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EFFECT OF TYPE OF FEEDBACK ON COUNSELOR SELF-EFFICACY, SELF-ESTEEM, ANXIETY, AND PERFORMANCE IN A SUPERVISION ANALOGUE

The Ohio State University. Ph.D. 1982

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EFFECT OF TYPE OF FEEDBACK ON COUNSELOR SELF-EFFICACY, SELF-ESTEEM, ANXIETY, AND PERFORMANCE IN A SUPERVISION ANALOGUE

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By
Ann Leslie Dunnewold, B.A., M.A.

* * * * *

The Ohio State University
1982

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Chapter I
INTRODUCTION

In recent years, research on the training and supervision of counselors and clinicians has steadily increased (Ford, 1979). Much of that research has been aimed at discovering the best methods by which to train beginning counselors and help them to develop their own personal styles as therapists. One specific component of this process of training counselors is providing feedback, or evaluative information to trainees on their behavior in the counseling situation.

The importance of feedback to a trainee's growth as a counselor has been stressed by several writers (Eskedal, 1975). Fyffe and Oei (1979) concluded from their comparison of the modeling and feedback components of a microskills training program that feedback increases the learning efficiency of training of beginning counselors, especially learning from one's supervisor. Worthington and Roehlke (1979) investigated specific behaviors that were related to effective supervision as perceived by supervisees and supervisors. Supervisors perceived supervision as primarily a process of providing feedback to counselor trainees. When the supervisors rated a list of behaviors as to their importance to effective supervision, five of the top twelve items involved giving feedback to the supervisee on his/her behavior in the interview setting. In addition, there is evidence that communication training without a feedback component can have a deleterious effect on trainees' skill levels (Tosi & Eshbaugh, 1978).
The critical nature of feedback in training and supervision has been stressed. However, the construct is often too broadly and vaguely defined, and the process of feedback has not been clearly delineated, resulting in a lack of concrete guidelines for practice (Bernstein, Bianca, & Lecomte, 1979). While there is some research on the topic of feedback in supervision, more is needed to clarify the process. Bernstein, Bianca, & Lecomte (1979, p. 297) have suggested a basic question to guide research exploring the impact of feedback in supervision. They asked "which types of supervisor feedback produce which immediate responses in which kinds of trainees?", and asserted that research in that direction would facilitate a more intentional, systematic approach to counselor supervision.

This approach to feedback in counseling supervision would entail a more detailed look at the personal characteristics of supervisees. Cronbach (1957) first suggested the examination of person by treatment interactions over twenty years ago, in regards to the effectiveness of various counseling interventions. Russell (Note 1) has developed a model for research on supervision which follows this same pattern, examining the impact of various approaches on different individuals, within a developmental framework. This developmental model, specifying different types of supervision as trainees become more skillful, is becoming increasingly popular in the literature on training counselors. Stoltenberg (1981) has presented such a framework,
consisting of four levels of development. Counselor characteristics and supervision environment are specified at each level. Likewise, Hill, Charles, and Reed (1981) outlined a four stage conceptual model, explaining the changes of students in a psychology graduate program. A similar paradigm, detailing the specific developmental crises a counselor trainee may face across the course of training, has been proposed by Dye (1981). Moskowitz (1981) examined the utility of the developmental model in explaining trainees' preferences for supervision. The results provided partial support for the model, with beginning and advanced trainees preferring different styles of supervision.

Other research has already investigated the effects of various personal characteristics of trainees on training and supervision processes. Grayson (1979) looked at trainees' tolerance of ambiguity and their preference for a didactic versus an experiential approach to supervision. It was discovered that intolerance of ambiguity and preference for an experiential approach were negatively correlated; the higher the tolerance of ambiguity, the greater the preference for an experiential format. Rosenthal (1977) found that low conceptual level trainees benefited more from direct contact with trainers than from a self-instructional approach, while high conceptual level trainees progressed equally well with either approach. Similarly, Berg and Stone (1980) reported that low conceptual level trainees were more satisfied with high-structured than with low-structured supervision, and felt that they had learned
more, while high conceptual level trainees benefited from either type of supervision. Another study (Cohen, 1980) examined the importance of different supervisor characteristics to behavioral as compared to analytic psychotherapy trainees, with the aim of providing those preferred aspects of supervision.

The intent of this current trend in research is to maximize learning from supervision by individualizing the approach employed for each trainee. Supervisors can assess what the trainee's learning needs are, and tailor their instructional responses according to critical issues faced, personal characteristics, or style of learning of the trainee (Holloway & Wolleat, 1981; Moskowitz, 1981). As outlined above, feedback is one instructional response a supervisor may employ. To address Bernstein, Bianca, and Lecomte's (1979) question, within the framework of this individualized approach, specific personal characteristics or issues must be delineated and examined.

One factor which appears repeatedly in the literature on counselor trainees is competence. In Dye's (1981) formulation of a developmental perspective of supervision, all the crises encountered are seen as challenges to the student's competence. Kobos (1981) asserted that, when utilizing audiotapes of counseling sessions in supervision, the primary issue that arises for the trainee is one of competence and evaluation. And in Stoltenberg's (1981) model, the final developmental stage addresses the dependency-autonomy conflict. Research has begun to support the contentions of the above writers,
emphasizing the importance of competence to counselor trainees. Levy (1979) conducted a descriptive study of the dilemmas clinical psychology graduate students perceived in training to be therapists. Particularly problematic for less-experienced trainees was lack of expertise due to inexperience. Based on the premise that therapeutic competence is a goal of training, Bradley and Olson (1980) examined the importance of that goal and factors influencing the attainment of the goal in clinical psychology trainees. Graduate students in clinical psychology responded to a questionnaire and overwhelmingly endorsed the future importance of their personal competence as psychotherapists (Bradley & Olson, 1980). Not only was competence an important issue, but self-ratings of current competence were significantly related to number of supervisors and total hours of formal supervision.

Competence in counseling may be an issue for trainees, and that issue may be affected by supervision. There is also evidence that training programs may succeed in facilitating that goal of developing competence. Hill, Charles, and Reed (1981) reported on a longitudinal analysis of changes occurring in counseling skills during training in doctoral psychology. Twelve students entering a doctoral program in counseling psychology in two successive years were studied over the course of the program. Participants' skills in counseling volunteer clients were assessed at six points over the course of three years. An in-depth interview at the completion of the training program explored trainees' subjective opinions about changes made over the
qualitative data suggested the greatest change occurred in the self-confidence of the students. In addition, a majority of the students attributed these changes in their perceived competence to supervision and client contact (Hill et al., 1981, p. 432).

Competence seems equivalent to another concept currently popular in the literature, Bandura's (1977, 1978) construct of self-efficacy. Self-efficacy is the expectation or conviction that one can successfully execute the behavior required to produce certain outcomes, and is postulated to be a cognitive mechanism operating to produce behavior change in many circumstances, including different methods of psychological treatment (Bandura, Adams, & Beyer, 1977, p. 126). Bandura (1977) is careful to point out the distinction between efficacy expectations and outcome expectations. An outcome expectation is a belief or estimate that a given behavior, if performed, will result in a specific outcome, while an efficacy expectation is based on a person's belief in his/her ability to perform the behavior involved. It is Bandura's (1977, p. 191) supposition that psychological procedures, whatever their format, serve as ways of creating and strengthening the client's expectations of personal efficacy. An individual's perceived self-efficacy affects her/his choice of activities and settings, the amount of effort expended, and how long that person will persist in the face of obstacles and aversive consequences. The stronger the perceived self-efficacy, the more active will be the efforts at coping. As clients persist in handling threatening experiences, they will
eventually overcome their inhibitions through corrective experience. If, however, they avoid feared situations or abandon coping efforts prematurely, they will maintain their self-defeating expectations and maladaptive behavior (Bandura & Adams, 1977, p. 288).

Self-efficacy theory and research may thus be a means of organizing and understanding the issue of competence of counselor trainees. Counseling self-efficacy is the expectation or conviction that one can successfully execute the behavior required to produce behavioral changes in clients; in other words, have the conviction that one is competent to employ counseling techniques effectively.

Two other concepts, self-esteem and anxiety, continually seem to be linked to self-efficacy in the literature, sometimes having an interactive effect. The issue of anxiety in the process of supervision of counselor trainees cannot be overlooked. Kreiser (1980) reflected on the recognized effect of counselor anxiety in the counseling process. Friedlander (1981, p. 11) has suggested that the responsibility for dealing with trainees' anxiety is one factor that distinguishes supervision from teaching. During certain stages of graduate training, anxiety about competence may be especially critical (Hill et al., 1981). The work of Bandura, Adams, Hardy, and Howells (1980) showed that anxiety may undermine the effective use of abilities people possess; anxiety of counselor trainees may also have a debilitating effect on self-efficacy beliefs and actual performance. Finally, Cohen (1980) found that the "ideal supervisor" was one who would help diminish supervisees' anxiety.
Just as anxiety seems to be closely tied to self-efficacy, so are competence and self-concept frequently juxta posed. A number of writers have stressed the importance of positive self-evaluations and the ability to be an effective counselor (Costello, 1981; Omizo, Ward, & Michael, 1979; Roy, 1980; and Schwab & Harris, 1981), as well as level of self-esteem and expectations of success (McFarlin & Blascovich, 1981). However, there is a lack of clarity in the literature as to the correspondence between self-efficacy and self-esteem or self-concept. Friedenberg and Gillis (1980) seemed to treat the two as synonymous, suggesting that Bandura's work (Bandura & Adams, 1977) on self-efficacy is aimed at increasing self-esteem. In the most recent research report (Bandura, Adams, Hardy, & Howells, 1980), Bandura and colleagues have drawn a distinction between perceived self-efficacy and self-concept. These writers suggested that "profound perceived inefficacy" (Bandura et al., 1980, p. 63) if not corrected, can lead to continuing self-doubt and ultimately to poor self-esteem. In other words, an individual could be bothered by his/her lack of perceived ability to perform a certain behavior. If that doubt about one's competence were to generalize to other behaviors, or was affecting an area of performance highly valued by the person, that lack of confidence could influence her/his self-concept (Bandura, 1977). Bandura (1978b) has related his theory about the development of the "self system"; conceptions about self govern behavior, but are themselves partly created from either direct or indirect transactions with the environment.
In this framework, self-concept would influence coping efforts or other behavior through cognitions about one's efficacy, and success or failure experiences could, in turn, act upon efficacy expectations and/or self-esteem.

Other writers have attempted to elucidate the differences between self-efficacy and self-esteem. Lang (1978, p. 188) distinguished between: (a) strength of self-efficacy or confidence in a specific situation or behavior; (b) generality of self-efficacy encompassing confidence in many similar instances; and (c) a more persistent response disposition of confidence or self-efficacy as a trait. LaLonde (1979) showed some correspondence between academic self-efficacy and self-concept, thus recognizing the importance of both constructs. It appears, therefore, that self-efficacy refers primarily to one's perceived competence at performing a certain behavior or set of behaviors, while self-esteem is a more general cognition about one's self as a person, i.e. an overall evaluation. The two most likely enhance each other, especially where valued behaviors are concerned. However, research is needed to clarify their correspondence and interaction, particularly with regards to specific behaviors.

Self-efficacy seems to offer a great deal of explanatory and predictive power, and therefore, may represent a useful construct for research on supervision. Rosenthal (1978, p. 205) suggested that the construct "permits comparison of individual differences in
self-efficacy as predictors of overt performance". Counselor trainees!
efficacy expectations with regard to developing skills as a successful
counselor are potentially important to training and supervision, and
seem to be inextricably tied to the concepts of self-esteem and anxiety.
Students who are highly confident that they can master empathic respon-
ding or other related skills may benefit from different approaches to
training and supervision than those students who are questioning their
abilities and basic self-worth. Feedback during supervision may provide
important information about one's efficacy beyond the intrinsic feed-
back stemming from actual experience within the counseling interview.
Bandura (1980) hypothesized that performance would be a more powerful
source of efficacy information than verbal feedback from others; perhaps
in the context of supervision verbal feedback is equally influential
and thus can be effectively employed. Research may begin to explore
this question profitably. The purpose of this project was to address
the question of Bernstein, et al. (1979, p. 297), "which types of
supervisory feedback produce which immediate responses in which kinds of
trainees?", with the focus on self-efficacy, self-esteem, and anxiety
as relevant dimensions for study.
Chapter II

REVIEW OF THE LITERATURE

The literature relevant to this dissertation falls into several related areas, around which this review is organized. The first topic covered is that of feedback in supervision, followed by a review of the concepts of competence, self-esteem, and anxiety as they relate to counselor trainees. A section addressing the theory and research on self-efficacy follows. A summary of these topics and the specific hypotheses complete the literature review.

Research on Feedback in Supervision

A review of much of the recent research on feedback in supervision has been provided by Ford (1979). Various aspects of feedback in supervision have been studied. As Ford (1979, p. 99) has outlined, feedback involves a message, a valence, a source, and a medium. "The message may be a simple 'right' or 'wrong' ... or it may include specific discriminative instructions, explanations, or modeling" (Ford, 1979, p. 99). The effects of these two messages on trainees have not been examined empirically. The message can also refer to the trainee's specific behavioral performance or to more global or affect-oriented aspects, with the former consistently more effective than nonspecific feedback (Ford, 1979, p. 99). On the other hand, if the trainee is provided clarifying instructions about his/her behavior, this can increase the effectiveness of global feedback to the level of specific feedback (Carlson, 1974).
Research has yet to systematically evaluate the effect on performance of positive versus neutral versus negative valence of feedback in supervision (Ford, 1979). However, there is some research on other aspects of valence. Yellin (1978) examined the differential impact of positive and negative evaluative feedback on the trainee's affective reactions toward the supervisor, the counseling task, and the feedback itself. The counselors' reactions to the counseling task were affected by different valences of feedback. Positive feedback did produce more attraction to the supervisor and that feedback than negative feedback. Yellin (1978) concluded from this analogue study that negative feedback may lessen the impact of the supervisor, especially for trainees with positive self-evaluations of their counseling performance.

Another study (Lee, Halberg, Hassard, & Haase, 1979) compared the interaction effects of success versus failure feedback and locus of control on counselor trainees. Those participants who received failure feedback in regards to their performance in a brief interview blamed themselves and environmental factors more than participants who received success feedback. Trainees in the success condition showed a significant increase in level of expectancy for their own counseling performance, a greater willingness to improve their skills, and greater receptivity to feedback (Lee et al., 1979). Similarly, Bernstein, Bianca, and Lecomte (1979) investigated the impact of four types of feedback: moderately positive, congruent with trainees' expectations for feedback, moderately negative, and extremely negative. Bogus feedback was constructed according to participants' expressed expectations for feedback received from a respected faculty.
member and the experimental condition involved. The researchers
discovered that there was significantly greater agreement with more
positive content evaluation and more accurate recall of positive
and congruent feedback than of moderately and extremely negative
feedback (Bernstein et al., 1979). Worthington and Roehlke's (1979)
results further support the importance of positive feedback,
especially with beginning supervisees who need to develop self-
confidence.

The source of the feedback is also an important parameter to
investigate (Ford, 1979). In summarizing the research, Ford (1979)
cited several contradictory studies. Some researchers have found
peer and self-evaluative feedback to be superior in efficacy to
supervisor feedback, while others demonstrated that such feedback
is useful only when preceded by supervisor feedback of an accurate
nature. Wise (1977) explored the differential effects of intrinsic
versus extrinsic feedback on the learning patterns of prepracticum
students. Intrinsic feedback was defined as the information derived
from self-monitoring of one's interview behavior. Wise (1977)
found no differences in performance of empathic ability between the
two feedback conditions. In a dissertation, Robinson (1978) compared
the impact of self-generated performance feedback and expert per-
formance feedback on reflection of feeling responses in beginning
master's degree students, and again revealed no differences. Source
of feedback, then, has not been shown to have a differential effect
on trainee performance.

The fourth parameter of feedback outlined by Ford (1979) is the medium or mode of presentation. Ford (1979) indicated that research consistently supports the superiority of immediate feedback, in the form of co-counseling, the "bug-in-the-ear" method, etc., over delayed feedback, unless the latter is reinforced by videotape self-confrontation. Kottler (1977) examined the effects of immediate feedback via the "bug-in-the-ear" technique, and found moderate effects on counselor performance. The trainees attested, through self-report, to the helpfulness of immediate feedback. However, Kottler (1977, p. 6277) failed to include a control group and drew conclusions from "visual inspection of graphically-portrayed data". Hodge, Payne, and Wheeler (1978) compared individual supervision, including personalized feedback, with programmed supervision, in which trainees listened to taped examples of low and high empathic responses. Ratings of simulated interviews, requiring participants to respond to client statements using a dictaphone, demonstrated that learning of empathy was greater in individual supervision.

A study by Condon (1978) provided a summary of the parameters of feedback reviewed above. A number of aspects of feedback on supervision were evaluated in relation to levels of counselor effectiveness. The feedback variables were verbal-nonverbal, strong-weak, here & now-there & then, supported-nonsupported, owned-not owned, positive-negative, directed-nondirected,
evaluative–nonevaluative, spontaneous–solicited, specific–general, and goal-related. The participants were 20 counselors, their supervisors, and 70 of their clients, all of whom evaluated levels of counselor effectiveness. The only feedback variables related to counselor effectiveness in this study were supported–nonsupported and owned–not owned, such that supported and owned feedback was positively related to counselor effectiveness and vice versa (Condon, 1978). Combining the results of this report with those above, provides some guidelines for feedback in supervision. Effective feedback should focus on specific behaviors, or include instructions, be positive, immediate, supported, and owned, and perhaps be provided by both a respected supervisor, peers, and self-evaluation.

Research on Relevant Personal Characteristics of Counselor Trainees

Considerable theory and research has been devoted to a counselor trainee's sense of competence in psychotherapeutic intervention. Nelson (1978) surveyed psychology trainees, finding that therapeutic competence is an important training goal. Dye (1981) asserted that throughout the distinct growth process that characterizes the development of all counselors, there are predictable crises. These crises are all challenges to the developing sense of competence of the trainee, and the resolution of same can determine the style and effectiveness of the counselor. Not only is a sense of competence important throughout graduate training in psychology, but even
more specifically becomes a focus in supervision utilizing audio-taped counseling session (Kobos, 1981). The student may feel a certain degree of evaluation apprehension in presenting tapes for review, reflecting concern about one's therapeutic abilities.

Research has further substantiated the significance of competence issues to counselor trainees. Nelson's (1978) study, mentioned above, is one example. Levy (1979), in an investigation of similar issues, had 45 graduate students rate themselves on a dilemma scale consisting of 77 items involving problems encountered by therapists in training. "Dilemmas identified as more problematic by trainees with less experience involved concerns about the ambiguity of therapeutic work and roles, concerns about patient-therapist interactions, and concerns about lack of expertise due to inexperience", i.e. competence (Levy, 1979, p. 356). In an effort to assess trainees' views regarding the importance of their personal competence as psychotherapists, Bradley and Olson (1980) surveyed 183 clinical psychology graduate students from ten programs. Future competence as psychotherapists was rated as moderately to extremely important for all students. The researchers also evaluated students' self-ratings of present level of competence and their relationship to a number of variables such as sex, age, training program, year in training, and supervision. Two variables, number of supervisors and total hours of formal supervision, were significantly correlated (p < .001) with self-ratings of competence in psychotherapy (Bradley & Olson, 1980, p. 933).
Hill, Charles, and Reed (1981) followed twelve students through a doctoral program in counseling psychology in an effort to identify resultant changes in counseling skills and other related abilities. The expected changes in counseling skills, such as increase in use of "minimal encouragers" and decrease in use of questions, were found. However, the qualitative interview data are most interesting for current purposes, in that many students reported significant increases in confidence in one's counseling abilities, becoming more comfortable with the counseling situation. Since only one graduate program was studied, generalization to other training settings is not justified.

