensive description of the data possible through the use of methodological pluralism. First, using a quantitative perspective, the goal is to get an overall picture of trainees' tasks and their development across time. Second, a discovery-

oriented perspective will also be employed, to allow for the detailed examination of each event, and to further examine the quality of the trainees' attitudes and behaviours across time.

Study I

The first study examined whether trainees tend to favor particular behaviours or attitudes/demeanours in response to weeping, and whether they favor different behaviours and attitudes across time. The first question in this study examined the behaviours and attitudes trainees most commonly employed without regard to the phase of therapy. Additionally, the second question of this study examined therapists' attitudes and behaviours over three phases of psychotherapy and tested whether there were changes in those two variables across time. According to the relevant literature and research on counsellor development, there is a change both in the type of counselling skills that trainees employ and in the quality of those skills across time, which reflects the impact of training. Using a quantitative methodology/perspective, this study examined whether similar results would be found in the present sample.

The research questions examined in the first study were:

Question 1. Which behaviours and attitudes/ demeanours do therapists-in-training employ most often when reacting to client weeping?

Question 2. Over three phases of psychotherapy (early, middle, and late), do the behaviors and attitudes/demeanours of therapists'-in-training change when reacting to client weeping)?

Study II

The second study examined the same variables as Study I at a finer-grained level. The goal of this study was to examine each of the weeping events along a number of different dimensions from the perspective of observers, and then report the findings of all nine events for each phase.

Different researchers have discussed the use of pre-existing theory in qualitative research. There is some tension in the field between bringing theory to bear on data or allowing results to emerge from the data (Hill et al., 1997). Some researchers - following a discovery-oriented methodology - approach the data with no pre-existing ideas. Instead, they attempt to describe all that they see without pre-existing expectations (Mahrer, 1988). Others maintain that no investigator can be free of theory (Koch, 1976; Stiles, 1997), since in order to develop any interest in a certain topic, requires a certain knowledge about the topic.

For the questions in this second study, existing literature was used to formulate basic questions (or domains). The four domains chosen for Study II were based on Elliott's literature examining in-session events (Elliott, 1989; Elliott & Shapiro, 1992). They are the following: (a) Context of the event (i.e., immediate context that preceded the event). (b) Content, in other words, what is the topic of discussion, (c) therapist action: "What is the therapist doing?", a question that involves both response modes and general therapist tasks (e.g., confront the client). Finally, (d) therapist style/manner of communicating ("How is the therapist talking?").

It is important to note that the number of domains was not limited: the initial questions themselves could be changed by other observations. This refers to the concept

of "permeability," which implies flexibility and receptiveness of observers to new information without ignoring their pre-existing knowledge or biases (Stiles, 1993; Stiles, 1997).

The domains of content and context were used in this study as a vehicle to help the reader gain a better conceptual understanding of the types of events examined, and to provide contextual information for the data. The domain of context is widely defined in the existing research and literature (e.g., background, pre-session context, session context, episode/event context) (Elliott, 1989; Elliott & Shapiro, 1992). Therefore each researcher is expected to make a choice as to what type of context he or she needs to focus on in order to best answer the research questions under investigation. For the goals of this study, it was considered that the most appropriate type of context that would stay close to the research goals was event context, which encompasses important characteristics of what was taking place immediately preceding the weeping event.

Attention to content and context allow examination of trainees' learning in different situations and under different conditions. The other domains used in this study also remain close to the main concepts communicated by the different training books for beginner trainees: According to these books, trainees are taught and are expected to do certain things (act), communicated in a certain way (style). Therefore, the goal of using these four dimensions was to provide a general structure as to how each event could be examined, without limiting the observers to the domains provided.

A fifth domain that observers were asked to comment upon was the quality of the trainees' tasks, since this was considered pertinent to the goals of this study. Quality refers to how appropriately the specific tasks were communicated to the client, and was based

exclusively on the judges' observations. Judges were instructed to evaluate the quality of trainees' reactions from the perspective of a supervisor, and provide an evaluation of each event as if they were giving feedback to the trainees. Specifically, the judges were instructed: "If you were the supervisor of the trainee under examination, how appropriately do you think he or she responded to the client weeping? On what criteria do you base that evaluation?" There were no further guidelines provided to the clinical judges as to how they should respond to the specific questions. The interest in examining appropriateness was derived from the literature on the counsellor training models that were previously discussed. These models operate on the underlying assumption that knowledge of specific skills is adequate and transferable across different counselling situations. This assumption implied that trainees would need to exercise personal judgment as when to communicate each intervention. Although all interventions can be appropriate in different situations, the choice of a specific intervention in a certain context is an important factor for the determination of the appropriateness of that intervention. Some refer to this skill as "therapist competence" (Beutler, Crago, & Arizmendi, 1986). Greenson (1967) referred to quality as the capacity to formulate an intervention and communicate it in a timely manner, that is, knowing what to say to the client when, and knowing how to formulate interventions in a helpful way. Appropriateness is included in the literature as one of the higher order skills such as case conceptualization or timing of the interventions. These skills are considered difficult for beginner trainees to master, and it is expected that they are acquired with training and experience (Greenberg & Sarkissian, 1984; Martin, 1991; Nutt-Williams et al., 1997). The interest of the principal researcher in the question of appropriateness was based on the above literature. However

none of this information was communicated to the clinical judges. This was to safeguard the spontaneous emergence of different categories from the examination of the events.

The central questions in Study II (to be structured with the help of the above mentioned domains) were:

Question 1. How do the reactions of therapists'-in-training change across the three phases of psychotherapy (early, middle, and late)?

Question 2. How do observers perceive changes in the quality (appropriateness) of the trainees' reactions to client weeping across the three phases of psychotherapy (early, middle, and late)?

CHAPTER 3

METHOD

The present study aims to describe the reactions that trainees have to client weeping. Additionally, there is an interest in understanding how these reactions change over the course of one year of training. Trainees' behaviours during client weeping events were examined with a combination of quantitative and discovery-oriented (qualitative) methodological perspectives. This in keeping with Elliot (1986) and Rennie and Toukmanian (1992) who stated that methodological pluralism offers several advantages to the study of psychotherapy process.

Methodological pluralism allows for the examination of data from different perspectives and therefore employing two methodologies should yield a more complete picture of the data. Specifically, quantitative research - or what has been called "paradigmatic" or deductive research - seeks to quantify relationships between phenomena. On the other hand, qualitative research - referred to as "narrative" or inductive research - takes a closer, contextual look at the variables under investigation. Uncovering the richness of information afforded by methodological pluralism was a central goal of this dissertation.

For this reason, the present dissertation was designed around these two complementary methodologies, aiming to provide a detailed picture and thorough understanding of the variables under investigation. The quantitative methodology should provide a framework that describes how trainees deal with client weeping over time. The addition of the discovery-oriented approach provides a more microscopic observation of what trainees did in each phase of training and how this changed across the three phases.

The same sample was used for both Study I and Study II, and the same events were examined in both studies. For this reason, the method of the present study will follow in this order: (a) Description of sample selection for both studies; (b) description of event selection for both studies. Following this, the methods and procedures for each of the two studies will be discussed separately.

Sample

The sample was drawn from a larger pool of data that the McGill Psychotherapy Process Research Team has been collecting since 1991. The data collection from the research team has progressed through two phases. In the first phase that began in 1991, archival data from tapes of prominent psychotherapists (e.g., Rogers, Ellis) with client-actors were examined in order to identify significant therapeutic ingredients, with an emphasis on emotional factors. The second phase of the research team began in 1995 with the examination of counsellors-in-training and their clients. The sample of the present study was drawn from archival data of first-year Master's students in counselling psychology. Students were required to work with actual clients as part of their practicum experience. Before the beginning of therapy and at termination, clients completed several questionnaires (e.g., Symptom Checklist-Revised, Hamilton, Tennessee Self-Concept Scale, Target Complaint Inventory) as methods to identify clients' presenting issues and level of distress. In order to assess in-session processes clients also completed several session measures (e.g., Session Impact Scale, Session Evaluation Questionnaire, and Working Alliance Inventory) at the end of each session. For this study, data from the second phase of the McGill Psychotherapy Process Research Team (began in 1995) were

used. Part of the team's data collection was, and continues to be, the systematic collection and study of videotaped sessions from counselling trainees and their clients.

Sample: Counsellors

All counsellors who participated in the present study were students in the Masters' degree program in counselling psychology at McGill University, (after having fulfilled a number of criteria set by the department, such as receiving a B.A. with honours in psychology or equivalent). Although both men and women of all ages are accepted into the program every year, the majority of students enrolled in the Master's program is in their 20's, which is reflected in the present sample. As a result of the selection criteria for the events to be examined (see below), all counsellors in the present sample are women. Finally, a large majority of these trainees come from a white, anglophone culture. No specific data are gathered in the department that would allow a more detailed description of the sample's demographics.

During the first year of the master's program, trainees participate in a (six credit – two semester) practicum class where the goals are to: (a) Learn basic interviewing skills, (b) learn assessment skills, (c) learn how to develop a good therapeutic relationship with the client, (d) learn how to work with the client in setting goals for therapy, and (e) learn how to deal with termination issues. The methods used to achieve these goals are both didactic and experiential, and include role playing, videotaping of counselling sessions, reviewing tapes, and discussing issues of psychotherapy in supervision (see Appendix A for attached copies of the course outlines of the Practicum course).

The program of studies for this first year includes theories of counselling and psychotherapy, theories of career counselling, assessment and diagnosis, as well as

diagnostic testing. The practicum in counselling psychology is the primary course for the teaching of counselling skills (Holloway, 1992) and the goals of the counselling psychology program of McGill University are compatible with the practice experiences followed in counselling psychology. Furthermore, the course outlines follow the same basic dimensions described by the three most commonly used training models described in the previous chapter. In short, the training model used in the Department of Educational and Counselling Psychology at McGill seems to be a generic and comprehensive model and it is equivalent to graduate programs in counselling psychology across North America.

Sample: Clients

The clients were students from another large North American University. They were enrolled in an undergraduate class in a health-related discipline and were given the opportunity to attend free counselling as part of their course requirements. From this group, a subgroup enlisted who were interested in participating in the general study of the McGill Psychotherapy Process Research Team. All prospective clients were expected to value the need for counselling, and to sign a consent prior to participation in the study (see a copy of a consent form in Appendix D).

Clients – Procedures of Selection. In order to safeguard the privacy and confidentiality of both counsellors and clients, a moratorium was imposed on all collected data. This precluded the use of any data that were less than three years. All participants (both counsellors and clients) were informed that they were free to withdraw from the study at any point, even after the end of the academic year, without any penalty.

Both counsellors and clients signed a consent form that indicated their willingness to participate in the research, and their freedom to withdraw at any time they chose to do so (see Appendix D for a copy of the consent forms). All ethical standards regarding confidentiality and anonymity of the participants were met (see Appendix D for a copy of ethical acceptability).

Data Preparation

The initial pool of data for this study was comprised of videotaped sessions. Videotaping of counselling sessions is a common practice in both psychotherapy research and training. Moreover, the use of videotaping has also been rendered important for counsellor training because it provides a wealth of information on both trainees' and clients' verbal and non-verbal aspects of behaviour, and it further allows trainees' to become better aware of disruptive counselling processes (Aveline, 1997; Yalom, 1995)

Despite the wealth of information that the use of the videotapes provide, in order to further increase the anonymity of the participants and to ensure confidentiality, audiotapes were made from videotapes, and all identifying information was removed from the tapes. Specifically, videotaped sessions were transferred to audiotapes and then transcribed to text by the primary investigator (who was not one of the judges for this study). Furthermore, in order to ensure that verbal and nonverbal information was not lost from the transfer to the audiotapes and that judges had most of the cues that could be related to their ratings, visual information from the videotape was identified in the transcript (e.g., "the therapist leans towards the client", or "therapist nods her head").

Selection and definition of weeping events

The selection of weeping events for this study followed a number of procedures and criteria. The primary investigator and three masters' level research assistants examined all videotapes (from the initial pool of data) for each of the dyads for the academic years of 1995-1998. Research assistants were required to meet the following conditions: (a) They did not have any relationship with either the counsellors or the clients in the tapes examined, and (b) they had to sign an agreement indicating that the content of the counselling sessions would be kept confidential. Each of the students along with the primary investigator was given all videotapes of the whole therapy of a dyad and was asked to determine whether weeping occurred. The sole task of the three students was to review each tape and identify the first instance of client weeping in each session. The definition of the weeping instances and the classification of counselling into phases was undertaken by the primary investigator. Of the total 72 dyads collected during the 1995-1998 period (N = 1,132 sessions), 27 sessions were selected from nine dyads at three points in therapy. The average number of sessions for the nine dyads was 16 (ranging between 10-19, M = 16.6, SD = 2.83). The inclusion criteria for the dyads were: (a) These dyads had given their consent to participate in the research, (b) they had weeping events in all three phases of their psychotherapy sessions (early, middle, and late), and (c) they had to have completed therapy.

All nine dyads found were comprised of women, both as counsellors and as clients.

Classification of weeping instances into phases

After the nine dyads were identified, the primary investigator classified the events into phases. The total number of sessions was divided in thirds. The criteria used to

classify the events in the three phases of psychotherapy were the following: (a) Each of these phases be comprised of three to five sessions, since the average total session number was 16. However, in the dyads where the total session number was more or less than 16, the duration of therapy was taken into consideration to equalise phase length. On only two occasions, the difference between two phases was three sessions. (b) In phases where there was more than one weeping event, the first event occurring in each phase was used for the sample of this study. (c) Additionally, the first weeping event of the session was chosen in order to avoid the possibility that a weeping event was influenced or was a sequence of another preceding event in the same session. (d) Other than the absence of any male clients, the research sample did not differ on important dimensions (e.g., Symptom Checklist-Revised (SCL-90-R), Target Complaints, described below) from the overall population of 72 dyads, therefore assuming that it was representative of the overall research sample. This information was obtained by examining both the Target Complaints and the scores of the SCL-90-R of the clients participating in this study across the other clients who were part of the larger pool of data of the research team.

Definition of weeping events

The examination of therapy events represents a relatively new research paradigm, with the aim of isolating meaningful patterns of interactions, and comes as an answer to earlier problems of segmentation of in-session communication. Various researchers employ different criteria in their definition and identification of important events (Hill, 1990). A number of researchers chose to use arbitrary counts of words, phrases, thought units, or turns of speech, as methods to define events, while some other researchers have chosen to segment in-session events based on specific markers, (e.g., a transition in the

client's level of experiencing, insight, mastery of problems). This latter method is thought to provide more meaningful results since the examination is based on a specific therapy condition (Kiesler, 1973). Had the goal of the study been to examine weeping events until their completion, then two methods could have been followed: Either (a) the clients themselves would have been asked to identify where they experienced the closure of the issue at hand (Labott et al., 1992), or (b) external judges would have been called upon to identify a change in topic or the end of the hour (Elliott, 1983; Clarke, 1996). Similarly, if the goal of the study had been to examine immediate in-session outcome, the end of the event would be defined as the point in therapy where there is resolution of the issue or lack of it (Greenberg, 1986). Finally, if the goal of the study was to measure therapist involvement, a number of therapist process measures could be used as the defining point for the end of the event. A therapist process measure could have been used if the interest of this study was the examination of therapists' state based on a certain predetermined criterion. However, since the goal of this study was to examine trainees' initial behaviours in response to weeping events, none of these methods was used.

For the purpose of this study, the marker for the beginning of an event was the beginning of the client's weeping. While the beginning of the event was easily identified, the definition of the ending point of a weeping event was a challenging task, since weeping may continue for an indeterminate amount of time during the session. The different methods that have been already applied by researchers so far (presented above) do not apply to the research questions of this study. Therefore, given that the interest of this study was to examine the initial reaction of the trainees to client weeping, and how these reactions change over time, the end point of a weeping event was based on the

following criteria: (a) Enough material from the event was needed to address the research questions. The interest of the study was to examine how trainees react to weeping in a way that would capture their initial reaction including both the first statement after the client began to weep and how their reaction began to unfold. (b) Equal length for the events was needed. Since the other goal of the study was to examine trainees' reactions to weeping across time, it was believed that the criteria set to define the end of the event would need to provide events of similar lengths in order to facilitate quantitative comparison between events.

Based on the above criteria, it was decided that, initial reaction would be defined as the first ten counsellors' statements following the beginning of the clients' weeping. It was judged that ten statements would be sufficient to examine trainees' initial reaction to weeping and the manner in which these reactions begin to unfold. It was believed that this criterion - although rather arbitrarily defined - would provide enough evidence for a thorough understanding and, at the same time, safeguard the homogeneity of the sample in order to make quantitative comparisons between events possible.

When defining the ten therapist statements that would encompass each event, each client and therapist speaking turn was numbered consecutively and was considered as a statement. A counsellor or client statement was defined as all the words spoken by one party, preceded and followed by words spoken by the other party.

At the end of this part of the process, the identified events were transferred to audiotapes by the principal investigator.

Study I – Method and Procedures

Study I comprised of a quantitative investigation of therapists' behaviours and attitudes in each of the 27 events (nine dyads in three phases), and provides information concerning changes in those variables across three phases of therapy. This line of study is situated primarily within a positivistic and a postpositivistic paradigm, where the main belief is that certain "truths" exist and can be uncovered using "objective" measures. The general method is hypothetico-deductive, where deductions are derived from testing hypotheses, and the relations among the variables are strictly defined (Heppner, Kivlighan, & Wampold, 1999). This type of research paradigm was employed in this study because the goal was to obtain a general picture of the data. Using a widely accepted instrument to measure variables similar to those in this specific study provides the means for arriving at a common "language" among researchers. The quantitative investigation that comprises Study I is designed to answer two central questions: First, "What are the behaviours and attitudes that trainee counsellors employ most frequently, regardless of the phase of therapy?" Second, "Are there significant changes in therapist's reactions to client weeping over time?" This second question was answered by comparing therapists' behaviours and attitudes/ demeanours for all nine therapists across three points in therapy (early, middle, and late phase).

Measures

Pre-Therapy Selection Measures

For the present study, two of the pre-therapy session measures collected by the larger research team were used, namely the Target Complaints Inventory (TCI: Battle et

al., 1966), and the Symptom Checklist-Revised (SCL-90-R: Derogatis, 1983). The two measures were used in order to identify the types of issues presented by the clients (TCI) and their general level of distress (SCL-90-R). These measures were also used to ensure that clients in the sample did not demonstrate severe levels of pathology or require crisis intervention.

Target Complaints Inventory

In order to identify the types of issues presented by clients as well as the extent to which these issues were addressed throughout the course of counselling, the Target Complaints Inventory (TCI; Battle et al., 1966) was administered both before counselling began and once it had been completed. The TCI is a questionnaire that asks clients to identify the main issues that they wish to work on in counselling. Mintz and Kiesler (1982) reported a test-retest reliability of .68 for the TCI, while the authors of the scale reported high correlations with other measures of outcome (Battle et al., 1966). The TCI is also used frequently as a measure of change in counselling (e.g., Paivio & Greenberg, 1995).

Clients reported a variety of issues; from everyday concerns (such as interpersonal issues, career and work-related issues), to issues of identity and self-esteem. The willingness to discuss such a large range of important topics is considered to be another indication of the clients' motivation to regard the counselling context as a place where they expect to do meaningful therapeutic work. Furthermore, their reports on the TCI after termination strongly indicated that during their counselling sessions, the issues that they had initially reported as important for them to work on, had been addressed in counselling.

Symptom Checklist-Revised (SCL-90-R)

In order to ensure that the clients participating in the study had real concerns and represent the general counselling population, their level of distress was examined with the Symptom Checklist-90-Revised (SCL-90-R: Derogatis, 1983; Derogatis & Lazarus, 1999; Derogatis & Melisaratos, 1983). The SCL-90-R is a brief (90- item), multidimensional self-report inventory designed to give a general picture of current psychological symptom status expressed by the Global Severity Index (GSI), and screen for a broad range of psychological problems and symptoms of distress and psychopathology. It is composed of nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticicsm) that provide an overview of the patient's symptoms and their intensity at a specific point in time (Derogatis & Lazarus, 1999).

Internal consistency (coefficient alpha) for the nine symptom dimensions ranges from $\alpha = .77$ to $\alpha = .90$, while test-retest reliability ranges between .80 and .90 over a 1-week interval (Derogatis, 1983). Numerous studies attest to the SCL-90-R's validity; these have been reviewed by Derogatis (1983), and are included in the SCL-90-R manual. According to the manual, the GSI "provides the most sensitive single numeric indicator of the respondent's psychological distress" (p.27). In the present study the SCL-90-R was used to screen for severe psychological distress. Clients with a T-score higher than 70, which is an indication of severe psychopathology, were not included in this study. The T-scores for the specific sample in the present study ranged from 30-64, ($M = 53$, $SD = 3.98$), which according to the manual, indicates levels of mild and moderate discomfort.

From both the TCI and the SCL-90-R there was a strong indication that the sample of this study was motivated for counselling, since: (a) On the TCI they had identified topics that they wanted to work on in counselling; these were related to either interpersonal problems or issues of personal development and self-actualization, and (b) their scores on the SCL-90-R ranged between indicators of no serious problems and scores that indicated mild discomfort.

Process Measure

The Vanderbilt Psychotherapy Process Scale (VPPS)

The goal of this study was to measure therapists' behaviours and attitudes/ demeanours. Based on the training models described in the literature, it was expected that trainees would be able to (a) communicate Rogers' (Rogers' et al., 1967) facilitative conditions to their clients (i.e., approval, empathy, support), and (b) recognise and understand the clients' perspectives, feelings and behaviours and work with these in therapy. In an effort to examine to what degree these behaviours and attitudes/ demeanours were adopted by the trainees in this sample, a process scale that would capture those content dimensions was needed.

The Vanderbilt Psychotherapy Process Scale (VPPS) (O'Malley, Suh, and Strupp, 1983) was identified as the most appropriate to answer the research questions posed. Although a number of other scales are used in the field to measure therapists' behaviours and attitudes, they were considered inappropriate for use with the present sample and for the questions of this study.

The appropriateness of the VPPS for the sample of this study was specifically indicated by the fact that it has been used in the area of counsellor training in order to

measure beginner and advanced trainees' acquisition of counselling skills in relation to their ego development (Borders & Fong, 1989). Furthermore, the VPPS is a scale widely recognized as one of the common observational measures of psychotherapy process (McLeod, 1994). Additionally, preliminary work with the scale indicated that it seemed to capture important characteristics of the client, the therapist, and their interaction in exploratory psychotherapy (Gomez-Swartz, 1978; Gomez-Swartz & Swartz, 1978; O'Malley et al., 1983; Rounsaville et al., 1987).

The VPPS is comprised of eight subscales that measure client and therapist behaviours and attitudes/demeanour; three of those subscales were selected to answer the present research questions. The subscales of "Negative Therapist Attitude" (6 items) and "Therapist Warmth and Friendliness" (9 items), with items referring to a therapist being "empathetic" or "authoritarian" were used to measure therapist's demeanour, and were considered appropriate to answer the question of therapist style. Previous literature has used the subscales of "Negative Therapist Attitude" and "Therapist Warmth and Friendliness" to evaluate "therapist's interactive style" (Henry, Butler, Strupp, Schacht, & Binder, 1993; Henry, Schacht, Strupp, Butler, & Binder, 1993). Finally, the "Therapist Exploration" subscale (13 items) was also employed, in order to rate therapist behaviour.

The VPPS was initially developed by Strupp, Hartley, and Blackwood (1974) and, after two revisions, the second and final revision of the VPPS was released in 1983 by O'Malley, Suh, and Strupp. Although based on general assumptions of psychotherapy as an interpersonal process, the VPPS " is intended to be largely 'neutral' with respect to any particular theory of psychotherapy, and to be applicable to a wide range of therapeutic interventions" (Suh, Strupp, & O'Malley, 1986, p.287). Furthermore, the

scale requires a minimal amount of training since there is a small level of inference that is required. The items of the scale are designed to be unidimensional, and descriptive rather than evaluative (Henry & Strupp, 1994). It is designed for rating entire sessions, selected segments of 10-15 minute length (Suh, Strupp, & O'Malley, 1986), or selected number of statements (H.H. Strupp, personal communication, October 17, 2001).

In terms of the psychometric properties of the VPPS, it was found that both internal consistency and interrater reliability are high for all subscales (Suh, Strupp, & O'Malley, 1986). Internal consistency as measured by coefficient alpha ranged from r = .81 for Patient Dependency to r = .96 for Patient Exploration and for Therapist Exploration. For all eight subscales, the interrater reliabilities between the two judges used, were ranging from r = .79 to r = .94 (Suh, Strupp, & O'Malley, 1986). Furthermore, the predictive validity of the scale has been demonstrated by a number of studies (O'Malley, Suh, & Strupp, 1983; Rousanville, et al., 1987; Windholz & Silberschatz, 1988).

Procedures

Rater selection and training

For this part of the study two raters used the VPPS to rate weeping events. The use of two raters for the VPPS has been established in the field (Henry et al., 1993). Each rater had an M.A. in Counselling Psychology and was pursuing a doctorate degree in the field. Both raters were women. Raters were trained according to the manual instructions. Training lasted for eight weekly meetings of approximately two hours each meeting. In the first meeting the group discussed the definition of each of the items that they were expected to rate and their understanding of them. In the remaining seven meetings, the

two raters rated individually segments from tapes of expert psychotherapists, and met to discuss their ratings. During those meetings, any disagreements were discussed, a common understanding for the meaning of the items was agreed upon, and a consensus version of the ratings was reached. The raters were considered ready to start rating the data of the study (a) after they had reached a level of interrater reliability varying between .68 to .88, with an average of .80, and (b) when they stated they had a clear understanding of the scale, the demands involved in rating, and felt confident to do so. Throughout the process of training, the role of the primary investigator was to be a participant-observant of the discussion between the two raters and to participate in order to help clarify disagreement when necessary.

Rating Procedure

Raters independently rated all 27 events, using the three subscales of the VPPS, rating one event each week. Raters were unaware from which phase of the therapy the event was taken. After they had completed their independent ratings, they met once a week to discuss the ratings. Between the two raters, interjudge reliability was calculated before the weekly meetings, and during the meetings, consensus was reached (Henry et al., 1993). Before consensus, raters achieved interrater reliabilities ranging from .61 to .92, with an average of .79. These reliabilities are adequate, according to criteria set forth by Fleiss (1981).

Study II – Method and Procedures

The procedure used for the analysis of Study II was discovery-oriented, with the aim of providing a description rather than an explanation or quantification of the event under examination (Henwood & Pidgeon, 1992). In a discovery-oriented methodology, researchers generate categories from the data rather than searching to support preconceived hypotheses or to test theories (Hill, Nutt-Williams, & Thompson, 1997). Counselling psychology researchers are progressively turning their attention towards using qualitative or discovery-oriented methodologies to examine infrequently occurring phenomena or inner experiences that have been difficult to investigate with existing, quantitative methodologies (Hill et al., 1997). One infrequently occurring phenomenon that requires such investigation is crying in psychotherapy (Hill, 1990; Hill et al., 1997).

The method for analysing the present data was based on Consensual Qualitative Research (CQR: Hill, et al., 1997), and borrowed elements from Comprehensive Process Analysis (CPA: Elliott, 1984). Traditionally, CQR has been used with interviews or questionnaires and not with in-session events. This study borrowed the methodological steps of CQR in order to apply them to the examination of therapy events, while at the same time using some constructs presented by CPA. This combination of methods in therapy events has been previously employed by Iwakabe (2000), and Gazzola (2001).

CQR is a method strongly influenced by grounded theory (Glasser & Strauss, 1967; Strauss & Corbin, 1990), and by other methodologies, such as CPA. It follows an inductive process with conclusions being built from the data rather than being imposed by an a priori theory. It also uses, similarly to grounded theory (Strauss & Corbin, 1990), the constant comparative method. In this method, the goal is to describe phenomena, by

continuously cycling through the data, and constantly comparing the data across cases to examine the same phenomenon in order to derive conclusions that are common to all cases. CQR does not rely on multiple sources of data for the analysis, and also stays very close to the explicit meaning of participants' statements rather than looking for implicit meanings (the specific steps followed by CQR will be discussed later in this section).

CQR is a method that has been employed in several process research studies to date (e.g., Gelso, Hill, Mohr, Rochlen, & Zack, 1999; Hayes et al., 1998; Hill, Zack, et al., 2000; Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000). The clear methodological steps allow for a detailed examination of the data under investigation from which a simple and understandable presentation of a large amount of information results. Additionally, the method of charting the data at the last stage of analysis is particularly appropriate for this study, since charting of the data allows for a clear comparison between the three phases of psychotherapy, thus making the results of the study more comprehensible to the reader. CQR is also particularly appropriate and helpful for areas that are relatively unexplored (Hill et al., 1997; Stiles, 1997), since the method allows the researchers to discover concepts and relationships between the variables that may not have been previously considered (Heppner, Kivlighan, & Wampold, 1992). In addition, since CQR is a method that allows for the examination of observed phenomena rather than making inferences about what is observed - as is the case with CPA - it is particularly useful for the goals of this study where the intention is to describe the phenomenon under investigation while making the least possible inferences. In general, CQR is situated within the constructivist research paradigm because it seeks to discover hypotheses and the relations between or among constructs,

using the constructions of the participants themselves. This recognises that reality is created by the participants of any system (Heppner, Kivlighan, & Wampold, 1999). CQR is further influenced by phenomenological approaches whereby it asserts that the data cannot be understood outside of context (Hill et al., 1997). In this specific study, the participants' (i.e., clients and counsellors) account of their experiences could not be taken into consideration since the events are extracted from already existing archival data base. However, the goal was not to make inferences about the participants' experiences but rather to understand the process of trainee development from a trainer's point of view. As a result, CQR was considered an appropriate method since it generates the kind rich information that was specific to how the clinical judges, from the perspective of a supervisor, evaluate trainees' reactions to client weeping.

