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Black, Virginia Wisz

THE MODIFICATION OF ANXIETY AND SELF DEFEATING COGNITION IN COUNSELOR TRAINEES THROUGH RATIONAL STAGE DIRECTED HYPNOTHERAPY: A COGNITIVE EXPERIENTIAL APPROACH

The Ohio State University

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THE MODIFICATION OF ANXIETY 
AND SELF DEFEATING COGNITION
IN COUNSELOR TRAINEES THROUGH
RATIONAL STAGE DIRECTED HYPNOTHERAPY:
A COGNITIVE EXPERIENTIAL APPROACH

DISSERTATION

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

By
Virginia W. Black, B.S., M.A.

** ** ** **
The Ohio State University
1982

Reading Committee
Dr. Donald J. Tosi
Dr. W. Bruce Walsh
Dr. Steve W. LeClair

Approved By
Dr. Donald J. Tosi
Advisor
Department of Education
Special Services
ACKNOWLEDGEMENTS

It is a difficult if not impossible task to adequately acknowledge all those who have assisted and encouraged me in the completion of this dissertation.

Under the guidance of Dr. Donald J. Tosi, my advisor, I chose to take instruction in hypnosis early in my graduate experience. Through the editing of his work I developed an appreciation for the Rational Stage Directed Model. As a treatment therapist in the Riverside Hospital hypertension project, my admiration for the model's depth and subtleties grew. As a treatment of choice for anxiety in practicum students, it was a natural. Dr. Tosi's earthy clinical and philosophical perspective has always been interesting and usually humorous.

The other members of my committee were well chosen. Dr. Steven LeClair is a veritable fount of information and an extremely reasonable faculty member, willing to be available to meet for conferences with a student whether the purpose was to discuss a dissertation or a class paper. One has the impression that he prefers quality.
Dr. Bruce Walsh is a careful listener who treats graduate students with respect, and greatly aids in the clarification of an idea. In addition, he is a good and decent human being.

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Thank you, too neighbors and friends who helped in many ways.

Thank God it is completed.
VITA

March 24, 1945 . . . . . . Born - Cleveland, Ohio

1967 . . . . . . . . . . . . . . . . . B.S. in Education
The Ohio State University
Columbus, Ohio

1973 . . . . . . . . . . . . . . . . . M.A. in Foreign Language Education
The Ohio State University
Columbus, Ohio

1969-77. . . . . . . . . . . . . . . . . Teacher
Scioto Darby Schools
Hilliard, Ohio

1977-79. . . . . . . . . . . . . . . . . Psychology Intern
VITA Counseling Services
Columbus, Ohio

1979-80. . . . . . . . . . . . . . . . . Graduate Research Assistant
Department of Education
Special Services
The Ohio State University
Columbus, Ohio

1981-82. . . . . . . . . . . . . . . . . Psychology Intern
Aukerman Medical Center
Jackson Center, Ohio

FIELDS OF STUDY

Major Field: Counseling

Counseling Psychology. Professor Bruce Walsh

Developmental Psychology. Professor Henry Leland

Clinical Application. Professor Donald Tosi
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CHAPTER I

INTRODUCTION

Counselors in training face a formidable task as learners. Background in theory often offers little practical information to applied counseling. Even carefully delineated, didactic-experiential training models cannot adequately provide exact answers moment to moment for appropriate counselor response and behaviors.

All of a counselor's previous life experiences and personal philosophy interact with selective responses to the material that the client reveals. The subject matter, the client, does not remain constant but changes from moment to moment. Transference and counter-transference actively intrude. The counselor/learner often does not have to choose from one of two to five possible answers, but instead has to choose from a multitude of correct answers. Every session implies assessment and treatment (Osipow, Walsh, Tosi, 1980) and both an analytical and interactive mode are required of the learner. For example, empathy, a quality that comprises analytical and interactive modes is prominent in the literature, Bergin and Garfield (1971) in their review of the literature found forty-one studies. Carkhuff
(1969) describes the empathic response:

The first person's responses add significantly to the feeling and meaning of the expressions of the second person in such a way as to (1) accurately express feeling levels below what the person himself was able to express (analytical) or (2) in the event of ongoing deep exploration on the second person's part to be fully with him in his deepest moments (interactive).