Not only is personal competence an important goal for counselors-in-training, there is also evidence that such a sense of one's ability as a counselor may be present in those already functioning in that role. O'Roark (1981) looked at the effectiveness of school counselors and the relationship to positive, open beliefs about self, others, and situations. The participants were public school counselors, with formal educational preparation and at least one year's experience, whose effectiveness was rated by their peers. The ten counselors rated as "most effective" and ten rated "least effective" by their peers were then compared on the Perceptual Dimension Scales (PDS), which are based on the premise that action is a result of perception of self, situation, and the interrelation of the two. O'Roark (1981) reported significant correlations between effectiveness and the PDS in previous studies. The resultant MANOVA comparing the two groups
suggested that both most and least effective counselors perceived themselves as adequate and able in their roles. Both groups also viewed themselves as liked and wanted, i.e. having a sense of self-worth.

This latter finding of O'Roark's (1981) introduces another characteristic of counselors and trainees often associated with a sense of competence or ability as an agent of therapeutic change, that of self-concept or self-esteem. Costello (1981) pointed out that another important issue in supervision, in addition to that of competence, is the student's self-esteem. Attending to the student-therapist's emotional needs, as in concerns over self-esteem, is seen as of equal importance for facilitating growth as attention to cognitive learning tasks.

Several other researchers have examined the relationship of self-concept to effectiveness as a counselor. Roy (1980) had clients rate "effective counselors" according to the California Psychological Inventory, the Porter Test of Counselor Attitudes, the Barrett Relationship Inventory, and the Counselor Evaluation Rating Scale. The perception of an effective counselor was of an individual who has a sense of personal worth, as well as is tolerant, nonjudgmental, conscientious, responsible, and interested in and responsive to others.

Citing previous research that found personal qualities of counselors to be critical factors in counselor effectiveness, Schwab and Harris (1981) examined the extent to which counselor
education programs did facilitate personal growth through a cross-sectional study of counselors in training. Advanced counselor trainees (N=37) and beginning counselor trainees (N=32) were compared on Shostrom’s (1976) Personal Orientation Inventory (POI), a measure of level of self-actualization. Both groups were also contrasted with the standardization groups of normal and self-actualized individuals. Both beginning and advanced groups were significantly higher than the normal group on self-regard, with the advanced trainees achieving the level of self-acceptance and self-regard of self-actualized persons. This suggested that not only do beginning counselor trainees have more positive self-concepts than normal adults, but by completion of training counselors may have an even greater sense of self-worth, though that increase cannot be attributed to the training program. Problems with this study require caution in employing these results; the use of multiple t-tests may contribute to Type I error.

Finally, Omizo, Ward, and Michael (1979) examined the predictive validity of the California Psychological Inventory (CPI) relative to success in graduate school. One predictor of performance on the Master's Comprehensive Exam (MCE) for students in counselor education was the CPI scale of self-acceptance. However, the extent to which performance on the MCE is related to counseling effectiveness is unclear, limiting the usefulness of this finding.

From the above discussion, it may be postulated that a counselor
trainee's sense of self-worth may impact his/her feelings of competence. Another factor which may significantly affect perceived psychotherapeutic ability is anxiety. Friedlander (1981) suggested that most supervisees may be anxious during supervision for varying reasons, and that anxiety can interfere with the productivity of the supervisory process. Not only may students be anxious about supervision in general, due to evaluation apprehension and issues of competence as suggested by others (Dye, 1981; Kobos, 1981; Levy, 1979); but Friedlander asserted that students may have other idiosyncratic predispositions to become anxious, such as lowered self-esteem (Friedlander, 1981, p. 11). In this way, competence, self-concept, and anxiety may be inextricably interrelated and mutually determined.

Hill, Charles, and Reed (1981) also addressed the issue of anxiety in counselor trainees. Over the course of graduate training, the participants in this study did not show significant change on a qualitative measure of anxiety. However, the subjective impression of the majority of students, especially with regards to nonverbal behavior, was that they became "more relaxed, natural, and spontaneous" (Hill, et al., 1981, p. 432). All trainees reported feeling considerably less anxious with clients. Again, accompanying this decreased anxiety was increased self-composure, raising the question of causality again.

That anxiety is a concern to supervisees has been empirically demonstrated (Kreiser, 1980). Cohen (1980) compared the preferences for supervisions of forty behavioral and analytic psychotherapy
trainees. Each participant was administered two 60-item Q-sorts, one ranking items in relative desirability of the ideal supervisor, and one ranking how characteristic items seemed for the typical supervisor (Cohen, 1980, p. 1496). The results indicated that the ideal supervisor for both groups of trainees was a supervisor who would help alleviate the student's anxiety by structuring supervision and therapy sessions, and focusing on the client or self, rather than on the supervisee. In another study, Kreiser (1980) attempted to assess the effects of counselor anxiety (state, trait, and interview) on actual behavior in the counseling interview, specifically degree of empathy and approach behavior. Ten experienced counselors, five high and five low on trait anxiety, videotaped two consecutive counseling interviews with a client. None of the types of anxiety assessed had a direct effect on the dependent variables, though there were significant interaction effects of interview and state anxiety and interview and trait anxiety on approach behavior. The participants in this study were experienced counselors, rather than trainees, and generalization is therefore limited.

Research on Self-Efficacy

Self-efficacy is concerned with a person's belief in the likelihood that s/he can organize and execute a given course of action required to deal with a certain situation (Bandura, 1980). Efficacy expectations influence choice behavior, in that people tend to avoid tasks they perceive as exceeding their coping capabilities, but they
readily approach and perform assuredly activities they judge themselves capable of completing successfully (Bandura, 1977). Self-percepts of efficacy also determine how much effort a person will invest and how long s/he will persist in the face of obstacles and aversive experiences (Bandura, 1980, p. 263). Bandura, Adams, Hardy and Howells (1980) asserted that the lower and weaker the efficacy expectations, i.e. the less confidence in one's ability to perform the task at hand, the greater the self-generated anxiety on that task. As Bandura (1980, p. 264) stated, "such self-referent concerns tend to undermine effective use of the competencies people possess".

Operating from a social learning framework, Bandura (1977) defined four sources of information that are influential in an individual's development of expectations of personal efficacy. These four sources can operate singly or in combination, which is often the case in psychological procedures. Performance accomplishments, the first source, are usually the most powerful, since they are based on experiences of personal mastery. Success experiences increase self-efficacy, while failures detract from expectation of mastery. An individual's direct experience of success or mastery, especially if repeated, becomes ingrained as a feeling of personal effectiveness that is fairly resistant to the negative impact of failure. Treatment procedures that rely on actual performance, such as participant modeling, in vivo desensitization, and self-instructed performance would fall under this category of information regarding efficacy expectations.
Vicarious experience, the second source of efficacy information, relies on techniques of modeling, live or symbolic. Individuals observe the successes of others with threatening tasks, and may conclude that they, too, can achieve that level of performance with effort. As the third source of efficacy information, verbal persuasion includes suggestion, exhortation, self-instruction, and interpretive treatments. This is a weaker source of influence, not based on personal experience. Finally, cues from physiological states influence personal efficacy expectations. Emotional arousal, especially high levels of anxiety, may inhibit performance and therefore contribute to lowered self-efficacy perceptions, as mentioned above (Bandura, et al., 1980).

Bandura and colleagues (Bandura & Adams, 1977; Bandura, Adams, & Beyer, 1977; Bandura et al., 1980) have conducted a number of studies designed to evaluate the concept of self-efficacy. Much of the early work was done with severe snake phobics, but they have recently expanded to include agoraphobics in treatment as well, increasing the generality of the concept. In 1977, Bandura, Adams and Beyer first tested the theory of self-efficacy. Participants were thirty-three snake phobics, whose lives had been disrupted by nightmares, ruminations, and/or changes in behavior to accommodate their fears. A multifaceted assessment procedure included tests of behavioral avoidance of a boa constrictor, fear arousal accom-
panying each task, self-report of efficacy expectations, and tests of situational generalization. Participants were matched in triads
according to baseline performance and assigned to one of three treatments: participant modeling, modeling, or control. In the first treatment, the experimenter would model the task briefly, then assist the client in successful performance, aided by breaking tasks into manageable components, using gloves, etc. Treatment continued until the client could complete all tasks and ascribed that success to self-efficacy. The modeling group observed the experimenter while receiving no help with performance, and the control group merely completed the measures at the same three times as the treated groups.

The results revealed the participant modeling group to be superior in performance and efficacy expectations, while the modeling group also exceeded the control group. Efficacy expectations were found to be better predictors of future performance than past performance. Finally, participants with the higher levels of self-efficacy at the completion of treatment also had higher levels of approach behavior, lower anticipatory fear, and showed greater generalization to similar situations (Bandura et al., 1977).

Bandura and Adams (1977) reported a study of self-efficacy and approach behavior in severe snake phobics treated by a standard systematic desensitization paradigm. Desensitization continued until all anxiety reactions to imaginal representations of snakes were extinguished. Pre and post treatment assessments of approach behavior and efficacy expectations revealed support for self-efficacy theory, in that the greater the perceived self-efficacy, the greater was the approach behavior.
In another investigation, Bandura and Adams (1977) examined the process of efficacy and behavior change during the course of the treatment itself. Again treating adult snake phobics with participant modeling, the tasks on the behavioral avoidance test were segmented into blocks of increasing threat and difficulty. Treatment continued until all activities in each block were mastered, with efficacy expectations and approach behavior assessed for that level. This allowed a microanalysis of the results, examining the congruence between self-efficacy and performance at each level. Further support for self-efficacy theory emerged, with the same relationship between self-efficacy and approach behavior found in previous research at completion of treatment also identified as operating at any point during treatment.

Bandura, Adams, Hardy, and Howells (1980) tested the explanatory and predictive generality of self-efficacy with other types of clients and treatments. The first study included the multifaceted assessment of behavioral avoidance, fear arousal, and efficacy judgment of snake phobics utilized in previous work, but with only half the participants making efficacy judgments after completion of the cognitive modeling treatment. This comparison of persons reporting and not reporting efficacy assessments led to the conclusion that making efficacy judgments had no effect on subsequent approach behavior or fear arousal. In addition, the positive relationship between self-efficacy and approach behavior found previously was substantiated, supporting the theory. The cognitive modeling process, in which participants imaged
a model performing threatening interactions with snakes, was also shown to enhance self-efficacy. Finally, this study showed that "perceived inefficacy is accompanied by high anticipatory and performance fear arousal, but as strength of perceived efficacy increases, fear arousal declines" (Bandura et al., 1980, p. 51).

In a second project (Bandura et al., 1980), treatment of agoraphobics utilizing an intensive ten-day mastery-oriented treatment was set within the self-efficacy framework. The treatment consisted of the client engaging in progressively more difficult and threatening tasks while accompanied by a therapist and support person. Each person's treatment was greatly individualized, with the specific treatment tasks differing according to clients' patterns of dysfunction, and clients supplying their own support persons. Efficacy judgments were measured before and after the behavioral pretest, at completion of the treatment program and after the behavioral posttest. The treatment program included preparatory group sessions, addressing issues such as relaxation, assertiveness, and self-expression, and field mastery trips, the latter being guided by the support persons and seven different field therapists, to enhance generalization. The field therapists recorded the tasks actually attempted and/or mastered by the participants. Again, support for self-efficacy theory was clear; both level and strength of self-efficacy were raised by the enactive mastery treatment; the higher and stronger the percepts of self-efficacy, the significantly greater was the coping behavior. In addition, self-efficacy was an accurate predictor of performance
on the behavioral tests and posttreatment assessment tasks (Bandura et al., 1980, p. 59).

To summarize, Bandura and colleagues (Bandura & Adams, 1977; Bandura et al., 1977; Bandura et al., 1980) have presented considerable support for the concept of self-efficacy, including evidence of generality. Using participant modeling, a process of demonstrating to and guiding clients through the feared behavior, they have successfully treated many individuals. They have also discovered that increases in self-efficacy accompany these changes in behavior. Perceived self-efficacy has also been shown to be an excellent predictor of subsequent performance, while previous behavior is a weak predictor by comparison. Indeed, self-efficacy predicted subsequent treatment for 92% of the total assessment tasks (Bandura & Adams, 1977, p. 303). Efficacy expectations have also been shown to account for differences in behavior between different clients receiving the same type of treatment (Bandura, 1977). While this research has not established a causal effect between increases in self-efficacy and improved performance, there is a strong correlational relationship between efficacy expectations and successful treatment of phobic clients.

Motivated by this question of causality in the theory, Feltz (1980) employed path analysis to examine the causal elements in self-efficacy, using back-diving performance. According to Bandura's model, a reciprocal relationship would exist between self-efficacy and back-diving performance, with self-efficacy the mediator of that performance (Feltz, 1980, p. 4329). The participants were female college
students (N=80), who were introduced to the dive through a verbal explanation and filmed demonstration. Measures assessed over four trials included monitoring heart rates, completing anxiety and self-efficacy self-reports, and which of four board heights the woman chose for the dive. The results showed that self-efficacy was the major predictor of performance on the first trial; after the first trial, performance on the previous trials became the major predictor of performance on the next trial. This finding is contradictory to Bandura's work cited above. A reciprocal cause-effect relationship between self-efficacy and back-diving performance was evident, though not equally reciprocal. With increased experience on the task, back-diving performance had a greater influence on self-efficacy than self-efficacy had on diving performance. Feltz (1980) concluded with a respecified model which included performance and self-efficacy as predictors of later performance.

The concept of self-efficacy has been examined by numerous researchers in reference to many diverse behaviors, also with mostly positive results and subsequent support for the theory. Brown and Inouye (1978) examined students' efficacy expectations and performance on anagrams, some of which were unsolvable. Regardless of the experimental phase or treatment conditions, which involved vicarious modeling and feedback levels, the participants with higher expectations of self-efficacy persisted longer on unsolvable tasks. Additionally, "there was a progressive increase in the magnitude of the relationship between expectations and persistence on succeeding blocks of trials,
suggesting that the students were relying more heavily on their judgments of self-efficacy in regulating expenditure of effort" (Brown & Inouye, 1978, p. 907).

Barrios (1980) tested the predictive validity of self-efficacy theory with respect to treatment of heterosocially anxious male psychiatric inpatients by either participant modeling or imaginal desensitization. As expected, high correlations were discovered between efficacy expectations and performance measures, with changes in efficacy corresponding to changes in behavior. The strength of efficacy expectations was related to the degree of perseverance in the face of obstacles (Barrios, 1980, p. 1099).

Goldsworthy (1980) and Kazdin (1979) have both reported on self-efficacy as it relates to interpersonal behavior. Goldsworthy (1980) compared an interpersonal skills training treatment and a verbal-persuasion treatment with an assessment-only control. Bandura's (1977) work would predict the more active treatment to result in greater changes in self-efficacy; performance is allegedly a more powerful source of efficacy information than verbal exhortation. The results showed that both treatments lead to increased efficacy expectations and improved performance as compared to the control group, with no differences between the treatments (Goldsworthy, 1980).

Kazdin (1979) examined the effects of covert modeling, including elaboration of treatment scenes, and changes in client self-efficacy as a result of treatment. A control group, involving visualizations
of neutral scenes, was also included. The covert modeling treatments lead to greater change in level of self-efficacy than the scene control group, and the changes in efficacy expectations were also significantly correlated with changes in two self-report measures and a behavioral measure, an assertiveness role play.

Self-efficacy has been investigated in relation to treatment for smoking in four studies. Corn (1978) compared two self-management approaches and a counselor-directed treatment for smoking cessation for two weeks, and then treated all participants with the identical aversive smoking procedures for two additional weeks. Self-efficacy, after both the first and second phases of treatment, was related significantly to smoking outcome, one and twelve weeks after treatment, such that an increase in efficacy expectancies accompanied a decrease in cigarettes smoked. However, efficacy expectations were not better predictors of behavior than smoking during treatment, contrary to Bandura's (1977) theory.

Condotte (1980) examined participants in two different smoking cessation programs, comparing self-efficacy and Marlatt's (1978) theoretical model of relapse. Efficacy expectations were significantly enhanced as a result of both treatment programs. This researcher also revealed that there was a large correlation between smoking situations in which relapsing subjects experienced a low degree of self-efficacy and the situation in which actual relapses were reported to have first
occurred. In a study by Chambliss and Murray (1979), participants were led to attribute their success in smoking reduction to either a placebo/drug condition or to their own efforts. The self-efficacy group reduced their smoking significantly more than the individuals who attributed their success to the drug.

DiClemente (1981) applied self-efficacy to the problem of long term maintenance of smoking cessation. Participants were heavy smokers who had stopped smoking by three different means. Self-efficacy was assessed four weeks after quitting smoking and at a five month follow up. Those persons who had continued to not smoke at the extended follow-up did not differ from the recidivists on type of treatment, demographic characteristics, or smoking history. However, those who maintained the changes did differ significantly from the recidivists on self-efficacy; nonsmokers showed greater self-efficacy.

In three other studies, self-efficacy has been tied to academic behavior. Schunk (1979) studied children who exhibited gross deficits in mathematical skills, comparing treatment components of modeling, self-directed mastery, corrective feedback, graded practice, and written instruction. All of these treatments helped to increase children's math skills, and also resulted in significant increases in self-efficacy when compared with the control group. In addition, the stronger the children's self-efficacy, the longer they persisted and the more likely they were to perform the tasks successfully.

LaLonde (1979) developed a Measure of Academic Self-Efficacy (MASE). Students who scored highly on MASE were less anxious, more willing
to accept responsibility for their academic success, had more positive self-concepts, and performed better and persisted longer on anagram tasks. In a study of 504 sixth graders, Keyser and Barling (1981) examined the determinants of academic self-efficacy beliefs. In the first project, these investigators looked at the effect and interactions of performance accomplishments, modeling, and locus of control. None of the variance in self-efficacy beliefs could be attributed to performance accomplishments, contrary to Bandura's theory (1977, 1978). The second phase of the project assessed whether contextual factors along with performance accomplishments and modeling, could account for significant variance in self-efficacy. Modeling was the most significant predictor of efficacy beliefs, reversing the hypothesized order of sources of efficacy information. Keyser and Barling (1981) suggested that this reversed importance of sources of influence may be attributed to the age of the sample.

The effect of self-efficacy on performance was expanded to include another treatment technique, Stress Inoculation Training, by Harmon-Bowman (1981). Stress Inoculation Training, aimed at teaching trainees how their thoughts influence their behavior while under stress, was utilized with a group of secondary school educators. The participants were split into high and low self-efficacy groups before training began, and were compared according to those groups. The results again support the theory of self-efficacy, with high self-efficacy trainees reporting more effective performance of stress management procedures and low self-efficacy trainees reporting lower performance levels.
Self-efficacy expectancies and persistence in pain control have been examined also (Manning, 1981). Participants were 52 "first pregnancy" women enrolled in childbirth preparation classes. Efficacy expectations, outcome expectations, and importance of utilizing pain control techniques were assessed after completion of the classes and in the early stages of labor, and were employed as predictor variables for use of medication during labor and delivery. Hierarchical multiple regression analysis revealed that self-efficacy expectancy contributed significantly more of the unique variance in the prediction of medication use than either outcome expectancies or importance, or those two variables combined (Manning, 1981, p. 1613). Manning's (1981) work extended the validity of self-efficacy theory to yet another useful area, as well as reemphasizing the importance of differentiating efficacy and outcome expectancies (Bandura, 1977, 1978).