CPA is a procedure that uses different quantitative and qualitative measures taken from both therapist, client, and external judges with the goal of understanding significant change events and analysing the implicit meanings of those events. It systematically considers both client and therapist in terms of five aspects of process (context, content, action, style, and quality), and draws on three points of view for doing so (observer, client, and therapist). The use of the sequential framework suggested in CPA by Elliott (1989, 1991) to analyze events as the general dimensions for the examination of the events (e.g., examination of events in terms of action, content, style, quality, and context), was considered appropriate to answer the research questions of the study. Therefore, the use of dimensions designed to examine therapy events in a methodology that facilitates the exploration of new research territory, was deemed to be the appropriate method for the data of this study.

Judges

A group of three judges, (different from the raters of the VPPS group), participated in a discovery-oriented investigation of the 27 events. The criteria for selecting the judges for this study were: (a) They had obtained at least an M.A. degree in counselling psychology, and (b) they had at least three years of counselling experience after the completion of their degree. (c) They were counselling psychologists, and were working either in private practice or in counselling centres. Two of the judges were men and had a Ph.D. degree, and the third judge was a woman who had a Master's degree. The three judges, therapists with clinical experience ranging from 3-8 years, have also worked in a supervisory capacity, which had particular relevance for one of the tasks that were asked for this study (i.e., judge the quality of the therapists' tasks).

An additional judge, called "auditor," was used to examine both the raw data and the judges' observations. The auditor for this study was one of the supervisors of this dissertation, and was not part of the main analysis of the data. The auditor's task was to examine the raw material in each domain and identify whether (a) the raw material had been classified in the correct domain, (b) all the important material in the domain had been abstracted, and (c) the wording chosen by the judges was appropriate, representing and reflecting the raw data (Hill et al., 1997).

Researcher's and Judges' Biases and Expectations

Prior to data collection, expectations and biases of the judges pertaining to their beliefs about therapist training and the importance of weeping in therapy were recorded. Hill and her colleagues (1997) defined "biases" as any "personal issues that make it difficult for researchers to respond objectively to the data" (p.539), and "expectations" as

the researchers' beliefs about the specific topic and research questions under study based on their knowledge from the literature.

Biases and expectations were discussed in the early stages of the ratings so that the judges would be aware of their own and each other's pre-existing notions and the manner in which these notions could influence data analysis. Additionally, the theoretical orientation of each judge was discussed in order to increase their awareness of any preconceived ideas stemming from their theoretical orientation. Specifically, all judges described themselves as humanistic in background, but currently practising eclectically, using techniques from different orientations. One of the two men described himself as being also influenced by the cognitive psychotherapies, while the second man described himself as being influenced by dynamic therapies. The principal researcher's theoretical orientation is mainly influenced by psychodynamic and existential theories.

Discussing biases, all three judges agreed that weeping is important in psychotherapy only if the emotion behind the weeping and its meaning is discussed and explored in therapy. In terms of their expectations, all three judges also agreed that as trainees feel more comfortable in their role as therapists, they will feel more comfortable to work with weeping and its meaning rather than avoid it. There were no expectations about the specific tasks that trainees would perform. The principal researcher shared the same biases and expectations. The judges referred to their statements about their biases and expectations every time they encountered difficulties reaching consensus in the meetings. This procedure helped them identify whether their difficulty in reaching consensus for the specific event was due to their theoretical orientation.

Rating Procedures

The procedure followed in this study is suggested by Hill and her colleagues (1997). The use of more than one or two judges is employed in order to achieve more reliable results and reduce potential biases of the judges (Hill, et al., 1992). The judges were aware of the goals of the study but were not aware of the phase of therapy from which the events were taken. The team met on a weekly basis to examine their observations of the events, and needed approximately one hour for the thorough discussion and final decision of the observations. Each week, each judge examined each event separately, analysed the event based on his or her observations, and sent his or her observations to the primary investigator. The primary investigator compiled all three versions and circulated them to each of the judges before their next meeting, in order to give them h. chance to examine each other's observations and reflect on them. When all agreed on their observations, a consensus version was developed and was incorporated in the results.

CQR steps in data gathering and analysis of the events

The steps followed in CQR will be briefly presented in this section and will be described in more details in following sections of this chapter. The procedure in gathering and analysing the data for this study involved five steps. Those steps were:

1. The first step in CQR involves conducting interviews, transcribing them, and then categorising all material that related to the same idea into one domain or more if necessary. Since this study used therapy segments rather than entire interviews , judges were asked to examine every therapist statement and describe what they observed, based

on the dimensions which were borrowed from CPA, namely therapist task, style, quality, content, and context. These descriptions formed the data that were later analysed.

2. In the second step of the analysis, the data from each transcript were grouped into general domains. Domains are topic areas used to cluster information or data about similar topics (Hill et al., 1997, p.543).

3. In the third step, the data from each domain were summarised into statements, called core ideas, and this version was sent to the auditor for his opinion.

4. At the end of this step, the events were divided into phases, and the core ideas from each event were compared with the core ideas from other events of the same phase. This was done in order to examine their similarities and differences, a process called cross-analysis.

5. In the next step, the final results were charted.

At the end of each step the auditor of this study examined both the individual evaluations and the consensus version of the team each time (in all five steps), in order to ensure that the correct decisions were made.

Detailed statement description. In the first step of the analysis, the goal was to provide a description of each therapist speaking turn in each of the 27 events. The dimensions that were considered appropriate to answer the research questions were the ones used by Elliott (1991). Those dimensions were used as the initial domains of the events. The dimensions were: (a) Context of the event (What preceded the event?), (b) content of the event (What is discussed?), (c) Therapist's tasks (What is the therapist doing in each statement? e.g., confronting the client, and the response modes, e.g.,

interpretation) (d) therapist's style (How is the therapist talking or acting? e.g., supportive, caring), and (e). quality (How appropriate were the therapist's tasks?),

Elliott's (1991) dimensions were the only component of the CPA used in this study. Finally, after examining each event, judges were instructed to listen to five or more speaking turns preceding the event in order understand the context of the event. The judges' description of each speaking turn formed the data for the study. After the judges analysed each speaking turn, the principal investigator compiled the three versions and distributed all three to each of the judges. After each judge studied the ratings of the other two judges, a consensus meeting was held to generate a final version for each speaking turn. For example, in a client's statement where the client cries while describing the pressure she feels, but ends her statement by saying "It is okay", and the therapist responds "But you don't feel so good about it". The judges agreed to describe this therapist's statement as "the therapist in a warm and soft voice re-directs the client to focus on her process by confronting her on her incongruity between her verbal and nonverbal messages".

Coding of Domains. The goal of this step was to classify each speaking turn into domains. The main research questions are used as initial domains in order to divide large data into smaller pieces (Hill et al., 1997). Domains are large conceptual areas used to cluster information or data about similar topics. At this step of the analysis, the judges classified each of their observations of therapists' speaking turns into one or more domains. Once each member of the team independently coded all the data from each event into domains, the team met to discuss the codings for that event. The goal was to arrive at a consensus version as to which domains the data would be classified in. The

final result of this stage was a consensus version that included the domain areas and all of the judges descriptions classified under each domain. After the team had assigned domains for several transcripts, each judge's evaluation, along with the consensus version and the raw data were sent to the auditor to comment on the results. Auditing of the rating process is an integral component of CQR at each step (Hill et al., 1997). After the auditor examined the data, comments about the analysis were sent to the team. The team discussed the auditor's comments, and if they were in agreement, they incorporated the new comments into the consensus version and sent this back to the auditor for his agreement. Throughout the analysis of the data, there were no major disagreements between the team and the auditor; rather, auditor comments were seen as complementary to the team's ratings.

Constructing Core Ideas. The goal of this phase is to summarise the description of the domains developed in the previous phase, into smaller units called core ideas in order to facilitate the comparison of the events in the next phase. The process of developing core ideas has also been called "abstracting" or "boiling down" (Strauss & Corbin, 1990). The aim of abstracting is to "capture the essence of what was said about the domain in fewer words and with more clarity" (Hill et al., 1997, p.546). Each of the three judges independently examined the transcribed data and their evaluations of them within each domain and summarised it into core ideas. The group then met to develop a consensus version of the core ideas for each event. At the end of this process, the auditor checked once more the raw data and the domains to ensure that they were appropriately sorted into accurate core ideas. The auditor once again gave written feedback to the team,

who discussed the feedback and came to an agreement about the changes needed to arrive at a consensus version of the core ideas.

Hill and her colleagues (1997) discuss a method for ensuring saturation of the categories or what they refer to as "stability of findings" (p.552). By this term they mean that the analysis has reached the level where, if new cases are added, these do not change the results. The auditor is also invited to review the data with the goal of ensuring that new categories do not emerge. Judges of this study were unable to generate further categories from the data after examining all 27 events. Hill and her colleagues suggest verifying saturation by adding extra cases until no more categories emerge. For this study (as is discussed at more length in the section of the limitations) we were unable to verify saturation in the manner suggested by the authors of CQR (Hill et al., 1997) due to the lack of additional events available in our data pool.

Cross-Analysis. Up to this fourth step of the process, the judges examined each event individually. At this point the focus shifted, and the events were classified into the three phases of therapy. A separate cross analysis was conducted for each of the phases. During the cross-analysis, core ideas within each domain across cases were clustered into categories. The goal was to draw a more general picture of an event and to examine how events might differ from each other. Thus, the judges looked across the already identified core ideas within each phase of therapy to determine whether these core ideas could be classified under larger categories that capture their similarities (Ladany et al., 2000; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Rhodes, Hill, Thompson, & Elliott, 1994). During this process they referred back to the transcripts and the initial steps of the

analysis in order to evaluate the fit of the categories to the core ideas based on the raw data.

In order to ensure that the categories that emerged from the data were representative of the sample under examination and at the same time describe possible variations within the sample, the authors of CQR classify categories based on the number of cases in which they appear (Hill et al., 1997). The authors of CQR propose that when a category applies to all cases it is labeled "general", when applied to half or more of the cases it is labeled "typical" and when applied to less than half of the cases it is labeled "variant". Any categories that apply to only one or two cases are dropped as they are not representative of the sample. An alternative to deleting categories is to make an effort to "fit" those infrequently occurring core ideas into other, broader categories. These suggestions were followed in this study. Specifically, categories were considered general if they applied to all nine cases, typical if they applied to between five to eight cases, and variant if they applied to between three to four cases, in each phase. Categories that were applicable to only one or two cases in all three phases were dropped from further consideration, unless they were part of a continuum (e.g., activity level: low, moderate, and high). Additionally, if one category was applicable to only one or two cases in one phase but to more that three cases in either of the other two phases, it was still included in the results.

Auditing of the cross-analysis. At the completion of the cross analysis for each of the three phases, the auditor inspected the cross-analyses, to verify whether core ideas fit under the specified category. The auditor provided written feedback to the team, and the team discussed and incorporated the changes when necessary.

Charting the data. The data were displayed in tables in order to identify patterns among domains within each event. Initially there was a separate chart for each phase of therapy (early, middle, and late). This gave a clearer picture of each weeping episode, along with a general picture of all the episodes for each phase. At the last step of this process, the data from each phase were summarized and a table including the data from the nine dyads across the three phases was constructed. This procedure is used by researchers conducting both CPA (Elliott, 1991) and CQR based studies (Hill et al., 1997).

Summary of Method

In order to answer the research questions of this study, namely how counsellor trainee skills develop across phases of therapy when reacting to client weeping, quantitative and discovery-oriented methodologies were employed. It was believed that the quantitative methodology would provide frequencies and a general framework within which trainees operate and change over time, and the discovery-oriented methodology would allow for a microscopic investigation of the events, where nuances of the therapists' behaviours and attitudes would be delineated. Furthermore, the discovery-oriented methodology employed would provide a picture of the quality and the appropriateness of counsellors' tasks. The VPPS was used to provide the data for the quantitative analysis and the methodology of CQR was employed to guide the judges of this study in their final conclusions.

CHAPTER 4

RESULTS

Study I

The purpose of the first study was to examine those therapist behaviours and demeanours/attitudes that occur in reaction to client weeping events and how these reactions change over time. In order to examine therapists' behaviours and attitudes, three subscales of the Vanderbilt Psychotherapy Process Research Scale (VPPS) were used. The research questions examined were the following:

Question 1. Which behaviours and attitudes/ demeanours do therapists-in-training employ most often when reacting to client weeping?

Question 2. Over three phases of psychotherapy (early, middle, and late), do the behaviors and attitudes/demeanours of therapists'-in-training change when reacting to client weeping)?

In order to examine the research questions, a repeated-measures MANOVA was used. The repeated-measures approach is appropriate when dependent-variable measures are conducted on the same subjects over more than one condition (i.e., the independent variables are within-subjects variables). The design of the current study, in which the three therapist subscales (i.e., therapist warmth and friendliness, therapist exploration, and negative therapist attitudes) were measured across three time periods in the same subjects, indicates the appropriateness of a repeated-measures approach to data analysis.

Repeated-measures designs are also more powerful because they better account for individual differences, thereby reducing error variance. Repeated-measures MANOVA was chosen as appropriate to examine data from the specific scales used, because the VPPS yields data that have traditionally been seen as interval and therefore testable with parametric statistics (Henry, Butler, Strupp, Schacht, & Binder, 1993).

The multivariate results for the first research question indicated that there was a significant main effect for the three subscales which measured attitudes and behaviours [F (2,16) = 64.54, p = .000] (see Table 1). The mean for negative therapist attitudes (subscale one) was M = 1.26 (SD = .31), for therapist warmth and friendliness (subscale two) was M = 2.72 (SD = .55), and for therapist exploration (subscale 3) was M = 2.35 (SD = .34) (see Table 2). Post-hoc pairwise multiple comparisons were conducted in order to examine where the difference between the subscales were found. Based on Least Significance Difference test, all mean scores were significantly different from each other with a p of .006 or smaller (see Table 3). Specifically, the mean scores on subscale one (Negative therapist attitude) (M = 1.26, p < .001) were significantly lower than mean scores of both subscale two (Therapist warmth and friendliness) (M = 2.72, p < .001) and subscale three (Therapist exploration) (M = 2.35, p < .001). Additionally, the Least Significance Difference test indicated that the mean score for subscale three was significantly lower than the mean score for subscale two (p = .01).

To address further the first question of whether the three subscale scores changed in different ways over the three phases of therapy, a repeated-measures MANOVA was used to examine the interaction effects between therapy phase and subscales. The results indicated that there was no significant phase by subscale interaction effect

[F (4, 32) = 1.21, p =.33]. That is to say, the scores of the subscales of negative therapist attitudes, therapist warmth and friendliness, and therapist exploration did not differ significantly over the three phases. Subscale one (negative therapist attitude) was always the lowest, subscale two (therapist warmth and friendliness) was always the highest, and subscale three (therapist exploration) was always in the middle.

Table 1

Repeated Measures Multivariate Analysis of Variance for Behaviour and Attitudes over Time

Source	df	F	η^2	P
Subscale	2	64.54	.890	.000
Error (Subscale)	16			
Time	2	.013	.002	.987
Error (Time)	16			
Time * Subscale	4	1.207	.131	.327
Error (Time * Subscale)	32			

Table 2

Mean Scores for VPPS Subscales

				95% Confidence Interval	
Subscale	Mean	Std. Dev	Std Error	Lower Bound	Upper Bound
1	1.26	.31	.076	1.08	1.44
2	2.72	.55	.117	2.45	2.99
3	2.35	.34	.072	2.18	2.51

Table 3

Pairwise Comparison of VPPS Subscales

				95% Confidence Interval	
Subscale	Mean Diff	Std Error	Sig.[a]	Lower Bound	Upper Bound
1 X 2	-1.46*	.181	.000	-1.88	-1.04
1 X 3	-1.09*	.102	.000	-1.32	-.85
2 X 3	.372*	.101	.006	.139	.605

* The mean difference is significant at the .05 level

[a]: Adjustment for multiple comparisons: Least Significant Difference.

The repeated-measures multivariate analysis of variance (MANOVA) was performed in order to answer the second question by comparing the VPPS ratings for the nine therapists' behaviours and demeanors across the three different phases of therapy. This specific analysis was used because the goal was to measure the same variables over time. There were two independent variables with three levels each (phase by subscale; N = 9); while the dependent measure was the judges' mean rating of the therapy subscales. Results for this second question revealed that there was no significant effect of therapy phase [$F(2,16) = 0.013$, $p = .99$], indicating that significant changes in therapist behaviours or demeanours over the three phases did not occur (see Table 1).

In summary, the results from the analysis of the data indicated that: (a) On the three subscales, all measured using a five-point scale, (where 1 = not at all, 2 = some, 3 = fair amount, 4 = pretty much, and 5 = great deal), trainees were mainly warm and friendly with their clients

(M = 2.72 out of 5), to a lesser degree exploratory in their behavior (M = 2.35 out of 5), and they did not demonstrate negative attitude (M = 1.26 out of 5), and (b) this pattern did not change significantly over the three phases of therapy.

However, the results also indicated low power for detecting a main effect of time (observed power = .052) and a time x subscale interaction effect (observed power = .334), due largely to the small N in this study. In addition, the small sample size in the present study may have increased the probability of violations of the standard assumptions associated with the repeated-measures MANOVA statistic; normality of distributions, homogeneity of variances, independence of observations, and homogeneous covariance among observations obtained from the same subject.

Even though repeated-measures MANOVA is robust to small violations of the assumptions of normality and homogeneity of variances, the following analyses were conducted to take into account any possible violations of assumptions. First, the repeated-measures analyses were subjected to a correction for violation of homogeneity of covariances, the Geisser-Greenhouse Epsilon. This correction adjusts the numerator and denominator degrees of freedom to increase the validity of the F statistic under violation of homogeneity of covariances. The results with this adjustment, however, were identical to the above reported results.

Second, a non-parametric analysis of the same data was conducted to take into account any possible violation of parametric assumptions. Previous researchers (Wiseman, Shefler, Caneti, & Ronen, 1993) have treated the VPPS as an ordinal scale, and analysed their results using non-parametric statistical tests. The results of the present study were re-analysed in a similar way, using the non-parametric alternative to the

repeated-measures MANOVA, the Friedman F (Cohen, 1996). The results of this non-parametric analysis were parallel to those obtained from the parametric analysis (see Appendix B).

Study II

Question 1: How did the context of the weeping events change over three phases of therapy (early, middle, and late)?

This question provided a description of the conditions preceding client weeping. Four categories were identified by the analysis of the data: (a) Topic of discussion, (b) task, (c) trigger of weeping, and (d) therapists' style before the event (see Table 4 for a summary of all context results).

Topic of discussion. The first category, topic of discussion, included three subcategories. The first subcategory was external stressors/health, including stressors related to everyday situations, (e.g., work) and/or health issues. The second subcategory, interpersonal issues, related to relational issues between the client and important people in his or her life (including family relationships). Finally, the third subcategory, intrapersonal issues, referred to client's personal dynamics, and goals.

Results indicated that, in the first phase, the topic of discussion was divided between the three subcategories. In the second and third phases, for the majority of the dyads, the discussion was mainly focused on interpersonal issues.

Task. The second category, task, referred to the manner in which the topic was discussed. Two subcategories were identified: (a) Describing the situation, and (b) describing/exploring feelings. The data (presented in Table 4) indicate that these subcategories of context occurred with approximately equal frequency throughout the three phases. Furthermore, although some clients engaged in only one of the subtasks during the event, a number of clients engaged in both of these subtasks.

Trigger of weeping. The third category, trigger of weeping, identified whether it was a client's or a therapist's statement that appeared to provoke the weeping: (a) Client provoked, or (b) therapist provoked.

It was found that in the first and second phase of therapy, the therapist was usually the one who seemed to have provoked the weeping. In the third phase, however, the number of cases where the client provoked the weeping was slightly higher than the ones in which the therapist provoked the weeping. The following is an example of therapist-provoked weeping:

> **Therapist**: What were those things at the time that made you want to leave?
> **Client**: Well, I think at that period of time he wasn't showing to me an indication that he, he didn't really, like he was too self-centered (T: Yeah), he was too concerned about his own needs, and that was when my son was really young, like, my son oh! When I think about it, you know, like, he would slap him across the face, and for nothing, you know? Oh!
> **Therapist**: So there was physical abuse.
> **Client**: Oh, yeah! A lot (client begins to weep)

In this example, the therapist's second statement was judged as the trigger for the weeping event. The rationale for this decision was that, until that moment, the therapist had been engaged in information gathering about the family situation and the client provided a description of this situation. The client's description was matter-of-fact, and according to the judges, emotionally detached. When the therapist named what was happening in the client's home as "physical abuse" - a reality that, judging both from the content and the style of her description, she was trying to avoid - the client began to weep.

Therapist style before the event. The fourth category, therapist style before the event, referred to whether the therapists' style before and during the weeping was the same or different. Examination of the events demonstrated that in the first phase, almost

an equal number of trainees changed or didn't change their style during the weeping event. In the second and third phases, the majority of trainees did not change their style in response to the weeping event.

When the therapist did change style, (which occurred mostly in the first phase), one of four behaviors was applied: trainees were either more or less active, and their style of interacting changed to either less empathic or friend-like.

If we consider the example given above, the therapist's style remained the same before and during the weeping event. She continued to adopt the same vocal style, and her interventions were mainly exploratory.

Table 4

Context of the Weeping Events Across the Three Phases of Therapy

	PHASE A	PHASE B	PHASE C
Topic of discussion			
External stressors/health	Variant (3)	Variant (3)	(2)
Interpersonal issues	Variant (4)	Typical (6)	Typical (6)
Intrapersonal issues	Variant (3)		(1)
Task			
Describing the situation	Typical (6)	Typical (5)	Typical (7)
Describing/exploring feelings	Typical (5)	Typical (5)	Variant (4)
Describing thoughts		(2)	(1)
Trigger of weeping			
Client provoked	Variant (3)	Variant (3)	Typical (5)
Therapist provoked	Typical (6)	Typical (6)	Variant (4)
Therapist style before the event			
Same as during the event	Typical (5)	Typical (7)	Typical (7)
Different than the during the event	Variant (4)	(2)	(2)
less active before the event	(2)		
more active before the event	(1)	(2)	
less empathic before the event	(1)		(1)
casual interaction before the event			(1)

Note. "Variant" = 3-4 trainees employed a specific category.
"Typical" = 5-8 trainees employed a specific category.
"General" = All trainees employed a specific category.
N.B.: Numbers in parentheses indicate the exact number of trainees who employed the specific category.
N.B.: Occurrence of each subcategory is not mutually exclusive (e.g., in the category of "Task," a client might have been engaging in both describing the situation and exploring feelings. As a result, frequencies do not always sum to the total number reported in the more general category.

Question 2. How did the content of the weeping events change over the three phases of psychotherapy (early, middle, and late)?

The question of content referred to what was discussed during the weeping events. The category topic of discussion had two subcategories: (a) interpersonal issues, and (b) intrapersonal issues (see Table 5 for the results).

The results indicated that throughout the three phases of therapy, the discussion centered on the clients' interpersonal issues. An example of an interpersonal issue is provided below. The example is taken from the first phase of therapy. The therapist and her client were discussing the client's recent breakup with her boyfriend and her past romantic relationships.

> **Therapist**: So you have, you have (ex-fiance's name) who said "I love you" (client blows her nose) and then he said "I didn't love you" and that was four years and then you have (recent ex-boyfriend's name) who after a short time he is saying "I love you", so you're thinking, you know, is anybody really being truthful when they say "I love you" (C: Exactly), you know? And, you're saying "well, when I say it I am truthful, so how come people aren't giving that back to me", (C: Yeah) you know?
> **Client**: Yeah, definitely. Like I want to trust, (slowly) I can't, they scare me and which I'm like Oh! My God, my next long-term relationship (laughs), whoa!
> **Therapist**: Scary!
> **Client**: Oh, yeah! Do I ever want the long-term relationship again? (T: mm-hm). Cause I'm so scared type of deal. Are they gonna all be like three week, you know, five week things, like (last ex-boyfriend's name) that I'm just gonna go through it and say "Oh, no. Never mind, I don't want him" (laughs). Okay.
> **Therapist**: Mm-hm, mm-hm. Or are you gonna do, do the dating or the short term because you are afraid to get into the long term?

The judges decided that this was an interpersonal issue since the client was discussing her history in regards to her romantic relationships and her feelings about future relationships.

Table 5

Content of the Weeping Events Across the Three Phases of Therapy

	PHASE A	PHASE B	PHASE C
Topic of discussion			
Interpersonal issues	Typical (7)	Typical (8)	Typical (7)
Intrapersonal issues	(2)	Variant (3)	Variant (3)

Note. "Variant" = 3-4 trainees employed a specific category.
"Typical" = 5-8 trainees employed a specific category.
"General" = All trainees employed a specific category.
N.B.: Numbers in parentheses indicate the exact number of trainees who employed the specific category.
N.B.: Occurrence of each subcategory is not mutually exclusive (e.g., a counsellor-client dyad might have engaged in both interpersonal and intrapersonal issues. As a result, frequencies do not always sum to the total number reported in the more general category.

Question 3. How do the tasks that therapists-in-training employ change across three phases of psychotherapy (early, middle, and late)?

Question three examined what the therapists did (tasks) during the weeping events in each of the three phases of therapy. The judges found five main dimensions, each one including a number of sub-categories. The dimensions were: (a) therapist time focus, (b) activity level, (c) therapist's initial reaction to weeping, (d) thematic focus, and (e) type of interventions, (see Table 6 for the results, and table C1 in Appendix C for a more complete table for this question). An explanation of each of the categories along with their respective sub-categories is provided in Appendix C.

Time focus. For therapist time focus, results indicate that trainees in the first phase chose to concentrate mainly on the past, however some also focused on the present. This focus changed in the second and third phases where all trainees chose to focus primarily on the present. In the third phase, a number of trainees maintained a dual focus on present and either the past or the future.

An example from the focus on the past exclusively in the first phase comes from an event where the client was describing her experience of her parents' separation when she was 14.

> **Therapist**: You must have felt so powerless because you wanted to help her, I'm sure.
> **Client**: And she'd asked me, she'd like "go and tell your father that you want him to come home". I couldn't do that, (T: Oh!) you know?
> **Therapist**: So, she was trying to get you to fix it?
> **Client**: Yeah. She, I guess she wanted to pull out his guilt (sniffles) cause he did feel guilty, you know?(sniffles) I mean, he paid everything for the, for the four years he was gone (T: mm-hm), he paid all the bills and, you know like, he didn't stay in the house (T: mm-hm) and he got an apartment and he was paying for both, and (T: okay) (sniffles) and, I guess the reason why he never changed that was of his guilt. Like he won't put us in an apartment...(sniffles)
> **Therapist**: Mm-hm. So you witnessed your mom's heartbreak.
> **Client**: Yeah.

The judges described this event as focused on the past. The therapist was trying to get information about the client's role in her parents' separation, specifically about the emotions she was experiencing at the time.

The following example is an excerpt from an event from the third phase in which the therapist focuses on two time frames, present and future. In the segment the client was describing her problems with school and her feelings about her difficulties.

> **Therapist**: So you are doing the best that you can.
> **Client**: Oh oh, I could do better
> **Therapist**: You can do better ?
> **Client**: I think I can do better, yeah, IF (with emphasis) like I say, if I had that time (T: yeah) if I were able to just concentrate, I have it all in my head (T: mm-hm) it's just, you know it's hard... (T: mm-hm) but, ah, I feel that, you know, it's a learning process and I'm gonna get better (T: mm-huh) you know, as I go. I feel confident in that, it's just, ju.. (voice breaks) past that disappointment (T: mm-hm) those disappointments and, the hell with it, it's okay you know, keep going
> **Therapist**: And it is a big disappointment.
> **Client**: Yeah, I think so ...
> **Therapist**: And it happens up, at every level.
> **Client**: (interjects with therapist) and I expect so much from myself too (T: yeah) you know, (sniffles) (T:mm-hm) so I don't know

> **Therapist**: Mm-hm. But getting one bad mark does not mean you're gonna make a bad counsellor ....

Up to this point the therapist and the client were engaged in a discussion about the client's difficulties in school. The therapist's focus is solely on how the client is feeling and how she is handling her disappointments at present (e.g. "you are doing the best that you can", "and it is a big disappointment", all statements on the present tense). Later, in the same event, the therapist shifts the focus towards the future.

> **Therapist**: And you mention (Client: that's my biggest challenge) that you're gonna get a tutor
> **Client**: Yeah, I'm just gonna tutor, I'm gonna get myself a tutor (T: mm-hm) through my husband. He's, he majored in that, in University or in CEGEP (T: mm-hm) and, my, my son is (incomprehensible) I think it's like he got it? It's like a game, eh? My brother said that to me once a long time ago, you know? When I was struggling with it? (T: mm-hm) he says it's a game. He says you just got to learn to rules of the game (T: that's right) and you just play so, you know, it's that socio- concept, you know, that stereotype male-female gender thing, you know? Like, females just don't know how to do math.. (T: mm-hm) you know?

Activity Level. The second task dimension, activity level, referred to how active the trainee was during the weeping events over the three phases. Activity level referred to two factors: (a) How often the therapist intervenes, and (b) length of the interventions. The results indicated that in the first phase of therapy, trainees were divided between low, moderate, and high activity levels. In the second phase, although some trainees were moderately active, the majority adopted a high level of activity. Finally, in the third phase, the majority adopted a moderate level of activity.

Since therapists in the first phase showed a mix of high, low, and moderate activity, an example of a high level of activity from the second phases of therapy is presented below. In this part of the event the client was describing how something that the therapist had said had made her upset.