Other counselor qualities, researched and considered to be important are: unconditional positive regard (Rogers, 1957), acceptance (Tyler, 1969), nonpossessive warmth (Truax and Carkhuff, 1967; Bergin and Garfield, 1971) genuineness (Truax and Carkhuff, 1967), self disclosure (Martin and Carkhuff, 1965), concreteness (Carkhuff and Berenson, 1967; Truax and Carkhuff, 1967), trustworthiness (Strong and Schmidt, 1970). Thus expectations for success depend not only on the counselor's intellectual skills, but on qualities that reflect on his adequacy in an intra-personal and interpersonal sense. The consequences of counselor inadequacy along some qualities (warmth, empathy and genuineness) are purported to be deterioration in personality and behavior functioning of the client (Rogers, Gendlin, Kiesler and Truax, 1967; Truax, Wargo, and Silber, 1966). Moreover, counselor fears of inadequacy may be intensified by the "threat" of evaluation (Patterson, 1964, Arbuckle, 1963). In fact Tyler (1968) exhorts the planners of counselor education and supervision to keep
morale high and minimize anxious motivation. Given that the expectation for a counselor in training is to function adequately both intellectually and emotionally, it is understandable that as early as the 1950's and 1960's authors of works on counselor education commented on the need to address the issue of counselor anxiety especially vis à vis performance (Bandura, 1956; Brams 1961; Hogan, 1969). Studies conducted to date, however, have focused on only interpersonal skill, the treatment of counselor anxiety, and the effect on counselor performance. Yet studies by Ellis (1962, 1973) have suggested that intrapersonal communication is an important aspect of emotional well being, and in a similar vein Raimy (1975) stated that successful therapeutic outcome is realized through modification of self talk.

Focusing on intrapersonal and interpersonal skills Tosi and Eshbaugh (1978) examined the effect of modifying irrational internalized cognitions about the self in counselor trainees and found that counselors increased the level of interpersonal and intrapersonal functioning when they modified their internalized irrational ideas in combination with learning communication training and feedback.

It is reasonable to assume, then, that a method that would propose to alleviate anxiety within both an interpersonal and
intrapersonal framework might increase the probability of lessened anxiety and raise the level of counselor performance. Rational Stage Directed Hypnotherapy developed by Tosi and Marzella (1975) is such a method. It combines cognitive self talk and relaxation and imagery within a perspective that includes stages of experiencing. It has shown to be significantly effective in decreasing anxiety and increasing learning in test anxious nurses (Tosi and Boutin, 1982) and undergraduate underachievers (Corley and Tosi, 1980). It combines an overt directive, educational approach to cognition at the conscious level with a self management method for alleviating anxiety and promoting internalization of ideas through relaxation and imagery.

NEED FOR THE STUDY

The experimental study of anxiety experienced by counselor trainees has much to recommend it. Spielberger (1971) has found that maladaptive levels of anxiety can affect performance. A large amount of research on the correlation between anxiety and learning in educational settings has demonstrated that high anxiety is associated
with a lower level of academic achievement at both the school and university level (Sarason, 1960; Paul and Eriksen, 1964; Spielberger, 1966; Whitmairer, 1974). The problem for highly test anxious persons seems to be that they exaggerate and personalize inordinately the threat of evaluation of a given situation (Mandler and Sarason, 1952; Sarason, 1956, 1957; Sarason and Minard, 1962; Watson and Friend, 1969; Giddings, 1971). Boutin and Tosi (1982) in a study of test anxiety with nurses noted that highly test anxious people in situation where their performance is being evaluated spend much of their time (1) worrying about their performance and about how well others are doing (2) ruminating over alternatives, (3) being preoccupied with such things as feelings of inadequacy, (4) anticipating punishment, loss of status or esteem, and (5) developing heightened somatic and autonomic reactions. Their findings corroborate Atkinsons's (1964) thesis that individuals high in trait anxiety experience a "fear of failure" motivation, and also corroborate findings by Blum (1972) regarding an inverse relationship between self esteem and anxiety.