In another unique direction for self-efficacy research, Coppel (1980) analyzed the relationship of perceived social support and self-efficacy to major and minor life stresses for three groups: undergraduates, university counseling center clients, and geriatric patients. The relative contributions of major negative life change events, minor conflict, social support variables, and personality variables to physical health and psychological adjustment were explored. The results confirmed previously identified-relationships between major life stresses and physical and psychological health, and also pointed out intra-personal support variables (self-esteem, self-efficacy, and locus of control) that accounted for a signifi-
cant amount of the variance in psychological and physical adjustment. In other words, self-esteem, self-efficacy, and locus of control seemed to affect psychological and physical health. Again, the aforementioned connection between self-esteem and self-efficacy arises, substantiating the importance of considering the concepts together.

Finally, self-efficacy recently has been applied as an explanatory concept in the area of women's career development (Ayres, 1980; Betz & Hackett, 1980). Ayres (1980) studied the extent to which the differences between males' and females' perceptions of preferred career options was due to differences in the level and strength of self-efficacy expectations about behaviors necessary for certain occupations. Undergraduate students utilized in the study rated their perceived self-efficacy of behaviors judged as essential to four occupations, two traditionally viewed as most appropriate for males and two traditionally viewed as most appropriate for females. The results suggested that there is some relationship between career-related self-efficacy expectations and career choice, though the nature of that relationship was unclear. Betz and Hackett (1980) are continuing to assess the relationship between efficacy expectations and specific occupational alternatives.
Summary and Hypotheses

The goal of research on training and supervision is to identify those procedures which will maximize a student's development as a counselor. As suggested above and stressed by Bernstein et al., (1979, p. 301), "supervisory feedback is frequently the vehicle by which the impetus is provided for student change". These authors have offered the question "which types of supervisory feedback produce which immediate responses in which kinds of trainees?" as a means of guiding research on feedback in supervision toward the goal of maximal training (Bernstein et al., 1979, p. 297). Ford (1979) also cited the matching of trainees with certain personal characteristics with corresponding training interventions as an important objective.

There is, however, little evidence in the literature that begins to answer the above question. Parameters of feedback have been specified (such as immediate, behaviorally-focused, owned, and supported), but the role of trainee characteristics remains relatively unexplored. A trainee's perceived efficacy expectation about role as a counselor may interact with different types of feedback, especially given that feedback may be a source of efficacy information (Bandura, 1980). For instance, Yellin (1978) discovered that students with negative self-evaluations about their performance had more negative affective reactions to the supervision situation. Trainees with low self-efficacy would perhaps benefit most from positive feedback.
The related concept of self-esteem also seems important with regards to feedback in supervision. As Bernstein et al., (1979) have stated, often the supervisor intends, through the feedback process, to influence the trainee's self-evaluation. This may be a more global self-evaluation, such as self-esteem, or behavior-specific, as in self-efficacy. Different forms of feedback may differentially effect the two types of self-evaluation. Likewise, given that supervision is a means to allay trainees' anxiety (Friedlander, 1981); different types of feedback may be more effective in that goal.

Ford (1979) found that performance-specific feedback has been demonstrated as more effective than non-specific, global feedback. Ford (1979) also indicated that the message of feedback can be a simple "right" or "wrong", or providing specific instructions or explanations. These two types of messages have not been compared empirically. Positive feedback has been shown to be preferred by trainees (Worthington & Roehlke, 1979). The question arises as to the effect of combining the above forms of feedback, offering simple, global, positive feedback as compared to specific, instructional, positive feedback. This would help to delineate the active components of feedback, comparing the valence or the message to see which has the greater effect.

This project examined the effects of different types of feedback on trainee self-esteem, self-efficacy, anxiety, and performance. It was hypothesized that type of feedback would interact with the
trainee's level of self-esteem, self-efficacy, and anxiety. For instance, if a trainee is experiencing a global demoralization in the form of low self-esteem, perhaps global, positive feedback would be most beneficial. On the other hand, if low self-efficacy or doubts about one's counseling abilities or skills are problematic, specific, technique-oriented feedback would lead to the greatest improvement. The specific hypotheses that were tested are as follows:

1. Global feedback will result in greater improvement of self-esteem and of performance in low self-esteem trainees.

2. Specific feedback will result in greater improvement of self-efficacy and of performance in low self-efficacy trainees.

3. Participants who receive feedback, whether global or specific, will show greater change in self-efficacy, self-esteem, and performance than subjects who receive no feedback.

4. A predictive relationship between self-efficacy and performance will be identified, such that high self-efficacy will accompany better performance in the role-play interviews.

5. Higher levels of anxiety will have a debilitating effect on performance.

6. There will be an inverse relationship between self-efficacy and anxiety.
Chapter III

METHOD

Participants

Participants in this study were undergraduate students recruited as volunteers from two upper-level Psychology classes, Psychology 539 and 540 (N=60) at the Ohio State University. Participants were also recruited by posted advertisements aimed at psychology majors at the university. The procedure for recruitment was as follows: early in the Spring and Summer terms of 1981, the experimenter attended the above-named classes and asked for volunteers to take two screening instruments, the Rosenberg Self-Esteem Scale and a Counseling Self-Efficacy scale developed by the experimenter. The experimenter obtained names, demographic data (see Appendix A), and telephone numbers of those who volunteered, explaining that not everyone would be called. Of the eighty-two students who completed the screening instruments, sixty actually participated in the study. It was emphasized that participation was strictly voluntary. The study was described as an experiment on feedback in supervision of counselors, and benefits to be gained from participation (such as increased knowledge of the process of counseling) were described. The task was described as role-playing a counselor in two short interviews with a confederate client.

The mean age of the participants was 23.56 years, with a range of 19 to 47 years of age. The majority of the participants were psychology majors (56%), 73% of whom were planning careers in counseling or
or clinical psychology. The educational level of the students was
diverse, with 2.7% freshmen, 12.3% sophomores, 31.5% each juniors and
seniors. In addition, the sample included 9.6% each master's level and
continuing education students and 2.7% Ph.D. students. Women comprised
75% of the participants. Other well-represented career goals included
undecided (17.8%), law or probation officer (11%); and guidance counse-
lor and medical professions with 6.8% each. Popular majors among the
sample were social sciences other than psychology (17.8%), education
(15.1%), criminology (6.8%), and child development/home economics and
language arts with 5.5% each. Thirty-eight percent of the participants
no experience with counseling or related activities; 27.4% cited
related experience within the framework of an academic course; 16.4%
identified volunteer experience on a telephone hotline, halfway house,
or similar setting. At least 6.8% of the students had actual work
experience in a helping profession. A summary of these characteristics
is presented in Appendix B.

Measures

All participants completed three paper-and-pencil inventories
at the time of the experiment, including retesting on the two scales
used in the screening. These three scales are the Rosenberg Self-
Esteem Scale, the Counseling Self-Efficacy Scale, and the Anxiety
Differential. Order of presentation of the scales was counterbalanced
across participants. The Counselor Rating Form was employed to evaluate each participant's performance in the counseling role play. Each of these instruments is described below.

**Rosenberg Self-Esteem Scale** (See Appendix C)

The Rosenberg Self-Esteem Scale (RSE), is a ten-item Guttman scale with satisfactory internal reliability, having a coefficient of reproducibility of 92 percent and a coefficient of scalability of 72 percent. Respondents rate their agreement with each item as strongly agree, agree, disagree, or strongly disagree. The range of scores is from 10 to 40. Test-retest reliability coefficients of \( r = .85 \) and \( r = .88 \) have been cited for college students (Rosenberg, 1979).

Support for the contract validity of the RSE has been provided by Rosenberg (1979). Studies listed in that work showed the clear relationship between the RSE and depressive affect, anxiety, and peer-group reputation. Several studies have also factor analyzed the RSE, revealing factors of "positive self-esteem" and negative self-esteem", or "self-confidence" and "self-deprecation". In each case, however, the two factors correlated more highly with criterion variables when analyzed together than when analyzed separately (Rosenberg, 1979). In addition, Rosenberg (1979) provided data on the convergent and discriminant validity of the RSE.

**Counseling Self-Efficacy Scale** (See Appendix D)

The Counseling Self-Efficacy Scale (CSE) was developed by the experimenter to assess the level and strength of the respondent's
belief in his/her ability to perform in a counseling situation. The participant checked which behaviors s/he felt capable of performing under Can Do, and then rated his/her confidence in performing that behavior. The CSE is patterned after Bandura's method of assessing self-efficacy (see Note 2). The level of self-efficacy was scored by tallying the number of items the person checked under Can Do. Strength of self-efficacy scores were obtained by adding up the confidence ratings and dividing the total by 14, the number of items in the scale. Only strength scores were actually used in the analysis.

The scale was pilot tested in Winter Quarter of 1981 with Psychology 540 (N=120) classes, and with counseling psychology graduate students (N=34). Initially, two forms of the CSE were examined in the pilot testing. Two sections of Psychology 540 were approached by the experimenter and asked to fill out the scale during classtime; the graduate students received the scale and request in their mailboxes, and returned completed questionnaires to the experimenter. All respondents were anonymous. The CSE form which was selected for use in the present study was chosen because most respondents from the undergraduate sample obtained lower scores on that form. These lower scores were judged by the experimenter to be less inflated and perhaps more related to actual performance for an undergraduate population.

Test-retest reliability for the CSE was assessed for the screening and pretest scores for the sixty participants involved in both of those phases of the experiment. The test-retest interval ranged from two to six weeks. A Spearman reliability coefficient of r=.77 was obtained,
indicating adequate stability, given that participants were enrolled in a course on counseling theory and techniques during that interval.

To assess the validity of the instrument, the graduate and undergraduate samples were compared using a two-tailed t-test. The CSE form chosen for use was found to discriminate significantly between the two groups (t=2.71, p<.01), with graduate students having scores that were significantly higher. Graduate students' scores on the CSE were also contrasted according to year in training, and further ability of the instrument to differentiate between groups was identified. All students were approximately halfway through the current academic year at the time of the assessment. When scores on the CSE for first year students (N=7) were compared with scores of second year students (N=11) there was a significant difference (t=4.68, p<.001), with first year students scoring lower. Likewise, advanced students (N=15) in their third year or more, scored significantly higher than students in their first and second years combined (N=18) (t=2.36, p<.05). However, the capability of the CSE scale to discriminate between second and third year students and third and fourth/fifth year students, respectively, was not as pronounced. Comparison of second (N=11) and third (N=8) year students' scores yielded a t=1.44, which is significant at the .20 level. Discrimination (t=1.65, p<.20) between the third year and fourth year and up groups was also evident. In these latter two cases, the Counseling Self-Efficacy Scale nevertheless might be expected to discriminate between graduate students at various levels of training, with an 80% accuracy rate at any one assessment.
Anxiety Differential  (See Appendix E)

The Anxiety Differential (AD) (Husek & Alexander, 1963) was administered to participants immediately before each role play, in order to examine changes in situationally-aroused anxiety, as suggested to be present by Bowman and Roberts (1979), Bowman, (1980), and Kottler (1977). The AD was constructed in a semantic differential format, and required respondents to rate 18 items on a 7-point scale, based on what each concept "means" to them at that moment. Scores were obtained by totaling those ratings, for a range of 18 to 126. The AD has a unique advantage in that most subjects do not know what the instrument is attempting to measure (Husek & Alexander, 1963). Internal consistency of the instrument is adequate, with Alpha coefficients ranging from .58 to .80, with a median of .68.

Counselor Rating Form  (See Appendix F)

The Counselor Rating Form (CRF) was used by the confederate clients and raters to rate the performance of the participant in terms of expertness, attractiveness, and trustworthiness in each segment of the role play. The CRF consists of 36 items, each a 7-point bipolar scale. The range of scores on each dimension is 12-84, obtained by adding the ratings of each item. Reliability data are provided by LaCrosse and Barak (1976). The CRF has also been shown capable of discriminating between and within counselors on each of the dimensions of expertness, attractiveness, and trustworthiness.
Procedure

A summary of the procedure is provided in Table 1.

The screening was conducted within the classroom setting as described above, except for those twelve students recruited outside the classroom, who skipped this phase of the experiment. Participants completed the Rosenberg Self-Esteem (RSE) and Counseling Self-Efficacy (CSE) scales. The purpose of the screening was to make possible the recruitment of participants with a wide range of scores on these measures, so that persons scoring low as well as high could be involved. In addition, the screening data were utilized in examining the reliability of the CSE scale. Appropriate persons were contacted by telephone and asked to participate. Those who chose to participate were assigned a date and time for the experiment and called the night before as a reminder.

Pretesting - When participants arrived for the experiment itself, they were administered the RSE, CSE, and Anxiety Differential (AD) scales. A brief explanation of the role play and supervision feedback procedure was then given to each individual.

Role play procedure - Each student participated in two fifteen minute counseling interviews with one of the confederate clients. During Spring quarter there were four confederates, and during Summer quarter two. Feedback was provided between the two role-played interviews, except for the delayed feedback control group, who received feedback at the end of the two role plays. The participant was told that the client was a student who was having some concerns she would like to
### Table 1

**Summary of the Procedure**

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<tr>
<th>SCREENING</th>
<th>PRETEST</th>
<th>ROLE PLAY I</th>
<th>FEEDBACK</th>
<th>POSTTEST</th>
<th>ROLE PLAY II</th>
<th>DEBRIEFING</th>
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<td>CSE</td>
<td>CSE</td>
<td>CRF-CL</td>
<td>Global or</td>
<td>CSE</td>
<td>CRF-CL</td>
<td>Feedback</td>
</tr>
<tr>
<td>RSE</td>
<td>RSE</td>
<td>CRF-R</td>
<td>Specific or</td>
<td>RSE</td>
<td>CRF-R</td>
<td>for</td>
</tr>
<tr>
<td>DD</td>
<td>AD</td>
<td></td>
<td>Reading or</td>
<td></td>
<td></td>
<td>Delayed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Task</td>
<td></td>
<td></td>
<td>Group</td>
</tr>
</tbody>
</table>

**KEY:**

CSE = Counseling Self-Efficacy scale  
RSE = Rosenberg Self-Esteem scale  
AD = Anxiety Differential  

CRF = Counselor Rating Form  
CL = Client ratings  
R = Audiotape ratings
discuss with the counselor, and that s/he (the counselor/participant) was to do his/her best in helping the student, by being "the best counselor you can, doing what you think a counselor would do". Each role play session was audiotaped for later rating of the counselor's performance.

The confederate clients were undergraduate female students trained in the required roles. There were two roles, which were counterbalanced across participants. The first role involved a first-year undergraduate female student who is having some difficulty adjusting to school in general and her roommates in particular. She is 18 years old, from a small town, undecided major, and an only child. She is somewhat naive, and some of one roommate's behavior has been rather unnerving given this characteristic. Her adjustment to school is complicated by a conflicted relationship with her parents and doubts and desires to establish some independence. The second role also portrayed a female undergraduate, a commuter student facing problems of adjusting to a large university. She lives at home, works the same job she maintained in high school. All her high school friends are away at school; a break-up with her boyfriend who is away at school seems imminent. She seems depressed over her isolation, lack of new friends, and the discrepancy between her imagined college experience and the reality she is facing. Summaries of the roles are presented in Appendix G.

Training for the confederate clients, who included two seniors and four juniors, involved two two-hour sessions in which the women received a verbal and written description of the roles, and then had an
opportunity to practice the roles with the experimenter and each other. Adherence to the role was monitored during the data collection phase, and coaching was provided as necessary to clarify the roles.

**Feedback** - Two experimental conditions of providing feedback, each lasting ten to fifteen minutes, were employed: global and specific. All feedback was positive in nature. The global feedback condition provided the participant with information about the general "rightness" of her/his performance in the previous role play. Global feedback took the form of comments such as "you really did a fine job", "you were very effective in drawing out the client". In this condition, the feedback focused more on characteristics of the counselor than on specific behaviors, e.g. "you seem to have a real way with this person" or "you convey a real aura of acceptance", etc.. In the specific feedback condition, the feedback focused on particular behaviors which the counselor engaged in during the interview. Examples of such specific feedback included "your use of open-ended questions really helped to draw her out" and "the way you sat forward and nodded seemed to convey acceptance to the client".

Advanced graduate students in counseling psychology acted as supervisors and delivered the feedback as described above. The three supervisors, all female, were trained to deliver both global and specific feedback. Training involved helping the supervisors to develop standard responses in both global and specific categories to certain counselor behaviors, as well as standard responses to counselor questions which fit within the frameworks of global and specific
specific feedback. Categories and examples of each type of feedback used by supervisors as guidelines throughout the project are found in Appendix H. The feedback responses of the supervisors were randomly monitored to check for consistency.

Posttesting - After the feedback segment was completed, all students were again administered the Rosenberg Self-Esteem scale, the Counseling Self-Efficacy scale, and the Anxiety Differential. They then were involved in another fifteen minute interview with another confederate client, playing the other role. The role play was again audiotaped for later rating of the counselor's performance. At the completion of the interview, the confederate client rated the counselor using the Counselor Rating Form.

Debriefing - When posttesting was completed, the experimenter met individually with each participant. The purpose, major hypotheses, and procedures of the experiment were explained, and the participants had an opportunity to ask questions.

Control Group - A delayed feedback control group was also included in the study to assess the effects of practice in the role play situation. Participants in this group were administered all inventories as described above, and their performance was rated on the Counselor Rating Form by clients. During the fifteen minute period between role plays in which experimental students received feedback, the control subjects completed a reading task on various counseling theories (see Appendix I). At the completion of the second role play, the
participants in this group then received feedback on their performance in the interviews. The feedback in this condition was positive, combining elements of the global and specific conditions, and was followed by debriefing as described above.

**Ratings of audiotapes** - Each role-played interview was recorded and then rated according to the Counselor Rating Form (CRF) by two undergraduate students. The raters, two males, and two females, were psychology majors who participated in the project as a source of research experience and course credit at the Ohio State University and Southern Methodist University. The raters, who were blind to the purpose of the experiment, were instructed to listen to each role play individually and respond to the counselor "as if you were the client", completing the CRF within that framework. Each student rated tapes from each feedback condition, and each tape was rated by one female and one male. Interrater reliability will be discussed in the following chapter.

**Statistical analysis**

Statistical analysis focused on the effects of types of feedback on self-efficacy, self-esteem, and anxiety as well as the interactions of those factors. The effects of those counselor characteristic and feedback factors on counselor expertness, attractiveness, and trustworthiness, as measured by the client ratings and the ratings of the audiotapes were also analyzed. Hierarchical multiple regression correlation analysis (MRC) (Cohen & Cohen, 1975) was employed for the analyses outlined above. Specifically, MRC analyses assessed the
effect of type of feedback on each of the scales, CSE, RSE, AD; the
effects of CSE, RSE, AD, and type of feedback on each of the Counselor
Rating Form subscales of expertness, attractiveness, and trustworthi-
ness. In addition, a multivariate analysis of variance (MANOVA) of
type of feedback, CSE, RSE, AD, and CRF subscales of expertness,
attractiveness, and trustworthiness was calculated, to address the
problem of multicollinearity of the variables, as well as to detect
influence of the independent variables on combinations of the dependent
variables (Strahan, 1982).
Chapter IV
RESULTS

The results from this study will be reported in the following order: first, examination of the consistency of participants' scores on the screening scales will be presented. A descriptive summary of the data, including means of each group on each dependent variable, is then reviewed, followed by statistics addressing the reliability of the ratings on the Counselor Rating Form (CRF). Then the results of the multiple regression/correlation (MRC) analyses will be examined. MRC analyses first were calculated to assess the effects of type of feedback on each of the counselor characteristic scales, the Counseling Self-Efficacy Scale (CSE), the Rosenberg Self-Esteem Scale (RSE), and the Anxiety Differential (AD). The hierarchical MRC analysis utilizing CSE, AD, and RSE scores and feedback type as covariates to predict CRF expertness, attractiveness, and trustworthiness scores will then be presented. The results of the multivariate analysis of variance of all the above factors will conclude this section.