Therapist: I made you think of something that upset you?
Client: No, you know sometimes - - you just, you're not really upset (T: Right) and someone asks you (T: Yes) and you realize, you are (small laughter).
Therapist: Or you are upset and, but you are holding on to it, and when somebody asks you, you can't hold on anymore. Um - - so, okay two things. You- you felt sad because he was asking you and it was - - it couldn't come out, (C: Mm-hm), - - and why were you feeling sad? What was it about the situation that made you feel sad?
Client: Well just the fact that I couldn't do it, (T: Yeah), you know, I don't know why (T: Mm-hm), I think, I think it's more, what makes me sad is that I don't know why.
Therapist: O.k. So is it, are you sad because you think something is wrong with you?

According to the judges, this is an example of high activity, since the therapist in this event intervened frequently, and her responses were approximately the same length - or longer - than the client's.

Immediate reaction to weeping. The category of immediate reaction to weeping referred to the therapists' first statement immediately after the clients began to weep. Judges found that there was a difference between some trainees' first reaction to weeping compared to how they reacted in the rest of the event. Two subcategories emerged from the data and each had a number of dimensions: emotive focus and cognitive focus. (The specific dimensions for each of the subcategories are provided in the table at Appendix C).

Examination of the events revealed a trend in the choice of reactions among the three phases. Specifically, in the first phase, the majority of trainees chose to respond immediately to the clients' weeping by focusing on the emotions expressed and by validating and encouraging these emotions. This focus shifted dramatically in the second phase where the majority of the therapists chose to focus on the client's cognitions; they chose to attend to details about the situation or asked for clarification. Finally, in the

third phase, trainees' focus returned to that of the first phase; choosing to focus on the clients' emotions, validating and encouraging emotional expression immediately after the beginning of the clients' weeping. What follows is an example of this category.

In the first phase, the client was describing how the interaction with other people helped her feel better about herself. At some point, immediately prior to the beginning of weeping, the therapist directed the client's attention to herself by commenting that by helping others she was helping herself. The client responded:

> **Client**: And helping myself (voice cracks).
> **Therapist**: (10 seconds pause) It really hurts.

In this first statement, after the beginning of the client's weeping, the judges decided that the therapist's reaction was to focus on the client's in-session experience of pain. She focused on the emotion, validated that emotion and, based on the client statements that followed, it seems that she encouraged further expression of emotions.

In the second phase of therapy, a therapist and her client were discussing difficulties surrounding financial issues and her children's inability to understand the seriousness of the problem:

> **Client**: I'd like to go out to a movie, and eh, yeah, I'd like to go out to a movie, I mean and the money thing is really another big worry that, so that I can't! (with emphasis) do things like that. So, and I, I've told them both, like, I really, it's not great and, wake up, you know? Yeah, so there is no food in the fridge because! I'm paying bills, you know? So (sighs and starts crying) that's the stress I guess (laughs).
> **Therapist**: And how could they understand and help you?

In this first statement of the event, the judges decided that the therapist was focused on searching for solutions to the problem, by asking the client how she would liked her children to help her.

Thematic Focus. Thematic focus refers to where trainees chose to focus during the event, after their immediate reaction to weeping. Two subcategories emerged from the data: Emotive focus and cognitive focus. Each of the two subcategories included three different types of therapist behaviours. (For a description and an explanation of each of these types see Appendix C).

The results indicated that in the first phase, a large majority of the trainees chose to focus mainly on emotions. Almost all of them chose to acknowledge the clients' emotions, while some of them also tried to actively work with those emotions by exploring them or trying to further provoke them. A smaller number of trainees chose to additionally focus on client's cognitions, by working with the information and thoughts that the client was providing.

In the second phase, the therapists' chose to focus both on cognitions and emotions to different degrees. Primarily, they chose to work with the clients' cognitions, either by exploring the facts or by exploring the clients' thoughts. A secondary focus was on emotions, which was accomplished by acknowledging the emotions that the client was experiencing.

Finally, in the third phase, the results were similar to the second phase. The primary focus was once more cognitive, and the secondary focus was emotive. Therefore, it appears that in the second and third phases of therapy, the pattern of the therapists' focus remained the same that is on the clients' cognitive experiences and to a lesser degree on their emotional experiences.

In order to demonstrate the change in therapist focus from phase one to phase two, two events from the same dyad are presented. The first excerpt comes from an event in the first phase where the client was describing the conditions around her divorce.

> **Therapist**: So looking back?
> **Client**: Yeah, yeah, when you look back and you sort of say hmmm (sniffles) 'did we really, yeah, yeah we might have looked okay (laughs) but I think a lot of people are like that in life, I think a lot of families, they look okay, but...'(cracking voice)
> **Therapist**: Still it doesn't take away the emptiness when you look back and you think
> **Client**: No
> **Therapist**: so what was really there?
> **Client**: Yeah. It didn't mean--I mean if he can hate someone that much after, (cracking voice) what did it, you know?
> **Therapist**: You feel hated?
> **Client**: Yeah, I think so.....

In this excerpt of the event the therapist's focus was exclusively on the client's emotional experience. Although this excerpt is taken from the middle of the weeping event, the client was still emotional as she described how she felt in her relationship. The therapist helped her maintain the focus on her emotional experience with her interventions.

The second example demonstrates how the therapist's focus changed from acknowledging the client's emotions to generating realistic solutions. In the event, the client was discussing her financial difficulties:

> **Therapist**: It all ends up sort of back on you and you need just to keep swallowing.
> **Client**: (sniffles) Yeah, and I think (T: inaudible) yeah, and probably that's the difficulty. Is that (sniffles) I keep it in to a certain extent and then like, this morning I said to both of them, I said 'I don't even know if we will be able to keep the house', you know, I mean, it's really, if I'm faced with a mortgage that we can't pay, would it, you know (laughs). So... and, so I guess that's a little bit of a, a concern, and I guess it comes out in, like I can't do the things that I want to do, and I can't provide them with the things (voice cracks) that I want to (crying).

Therapist: Some of the most important things for you are not accessible right now.
Client: Yeah, yeah! So, and you sort of think "Ok, what else can we do?" (T: Okay) I mean, I do have that attitude. Okay, (sniffles) so like I was thinking about this weekend, okay so, we can't do a lot that requires money, so why don't we go up to the mountain and go sliding or something, you know? (T: Uh-huh, uh-huh) And we haven't seen my aunt and try to giving her her Christmas presents so, so maybe we'd stop by there and see her or something, you know? But,
Therapist: And how does that feel coming up with those kinds of alternatives, and...?
Client: (sniffles) Yeah! I mean, and it's good, and I sort of think .....

In her first statement, the therapist acknowledged the emotional pressure the client was experiencing which provoked further exploration and elicited more emotions from the client (laughter and tears in the same statement). In her second statement, the therapist acknowledged the reality of the situation and helped the client direct her attention towards an exploration of alternatives. Finally, in her third statement, the therapist placed an emphasis on the client's choice to seek alternatives and seemed to encourage the new approach the client was taking. According to the judges, this event was a clear indication of the shift from acknowledging the emotions to directing the client towards a cognitive exploration of the situation.

Type of interventions. Trainees seemed to use different types of interventions at different phases of therapy. First, it is important to note that minimal encourager is the only intervention that is employed by the majority of trainees in all three phases. Reflection of feelings is an intervention that is used mostly in the first phase and to a much lesser degree in the last two phases of therapy. More trainees employed open-ended questions in the last phase of therapy, while the number of trainees who employed closed-ended questions slightly decreased in the third phase. Another finding is that interpretation was the intervention that had a significant increase in the third phase.

Finally, in the last two phases, some trainees chose to employ specific directive techniques such as role-playing, assigning homework or educating the client.

An example of an interpretation will be provided from an event from the third phase of therapy. Therapist and client were discussing the changes that the client had undergone. This excerpt begins with the client's response to the therapist's previous metaphor that the client "was coming out from behind that wall" she had previously built around herself:

> **Client**: Yeah. I still trip on the bricks, they're still there, I'm still gonna have, (sniffles) I think we talked about that before (T: Yeah) I don't think I (sighs) (sniffles)- I don't know if I can ever totally (sighs), you know, (sniffles) but I don't know if it's totally a good idea to
> **Therapist**: Exactly. You need some.
> **Client**: You need some. You just probably don't need a fortress (laugh) (sniffles) (T: Mm-hm)Yeah, I guess that would be how I'd look at it. I've been thinking about a lot of people in my life, (sniffles) where ah, I could have enjoyed ah, the friendship so much more, had I just been willing to live in the moment (sniffles) (T: Mm-hm), instead of knowing, well I'm gonna move again, or, you know, this is a temporary situation. (T simultaneously: without thinking about the outcome, the end alls). Yeah, looking at that, instead of enjoying, enjoying it, and I'm gonna, (sniffles) I do have a few friends that I'm gonna really make an effort to keep in contact with that I've really neglected, and thankfully that they still kept in touch with me, they didn't give up on me but eh,
> **Therapist**: And you haven't given up on yourself.

According to the judges, the therapist's last statement was an interpretation. She interpreted the client's new attitude towards people as an additional new attitude towards herself. She gave the client the message that adopting this new attitude towards people was an indication that she has not given up on herself.

In conclusion, there seemed to have been a change in all the tasks that therapists-in-training chose to employ over the three phases of therapy during client weeping events. (a) In their time focus trainees changed from exploring the past in the first phase, to exploring mainly the present in the third phase, while also connecting it either with the

past or the future. (b) In their activity level, trainees were equally divided among the three levels of activity in the first phase, were mainly highly active in the second phase, and mainly moderately active in the third phase. (c) There was a trend in their immediate reaction to weeping, from predominantly emotive in the first phase, to predominantly cognitive in the second phase, and emotive, once more in the third phase. (d) Another change was observed in trainees' thematic focus, mostly between the first and the last two phases. In the first phase, the majority of trainees chose to focus on emotions and only a small number of them chose to also focus on cognitions.

In the second and third phases however, the primary focus for the majority of trainees was on clients' cognitions, while some also chose to also focus on the clients' emotions. Trainees employed a number of different interventions throughout the three phases, although certain choices are particularly noteworthy: (a) They all used minimal encouragers in all phases, (b) the number of trainees using interpretations significantly increased in the last phase, and (c) some of them employed specific directive techniques in the last two phases.

Table 6

Therapists' 'Tasks During the Weeping Events Across the Three Phases of Therapy

	PHASE A	PHASE B	PHASE C
Therapist Time Focus			
Present/Here-and-now	Typical (5)	General (9)	General (9)
Past	Typical (7)	(2)	Variant (3)
Future	(1)		Variant (4)
Activity Level			
Low (minimal interjection)	Variant (3)		(1)
Moderate	Variant (3)	Variant (3)	Typical (5)
High	Variant (3)	Typical (6)	Variant (3)
Immediate reaction to weeping			
Emotive Focus	Typical (7)	(2)	Typical (7)
Cognitive Focus	(2)	Typical (7)	(2)
Thematic Focus (apparent goal)			
Emotive Focus	Typical (8)	Typical (6)	Typical (5)
Elaborate/evoke feelings	Variant (3)	Two	Variant (3)
Explore feelings	Variant (4)	(2)	(2)
Acknowledging the feeling	General (8)	Variant (4)	Variant (4)
Cognitive Focus	Variant (4)	Typical (8)	Typical (7)
Explore thoughts/patterns	Variant (3)	Variant (3)	Variant (3)
Seeks alternatives		(2)	Variant (4)
Explores content/facts	Variant (3)	Typical (5)	Typical (6)
Type of Interventions			
Clarification	(1)	Variant (3)	
Reflection	Typical (6)	(1)	Variant (3)
Paraphrase/Restatement	Variant (3)	Variant (3)	Variant (4)
Summarization	Variant (3)	Variant (3)	
Minimal encouragers	Typical (8)	Typical (7)	General (9)
Interpretations	Variant (3)	Variant (4)	Typical (7)
Confrontation/challenge	(1)	(1)	(2)
Open-ended questions	Variant (3)	(2)	Typical (5)
Closed-ended questions	Typical (5)	Variant (4)	Variant (4)
Specific directive techniques		Variant (3)	Variant (3)

Note. "Variant" = 3-4 trainees employed a specific category. "Typical" = 5-8 trainees employed a specific category. "General" = All trainees employed a specific category.
N.B.: Numbers in parentheses indicate the exact number of trainees who employed the specific category.
N.B.: Occurrence of each subcategory is not mutually exclusive (e.g., in the category of "Emotive Focus," a therapist intervention may be both evoking and elaborating emotions. As a result, frequencies do not always sum to the total number reported in the more general category.

Question 4. How does the style of therapists-in-training change across three phases of psychotherapy (early, middle and late)?

The second question, style of interaction, referred to the manner with which the therapists were communicating with the client. Table 7 (below) presents the list of categories and the number of trainees under each category.

Three categories emerged from the analysis of the data: Therapist vocal attitude, communication style, and process style. The category vocal attitude was defined as the therapist tone of voice and it included two subcategories: (a) accepting, and (b) distant/detached. The category of therapist communication style referred to the way in which the therapist was presenting herself. This category was divided into four subcategories: (a) tentative/uncertain, (b) empathic/in-tune/supportive, (c) non-empathic/out of tune, and (d) casual interaction. Finally, the category of process style referred to the therapists' style of interacting in the therapeutic context. There were two subcategories identified under this larger category: directive and non-directive (definitions for each one of the subcategories are provided in Appendix C).

Vocal attitude. Results indicated that the majority of trainees adopted an accepting tone throughout the three phases of therapy. Trainees who were judged as having an accepting tone spoke in a soft and caring tone of voice, which matched the client's voice. They displayed a warm attitude towards their clients as well as a general attitude of acceptance and approval, and they lowered their tone of voice when the client was experiencing strong emotion. Additionally, they gave the clients "space" to process their emotions, as indicated by the pauses between their clients' statements and their own

interventions. Since it is difficult to communicate vocal attitude in a written text, an example of this subcategory will not be provided.

Communication style. The results indicated that the style with which the trainees communicated their interventions was, throughout the three phases of therapy, mainly empathic and supportive, and in-tune with their clients' emotional experiences. However, in the second phase, the number of trainees who adopted such an attitude, although still in the majority, decreased compared to the other two phases, and the number of trainees who adopted a non-empathic and out-of-tune attitude slightly increased compared to the other two phases. Additionally, some of the trainees in the first phase had adopted a tentative and uncertain style, but by the third phase of therapy no trainees were tentative and/or uncertain in communicating their interventions.

The following example of an empathic communication style is drawn from an event in the third phase of therapy. In the event the client was describing how she felt good about herself and "gentle inside" which is something she didn't feel before:

> **Client**: And now I do, and now I feel good, and I don't feel like a fake (breaking voice).
> **Therapist**: (4 seconds pause) You're real.
> **Client**: (3 seconds pause) (crying) And that's been a long time coming.
> **Therapist**: (6 sec. pause) Definitely.
> **Client**: I don't even like to think about how many years- I felt like such a fake (sniffles). It's a long time (sniffles) and I don't have to, I don't have to do that anymore.
> **Therapist**: No you don't, and you're not! doing it anymore (with emphatic voice).
> **Client**: No, and that's scary, (crying) (sniffles) that's scary cause it's hard, it's hard to come up from behind that wall.
> **Therapist**: Yeah, it is.

The judges decided that the therapist was in tune with and followed closely her client's emotional experience. She was compassionate of the client's feelings while at the

same time supporting and validating both what she was saying in the session and the changes that she was reporting.

Process style. In terms of their level of directiveness in their interventions, the results indicated that there was a change in the therapists' style across the three phases. In the first and second phases trainees were divided between directive and non-directive. In the third phase however, there was a clear differentiation in their style; almost all chose to become directive. An example of how one therapist's style changed from non-directive to directive is provided by events taken from the second and third phase. In the first event the client was describing how she felt when her sick father told her he loved her:

> **Therapist**: It was important for you to hear.
> **Client**: Well yeah, but I never expected to hear it, especially not in that way, like it was (crying) out of the blue (T: Yeah). Like I was expecting to hear the "me too" and I was like- (laughing while crying), I was like, I must be hearing things.
> **Therapist**: Did you go back and say anything too him, or...?
> **Client**: No (laughing). I just kept walking cause I was like all teary eyed (crying) and I didn't want anybody to see me (sniffle), I was like, "oh my God".
> **Therapist**: It felt good to hear it.

The judges decided that in this event the therapist was non-directive in that she was following the client and was supportive to her experience. At the same time she allowed the client to take the lead for the therapeutic interaction without presenting any of her own agenda.

In the third phase, when the therapist was discussing the death of the client's father and the nature of her relationship with her mother, she became directive:

> **Therapist**: Mm-hm. What does... what happens when she, when she yells or what is..
> **Client**: She doesn't yell, she just annoys me (laughs)....It's just like...
> **Therapist**: She's been hard to you?
> **Client**: No, she, and she walks away with this face (laughs) this, you know, this disapproving face, like, I like, she slams the cupboards, or you know she's putting the dishes down like "kshh", you know, like, and I'm like sitting there and I'm like

> I know she is mad at me, like 'what's wrong?' and she's like (imitating mother's voice) "nothing! You want me to dance?" (laughs) And I'm like, 'Oh my God! Why do I bother coming downstairs?' You know, and then, then I say 'See? And you want me to live with you'. She's like (imitating mother's voice) "I'll be different if you live with me". Right! (laughs) different in a more awful way (laughs). Like, no!
> **Therapist**: I asked you one time how you thought that your mother perceives you...?

In this event, the judges decided that the therapist was "setting the agenda" for the discussion. During this excerpt she was directing the discussion into specific areas that she thought were important to explore. Both in this excerpt, and during the rest of the event, the therapist seemed to have specific expectations from her discussion with her client and she seemed to direct the conversation towards fulfilling those expectations. The examples given demonstrate the difference in the therapist's style during the two phases. In the event from the second phase of therapy, the therapist was following the client, making interventions that aimed to clarify the situation but did not seem to have specific expectations other than listening and understanding what the client was describing. However, in the event from the third phase of therapy, the therapist seemed to direct the client into specific areas, exercising more influence on the client's storytelling than previously demonstrated.

Table 7

Therapists' Attitudes Across the Three Phases of Therapy

	PHASE A	PHASE B	PHASE C
Vocal attitude			
Accepting tone	Typical (7)	Typical (6)	Typical (6)
Distant/Detached	(2)	Variant (3)	Variant (3)
Communication style			
Tentative/uncertain	Variant (4)	(1)	
Empathic/In-tune/Supportive	Typical (6)	Typical (5)	Typical (7)
Non-empathic/Out of tune	(2)	Variant (4)	(2)
Casual interaction	Variant (3)	Variant (4)	Variant (4)
Process style			
Directive	Variant (4)	Typical (5)	Typical (8)
Non-directive	Typical (5)	Variant (4)	(1)

Note. "Variant" = 3-4 trainees employed a specific category. "Typical" = 5-8 trainees employed a specific category. "General" = All trainees employed a specific category.
N.B.: Numbers in parentheses indicate the exact number of trainees who employed the specific category.
N.B.: Occurrence of each subcategory is not mutually exclusive (e.g., a counsellor could be both tentative and empathic. a result, frequencies do not always sum to the total number reported in the more general category.

In conclusion, trainees adopted primarily an empathic and supportive communication style throughout the three phases of therapy. This attitude was communicated in a warm and accepting tone. Therapists' level of directiveness in the therapeutic process changed over the course of therapy. In the first two phases both directive and non-directive styles were equally represented, while in the last phase a directive style was clearly predominant.

Question 5. How did observers perceived the change in the quality (appropriateness) of the trainees' reactions to client weeping across the three phases of psychotherapy (early, middle, and late)?

The purpose of this question was to examine if and how the quality of the therapists' tasks in response to client weeping changed over the three phases of therapy.

The results from the analysis of the events indicated that there was no specific pattern on how trainees changed over time. Rather, change for each trainee took place in different ways and at different paces. However, some other findings emerged from the examination of this question that will be discussed.

General Quality of the Events Irrespective of Phases. Examining each event separately, the judges evaluated the quality of an event based on their opinion about the appropriateness of the tasks undertaken given the specific conditions and context of each event. In order to develop a system of classification for the appropriateness of therapists' tasks, judges examined each event separately and then compared each event to the remaining events in the sample. Three main types of events (irrespective of phase of therapy) were identified: (a) contextually appropriate, (b) somewhat appropriate, and (c) contextually inappropriate (for a description of each type of quality, see table 8).

Examination of Table 8 (below) displays a pattern among the three different types of quality. The main characteristics that differentiate the different types of quality are: (a) The degree of comfort between the therapist and the client, (b) the accuracy and timing of the therapists' tasks.

Table 8

Common Characteristics Between the Three Different Types of Quality Identified

Contextually appropriate	**Somewhat appropriate**	**Contextually inappropriate**
Client and therapist seemed comfortable with each other.	Client and therapist seemed comfortable with each other.	No indication of a good interaction between clients and therapists
Therapists were listening and validating of the clients' experiences. Therapists were caring, gentle, and supportive. Therapists were not phased by emotions and worked with them.	Therapists validated clients.	Therapists disregarded/ignored clients' emotions.
Therapists followed well the clients' processes.	Gave client room/space to vent	Therapists did not listen/did not give space to the clients.
Therapists were focused on the clients and paced well with the clients' material.	Therapists appeared to follow the content of the clients' material.	Unsystematic/no focus
Appropriate interventions with good timing.	Interventions divided between appropriate and inappropriate.	Inappropriate interventions.
<u>General communication style</u>	<u>General communication style</u>	<u>General communication style</u>
Therapists closely focused on the clients	Therapists were either: overly inactive/did not provide focus, or	Therapists imposed their agenda/Pushy
Therapists did not impose their agenda	overly active, narrow-minded and focused on a single agenda	Therapists put focus on themselves

From the three general types of appropriateness/quality emerging from the judges' decision, it appears that in the "contextually appropriate" events, both variables - level of comfort and appropriateness of tasks - were appraised positively by the judges. In the "somewhat appropriate" category, the variable of the level of comfort was valued positively by the judges (i.e., the judges observed that there was a good level of comfort), but there was a negative evaluation of the appropriateness of the therapists' tasks. Finally, in the "contextually inappropriate" category judges evaluated negatively both the level of comfort between client and therapist and the appropriateness of the therapists' tasks.

Common Pattern of Change in the Last Phase of Therapy Irrespective of Quality. No particular trend was found as to how the quality of the trainees' actions changed over time. However, a serendipitous finding with regards to changes in the nature of the tasks used by trainees in the last phase of therapy was found. While evaluating quality/ appropriateness, the judges' comments revealed a pattern concerning the nature of tasks. As these findings emerged during the appropriateness/quality analysis, results will be reported within this context, rather than in the context of the analysis of therapists' tasks

Trainee's became more active in response to weeping events in the last phase. This increase was unrelated to judges' evaluations of the quality of events. Becoming more active had a different manifestation for each therapist. In its simplest form, for some trainees, an increased level of activity was reflected in an increased ability to participate in the session. A number of trainees moved from using mainly minimal encouragers and brief responses that did not add anything to the client's material, to being more present in the therapeutic interaction by taking a more active role, either by asking more questions or by adopting more complex interventions (e.g., interpretations).

Some other trainees became more active by becoming more action-oriented, or tried to impose their agenda on the client.

Action-oriented. Where trainees became more action-oriented in the last phase they directed the client towards initiating some action (behaviour) in order to address her problems. Directing towards action appeared in different forms. In one example, the therapist reminded the client of the options she had suggested, possibly as a way to emphasize that there are other viable choices, an intervention that was considered to be appropriate by the judges, under the specific conditions. For example, when the client was frustrated at herself for having problems at school, the therapist reminded her:

Therapist: And you mentioned that you're gonna get a tutor.

In another example, the therapist probing for action was not considered appropriate. For example, while a client was describing her feelings for her children's estrangement from her, the therapist asked her:

> **Therapist**: So, in the meantime that you are waiting for your children to come around, what are you gonna do in the meantime?

The therapist repeated the same question in different ways throughout the event. Although the therapist's goal seemed to be to help the client take some action in her life, in this specific situation it was considered an inappropriate intervention that was incompatible of the client's needs.

The previous examples of therapist action-oriented style illustrate that although therapist activity level increased, this increase was not always deemed appropriate.

Imposing an agenda. Some other therapists became action-oriented by developing an agenda in the last phase of therapy. This occurred either while the therapist was trying to impose an agenda based on a certain theoretical orientation, or

based on her own beliefs. However, in all instances where this occurred, the judges considered that it was not an indication of a good therapeutic intervention.

An example of a theory-based intervention came from an event where the client was describing her difficulty to describe her feelings. The therapist instructed her on a number of interventions:

Therapist: Think about it. What are you feeling right now?

The therapist's insistence on extracting an answer was judged as inconsiderate of the client's needs.

An example where the therapist was imposing her own ideas, comes from an event where the client was describing the communication problems she had with her ex-husband. The therapist was directing her client towards action in trying to find alternatives on how she could deal with her ex-husband. Without the client making any suggestions, the therapist insisted in a number of interventions, that she had to find a way. For example, in one of those interventions, the therapist said:

> **Therapist**: This is a man that you do share children with, and you're gonna have to deal with him, long term.

The judges decided that the therapist did not consider the client's wishes but rather assumed what the client needed to do without asking her what she wanted to do.

The previous examples of therapists' increased level of activity by imposing an agenda again illustrate that although therapist activity level increased, this increase was not always deemed appropriate.

To summarize, results from the nine dyads examined in this study indicated that trainees in general, tend to become more active in the therapeutic interaction over time. Their increased activity appears in different levels and degrees. Some would do more

frequent and "complex" interventions, while others would try to direct the client towards a solution to the problem, either by sharing their opinion, insisting on a theoretically-based intervention, or adopting a combination of some of the above. Appropriateness was not consistently associated with activity level especially when context and client response were taken into consideration.

Trainees' Reactions to the Emotions Expressed during Weeping

A second important finding from the results relates to how trainees reacted specifically to the emotions expressed by the weeping. It was found that only five out of the nine trainees tried to actively work with clients' emotions during the weeping events, and out of these five, only three tried to do it consistently across phases (a thorough picture of the trainees' reactions is presented in Figure 1).

Appropriately reacted to emotions. Of the events where judges agreed that an appropriate reaction to emotion had occurred, a few important characteristics were observed: (a) The therapist's interventions explore feelings in the here-and-now, (b) the therapist used an intervention that captured the "essence" of the feeling the client was describing.

Overall, when therapists were reacting appropriately to client emotion, they often were seen to be fostering further exploration or acknowledging the emotions and while maintaining an attitude of acceptance and understanding of the client's deeper issues.

Inappropriately reacted to emotions. Characteristics of therapists who did not react appropriately to emotions included attempts to get into the "correct" emotion by imposing her views on what that emotion was. An example is provided of a client

describing her experiences at her parents' breakup when she was a teenager. The therapist said, without reference to anything the client had said:

> **Therapist**: you must have felt so powerless because you wanted to help her, I'm sure.

The therapist in this event told the client how she must have felt, and did not give her the freedom to describe it herself. A further indication of the inappropriateness of the therapist's response was the client's reaction; she completely ignored the therapist's comment.

Another example of a response judged as inappropriate was when the therapist was trying to make the client feel better. The client was describing feeling guilty for her boyfriend's unhappiness when she decided to leave him, and the therapist said:

> **Therapist**: But it's not like you are the only person he has in his life

At this point it seemed like the therapist was trying to convince the client to feel better instead of trying to deal with the real issue.

Finally, another incident of poor reaction to emotions was where the therapist tried to provoke further expression of emotions by using words to refer to the emotion that the client did not use (i.e., "poor language"). The client was saying how angry she was with her boyfriend for having come home late without letting her know, and the therapist said:

> **Therapist**: Felt like hitting him? Is that how you felt? It's okay. So, if he would be sitting right there now, what would you be telling him?

The judges considered this intervention inappropriate because the therapist, trying to provoke the client's emotions, used words (i.e., "felt like hitting him?") that did not fit with the client's experience.

In conclusion, there were only a small number of events where the therapist was considered to have reacted appropriately to the emotions related to weeping. In those events, the therapists were able to either: (a) explore the client's feelings in the here-and-now, or (b) capture the "essence" of the emotion. The characteristics of inappropriate reactions were: (a) misunderstanding the emotion, (b) imposing on the client how she must have felt, (c) trying to ease the negative emotion, and d) unsuccessfully provoking it.

Conclusion of the findings

Study I Conclusions

Results of study I indicate the following: (a) During weeping events, trainees adopted a mainly warm and empathic attitude towards clients. (b) To a lesser degree, they adopted an exploratory stance by working with clients' thoughts, feelings, and behaviours. (c) Trainees in this sample demonstrated almost no negative attitudes. Finally, (d) therapist attitudes and behaviours did not significantly change across the three phases of psychotherapy.

Study II Conclusions

When the data were examined qualitatively, a slightly different picture emerged. The general findings from Study II indicated that there is a change in the behaviours and attitudes when trainees react to client weeping across three phases of psychotherapy. Therapists became more focused on the present time in the last phase, they learned to balance their focus on clients' cognitions with emotions in the third phase, and they used a variety of interventions to do this. Throughout the three phases, they were found to

adopt an empathic and accepting attitude towards their clients. Trainees were also found to become more active and solution-oriented in the last phase of therapy. In terms of the quality of trainees' tasks, some commonalities were found between tasks judged positively and negatively regardless of time, however, no clear pattern of quality of tasks was found across the three phases.

CHAPTER 5

DISCUSSION

The goal of this study was to examine how therapists-in-training react to client weeping across three phases of psychotherapy (early, middle, and late). In order to address this goal, two studies were employed. In both studies, trainees' reactions were divided into therapists' behaviours/tasks and therapists' attitudes/style. In the first study, based on a quantitative methodology, statistical manipulations were used to examine the relationship among the three concepts which were: (a) *therapist exploration*, used to measure therapist behaviours, and (b) *therapist warmth and friendliness* and (c) *negative therapist attitudes*, used to measure therapist attitudes. In the second study, a qualitative methodology was used to examine five therapist dimensions suggested by Elliott (1989): (a) content and (b) context, used to situate the reader, (c) task, used to describe therapists' behaviours, (d) style, used to describe therapists' attitudes, and (e) quality, used to describe the clinical appropriateness of therapists' tasks and style. In the sections that follow, these findings will be discussed.