While a supervised, observed counseling session is different from a written exam situation, there are enough similarities of evaluation for the counseling learner to elicit similar learner anxiety. As aforementioned, Boutin and Tosi (1982) and Corley and Tosi (1980), found that anxiety decreased and learning increased in learners with
the application of the RSDH method. Therefore, the RSDH model with its cognitive, affective, physiological approach was selected as the experimental treatment of choice for anxiety in pre-practicum students.

PURPOSE

The purpose of the study was to examine the feasibility of an integrated cognitive-behavioral-imagery approach to treatment of anxiety in counselor trainees in a pre-practicum class. The major research question is whether the application of Rational Stage Directed Hypnotherapy (RSDH), hypnosis only (H), or cognitive restructuring (CR) is the most effective treatment for anxiety as measured by the State-Trait Anxiety Inventory (Speilberger, 1970). Two subquestions are to examine how a reduction of irrational beliefs will correlate with levels of anxiety and how both changes in anxiety and irrational beliefs correlate with levels of counseling performance.
HYPOTHESES

The Hypotheses stated are:

HO: Anxiety as measured by the State-Trait Anxiety Inventory, irrational beliefs as measured by the Common Beliefs Survey and counseling performance as measured by the adapted rating scales by Tosi, Howard and Fuller, for groups of subjects defined in terms of treatment levels RSDH, H, CR and C will not differ significantly across the pre, post I, and post II measurements.

HI: Anxiety as measured by the State-Trait Anxiety Inventory, irrational beliefs as measured by the Common Beliefs Survey and counseling performance as measured by the adapted rating scales by Tosi, Howard and Fuller for groups of subjects defined in terms of treatment levels RSDH, H, CR and Control will differ significantly across the pre, post I, and post II measurements, with the RSDH group being statistically superior as compared to the H, CR, and Control groups across the pre, post I and post II measurements. Furthermore, the effects of CR and H will be superior to the control condition.
DEFINITION OF TERMS

The following definitions are presented for a more thorough understanding of terms used throughout the study:

**Anxiety:**

Anxiety is operationalized as that which is measured by the **State-Trait Anxiety Inventory**. Both state and trait anxiety will be considered and reduction on each scale will be representative of reduced anxiety in the respective categories (state and trait anxiety). **State anxiety** is seen as a transitory emotional state or condition that fluctuates over time, varies in intensity and is characterized by consciously perceived feelings of tension and heightened autonomic nervous activity. **Trait anxiety** refers to relatively stable individual differences between people in the tendency to respond to situations perceived as threatening with elevations in state anxiety (Spielberger, 1970).

**Cognitive Rehearsal and Imagery:**

The ability to imagine, mentally picture and vicariously rehearse and experience the thinking, acting and emotional qualities appropriate to a given situation.
Susceptibility to Hypnosis:

Susceptibility to Hypnosis is operationally defined as the score each subject obtains on the Harvard Group Scale of Hypnotic susceptibility. A score greater than "5" implies high susceptibility. Susceptibility refers to the responsiveness with which a subject responds to suggestions offered in a state labeled as hypnosis.

Rational:

Rationality is a non-static concept based upon logically correct thinking relative to a given set of facts (Tosi and Marzella, 1975). Maultsby (1971) list five criteria to determine whether or not thinking is rational. Thinking is rational when:

1) It is based on objective and subjective reality.
2) It helps preserve life.
3) It helps one achieve immediate and long term goals.
4) It minimizes personal stress.
5) It minimizes environmental stress.

Locus of Control:

As used in this study, when referred to as one of the dependent variables, represents the following three scores on the Common Beliefs
Survey III: (1) importance of past, (2) control of emotions, and (3) importance of approval.

A detailed explanation of the beliefs included in the three scores is given in Chapter 2, under measurement of irrational beliefs.

Evaluation:

As used in this study, when referred to as one of the dependent variables, represents the following three scores on the Common Beliefs Survey III: (1) importance of past, (2) control of emotions, and (3) blame proneness.

A detailed explanation of the beliefs included in the three scores is given in Chapter 2, under measurement of irrational beliefs.