Results of the Screening Procedure

All participants who were recruited from the classes of Psychology 540 (N=60) completed the Counseling Self-Efficacy (CSE) and Rosenberg Self-Esteem (RSE) scales during class time as part
of the recruitment process. These data provided information on the change in those scores that may have occurred due to participation in the class and/or the passage of time before involvement in the experiment. A dependent t-test using the direct difference method was calculated on the screening scores versus pretest scores for each of these scales, CSE and RSE. Neither of these t-tests approached significance, indicating good consistency of participants' scores on these measures over the two to six week interval from recruitment to involvement in the experiment.

**Descriptive Summary**

The means and standard deviations of the two experimental feedback groups and the delayed feedback control group on the counselor characteristic measures for screening, pretest, and posttest, are presented in Table 2. Generally, these means show slight increases in self-efficacy scores for all groups, with little change of the other measures. The range of scores was broad, and regression to the mean may account for the lack of change suggested by these figures.

Table 3 is comprised of the means and standard deviations of each of the three subscales, expertness, attractiveness, and trustworthiness on the Counselor Rating Form (CRF). These figures are arranged according to type of feedback and source of the rating. As can be seen, there is again only slight, if any, change in the majority of scores over time. Small increases in ratings of expertness are
Table 2
Means and Standard Deviations of Counselor Characteristic Variables by Type of Feedback

Specific Feedback (N=24)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Screening</th>
<th></th>
<th>Pretest</th>
<th></th>
<th>Posttest</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>CSE</td>
<td>58.84</td>
<td>19.68</td>
<td>58.72</td>
<td>21.90</td>
<td>61.04</td>
<td>20.86</td>
</tr>
<tr>
<td>RSE</td>
<td>33.10</td>
<td>3.73</td>
<td>31.88</td>
<td>4.16</td>
<td>32.08</td>
<td>3.99</td>
</tr>
<tr>
<td>AD</td>
<td>n/a</td>
<td></td>
<td>55.00</td>
<td>9.10</td>
<td>54.17</td>
<td>8.20</td>
</tr>
</tbody>
</table>

Global Feedback (N=24)

| Variable | Screening | | Pretest | | Posttest | |
|----------|-----------|------------------|------------------|------------------|------------------|
|          | Mean  | S.D. | Mean  | S.D. | Mean  | S.D. |
| CSE      | 56.57 | 18.21 | 58.20 | 17.40 | 61.43 | 16.69 |
| RSE      | 32.25 | 3.67  | 32.25 | 3.39  | 32.58 | 3.98  |
| AD       | n/a   |       | 58.25 | 10.11 | 59.79 | 10.77 |

Delayed Feedback (N=24)

| Variable | Screening | | Pretest | | Posttest | |
|----------|-----------|------------------|------------------|------------------|------------------|
|          | Mean  | S.D. | Mean  | S.D. | Mean  | S.D. |
| CSE      | 60.85 | 17.34 | 60.53 | 19.37 | 61.10 | 21.38 |
| RSE      | 31.90 | 3.67  | 32.00 | 3.41  | 31.64 | 3.53  |
| AD       | n/a   |       | 55.75 | 9.55  | 56.54 | 12.24 |

Collapsed Across Groups (N=72)

| Variable | Screening | | Pretest | | Posttest | |
|----------|-----------|------------------|------------------|------------------|------------------|
|          | Mean  | S.D. | Mean  | S.D. | Mean  | S.D. |
| CSE      | 58.75 | 18.41 | 59.15 | 19.39 | 61.19 | 19.48 |
| RSE      | 32.42 | 3.98  | 32.07 | 3.62  | 32.10 | 3.81  |
| AD       | n/a   |       | 56.32 | 9.57  | 56.83 | 10.65 |

KEY:
S.D.=standard deviation
CSE=Counseling Self-Efficacy scale
RSE=Rosenberg Self-Esteem scale
AD=Anxiety Differential
n/a=not applicable
Table 3
Counselor Rating Form Subscale Means and Standard Deviations by Rater, Time, and Type of Feedback

<table>
<thead>
<tr>
<th>Variable</th>
<th>Client Rating</th>
<th>Specific Feedback (N=24)</th>
<th>Combined Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>pre</td>
<td>post</td>
<td>pre</td>
</tr>
<tr>
<td>CRF-A</td>
<td>Mean</td>
<td>66.04</td>
<td>67.50</td>
</tr>
<tr>
<td>CRF-E</td>
<td>Mean</td>
<td>59.00</td>
<td>65.37</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>15.88</td>
<td>13.38</td>
</tr>
<tr>
<td>CRF-T</td>
<td>Mean</td>
<td>65.38</td>
<td>66.83</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>11.73</td>
<td>10.10</td>
</tr>
</tbody>
</table>

Global Feedback (N=24)

|          | pre           | post                     | pre  | post | pre  | post | pre  | post |
| CRF-A    | Mean          | 65.33                    | 64.71 | 60.75 | 65.46 | 60.25 | 62.04 | 62.04 | 65.10 |
|          | S.D.          | 12.34                    | 14.10 | 10.16 | 9.21  | 9.60  | 12.15 | 10.70 | 11.82 |
| CRF-E    | Mean          | 60.96                    | 63.71 | 61.13 | 65.58 | 64.42 | 59.17 | 62.55 | 63.01 |
| CRF-T    | Mean          | 66.13                    | 68.00 | 62.75 | 65.75 | 66.79 | 65.09 | 65.83 | 66.63 |
|          | S.D.          | 14.35                    | 12.16 | 10.23 | 8.31  | 10.11 | 10.91 | 11.56 | 10.46 |

Delayed Feedback (N=24)

|          | pre           | post                     | pre  | post | pre  | post | pre  | post |
| CRF-A    | Mean          | 62.13                    | 61.67 | 59.25 | 60.42 | 57.96 | 58.29 | 60.86 | 60.22 |
|          | S.D.          | 14.78                    | 14.10 | 12.27 | 8.96  | 11.62 | 8.22  | 12.89 | 10.43 |
| CRF-E    | Mean          | 59.44                    | 61.28 | 61.62 | 62.29 | 58.46 | 59.17 | 61.43 | 62.06 |
|          | S.D.          | 14.94                    | 11.61 | 11.59 | 10.75 | 11.77 | 10.89 | 12.77 | 11.08 |
| CRF-T    | Mean          | 66.25                    | 65.42 | 65.00 | 63.86 | 62.92 | 62.04 | 65.62 | 64.30 |
|          | S.D.          | 12.98                    | 10.69 | 10.61 | 11.72 | 8.73  | 6.38  | 10.77 | 9.60  |

Collapsed Across Groups (N=72)

|          | pre           | post                     | pre  | post | pre  | post | pre  | post |
| CRF-A    | Mean          | 64.50                    | 64.47 | 62.50 | 63.82 | 60.58 | 60.86 | 62.72 | 63.47 |
|          | S.D.          | 13.13                    | 13.27 | 11.21 | 8.93  | 11.33 | 10.59 | 11.89 | 10.93 |
| CRF-E    | Mean          | 59.99                    | 62.65 | 62.96 | 64.90 | 60.53 | 58.97 | 61.58 | 63.06 |
|          | S.D.          | 15.95                    | 14.22 | 12.32 | 11.08 | 13.56 | 13.08 | 13.94 | 12.79 |
| CRF-T    | Mean          | 65.92                    | 66.75 | 65.51 | 66.00 | 65.03 | 63.78 | 65.94 | 65.81 |
|          | S.D.          | 12.88                    | 10.91 | 10.19 | 9.92  | 10.59 | 10.01 | 11.22 | 10.28 |

KEY:
S.D. = standard deviation
CRF-E = Expertness
CRF-A = Attractiveness
CRF-T = Trustworthiness
evident for the specific and global groups for the client raters. Ratings of trustworthiness by client raters also increased for the specific and global groups. Declines in rated attractiveness are noted for the specific feedback participants for both sets of raters of the audiotapes, while that quality was enhanced according to the same sources in the global feedback condition. There is a great deal of variability in these ratings, including direction and magnitude of change, that may be due to low interrater reliability and perhaps enhanced by a sex-of-rater factor.

Reliability of Counselor Ratings

Interrater reliability was assessed by correlating Counselor Rating Form (CRF) data from all three sources (client and two raters of audiotapes) for each of the three subscales of the CRF. Reliability of these three sources of information was moderate, yet significant according to Snedecor (1956). The correlations of each rater's scores on each CRF subscale, Expertness, Attractiveness, and Trustworthiness, combined for pretest and posttest, are shown in Table 4. The correlations ranged from .25, for agreement by the client and female and female and male raters for perceived trustworthiness to .53 for client/male agreement on expertness ratings. Even though the interrater reliability coefficients were significant, some variability is suggested by the level of the correlations. This variability in ratings raises questions about the utility of these measurements in representing change in experiment participants, especially as a combined source of data. In the
Table 4

Interrater Reliability of Counselor Rating Form Scores

<table>
<thead>
<tr>
<th>Rater Pair</th>
<th>Expertness</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client/Female</td>
<td>.32&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.38&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.33&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Client/Male</td>
<td>.53&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.29&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.29&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Female/Male</td>
<td>.32&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.44&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.29&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup><sub>p &lt; .01</sub>
<sup>b</sup><sub>p &lt; .05</sub>
statistical analyses, these CRF scores thus were used as three separate pieces of information, since raters did not have access to the same data.

**Multiple Regression Analysis of Counselor Characteristics**

Three multiple regression/correlation (MRC) analyses of the counselor characteristic measures were calculated, to examine change among groups from pretest to posttest. It was hypothesized that global feedback would result in greater improvement of self-esteem than other feedback conditions. The analysis of variance (ANOVA) for significance of the MRC analysis of groups by time for the Rosenberg Self-Esteem (RSE) scale was not significant, as can be seen in Table 5. Scores on the RSE scale were relatively stable, showing negligible change as a result of feedback condition or time of testing.

An MRC analysis of Counseling Self-Efficacy (CSE) scale scores addressed the second hypothesis, that specific feedback would result in greater change in participants' self-efficacy ratings from pretest to posttest than either global or delayed feedback. Again, ANOVA F tests of the significance of the MRC analysis did not support this hypothesis. Participants in the specific feedback group did not change their perceptions of their ability to act as a counselor any more than the other groups of students. However, the CSE MRC analysis did reveal a significant change in participants' scores from pretest to posttest on this measure, regardless of group, with F=7.028, d.f.=1,69, p ≤.05 (see Table 5). The mean scores of the
Table 5

Analysis of Variance F Test Results for Counselor Characteristic Variables

<table>
<thead>
<tr>
<th>Measure</th>
<th>Effect</th>
<th>Result (degrees of freedom)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSE</td>
<td>Group</td>
<td>F(2,69)=0.188</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>F(1,69)=0.056</td>
</tr>
<tr>
<td></td>
<td>Group by Time</td>
<td>F(2,69)=1.341</td>
</tr>
<tr>
<td>CSE</td>
<td>Group</td>
<td>F(2,69)=0.02</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>F(1,69)=7.028*</td>
</tr>
<tr>
<td></td>
<td>Group by Time</td>
<td>F(2,69)=1.066</td>
</tr>
<tr>
<td>AD</td>
<td>Group</td>
<td>F(2,69)=1.31</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>F(1,69)=0.44</td>
</tr>
<tr>
<td></td>
<td>Group by Time</td>
<td>F(2,69)=1.01</td>
</tr>
</tbody>
</table>

KEY:
RSE=Rosenberg Self-Esteem scale
CSE=Counseling Self-Efficacy scale
AD=Anxiety Differential
aF=3.98; d.f.=1,70; p≤.05
F=3.13; d.f.=2,70; p≤.05
three groups on the CSE scale and an examination of the raw data suggested that most participants significantly increased the strength of their counseling self-efficacy expectations over the course of the experiment.

The third MRC analysis addressing change in the counselor characteristic variables looked at the effects of type of feedback on anxiety over time. The ANOVA of the MRC analysis revealed no significant change on the Anxiety Differential from pretest to posttest. This result was consistent across all three feedback groups. The F tests are also reported in Table 5.

The final hypothesis addressed by the MRC analyses of the counselor characteristic variables suggested that there would be an inverse relationship between self-efficacy (CSE) scores and anxiety (AD) scores. Correlations of CSE and AD scores, pretest and posttest, across groups and for each feedback group individually, were calculated in order to examine the relationship between the two variables. The Pearson correlation values are displayed in Table 6. As expected, there was a significant negative relationship between self-reports of anxiety (AD) and counseling self-efficacy (CSE) scores overall ($r = -.32, p < .01$). However, when the relationship between these variables was examined according to type of feedback received, only scores of those participants receiving specific feedback showed the hypothesized negative relationship in a significant manner. Represented in Figure 1 are the pretest to posttest changes of each group on each of the two measures. These mean scores suggest
### Table 6
Correlations of Self-Efficacy and Anxiety by Time and Group

<table>
<thead>
<tr>
<th></th>
<th>Overall Groups</th>
<th>Specific Feedback Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CSE1</td>
<td>CSE2</td>
</tr>
<tr>
<td>AD1</td>
<td>-.30&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.26&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>AD2</td>
<td>-.29&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-.31&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Global Feedback Group</th>
<th>Delayed Feedback Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CSE1</td>
<td>CSE2</td>
</tr>
<tr>
<td>AD1</td>
<td>-.27</td>
<td>-.17</td>
</tr>
<tr>
<td>AD2</td>
<td>-.28</td>
<td>-.20</td>
</tr>
</tbody>
</table>

Over Time and Groups: -.32<sup>a</sup>

**Key:**
- CSE=Counseling Self-Efficacy scale
- AD=Anxiety Differential
- 1=pretest
- 2=posttest

<sup>a</sup> = p < .01
<sup>b</sup> = p < .05
that, for participants receiving specific feedback, CSE scores increased and AD scores decreased slightly. For participants in the global feedback condition, CSE scores and AD scores increased. And for students receiving delayed feedback, both CSE and AD scores increased slightly. These results indicated a small effect of type of feedback on counseling self-efficacy and anxiety.

**Multiple Regression/Correlation Analyses of Counselor Ratings**

Three hierarchical multiple regression/correlation (MRC) analyses were calculated to assess the effects of type of feedback on participant performance in the role play interviews in the form of scores on the Counselor Rating Form (CRF). One MRC analysis was calculated on each of the CRF subscales of Expertness, Attractiveness, and Trustworthiness. For each MRC analysis, the mean scores of the pretest and posttest scores on the counselor characteristic scales (Counseling Self-Efficacy (CSE), Rosenberg Self-Esteem (RSE), and Anxiety Differential (AD)) for each participant were included as covariates. The mean score was utilized for these measures, rather than actual pretest and posttest scores, due to inability of the computer program which was used to handle changing covariates. The order of the variables introduced into the hierarchical MRC analyses for each CRF subscale was as follows: CSE mean, AD mean, RSE mean, type of feedback (group), time of testing, group by time of testing interaction, source of rating (i.e. client, female, or male rater), group by rater interactions, rating source by time interactions, and group by time by source of rating interactions.
KEY:
=Counseling Self-Efficacy scale
=Anxiety Differential scale
----------Specific feedback group
----------Global feedback group
• • • • =Delayed feedback group

Figure 1

Counseling Self-Efficacy and Anxiety Differential Scores by Type of Feedback and Time of Testing
The first hypothesis concerning the CRF data was that global feedback would result in greater improvement of scores on expertness, attractiveness, and trustworthiness (i.e. performance) for participants with low self-esteem than other types of feedback. In other words, self-esteem would covary positively with CRF subscale scores for the global group. The MRC analyses for each CRF subscale showed lack of support for this hypothesis in two ways. Examination of the analysis of the Rosenberg Self-Esteem (RSE) scale scores as a covariate revealed minimal effect of that trait on CRF subscale scores of Expertness, Attractiveness, and Trustworthiness. For the ratings of attractiveness and trustworthiness, self-esteem (RSE) scores accounted for less than 1% of the unique variance in those scores. Similarly, approximately 2% of the variance in ratings of expertness could be attributed to participants' RSE scores. Actual variance accounted for can be found in Table 7. Scores of expertness, attractiveness, and trustworthiness, therefore, were not significantly affected by level of self-esteem. This was true regardless of type of feedback received. Hierarchical MRC analysis examined the effect of type of feedback also. Analysis of variance F tests (see Table 8) were nonsignificant, indicating that ratings of expertness, attractiveness, and trustworthiness were affected minimally by type of feedback received.

This finding suggested lack of support for yet another hypothesis, i.e. that increases in ratings of counselors with low self-efficacy would be greater for the specific feedback condition. As stated above, there were no significant changes in ratings of expertness,
Table 7
Sources of Variance in
Counselor Rating Form Subscales

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Expertness</th>
<th></th>
<th></th>
<th>Attractiveness</th>
<th></th>
<th></th>
<th>Trustworthiness</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CSE</td>
<td>0.0221</td>
<td>0.0221</td>
<td>0.0040</td>
<td>0.0040</td>
<td>0.0090</td>
<td>0.0090</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>0.0318</td>
<td>0.0097</td>
<td>0.0040</td>
<td>0.0000</td>
<td>0.0142</td>
<td>0.0051</td>
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<td>RSE</td>
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<td>0.0488</td>
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<td>0.0246</td>
<td>0.0067</td>
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<td>0.0492</td>
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<td>0.0246</td>
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<td>0.0517</td>
<td>0.0025</td>
<td>0.0263</td>
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<td>0.0638</td>
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<td>0.0289</td>
<td>0.0026</td>
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<td>Group by rater</td>
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<td>0.0009</td>
<td>0.0651</td>
<td>0.0013</td>
<td>0.0324</td>
<td>0.0035</td>
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<tr>
<td>Pre-post by rater</td>
<td>0.0620</td>
<td>0.0042</td>
<td>0.0653</td>
<td>0.0002</td>
<td>0.0349</td>
<td>0.0025</td>
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<td>Group by pre-post by rater</td>
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<td>0.0692</td>
<td>0.0039</td>
<td>0.0374</td>
<td>0.0025</td>
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KEY:
Cum. $R^2$=Cumulative $R^2$
Incr. $R^2$=Incremental $R^2$
CSE=Counseling Self-Efficacy scale
AD=Anxiety Differential
RSE=Rosenberg Self-Esteem scale
Group=type of feedback received
Pre-post=pretest to posttest change
Rater=source of rating
Table 8
Summary of Analyses of Variance for Counselor Rating Form Subscales

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>D.F.</th>
<th>Expertness</th>
<th>F Test Results</th>
<th>Trustworthiness</th>
</tr>
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<td>Attractiveness</td>
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<tr>
<td>CSE</td>
<td>1,66</td>
<td>F=1.69</td>
<td>F= .33</td>
<td>F= .66</td>
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<td>AD</td>
<td>1,66</td>
<td>F= .75</td>
<td>F= .00</td>
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<td>F=1.34</td>
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<td>F= .34</td>
<td>F=3.20^a</td>
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<td>Pre-post</td>
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<td>F= .89</td>
<td>F= .22</td>
<td>F= .02</td>
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<td>2,69</td>
<td>F= .12</td>
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<td>Rater</td>
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<td>F= .58</td>
<td>F=2.95^b</td>
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<tr>
<td>rater</td>
<td>4,138</td>
<td>F= .11</td>
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<tr>
<td>rater</td>
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<td>rater</td>
<td>4,138</td>
<td>F= .45</td>
<td>F= .86</td>
<td>F= .55</td>
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</table>

KEY:
CSE=Counseling Self-Efficacy scale
AD=Anxiety Differential
RSE=Rosenberg Self-Esteem Scale
Group=type of feedback received
Pre-post=pretest to posttest change
Rater=source of rating
^a p<.05
^b p<.10
attractiveness, and trustworthiness attributable to type of feedback. Also, the hypothesized result of greater improvement in ratings of counselors with weak efficacy expectancies for the specific feedback group was not confirmed. Minute percentages of the unique variance in ratings of expertness, attractiveness, and trustworthiness were accounted for by participants' Counseling Self-Efficacy (CSE) scores. Less than 1% of the variance in ratings of two CRF subscales, Attractiveness and Trustworthiness, was attributable to CSE scores, while 2.2% of the variance in ratings of expertness was accounted for by efficacy expectancies (see Table 7).