Study I - Quantitative Analysis of the Relationship Between Trainees' Behaviors and Demeanours/Attitudes and Change over the Three Phases of Therapy.

Research findings 1 and 2

Question 1. Which behaviours and attitudes/ demeanours do therapists-in-training employ most often when reacting to client weeping?

The analysis of the data indicated that trainees employed certain behaviours consistently throughout the three phases of therapy. Throughout the three phases of therapy, trainees were consistently adopting an attitude of warmth and friendliness, and demonstrated empathy and support to their clients more than any other behaviour or demeanor. Secondly, they adopted an exploratory stance, whereby they tried to help clients examine their feelings, understand their situation, and gain a new perspective.

Since the results indicated that the specific attitudes (i.e., warmth and friendliness) were present from the first phase of therapy in the same degree as in the later phases, these findings suggest that trainees developed these relational skills early on in their training and this is consistent with the notion that a good therapeutic relationship is essential in clinical work. Additionally, they were able to use the microskills to engage the client in exploratory focus of their issues. The above two findings support previous research that strongly suggests that counsellor training is effective in teaching both the facilitative conditions and specific microskills (Alberts & Edelstein, 1990; Russell, Crimmings, & Lent, 1984; Toukmanian & Rennie, 1975). In other words, the present study is consistent with the research that concludes that the training objectives can be met as early as the first stages of training. The finding that empathy and warmth are

qualities that show themselves early in the training process, seems to be related to the conclusions from the researchers that suggest that the bond component of the working alliance can develop early and at levels similar to experienced therapists (Mallincrodt & Nelson, 1991).

It appears that early in their training, counselors were able to develop the appropriate attitudes in moments of client weeping, namely the communication of acceptance and understanding, within a climate of warmth and empathy. This is in keeping with the work on client weeping which stipulates that positive therapeutic work cannot evolve if acceptance and understanding of the client's emotions does not take place (Elliott, 1983; Greenberg, 1999; Labott, Elliott, & Eason, 1992).

The results from question one strongly suggest that trainees of this sample seem to possess the necessary personal resources to respond appropriately to client weeping. Although the ratings on the VPPS indicate that these attitudes are employed to a relatively low degree (Table 2, p. 88), these results were expected, since, even by the end of the academic year, trainees were still at the initial stages of their training. Furthermore, since the main objective of training programs at this level is to teach these facilitative conditions, trainees in this sample were using all the resources they had available, and they were also using them at a level described by the VPPS as "fair."

Finally, the third dimension that was measured was trainees' negative attitude. It was found that in general, novices did not display a negative attitude towards their clients. This indicates that a climate of empathy and acceptance prevailed and there were no occurrences of a critical, intimidating, or judgmental posture on the part of the

counsellors. In spite of the fact that counsellors' ratings of warmth and friendliness were at a "fair" level, this was consistent and unbroken by evidence of negative attitude.

In summary, the results from this question suggest that: (a) Trainees showed the expected positive behaviours and attitudes early on in their training; (b) The level at which they communicate these attitudes and behaviours was "fair"; (c) This is in keeping with the role demands which require a communication style intended to facilitate the therapeutic relationship.

Question 2. Over three phases of psychotherapy (early, middle, and late), do the behaviors and attitudes/demeanor of therapists'-in-training change when reacting to client weeping)?

When examined quantitatively, the results of question two indicated that, trainees' attitudes and behaviours did not change significantly across the three phases of therapy. This was a rather surprising finding since the majority of the research in the area of counsellor development has clearly indicated that trainees systematically do different things over time as a result of their training (Fong et al., 1997; Kivlighan, 1989). Specifically, it was found that these trainees were able to develop more complex interventions and were also able to deliver them in a more effective manner.

The findings with regard to this question suggested that, although trainees learn different skills during their training, there was little variety in the use of the skills in different phases, specific to weeping. The ability to apply counselling skills to specific moments in psychotherapy requires the flexibility to transfer general knowledge to very specific in-session events. Research has indicated that trainees in the first stages of their

training are primarily preoccupied with what to do in the moment (microskills), rather than how to conceptualize the clients' difficulties (Fong et al., 1997; Kivlighan, 1989). Therefore, it seems that, even by the last phase of therapy, trainees are not flexible to integrate their conceptual views of the client with different skills needed at different times in therapy. It is also possible, that trainees are still not adequately tracking the changes in their own therapeutic process, and therefore have not developed the "elasticity" that allows them to use varied techniques at different moments in psychotherapy. This might explain why the tendency was to use the same types of techniques throughout the three phases.

A second explanation of these findings is that while trainees may have a good theoretical grasp about what to do, they do not yet have the confidence in their roles as counselors. This is bound to erode their ability to apply in the actual therapeutic context what they have already mastered in the classroom. Thus, they chose to apply the skills that were familiar to them in spite of the fact that an alternative skill might be more appropriate or effective.

This view is supported by a number of studies, which has indicated that beginning counsellors have low self-appraisals of their abilities, but with experience and training their self-efficacy and level of comfort increases (Johnson et al., 1989; Larson et al., 1992). This fits with Stoltenberg's (1981) model where identity issues are typical of the first stage of development. In addition, Greenberg and Paivio (1997) report that, in order to deal with clients' emotional experiences, counsellors need to be aware of, and comfortable with their own emotions, a particularly difficult task for trainees who still struggle with their counsellor identity. It is possible that client weeping elicits an

emotional reaction in trainees and this limits their ability to try out different skills over time. Studies examining trainees' reactions to client emotional expression have indicated that they tend to feel overwhelmed by such strong client expressions (Nutt-Williams et al., 1997), a finding that may explain the reactions of the group of trainees. Thus, at this level of training, novices might be ready to react to many types of events, but not to strong emotional ones.

An alternative explanation to these specific findings is that trainees did indeed try out different attitudes and behaviours across time, but the three concepts used to examine those changes—therapist warmth/friendliness, exploration, and negative attitudes—were not appropriate or sufficient to capture these changes. This point will be returned to in greater detail below (in the discussion of qualitative findings).

Some authors explain that initially, trainees may feel that they have to solve clients' problems or make the pain go away, which is an additional struggle when they try to define their role and personal style (Hill & O'Brien, 1999). Hill et al's (1981) model of counsellor development, suggests that counselors at initial stages of their training tend to experience sympathy for their clients and feel responsible for their well-being. The degree to which trainees experience these emotions is personal to each of them, and is related to their own abilities and needs. Greenberg and Paivio (1997) postulate that it requires time and experience to identify those abilities and needs and adjust them to their work (Greenberg & Paivio, 1997). Furthermore, according to different models of counsellor development, trainees at the first stages of their development are afraid to take risks. Responding to client weeping may be considered a particularly risky task for trainees, since it requires awareness of the various factors discussed above (i.e., self and

other-awareness, etc.) (Stoltenberg, 1981). In other words, it is clear that counsellor development is a complex phenomenon that requires negotiating multiple tasks and learnings throughout the training process. There is ample evidence that counsellors struggle with their own feelings of adequacy and efficacy as they try to deal with a client's issues and concerns (Johnson et al., 1989; Larson et al., 1992). This early, self-conscious attitude tends to make counsellors resist their own risk-taking impulses where they prefer to stay with a safe and predictable response rather than attempting something new and different. This dynamic is probably accentuated with client weeping since it requires of the trainee a level of comfort with their emotions as well as an awareness of their own needs, reactions, and personal style.

In summary, the findings from Study I led to the following conclusions: (a) Trainees in this study used an attitude of warmth and friendliness to a level described by the VPPS as "fair," and they showed an exploratory behaviour towards their clients to a level slightly lower than their levels of warmth and friendliness. (b) Trainees tend to display these attitudes and behaviours at the same level throughout the three phases of therapy. It is likely that these results were obtained because the particular events were complex and demanding and trainees were unable to respond to these events differently. This difficulty on the part of the trainees could be related to a number of reasons: (a) Trainees have not yet adequately developed a large repertoire of skills. (b) Trainees have the knowledge and the skills but they don't know how to apply those in a real life context. (c) Their identities as counsellors have not yet been adequately developed and therefore, they did not feel comfortable to experiment with different attitudes and behaviours; and (d) client weeping triggered particular emotional reaction that prevented

an appropriate response to the client. Finally, it is possible that the concepts used to measure fluctuations in therapists' behaviours were not fine-grained enough for this type of event.

In the next section, findings from Study II will be discussed and their relationship to Study I will be examined.

Study II - A Qualitative Analysis of the Therapists' Tasks (behaviours) and Style (attitudes/demeanours) Across Three Phases of Psychotherapy (early, middle, and late).

Questions 1 and 2. How did the Context and Content of the Weeping Events Change Over Three Phases of Psychotherapy (early, middle, and late)?

The dimensions of context and content were introduced in order to provide a reference point for an ecological validity of the study. There were some interesting findings stemming from these dimensions that will be briefly discussed in this section and related to other findings of this study.

Clients and therapists dealt with both interpersonal (e.g., relationship and family) and intrapersonal issues (e.g., personality patterns, individual dynamic etc.) in the weeping events. This suggests that weeping is not content or issue specific but occurs as a result of the client's in-session experience of the material under discussion. This is consistent with Carl Rogers' (1961) idea that the content is much less important than is the client's phenomenological experience. This supports what we already believe, which is that it is very important to prepare trainees for how to be in the moment with their clients.

Another finding from the question of context is the difference in patterns observed through the phases in the trigger of weeping. While in the first two phases, a large number of clients wept in reference to a counselor response or remark, in the third phase, more clients seemed to weep for reasons unrelated to the counselor responses compared to the previous phases. This suggests that clients in the third phase were more comfortable with their own emotional experiences and into the therapeutic interaction and so allowed themselves to express an emotional reaction like weeping.

Finally, another interesting pattern that occurred across phases was the trainees' style of communicating with the client before and during the weeping event. In the first phase, almost half of the trainees changed their style of communicating with the client immediately after the client began to weep. These changes were related to their level of activity or empathy. In the last two phases, the majority of trainees used the same style before and during the event. This suggests that in the first phase, trainees were still defining their style, and perhaps, since this was the beginning of their training, they were startled when faced with the clients' tears and decided to change style during the weeping event. In the second and third phases they were more "secure" in their style, and did not feel they need to change so as to accommodate client weeping.

In summary, the findings from these two questions suggest that: (a) Trainees dealt with a wide range of issues when reacting to weeping, (b) in the last phase, fewer trainees provoked client weeping, and (c) in the last phase, the majority of trainees who reacted to weeping sustained the same style they were had been using prior to the beginning of weeping (i.e., did not feel the need to sharply change their role). These

findings suggest that progressively, trainees felt more comfortable in their role and the therapeutic interaction.

Question 3. How do the Tasks that Therapists-in-Training Employ When Reacting to Client Weeping Change Across Three Phases of psychotherapy (early, middle, and late)?

In examining the therapist tasks within and across phases, a different pattern was observed in almost all tasks throughout the three phases of therapy. First, there were changes in the time focus that novices used, from a focus mainly on the past in the first phase, to a combination of the present with past and future in the third phase. Trainees' activity level fluctuated from being evenly divided between the three levels of activity (low, moderate, and high) in the first phase to being predominantly "moderately" active in the third phase. There was also a fluctuation in trainees' immediate reaction to weeping, from being mainly focused on emotions in the first phase, to a focus on cognitions in the second phase and, once more, on emotions in the last phase. The thematic focus during the event changed from mostly on emotions in the first phase, to mostly on cognitions and to a lesser degree on emotions in the second and third phases. Finally, trainees used diverse interventions at different phases.

These findings clearly suggest that by the third phase, trainees were more flexible in their ability to work in the present, while making connections with the past or the future whenever necessary. This also suggests an increased flexibility in their trying out different techniques. At the same time, there is an interesting trend that appears for the types of interventions that changed frequency throughout the phases. As will be argued, by the last phase of therapy, trainees chose to employ interventions that required the use

of a more active approach. In other words, a change in specific types of interventions was apparent across the three phases. Specifically the interventions of clarification, reflection, and summarization, are all interventions whose use diminished by the third phase. One characteristic that all these interventions have in common is that they are less directive. At the same time, the use of interpretations and open-ended questions increased in the last phase of therapy. These two interventions are seen as more active since they are both used to challenge the client's perceptions of a specific task (e.g., interpretation is used to challenge the client's dynamics, and open-ended questions can used to challenge the client to further explore the material). In examining the specific questions asked by trainees in this sample, it appears that there is a general trend in asking action-oriented questions that concern the client's immediate or future plans. For example, in trying to direct the client towards action, a therapist asked: "So in the meantime that you are waiting for your children to come around, what are you gonna do in the meantime?"

A last type of intervention was termed "specific directive technique" because a common characteristic of this intervention was a particularly active approach by the therapist. This type of intervention was also found to be most common in the later phases. Therefore, it appears that by the third phase, trainees reduced the types of interventions that were not particularly active or directive and increased the number of more active interventions. This choice of interventions further suggests, in combination with previous findings, there was an increased level of flexibility in their use of counselling skills. Consequently, increases in levels of flexibility and comfort contribute to the development of trainees' identity role. Implications of these finding and their

relationship with existing research and literature will later be discussed in conjunction with other findings.

A minimal encourager was a type of intervention that was consistently chosen by the majority of trainees in the first two phases, and by all of them in the third phase. This suggests that trainees were trying to promote more talk from their clients but without trying to interfere with the client's verbal process. It also suggests that minimal encourager is a general reaction when someone cries.

In summary, novice counsellors use different interventions at different phases of therapy when reacting to client weeping, with three general trends: (a) Towards the last phase they adopt more "active" interventions. (b) They seem to become more flexible in the use of different tasks and the combination of those tasks, and (c) they seem to become more comfortable in their role, and in less need to control the therapeutic interaction.

Question 4. How Does the Style of Therapists-in-Training Change Across Three Phases of Psychotherapy (early, middle and late)?

The dimension of style examined the manner in which trainees communicated their tasks. The judges identified three categories of style: Vocal attitude, communication style, and process style.

Results from this dimension of therapists' reaction indicate that a large number of trainees - from as early as the first phase of therapy - were able to communicate an attitude of empathy and understanding through a warm and accepting tone of voice. They were able to be supportive of the client and in tune with the client's experience.

Additionally, it was also found that in the first and second phases trainees were divided between directive and non-directive styles, whereas in the third phase the majority of trainees became directive.

Combining the findings from the dimensions examined so far, we can start to sketch a general picture of trainees' reactions in each phase and how these reactions changed across time.

In the first phase of therapy, weeping occurred when clients presented their story, describing the situation and the feelings they were experiencing. In most cases in this early phase, it was the therapist's response that triggered the client's weeping. In the early phase, changes were noted in the therapists' style at the moment of weeping. As they were listening to the clients' story after the beginning of weeping, trainees focused mainly on the past with a particular emphasis on clients' emotions. At this phase, counsellors were divided in terms of their level of activity and their degree of directiveness during the weeping event. Some of the trainees at this point were also tentative in the way they communicated their interventions. They chose to use a variety of different interventions when reacting to the clients.

These findings suggest that from as early as the first phase, trainees were able to communicate an empathic and accepting attitude. However, they were more ambivalent and uncertain in their role as counsellors. Their uncertainty was indicated by the fact that almost half of them chose to change their style of interacting with the client at the onset of weeping. They also seemed to be unsure as to the level of activity and directiveness that they should display. Their possible lack of comfort could also be indicated by the choice, by some of the trainees, to communicate their interventions in a tentative manner.

Additionally, according to the judges, in some events it was the therapists' deliberate attention to emotions that triggered client weeping. Their main focus was on the clients' past, suggesting that trainees used the early phase for information-gathering and for getting a sense of the clients' history - information that is used to intervene at various points, including during weeping. Their choice to mainly work with the clients' feelings is an indication that in this phase they felt best equipped to deal with emotions. In this phase, counsellors seem to be tentative, empathic and attending to the past when reacting to client weeping.

In the second phase of therapy, while clients were describing the situation and exploring their emotions about specific issues, a statement from their therapists was more likely to provoke client weeping. The therapists - probably more at ease in their role - now sustained the same style they were using prior to the onset of weeping, while their immediate reactions now focused on clients' cognitions. Their tone of voice was accepting, but in their attitude they were divided and some of them were being empathic while some others, non-empathic. They chose to work with the clients' present cognitions and, to a lesser degree, with the clients' emotions during the remainder of the events, while adopting mainly a high level of activity. Although highly active during the event, they were still divided between directive and non-directive styles. They used a variety of interventions to achieve their goals.

The findings from this second phase suggest that after trainees accumulated sufficient historical information, they tended to work with the clients' present issues. It appears that at this phase they preferred to work with clients' cognitions. Still, despite their attempt to work with emotions in addition to cognitions, they seemed to become

less empathic. This finding suggests that by this phase, they have not acquire the level of flexibility that allows them to be empathic while working concurrently with cognitions or with other aspects of the clients' difficulties. They seemed to be experimenting with different styles, indicated by their choice to be highly active at this second phase, but at the same time, they were still ambivalent as to how directive they needed to be in the session. In other words, the general picture from this phase is that it appears to be a period of trying out new tasks and skills, but at times at the expense of maintaining an empathic attitude.

In the third phase of therapy, it was a common occurrence for clients to begin to weep while they were in the process of describing some aspects of their story or their feelings. During this phase, client weeping occurred as a reaction to a counsellor remark as well as to their own unfolding narrative. In this phase they maintained the same style of interacting with the client, prior and after the beginning of weeping. Using an accepting tone with an empathic attitude, trainees worked with the cognitions and emotions of the clients in the present, while also making connections to the past or the future where appropriate. For the most part, they were moderately active during this phase, but were directive of the therapeutic process. At this phase of therapy they also used a variety of interventions, with an increase of open-ended questions and interpretations.

The results from this phase of therapy clearly suggest an increased level of comfort with their professional role and an increased flexibility in the use of different tasks. Trainees' increased flexibility is indicated by their ability to work concurrently with different issues within different time frames. This new direction of the therapists'

focus suggests that at this phase they chose to react to client weeping in a way that would lead to some potential action. By choosing to focus both on the present and the past, trainees help clients to make meaningful connections between past issues or behaviours and present reactions. On the other hand, by choosing to focus on both the present and the future, trainees also directed their clients towards using the present experience to take future action. Trainees were now able to work with both client cognitions and emotions, while at the same time maintaining an empathic and accepting attitude. Their increased level of comfort in this counselling role is suggested by their choice to be moderately active in the session, and felt comfortable in allowing the client to be equally involved. Thus, trainees seemed to develop a more stable counsellor style of being empathic and at the same time, moderately active. Another indication of their increased comfort in their role is suggested by their choice to become directive of the counselling process, and to use more active interventions. Although they did not feel the need to take the lead in the therapeutic interaction, it appears that they wanted to guide the clients towards certain directions, a task that is also consistent with the general goal of therapy as it enters later phases of counselling.

The findings from the questions discussed so far are consistent with the literature. The objectives of the three training models (HRT/HRD, IPR, and MC) appear to have been borne out by the changes in trainees' behaviours and attitudes found in the present study. Specifically, the present sample demonstrated an empathic attitude that is related to the development of good rapport with clients. The importance of building a good therapeutic relationship from the beginning of therapy is outlined by a number of sources. Both the training models and counselling textbooks for beginners emphasize the

importance of developing a good therapeutic relationship from early on in therapy, and suggest that a way to do that, is with an empathic understanding of the clients' experiences (e.g., Brammer, Abrego, & Shostrom, 1993; Egan, 1994, 1998, 2002; Hackney & Cormier, 1993, 1996).

Additionally, the findings support another main focus of the training models for the beginning stages of training. Specifically, all models initially focus on teaching trainees how to work with clients' emotions, either by teaching them how to acknowledge their own and their clients' emotional experiences (HRT/HRD and IPR) or by teaching them specific microskills aimed at facilitating emotions and emotional expression (MC). A second focus is to teach students different techniques to promote cognitive exploration of the clients' issues. Thus, the first goal of the training models is to teach the student how to respond to clients' emotional experiences (i.e., from acknowledging the experience to actively working with it), and the second goal is to work on exploring the clients' issues in a more intellectual and analytical manner. Thus, the models support the notion that trainees' development and learning should progress through a sequence, starting from the ability to communicate facilitative conditions, moving towards working with the clients' emotional experiences, and finally learning to promote exploration of clients' issues. This unfolding sequence was apparent in the findings of the present study where a change of focus through the three phases was seen, culminating in the last phase, where trainees were able to work both on an emotional and a cognitive level during the weeping events.

The findings of this study also support the suggestions that the first stage of the therapeutic process is the exploration stage where the focus is on getting to know the

client, gathering information about the client's past and finding ways to connect it to the present issues, and on developing a therapeutic relationship with the client (Hill and O'Brien, 1999). One effective way to develop a good therapeutic relationship is by acknowledging and exploring the clients' emotions (Hackney & Cormier, 1996; Hill & O'Brien, 1999), a task undertaken by the trainees of this sample. It is also important to focus on the past, in order to gather information about the client's history and their relationships with significant others.

In the present study, trainees chose to focus on the past in the first phase of therapy when the client wept, suggesting that for these trainees weeping did not represent a moment in the therapy that required a unique and different response. That is, trainees tended to follow the established protocol that is suggested by standard textbooks and manuals. In terms of trainees' activity level, Hill and O'Brien (1999) suggest that in the exploration stage, trainees need to be less active and practice attentive listening, while encouraging the client to talk. The results from this study, although not exclusively supporting these authors' suggestions, point to the trainees' confusion with regards to how active they need to be.

Both the trainees' immediate reaction to weeping and their thematic focus (a focus on emotions), are in line with Hill and O'Brien's (1999) suggestions that in the first phase, trainees need to develop a therapeutic relationship and facilitate the arousal and exploration of emotions.

In the second stage—Hill and O'Brien's "insight stage"—the goal is to help the client understand his or her issues. In order to achieve this goal, the focus needs to be on the present by exploring the current situation, something that novices in this sample did

do. Trainees are also expected to be particularly active by helping the clients achieve insight on their issues. The focus on promoting insight in the second phase of therapy, suggests that the techniques or interventions in this phase are mostly focused on clients' cognitions. Again, findings from the present study indicate that trainees at this phase were highly active, and mainly focused on clients' cognitions, supporting Hill and O'Brien's descriptions of this stage. Trainees' tone of voice was mainly warm and accepting towards the client throughout the three phases of therapy. Hill and O'Brien suggest that trainees need to adopt such a tone of voice throughout therapy since they postulate that tone of voice is considered by many theorists as one of the powerful tools to communicate a message to the clients (Hill & O'Brien, 1999).

In the third stage - Hill and O'Brien's (1999) "action stage" - the goal is to help the client explore new behaviours as well as take action. In order to achieve these goals the focus needs to be on the present by exploring the current situation or by making decisions. Trainees, say Hill and O'Brien, are expected to be less active compared to the previous stage, and instead, allow the client to take the lead. These suggestions are supported by the results of the present study, both in the use of a moderate activity level and by the findings concerning who initiated weeping in the question of context. In the third phase, clients and therapists in the present study almost equally initiated weeping. Hill and O'Brien also suggest that in the third phase trainees need to be understanding and encouraging of the clients' efforts to initiate action. This suggests that trainees are expected to focus both on client cognitions and emotions, which was found in this study in the third phase. Since trainees are expected to help the client move towards action, it follows that trainees need to be more directive of the therapeutic process, which was one

of the findings of this study. Finally, in terms of specific interventions, Hill and O'Brien (1999) seem to suggest that different interventions can be used to different degrees in all three stages, a suggestion that was supported by the present findings.

Fong, Borders, Ethington, and Pitts (1997) suggest that there will be a change in the types of interventions that trainees adopt throughout training. These authors found that trainees changed significantly over time in the types of responses they were adopting, since they were using more complex responses, and using them more effectively. For example, interpretation can be considered a "complex" intervention, since it is related to different therapeutic intentions, can be communicated in different depths and has different functions depending on the particular theory. In the present study, interpretations were used by trainees in the last phase of therapy more than in any other phase. However, Hill and O'Brien (1999) postulate that trainees should be doing more interpretations in the second phase ("insight" phase). A possible reason for this, is that since weeping is a behaviour associated with different emotions that expose the clients' vulnerability and anxiety, trainees needed more time to feel comfortable in their role and their abilities in order to communicate challenging interventions such as interpretations.

Another finding of the present study, consistently seen to the same degree across phases, is a casual, informal interaction that is social and friend-like. It is possible that some of the trainees adopted this style in their effort to appear nice to their clients and to develop good rapport. This is a behaviour that more frequently happens with beginners when they feel uncomfortable in their role as therapists and want to gain the acceptance by their clients (Hill & O'Brien, 1999).

In conclusion, it appears that the changes in the behaviours and attitudes in trainees of this sample, support the suggestions by Fong and colleagues (1997) and Hill and O'Brien (1999) concerning the appropriate reactions at different phases of therapy. Although different tasks can be used to different degrees in all stages, therapy goals differ between stages. The findings from the present study indicated that trainees used the same tasks to different degrees in the different phases. In terms of different goals in different phases of therapy, although there are indications in the first and second phases that the goal was to gather information and explore clients' issues respectively, the findings offer strong indications that the goal in the last phase was to direct clients towards action. This last suggestion will be further discussed in a later section of this chapter, where findings concerning the appropriateness (quality) of events clearly indicate that a trend of counsellors was to direct clients towards taking action.

The findings of the present study are also consistent with existing research and literature on emotional expression in general, and on weeping in particular. Specifically, it is suggested that in order to deal effectively with clients' emotional expression, the first step is to allow this emotional expression to occur and the second step is to cognitively process the clients' emotional experiences, a process that the trainees of this study seemed to follow in the last stage of therapy (e.g., Greenberg, 1999). Working with the expressed emotions is generally found to be therapeutic in any phase of therapy (e.g., Mackay, Barkham, & Stiles, 1998). Specifically to weeping, Elliott (1983) found that when the therapist's immediate response to weeping was focused on the client's emotions, this was seen as very helpful. Thus, the counsellors in the present study appear to have acted according to the expectations of the literature and research in the area.

Some of the findings of the present study support the concepts of the developmental models of training, such as the ones by Stoltenberg (1981) and Hill and her colleagues (1981). The nature of the changes found across phases suggest an increased level of comfort in trainees' counsellor identity and in their flexibility in using different counselling skills. This progress through stages of development is discussed in the models both by Stoltenberg and Hill and her colleagues and it appears to be further supported by the present findings. Additionally, self-efficacy appears to have increased in our sample. It could be speculated that, if the observed changes in trainees' behaviours and attitudes across time were an indication of increased levels of comfort with their professional identity and flexibility in counselling skills, then there would also be an increase in counsellor self-efficacy (Larson & Daniels, 1998).

Another finding of this study that could be related to the levels of trainees' self-efficacy is that, in the first phase of therapy, some trainees were tentative in their style of communicating their interventions. One explanation of this style of communicating is that it could be an indication of trainees' efforts to give the client the option to disagree. Trainees may have wanted to communicate that they were not trying to be authoritative and impose their views. However, an alternative explanation may be related to trainees' lack of confidence in their ability to communicate effectively with their client. It is possible that trainees at the first stage have a low sense of self-efficacy, that is, they consider themselves incapable of effectively counselling a client (Larson et al., 1992; Larson et al., 1998). Therefore, it is possible that in the first phase, trainees' self-efficacy was related to tentativeness in their interaction. Growing confidence may explain the finding that, in the second and third phases of therapy, trainees were not tentative. In

those phases they were also experimenting with different behaviours, which may be taken as increased comfort in their counsellor role.

Comparison of Quantitative and Qualitative Findings

In comparing the findings of the qualitative to findings of the quantitative analysis, important commonalties emerge. First, in the quantitative analysis it was found that the most prominent characteristic of therapists' reactions to weeping was a warm and friendly attitude reflecting an empathic stance towards the clients. Similar results were found from the discovery-oriented analysis of the data. The therapists' empathic style of communication was one of the few characteristics of therapists' reactions that remained consistent throughout the three phases of therapy. It is important to note that this was a preliminary study aiming to discover categories that emerged from the data without reliance on pre-existing expectations. Although empathy was one of the main therapist attitudes that was found in both the quantitative and discovery-oriented studies, it was not an attitude that was purposefully explored. For this reason, there were no specific measures used to examine empathy. Future studies on client weeping could focus on trainees' behaviours and attitudes by using specific measures to examine their levels of empathy and whether it changes across time.

An interesting observation from the findings on trainees' attitudes in both the quantitative and qualitative/discovery-oriented studies, was that empathy and a warm and friendly attitude remained generally consistent throughout the three phases. It is possible that the trainees in question were able to adequately develop this attitude in the first month of their counselling training, a time during which they were not yet assigned clients. However, this finding raises the issue of whether the specific sample entered

training with a pre-existing empathic attitude and therefore it was not something they developed as a result of training. Typically, the criteria for acceptance into counselling programs do not include an evaluation of students' pre-training levels of empathy, and there are no measures of empathy administered at the beginning and the end of their practicum year. Therefore, it is difficult to concluded that training was not responsible for novice counsellors' levels of empathy as early as the first phase of their work with clients.

It was also found, to a lesser degree, that trainees adopted an exploratory stance. This finding is also consistent with the qualitative analysis, since it was found that there were fluctuations in trainees' use of exploratory interventions (i.e., working with emotions and cognitions) across the different phases, which could account for the lower rating of exploration in the quantitative findings. Finally, therapists' negative attitude was the lowest rated subscale in the quantitative analysis, a finding that is consistent with the one from the qualitative findings, since only a small number of trainees' were found to adopt a negative style (i.e., non-empathic, detached).