Hypnoidal:

The stage of hypnosis used in this study and defined by Davis and Husband Susceptibility scoring System as evidenced the following symptoms: (1) relaxation, (2) fluttering of lids, (3) closing of eyes, and (4) complete physical relaxation. (See Chapter 3, Figure 6.)
RATIONAL STAGE DIRECTED HYPNOTHERAPY

Rational Stage Directed Hypnotherapy (RSDH) may be considered a cognitive behavior therapy that is heavily experiential. Developed by Tosi (1973) and Tosi and Marzella (1975), Tosi (1980) RSDH includes four major components: (1) the hypnotic state; (2) the identification, vivid imagining, and experiencing of self defeating as well as self-enhancing thoughts, emotions, physiological responses, and behaviors, (3) the cognitive restructuring of irrational attitudes, i.e., disputing, challenging, confronting cognitive distortions and irrational ideas and ultimately replacing them with more rational ones and (4) the directing of these processes through six developmental stages: awareness, exploration, commitment, implementation, internalization, and behavioral stabilization.

Stages of Experiencing

The six stages of therapeutic experience as outlined by Tosi (1980) and revised by Tosi and Baisden (1982):

Awareness:

In this first stage clients are introduced to healthier conditions which oppose self-defeating thoughts, feelings, physiological responses and behavior. Self observation and monitoring are given special emphasis, leading the person to discriminate
between adaptive and maladaptive behavior patterns. The focus is upon cognitive functioning.

Awareness may be passive-reflective or active-subjective. Passive-reflective awareness utilizes the human ability to be conscious of self and to treat the self as object. Essentially, one becomes an observer of one's thoughts, feelings, body responses and behavior. This form of awareness is somewhat dissociative in that one view oneself as a camera might, from a distance, but the attention here is selectively focused on relevant themes as described within the A-B-C-D-E framework.

Active awareness, on the other hand, implies a more subjective participation in thought, feelings, and action—a greater involvement with self and environment in the immediate moment. Where passive-reflective awareness is dissociative, active-subjective awareness is associative and integrative.

Reflective awareness gives perspective to subjective experience.

Exploration:

In the second stage clients are encouraged to experiment with ideas derived from therapy (in this case the counselor pre-practicum). Both in the imagination, via hypnosis/imagery and in "safe" real life situations, cognitive restructuring skills can be applied and consequences experienced and evaluated. Self exploration reinforces the development and expansion of self awareness, but in this stage awareness is directed to more realistic and concrete matters.

Cognitively, exploration involves the directing of attention to psychological content occurring in each quadrant of the awareness and time continua. The
therapist can guide the client's focus of attention to specific areas of concern, or can suggest free movement within the experiential life space until some A-B-C-D or E event becomes figural and demands its own attention.

Commitment:

After giving full consideration to new information and skills learned in the first two stages, the client reaches a point of commitment to implement constructive action. This stage is often accompanied by mixed emotions and high anxiety. Commitment implies choice, decision and risk; the decision to change is weighed against the costs and rewards of old but familiar behavior.

The stage of commitment serves as the threshold for a heightened motivation that tends to be realized in the following stage.

Implementation:

Implementation, the fourth stage, implies deliberate and constructive use of cognitive/behavioral skills that are being developed. Commitments need to be translated into situationally appropriate action if they are to be reinforced, maintained, and generalized to other situations.
Internalization:

The fifth stage, internalization, is characterized by an integration of more constructive thoughts, feelings, bodily responses and behavior into the self-system to the point where they operate more naturally to the person. While integrated behavioral patterns appear to be internalized under certain stimulus conditions such as therapy (or classrooms) some form of mediational bridging is required if outcomes of significant value are to be maintained.

Behavioral Stabilization:

The final stage of experience, behavioral stabilization, is evidenced when behavioral changes realized through the preceding stages become more frequent and permanent.

Facilitative Conditions:

These five conditions were adapted by Howard and Fuller (1978) based on work by Egan (1975), Carkhuff (1969) and Strong and Schmidt (1970):

GENUINENESS:

Genuineness involves congruence between the counselor's words, expressions, tone, actions and feelings. This is done in a spontaneous, non-defensive, consistent and open manner.
CONCRETENESS:

Concreteness is the ability of the counselor to identify specific behaviors, feelings and experiences in the counseling relationship and facilitate the same in the client. This can be done by modeling, by not letting the client ramble and by asking the client for more specific information.