This result addressed the fourth hypothesis, that a predictive relationship between self-efficacy and performance would be evident, with high self-efficacy accompanying improved performance. This was not the case, however. As stated previously, there were significant increases in Counseling Self-Efficacy (CSE) scores for the majority of participants from pretest to posttest. If the above hypothesized relationship was observed, increases in Counselor Rating Form Expertness, Attractiveness, and Trustworthiness scores would also be significant. The analysis of variance F tests of the changes in CRF ratings over time are in Table 8. Lack of notable change in these ratings was found from pretest to posttest; thus this hypothesis was not confirmed.

It was also proposed that higher levels of anxiety would have a debilitating effect on performance; scores on the Anxiety Differential (AD) therefore would be expected to covary with CRF ratings of
Expertness, Attractiveness, and Trustworthiness. The three MRC analyses of the CRF subscales with AD scores as covariates again were not in the expected direction. Less than one one-hundredth of a percent of the variance in CRF ratings of Attractiveness was attributable to participants' AD scores. As Table 7 shows, anxiety accounted for approximately 1% of the variance in ratings of expertness and trustworthiness. According to previous studies (Husek & Alexander, 1963; Lent & Russell, 1978) the mean scores on the AD represented in this sample are suggestive of moderate to high anxiety levels in the participants. Thus, this hypothesis was not supported.

Overall, the results of the three MRC analyses of CRF data with CSE, RSE, and AD as covariates are disappointing. Table 7 summarizes the variance attributable to each factor in the hierarchical analysis, for each counselor attribute of expertness, attractiveness, and trustworthiness. The total controlled elements in the experiment accounted for a very small portion of the unique variance. For example, of the variance in the CRF ratings of Attractiveness, only 6.9% of the variance can be identified as the effect of some element in the experimental procedure, such as self-efficacy (CSE) score, self-esteem (RSE) score, anxiety (AD) score, type of feedback, pretest to posttest change, or source of CRF ratings. Likewise, for CRF ratings of Expertness and Trustworthiness, the amount of unique variance attributable to experimental conditions is 6.5% and 3.7%, respectively.
As stated above and illustrated in Table 8, the three hierarchical multiple regression/correlation (MRC) analyses conducted on the Counselor Rating Form (CRF) data resulted in no significant hypothesized effects. However, for the analysis of the CRF subscale of Attractiveness, there are two significant unexpected F tests. The first of these is an effect of groupmembership (F=3.20, p≤.05), regardless of time of testing, eliminating any particular form of feedback as a mechanism of change. As can be seen from Figure 2, the three groups were substantially different in how they were rated on perceived attractiveness at both pretest and posttest, with only the global feedback group showing a great deal of change across time.

This variability in ratings of perceived attractiveness is reflected again by an analysis of variance F test that nears significance (f=3.07, p≤.10) for effect of rater. Source of rater thus appears to have influenced ratings on this subscale. Again, Figure 3 illustrates this effect for pretest and posttest, though there was no significant change over time in this effect according to the MRC analysis. Client raters gave higher scores on perceived attractiveness than raters who listened to audiotapes. This underscores the lack of agreement between raters pointed out in a previous section.
KEY:

---------- = Specific feedback group
- - - - = Global feedback group
****** = Delayed feedback group

Figure 2

Ratings of Perceived Attractiveness by Group and Time
KEY:

Δ = Client Rater
□ = Female Rater
* = Male Rater

Figure 3
Ratings of Perceived Attractiveness
by Source of Rating and Time
Multivariate Analysis of Variance

A two factor multivariate analysis of variance (MANOVA) was calculated on all the dependent variables to assess any composite change from pretest to posttest attributable to type of feedback received. Twelve dependent variables were analyzed; in addition to the Counseling Self-Efficacy (CSE), Anxiety Differential (AD), and Rosenberg Self-Esteem (RSE) scales, each source of the Counselor Rating Form was treated as a separate variable so that rater effects could be evaluated more thoroughly. In other words, each source of rating for each subscale was identified as one variable, such that client rating of expertness comprised a variable, as did female rating of expertness, male rating of expertness, and so on.

Wilks's lambda was chosen as the multivariate test of significance for the MANOVA, based on the previous MRC analyses suggesting that differences in the data were concentrated in one variable, counseling self-efficacy, and more than five dependent variables were involved in the analysis (Larrabee, 1982). The MANOVA of the above mentioned variables was not significant according to Wilks's lambda for group by time interactions. In other words, composite change on the twelve variables showed no difference in pretest to posttest scores that could be attributed to type of feedback received. A significant time-of-testing effect was identified by the MANOVA, however. The combined changed in the twelve dependent variables was
significant from pretest to posttest, regardless of group membership, with the approximation to the F test of Wilks's lambda equal to 2.04, (d.f. = 12.58; p ≤ .04). This result indicates that the small changes in mean scores observed in Tables 2 and 3 are significant when taken as a total measure of change.

Univariate F tests were then calculated to further explore this composite change. These tests duplicated the ANOVA F tests examining the multiple regression analyses of each dependent measure; the only univariate test to achieve significance was on the Counseling Self-Efficacy (CSE) scale. As stated previously, participants' CSE scores improved significantly from pretest to posttest, regardless of type of feedback received.

Roy-Bargman setdown F tests were also conducted, to examine change in successive variables when the influence of other variables was removed (Larrabee, 1982). In this analysis, the contributions of the counselor characteristic variables (CSE, RSE, AD) and the audiotape raters were eliminated step by step, in order to evaluate the client ratings alone. The rationale was that the client ratings may most accurately reflect change in performance, having been based on all available interview data. There were no significant group effects or group by time of testing interactions; however, one time of testing main effect was identified. Client ratings of CRF Expertness did change significantly from pretest to posttest for all feedback conditions (F = 7.08, d.f. = 1.59, p ≤ .01).
The MANOVA also enabled an intensive analysis of the between rater variability on the Counselor Rating Form (CRF). In preceding sections, the lack of correspondence between CRF scores, especially on the Attractiveness subscale, was outlined. The univariate F test for the female raters' ratings of perceived attractiveness showed significant changes from pretest to posttest according to type of feedback received. These scores are diagrammed in Figure 4, illustrating the differential ratings of each group by the female raters on this measure. Female raters increased their ratings of perceived attractiveness for the global feedback condition, while decreasing them for the other two groups. The variability in attractiveness scores cited previously is very similar, as can be seen from comparing Figure 2 with Figure 4. However, the univariate F tests for the client and male raters were not significant on this variable.

The correlations among all the variables resulted from the MANOVA analysis, providing information about the relationships between the dependent variables that was not evident in any of the previously discussed statistical analyses. High correlations, ranging from .66 to .89, among the subscales of the Counselor Rating form were found. The inverse relationship between the Anxiety Differential (AD) and Counseling Self-Efficacy (CSE) scales cited above was reiterated. In addition, some interesting relationships
KEY:

- - - Specific feedback group
- - - - - Global feedback group
- - - - - - - Delayed feedback group

Figure 4

Ratings by Female Raters of Perceived Attractiveness by Group and Time
were noted. First of all, a significant relationship between Rosenberg Self-Esteem (RSE) scores and CSE scores was identified ($r = .53$, $p \leq .01$). Given this high degree of relationship, it was not surprising to find AD scores significantly correlated with RSE scores, even more so than with CSE scores ($r = -.37$, $p \leq .01$).

Another finding worthy of report is that Counseling Self-Efficacy (CSE) scores showed a substantial relationship to client ratings of expertness on the Counselor Rating Form (CRF) ($r = .28$, $p \leq .05$).

And finally, self-esteem (RSE) scores showed an even stronger positive relationship ($r = .35$, $p \leq .01$) to client ratings on this CRF subscale.
Chapter V
DISCUSSION

The objective of this dissertation was to examine the relationship of self-efficacy, self-esteem, and anxiety of counseling trainees to two types of feedback in the process of supervision. The results were mixed in terms of confirmation of the hypotheses. This discussion will begin with an analysis of the hypotheses and the extent of support provided by the data, with reference to previous research. Limitations of the study, including reasons for lack of expected results, will follow. Practical implications of the findings and recommendations for further research will conclude this section.

Confirmation of the Hypotheses

First of all, it was hypothesized that global feedback would result in greater increases in self-esteem than other types of feedback. This was not found; rather, self-esteem did not change significantly from pretest to posttest in any of the feedback conditions. This may suggest that self-esteem is a much more stable characteristic than had been supposed, especially over a relatively short period of time. The work of Rosenberg (1979) seems to support this idea, indicating self-esteem is fairly constant unless directly and purposefully manipulated, as in previous research (Friedenberg & Gillis, 1980).
The second set of hypotheses will be addressed together, having postulated similar effects. It was hypothesized that specific feedback would result in a greater improvement of performance in the role-play interview for students low on self-efficacy than other types of feedback. Likewise, it was expected that global feedback would effect greater change in performance in low self-esteem participants. However, lack of significant change in performance, in the form of Counselor Rating form scores, was found throughout the three feedback groups, for pretest to posttest change. In addition to stability of the performance scores, only very small amounts of variance in those scores were identified as due to the counselor variables of self-efficacy or self-esteem. This was especially true when ratings from all three sources were analyzed as opposed to only data from client ratings. These hypotheses were based on theoretical speculations that since self-esteem is a global self-evaluation, positive, general feedback comments might have the greatest impact, while the more task-specific self-evaluation of self-efficacy called for specific, task-oriented feedback. Given the above results, these hypotheses could not be confirmed.

It had also been proposed that participants receiving feedback between the two role-play interviews would show greater increases in self-esteem, performance, and self-efficacy scores than those receiving delayed feedback. As has already been detailed, self-esteem appeared to be a fairly stable trait among study participants.
Likewise, little or no change was seen in performance ratings. This hypothesis lacked support, therefore, given the lack of change in self-esteem and Counselor Rating Form scores, and the comprehensive change evident on the Counseling Self-Efficacy scale. The majority of participants improved their self-efficacy evaluations, regardless of type of feedback they had been offered. This result suggests confirmation of a previous study by Yellin (1978) and of Bandura's proposed model of the power of efficacy information from various sources (Bandura, Adams, & Beyer, 1977). In an assessment of the role of evaluative feedback in supervision, Yellin (1978) discovered that trainees' reactions to a counseling task were not affected by differential feedback, e.g. positive or negative. In this study, participants also were unaffected by the type of feedback, and even lack of feedback made no difference. Both situations involved supervision analogues, raising questions about the use of 'analogue' techniques in this area of research.

From another viewpoint, the discovery that participants increased their efficacy expectancies even when they did not receive feedback until after posttesting lends support to Bandura's model of sources of efficacy information. Bandura, Adams, and Beyer (1977) asserted that performance accomplishments are the most powerful source of efficacy information, followed in decreasing order of influence by vicarious experience, verbal persuasion, and physiological cues. Participants
in this study may have been attending primarily to their experiences in the actual role play interviews as a means to gather information about their abilities to function effectively as counselors, rather than to that less powerful source, the supervisor. The supervisor would be classified as a "verbal persuasion" source of efficacy information, offering positive feedback and reassurance. The delayed feedback group had only their experience in the interview as a source of efficacy information, and did show improvement on self-efficacy equal to the groups receiving both sources of data. This seems to confirm the supposition that direct experience was the most influential source of efficacy information.

The fourth hypothesis was postulated in terms of Bandura's (1978) theory, that counseling self-efficacy would be predictive of performance in the role play interview. Again, lack of change in Counselor Rating Form (CRF) scores already cited prevented confirmation of this hypothesis when all raters were included. When only the client raters were analyzed and the effects of the counselor characteristics were removed, there was significant improvement on expertness from pretest to posttest for all participants. This enables a degree of support for the hypothesis, since all participants also improved on counseling self-efficacy across time. A significant relationship between client ratings of expertness and self-efficacy was also noted in the multivariate analysis of variance correlations. While not
strong, these results suggest that the relationship between self-efficacy and performance found in previous work by Bandura and others (Bandura & Adams, 1977; Bandura, Adams, & Beyer, 1977; Bandura, Adams, Hardy, & Howells, 1980; Barrios, 1980; Brown & Inouye, 1978; Condiotte, 1980; Corn, 1978; DiClemente, 1981; Manning, 1981), may also be present in counseling, with self-efficacy in this study accounting for 7.8% of the variance in client ratings of expertness.

Again in accordance with Bandura's theory (1977), counselor anxiety was expected to have a debilitative effect on performance. Not only was this not found due to the lack of change in performance for all raters, CRF scores for client raters alone also failed to show the hypothesized relationship. In comparison with previous studies that used the Anxiety Differential (Husek & Alexander, 1963; Lent & Russell, 1978), participants in this study exhibited moderate to high levels of situational anxiety. All participants knew they would be audiotaped and observed via videocamera, which according to Bowman (1980), is anxiety-inducing. Kreiser (1980) discussed the "accepted" role of counselor anxiety in the counseling process, asserting that how anxiety actually interferes with the process is unclear. The results of this study are suggestive of a Yerkes-Dodson effect; the majority of participants did report some anxiety, but that anxiety did not appear to have negative impact on performance as assessed by the Counselor Rating Form. It may be that the level of anxiety experienced by participants was not so high as to be debilitative; rather, it may have provided a motivating factor. Haymes (1979)
reported a similar results, finding no significant difference in rated
counselor effectiveness at different levels of counselor anxiety.
Extreme debilitating levels of anxiety may simply be absent or small
enough in number as to have little effect in these studies; on the
other hand, anxiety may be so low as to not provide any motivation.

The final hypothesis specified the existence of an inverse
relationship between counseling self-efficacy and anxiety, again in
concurrency with Bandura's (1977) theory. A significant negative
relationship between counseling self-efficacy and anxiety was identi-
fied, such that 9.6% of the variance in these scores was accounted
for by the relationship, resulting in confirmation of this hypothesis.
This extends the work done by Bandura and colleagues (Bandura &
Adams, 1977; Bandura et al., 1977; Bandura et al., 1980) into a new
area, suggesting that self-efficacy may warrant further research in
terms of its predictive value for counseling performance.

In addition to the above hypotheses, the results facilitated
an exploration of the relationship of self-esteem and self-efficacy.
The confusion of these two terms in the literature is common; Frieden-
berg and Gillis (1980) used the concepts interchangeably, while Bandura
et al., (1980) and Lang (1978) sought to present the distinctions.
This study found a significant relationship between self-efficacy and
self-esteem, with 28% of the variance in either term ascribed to the
correspondence between them. While this serves to show the degree of
relatedness, it also verifies that even though there is a great deal of
overlap, they are two distinct concepts, at least as they were assessed in this project. Self-esteem is a more global, stable self-evaluation; self-efficacy is self-evaluation with regard to ability to perform successfully on a given task.

It was not surprising, given the extent of the relationship between self-esteem and self-efficacy, to observe relationships between self-esteem and the variables which were significantly correlated with self-efficacy. Self-esteem was found to have a significant inverse relationship with anxiety, and a significant positive relationship with client ratings of expertness. In fact, the relationships of self-esteem with these variables were even stronger than the concomitant relationships of the same variables with counseling self-efficacy. This observation raises some questions about Bandura's (1977) theory of self-efficacy, since that theory postulates a causal effect of self-efficacy on performance. The nature of the relationship between self-esteem and self-efficacy demands further exploration, in other situations and especially in relationship to performance and anxiety, before the causal chain between these variables is clarified.

Finally, high correlations were found between the client ratings of subscales of Expertness, Attractiveness, and Trustworthiness of the Counselor Rating Form (CRF). While initially it was supposed that the CRF assessed three distinct dimensions, LaCrosse (1977)
discovered a great deal of overlap of the scales. Because of this, a unitary "good guy" factor has been proposed which may reflect clients' perceptions of counselors (LaCrosse, 1977). The results of this study provide support for this "good guy" dimension.

**Limitations of the Study**

One major limitation of this study is the amount of extreme variability among raters of the role-play interviews. This lack of consistency in how the raters responded to the interviews may have obscured any actual changes in performance that occurred throughout the study, resulting in rejection of hypotheses. This problem is particularly apparent due to the multivariate analysis of variance. This analysis revealed a significant pretest to posttest by type of feedback interaction effect attributed to the female raters of the audiotapes. In other words, the female undergraduate research assistants who rated the tapes according to the Counselor Rating Form (CRF) rated the three groups significantly differently from pretest to posttest on the CRF subscale of Attractiveness, while the male and client raters did not detect significant changes.

It seems likely that the raters of the audiotapes did not have access to the same information as the client raters, who actually observed the counselor. This is illustrated by the fact that for one hypothesis, the ratings by clients did fit the expectations while ratings of audiotapes did not. Corrigan, Dell, Lewis, and Schmidt (1981)
stressed that nonverbal and behavioral cues may be very important factors in clients' formation of perceptions about counselor expert-ness and attractiveness. The audiotape raters in this study lacked this crucial source of information, and thus made few changes in their perceptions of the counselor from pretest to posttest. The changes in ratings of attractiveness made by female raters were significantly different from ratings made by clients, who were also female, thus ruling out the effect of the sex of the rater. The differential data available to the raters seems critical in explaining this variability in ratings. The female raters may have identified with the confederate clients, who were also female, slipping into that role and responding more as the clients. This may have served to set their ratings apart from those of the male raters, who perhaps did not identify with the role as easily. The women thus may have increased their ratings of perceived attractiveness, seeing the counsel-ors as more like themselves. The female raters may have empathized with the roles, but did not have the same information available to the client raters. The female raters lacked all the behavioral cues which may have provided corrective information about the counselor that would alter their perceptions of attractiveness, becoming more congruent with the client raters. The fact that three-quarters of the participants were female may have further confounded this effect of the female raters perceiving themselves as like the counselor.
Another problem with the use of raters within the study was the inexperience of those students in relation to counseling skills. The raters, both clients and raters of audiotapes, were undergraduate students who responded as clients rather than in evaluation of counseling skills, as a supervisor might. This lack of experience may have contributed to rather inflated Counselor Rating Form scores, when compared to other studies (cf. Zamostny, Corrigan & Eggert, 1981). More importantly, this lack of familiarity may have resulted in little ability to discriminate among counselors showing up as no change across time or no differences between group. The raters responded fairly positively to nearly all counselors, and made those ratings after a very brief sample of the counselor's behavior, suggesting a response set of positive reactions based on first impressions.

There also may have been little change on the Counselor Rating Form (CRF) over time because the dimensions assessed by that measure were relatively stable. There may have been a number of changes in specific verbal or nonverbal actions of the counselor as a result of feedback which were not tapped into by the CRF and hence went unnoticed. Another method of assessment of the role-play interviews would have strengthened the study.

Just as the sample of the counselor's behavior may have been too constricted to consistently assess differences among counselors, so
may the supervision/feedback session have been too limited a time period to show consistent change. As Corrigan, Dell, Lewis, and Schmidt (1980, p. 427) stated, "it may be unreasonable ... to expect changes in extra-interview behaviors to follow from a single, brief interview".

According to Scrivner (Note 3), few supervisors expect change in a trainee over just one supervision session. The hour-long period necessary to complete the experiment, with a ten minute feedback interlude, may have been too short an interval for any significant changes to occur.