A second major finding from the quantitative analysis was that trainees did not significantly change behaviours and attitudes when reacting to weeping over the three phases of therapy. This finding appears to contradict the qualitative analysis, but a closer examination of the qualitative data may explain this. Although it is possible that issues such as (a) the numbers used by the scale to measure behaviours and attitudes could not capture the clinical meaningfulness of the data and therefore allowed important information to be lost, or that (b) the aggregation of the results for the statistical manipulation of the data and the focus on averages, may have obscured meaningful differences between the phases, there is another possible explanation to these seemingly

discrepant results. It is likely that the quantitative study employed a molar concept of exploration, whereas the qualitative study allowed this to be broken down to a more molecular level (e.g., not simply exploration or not, but cognitive exploration or emotional exploration, etc.). In other words, it is possible that the concepts examined in the quantitative study were perhaps not fine-grained enough to capture the smaller changes in trainees' behaviours found by the judges in the qualitative study.

Question 5. How did Observers Perceive the Change in the Quality (appropriateness) of the Trainees' Reactions to Client Weeping Across the Three Phases of Psychotherapy (early, middle, and late)?

The dimension of quality refers to judges' evaluations of the appropriateness of the tasks that the trainees performed in specific contexts. Therefore, the quality of those events was evaluated as "contextually appropriate", "fairly appropriate" and "contextually inappropriate" based exclusively on the appropriateness of the therapists' work under those specific circumstances.

The results of the question examining change in the quality of the trainees' reactions to weeping did not indicate any clear trend with regard to each phase or how they changed across phases. Each one of the trainees seemed to have their own individual way of being as a therapist and it was difficult to identify any trends either within or across phases. This finding suggests that trainees are not yet consistent in their skills over time.

A second step in the analysis of this question was to find the specific factors that led the judges to evaluate the events under the three different levels of appropriateness.

Examining each event separately, it was found that there were some common characteristics between the events that were evaluated as "contextually appropriate", "somewhat appropriate" and "contextually inappropriate", irrespective of phase. A brief summary of the results will be provided to facilitate the reader's understanding of this issue.

Two common characteristics were identified in events deemed "contextually appropriate": (a) Trainees and clients felt comfortable with each other, and (b) trainees were communicating appropriate interventions with good timing.

In events seen as "somewhat appropriate," the comfort between the client and the therapist was generally present in the events, but the therapists' tasks were not particularly appropriate or done with good timing.

Finally, in the "contextually inappropriate" events, it was found there was neither a comfortable relationship between the therapists and clients nor appropriate interventions with good timing.

Since, the events classified under each of the three categories, belong to different phases in therapy, the above findings suggest that trainees learn the appropriate skills and use them when reacting to client weeping, but they were not consistent in how they apply these across time. Therefore, although trainees have the necessary knowledge and skills, they have not yet integrated this knowledge in a manner that allows them to be consistent across phases. At the same time, the demands of each event are different and therefore some events may have been easier to react to than others.

A training implication of this finding is that learning to deal with client weeping is a long and complex process that requires more than one academic year of training for

students to effectively master. It is for this reason that extended training and experience is expected to provide, along with a more effective mastery of skills, an increased maturity in their counselling role that may be necessary to appropriately react to weeping. Additionally, because weeping is not a type of event that occurs often in the therapeutic interaction, it is possible that an increased level of experience in dealing with events of such nature would have more positive and consistent results.

Related to this finding is the observation that judges deemed a comfortable relationship between clients and therapists a central ingredient in the quality of events. Since there were fluctuations in a therapist's ability to have a comfortable relationship with her client across time, this finding also suggests that, along with the ability to effectively react to weeping, the ability to develop a comfortable relationship with a client does not appear to be a stable characteristic of the trainees' attitudes across time.

There are a number of training implications from the above findings. A first training implication is that since the ability to develop rapport can be challenged in different therapeutic situations, training programs need to train their students on how to develop and preserve good rapport in different situations. As a consequence, it is important to teach trainees that therapy is a constantly changing process, and that each event is unique. A second training implication related to the first, is that it is important to teach trainees the importance and the possible difficulty of building rapport. According to Sipps, Sugden, and Faiver (1988) at the early stages of their training trainees tend to have higher level of confidence because they use relational methods of common sense, therefore underestimating the difficulty of the therapeutic situation and in turn, the complexities of the therapeutic relationship. If trainees are left to believe that the

development of the therapeutic relationship is an easy task, similar to any everyday social interaction, they will not appreciate the relevance of a real therapeutic relationship and its role in the outcome psychotherapy.

In a previous chapter, the existing debate in the field of trainee development of working alliance was presented, and it was suggested that the present study could, to a certain degree, be used to clarify the debate. The debate centers on whether novice therapists can develop the bond aspect of the alliance as well as experienced therapists from early in their work with clients. The present results suggest that, trainees do have the ability and skills to develop a good therapeutic relationship with their clients, but this ability may not be exercised consistently throughout the three phases of therapy. This might suggest that (a) they have not mastered the required skills adequately to maintain and sustain the bond or (b) challenges to the bond can upset the fragile alliance. Therefore, the present results seem to support both positions, to a certain extent. That is, novices are capable of forming a strong bond, but they may not be sensitive to fluctuations and changes in these bond situations that need constant attention and maintenance.

Finally, a third training implication is that trainees need to understand the link between therapeutic rapport and counselling techniques. Trainees need to know that when bad rapport develops between themselves and their clients it will have an impact on their level of comfort in their therapeutic role and in their attitude in the session. As a consequence, this will have an impact on their self-confidence, and levels of self-efficacy. In turn, negative self-image and self-talk leads to poor performance (Hiebert, Uhlemann, Marshall, & Lee, 1998). A training implication related to this, is for training

programs to teach students that the therapeutic relationship goes beyond a simple technique that can be easily learned. Rather it is a therapeutic condition that takes time and active work to develop and preserve. It is important to consider that both Rogers (1980) and Patterson (1974) argued for empathy and its development. They both agreed that empathic skills develop with experience, both professional and personal, and that trainees learn these skills through cognitive and experiential training.

Another main conclusion from this part of the study is that it is not only important to know how to construct a specific intervention (e.g., interpretation), it is of equal importance to know when it is appropriate to communicate this intervention. The findings suggest that the ability to communicate a certain task at the appropriate time is an important component that defines the quality of the event. Trainees in this sample were not necessarily able to deliver their interventions with appropriate timing. Appropriateness and timing of interventions are considered by different authors as part of conceptualization, or higher order skills (Greenberg & Sarkissian, 1984; Martin, 1991; Nutt-Williams et al., 1997). Although the existing research stipulates that conceptualization skills develop later in training, it is important to teach trainees the significance of learning to use different techniques based on the specific context and timing. It is important to start teaching trainees from an early stage in their training, not only what to do in therapy (e.g., utilize specific techniques), but mostly how to think about a client. Future research could examine how trainees conceptualize different psychotherapy events.

A final finding that became apparent when examining judges' ratings of "quality" is important to note. The majority of trainees became more active in the last phase,

directing clients towards action and solutions to their problems. While, in the final phase, most therapists showed higher action levels or solution-oriented activity, judges decided this was quite unrelated to the quality of their work. In other words, activity is not equated with good quality. Deciding that in a specific event the therapist was particularly active does not necessarily imply that the specific behaviour was considered contextually appropriate. Hill and O'Brien (1999) suggest that therapists should be more solution-oriented in the later phases, and indeed, in our sample this was the case. The important point, however, is that the tendency to be more active and solution-oriented was observed for each trainee in different ways (i.e., some good, some not), and did not always result in a contextually appropriate quality of work.

Change in trainees' reactions to client emotions. An important result concerning the quality of the trainees' work relates to how they reacted specifically to the clients' emotions. This was seen by how they worked with the emotions that were related to the weeping. The results indicated that, in general, only few trainees actively dealt with the client's emotions, that is, most counselors did not go beyond a simple acknowledgment of the emotions. This tendency was consistent across the three phases of therapy. Where trainees did try to access deeper levels of feeling or experiencing during the weeping, this tendency was not sustained across phases.

Also, dealing with the underlying emotions of the weeping was not equated with appropriateness. This means that, while the counsellors' techniques were intended to encourage clients to actively deal with emotions, the particular responses used were not judged as appropriate. This suggests that trainees have not appropriately mastered, or were not confident in the execution of these techniques, in the timing or the manner of

delivery. Hill and O'Brien (1999) present several appropriate or inappropriate ways that trainees can use when dealing with client emotions.

In later phases of therapy it was found that trainees place less emphasis on client's emotions. The emotion focus of earlier sessions is replaced by clients' thoughts and behaviours. Another possible meaning of this finding is that trainees find the task of actively working with client emotions a particularly difficult one, and therefore, chose shift the work to a different aspect of the clients' story. This supports Nutt-Williams and her colleagues' suggestion (1997) that emotion focused work is demanding and that trainees may become overwhelmed by this, and as a result, chose to avoid it altogether, or (b) to the nature of the task itself (i.e., the inherent difficulty of dealing with another's strong negative emotions).

Conclusions

Prior to discussing the findings of this study, it is important to note that the results obtained from the analysis of the specific data, are based on clients' reporting of low to moderate levels of discomfort. As a result, it is not possible to know whether trainees would react in the same manner to clients demonstrating higher levels of discomfort. Nevertheless, the combination of the findings from all questions in this study, resulted in a number of clear indications. First, the findings suggest that trainees develop the skills and attitudes that are consistent with the goals and expectations with counsellor training models. Secondly, it was found that throughout the three phases, a number of trainees tended to react to client weeping in a way that it is considered appropriate by judges with clinical experience. This rating by the judges of the appropriateness of trainees' tasks

was based on two dimensions: (a) empathy and the ability to develop a comfortable interaction with their clients, and (b) the appropriateness and timing of different interventions/tasks.

At the same time, there were events where the timing of trainees' communication of these tasks/ interventions was not appropriate. Although trainees were able to construct certain interventions (e.g., they knew how to "make" an interpretation), the timing of those interventions was often detrimental to the ultimate quality of the intervention. It was generally found that the interventions that were appropriate were also delivered with the appropriate timing, and timing is a concept that is related to conceptualization skills.

Examining trainees' active exploration of the emotions underlying weeping - as opposed to simple acknowledgment of client emotions - trainees in the present sample did not always do this in a way judged appropriately by observers. This finding further suggests that more training and experience may be necessary before trainees are capable of effectively exploring client emotions.

The above is not intended as a criticism of the trainees, but rather the findings suggest that a single year of training (in a two-year program) is not sufficient to integrate complex skills and case conceptualizations. Trainees need time, experience, and more mature counsellor identity in order to develop these skills. Overall, the finding - that trainees may not always have adequate time to develop conceptualization skills - is consistent with existing research and theory, which holds that (a) learning to actively engage clients' emotions takes considerable time, and (b) learning conceptualization and timing skills is an ongoing endeavour. Fong and her colleagues (1997) corroborated this

suggestion when they found an increase in counselling skills, level of thoughts about the client, and response effectiveness, but not a concurrent increase in trainee conceptual level or level of ego development. It is clear that the first task of beginning counsellors is to develop specific appropriate responses probably at the expense of case conceptualization skills. The implication and task for trainers is how to help new counselors develop both abilities, a point also shared by Martin (1990).

Finally, while the nature of the trainees' tasks in the last phase becomes oriented towards encouraging the client to find solutions and take action in her life, this new focus is not always appropriate. Although trainees in the present sample seem to be following the stages of therapy recommended by Hill and O'Brien (1999), they did not always do it well. For example, in some cases judges thought that although the therapists appeared systematic and focused, they also exhibited "tunnel vision" which prevented them from recognizing clients' broader issues. This finding offers an additional support to the idea of timing, since it was observed that in a number of instances trainees were not able to identify the appropriate time in the event to direct the client towards action.

Two training implications are inherent in these points: (a) Empathy is an important therapeutic condition and training programs need to keep this emphasis, and (b) empathy by itself is not enough and therapists need to develop other appropriate ways of responding. In the weeping events in the present sample, it was found that, in addition to empathy, trainees require the ability to communicate the appropriate techniques at the appropriate time, in order for an event to be considered useful. The implication for this, is that training programs need to teach trainees how to decide when empathy makes it appropriate to use certain techniques and when it does not suffice. At such moments,

therapists need to refine their conceptualization of the case and appropriate timing of the interventions.

Model of Trainees' Reactions to Client Weeping

Examining the results of the different ways the trainees in the present sample responded to client weeping, a general pattern emerged (see Figure 1 for a graphical representation of this pattern). Graphically presented, it becomes clear that the present study suggests that trainees' reactions to weeping occur at two co-existing levels: a conceptual and an instrumental level.

At a conceptual level, trainees appeared to have embodied an appreciation for the communication of empathy and the importance of a good rapport as important therapeutic ingredients. This is an idea that is emphasized throughout their training, and is part of the history and culture of counselling psychology. There is sufficient evidence from this study that trainees are able to manifest this empathic attitude, especially as it relates to the interpersonal relationship they develop with their clients.

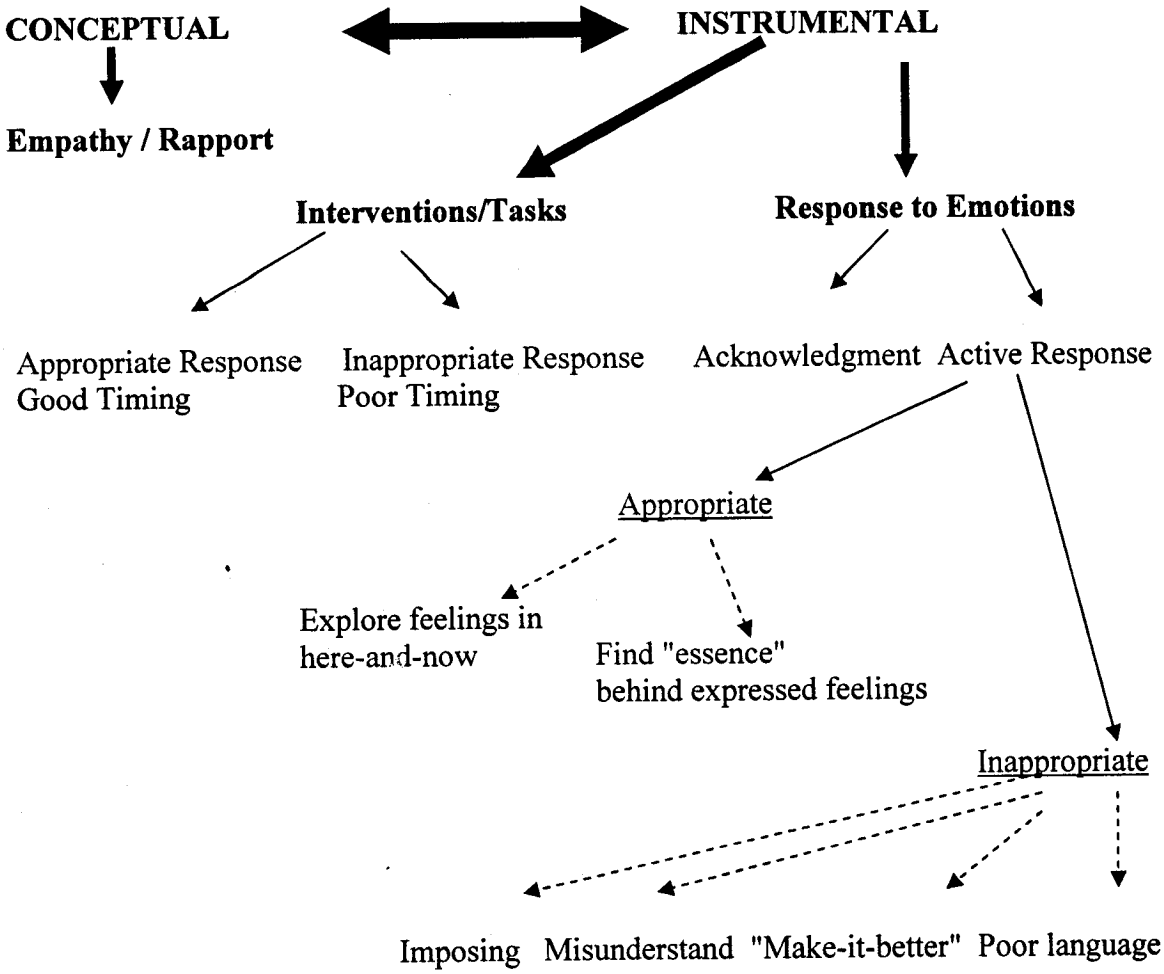
Concurrently with developing rapport, trainees' reactions also included an instrumental level where they were performing certain tasks. The results from Study II indicate that trainees were doing different things throughout the three phases, choosing different foci, and using a variety of interventions. If we take a closer look at these actions, we can classify them in two categories: (a) types of interventions/tasks used, and (b) responses to client emotions. The types of interventions/tasks refers to the actual response modes (e.g., reflection of feelings) and therapeutic tasks they undertook (e.g., directed client towards further exploration). According to the judges' decision, the

interventions used were divided between two types: (a) appropriate interventions with good timing, and (b) inappropriate interventions with poor timing.

In terms of the trainees' responses to client emotions, results suggested that only a very small number of reactions was considered appropriate, whereas the majority of reactions were considered inappropriate given the specific context in which they were delivered. Judges deemed reactions to emotions appropriate in instances where: (a) The client's feeling was explored in the here-and-now and (b) the "essence" behind the feeling expressed was identified. Reactions to emotions that were considered inappropriate had the following characteristics: (a) Trainees "imposed" an emotion on the client, (b) trainees misunderstood the clients' emotion, (c) they tried to make the client "feel better", and (d) trainees tried to provoke the emotion, but did so inappropriately.

In summarizing the above conclusions, the findings of this study suggest that trainees are generally successful at developing good rapport with their clients. This is considered one of the main ingredients for effective reaction to weeping by both researchers on client emotions and theorists in the field of counsellor training. At the same time, trainees seem to have been able to satisfactorily learn how to construct different types of interventions (e.g., how to "create" an interpretation). However, what they seem not yet to have perfected is knowledge of appropriate timing of when to execute a specific task, be it a specific intervention or a more general therapeutic task (i.e., provoke emotion, challenge beliefs).

Figure 1.
Trainees' Reactions to Weeping Events



Limitations and Recommendations for future Research

This study concerns the area of counsellor training and development and its aim was to examine two main areas: (a) How trainees react to client weeping, and (b) whether these reactions changed across three phases of psychotherapy (early, middle, and late). The results from the analysis of the data provided a wealth of information about therapists' behaviours and attitudes during client weeping, and the appropriateness of those behaviours and attitudes. However, as with most dissertations some shortcomings are inherent in the present study that may restrict the generalisability of the results.

Small sample size. The sample consisted of only nine counsellors-in-training, which may limit the generalisability of the results. This might have been responsible for the lack of statistically significant results for the quantitative part of the study. However, given that psychotherapy process research in general - and qualitative research in particular - is extremely labor intensive, small sample sizes are common throughout the field (Clarke, 1996; Hill et all, 1997). Small sample sizes tend to be the norm when examining specific in-session occurrences like weeping, which may be infrequent and unpredictable (Labbott, et al., 1992; Mahrer, Fairweather, Passey, Gingras, & Boulet, 1999). Furthermore, the idiosyncrasy of the present study, highlighted by the specific restrictions imposed by the design of this study (i.e., client weeping events across three phases of therapy) restricted the sample to a smaller size. The goal of the present research - especially since it is the first known study conducted in this specific area - was also heuristic in that one of the interests was to generate more ideas and questions that

can inform future investigation of these newly found areas of interest. Future studies with a larger sample should test for the comparability of the present results.

Lack of saturation of the results. In CQR, cases are added to the analysis until subsequent cases fail to generate unique categories. In this way the categories are considered to be 'saturated'. The concept of saturation encompasses the idea that the categories that result from analysis of the data generally explain the phenomenon for the specific group being examined, and, if new cases are added, the results will not change, and new categories will not emerge (Hill et al., 1997; Strauss & Corbin, 1990). Since only nine cases fit the selection criteria, new cases could not be added to determine whether categories were saturated or not. The number of cases that were available made this final step impossible, and therefore it was not possible to determine whether the addition of new cases would result in the emergence of new categories. Future research is needed in order to determine whether increasing sample sizes allows new categories to emerge.

Use of a single perspective. In psychotherapy research in general, there is an effort to combine multiple perspectives of the data in order to "triangulate" the findings (Hill, et. al., 1997; Stiles, 1993). For this reason, whenever possible, researchers use the perspectives of clients, therapists, and external observers/judges, in order to enrich the results of their studies (Elliott & Anderson, 1994). This study used only the perspective of external raters. This dissertation drew upon a pool of data collected prior to the conception of the present study. The pool did not include client and therapist perspectives, therefore it was impossible to include these in this study.

Access to client perspectives would have enabled us to assess the impact of therapist tasks on the client during weeping segments. At the same time, the addition of therapists' perspectives would have provided information on therapists' intentions and thought processes while using specific tasks during the event. Client and therapist accounts would add to the external judges' perspectives and provide a richer amount of information.

In the current study, the use of external raters who have had experience in supervising trainees is particularly useful when examining trainees' development, as these raters had the experience needed to identify changes that were at times small and subtle. Additionally, multiple raters were used and consensus was reached in both Study I and Study II, in order to minimize research biases (Hill, O' Grady, & Price, 1988; Mahr :r, Gagnon, Fairweather, & Cote, 1992; Tinsley & Weiss, 1975). Furthermore, judges' theoretical biases were discussed at different points of the data analysis, in order to alert them to how theoretical biases might influence their ratings.

Use of audiotapes. Another limitation of this study was the transfer of videotape material on to audiotapes. As was previously discussed, the use of videotapes offers a wealth of information that would allow for the examination of other important in-session variables. For example, in examining client weeping, the observation of client and therapist non-verbal behaviours and interactions would have allowed for a richer and more thorough description of those events. The decision to use audiotapes was based on the priority given to the anonymity and confidentiality of the participants. As an attempt to counter the shortcomings of the use of audiotapes, transcripts of the events included descriptions of non-verbal information.

Gender of the sample. The sample of this study consisted of women only, as both counsellors and clients. Although it is typical in counselling programs that the majority of trainees are women, and that clients who seek therapy are mostly women, the results of this study cannot be considered applicable in a therapeutic interaction between men or a man and a woman. Hill (1975) found that inexperienced counsellors, both men and women, were most empathic and active and elicited more feelings with same-sex clients than with opposite-sex clients. With opposite-sex clients, inexperienced counsellors tended to talk more about their own feelings, perhaps as a result of their own anxiety. Therefore, it is possible that with a more gender-diverse sample, different results would have been obtained. Authors who examined studies in the area of counsellor gender and counselling skills, postulate that in general, findings are inconclusive (Beutler, Machado, & Allstetter-Neufeldt, 1994). Future studies could examine the same variables in a sample of both men and women as therapists and clients, and analyze gender as a variable in the way therapists-in-training react to client weeping.

Lack of pre-existing measures of empathy. As was previously discussed, there were no pre-training measures of trainee empathy. Therefore it is not possible to evaluate whether this particular group's demonstrated levels of empathy were present before their training or a result of it. Future studies could examine trainees' ability to be empathic prior to their entrance into a counselling program, as well as at the beginning and the end of their practicum year. This could help account for possible training influences on the levels of trainees' empathy.

The present study has been the first step in closely examining therapists' reactions in specific events developmentally. Future research could add to the present findings in a

number of ways. First, trainees' reactions to client weeping could be examined across time using perspectives from all three sources (i.e., client, therapist, and external rater). This could be done by using the interpersonal process recall method where post-session interviews of clients and therapists could be conducted requesting the participants' experiences.

Results from future studies of this type would have implications for training, since they would enrich our knowledge about both the therapeutic interaction and trainees' development. We would be able to learn about trainees' thought processes, how they develop with training and experience, and how they impact the actual moment-by-moment process of therapy. Another area that could be explored is how trainees' self-efficacy changes during difficult moments like client weeping events. An examination of self-efficacy could include a focus on trainees' emotional experiences during client weeping, and how these experiences impact on their own maturation as counsellors, could also be explored through interviews. This knowledge would in turn inform training programs as to how trainees evolve in their ability to navigate and work constructively with emotional events such as weeping, and in what direction training needs to go in order to help counsellors develop these skills.

Final Conclusions and Contribution to Knowledge

This present research examined the relationship between therapists' attitudes and behaviours during client weeping across three phases of therapy. The main contribution of this study is that it is the first to combine an examination of (a) specific in-session events, and (b) the area of counsellor training and development, therefore providing a very specific focus in the area of trainee development. Results from this study highlighted specific areas of the therapists' processes and interactions with their clients that lead the way to more questions and initiate further studies combining the above areas.

Trainee tasks and the changes in those tasks across training, when examined in longitudinal studies have previously been examined without a focus on specific therapeutic events. This study tried to bring into the area of research in therapist training a variable that has so far been very little examined, namely client weeping, a specific behaviour associated with moments of emotional expression.

A second important contribution of this study is that it adds to our knowledge about trainees' development. The first finding of this study is that trainees in general were empathic, and understanding of their clients' experience when reacting to weeping. This suggests that even when they were dealing with clients' emotional expression - a situation that research has shown can overwhelm trainees - most trainees in this sample were able to respond in an empathic and accepting tone towards their clients, irrespective of the types of interventions they chose to use. This finding represents a contribution to theory and future research, in that it allows us to verify that trainees learn, from early on

in their training, the importance of adopting an empathic style and how to apply it, and this finding will lead us to test this finding in other types of emotional expression.

Another important contribution suggests that, by the end of their training, although trainees know what to do when reacting to client weeping, they do not always do it well. In particular, it was found that in the last phase of therapy, trainees reacted to client weeping according to suggestions common in the existing literature and research on weeping. In other words, they reacted to both client emotions and cognitions. At the same time, they chose to be more solution-oriented and to direct the clients towards taking action for the future, something that they did not always do well. The contribution of this finding in the field of counsellor training, is that we now know that, although trainees seem to know what to do, they do not always seem to know how to do it, and the important training implications of this were discussed in the text.

Additionally, in terms of the question of quality of trainees' reactions, it was found that the ingredients of the events judged as "contextually appropriate," were (a) an empathic attitude and (b) the communication of fitting interventions with appropriate timing. "Fairly appropriate" events, according to judges employed in this study, lacked one or the other of these ingredients, while the "contextually inappropriate" events lacked both. This finding represents a contribution to the area of counsellor training, because it strongly supports the notion that empathy is an important and necessary therapeutic ingredient, but by itself it is not sufficient for an appropriate reaction to client weeping. Trainees need to learn what interventions/tasks to use and when it is the appropriate time to use them.

Finally, the findings of this study were distilled in the form of a model depicting the trajectory followed by trainees in the present sample throughout the one year-period examined. This model offers a clear picture of the ways in which trainees construct their responses to client emotions. It will be a useful tool for training since it allows a step-by-step tracking of trainees' reactions to client weeping. This model offers a taxonomy of more and less desirable trainee steps that - although derived from a study of client weeping - will presumably be useful in training novice counsellors to deal with a broad range of client emotions.

References

Alberts, G., & Edelstein, B. (1990). Therapist training: a critical review of skill training studies. *Clinical Psychology Review, 10*, 497-511.

Alexander, F., & French, T. M. (1946). *Psychoanalytic Therapy: Principles and Application*. New York: The Ronald Press Company.

Allen, D. (Ed.). (1967). *Microteaching: A description*. Palo Alto, CA: Stanford University Teacher Education Program.

Aveline, M. (1997). The use of audiotapes in supervision of psychotherapy. In G. Shipton (Ed.), Supervision of psychotherapy and counselling (pp. 80-92). Philadelphia: Open University Press.

Bachelor, A., & Salame, R. (2000). Participants' perceptions of dimensions of the therapeutic alliance over the course of therapy. *Journal of Psychotherapy practice and Research, 9*, 39-53.

Baker, S.B., Daniels, T.G., & Greeley, A.T. (1990). Systematic training of graduate-level counselors: Narrative and meta-analytic reviews of three major programs. *The Counseling Psychologist, 1*, 355-421.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. *Psychological review, 84*, 191-215.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*, 122-147.

Bandura, A. (1986a). Self-efficacy. In A. Bandura (Ed.), *Social foundations of thought and action: A social cognitive theory* (pp.390-453). Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist, 44*, 1175-1184.

Battle, C.C., Imber, S.D., Hoehn-Saric, R., Stone, A.R., Nash, E.H., & Frank, J.D. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy, 20*, 184-192.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Besag, F. P., & Besag, P. L. (1985). *Statistics for the helping professions*. Beverly Hills. CA: Sage.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Therapist variables in psychotherapy process and outcome. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed.), (pp 257-310). New York: Wiley.

Beutler, L.E., Machado, P.P.P., Allstetter-Neufeldt, S. (1994). Therapist variables. In A.E. Bergin, & S.L. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change* (pp.229-269). New York: John Wiley & Sons.

Bloom, B.S. (1954). The thought process of students in discussion. In J. French (Ed.), *Accent on teaching: Experiment in general education*. New York: Harper and Brothers.

Bohart, A. C. (1977). Roleplaying and interpersonal-conflict reduction. *Journal of Counseling Psychology, 24*, 15-24.

Bohart, A. C. (1980). Toward a cognitive theory of catharsis. *Psychotherapy: Theory, Research, and Practice, 17*, 192-202.

Borders, L. D., & Fong, M. L. (1989). Ego development and counseling ability during training. Counselor *Education and Supervision, 29*, 71-83.