EMPATHY:

Empathy involves the ability to perceive and communicate accurately the feelings of the client. An ability to see the world from the frame of reference of the client. Empathy enhances self-exploration by communicating to the client his behavior on a level unaware to him. It involves communicating implicit and explicit meaning and often summarizing the client's fragmented messages and feelings.

SELF DISCLOSURE:

The counselor is willing to share his own experiences with the client if sharing it will actually help the client understand himself better. He is extremely careful, however, not to lay another burden on the client.

TRUSTWORTHINESS:

If the counselor is to help the client in a meaningful way, the client must develop a trust for the counselor. In order to develop trustworthiness the counselor must convey a feeling to the client that he will care and possess the skill to help the client. This involves the client feeling that the counselor will not directly hurt him and that the counselor will try to help the client in situations where the client might hurt himself.
LIMITATIONS OF THE STUDY

The study is limited to a sample of thirty-two students, six males and twenty-six females who enrolled in a master's level introductory counseling course. The course, offered in the evening, is attended by many parttime students who are fully employed. The educational level of the students consisted of ten doctoral level, twenty at the master's level, and two last quarter seniors. Regardless of the educational level, none self-reported more than minimal counseling experience, although several had experienced relaxation training.

Time limitations are the period for treatment (8 weeks), the length of each session (1 hour) and the length of time between post test I and the follow up, post test II (3 weeks).

A statistical limitation lies in the number of people randomly assigned to each cell (8) and the total N of thirty-two (32).

A treatment limitation was the random assignment of only one (1) therapist to each treatment level.
A measurement limitation was the interrater reliability among the five tape raters (.40 to .90) and the intrarater reliability (.59 to .89).

A final limitation was the implementation of only two stages of experiencing, awareness and exploration, because of the constraints imposed by time and by the necessity to present and implement counseling skills within the treatment hour.
CHAPTER II

The purpose of this chapter is to present a review of the literature which substantiates the inclusion of the various components of the treatment, and the utilization of those instruments of measurement.

COGNITIVE THERAPY

The concept that man's behavior and emotions are affected by his cognitions has been in existence since early Greek and Roman times. Epictetus (Watson, 1978) remarked, "Men are disturbed not by things but by the views they take of them. Descartes, the father of existentialism, is often quoted for his implication of cognition as the sine qua non of existence, "I think, therefore I am." Many of modern psychology's authors allude to the role of cognition in human functioning. The fact that Freud's (1900) development of a "talking therapy" implied the role of thought in the curative process. Janet (1907) believed that fixed ideas were causal factors in mental
disturbance and Adler (1933) stated, "In a word I am convinced that man's behavior springs from his ideas." In his original work on self concept Raimy (1943) examined the relationship between negative and positive self statements and pathology, with higher functioning individuals tending towards positive self statements. He believed that maladjustments could be eliminated if an individual could change his/her ideas regarding psychological problems in the direction of greater accuracy in reality. Kelly (1955) developed "Fixed Role Therapy" which incorporated cognitive, affective, and behavioral aspects of human functioning.

Ellis (1957, 1962, 1971, 1973, 1977), an active directive cognitive therapist developed Rational Emotive Therapy (RET) which views emotional and behavioral disturbances as resulting from a person holding to illogical or irrational beliefs, ideas or attitudes about self or situations both real and imagined. It restructures implied irrational beliefs which underlie emotional disturbance and self defeating behaviors. The RET procedure is represented by the following model, referred to as the A–B–C model:

A - events, situations
B - cognitions, beliefs
C - emotions, affective responses
In this model, "B" (cognitions), and not "A" (events) are responsible for "C" (emotions). Ellis (1961) identified what he believed to be commonly held irrational beliefs. The first six of which are supposed to figure prominently in the development of anxiety:

1) I must be loved or approved of by everyone, or if not by everyone, at least by those I deem significant.

2) I am unable to control my own happiness.

3) I am controlled by my past history and by my important past experience.

4) I am not worthwhile unless I am completely competent, adequate and achieving.

5) I face disaster if I cannot find the one perfect solution to my problems.

6) I must always be prepared for the worst by constantly agonizing over it.

7) I believe that wicked people should be blamed and punished.

8) I am better off if I avoid difficulties and responsibilities rather than face them.

9) I face disaster if my life does not work out just as I would like to have it.