An additional limitation of the study involves the generalizability of the analogue situation. Particularly, questions are raised about the equivalence of the participants to actual beginning counselor trainees. One concern centers around the investment of the participants in the interview process. Teasdale (1978) stressed the importance of investment in the task as a predictor of success experiences within self-efficacy theory. Students not interested in being able to counsel persons effectively would not be as invested in receiving feedback as a means of changing their behavior as would students valuing their ability to be successful counselors. The participants in the study seemed invested in helping professions as a career choice, but the intensity of that investment may not have matched that of beginning counselor trainees. The fact that participants in analogue studies such as this and that done by Yellin (1978)
appears unaffected by feedback may signal that the students are less involved than counselor trainees. There seems to be a different quality to sitting in an interview room talking to a confederate client and receiving feedback from a person the student will never see again versus facing first clients while working with the same supervisor week after week. That may certainly influence the extent of assimilation of feedback received and efforts to put changes into action.

Practical Implications

This study was intended to address the question posed by Bernstein, Bianca, and Lecomte (1979, p. 297) of "which types of supervisor feedback produce which immediate responses in which kinds of trainees?" The results reported here contribute little to understanding the diverse effects of global versus specific feedback, since in this study neither had an influence on the parameters measured. Questions raised by Ford (1979, p. 119) about the "interactive effects of trainee personal characteristics and training methods" remain open to further research.

An alternative perspective to the position expressed by Bernstein et al. (1979) and Ford (1979) is presented by Campbell (1977). Emphasis has been placed on supervisory feedback as a primary teaching method in this study as well as previous research. Campbell (1977, p.
4576) stated that it was difficult to conclude from a comparison of two models of feedback that "supervisory behavior in the form of feedback makes any difference in terms of participant change before and after treatment". This author therefore proposed that perhaps too much importance has been placed on the role of the supervisor as source of feedback, and emphasis may be more effectively placed on facilitating intrinsic feedback.

The results of this study, as well as the work of Bandura (Bandura & Adams, 1977; Bandura et al., 1977; Bandura et al., 1980) seem to support this idea (Campbell, 1977) that supervisory feedback is overrated and emphasis should instead be on intrinsic feedback as a training tool. In this study, it seemed that participants were not influenced by supervisory feedback, but relied on actual experience in the role-play interviews as feedback. This speculation fits within Bandura's (Bandura et al., 1977) framework of sources of efficacy information; supervisory feedback, as a verbal persuasion source of efficacy information, is less powerful than intrinsic feedback, coming from direct experience as the source of information. Supervisors may thus look for ways to facilitate the impact of intrinsic feedback in training counselors. Future research may be profitably directed toward evaluating the differential impact of intrinsic versus supervisory feedback.
The goal of research in supervision is to develop the most effective counselors and therapists through the best training methods. Previous literature has suggested that an important part of that task is developing a sense of competence and self-confidence in the counselor (Bradley & Olson, 1980; Costello, 1981; Dye, 1981; Hill, Charles, & Reed, 1981; Levy, 1979; O'Roark, 1981; Roy, 1980; Schwab & Harris, 1981; Worthington & Roehlke, 1979). In this study, competence was framed as counseling self-efficacy, the belief in one's ability to function effectively as a counselor, and self-confidence was studied in the form of self-esteem. Self-efficacy and self-esteem were focused upon as a means to understand how those characteristics impact upon the process of supervision, and how they might be related to being an effective counselor.

Research has suggested that counselor self-esteem is related to counseling effectiveness. Roy (1980) discovered that counselors perceived by clients as effective are individuals who have a sense of personal worth. Schwab and Harris (1981) also determined that advanced counselor trainees were more self-accepting than others, suggesting positive self-concept. Some work has revealed that self-evaluations similar to self-efficacy are also related to counselor effectiveness. Effective counselors in a study by O'Roark (1981) perceived themselves as adequate and able. In addition, Worthington and Roehlke (1979) found that one area associated with improved
counseling ability was the development of self-confidence and personal style.

There is thus some evidence that a sense of competence and self-esteem are related to counseling effectiveness. The results of this study provided further support for this previous research, and added Bandura's (1977) self-efficacy as a useful way of conceptualizing the competence dimension. As in the previous work, counseling self-efficacy and self-esteem were both related to counseling effectiveness, though indirectly by virtue of their relationship to perceived expertness of the counselor. Increases in counseling self-efficacy for the majority of participants were accompanied by increases in client ratings of perceived expertness. Self-esteem was also significantly correlated with client ratings of expertness, even though the latter remained stable over the course of the experiment. A direct test of Bandura's (1977) theory in this area is still lacking; in this study the assessment of self-efficacy is not directly tied to the behavioral assessment of expertness. Further research is needed to directly test Bandura's theory, with the one-to-one correspondence of self-efficacy measurement and performance. For example, a direct test of the theory would take the form of asking "how effectively do you feel you can counsel with a depressed person?" and then rating the effectiveness of several counseling sessions with a depressed client. In spite of this limitation in the present study, the correspondence between self-efficacy and effective performance is suggested as a topic for further exploration in counseling research.
To support the tentative conclusion that counseling self-efficacy and self-esteem are related to effective counseling, it is necessary to explore research on the relationship of perceived expertness to effectiveness in counseling. LaCrosse (1980, p. 324) examined the impact of counselor social influence on counseling outcome, and found that "perceived expertness appeared by far to be the crucial variable for predicting outcome". Perceived expertness was thus linked to counseling effectiveness. Zamostny, Corrigan, and Eggert (1981) demonstrated the importance of perceived expertness to counseling effectiveness, with a more limited measure of effectiveness, i.e. client satisfaction with an intake interview. The determination that a "significant proportion of variance in client satisfaction was accounted for by perceived counselor expertness" (Zamostny et al., 1981, p. 488) provided further support for the relationship of perceived expertness to counseling effectiveness.

Corrigan, Dell, Lewis and Schmidt (1980) pointed out that previous research found no relationship between outcome and characteristics of the counselor, but a relationship did exist between outcome and client perceptions of counselor characteristics. These authors stated that perceived expertness may be a prerequisite to expert power and actually comprise legitimate power as well, thus giving counselors their primary source of influence (Corrigan et al., 1980, p. 432). Counselors perceived as expert by their clients may thus be more effective. It is possible that, especially for beginning counselor trainees, belief in one's counseling self-efficacy may be necessary before one can comfortably project verbal and nonverbal cues
that are perceived as expert by the client (Corrigan et al., 1980). In other words, a beginning counselor may have difficulty taking charge of the counseling interview and acting confident that s/he can help the client if belief in one's ability to counsel effectively is lacking. Facilitating the development of counseling self-efficacy within each counselor trainee may thus be an important step in achieving a perceived sense of expertness that leads to creation of an effective counselor. Recognition of this significant goal as part of the supervisory process is necessary, and research may profitably explore the most effective methods for helping trainees develop a sense of self-efficacy.

Counseling self-efficacy and self-esteem thus become meaningful concepts to attend to in the training of effective counselors. The nature of the relationship between counseling self-efficacy, self-esteem, and effectiveness as a counselor is still unclear, however. Bandura and Aqams (1977) first postulated a causal relationship between self-efficacy and performance, but others (Feltz, 1980; Poser, 1978) disputed existence of such an effect. The results of this study also fail to support such a causal explanation; counseling self-efficacy and perceived expertness may both have been enhanced, yet whether one preceded or caused the other is unclear. Likewise, clients may perceive their counselors as more expert because they are receiving benefits of counseling, or counseling may become more effective because the counselor's perceived expertness is enhanced. In the present study there is also confusion as to the differential impact of self-efficacy and self-esteem on perceived expertness. Research addressing these concerns
of the nature of the relationship of self-efficacy, self-esteem, and performance in counseling is needed.

Given that counseling self-efficacy and self-esteem are important characteristics of counselor trainees, and are associated with effectiveness, how can supervisors best enhance these dispositions in the training process? It may be beneficial to first consider the expectations of trainees entering a graduate program in psychology. Poser (1978, p. 195) suggested that the optimal mode for inducing self-efficacy expectations in a client is crucially tied to the client's pattern of expectancies acquired before treatment. As McFarlin and Blascovich (1981, p. 521) reported, persons "continue to expect success or failure in a manner consistent with their chronic level of self-esteem". Students entering a graduate program in psychology usually have had a number of success experiences, necessary for admission to a program, and have fairly positive self-concepts, high self-esteem, and a general expectancy for success. The task is to facilitate generalization of those success expectancies to counseling. Poser (1978) asserted that the most effective way to accomplish that is by arranging successful counseling experiences for trainees.

Providing success experience in a counseling setting would also be advocated by Bandura and colleagues (Bandura & Adams, 1977; Bandura et al., 1977; Bandura et al., 1980) as a way of providing efficacy information through the most powerful source, direct experience. This is fairly routine practice in graduate training programs; trainees begin with role play interviews, advance to clients with problems which are not too complex, and take on increasingly difficult problems and
and clients as skills are established. Supervisors have an important role throughout, enabling trainees to process and assimilate success and failure experiences. As Bandura (1978a, p. 239-240) stated, it is "attributions of causes of outcomes to personal inefficacy that is most likely to undermine performance and cause despondency". Supervisors and faculty can help trainees to sort out the causes of failure experiences and thus avoid unnecessary attributions to personal inefficacy which otherwise may occur. Further research is needed to determine the role of attributions in self-efficacy, and to assess any differences among trainees at different levels. Beginning counselors may be more likely to attribute failures to personal inefficacy than would more advanced students.

Enhancement of counseling self-efficacy and self-esteem is thus a valuable goal for the training process, perhaps leading to heightened perceptions of expertness and consequent increased effectiveness as a counselor. This goal can be addressed through provision of success experiences for the trainee, with assistance in appropriate attribution of success and failure offered by the supervisor. Finally, the attitude of the supervisor and faculty may be important. Recognition of the stress of graduate school and the crises of training, and openness to providing help in coping with those, may help to alleviate any negative effects of those factors upon the trainee's sense of self-esteem and self-efficacy (Dye, 1978; Goplerud, 1980). Such a supportive approach could maximize training.
Reference Notes


2. Bandura, A. Personal communication, December 1980.

References


Appendix A
Demographic Data

Name____________________ Telephone #__________________________

Sex: F M Age______ Year in school__________
(circle)

Major____________________________________________________

Career Goal_______________________________________________

Any experience with counseling or related activities?______________________________

If so, please describe type of activity, setting, and approximate number of hours of experience.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Appendix B
**PARTICIPANT CHARACTERISTICS**

N=72

Age $\bar{x}$=23.56 years

Age range:19 to 47 years

<table>
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<th>Class</th>
<th>%</th>
<th>Major</th>
<th>%</th>
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<td>Sophomore</td>
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<td>Education</td>
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<tr>
<td>Senior</td>
<td>31.5</td>
<td>Criminology</td>
<td>6.8</td>
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<td>5.5</td>
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<td>Ph.D. level</td>
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<td></td>
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</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>Anthropology</td>
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<td>75</td>
<td>Computer Science</td>
<td>1.4</td>
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Career Goal

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<td>Clinical/Counseling Psychology</td>
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<td>17.8</td>
</tr>
<tr>
<td>Law/Probation Officer</td>
<td>11</td>
</tr>
<tr>
<td>Guidance Counselor</td>
<td>6.8</td>
</tr>
<tr>
<td>Medical Professions</td>
<td>6.8</td>
</tr>
<tr>
<td>Business/Industrial Psychology</td>
<td>5.5</td>
</tr>
<tr>
<td>Other Helping Professions (e.g. social work, ministry)</td>
<td>5.5</td>
</tr>
<tr>
<td>Education</td>
<td>4.1</td>
</tr>
<tr>
<td>Other</td>
<td>1.4</td>
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</table>

Experience

<table>
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</tr>
<tr>
<td>Class-related</td>
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</tr>
<tr>
<td>Volunteer</td>
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<tr>
<td>Actual work experience</td>
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</tr>
<tr>
<td>Helping friends</td>
<td>5.5</td>
</tr>
<tr>
<td>Teaching</td>
<td>5.5</td>
</tr>
<tr>
<td>As client</td>
<td>4.1</td>
</tr>
</tbody>
</table>
Appendix C
To the items below, circle the letters which describe your feelings about yourself at this time.

SA=strongly agree  D=disagree  SD=strongly disagree
A=agree

1. On the whole, I am satisfied with myself.  SA  A  D  SD
2. At times, I think I am no good at all.  SA  A  D  SD
3. I feel that I have a number of good qualities.  SA  A  D  SD
4. I am able to do most things as well as most other people.  SA  A  D  SD
5. I feel I do not have much to be proud of.  SA  A  D  SD
6. I certainly feel useless at times.  SA  A  D  SD
7. I feel that I'm a person of worth, at least on an equal plane with others.  SA  A  D  SD
8. I wish I could have more respect for myself.  SA  A  D  SD
9. All in all, I am inclined to feel that I am a failure.  SA  A  D  SD
10. I take a positive attitude toward myself.  SA  A  D  SD
Appendix D
The attached form lists activities that could be performed that could be labeled as counseling. Under the Can Do, check (✓) the tasks you expect you could do if you were asked to perform them now.

For the tasks you check under Can Do, indicate in the column Confidence how confident you are that you could do them. Rate your degree of confidence by recording a number from 10 to 100 using the scale given below:

<table>
<thead>
<tr>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>uncertain</td>
<td>moderately certain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Practice Rating**

To familiarize you with the rating form, please complete this practice item first. Remember, rate what you expect you could do and your confidence if you were asked to perform the tasks now.

<table>
<thead>
<tr>
<th>PHYSICAL STRENGTH</th>
<th>Can Do</th>
<th>Confidence</th>
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</thead>
<tbody>
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<td>Lift a 10 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 15 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 20 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 30 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 40 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 50 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 60 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 70 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift an 80 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 100 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 120 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 140 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 160 pound box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift a 180 pound box</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Remember, rate what you expect you could do and your confidence if you were asked to perform the tasks now.**

**CONFIDENCE SCALE**

<table>
<thead>
<tr>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>quite uncertain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>certain</td>
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</table>

**COUNSELING**

<table>
<thead>
<tr>
<th>Can Do</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk with close friend about a problem with his/her roommate</td>
<td></td>
</tr>
<tr>
<td>Talk with close friend about a problem with his/her dating partner</td>
<td></td>
</tr>
<tr>
<td>Talk with a close friend who is upset and crying</td>
<td></td>
</tr>
<tr>
<td>Talk with an acquaintance about a problem with her/his roommate</td>
<td></td>
</tr>
<tr>
<td>Talk with an acquaintance who seems very depressed</td>
<td></td>
</tr>
<tr>
<td>Function as a peer counselor with a student who is facing a career decision</td>
<td></td>
</tr>
<tr>
<td>Function as a peer counselor with a student who has a problem with his/her dating partner</td>
<td></td>
</tr>
<tr>
<td>Function as a peer counselor with a depressed student</td>
<td></td>
</tr>
<tr>
<td>Function as a volunteer counselor in a center for runaway youth</td>
<td></td>
</tr>
<tr>
<td>Function as a volunteer counselor in a crisis center with a rape victim</td>
<td></td>
</tr>
<tr>
<td>Function as a full time staff counselor in a mental health center with a client who is vaguely unhappy with his/her life</td>
<td></td>
</tr>
<tr>
<td>Function as a full time staff counselor in a mental health center with a client whose spouse has just sued for divorce</td>
<td></td>
</tr>
<tr>
<td>Function as a full time staff counselor with a client who has attempted suicide</td>
<td></td>
</tr>
<tr>
<td>Function as a full time staff counselor with a psychotic client</td>
<td></td>
</tr>
</tbody>
</table>

112
INSTRUCTIONS

In answering the items below, please make your judgments on the basis of what these things mean to you now. Each item contains a different concept to be judged and beneath it a scale. You are to rate the concept on the scale.

Here is how you use the scales:

If you feel that the concept is VERY CLOSELY RELATED to one end of the scale, place your check mark as follows:

EXAMS


or


In the example above, EXAMS were rated as extremely fair or extremely unfair.

If you feel that the concept is QUITE CLOSELY RELATED to one or other end of the scale (but not extremely unfair), you should place your check mark as follows:

EXAMS

STRONG : __ : __ : __ : __ : __ X : __ WEAK

or


If the concept seems only SLIGHTLY RELATED to one side as opposed to the other (but is not really neutral), then you should check as follows:

EXAMS


or


The direction which you check depends upon which of the two ends of the scale seem most characteristic of the thing you are judging.

If you consider the concept to be NEUTRAL on the scale, both sides of the scale EQUALLY ASSOCIATED with the concept, then you should place your check mark in the middle space:

EXAMS

Make each item a separate and independent judgment. Do not worry or puzzle over individual items. It is your first impression, the immediate feelings about the items that we are interested in. On the other hand, please do not be careless, because we want your true impressions.

If you have any questions, raise your hand. Go ahead and rate the following concepts.

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tr>
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<td>HELPLESS</td>
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<td>SECURE</td>
</tr>
<tr>
<td>3</td>
<td>TIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LOOSE</td>
</tr>
<tr>
<td>4</td>
<td>STRONG</td>
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<td></td>
<td>WEAK</td>
</tr>
<tr>
<td>5</td>
<td>WET</td>
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<td></td>
<td>DRY</td>
</tr>
<tr>
<td>6</td>
<td>LOOSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TIGHT</td>
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<tr>
<td>7</td>
<td>FRIGHTENED</td>
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<td>SHALLOW</td>
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<tr>
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<td></td>
<td>BAD</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>CAREFREE</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>TIGHT</td>
</tr>
<tr>
<td>12</td>
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<td>13</td>
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<td></td>
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<td></td>
<td>JITTERY</td>
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<tr>
<td>14</td>
<td>TIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LOOSE</td>
</tr>
<tr>
<td>15</td>
<td>HOT</td>
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<td></td>
<td></td>
<td>COLD</td>
</tr>
<tr>
<td>16</td>
<td>CAREFREE</td>
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<td></td>
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<td>WORRIED</td>
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<td>17</td>
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<td>HAZY</td>
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<tr>
<td>18</td>
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<td>TIGHT</td>
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Appendix F
COUNSELOR RATING FORM

Listed below are several scales which contain word pairs at either end of the scale and seven spaces between the pairs. Please rate the counselor as you perceived him/her. The closer the counselor resembles the word at one end of the scale, the closer you will place the check mark to that word.

If you feel that the counselor very closely resembles the word at one end of the scale, place a mark as follows:

fair ___:___:___:___:___:___:X unfair

If both sides of the scale seem equally associated with your impression of the counselor or if the scale is irrelevant, then place a mark in the middle space:

hard ___:___:___:___:___:___:____ soft

Your first impression is the best answer.