Brammer, L. M., Shostrom, E. L., & Abrego, P. J., (1989). *Therapeutic psychology: Fundamentals of counseling and psychotherapy*, 5th Ed., Englewood Cliffs, NJ: Prentice Hall.

Brammer, L. M., Abrego, P. J., & Shostrom, E. L., (1993). Therapeutic counseling and psychotherapy (6th ed.) Boston, Mass: Allyn and Bacon.

Breuer, J. & Freud, S. (1955). *Studies oh Hysteria*. (J. Starchey, Trans.), London: Hogarth Press. (Original work published 1895)

Butler, S. F. & Strupp, H. S. (1986). Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy: Theory, Research, and Practice, 23*, 30-40.

Carkhuff, R. R. (1969a). *Helping and human relations: A primer for lay and professional helpers* (Vol. 1). New York: Holt, Rinehart & Winston.

Carkhuff, R. R. (1969b). *Helping and human relations: A primer for lay and professional helpers* (Vol. 2). New York: Holt, Rinehart & Winston.

Carkhuff, R. R., & Berenson, B. G. (1976). *Teaching as treatment*. Amherst, MA: Human Resource Development Press.

Clarke, K.M. (1989). Creation of meaning: An emotional processing task in psychotherapy. *Psychotherapy, 26*, 139-148.

Clarke, K.M. (1996). Change processes in a creation of meaning event. *Journal of Consulting and Clinical Psychology, 64*, 465-470.

Cohen, B. H. (1996). Explaining Psychological Statistics. N.Y.: Brooks/Cole.

Collins, T. E. (1932). The Physiology of Weeping. *British Journal of Ophthalmology 16,* 1-20.

Darwin, C. (1872). *The Expression of the Emotions in Man and Animals*. London, Reprint New York: Philosophical Library, 1955, 162-175.

Derogatis, L. R., & Melisaratos (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine 13*, 595-605.

Derogatis, L. R., Lazarus, L. (1999). SCL-90-R Brief Symptom Inventory and matching clinical rating scales. In M. E. Maruish (Ed.), The use of psychological testing for treatment planning and outcome assessment (pp.217-248). Mahwah, N.J.: Lawrence Erlbaum Associates.

Derogatis, L. R. (1983). *Symptom Checklist-90-R: Administration, scoring, and procedures manual* ((3rd ed.). Minneapolis, MN: National Computer Systems)

Dunkle, J.H., & Friedlander, M. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43*, 456-460.

Efran, J. S. & Spangler, T. J. (1979). Why grown-ups cry. A two- factor theory and evidence from the miracle worker. *Motivation and Emotion, 12*, 63-72.

Egan, G. (1994). *The Skilled Helper. A problem-management approach to helping,* 5th Ed., Pacific Grove, California: Brooks/Cole.

Egan, G. (1998). *The Skilled Helper: A problem-management approach to helping,* 6th Ed., Pacific Grove, California: Brooks/Cole.

Egan, G. (2002). *The Skilled Helper: A problem-management and opportunity development approach to helping,* 7th Ed. Pacific Grove, California: Brooks/Cole.

Elliott, R. (1983). "That in your hands": A comprehensive process analysis of a significant event in psychotherapy. *Psychiatry, 46*, 113-129.

Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal Process Recall and Comprehensive Process Analysis. In L. N. Rice, & L. S. Greenberg (Eds.), *Patterns of Change: Intensive Analysis of Psychotherapy Process*, (pp. 249-286). New York: Guilford.

Elliott, R. (1986). Interpersonal Process Recall (IPR) as a psychotherapy process research method. In L. S. Greenberg, & W. M. Pinsof (Eds.), *The Psychotherapeutic Process: A Research Handbook*, (pp.503-527). New York: Guilford.

Elliott, R. (1989). Comprehensive Process Analysis: Understanding the change process in significant therapy events. In M.J. Packer & R.B. Addison (Eds.) *Entering the Circle. Hermeneutic Investigation in Psychology* (pp.165-184. Albany: State University of New York Press.

Elliott, R. (1991). Five dimensions of therapy process. *Psychotherapy Research 1*, 92-103.

Elliott, R., & Anderson, C. (1994). Simplicity and complexity in psychotherapy research. In R.L. Russell, (Ed.), *Reassessing psychotherapy research* (pp.65-113). New York: Guilford Press.

Elliott, R., & Shapiro, D. A. (1992). Client and therapist as analysts of significant events. In S. G. Toukmanian & D. L. Rennie (Eds.), Psychotherapy process Research: Paradigmatic and Narrative Approaches. London: Sage Publications.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stuart.

Fong, M.L., Borders, L.D., Ethington, C.A., & Pitts, J.H. (1997). Becoming a counselor: A longitudinal study of student cognitive development. *Counselor Education and Supervision, 37*, 100-114.

Fleiss, J. L. (1981). Balanced incomplete block designs for inter-rater reliability studies. *Applied Psychological Measurement, 5*, 105-112.

Frank, J. D. (1973). *Persuasion and healing: A comparative study of psychotherapy.* Baltimore: Johns Hopkins University Press.

Frank, J. D., Hoehn-Saric, R., Imber, S. D., Liberman, b. L., & Stone, A. R. (1978). *Effective ingredients of successful psychotherapy.* New York: Brunner/Mazel.

Frey, W. H. II (1985). Crying. The mystery of tears. USA: Winston.

Gazzola, N. (2001). Therapist interpretations and client change: An investigation of process in non-dynamic psychotherapies. Unpublished Doctoral Dissertation, Department of Educational and Counselling Psychology, McGill University, Montreal, Canada.

Gelso, C. J., Hill, C. E., Mohr, J. J., Rochlen, A. B., & Zack, J. (1999). Describing the face of transference: Psychodynamic therapists' recollections about transference in cases of successful long-term therapy. *Journal of Counseling Psychology, 46*, 257-267.

Glasser, B., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. Hawthorne, NY: Aldine de Gruyter.

Gomes-Swartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology, 46,* 1023-1035.

Gomes-Swartz, B., & Swartz, J. M. (1978). Psychotherapy process variables distinguishing the "inherently helpful" person from the professional psychotherapist. *Journal of Consulting and Clinical Psychology, 46*, 196-197.

Greenacre, B. (1965). On the development and function of tears. *Psychoanalytic Study of the Child, 20*, 249-259.

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

Greenberg, L. S. (1994). The investigation of change: Its measurement and explanation. In R. L. Russell, (Ed.), *Reassessing psychotherapy research* (pp.114-143). New York: Guilford.

Greenberg, L. S. (1999). Ideal Psychotherapy Research: A Study of Significant Change Processes. *Journal of Clinical Psychology, 55*, 1467-1480.

Greenberg, L.S. & Paivio, S. C. (1997). *Working with Emotions in Psychotherapy*. New York: Guilford.

Greenberg L. S. & Pascual-Leone, J. (1997). Emotion in the creation of personal meaning. In M. Power & C. R. Brewin (Eds), *The Transformation of Meaning in Psychological Therapies.* (pp. 157-173). New York: John Wiley & Sons.

Greenberg, L.S., Rice, L.N., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process.* New York: Guilford.

Greenberg, L.S. & Safran, J. D. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research, 8*, 559-578.

Greenberg, L.S. & Safran, J. D. (1987). *Emotion in Psychotherapy*. New York: Guilford.

Greenberg, L.S. & Safran, J. D. (1989). Emotion in Psychotherapy. *American Psychologist, 44*, 19-29.

Greenberg, L.S. & Sarkissian, G. M. (1984). Evaluation of counselor training in gestalt methods. *Counselor Education and Supervision, 23,* 328-340.

Greenson, R. (1967). *The techniques and practice of psychoanalysis*. New York: International University Press.

Hackney, H., & Cormier, S. (1996). *The Professional Counselor. A Process guide to Helping*, 3rd Ed., Boston, MA: Allyn & Bacon.

Hackney, H., & Cormier, S. (1993). *Counseling Strategies and Interventions*, 4th Ed., Boston, MA: Allyn & Bacon.

Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology, 45*, 468-482.

Heilbrunn, G. (1955). On weeping. *Psychoanalytic Quarterly, 24*, 245-255.

Henry, W. P., Butler, S. F., Strupp, H. H., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61*, 434-440.

Henry, W. P., Schacht, T. E., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Mediators of therapists' responses to training. *Journal of Consulting and Clinical Psychology, 61*, 441-447.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential

psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology, 54*, 27-31.

Henry, W. P., & Strupp, H. H. (1994). The Therapeutic alliance as interpersonal process. In A. O. Horvath & L. S., Greenberg (Eds.), *The Working Alliance: Theory, Research, and Practice*. New York: John Wiley & sons.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology, 83*, 97-111.

Heppner, P. P., Kivlighan, D. M., Jr., & Wampold, B. E. (1999). *Research design in Counseling*. Pacific Grove, CA: Brooks/Cole.

Hiebert, B., Uhlemann, M.R., Marshall, A., & Lee, D.Y. (1998). The relationship between self-talk, anxiety, and counselling skill. *Canadian Journal of Counselling, 32*, 163-171.

Hill, C. E. (1975). Sex of client and sex and experience level of counselor. *Journal of Counseling Psychology, 22*, 6-11.

Hill, C. E. (1978). The development of a system for classifying counselor responses. *Journal of Counseling Psychology, 25*, 461-468.

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

Hill, C. E. (1985). *Manual of Counselor Verbal Response Modes Category System* (rev. version). Unpublished manuscript, University of Maryland, College Park.

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., Charles, D, & Reed, K.G. (1981). A longitudinal analysis of changes in counseling skills during doctoral training in counseling psychology. *Journal of Counseling Psychology, 28*, 428-436.

Hill, C. E., Corbett, M. M., Kanitz, B., Rios, P., Lightsey, R., & Gomez, M. (1992). Client behavior in counseling and therapy sessions: Development of a pantheoretical measure. *Journal of Counseling Psychology, 39*, 539-549.

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., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 207-217.

Hill. C. E., Nutt-Williams, E., & Thompson, B. J. (1997). A rejoinder to Stiles', Hoshmands', and Tinsley's comments about "A *Guide to Conducting Consensual Qualitative Research". The* Counseling Psychologist, 25, 5606-5614.

Hill. C. E., & O'Brien (1999). *Helping skills: Facilitating Exploration, Insight, and Action.* Washington, DC: American Psychological Association.

Hill, C. E., & O' Grady, K. G. (1985). List of therapist intentions illustrated in a case study and with therapists of varying theoretical orientations. *Journal of Counseling Psychology, 32*, 3-22.

Hill, C. E., O' Grady, K. G., & Price, P. (1988). A method for investigating sources of rater bias. *Journal of Counseling Psychology, 35*, 346-350.

Hill, C.E., Thompson, B.J., & Nutt-Williams, E. (1997). A guide to conducting Consensual Qualitative Research. *The Counseling Psychologist, 25*, 517-572.

Hill, C.E., Zack, J. C., Wonnell, T. L., Hoffman, M. A., Rochlen, A. B., Goldberg, J. L., Nakayama, E. Y., Heaton, K. J., Kelly, F. A., Eiche, K., Tomlinson, M. J., & Hess, S. (2000). Structured brief therapy with a focus on dreams or loss for clients with troubling dreams and recent loss. *Journal of Counseling Psychology, 47*, 90-101.

Holloway, E. L. (1992). Supervision: A way of teaching and learning. In S. D. Brown & R. W. Lent (Eds.), *Handbook of Counseling Psychology*, (2nd ed.), (pp.177-214). NY: John Wiley & Sons.

Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Springfield, IL: Charles C Thomas.

Iwakabe, S. (2000). *The relationship between Client Emotional Expression and the Working Alliance: An Exploration of Emotional Expression Episodes*. Unpublished Doctoral Dissertation, Department of Educational and Counselling Psychology, McGill University, Montreal, Canada.

Iwakabe, S., Rogan, K., & Stalikas, A. (2000). The relationship between client emotional expressions, therapist interventions, and the working alliance: An exploration of eight emotional expression events. *Journal of Psychotherapy Integration, 10*, 375-401.

Janov, A. (1970). *The primal scream*. New York: Dell.

Johnson, E., Baker, S. B., Kopala, M., Kiselica, M. S., & Thompson, E. C. (1989). Counseling self-efficacy and counseling competence in prepracticum training. *Counselor Education and Supervision, 28* (3), 205-218.

Kagan, N. (1984). Interpersonal process recall: Basic methods and recent research. In D. Larson (Ed.), *Teaching psychological skills: Models for giving psychology away* (pp.229-244). Monterey, CA: Brooks/Cole.

Kagan, N., Krathwohl, D. R., & Miller, R. (1963). Stimulated recall in therapy using videotape: A case study. Journal of Counseling Psychology, 10, 237-243.

Kennedy-Moore, E., & Watson, J.C. (1999). *Expressing Emotion: Myths, Realities, and Therapeutic Strategies*. New York: The Guilford Press.

Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin, 65*, 110-136.

Kiesler, D. J. (1973). *The process of psychotherapy; empirical foundations and systems of analysis*. Chicago: Aldine.

Kingsley, M. C. & Wooster, A.D. (1987). Crying in the Counselling Situation. *British Journal of Guidance and Counselling, 15*, 125-130.

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

Kivlighan, D. M., Patton, M.J., & Foote, D. (1998). Moderating effects on client attachment on the counselor experience-working alliance relationship. *Journal of Counseling Psychology, 45*, 274-278.

Koch, S. (1976). Language communities, search cells, and the psychological studies. In W. J. Arnold (Ed.), *Nebraska Symposium on Motivation*, 1975 (vol. 23). Lincoln: University of Nebraska Press.

Kosmicki, F. X., Glickauf-Hughes, C. (1997). Catharsis in psychotherapy. *Psychotherapy, 34*, 154-159.

Kottler, J. A. (1996). *The language of tears*. San Francisco: Jossey-Bass.

Labott, S. M., & Martin, R. B. (1988). Weeping: Evidence for a cognitive theory. *Motivation and Emotion, 12*, 205-216.

Labott, S. M., & Martin, R. B. (1987). The Stress-moderating Effects of Weeping and Humor. *Journal of Human Stress, 13*, 159-164.

Labott, S. M., Elliott, R., & Eason, P. S. (1992). "If You Love Someone, You Don't Hurt Them": A Comprehensive process Analysis of a Weeping Event in Therapy. *Psychiatry, 55*, 49-61.

Ladany, N., Constantine, M. G., Miller, K., Erickson, C. D., & Muse-Burke, J. L. (2000). Supervisor countertransference: A qualitative investigation into its identification and description. *Journal of Counseling Psychology, 47*, 102-115.

Larson, L.M., & Daniels, J.A. (1998). Review of the Counseling Self-Efficacy Literature. *The Counseling Psychologist, 26*, 179-218.

Larson, L.M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology, 39,* 105-120.

Leach, M. M., Stoltenberg, C. D., McNeil, B. W., & Eichenfield, G. A. (1997). Self-efficacy and counselor development: Testing the integrated developmental model. *Counselor Education and Supervision, 37*, 115-124.

Lofgren, L. (1966). On Weeping. *International Journal of Psychoanalysis, 47*, 345-383.

Mackay, H. C., Barkham, M., & Stiles, W. B. (1998). Staying with the feeling: An anger event in psychodynamic-interpersonal therapy. *Journal of Counseling Psychology, 45*, 279-289.

Mackewn, J. (1997). *Developing Gestalt Counselling: A field theoretical and relational model of contemporary Gestalt counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Mahoney, M. J. (1991). *Human Change processes: The Scientific Foundations of Psychotherapy*. USA: Basic Books.

Mahoney, M. J. & Eiseman, S. C. (1989). The object of the dance. In W. Dryden and L. Spurling (Eds), *On becoming a psychotherapist*, 17-32. London: Croom Helm.

Mahrer, A. R., (1988). Discovery-oriented psychotherapy research. *American Psychologist, 43,* 694-702.

Mahrer, A. R., Fairweather, D. R., Passey, S., Gingras, N., & Boulet, D. B. (1999). The promotion and use of strong feelings in psychotherapy. *Journal of Humanistic Psychology, 39*, 35-53.

Mahrer, A. R., Gagnon, R., Fairweather, D. R., & Cote, P. (1992). How to determine if a session is a very good one. *Journal of Integrative and Eclectic Psychotherapy*, 11, 4-7.

Mahrer, A. R., & Nadler, W. P. (1986). Good Moments in Psychotherapy: A Preliminary Review, a List, and Some promising Research Avenues. *Journal of Consulting and Clinical Psychology, 54*, 10-15.

Mallinckrodt, B., & Nelson, M.L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology, 38*, 133-138.

Martin, J. (1990). Confusions in psychological skills training. *Journal of Counseling and Development, 68*, 402-407.

Martin, J. (1991). The perils of "process talk" in counseling and counselor education. *Counseling Psychologist, 9*, 260-272.

Matarazzo, R. G., & Garner, A. M. (1992). Research on training for psychotherapy. In D. K. Freedheim, H. J. Freudenberger, J. W. Kessler, S. B. Messer, D. R. Petevsm, H. H. Strupp, & P. L. Wachtel (Eds.), *History of Psychotherapy: A century of change* (pp. 850-877). Washingthon, DC: American Psychological Association.

Matarazzo, R. G., Wiens, A.N., & Saslow, G. (1966). Experimentation in the teaching and learning of psychotherapy skills. In L.A. Gottschalk & A. Auerbach (Eds.), *Methods of research in psychotherapy* (pp.597-635). New York: Appleton-Century-Crofts.

McLeod, J. (1994). *Doing Counselling Research*. London: Sage.

McNeill, B.W., Stoltenberg, C.D., & Pierce, R.A. (1985). Supervisees' Perceptions of Their Development: A Test of the Counselor Complexity Model. *Journal of Counseling Psychology, 32*, 630-633.

Mintz, J., & Kiesler, D. J. (1982). Individual measures of psychotherapy outcome. In P.C. Kendall, & J. N. Butcher (Eds.), *Handbook of research methods in clinical psychology*, (pp.491-534). New York: Wiley.

Nichols, M. P., & Zax, M. (1977). *Catharsis in Psychotherapy*. New York: Gardner.

Nutt Williams, E., Judge, A.B., Hill, C., & Hoffman, M.A. (1997). Experiences of novice therapists in prepracticum: trainees', clients', and supervisors' perceptions of therapists' personal reactions and management strategies. *Journal of Counseling Psychology, 44*, 390-399.

O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology, 51*, 581-586.

Ogles, B.M., Anderson, T., & Lunnen, K.M (1999). The contribution of models and techniques to therapeutic efficacy: Contradictions between professional trends and clinical research. In M.A.Hubble, B.L.Duncan, & S.D.Miller (Eds.), *The heart & soul of change: what works in therapy* (pp.201-225). Washington, DC: American psychological Association.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving "Unfinished Business": Efficacy of Experiential Therapy Using Empty Chair Dialogue. *Journal of Consulting and Clinical Psychology, 63*, 419-425.

Patterson, C. H. (1974). Humanistic education: The challenge to the counsellor. *British Journal of Guidance and Counselling, 2*, 2-14.

Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status* (pp.29-62). New York: McGraw-Hill.

Perls, F., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy*. New York: Dell.

Pierce, R.A., Nichols, M.P., & DuBrin, J.R. (1983). *Emotional Expression in Psychotherapy*. New York: Gardner.

Puzner, K. (1988). Psychoanalysis as therapeutic crisis induction: Affect and emotion as a prerequisite of radical change. *Psychopathology, 21,* 143-148.

Reich, W. (1949). *Selected Writings*. New York: Noonday.

Reich, W. (1960). *Character-Analysis*. New York: Noonday.

Rennie, D. L., & Toukmanian, S. G. (1992). Explanations in psychotherapy process research. In S. G. Toukmanian, & D. L. Rennie (Eds.), *Psychotherapy Process Research: Paradigmatic and narrative approaches* (pp. 234-251). Newbury Park, CA: Sage.

Rhodes, R. H., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology, 41, 473-483.*

Rice, L. N., & Greenberg, L. S. (1984). The new research paradigm. In L. N. Rice, & L. S. Greenberg (Eds.) *Patterns of Change Intensive Analysis of Psychotherapy Process*. New York: Guilford.

Rogers, C.R. (1942). *Counseling and Psychotherapy. Newer concepts in practice.* Massachusetts: Houghton Mifflin.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

Rogers, C.R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton-Mifflin.

Rogers, C., Gendlin, E., Kiesler, D., & Truax, C. (1967). *The therapeutic relationship and its impact*. Madison: University of Wisconsin Press.

Rousanville, B. J., Chevron, E. S., Prusoff, B. A., Elkin, I., Imber, S., Sotsky, S., & Watkins, J. (1987). The relation between specific and general dimensions of the psychotherapy process in interpersonal psychotherapy of depression. *Journal of Consulting and Clinical Psychology, 55*, 379-384.

Russell, R. K., Crimmings, A. M., & Lent, R. W. (1984). Counselor training and supervision: Theory and research. In S. D. Brown & R. W. Lent (Eds.), *Handbook of Counseling Psychology* (1st ed.), p. 625-681. New York: John Wiley & sons.

Sipps, G. J., Sugden, G. J., & Favier, C. M. (1988). Counselor training level and verbal response type: Their relationship to efficacy and outcome expectations. *Journal of Counseling Psychology, 35*, 397-401.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Stein, D. M., & Lambert, M. J. (1984). On the relationship between therapist experience and psychotherapy outcome. *Clinical Psychotherapy Review, 4*, 1-16

Stein, D. M., & Lambert, M. J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, 63*, 182-196.

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

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychological Review, 13*, 593-618.

Stiles, W. B. (1997). Consensual qualitative research: Some cautions. *The Counseling Psychologist, 25*, 586-598.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The Counselor Complexity Model. *Journal of Counseling Psychology, 28*, 59-65.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strupp, H. H., Butler, S. F., & Rosser, C. L. (1988). Training in Psychodynamic Therapy. *Journal of Consulting and Clinical Psychology, 56*, 689-695.

Strupp, H. H., Hartley, D., & Blackwood, G. L., Jr. (1974). *Vanderbilt Psychotherapy Process* Scale. Unpublished manuscript, Vanderbilt University.

Suh, C. S., O'Malley, S. S., Strupp, H. H., & Johnson, M. E. (1989). The Vanderbilt Psychotherapy Process Scale (VPPS). *Journal of Cognitive Psychotherapy: An International Quarterly, 3*, 123-154.

Suh, C. S., Strupp, H. H., & O'Malley, S. S. (1986). The Vanderbilt Process Measures: The Psychotherapy Process Scale (VPPS) and the Negative Indicators Scale (VNIS). In L. S. Greenberg, & W. M. Pinsof (Eds.), *The Psychotherapeutic Process: A Research Handbook*, (pp.285-323). New York: Guilford.

Thompson, A. (1986). Changes in counseling skills during graduate and undergraduate study. *Journal of Counseling Psychology, 33*, 65-72.

Tinsley, H. E. A., & Weiss, D. J. (1975). Interrater reliability and agreement of subjective judgments. *Journal of Counseling Psychology, 22*, 358-376.

Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy: Training and practice*. Chicago: Aldine.

Toukmanian, S. G., & Rennie, D. L. (1975). Microcounseling versus human relations training: Relative effectiveness with undergraduate trainees. *Journal of Counseling Psychology, 22*, 345-352.

Vingerhoets, Ad J. J. M., Cornelius, R. R., Van Heck, G. L., & Becht, M. C. (2000). Adult Crying: A Model and Review of the Literature. *Review of General Psychology, 4*, 354-377.

Weissmark, M. S., & Giacomo, D. A. (1998). *Doing psychotherapy effectively*. Chicago: University of Chicago press.

Windholz, M. J. & Silberschatz, G. (1988). Vanderbilt Psychotherapy Process Scale: A replication with adult outpatients. *Journal of Consulting and Clinical Psychology, 56*, 56-60.

Wiseman, H., Shefler, G., Caneti, L., & Ronen, Y. (1993). A systematic comparison of two cases in Mann's time-limited psychotherapy: An events approach. *Psychotherapy Research, 3*, 227-244.

Wright, D. B. (1997). Understanding statistics: An introduction for the social sciences. Thousand Oaks, CA: Sage Publications.

Yalom, I. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.). New York: Basic Books.

Appendices

A: McGill Counselling Psychology 1995-1998 course outlines

B: Results of non-parametric analysis of VPPS

C: Detailed explanation of categories yielded by Study II

D: Ethics forms

412-665 - Practicum in Counselling (6 credits)

Fall 1995 - Winter 1996

Instructor: Anastassios Stalikas, Ph.D.

Office: 521

Office Hours: Tuesdays 2-4 p.m., Thursdays 2:30 -4:00 p.m. or by appointment

Calendar Description

Practice in counselling interactions in preparation for internship. Developing expertise and confidence in a full range of skills to help clients make and implement self-directed choice. Emphasis on the counsellor as an educational and therapeutic agent dealing with vocational, educational, and personal counselling using various intervention modes.

Aims

The aim of this two-semester course is to provide students with an introduction to the basic concepts and techniques of the major approaches to psychological therapeutic interventions.

In the first semester we will concentrate on the logistics of the therapeutic encounter, (such as scheduling appointments and billing), and on the basic listening and counselling skills and techniques (such as paraphrasing, reflecting, open and closed questions and confrontation).

In the second semester we will learn to think, plan and act as counsellors within and across various therapeutic approaches and models, while using confidently and appropriately the techniques and skills acquired in the first semester. The scope of the second part of this course is: (a) introduce you to cognitive-behavioral techniques in counselling, (b) to provide you with further hands-on counselling experience, (c) to give you more supervision and training in effectively using several counselling skills and techniques, (c) to introduce you to specific "advanced" counselling techniques such as flooding, systematic desensitization and focusing, (d) to teach you how to write termination reports,and case summaries, and (e) to acquaint you with couple and family counselling.

Course Goals

-to learn the major techniques used in counselling psychology in a variety of clinical settings.

-to learn the theoretical underpinnings of the aforementioned techniques and the rationale of their therapeutic value.

-to learn those counselling skills that will allow one to initiate, maintain and successfully terminate a counselling session.

-to learn the basic intervention concepts and modalities and their relation to the major approaches to counselling psychology, such as interpretation and dynamic models, behaviour modification and learning theories, experiencing and existential-humanistic approaches, problem-solving and cognitive approaches.

- to learn the practical aspects of counselling from scheduling an appointment to note-taking, file management and billing.

Course Procedure

There are three parts in this course; the one is didactic, the second is applied and the third is experiential/supervisory.

The Didactic Part

During the didactic part I will lecture. My lectures will be partially based on the textbook and partially on other sources including my own clinical experience and practice.

I will lecture on the basic skills and techniques used in counselling psychology and/or on the various theoretical approaches and their positions regarding these skills and techniques. If, at any moment what I say invites you to respond, do so.

In lecturing I will be introducing questions and then I will be answering these questions from one or different perspectives. If you have an answer to the questions I will ask, speak out. Your class-notes will be questions and answers to questions.

In class, talk, ask questions, comment, discuss or argue. Do these from your readings or from your own thoughts, ideas and opinions.

Bring food and drink. Attend every lecture. Be on time. I will include attendance and promptness in your final grade. You are expected to be in class at every lecture.

The textbook for this course is:

Cormier, L.S. & Hackney, H. (1993). The Professional Counsellor: A Process Guide to Helping (2nd Edition) Englewood Cliffs, N.J.,: Prentice Hall.

Other textbooks which are not required but recommended are:

J. Moursund (1993). The Process of Counselling and Therapy Englewood Cliffs, N.J.: Prentice Hall.

Hackney, H., & Cormier, S. (1994). Counselling Strategies and Interventions. Boston: Allyn and Bacon.

Benjamin, A. (1991). The Helping Interview. (2nd Edition). Boston: Houghton Mifflin.

Young, M. E. (1992). Counselling Methods and Techniques. New York: Maxwell Macmillan.

The Applied Part

The applied part of the course deals with skills-training, and techniques-acquisition. To that respect, in this part of the course you will participate in role-playing, complete exercises, discuss the techniques we covered in the didactic part, review video- and audio-tapes of counselling sessions, observe and be observed while you act as a counsellor or as a client. We will review your counselling tapes with your volunteer client. We will watch films and carry on discussions. This applied part will be conducted primarily by Ph.D. Counselling Psychology students who will act as teaching assistants. The class will be divided in five groups and the groups may periodically change T.A. In this way you will be exposed to all five T.As and you will be exposed to different styles of interaction. The five T.As are: Carleen Joseph, Shigeru Iwakabe, Miriam Berkovic, Suzanne Kuchel and Kieron Rogan.

The Experiential/Supervisory Part

This part deals with the application and utilization of the skills you learned in the didactic and rehearsed in the applied part, with a real client. Each student will have the opportunity to work with a client for approximately 20 sessions. You will start your sessions in October and you will terminate in April. The sessions will be videotaped and then in groups of three you will have supervision with a Ph.D. Counselling Psychology student.

Requirements and Grading

There are three parts in your evaluation. The first concerns the actual skills you have learned (didactic part). The second includes a number of assignments (applied part), while the third, addresses your overall performance, perceptiveness, sensitivity, and maturity as a counselling psychologist (experiential part), and includes your attendance, punctuality and participation. The grade you will get will reflect the level of your preparation as a counsellor at three different levels; actual counselling skills, integration of counselling skills and theoretical grounding of counselling skills. A grade of (A) will indicate that you have an excellent grasp of the counselling skills taught, that you can incorporate them, and flexibly use them in a counselling session and that you have an very good understanding of their usefulness and their purpose. A(B) grade will indicate that you have an excellent grasp in two areas but you are somehow weak in the third. Finally a mark of (C) will indicate some serious weaknesses in all three areas. You will be receiving formal and informal feedback during the whole year regarding your performance. If at any moment you feel you need some feedback or that you did not get enough please talk to me or to your T.A. about it.