PLEASE NOTE: PLACE MARKS IN THE MIDDLE OF THE SPACES

agreeable ___:___:___:___:___:___:___ disagreeable
unalert ___:___:___:___:___:___:____ alert
analytic ___:___:___:___:___:___:____ diffuse
unappreciative ___:___:___:___:___:___:___ appreciative
attractive ___:___:___:___:___:___:___ unattractive
casual ___:___:___:___:___:___:___ formal
cheerful ___:___:___:___:___:___:___ depressed
vague ___:___:___:___:___:___:___ clear
distant ___:___:___:___:___:___:___ close
compatible ___:___:___:___:___:___:___ incompatible
unsure ___:___:___:___:___:___:___ confident
suspicious ___:___:___:___:___:___:___ believable
undependable ___:___:___:___:___:___:___ dependable
indifferent ___:___:___:___:___:___:___ enthusiastic
inexperienced ___:___:___:___:___:___:___ experienced
inexpert ___:___:___:___:___:___:___ expert
unfriendly ___:___:___:___:___:___:___ friendly
honest ___:___:___:___:___:___:___ dishonest
informed ___:___:___:___:___:___:___ ignorant
insightful ___:___:___:___:___:___:___ insightful
stupid ___:___:___:___:___:___:___ intelligent
unlikeable ___:___:___:___:___:___:___ likeable
logical ___:___:___:___:___:___:___ illogical
open ___:___:___:___:___:___:___ closed
prepared ___:___:___:___:___:___:___ unprepared
unreliable ___:___:___:___:___:___:___ reliable
disrespectful ___:___:___:___:___:___:___ respectful
irresponsible ___:___:___:___:___:___:___ responsible
selfless ___:___:___:___:___:___:___ selfish
sincere ___:___:___:___:___:___:___ insincere
skillful ___:___:___:___:___:___:___ unskillful
sociable ___:___:___:___:___:___:___ unsociable
deceitful ___:___:___:___:___:___:___ straightforward
trustworthy ___:___:___:___:___:___:___ untrustworthy
genuine ___:___:___:___:___:___:___ phony
warm ___:___:___:___:___:___:___ cold
insincere ___:___:___:___:___:___:___ sincere
valuable ___:___:___:___:___:___:___ worthless
effective ___:___:___:___:___:___:___ ineffective
Appendix G
Please Return to:
The Ohio State University
Department of Psychology
Student Consultation Service
Room 333 Arps Hall
1945 North High Street
Columbus, Ohio 43210

Full Name Role # 1 Age 18 Sex F
Marital Status single No. of children 0
OSU Address 816 Taylor Tower Phone 48555
Home Address R.R. #6, Archbold, Ohio Phone 19-555-5076
High School Attended Archbold Consolidated H.S. Year Graduated 1980
No. in your class 3rd of 87

High School course: (circle) college prep., general, commercial, vocat. shop, vocat. agr., technical, other:

Other schools attended since high school none

Qtr. you first entered OSU Fall Quarter, 1980
No. of quarters at OSU 3 Pt. Gr. Ratio 3.3
College UVC Major undecided

Present vocational plans

Type of housing: (circle) at home, res. hall, fraternity/sorority, rooming house, apartment, other:

Activities or organizations

Present employment none Hours per wk.

Major interests reading, sewing, bowling

Honors National Honor Society

General health: (circle) excellent, good, fair, poor
Reason for requesting counseling: Adjustment to school, fights with parents.

Have you previously received counseling or psychotherapy? (circle) yes no
Are you now seeing another counselor or therapist? (circle) yes no

Important Work Experience:

<table>
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<tr>
<th>JOB</th>
<th>Inclusive Dates</th>
<th>Part or Full Time</th>
<th>Liked or Disliked</th>
</tr>
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Family Data: Fill out for all members of your family, including yourself.

Circle your own rank among the children.

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<th>Occupation</th>
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<td>No</td>
<td>Yes</td>
<td>18</td>
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<td>Mother</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>4th Child</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
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</tr>
</tbody>
</table>

Date: ____________________________

If you have any questions about this, please discuss it with your counselor.
Summary of additional client dynamics, Role #1:

For this client, Ohio State University has been a tougher academic challenge than she had expected. This may be due to her coming from a small high school. She has not yet declared a major, and her parents are pressuring her in this area. One of her roommates has engaged in a lot of "wild" partying, smoking marijuana, drinking, and having men stay all night in the room, regardless of the presence of the other three women. The client's parents did not want her to come to O.S.U. in the first place, they would have preferred that she attend a smaller school closer to home. They are still controlling her even though she is not living at home, especially with regards to her spending money. She has a checking account out of her home bank for this purpose, and her mother still does all the book work and record keeping on that account. The client is determined to show her parents that O.S.U. is right for her, even though it is not working out particularly well at this time. In addition, her parents would be mortified if they found out that she was going to a counselor.
Please Return to:
The Ohio State University
Department of Psychology
Student Consultation Service
Room 333 Arps Hall
1945 North High Street
Columbus, Ohio 43210

Full Name: Jane Doe  Age: 17  Sex: F
Marital Status: Single  No. of children: 0
OSU Address: 1712 Shady Lane  Phone: 555-6381
Home Address: Same  Phone: —
High School Attended: Jefferson  Year Graduated: 1990
No. in your class: 569
High School course: (circle) College prep., general, commercial, vocat. shop, vocat. agr., technical, other:
Other schools attended since high school: —
Qtr. you first entered OSU: Autumn  Quarter, 1931
No. of quarters at OSU: 2  F. Hr. Ratio: 2.76
College: UWC  Major: Fashion Merchandising
Present vocational plans: Fashion Merchandising
Type of housing: (circle) at home, res. hall, fraternity/sorority, rooming house, apartment, other:
Activities or organizations: Home & Club
Present employment: Laumann  Hours per wk: 16-20
Major interests: Tennis, Reading
Honors: None
General health: (circle) excellent, good, fair, poor
Reason for requesting counseling: **want to meet people**

Have you previously received counseling or psychotherapy? (circle) yes **no**

Are you now seeing another counselor or therapist? (circle) yes **no**

Important Work Experience:

<table>
<thead>
<tr>
<th>JOB</th>
<th>Inclusive Dates</th>
<th>Part or Full Time</th>
<th>Liked or Disliked</th>
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<td>Part</td>
<td>Liked</td>
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Family Data: Fill out for all members of your family, including yourself.

Circle your own rank among the children.

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<th>Age</th>
<th>Sex</th>
<th>Living at Home</th>
<th>No. of Yrs. of Schooling</th>
<th>Occupation</th>
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<td>M</td>
<td>Yes</td>
<td>18</td>
<td>Engineer</td>
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<td>Mother</td>
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<td>F</td>
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<td>Yes</td>
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<td>3rd Child</td>
<td>Yes</td>
<td>F</td>
<td>Yes</td>
<td>12</td>
<td>Student</td>
</tr>
<tr>
<td>4th Child</td>
<td>Yes</td>
<td>M</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Date: ________________________

If you have any questions about this, please discuss it with your counselor.
Summary of additional client dynamics, Role #2:

This student is primarily having trouble balancing the demands of living at home, working part-time, and adjusting to O.S.U.. She is lonely and confused, finding college is not the fun and exciting time she had expected. In addition, she seems to be about to be dumped by her high school sweetheart, who is a freshman at Oberlin College. She went up to see him several times earlier in the year, but now he is reticent when he talks to her, and has not been home for some time, so they are losing touch. She had always thought she would marry him, and is in crisis when she thinks that he may be in love with another girl at school. All her high school friends went away to school, and she has had difficulty meeting new people. Overall, she feels rather depressed and down on herself, feeling no one will ever like her or want to date her again.
SPECIFIC FEEDBACK

Focus was on particular behaviors that the counselor actually performed in the interview. The supervisor observed the interview and generated five positive statements that could fall into either of the following categories.

Verbal Behavior - Your use of open-ended questions really drew her out, (give example). When you summarized her feelings, (give example), she really lit up. Your comment about (example) was really to the point. The advice you gave about (example) was really helpful.

Nonverbal Behavior - Your nodding seemed to encourage her to talk. The way you maintained eye contact was effective. When you leaned forward, that seemed to convey your acceptance. When you let the silence continue, that seemed to make her think. I liked how you patted her arm while she cried.
GLOBAL FEEDBACK

Focus was on general characteristics of the counselor and the interview setting. The supervisor observed the interview and generated five positive statements that could fall into any of the following categories.

Atmosphere - You conveyed a real aura of acceptance. You really established a comfortable atmosphere. You set up the interview so she was able to really open up.

Verbal Behavior - The kinds of questions you asked were effective. The direction you gave was helpful. You really have a way with words.

Nonverbal Behavior - The way you acted really conveyed your understanding. Your nonverbal gestures were good. The way you carry yourself in this setting is effective.

Person-directed - You seemed to have a real way with her. You are a very warm person. You seem to have a natural talent of talking to people.

General Evaluation - You really did a fine job. You were very effective in drawing her out. I was really pleased with the course of the interview. You seemed to develop a valuable rapport with her.
Appendix I
WHAT IS PSYCHOTHERAPY?

So diverse are the methods and language of psychotherapy today—from psychoanalysis to behavior modification, from Gestalt therapy to transactional analysis—that we should probably speak of psychotherapies in the plural. Yet the definition offered by Jerome Frank, a psychiatrist who is also a clinical psychologist, does cover most of the approaches. Psychotherapy, he wrote, is "the systematic effort of a person or group to relieve distress or disability by influencing the sufferer's mental state, attitudes, and behavior. Drugs may be used as adjuncts, but the healing influence is exerted by words and actions that are believed by the sufferer, therapist, and group to which they both belong to have healing powers, and that create an emotionally charged relationship between them." Although not to the exclusion of other, physical types of treatment, psychotherapy is used in an attempt to relieve all forms of suffering—even heart disease and cancer—in which emotional factors are thought to play a part.

TRADITIONAL PSYCHOTHERAPIES

Freudian psychoanalytic theory and practice continues to be influential. Despite changes in emphasis and method, it underpins all the analytic psychotherapies. Their central aim, like Freud's, is to explore forbidden childhood impulses that lie buried but still active in the unconscious, often giving rise to unsatisfying behavior and relationships, contrary to our conscious purposes. When these repressed impulses are uncovered, with all the events associated with them, patients can examine them with their conscious minds and, so to speak, defuse them. It is a paining process, involving a reliving of early experiences charged with primitive passions and terror of punishment. Hence it often provokes what Freud called resistance—an unconscious blocking of the flow of memories that takes the form of an embarrassed silence or a lot of idle, repetitive talk. In time that, too, must be analyzed.

the fear of losing control

Martha M., 25, a law student married to a young lawyer, comes to a psychoanalytically trained psychiatrist because she's afraid she's losing her mind. "After we've spent an evening with friends," she explains, "my husband mentions things that were said, and I haven't a notion what he's talking about. Oh, I know I'm not expected to remember everything that went on, but this is different. It's as if I hadn't been there at all."

"Perhaps you weren't," says Dr. Hart, "at least not in spirit. You may have been too preoccupied with what was going on inside you to pay attention."

So begins Martha's therapy. Martha is an only child whose parents have competed for her love. Her mother, clinging to a traditional domestic role, expected her daughter to do the same. But her father, a self-made businessman, wanted her to have a career. How often he had remarked that he wished he could have become a lawyer! So Martha, after graduating from college with honors, went on to law school. Hating her mother, hating living at home, she readily fell for the fourth-year law student who courted her. By the end of her first year in law school, they were married.

the crisis point

Now five months pregnant, Martha is faced with the necessity of giving up school for motherhood. The thought of being responsible for a baby fills her with panic. It is this situation, Dr. Hart surmises, that has sharpened her inner conflicts to the point where she can't pay attention to what is going on around her.

If this were a classic psychoanalysis, Martha would meet her doctor four or five times a week for a period of three to six years. Lying on a couch to promote relaxed introspection, she would follow the analytic basic rule: to say whatever came to her mind, however trivial, insulting to the analyst, or taboo it might seem to her. Her free associations to her dreams and waking fantasies, to incidents in her past and present life, to songs she finds herself humming, even thoughts that seem totally disconnected—all these would be grist for the analytic mill.

So would what Freud called transference. All of us tend to transfer to others the loves and hates we felt as children for our parents and siblings, so that we don't see these people as they...
really are. By remaining as neutral as possible, an analyst allows these "transferred" attitudes to take center stage, to be explored by patient and therapist together.

Although at times Dr. Hart invites free association and studies resistance and transference, he does not rely on these exclusively. Not all patients can invest the time and money for full-scale psychoanalysis; and some could not tolerate what it would reveal. Many have work, family, or other problems that demand a speedier solution than analysis can offer. Dr. Hart sees Martha only twice a week, in a face-to-face dialogue, and is more active in their interchange than a traditional analyst would be.

a moment of truth
When Martha inquires her forthcoming withdrawal from law school, for example, Dr. Hart asks directly. "Do you want to be a lawyer?" "Why, of course. My father—" She stops, startled. "Well, I—I don't know. I've never thought about what I want. I guess I always try to do what other people want."

The impact of this exchange on Martha is tremendous. Now, for the first time, it occurs to her that maybe she is permitted to have desires and goals of her own. But what are they? She will have to search for the self she had denied. Even as she has rebelled against her mother and striven to achieve in a "man's world," she discovers, she has unconsciously expected to fail and be thrust back into the role her mother offers as the sole expression of femininity. Analysis of her intense transference feelings toward her therapist—at first adoring, then angry—reveal her overriding desire to please her father and rival her mother in his affections, masking resentment of his domination.

Noting clues and the patterns they fall into, Dr. Hart is aware of Martha's unconscious drives long before she is. But he cannot push her into facing truths about herself she has spent her life warding off. She must discover them herself, and in the permissive, understanding climate he creates, gradually does. New perspectives open up, new feelings emerge. "Visceral comprehension"—the fusion of intellectual and emotional recognition that is insight—is a necessary prelude to any basic personality change. Yet no therapist can force it. The more he or she can do is create the conditions that foster its growth.

the therapeutic relationship
One crucial condition is the quality of the therapist-patient relationship. It is determined by numerous factors in addition to transference; inevitably, the therapist's personality has an influence and can be used for therapeutic ends. Despite their aim to remain neutral and detached, even strictly Freudian analysts probably relate to their patients in a positive way, inspiring hope and certainly trust. Studies have shown that successful therapists have "high levels of accurate empathy, nonpossessive warmth, and genuineness," and that these qualities are not limited to therapists of any particular school. Since a therapist must be a person who can enter into this kind of relationship, it is essential for him or her to undergo psychotherapy during training to deal with any personal problems that might hamper the work.

To benefit from the relationship, the patient, too, must be able to experience it. Many people can't at first. They are too distrustful, too much in the habit of talking mechanically without conveying any real meaning or wanting to, too distracted and out of touch with their feelings. So therapists must work first on whatever blocks patients' capacity to be engaged as whole persons.

The therapist-patient relationship plays a large role in the theories of Neofreudian analysts such as Karen Horney and Harry Stack Sullivan. Although, like Freud, they saw inner conflicts generated in infancy as the roots of neurosis, they also gave great weight to the influence of culture and interpersonal relations. The schools they founded focus on patients' capacity for self-assertion, self-esteem or the lack of it, and ways of meeting the need for security. They aim to set free, in Karen Horney's words, "the healthy striving toward self-realization" that they believe to be a universal human potential. This view, much more optimistic than Freud's, is particularly congenial to Americans.

the analytic psychology of Jung
Actually it was Carl Gustav Jung, an early associate of Freud's, who introduced the idea of self-realization as a goal of therapy. He argued that patients needed a constructive thrust toward the future, which creative forces in their unconscious minds, once released, could help them fulfill. Where Freud asked "Why?" in dream interpretation, Jung asked "To what purpose?" He also
noted that the tensions of parents, not just repressed infantile incestuous wishes, contributed to neuroses in children. This downplaying of the sexual theme, so central to Freud’s theory, was a major factor in Jung’s break with the master in 1912-1913.

Widely read in mythology, Jung saw parallels between mythological motifs and the hallucinations of schizophrenics and mythical figures appearing in children’s dreams. From these observations he formulated his concept of the collective unconscious—a deep reservoir of memories derived from the experience of the whole human race, which he believed to be part of everyone’s heritage. For him the road into the collective unconscious was through the dream, and contact with it through archetypes (original models)—mythical figures such as Hero, the Great Mother, or the Wise Old Man, mythical settings such as the cave or the river crossing. What mainly distinguishes Jungian from other analysts is their ability to identify and interpret these archetypes when they appear in patients’ dreams and artwork.

Had Martha M. gone to a Jungian analyst, a woman perhaps, they would have met as equals, face to face. The therapist would have used whatever initial approaches seemed appropriate for Martha’s problems. For Jungians in their training institutes are taught all the depth psychologies and a wide range of psychotherapeutic procedures, some quite matter-of-fact. When Martha dreamed of her father, the therapist would first have helped her see how the dream related to her life. Then she would have asked Martha to elaborate imaginatively on the dream content, while the therapist contributed her own fantasies and interpretations.

Thus, the dream about Martha’s father might have evolved into an encounter with all fatherhood, the father archetype. When critics claim that this amounts to indoctrinating the patient with the analyst’s theory, Jungians reply that only the interpretation that wins the patient’s vital assent is the true one.

The belief that treatment of a neurosis involves more than the individual psyche, and that patients have inner resources for dealing with it which they haven’t yet recognized, can in itself relieve some neurotic distress. Perhaps because of its transpersonal aspect, as well as its attention to unfilled parts of the personality, this therapy has a special appeal for people in their middle or later years, particularly those of a scholarly persuasion.

Adler’s individual psychology
Another associate of Freud who parted company with him was Alfred Adler. As early as 1911, he theorized that the “will to power,” not sexual drives, was the mainspring of human behavior. He discarded the search for the causes of neurosis in the past and looked instead to the future, to the striving to reach “fictive goals.”

Because of our smallness and helplessness as children, Adler argued, we all have inferiority feelings, often compounded by parental attitudes. (It was Adler who coined the term inferiority complex.) To compensate, we set up goals of superiority, which are largely determined by our competitive culture. When these goals are grossly unrealistic, they lead to neurosis.

Adler opened up new avenues of psychological exploration. He saw the patient’s pathology as an expression of his or her alienation from the social network, not as a purely internal deficit. This view threw new light on the emotional disturbances of women, to whom the society of Adler’s time accorded only inferior status. Adler’s ideas have had considerable influence on some of the later schools of therapy that, similar to Adler’s approach, regard their work as a form of re-education and deal with patients on a conscious level.

short-term psychotherapy
Analytic therapy has also been adapted to deal with temporary emergency situations. Because of the immediacy of the crisis, the therapist must intervene from the start, instead of just listening as a psychoanalyst would. In the case of Gary F., reported in an article in The New York Times Magazine, the problem was acute anxiety about his imminent marriage. “Is it possible that your mother is jealous of your fiancé?” the therapist asked. “Are you afraid that your father will be enraged at your getting married?” Gary probably could not have put these questions to himself because they would have aroused more anxiety than he could have handled alone. Now, however, he could confront his anxieties in a safe setting and begin to make connections between his current feelings and events in his past. Such rapid clarification of a problem (eight sessions) requires of the patient some psychological sophistication and a strong motive to change.
'HUMAN POTENTIAL' THERAPIES

Most of the newer therapies have departed radically from psychoanalytic concepts. Indeed, the leaders of some of them frankly scorn psychoanalysis as elitist and overintellectualized. They gather under the umbrella of the human potential movement.

Rogerian client-centered therapy

The father of the nonanalytic, humanistic approach is the psychologist Carl Rogers. He holds that "the innermost core of man's nature, the deepest layers of his personality, the base of his 'animal nature,' is positive...forward-moving, rational, and realistic." Not Freud's repressed primitive passions, but the good whole person must be encouraged to emerge under the benign influence of the therapist's empathy and "unconditional positive regard." The client's autonomy is stressed, and he or she decides how often to come for therapy as well as when to end it.

A Rogerian therapist reflects what you say back to you without judgment or interpretation, helping you become aware of how you are judging yourself. In this positive climate, a re-education and re-socialization process—akin to Adler's—is set in motion. It is a popular therapy, well suited for people whose feelings of inadequacy have been stirred up by a stressful life transition, or who feel isolated and lonely but do not want to—or cannot—dig very deep into themselves, including some psychotic patients.

gestalt therapy

Another popular humanist model is Gestalt therapy, founded by Frederick S. (Fritz) Perls, a former psychoanalyst, in the 1940s. Although he borrowed the name and some of its terms from Gestalt psychology, he assigned his own meanings to them. Gestalt for him meant a unit of experience. Influenced by Wilhelm Reich, a defector from Freud who saw in "body armor" manifestations of repressed conflicts, Perls paid close attention to his patients' body language—breathing, posture, muscular behavior, voice tone, and facial expression.