The numeric value attached to each of the segments (for the 1st semester) has as follows:

Skills Learned	30%
Assignments, Exercises	25%
Overall Perceptiveness, Participation, Attendance, etc	30%
Intake Interview Report	15%

Skills Learned

For this part your evaluation will be based on the amount of expertise, diversity and efficiency that you will acquire during this course, as seen in your video and/or audio tapes of counselling. At the conclusion of the first semester you will provide five segments of counselling sessions. Each segment could be as short as one client and one therapist statement and **not longer** than a five counsellor-client exchanges. These segments could be coming from one or more sessions with the same or different clients. You will have to give me the whole session indicating the segment(s) that you want me to look at accompanied with a typed transcript of the segment(s) as well as, the answers to the following questions:

1. What is/are the techniques or skills that I am applying at this segment?
2. How did it/they work?
3. What could I do to make this/these intervention(s) more efficient?
4. What was the reasoning for choosing this technique at this particular point in the session?

Three of the five segments must be among the best you ever had. They are segments for which you feel proud, delighted and dignified.

The remaining **two** segments have to be the worst you ever had. They are segments in which you were rotten and lost, segments for which you feel embarrassed, humiliated and shameful, segments which you rather die than let someone look at.

Assignments, Exercises

The second part, comprises the process and the level of your skill-acquisition, expertise, choice of techniques, efficiency and efficacy as a counsellor, as it will be demonstrated in your home and class assignments and exercises. The purpose of the assignments is to evaluate how well you understand the readings, how well you can apply the skills taught, and how well you can evaluate the therapeutic encounter. As such, the assignments will be constituted of 2-3 practical problem-type questions based on the material covered in the textbooks and in the classroom. They may include topics such as, non-verbal behaviour, the role of strength of feeling in the therapeutic encounter, paraphrasing versus reflecting, or the role of confrontation in Gestalt therapy. The assignments are to be typed, double spaced and no longer than 2-4 pages. No bibliography or references is required. You are to hand in your assignments at a particular time, as it is indicated in the syllabus. I will not accept assignments overdue. The assignments will be collected and corrected by the T.As.

Participation

This part of the evaluation aims in assessing your process of learning and your active effort to learn and understand the way counselling works. That is, your ability to choose the right intervention at the right time, your ability to theoretically connect each technique or skill with its therapeutic efficiency and its theoretical roots and value, and your overall participation. This evaluation will be done through your participation in the class, and through your encounters with your clients and colleagues. Your overall readiness as counsellor, and more specifically the degree to which you have mastered the major listening

and counselling techniques taught during the semester will determine your mark. In addition, your adherence to deadlines, your professional conduct, your attendance and punctuality are also included in that part of the evaluation. This part of the evaluation is done partly by me and partly by the Teaching Assistants.

Intake Interview Report (IIR)

The IIR is your clinical observations, impressions and judgements about the client based on your assessment which may have lasted one or several sessions. You should include : a) behavioral observations (dress, verbal non-verbal behaviour, overall behaviour of the client during the session), b) life history including family, relationships, work, studies and significant others, c) the presenting problem, d) short-term and long term goals of counselling, and e) your tentative hypothesis(-ses), possible diagnosis and plan of action (i.e. key issues to be addressed, explored and other interventions you may deem necessary).

Syllabus

Fall Semester 1995

Date	Topic	Chapter	Assignments
Sept. 11	Introduction, Case planning Scheduling Appointments Recording the interview	Cormier #1	
Sept. 18	Genuiness, Empathy Unconditional positive regard	Cormier #2,3 Classnotes	
Sept. 25	Rapport & Relationship Intake report writing	Cormier #2,3,4	Ass. #1 handed out
Oct. 02	Listening, following, probing	Cormier #2, 6	Ass. #2 handed out
	Paraphrasing, Reflecting,	Cormier #3, 5, 10	Ass. #1 due Ass. #3 handed out
Oct. 09	Thanksgiving - no class		
Oct. 16	Open and closed Questions Confronting	Cormier #4	Ass. #2 due Ass. #4 handed out
Oct. 23	Interpreting	classnotes	Ass. #3 due Ass. #5 handed out
Oct. 30	Affective Strategies Dealing with emotions	Cormier #7	Ass. #4 due Ass #6 handed out
Nov. 06	Affective Strategies Focusing, Flooding	Cormier #7	Ass. #5 due Ass. #7 handed out
Nov. 13	Affective Strategies Heightening Emotional Arousal	Cormier #7	Ass. #6 due
Nov. 20	Cognitive Strategies	Cormier #8	Ass. #7 due
Nov. 27	In case we are behind		
Dec. 04	In case we are behind		Intake report due
Dec. 11	In case we are behind		

Winter Semester 1996

Date	Topic	Chapter	Important Dates
January 8	Cognitive Strategies Case planning	Cormier #8	
January 15	Cognitive Strategies	Cormier #8	Ass #8 handed out
January 22	Cognitive Strategies	Cormier #8	Ass. #9 ass. handed out
January 29	Systematic Desensitization	Cormier #8	Ass. #8 due
February 5	Behavioral Strategies	Cormier #9	Ass. #10 handed out Ass. #9 due
February 12	Behavioral Strategies	Cormier #9	Ass. #11 handed out
	Paradoxical Interventions	Cormier #8	
February 19	Mid-Term Break		
February 26	Stress management	Cormier #9	Ass. #12 handed out Ass. #10 due
March 4	Termination issues	Cormier #11	Ass. #13 handed out Ass. #11 due
March 11	Terminating, case summary	Cormier #11	Ass. #14 handed out Ass. #12 due
March 18	Couple Therapy	Cormier #10	Ass. #13 due
March 25	Couple and Family Therapy	Cormier #10	Ass. #14 due
April 1	in case we are behind		Progress notes, Case Summary, Skills Learnt due

Nota Benne

1 This syllabus is provisional. While we will cover all the aforementioned topics, the actual dates or the time that we will spend for each of the topics may vary according to the needs of the class.

2 When I teach I mix up the genders. I sometimes say "he" and sometimes "she", especially when I give examples, and refer to possible implications of one thing or another. This is so because I have in mind a particular client or therapist or theorist. I am not trying to be sexist, nonsexist, politically correct or incorrect. When I give examples in order to make a point, or make something clear I use persons present in my everyday life such as friends, parents, relatives, students, and professors. When I do this, my purpose is to reflect what I have in mind and to address the issue at hand. I am not attempting to be critical, friendly, despiteful, mean, or antagonistic to these persons.

3 When I teach, especially when I use clinical examples and verbatim expressions of clients, counsellors and other I may use graphic and explicit language. This is so you get sensistized to real issues with real people in the real world. By no means it should be seen as an adoption of this language or these behaviours as acceptable, moral, ethical, normal etc. I try and keep my personal views outside my classroom. Yet, if anything that happens in class make you feel uncomfortable talk to me. We may find alternative ways to accommodate your sensitivities, belief system, and convictions with the material taught.

4 There is a fee (non refundable) for the preparation of stickers to go on your tapes and for a key. The tapes are available from the Media Centre, located on the 1st floor of the Education Building, next to the Library. You need to see Selma Abu-Merhy (Rm 513) to pay $15.00 (non-refundable) in order to get your key to the file cabinet where the tapes are stored. Please bring checks, no cash, payable to McGill University. You will have to buy the tapes for your recordings.

5 You will start seeing clients during in the first week of October. Do not erase your first session and take good notes, you will need these for your first assignment of the second semester. I will ask you to write an intake report.

412-665 - Practicum in Counselling

Part I (3 credits)

Fall 1996

Instructors: Anastassios Stalikas, Ph.D. (First semester)
Theodore (Ted) Maroun, Ph.D. (Second semester)

Offices: Anastassios Stalikas, Rm. 521
Ted Maroun, Rm. 520

Office Hours (Anastassios Stalikas): Tuesdays 2-4 p.m., or by appointment
(Ted Maroun): TBA

Calendar Description

Practice in counselling interactions in preparation for internship. Developing expertise and confidence in a full range of skills to help clients make and implement self-directed choice. Emphasis on the counsellor as an educational and therapeutic agent dealing with vocational, educational, and personal counselling using various intervention modes.

Aims

The aim of this two-semester course is to provide students with an introduction to the basic concepts and techniques of the major approaches to psychological therapeutic interventions.

In the first semester, taught by Prof. Stalikas, we will concentrate on the logistics of the therapeutic encounter, (such as scheduling appointments and billing), and on the basic listening and counselling skills and techniques (such as paraphrasing, reflecting, open and closed questions and confrontation).

In the second semester, taught by Prof. Maroun, we will learn to think, plan and act as counsellors within and across various therapeutic approaches and models, while using confidently and appropriately the techniques and skills acquired in the first semester. The scope of the second part of this course is: (a) introduce you to cognitive-behavioural techniques in counselling, (b) to provide you with further hands-on counselling experience, (c) to give you more supervision and training in effectively using several counselling skills and techniques, (c) to introduce you to specific "advanced" counselling techniques such as flooding, systematic desensitization and focusing, (d) to teach you how to write termination reports, and case summaries, and (e) to acquaint you with couple and family counselling.

Course Goals

-to learn the major techniques used in counselling psychology in a variety of clinical settings.

-to learn the theoretical underpinnings of the aforementioned techniques and the rationale of their therapeutic value.

-to learn those counselling skills that will allow one to initiate, maintain and successfully terminate a counselling session.

-to learn the basic intervention concepts and modalities and their relation to the major approaches to counselling psychology, such as interpretation and dynamic models, behaviour modification and learning theories, experiencing and existential-humanistic approaches, problem-solving and cognitive approaches.

- to learn the practical aspects of counselling from scheduling an appointment to note-taking, file management and billing.

Course Procedure

There are three parts in this course; the one is didactic, the second is applied and the third is experiential/supervisory.

The Didactic Part (This part applies only to the 1st semester, Prof. Maroun will provide you a complete outline in January)

During the didactic part I will lecture. My lectures will be partially based on the textbook and partially on other sources including my own clinical experience and practice.

I will lecture on the basic skills and techniques used in counselling psychology and/or on the various theoretical approaches and their positions regarding these skills and techniques. If, at any moment what I say invites you to respond, do so.

In lecturing I will be introducing questions and then I will be answering these questions from one or different perspectives. If you have an answer to the questions I will ask, speak out. Your class-notes will be questions and answers to questions.

In class, talk, ask questions, comment, discuss or argue. Do these from your readings or from your own thoughts, ideas and opinions.

Bring food and drink. Attend every lecture. Be on time. I will include attendance and promptness in your final grade. You are expected to be in class at every lecture.

The textbook for this course is:

Cormier, L.S. & Hackney, H. (1996). The Professional Counsellor: A Process Guide to Helping (3nd Edition) Englewood Cliffs, N.J.,: Prentice Hall.

Other textbooks which are not required but recommended are:

J. Moursund (1993). The Process of Counselling and Therapy Englewood Cliffs, N.J.: Prentice Hall.

Hackney, H., & Cormier, S. (1994). Counselling Strategies and Interventions. Boston: Allyn and Bacon.

Benjamin, A. (1991). The Helping Interview. (2nd Edition). Boston: Houghton

Mifflin.

Young, M. E. (1992). Counselling Methods and Techniques. New York: Maxwell Macmillan.

The Applied Part (Applies to both semesters)

The applied part of the course deals with skills-training, and techniques-acquisition. To that respect, in this part of the course you will participate in role-playing, complete exercises, discuss the techniques we covered in the didactic part, review video- and audio-tapes of counselling sessions, observe and be observed while you act as a counsellor or as a client. We will review your counselling tapes with your volunteer client. We will watch films and carry on discussions. This applied part will be conducted primarily by Ph.D. Counselling Psychology students who will act as teaching assistants. The class will be divided in groups and the groups may periodically change T.A. In this way you will be exposed to all T.As and you will be exposed to different styles of interaction. The T.As are:

The Experiential/Supervisory Part (applies to both semesters)

This part deals with the application and utilization of the skills you learned in the didactic and rehearsed in the applied part, with a real client. Each student will have the opportunity to work with a client for approximately 20 sessions. You will start your sessions in October and you will terminate in April. The sessions will be videotaped and then in groups of three you will have supervision with a Ph.D. Counselling Psychology student.

Requirements and Grading (First semester only)

There are three parts in your evaluation. The first concerns the actual skills you have learned (didactic part). The second includes a number of assignments (applied part), while the third, addresses your overall performance, perceptiveness, sensitivity, and maturity as a counselling psychologist (experiential part), and includes your attendance, punctuality and participation. The grade you will get will reflect the level of your preparation as a counsellor at three different levels; actual counselling skills, integration of counselling skills and theoretical grounding of counselling skills. A grade of (A) will indicate that you have an excellent grasp of the counselling skills taught, that you can incorporate them, and flexibly use them in a counselling session and that you have an very good understanding of their usefulness and their purpose. A(B) grade will indicate that you have an excellent grasp in two areas but you are somehow weak in the third. Finally a mark of (C) will indicate some serious weaknesses in all three areas.

You will be receiving formal and informal feedback during the whole year regarding your performance. If at any moment you feel you need some feedback or that you did not get enough please talk to me or to your T.A. about it. This is a graduate course and you are expected to be proactive rather than reactive. In that sense, do not expect things to happen but make them happen. Any issue, difficulty or question you may have, along with suggestions, new ideas, and propositions please bring them forward so we can discuss them.

The numeric value attached to each of the segments (for the 1st semester) has as follows:

Skills Learned..... 30%
Assignments, Exercises.....25%
Overall Perceptiveness, Participation, Attendance, etc.....30%
Intake Interview Report.....15%

Skills Learned (First semester only).

For this part your evaluation will be based on the amount of expertise, diversity and efficiency that you will acquire during this course, as seen in your video and/or audio tapes of counselling. At the conclusion of the first semester you will provide five segments of counselling sessions. Each segment could be as short as one client and one therapist statement and **not longer** than a five counsellor-client exchanges. These segments could be coming from one or more sessions with the same or different clients. You will have to give me the whole session indicating the segment(s) that you want me to look at accompanied with a typed transcript of the segment(s) as well as, the answers to the following questions:

1. What is/are the techniques or skills that I am applying at this segment?
2. How did it/they work?
3. What could I do to make this/these intervention(s) more efficient?
4. What was the reasoning for choosing this technique at this particular point in the session?

Three of the five segments must be among the best you ever had. They are segments for which you feel proud delighted and dignified.

The remaining **two** segments have to be the worst you ever had. They are segments in which you were rotten and lost, segments for which you feel embarrassed, humiliated and shameful, segments which you rather die than let someone look at.

Assignments, Exercises (First semester only)

The second part, comprises the process and the level of your skill-acquisition, expertise, choice of techniques, efficiency and efficacy as a counsellor, as it will be demonstrated in your home and class assignments and exercises. The purpose of the assignments is to evaluate how well you understand the readings, how well you can apply the skills taught, and how well you can evaluate the therapeutic encounter. As such, the assignments will be constituted of 2-3 practical problem-type questions based on the material covered in the textbooks and in the classroom. They may include topics such as, non-verbal behaviour, the role of strength of feeling in the therapeutic encounter, paraphrasing versus reflecting, or the role of confrontation in Gestalt therapy. The assignments are to be typed, double spaced and no longer than 2-4 pages. No bibliography or references is required. You are to hand in your assignments at a particular time, as it is indicated in the syllabus. I will not accept assignments overdue. The assignments will be collected and corrected by the T.As.

Participation (First semester only)

This part of the evaluation aims in assessing your process of learning and your active

effort to learn and understand the way counselling works. That is, your ability to choose the right intervention at the right time, your ability to theoretically connect each technique or skill with its therapeutic efficiency and its theoretical roots and value, and your overall participation. This evaluation will be done through your participation in the class, and through your encounters with your clients and colleagues. Your overall readiness as counsellor, and more specifically the degree to which you have mastered the major listening and counselling techniques taught during the semester will determine your mark. In addition, your adherence to deadlines, your professional conduct, your attendance and punctuality are also included in that part of the evaluation. This part of the evaluation is done partly by me and partly by the Teaching Assistants.

Intake Interview Report (IIR) **(First semester only)**

The IIR is your clinical observations, impressions and judgements about the client based on your assessment which may have lasted one or several sessions. You should include a) behavioural observations (dress, verbal non-verbal behaviour, overall behaviour of the client during the session), b) life history including family, relationships, work, studies and significant others, c) the presenting problem, d) short-term and long-term goals of counselling, and e) your tentative hypothesis(-ses), possible diagnosis and plan of action (i.e. key issues to be addressed, explored and other interventions you may deem necessary).

Syllabus

Fall Semester 1996

Date	Topic	Chapter	Assignments
Sept. 09	Introduction, Case planning Scheduling Appointments Recording the interview	Cormier #1	
Sept. 16	Genuiness, Empathy Unconditional positive regard	Cormier #2,3 Classnotes	
Sept. 23	Rapport & Relationship Intake report writing	Cormier #2,3,4	Ass. #1 handed out
Sept. 30	Listening, following, probing Paraphrasing, Reflecting,	Cormier #2, 6 Cormier #3, 5, 10	Ass. #2 handed out Ass. #1 due Ass. #3 handed out
Oct. 07	Open and closed Questions Confronting	Cormier #4	Ass. #2 due Ass. #4 handed out
Oct. 14	Thanksgiving - no class		
Oct. 21	Interpreting	classnotes	Ass. #3 due Ass. #5 handed out
Oct. 28	Affective Strategies Dealing with emotions	Cormier #7	Ass. #4 due Ass #6 handed out
Nov. 04	Affective Strategies Focusing, Flooding	Cormier #7	Ass. #5 due Ass. #7 handed out
Nov. 11	Affective Strategies Heightening Emotional Arousal	Cormier #7	Ass. #6 due
Nov. 18	Cognitive Strategies	Cormier #8	Ass. #7 due
Nov. 25	In case we are behind		
Dec. 02	In case we are behind		Intake report due
Dec. 09	In case we are behind		

Nota Benne

1 This syllabus is provisional. While we will cover all the aforementioned topics, the actual dates or the time that we will spend for each of the topics may vary according to the needs of the class.

2 When I teach I mix up the genders. I sometimes say "he" and sometimes "she", especially when I give examples, and refer to possible implications of one thing or another. This is so because I have in mind a particular client or therapist or theorist. I am not trying to be sexist, nonsexist, politically correct or incorrect. When I give examples in order to make a point, or make something clear I use persons present in my everyday life such as friends, parents, relatives, students, and professors. When I do this, my purpose is to reflect what I have in mind and to address the issue at hand. I am not attempting to be critical, friendly, despiteful, mean, or antagonistic to these persons.

3. When I teach, especially when I use clinical examples and verbatim expressions of clients, counsellors and other I may use graphic and explicit language. This is so you get sensistized to real issues with real people in the real world. By no means it should be seen as an adoption of this language or these behaviours as acceptable, moral, ethical, normal etc. I try and keep my personal views outside my classroom. Yet, if anything that happens in class make you feel uncomfortable talk to me. We may find alternative ways to accommodate your sensitivities, belief system, and convictions with the material taught.

4 There is a fee (non refundable) for the preparation of stickers to go on your tapes and for a key. The tapes are available from the Media Centre, located on the 1st floor of the Education Building, next to the Library. You need to see Selma Abu-Merhy (Rm 513) to pay $15.00 (non-refundable) in order to get your key to the file cabinet where the tapes are stored. Please bring checks, no cash, payable to McGill University. You will have to buy the tapes for your recordings.

5. You will start seeing clients during in the first week of October. Do not erase your first session and take good notes, you will need these for your first assignment of the second semester. I will ask you to write an intake report.

PRACTICUM IN COUNSELING
412-665B

Instructor: *Prof. Ted Maroun* Winter, 1997

Refinement of the basic attending skills and relationship building techniques begun in the first semester will be continued. As well, the philosophical and theoretical underpinnings of the counseling process, counselling strategies, techniques and case management, including diagnostic and prognostic issues will continue to be developed and refined. Emphasis during the winter term will be on the development of your personal approach to counseling. That is, a synthesis and integration of the basic intervention techniques/strategies and their relation to the major approaches to counselling and psychotherapy such as problem solving and cognitive approaches, behaviour modification and learning theories, experiencing and humanistic-existential approaches, interpretation and the dynamic models. In conjunction with the development of your "personal approach to counseling", inclusion of various skill training methodologies, observation and demonstration exercises, role playing, etc., will be utilized and augmented with video and audio tapes where appropriate.

The course for the winter term will be comprised of lecture/discussion and the applied clinical portion.

Lecture / Discussion

Material for the lecture will be based on the textbook, journal articles and my own clinical experience and practice.

You are invited to discuss and share your reasoned opinions as class participation means active participation in class activities - be it class discussion, skill exercises, skill practice, role playing, case review, etc. The best way to be prepared is to read and be familiar with the assigned materials, so that class time can be utilized for an evaluation of rather than a review of assigned readings.

Applied / Clinical

This portion of the course is devoted to skills training and the acquisition of appropriate clinical strategies and techniques. Necessarily, this involves your active participation in role playing and observations of role played episodes - either as the counselor or as the client.

Tape review of your counseling tapes as well as audio tapes and films will be shown and discussed.

Course Requirements and Grading

There are three (3) parts to your evaluation. The first concerns the actual skills you have learned. The second part includes the development of your personal approach to counseling, and the completion of a client termination report. The third part of your evaluation, addresses your overall perceptiveness, sensitivity, and maturity as counselors, and includes your attendance, punctuality and participation.

The numeric value attached to each of the three segments is as follows:

Skills learned	30 %
Creative synthesis: Personal counseling approach	30 %
Termination Report	15 %
Overall perceptiveness, participation, attendance, etc.	25 %

Skills Learned

For this part your evaluation will be based on the amount of expertise, diversity and effectiveness that you will acquire during this course, as seen in your video and/or audio tapes of counseling. At the conclusion of the semester you will provide five segments of counseling sessions. Each segment could be as short as one client and one therapist statement and no longer than a five counselor-client exchange. These segments could be coming from one or more sessions with the same or different clients. You will have to give me the whole session indicating the segment(s) that you want me to look at or listen to, accompanied with a typed transcript of the segment(s) as well as the answers to the following questions:

1. What is / are the techniques or skills that I am applying at this segment?
2. How did it / they work?
3. What could I do to make this/these intervention(s) more effective?
4. What was the reasoning for choosing this technique at this particular point in the session?

The five segments should be reflective of your developing personal approach to counseling and therapy.

Creative Synthesis: Personal Approach to Counseling

The major task for this semester is on the counselor candidate's development of his or her own approach to counseling and therapy. Therefore, a major responsibility of each student will be the development of a personal approach to counselling that reflects his/her unique personality

According to Birks & Stefflere (1979): One's personal theory of counseling can be developed or modified on the basis of a reasoned and critical examination of the best thinking, experience and research by others who have faced counseling problems and have made their answers available for public scrutiny , (p. vii).

Y.our guide in this endeavour will be the "*Creative Synthesis Approach*" advanced by Brammer, Abrego ,& Shostrom, (1993), chapters 1 and 3.

To clarify the term paper assignment, I invite you to carefully read "*The Creative Synthesis Approach*", pages 15 to 21, Brammer et al. (1993).

Please keep in mind that your paper must conform to the 4th Edition, APA Manual, regarding writing style, format and structure, and referencing. ***This paper is due on March 17, 1997*** and **should not exceed 15 pages double-spaced.** *In fact, I stop reading after p. 15!*

Termination Report

A brief (5 pages or less) typewritten, double-spaced summary report of the counselling experience. For specific information regarding the composition and structure of this report please read very carefully The Termination Report in your text Hackney & Cormier (1996) , pp. 290-291. ***This report is due the week of March 31st, 1997 and no later than Noon (12:00 p.m.) Friday, April 4th.***

Please remember to follow the APA Manual (4th Edition) regarding format, structure, writing style and referencing.

Participation

This part of the evaluation (20%) is based on your active effort to learn and understand the way counselling works. That is, your ability to choose the right intervention at the right time, your ability to theoretically connect each technique or skill with its therapeutic effectiveness and its theoretical underpinning. This evaluation will be based on your participation in the class, your in-class exercises and your demonstration of skills in classroom, and through your encounters with your clients and colleagues. Your adherence to deadlines, your professional conduct, your attendance and punctuality are also included in this part of the evaluation.

Syllabus

Jan. 6	Creative Synthesis	Class Material
Jan. 13	Cognitive Strategies	Hackney & Cormier, ch. 8
Jan. 20	Theories and Interventions	Class materials
Jan. 27	Cognitive Strategies	Hackney & Cormier, ch. 8
Feb. 3	Behavioral Interventions	Hackney & Cormier, ch. 9
Feb. 10	Behavioral Strategies	Hackney & Cormier, ch. 9
Feb. 17	Termination & Follow-Up	Hackney & Cormier, ch.
Feb. 24	Mid-Term Break	
March 3	Systemic Theories	Hackney & Cormier, ch. 10
March 10	Systemic Theories	Hackney & Cormier, ch. 10
March 17	Couple Therapy	Class materials
March 24	Crisis Intervention	Hackney & Cormier, ch. 12
March 31	Holiday - Easter Monday	
April 7	Review of Tapes	
April 14	Review of Tapes	

Nota Bene

This syllabus is provisional. While we will cover all the designated topics, the actual dates of the time that we will spend on each of the topics may vary according to the needs of the class.

PRACTICUM IN COUNSELLING
412-665D

Instructors: Profs. Gary Torbit / ANDY HUM Fall: 1997
September 8th. - December 8th., 1997.

COURSE DESCRIPTION (CALENDAR)

"Practice in counselling interactions in preparation for internship. Developing expertise and confidence in a full range of skills to help clients make and implement self-directed choices. Emphasis on counsellor as an educational and therapeutic agent dealing with vocational, education, and personal counselling using various intervention modes."

REQUIRED TEXTBOOK

HACKNEY, HAROLD, L.. (1996) THE PROFESSIONAL COUNSELLOR: A PROCESS GUIDE TO HELPING. 3rd. edition. Allyn & Bacon.

ADDITIONAL REFERENCES

EGAN, ALLEN, E. (1995) THE SKILLED HELPER: A Systematic Approach to Effective Helping. 5th edition. Brooks / Cole Pub. Co..

IVEY, ALLEN, E. (1994) INTENTIONAL INTERVIEWING AND COUNSELLING: Facilitating Client Development In A Multicultural Society. 3rd. edition. Brooks / Cole Pub. Co..

COURSE OBJECTIVES

1. Development of 'active attending / listening' skills and relationship-building skills and techniques.
2. Developing theoretical knowledge of the dynamics of the counselling process, counselling strategies, clinical assessment and case management.
3. Developing self- awareness of one's "personal orientation" toward an effective counselling style.

COURSE OVERVIEW

The course will be comprised of both lecture/ discussion and an applied clinical component.

1. LECTURE / DISCUSSION

Material for the lecture/discussion portion will be based on the textbook, suggested references and my own clinical experience. You are invited,if not urged, to share your reasoned opinions. Class participation means active participation in class activities - be it class discussion, skill exercises, skill practice, role playing, case review, etc.. THE BEST WAY TO BE PREPARED IS TO READ AND BE FAMILIAR WITH THE ASSIGNED MATERIALS, SO THAT CLASS TIME CAN BE UTILIZED FOR AN EVALUATION, RATHER THAN A REVIEW, OF THE CONTENT OF ASSIGNED READINGS.

2. APPLIED / CLINICAL

This component of the course is devoted to skills training and the acquisition of appropriate counselling strategies and techniques. Necessarily, this involves your active participation in role playing activities and the observations of role-played episodes - either as the counsellor or as the client.

Video - taped recordings of student-counsellor/volunteer-client interviews are typically used for class instructional purposes.

COURSE REQUIREMENTS

There are (3) requirements upon which your evaluation in this course will be determined; (1) demonstration of actual counselling 'skills' you have learned; (2) demonstration of your ability to write an Intake interview and Summary report; (3) demonstration of professional behavior / conduct.

1. COUNSELLING SKILLS

Your evaluation will be based upon demonstrated expertise, diversity, and effectiveness of skills which you have acquired, as determined by your video-taped recordings of selected segments of volunteer -client interviews. Two(2) video-taped recordings, one

representative of your counselling skills prior to the mid-point of the total number of interviews conducted over the semester, and the second representative of your counselling skills during the latter interviews conducted before the end of the semester. Each video tape should include a "typed" transcript of segments which you want me to look at and listen to. In addition, a 'typed transcript of these segments should address the following questions:

(a) What is/are the techniques or skills being applied in this segment?

(b) What was the reasoning for choosing this technique at this particular point in the session?

(c) How well did it work?

(d) What could I do to make this/these interventions more effective?

Note: The above questions based on the segments you have selected should give you some beginning sense of your developing 'personal' approach to counselling and therapy.

2. IN-TAKE AND TERMINATION SUMMARY REPORTS

The purpose of these assignments into give you experience in conducting In-take interviews and writing reports about your your client. You will provide an In-take interview report for each client volunteer during the First term and a Termination Summary report for each client volunteer at the end of the Second term. The content that you should include in these reports is as follows:

INTAKE INTERVIEW REPORT

a) Behavioral observations (i.e., general appearance, verbal / nonverbal behavior, motivation etc.),

b) Life history including family relationships, significant others,

c) Presenting problem (e.g., reason for seeing you),

d) Short-term and long-term goals of counselling,

e) A plan of action.

TERMINATION SUMMARY REPORT

a) Number of sessions, pattern of cancellations, etc.,

b) Presenting problem and relevant life history information,

c) Therapeutic history, including both content and process(i.e, clients response to counselling interventions),

d) Presentation of psychological profile of the client, ways of relating to self, others, the manner in which the client's world is constructed, and possible directions of change,

e) Suggestions for the future.