Practitioners today attend also to what modern brain research has identified as the language of the nondominant hemisphere (in most people, the right half) of the brain. It is the language of imagery, fantasy, music, jokes, metaphors, puns, and other word play. Where the left brain, the seat of logic and reason, often cannot see the forest for the trees, the right brain intuitively recognizes a whole in a part—a whole face, for example, in three or four sketched lines. Gestalt therapists consider this synthesizing function crucial in their work.

In its original form Gestalt therapy was typically carried on in sporadic workshops lasting a day, a weekend, a week—many of them in growth centers like Esalen Institute at Big Sur, California. Today many patients are seen individually in combination with regular or occasional workshops, or in brief therapy—lasting from ten sessions to a year.

A workshop participant who volunteers to "work" and takes the "hot seat" beside the therapist is in effect engaged in individual psychotherapy. It becomes a more intense experience by virtue of the presence of the group. While other group members vie for the working patient undergoes and may learn from it, in a Gestalt workshop there is no deliberate use of group process as such.

in the 'hot seat'

If Martha M., with her fear of losing control, had come to a Gestalt therapy workshop and eventually screwed up her courage to take the hot seat, what might she have experienced? The therapist—we'll call her Karen, since informality is a hallmark of the humanists—would have focused on her behavior in the here-and-now. Not "Why?" but "How?" and "What?" are key words for Gestaltists. "How are you breathing?" Karen asks. "What are you doing with your right hand?" "It's clenched," Martha replies. "It?" Karen repeats, until Martha catches on and corrects herself, "I am clenching my fist," taking responsibility for her action.

She realizes that she wants to punch someone with that clenched fist. A pillow is thrown onto the stool in front of her, and Karen invites Martha to pound it and cry out whatever she feels. "Can't," Martha says. She's still the good girl who accommodates others and never shows hot anger. "Instead of 'I can't' say 'I won't,'" Karen suggests. Martha tries it and begins to feel a mounting wave of resentment. Shouting "I won't, I won't," she pounds the pillow with all her breath. When at last she pauses for breath, her whole being is flooded with energy.
Martha recalls a dream and Karen asks her to tell it in the present tense, to re-experience it now. Dreams, for Gestaltists, contain messages from split-off parts of the self. These deal not with repressed memories but with blocked expression of current, immediate needs of the whole person. It is up to the patient to decipher the messages by enacting the dream. In one part of Martha’s dream her feet are mired in thick mud; she calls to a woman at a distance to help her out of it. The woman neither hears nor sees her, and Martha feels despair and terror. “You write the script,” Karen says, suggesting a dialogue with the woman. First Martha addresses the woman, then switches places and plays the woman addressing her. What emerges is a sharp confrontation with her mother—not her actual mother, but the negative mother part of herself. In dealing with this part, Martha experiences how she is blocking her own way, and so locking up energy. At the same time, she recalls that her mother was not always critical of her—there was love, too. From the part she has so vividly experienced she begins to see the whole, in all its complexity. She will now be better able to deal with that complexity.

While Gestalt therapy’s early exposure of “gut” problems may be an advantage for some, the emotional impact of the experience may be too much for others. Gestalt centers now usually conduct intake interviews for screening purposes and refer patients to a different type of therapy if that seems advisable.

**bioenergetics**

As part of their concern for the whole person, growth centers generally offer body work in one format or another. It often stirs up memories, thoughts, and feelings of psychological significance, but these are not always noted or discussed. One model that does aim to approach the mind through the body is bioenergetics, which Alexander Lowen developed on the basis of Wilhelm Reich’s theories. Its practitioners use exercises and physical manipulations to get your energy moving, as they put it. Their theory links particular areas of the body with particular emotions. Hence, they expect the loosening of these areas to release inhibited impulses—impulses to cry, scream, and shout, for example, when the throat, chest, and diaphragm are relaxed. They discuss and offer interpretations of such emotional outbursts and the memories they evoke.

**eclectic therapies**

Eclectic therapists are those who use a mix of methods derived from different schools. Some postdoctoral programs in psychotherapy deliberately expose trainees to a variety of theories and procedures, so that they can choose the approaches they believe they can use most effectively. Thus, an analytically oriented therapist may on occasion teach a tense patient deep breathing exercises to promote relaxation and free association.

To take another example, Arthur Janov’s primal therapy may also be combined with other methods. Janov concentrates on directing the patient to relive the primal pain (always capitalized in his writings) of childhood hurts inflicted by parents. Although he claims this is the only cure for neurosis, some therapists trained in primal therapy believe that expressing the deep past pain in the Primal Scream is not enough. The DiMele Center for Psychotherapy in New York City, for instance, uses a primal approach to elicit intense feelings stemming from the past, then Gestalt and other techniques to enhance patients’ awareness of their present behavior, and of the connection between the two.

**GROUP APPROACHES**

Although sometimes conducted in a group setting, the therapies discussed so far are essentially one-to-one work with individuals. Group therapies, by contrast, deliberately focus on group interactions as the agent of change.

**psychodrama**

The term *group psychotherapy* is said to have been coined by Jacob L. Moreno in 1932. He designed a special form of it called psychodrama, in which group members in turn act out a personal problem under the therapist’s guidance as stage director. Others in the group take the roles of persons involved in the problem. Two or three members act as the protagonist’s auxiliary ego, dramatizing alternative ways of dealing with the situation. The mutual helping and learning that go on in such a group are of distinct benefit, and role-playing derived from psychodrama has become a widely used learning tool. Psychodrama itself is now mainly practiced by psychiatrists, psychologists, and social workers who have taken training in it and who use it as part of their group therapy.
<table>
<thead>
<tr>
<th>TRADITIONAL PSYCHOTHERAPIES</th>
<th>GROUP THERAPIES</th>
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<td><strong>GROUP THERAPIES</strong></td>
</tr>
<tr>
<td>Uses Freud's method of uncovering unconscious conflicts through the patients' free associations—while lying on a couch—to dreams, fantasies, and early memories, as well as transference of the passionate feelings embedded in those memories onto the analyst.</td>
<td>Frequency &amp; duration: Once or twice-a-week 2-hour group sessions for 15 participants, ranging as a rule from a few months to 2 years, may be supplemented by individual therapy sessions.</td>
</tr>
<tr>
<td><strong>ANALYTICALLY ORIENTED PSYCHOTHERAPY</strong></td>
<td><strong>TRADITIONAL GROUP THERAPY</strong></td>
</tr>
<tr>
<td>Based on Freud's theory of unconscious conflicts, but permits much more direct and spontaneous therapist-patient dialogue, face to face, than classical psychoanalysis.</td>
<td>Frequency &amp; duration: Once-a-week group sessions for 6 to 10 persons focus on group interaction, with members giving each other feedback on how they come across. The aim is to expose maladaptive attitudes and behaviors and learn new and better ways of relating to others.</td>
</tr>
<tr>
<td><strong>ADLERIAN THERAPY</strong></td>
<td><strong>TRANSACTIONAL ANALYSIS</strong></td>
</tr>
<tr>
<td>Often supportive, in a practical way, with a therapist who is personally involved; but goes beyond the personal sphere to engage the patient in imaginative amplification of dreams and art work in an attempt to put him or her in touch with the archetypical figures of the collective unconscious. A transcendental approach.</td>
<td>By improving communication among family members and helping them to express the full range of their emotions, seek to promote family understanding and cooperation. Often used to handle a family crisis.</td>
</tr>
<tr>
<td><strong>HUMAN POTENTIAL THERAPIES</strong></td>
<td><strong>COGNITIVE-BEHAVIORAL THERAPIES</strong></td>
</tr>
<tr>
<td><strong>CLIENT-CENTERED THERAPY</strong></td>
<td><strong>COGNITIVE THERAPIES</strong></td>
</tr>
<tr>
<td>Seeks to build self-esteem through the therapist's empathy and &quot;unconditional regard&quot; for the client, and invites the client to participate in setting terms for the therapy.</td>
<td>Based on the theory that habitual errors in perception and thinking cause psychological disturbances and that these errors can be corrected through rational, intellectual understanding.</td>
</tr>
<tr>
<td><strong>GESTALT THERAPY</strong></td>
<td><strong>BEHAVIOR THERAPY</strong></td>
</tr>
<tr>
<td>Fosters awareness of moment-to-moment experiences of the patient as a whole person, body and mind, and seeks to build acceptance of full responsibility for them as a condition for growth.</td>
<td>Considers symptoms to be learned bad habits and seeks to eliminate them through teaching new adaptive skills.</td>
</tr>
<tr>
<td><strong>BIOENERGETICS</strong></td>
<td><strong>BIOFEEDBACK</strong></td>
</tr>
<tr>
<td>Based on Reich's theory that emotional blockages are built into the body and that they can be released, to</td>
<td>A behavioral format in which patients are trained to modify autonomous body processes through deep muscle relaxation as they receive feedback from electronic machines to which they are attached.</td>
</tr>
</tbody>
</table>
traditional group therapies

In group therapy, one therapist can work with several patients at once—usually six to ten. Hence, it is a way of spreading therapeutic resources around and cutting their cost. For some patients it is actually more effective than individual therapy. After World War II, therapists of various schools took up the method. Whatever the therapist's theory, however, it was apparent that certain healing influences characterized therapy groups.

Often, people in deep emotional distress believe that their suffering is unique. Discovering that they are not alone in their misery can be a great relief. Usually, too, they feel they have nothing to contribute. Yet in the group at times they support and comfort one another or offer constructive suggestions—a boost to self-esteem and an experience of a new way of relating to others.

The small family-like group at first provokes intense transference reactions, and not just toward the therapist. Here the transference is diffused; you may see one group member as a rival sibling, another as a critical mother. These reactions are not always interpreted in psychoanalytic terms but, rather, in terms of their inappropriateness in the present. Indeed, you may benefit more from your group partners' comments than from those of a therapist whom you may be resisting as an "authority." In contrast to the outside world, the group gives candid feedback on how you come across to others. You may be made aware, for instance, that you are competing with or trying to manipulate others, rejecting them, or courting them for love and admiration. While these revelations can be quite painful, they are valued by the group as a whole because self-exposure is valued. Being accepted by the group, no matter what you reveal about yourself, is a powerful healing force, sometimes greater than the support of the therapist.

Despite the feeling of solidarity and the code of confidentiality that develop in the group, hostility must have an outlet, or genuine communication will grind to a halt. The expression of anger, constructively dealt with so that the feared catastrophic results do not occur, encourages further self-exposure and mutual understanding. So there is movement toward honesty in relationships.

Group therapy is sometimes organized to deal with specific life stresses, like those of adolescents and delinquents, or of parents whose children suffer from physical or mental handicaps. It is not for every troubled person, however. Some people cannot tolerate a group's frank expression of feelings. Suspicious or socially awkward persons are apt to be too uncomfortable in a group to get much help from it. Candidates for group therapy must therefore be carefully screened.

family therapy

Another group approach now widely used is family therapy, in which a therapist meets regularly, usually once a week, with a troubled family as a whole. The psychiatrist Nathan W. Ackerman, who pioneered this method, invited even grandparents into the therapeutic sessions if he suspected they were part of the problem. Child participants are generally nine years old or older.

The emphasis here is less on the inner conflicts of each person than on family interaction. The therapist encourages the honest expression of each member's full range of feelings. Plain speaking about tensions and resentments can clear the air and lead to mutual understanding. Only after the expression of negative feelings can family affection once more emerge and be appreciated. So, without directions from the therapist, in time the family learns to live cooperatively.

In couple or marital therapy there is a similar stress on improving communication between the parties, showing how each reinforces the other's negative behavior and correcting their stereotyped images of one another.*

transactional analysis

In the fertile soil of American optimism, simplified variants of group therapy have sprung up. Transactional Analysis (TA) is one of these. Designed in the late 1950s by a Freudian analyst, Eric Berne, author of Games People Play, it was further popularized in the 1970s by Thomas A. Harris with his best-selling book, I'm O.K.—You're O.K. It uses a kind of shorthand to describe "transactions" between people. Key terms are "O.K." (for feelings of security and self-esteem), "not O.K." (for feelings of insecurity), and Parent, Adult, and Child—"P-A-C"—for three different "ego" states.

* Other approaches to improving marital relationships are discussed in New Ways to Better Marriages, by Elizabeth Ogg, Public Affairs Pamphlet No. 347.
states. In our dealings with others, according to TA, we function through one of these states. It is by understanding when we are behaving like a critical Parent or a Child who has overadapted to negative parental commands and learning to put our Adult self in control, that we begin to feel O.K. At times we can be a nurturing Parent, nurturing ourselves as well as others, or, in play and in sexual situations, a free Child, and still feel O.K. Like Adler, TA therapists focus on conscious behavior and an educational process.

Berne claimed that he had demystified psychology and made it accessible to everyone. So TA theory and its shorthand labels are imparted directly to patients, who use them freely. Undoubtedly the simplicity, not to say colloquialism, of TA language contributes to its appeal. Many TA therapists make a contract with a patient to bring about a specific change. This may be accomplished through a concentrated TA experience lasting several days or through once-a-week group meetings over a period of weeks.

**GROUP THERAPY VERSUS INDIVIDUAL THERAPY**

In addition to being less expensive, group therapy exposes neurotic patterns in interpersonal relations quite quickly and dramatically, and it tends to bring about changes in behavior quickly, too. But it can never delve as deeply into a person's psyche as individual therapy can. This is partly because the group takes over and focuses only on those matters that are important to the group. To ensure that the group provides an experience of intimacy without violating anyone's freedom, a highly skilled, sensitive, and, above all, ethical leader is essential.

**COGNITIVE-BEHAVIORAL THERAPIES**

All therapies aim to persuade patients to change and hence are directive, if only in subtle ways. Behavior therapists, however, openly tell the patient what to do. They are concerned only with some observable aspect of the patient's behavior, which they set out to change in a very direct way.

In hypnosis, the original directive method, the therapist lulls the patient into a trance-like state with repetitive suggestions, then gives specific commands, such as "When you wake up, you'll stop smoking," or "...your pain will be gone."

Other, less authoritarian directive therapies seek to identify and change errors in cognition—that is, in perception and thinking—and work with the patient's conscious mind. Psychiatrist William Glasser's reality therapy underscores the consequences of patients' irrational behavior and charges them with responsibility for changing it. Psychologist Albert Ellis's rational-emotive therapy and psychiatrist Aaron T. Beck's cognitive therapy use logic and reason to correct irrational assumptions.

In contrast to the analytic approach, cognitive therapies focus on the immediate contingencies that have given rise to the behavior the patient and therapist wish to change and how to change it, rather than on its roots in the distant past.

**BEHAVIOR THERAPY**

Traditionally, behavior therapy has zeroed in on particular symptoms, such as stuttering, enuresis (bed-wetting), a phobic fear (for example, fear of flying), or a sexual problem like premature ejaculation. Because the problem is specific, the methods clearly defined, and the therapeutic results measurable, research-oriented psychologists favor this method. In their view, maladaptive behaviors, having been learned through life experiences, can be replaced by new behaviors taught by new experiences.

Assessment of the problem is the first step: How severe is it, and how is it affecting your work and relationships? Is your fear connected with inability to assert yourself, or is it fear of a specific situation? The therapist may begin with assertiveness training or with systematic desensitization, an approach developed by Joseph Wolpe, a South African psychiatrist, in the 1960s.**

He showed that training a patient to respond to a fear-provoking situation with behavior that contradicted the fear would break the link between that situation and the fear.

A behavior therapist teaches you to inhibit anxiety through breathing exercises and deep muscle relaxation. After learning to relax in this way, you are asked to imagine yourself in the least terrifying of the situations you're afraid of. Say you have a dread of heights. You might start with a fantasy of climbing a

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*For a discussion of phobias, see Phobias: The Ailments and the Treatments, by Harry Milt, Public Affairs Pamphlet No. 580.

**For more information, see Behavior Modification, by Irving R. Dickman, Public Affairs Pamphlet No. 546.
short ladder, then go on to taller and taller ones, always provided you remain relaxed. Finally, when you can picture yourself on top of a skyscraper, without tension, you are encouraged to try scaling heights in real life.

Behavior therapists also practice in groups, whose members reinforce the treatment with their mutual approval and support. Role-playing, too, is used to rehearse the desired behaviors. This has been especially helpful to people who want to lose weight or stop smoking or drinking or gambling.

**Behavioral strategies in sex therapy**

In systematic desensitization, the first tasks assigned demand less than the patient is capable of. This builds confidence and stimulates an urge to do more. It is a key strategy in sex therapy.

Almost all sex therapists prescribe for couples with sexual problems that they first of all stop trying for complete sexual intercourse. Instead, they are asked to concentrate on the pleasures of touch and to talk with one another about any sexual topics they may have previously avoided. When they can mutually enjoy their bodies and talk freely about their sexual desires without feeling driven to achieve orgasm, they often spontaneously kick over the therapist's prohibitions and reach the desired goal.

At least that is what usually happens where both partners genuinely want to solve the sexual problem. The two-week sex therapy devised by William Masters and Virginia Johnson in the late 1960s is generally successful with such couples. But where there is deep-seated antagonism between the partners or great fear of intimacy, any benefit is likely to be temporary unless they are in psychotherapy or marital counseling at the same time.

There can be no doubt, though, that behavior therapy usually succeeds in doing what it sets out to do—that is, teach new skills to replace the old maladaptive behavior. And the symptom rarely comes back, as some argue that it will. A stammerer who no longer stutters, a child who no longer wets the bed, a woman formerly confined to her home by agoraphobia who can now go out alone—these people gain not only in self-esteem but also in their social lives. Such secondary gains reinforce the primary gain. In some instances, too, the behavior therapist's relationship with the patient may have contributed to all-around improvement.

Although still poles apart, behavior therapy and psychoanalysis have begun to explore some common ground. A few psychoanalysts now see the importance of helping patients translate their insights into action. The idea of neurosis as a fixed "set" operating at all times within a person is giving way to more concern with the context in which behavior occurs—a person may behave neurotically only in certain kinds of situations. And a few behaviorists now accept the concept of the unconscious, although not in Freud's terms, and in the light of modern dream research, are willing to consider dreams as part of the learning process.

**Biofeedback—meditation with machines**

Biofeedback, another behavioral approach, seems like an odd mixture of Eastern Yoga and Western technology. After entering the deep relaxation taught by both Yogis and behavioral therapists, patients try to control their autonomous processes, such as heart beat, blood pressure, muscle tension, or blood vessel constriction and dilation. Electronic machines to which they are attached relay the results to them via dials or fast or slow beeps.

After weeks or months of training in this method, some hypertension and migraine-headache victims have been cured.

Excerpted from:

Appendix J
---THE OHIO STATE UNIVERSITY---

Consent for Participation in
Social and Behavioral Research

I consent to participating in a study entitled **Effect**

of types of feedback in supervision on self-esteem and self-

**efficacy.**

Richard K. Russell/A. Dunnewold

(Investigator/Project Director)

explained the purpose of the study and procedures to be followed. Possible benefits of the study have been described. Possible risks have also been fully explained.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Further, I understand that I am free to withdraw consent at any time and to discontinue participation in the study without prejudice to me. The information obtained from me will remain confidential and anonymous unless I specifically agree otherwise.

Finally, I acknowledge that I have read and fully understand the consent form. I understand that I am voluntarily submitting to any risks involved, and therefore, the investigator can not be held responsible. I have signed this form freely and voluntarily and understand a copy will be available upon request.

Date: ___________________ Signed: ___________________

(Participant)

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(Investigator/Project Director or Authorized Representative)