3. PROFESSIONAL DEVELOPMENT / BEHAVIOR

This segment of the evaluation is based on observations of your active efforts to learn and understand the way counselling works. That is, your ability to select or engage in appropriate strategies and interventions that are appropriate at the time for the client; your ability to theoretically connect each technique or skill with its therapeutic effectiveness and theoretical underpinnings. This component of your evaluation will be based on your class participation in exercises, demonstration of counselling skills in class, with your teaching assistants (TA's) and your encounters with your clients and fellow colleagues. Your adherence to assignment deadlines, client appointment schedules and general professional conduct are also included in this part of the evaluation.

COURSE EVALUATION

Course evaluation is based on the numeric value attached to each of three components as follows:

1. COUNSELLING SKILLS.....60%
2. IN-TAKE INTERVIEW REPORT (FIRST TERM) }...20%
   TERMINATION SUMMARY REPORT (SECOND TERM) }
3. PROFESSIONAL DEVELOPMENT / BEHAVIOR.....20%

COURSE SYLLABUS

FIRST SEMESTER: September 8th - December 8th. 1997.

Sept. 8th Course introduction: Orientation Session

Sept.15th STAGES AND SKILLS OF COUNSELLING (Text:chap.2 & class materials)

Sept.22th STAGES AND SKILLS OF COUNSELLING (Class materials)

Sept.29th STAGES AND SKILLS OF COUNSELLING (Class materials)

Oct. 6th ASSESSING CLIENT PROBLEMS (Text:Chap. 4)

Oct.13th Holiday - Class canceled

Oct.20th ASSESSING CLIENT PROBLEMS (Text: Chap: 4)

Oct.27th COUNSELLING RELATIONSHIP (Text: Chap: 3)

Nov. 3rd DEVELOPING COUNSELLING GOALS (Text: Chap: 5)

Nov.10th DEVELOPING COUNSELLING GOALS (Class materials)

Nov.17th DEFINING STRATEGIES / SELECTING INTERVENTIONS (Text: Chap: 6)

Nov.24th DEFINING STRATEGIES / SELECTING INTERVENTIONS (Class materials)

Dec. 1st COUNSELLOR / CLIENT VIDEO-TAPED INTERVIEWS

Dec. 8th COUNSELLOR / CLIENT VIDEO-TAPED INTERVIEWS

DUE DATES: FIRST TERM ASSIGNMENTS:

1. IN-TAKE INTERVIEW REPORT: ..... NOV. 10th.

2. MID-TERM COUNSELLOR / CLIENT VIDEO-TAPED

INTERVIEW .....(Week of.. NOV. 17th

3. END-TERM COUNSELLOR / CLIENT VIDEO-TAPED

INTERVIEW .....(Week of..DEC. 8th

Instructors: G. Torbit & A. Hum — Winter: 1998

Second Semester: Jan. 5 - April 6, 1998 — Monday: 9-12

COURSE SYLLABUS

Jan. 5 Establishing Counselling Goals: Review	Hackney, ch. 5
Jan.12 Defining Strategies & Selecting Coun. Interventions	Hackney, ch. 6
Jan.19 Defining Strategies & Selecting Coun. Interventions	Hackney, ch. 6
Jan.26 Affective Interventions	Hackney, ch. 7
Feb. 2 Affective Interventions	Hackney, ch. 7
Feb. 9 Cognitive Interventions	Hackney, ch. 8
Feb.16 Cognitive Interventions	Hackney, ch. 8
Feb.23 ---------- Spring Break----------	
Mar. 2 Behavioral Interventions	Hackney, ch. 9
Mar. 9 Behavioral Interventions	Hackney, ch. 9
Mar.16 Systemic Interventions	Hackney, ch.10
Mar.23 Systemic / Couples Interventions	Hackney, ch.10
Mar.30 Terminating the Counselling Relationship	Hackney, ch.11
Apr. 6 Wrap-up: Client / Counsellor Case Summary	

Please Note: The above syllabus is flexible. While we will cover all of the designated topics, the actual dates and time 'may' vary according to the needs of the class. Additional course materials will be used to augment certain topics cited in the syllabus.

SECOND SEMESTER ASSIGNMENTS	DUE DATE
Counsellor / Client Video-taped Interview # 2	Feb. 2, 1998
Counsellor / Client Video-taped Interview #3	Mar. 2, 1998
Counsellor / Client Video-taped Interview #4	Apr. 6, 1998

Appendix B. Results from Study I and Study II

Appendix B. Results from Study I and Study II

Non-parametric Analysis of the Data

Likert-type scales have been treated by many researchers as interval scale (Wright, 1997, p.5-7; Besag & Besag, 1985, p.62), and for this reason the VPPS has also been treated as an interval scale by some researchers (Bachelor & Salame, 2000; Henry at al., 1993). Therefore parametric statistics, and specifically Multivariate Repeated Measures Analysis of Variance (MANOVA) were performed in this study. However, even though Repeated Measures MANOVA is a powerful statistical procedure, in small sample sizes its power to detect differences is weakened. This limitation raises the question whether the non-significant results of the effect of the phases, and of the interaction effect between phase and subscale did not represent the actual results of the study. In order to ensure that the results of the Repeated Measures MANOVA were not due to some artifact of the parametric procedure, a parallel non-parametric analysis of the same data was performed. This type of analysis (i.e., non-parametric) has also been performed by some researchers who treated the Likert-type scale of the VPPS as an ordinal variable (Wiseman et al., 1993). Therefore, the non-parametric analysis was used in order to verify whether the parametric results were indeed accurate.

The non-parametric alternative to the Multivariate Repeated Measures ANOVA is Friedman F. It is used to compare observations repeated on the same subjects, and it is also known as Friedman two-way analysis of variance.

In order to answer the first research question, subscale effects were also examined. Firedman F test revealed that differences in rank across the three subscales were statistically significant. For phase one, the ranking of the subscales was significant X (2, $\underline{N}$ = 9) = 18, $\underline{p}$ < .001, where the subscale of "Therapist warmth and friendliness" was ranked the highest with mean rank = 3 ("fair amount"), the subscale of "Therapist exploration" was ranked in the middle, with mean rank = 2 ("poor"), and the subscale of "Negative therapist attitude" was ranked the lowest, with mean rank = 1 ("not at all"). For phase two, the same significant results emerged, X (2, $\underline{N}$ = 9) = 11.56, $\underline{p}$ = .003, and

the ranking between the subscales was the same as in phase one. Finally, for phase three, the ranking of the subscales was also significant, X (2, $\underline{N}$ = 9) = 14.89, $\underline{p}$ = .001, following the same rankings.

In order to answer the second research question, the Friedman F test examined each subscale separately and compared whether the mean scores for each specific subscale changed significantly across phase. The test revealed no significant difference in mean ratings across phases for the "Negative therapist attitudes" subscale, X (2, $\underline{N}$ = 9) = 2.69, $\underline{p}$ = .26, no significant differences in mean rating scores of the subscale "Therapist warmth and friendliness" across phases, X (2, $\underline{N}$ = 9) = 2.67, $\underline{p}$ = .26, and no significant differences in mean rating scores for the "Therapist exploration" subscale across phases, X (2, $\underline{N}$ = 9) = 2.8, $\underline{p}$ = .25.

The results indicated that there were no significant differences between the subscales across the three phases, but there was significant subscale effect within each phase. Therapist warmth and friendliness (subscale two) had the highest rank, therapist exploration (subscale three) was ranked in the middle between the other two subscales, and negative therapist attitude (subscale one) had the lowest rank. These results validate the parametric statistics and we can confidently conclude that trainees' reactions (as measured by behaviours and demeanors) to client weeping did not significantly change across the three phases of therapy. The main characteristic of their interaction with their clients was a warm and friendly attitude without any negative traits and a tendency to help the client explore her issues, irrespective of phase in therapy.

Table B1
Descriptive Statistics for Negative Therapist Attitude Across Phases

	N	Mean	Std. Deviation
Negative therapist attitude, mean scores, time 1	9	1.0926	.13466
Negative therapist attitude, mean scores, time 2	9	1.3241	.47406
Negative therapist attitude, mean scores, time 3	9	1.3611	.32005

Table B2
Ranks forNegative Therapist Attitude Across Phases

	Mean Rank
Negative therapist attitude, mean scores, time 1	1.61
Negative therapist attitude, mean scores, time 2	2.06
Negative therapist attitude, mean scores, time 3	2.33

Table B3

Test Statistics for Negative Therapist Attitudes Across Phases

N	9
Chi-Square	2.69
Df	2
Asymp. Sig.	.261

Table B4

Descriptive Statistics for Therapist Warmth and Friendliness Across Phases

	N	Mean	Std. Deviation
Therapist warmth and friendliness, mean scores, time 1	9	2.8580	.47394
Therapist warmth and friendliness, mean scores, time 2	9	2.5988	.48415
Therapist warmth and friendliness, mean scores, time 3	9	2.6975	.71043

Table B5

Ranks for Therapist Warmth and Friendliness Across Phases

	Mean Rank
Therapist warmth and friendliness, mean scores, time 1	2.44
Therapist warmth and friendliness, mean scores, time 2	1.78
Therapist warmth and friendliness, mean scores, time 3	1.78

Table B6

Test Statistics for Therapist Warmth and Friendliness Across Phases

N	9
Chi-Square	2.67
df	2
Asymp. Sig.	.264

Table B7

Descriptive Statistics for Therapist Exploration Across Phases

	N	Mean	Std. Deviation
Therapist exploration, mean scores, time 1	9	2.3846	.33253
Therapist exploration, mean scores, time 2	9	2.3675	.30716
Therapist exploration, mean scores, time 3	9	2.2863	.39228

Table B8

Ranks for Therapist Exploration Across Phases

	Mean Rank
Therapist exploration, mean scores, time 1	2.28
Therapist exploration, mean scores, time 2	2.17
Therapist exploration, mean scores, time 2	1.56

Table B9

Test Statistics for Therapist Exploration Across Phases

N	9
Chi-Square	2.80
df	2
Asymp. Sig.	.247

Table B10

Descriptive Statistics for all Three Subscales Across Phases

	N	Mean	Std. Deviation
Negative therapist attitude, mean scores, time 1	9	1.0926	.13466
Therapist warmth and friendliness, mean scores, time 1	9	2.8580	.47394
Therapist exploration, mean scores, time 1	9	2.3846	.33253

Table B11

Ranks for all Three Subscales First Phase

	Mean Rank
Negative therapist attitude, mean scores, time 1	1.00
Therapist warmth and friendliness, mean scores, time 1	3.00
Therapist exploration, mean scores, time 1	2.00

Table B12

Test Statistics for all Three Subscales First Phase

N	9
Chi-Square	18.000
df	2
Asymp. Sig.	.000

Table B13

Descriptive Statistic for all Three Subscales Second Phase

	N	Mean	Std. Deviation
Negative therapist attitude, mean scores, time 2	9	1.3241	.47406
Therapist warmth and friendliness, mean scores, time 2	9	2.5988	.48415
Therapist exploration, mean scores, time 2	9	2.3675	.30716

Table B14

Ranks for All Three Subscales Second Phase

	Mean Rank
Negative therapist attitude, mean scores, time 2	1.11
Therapist warmth and friendliness, mean scores, time 2	2.67
Therapist exploration, mean scores, time 1	2.22

Table B15

Statistics for All Three Subscales Second Phase

N	9
Chi-Square	11.556
df	2
Asymp. Sig.	.003

Table B16

Descriptive Statistics for All Three Subscales Third Phase

	N	Mean	Std. Deviation
Negative therapist attitude, mean scores, time 3	9	1.3611	.32005
Therapist warmth and friendliness, mean scores, time 3	9	2.6975	.71043
Therapist exploration, mean scores, time 3	9	2.2863	.39228

Table B17

Ranks for All Three Subscales Third Phase

	Mean Rank
Negative therapist attitude, mean scores, time 3	1.00
Therapist warmth and friendliness, mean scores, time 3	2.78
Therapist exploration, mean scores, time 3	2.22

Table B18

Test Statistics for All Three Subscales Third Phase

N	9
Chi-Square	14.889
df	2
Asymp. Sig.	.001

Appendix C: Detailed explanation of categories yielded by Study II

Question 1. How did the context of the weeping events change over three phases of therapy (early, middle, and late)?

Context: variables related to what immediately preceded the weeping event. Four main categories were found:

1. Topic of discussion: what was discussed immediately preceding client weeping. Three subcategories were found:

(a) External stressors/health

(b) Interpersonal issues: relationship issues and family relationship issues, therapy process.

(c) Intrapersonal issues: personality patterns, emotional state, internal changes.

2. Task: how the issue was discussed.

(a) Describing the situation

(b) Describing/exploring feelings

(c) Describing thoughts.

3. Trigger of weeping: who provoked the weeping.

(a) Client provoked

(b) Therapist provoked.

4. Therapist style before the event

(a) Same as during the event

(b) Different than the during the event

--less active before the event

--more active before the event

--less empathic and caring before the event

--friend-like interaction before the event

Question 2. How did the content of the weeping events change over the three phases of psychotherapy (early, middle, and late)?

Content

Topic of discussion: referred to content of the client's material. Two subcategories were found:

1. Interpersonal: it included topics related to
   (a) Past and/or present relationship issues
   (b) Past and/or present family relationship issues
   (c) Therapy events related to the client's relationship with the therapist
   (d) External life events.
   (e) Intrapersonal: refers to
   (f) Clients' personality patterns and
   (g) Life goals.

Question 3. How do the tasks that therapists-in-training employ change across three phases of psychotherapy (early, middle, and late)?

1. Therapist time focus: refers to the time focus that the therapist was using throughout the event, whether it was on the present and the here-and-now, past or future. The instances where trainees worked on the "here-and-now" were very infrequent, and for this reason it was decided that those instances would be "incorporated" into the subcategory of "present".

2. Activity level: refers to how active the counsellors were during the weeping events over the three phases or how frequently they were responding to the client.

a) Low activity level: the therapist made minimal interjections. For example, in events where the therapist would make short statements in-between long client statements, it was considered that the specific therapist had a low activity level.

b) Moderate activity level: the therapist made moderate interjections. In interactions where there was approximately similar level of activity between client and therapist

(they would both speak approximately the same amount), the therapist was considered to have a moderate activity level.

(c) High activity level: the therapist made high interjections. For example, in interactions where the therapist would talk more than the client, it was considered that the specific therapist had a high activity level.

3. Therapist immediate reaction to client weeping. It included the first statement that counsellors made after the client initially started weeping. Two large subcategories:

A. Emotive focus: focus on emotions. Three behaviors were identified:

(a) the therapist validates and encourages client's emotions,

(b) the therapist reflects the client's emotions (definitions for these behaviors have been provided for the previous dimension)

B. Cognitive focus: focus on cognitions. Four main behaviors were identified:

(a) the therapist focused in details about the situation,

(b) the therapist validated the client's thoughts,

(c) the therapist was trying to find solutions with the client, and

(d) the therapist challenged the client's attitudes and behaviors.

4. Thematic focus: referred to the content of the therapists' tasks, or what the therapists were focusing on. In the analysis of this study, results indicated that for the nine dyads there were three main foci that were the main subcategories: emotive, cognitive, and other.

A. Emotive focus: focus on emotions. Three main behaviors were found:

(a) elaborate or tried to evoke feelings in the event

(b) explored the feelings the client was reporting

(c) accepted the feeling that the client brought and stayed with it but made no effort to explore or elaborate it.

B. Cognitive focus: focus on cognitions. Four main behaviors were found:

(a) the therapists tried to explore the client's thoughts, beliefs, and personality patterns

(b) the therapists focus was to find alternative solutions to the problem or future options,

(c) the therapist was exploring facts and the content of what the client was saying.

5. *Types of interventions*: it refers to therapist verbal responses (e.g., interpretation, etc.).

(a) Interpretations: refers to the therapist interventions that go beyond what the client has overtly stated and present a new meaning or explanation for the client's behaviors, thoughts or feelings, with the goal to provide the client a new perspective on his or her issues (Hill & O'Brien, 1999).

(b) Confrontation/challenge: refers to an intervention that aims to point out contradictions or discrepancies in the client's thoughts, feelings or behaviors. Challenges can be stated either tentatively or using a confrontational tone.

(c) Self-disclosure: refers to the therapist revealing something personal about themselves, either personal information, feelings, experiences or strategies.

(d) Open-ended questions: refers to an intervention that is formed as a question and aims to ask clients to explore feelings or thoughts; it is an intervention that requires more than one or two-word response.

(e) Closed-ended questions: refers to an intervention formed as a question that asks for specific information and require a one or two-word answer.

(f) Validates client's feelings and/or experience: aims to communicate to the client the therapist's acceptance of her feelings and experience

(g) Clarification: refers to a therapist's question to the client aimed to clarify the meaning of what the client has said or to clarify information

(h) Reflection: refers to a rephrase of the client's statement with an emphasis on feelings aiming to help clients identify, clarify, and express feelings.

(i) Summarization: aims to tie together several ideas or present the highlights and themes of what has been expressed by the client.

(j) Minimal encouragers: refers to sounds or small words such as "mm-hm", "yeah", "right", aiming to communicate attentiveness, provide support, and encourage the client to keep talking.

(k) Paraphrase and restatement: refer to the repetition of the content or the meaning of what the client has said that is more clear than the client's statement and contains fewer words. They can relate to either present or past material and the emphasis is on the content of what the client has said rather than the feeling. Although restatements are similar to summarization (or "summaries"), summarization does not go beyond what the client has said or aims for the reason for client's behaviors, while restatements may do so.

(l) Specific directive techniques: refers to a number of techniques that have the common characteristic of being directive in nature and assume a directive role by the therapist. Since each one of them occurred only once, it was decided to collapse all of them under one general label. They are as follows:

Psycho-education: referred to the therapist providing an informative opinion aiming to educate the client.

Role-playing: referred to a type of intervention where the goal is to help clients learn new ways of responding to specific life situations by acting out situations in which the new behavior could be used.

Reality testing: the goal is to challenge the clients' beliefs and expectations as to whether and how realistic they are.

Homework assignment: the goal is to get the client to try new ways of behaving and report the results back in the session.

Table C1

Therapists' tasks across the three phases of psychotherapy

	PHASE A	PHASE B	PHASE C
Therapist Time Focus			
Present/Here-and-now	Typical (5)	General (9)	General (9)
Past	Typical (7)	(2)	Variant (3)
Future	(1)		Variant (4)
Activity Level			
Low (minimal interjection)	Variant (3)		(1)
Moderate	Variant (3)	Variant (3)	Typical (5)
High	Variant (3)	Typical (6)	Variant (3)
Immediate reaction to weeping			
Emotive Focus	Typical (7)	(1)	Typical (7)
Validates/encourages emotions	Typical (6)	(1)	Typical (6)
Reflects feelings	(2)		(1)
Cognitive Focus	(2)	Typical (7)	(2)
Attends to details	(1)	Variant (3)	
Validates client's thoughts	(1)		
Asks for solutions		(1)	
Challenges attitudes/behaviors		(1)	(1)
Asks for clarification		(2)	(1)
Thematic Focus (apparent goal)			
Emotive Focus	Typical (8)	Typical (6)	Variant (5)
Elaborate/evoke feelings	Variant (3)	(2)	Variant (3)
Explore feelings	Variant (4)	(2)	(2)
Acknowledging the feeling	General (8)	Variant (4)	Variant (4)
Cognitive Focus	Variant (4)	Typical (8)	Variant (7)
Explore thoughts/patterns	Variant (3)	Variant (3)	Variant (3)
Seeks alternatives		(2)	Variant (4)
Explores content/facts	Variant (3)	Typical (5)	Typical (6)
Type of Interventions			
Clarification	(1)	Variant (3)	
Reflection	Typical (6)	(1)	Variant (3)
Paraphrase/Restatement	Variant (3)	Variant (3)	Variant (4)
Summarization	Variant (3)	Variant (3)	
Minimal encouragers	Typical (8)	Typical (7)	General (9)
Self-disclosure	(1)	(1)	(1)
Interpretations	Variant (3)	Variant (4)	Variant (7)
Confrontation/challenge	(1)	(1)	(2)
Open-ended questions	Variant (3)	(2)	Typical (5)
Closed-ended questions	Typical (5)	Variant (4)	Variant (4)
Specific directive techniques		Variant (3)	Variant (3)

Question 4. How does the style of therapists-in-training change across three phases of psychotherapy (early, middle and late)?

1. Vocal attitude: the therapist tone of voice. Two subcategories were found:

(a) Accepting tone: it included a soft and caring tone of voice, in tune with the client's.

(b) Distant/detached: it included a harsh and authoritative tone of voice, sometimes loud, and out of tune with the client's voice and loud.

2. Therapist communication style: the way the therapist was presenting herself. Four subcategories were found:

(a) Tentative/uncertain: referred to the therapist communicating their interventions in a non-affirmative manner either as an indication of their intention to give the client the chance to disagree, or as an indication of their insecurity in delivering the interventions

(b) Empathic/in tune/supportive: included the therapist ability to be empathic, supportive, and emotionally in tune with the client. Although the term "empathy" is quite controversial in the field in terms of whether it is an intervention, a tone of voice or a therapeutic condition, the judges chose to include this term as a subcategory under the category of communication style. Additionally, although aware of the different definitions of "empathic", the judges chose to use the same definition as the training books for beginner trainees. According to these books, the main "ingredients" of the therapist communicating empathy to the client are: (a) the accurate perception and understanding of the client's worldview; and (b) the communication of this understanding to the client (Egan, 1994, 1998, 2002; Hackney & Cormier, 1996)., non-empathic, comfortable in her role/systematic, uncomfortable in her role, and behavior outside professional frame. Therefore the definitions are: *Empathic*: the counsellor's ability to communicate that she has understood the meaning of the client's message.

In tune: that is the therapist's ability to comprehend how the client was feeling at each specific moment in therapy.

Supportive: the counsellor's communication to the client of being encouraging and reinforcing

(c) Non-empathic/out of tune: a behaviour that indicated a lack of support, understanding and "tuning-in" with the client's emotions.

(d) Casual interaction: referred to behaviours outside the professional frame. Three types of behaviours were included in this subcategory:

Friend-like interaction where the trainee was talking to the client as if to a friend

Therapist was pushy and imposing her own views and values.

Use of everyday language and exclamatory responses.

It was believed that in all of the above behaviors the therapists were not just focusing on their clients but also brought their own needs or agendas to the event and therefore it was considered appropriate to lump all these behaviors under the same subcategory of "casual interaction".

3. Process style: referred to the therapists' style of interacting related to the therapeutic process. Two subcategories were identified:

(a) Directive: a therapist who sets the agenda as to what would be discussed and how.

(b) Non-directive: allowed the client to take the lead (i.e., followed the client's material).

McGill

Department of Educational and Counselling Psychology
Département de psychopédagogie et de counseling

Faculty of Education
McGill University

Faculté des sciences de l'éducation
Université McGill

McGill Counselling Psychology Research Project
Counsellor Consent Form

We would like to request your participation in a research project that some members of the counselling psychology program are conducting.

Our project involves a study of the process variables that influence the course of counselling; its goal is to examine the interaction between counsellor and client, and to examine the manner in which the counsellor and client perceive the therapeutic encounter. In order to discover relationships between the characteristics of you, your counsellor and the unfolding of therapy, we will ask volunteers to respond to several questionnaires and paper-and-pencil tests to describe facets of themselves which may be relevant to the psychotherapeutic endeavour.

The method of gathering data will involve our taping counselling sessions, and then transcribing the dialogue with a view to coding segments into categories of process variables. In the transcription process, all personal and identifying information will be deleted or altered to conceal your identity, as well as the identity of the client and anyone mentioned in the session. Transcribers and coders will all be professionally trained counsellors, and so will be bound by the strict code of ethics and confidentiality that regulates their profession and the conduct of research. Moreover, all information will be treated as private and privileged even when identifying features have been deleted. These measures will ensure the anonymity and confidentiality of all involved.

The results of our research will be presented at various conferences, and may eventually be published, but the data by then will be combined into sets of categories and so confidentiality will in no way be compromised.

Participation is voluntary, and you may withdraw from the study, at any point. There is no penalty for anyone who retires from the study - your counselling will continue as before, only now data from your sessions will not be gathered or used in our research, but will continue to be used for supervisory purposes.

Whether or not you decide to participate in our study, we hope that this experience as a counsellor will be a beneficial and informative experience. We believe this research to be interesting and, more importantly, a step in the direction of coming to understand what it is that goes on in the psychotherapeutic encounter. Once completed, the scientific results of this investigation will be made available to any who should request them.

If any further information is required, please contact:

Dr. Anastassios Stalikas, Counselling Psychology (Faculty of Education)
McGill University.

If you have understood what is involved in this project and wish to participate, kindly indicate your willingness by signing and dating this form on the lines provided below.

Participant's Name: _____

Participant's Signature: _____ ***Date:*** _____

Researcher's [Co-Principal's] Name: _____

McGill

Department of Educational and Counselling Psychology
Département de psychopédagogie et de counseling

Faculty of Education
McGill University

Faculté des sciences de l'éducation
Université McGill

McGill Counselling Psychology Research Project
Client Consent Form

We would like to request your participation in a research project that some members of the counselling ychology program are conducting.

Our project involves a study of the process variables that influence the course of counselling; its goal is to amine the interaction between counsellor and client, and to examine the manner in which the counsellor and ent perceive the therapeutic encounter. In order to discover relationships between the characteristics of you, ur counsellor and the unfolding of therapy, we will ask volunteers to respond to several questionnaires and per-and-pencil tests to describe facets of themselves which may be relevant to the psychotherapeutic endeavour.

The method of gathering data will involve our taping counselling sessions, and then transcribing the dialogue th a view to coding segments into categories of process variables. In the transcription process, all personal and ntifying information will be deleted or altered to conceal your identity, as well as the identity of the counsellor d anyone mentioned in the session. Transcribers and coders will all be professionally trained counsellors, and will be bound by the strict code of ethics and confidentiality that regulates their profession and the conduct of earch. Moreover, all information will be treated as private and privileged even when identifying features have en deleted. These measures will ensure the anonymity and confidentiality of all involved.

The results of our research will be presented at various conferences, and may eventually be published, but the a by then will be combined into sets of categories and so confidentiality will in no way be compromised.

Participation is voluntary, and you may withdraw from the study, at any point. There is no penalty for anyone o retires from the study - your counselling will continue as before, only now data from your sessions will not gathered or used in our research.

Whether or not you decide to participate in our study, we hope that this experience as a client in counselling ll be a beneficial and informative experience. We believe this research to be interesting and, more importantly, a p in the direction of coming to understand what it is that goes on in the psychotherapeutic encounter. Once npleted, the scientific results of this investigation will be made available to any who should request them.

If any further information is required, please contact:

Dr. Anastassios Stalikas. Counselling Psychology (Faculty of Education)
McGill University.

If you have understood what is involved in this project and wish to participate, kindly indicate your willingness signing and dating this form on the lines provided below.

rticipant's Name: _____

rticipant's Signature: _____ *Date:* _____

searcher's [Co-Principal's] Name: _____ .

CONFIDENTIALITY AGREEMENT

I have been informed and am aware that I will be exposed to a substantial amount of confidential material during the course of my work as a research team member. In consideration of my being allowed to work as a research team member and in order to obtain the educational benefits accruing therefrom, I agree to the following:

1. I will not disclose the name or identity of any research subject or participant, nor contact a research subject or participant without the expressed permission of the principal researcher.

2. I will not discuss my impressions of the research material with anyone but my own research team members and the principal researcher.

3. I will not use any data collected by the principal researcher for any purpose without the express consent of the principal researcher.

4. I will not write or participate in any independent research based upon the principal researcher's work until such time as that work has been published by the principal researcher or said proposed research is approved by the principal researcher.

_____
Team Member Name (PRINT CLEARLY)

Address: _____

Phone: _____

_____ _____
Signature Team Member Date

_____
Principal Researcher

_____
Anastassios Stalikas, Ph.D.

RECEIVED DEC 0 4 2001

MCGILL UNIVERSITY
FACULTY OF EDUCATION

CERTIFICATE OF ETHICAL ACCEPTABILITY FOR FUNDED AND NON FUNDED RESEARCH INVOLVING HUMANS

he Faculty of Education Ethics Review Committee consists of 6 members appointed by the Faculty of Education ominating Committee, an appointed member from the community and the Associate Dean (Academic Programs raduate Studies and Research) who is the Chair of this Ethics Review Board

he undersigned considered the application for certification of the ethical acceptability of the project entitled ovice counsellors' skill development. An investigation of weeping events

s proposed by

pplicant's Name Polyxeni Georgiadou

Supervisor's Name A. Stalikas & J. De Stefano

pplicant's Signature

Supervisor's Signature

egree / Program / Course Ph D Counselling Psych

Granting Agency N/A

he application is considered to be
Full Review _____

An Expedited Review Yes

Renewal for an Approved Project _____

A Departmental Level Review _____
Signature of Chair / Designate

he review committee considers the research procedures and practices as explained by the applicant in this pplication to be acceptable on ethical grounds

Prof. Ron Stringer
ept of Educational and Counselling Psychology

ignature / date

4. Prof. Ada Sinacore
Department of Educational and Counselling Psychology

Signature / date

Prof. Ron Morris
epartment of Culture & Values

Dec 21 2001
ignature / date

5. Prof. Brian Alters
Department of Educational Studies

Signature / date

Prof. René Turcotte
epartment of Physical Education

Jan 7/2002
ignature / date

6. Prof. Kevin McDonough
Department of Culture and Values in Education

Signature / date

Member of the Community

ignature / date

lary H. Maguire Ph. D.
hair of the Faculty of Education Ethics Review Committee
ssociate Dean (Academic Programs, Graduate Studies and Research)
aculty of Education, Room 230
els. (514) 398-7039/398-2183 Fax (514) 398-1527

Signature / date

Updated June 2001)