10) I must become very disturbed over other people's problems.
Part of the success of RET has been the willingness of the clinicians and researchers to incorporate other techniques.


Beck (1952, 1961, 1963, 1967, 1970, 1974) utilized a cognitively therapeutic approach to depression which he later applied to anxiety. According to Beck, the depressive has a negative view of self, the world, and the future. The depressive maintains this view through maladaptive illogical processes of magnification, minimization, overinclusion, incorrect labeling, and selective abstraction, all processes which he and others later applied to
anxiety. Beck (1970) proposed that the anxious individual operates with a distorting conceptualization or schema that acts as a kind of Procrustean mold. This schema interprets many stimuli as "dangerous," and Beck conceptualizes the feedback among systems in this manner:

![Stimulus Situation Diagram]

Figure 1
Anxiety Feedback Systems

He suggested that if the ability to experience anxiety developed in phase with an evolving intelligence that functions with the use of
knowledge stored in symbolic form for problem-solving, it seemed reasonable to expect that the same intelligence could be used to search out the roots of anxiety and devise methods for either preventing its growth or neutralizing its incapacitating effects.

Perhaps the most significant recognition accorded to cognition's role in the maintenance of anxiety is offered by Spielberger (1966) as he delineated the process diagrammatically:

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**Figure 2**

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and explains the response loops:
A trait-state theory of anxiety in which two anxiety constructs, A-Trait and A-State, are posited and conceptually distinguished from the stimulus conditions which evoke A-State reactions and the defenses against A-States. The cognitive appraisal of a stimulus as dangerous or threatening evokes an A-State reaction, which may then initiate a behavior sequence designed to avoid the danger situation. An A-State reaction may also evoke defensive maneuvers which reduce A-State or alter the cognitive appraisal of the situation. Individual differences in A-Trait, along with past experience, determine the particular stimuli that are cognitively appraised as threatening. Reprinted with permission from Spielberger (1966a, p. 17).
LOCUS OF CONTROL AND ANXIETY

When locus of control is referred to in the literature it generally is represented as a personality trait measure that reflects a person's style of dealing with his environment along a dimension of control by self or others. It is as explained by Hoehn-Saric (1981):

Persons with internal locus of control see themselves as being in control of themselves and their environment and responsible for their actions. Those with external locus of control perceive themselves as being at the mercy of external forces.

Julian Rotter (1954) is perhaps the most renowned proponent of viewing persons as social beings in interaction with their environment who function along a dimension of locus of control with internal control at one end and total external control at the other. He linked locus of control to expectancy regarding the outcome of behavior in a given situation. Rotter's later work (1971) linked expectancies to what he called perceived freedom of movement and interpersonal trust.

Support for the link between locus of control and anxiety was found by Butterfield (1964), who correlated the Locus of Control Scale with the Alpert-Haber Achievement Anxiety Test and found a correlation
of .81 for debilitating and facilitating anxiety combined. He concluded that the more external the appraised locus of control, the more anxiety reported. Similar, but less pronounced results were reported by Watson (1967).

In a recent study by Masek and Hoehn-Saric (1980) it was found that externally controlled patients showed rating patterns similar to introverted patients (not to be confused with internal locus of control patients). In other words, externally controlled patients exhibited greater psychopathology in their ratings on neuroticism and trait anxiety, rated higher on negative affects such as anxiety and differed by being less content and more depressed than internally oriented patients, and expressed a considerable amount of demoralization. The authors concluded that it is plausible that patients who have an external orientation fail to deal with conflict situations in a constructive manner and consequently become increasingly anxious and depressed.

On the other hand, they concluded that extroverted and internally controlled patients exhibited less psychopathology, were more positive in their outlooks and more capable of using offered help in a constructive way.
A RATIONALE FOR
HYPNOBEHAVIORAL MODELS

Fromm (1972) predicted that the integration of diverse treatment models such as behavior modification, desensitization and self actualization with hypnotherapy.

Kroger and Fezler (1976) stated that any stimulus can induce relaxation by being paired with relaxation, a classical conditioning paradigm and the basis for learning theory and behavior modification. They noted that most of the behavior modification literature did not make use of hypnosis per se to potentiate conditioning, yet a conditioned reflex is more readily established and less likely to be extinguished when hypnosis is employed.

They propose that Jacobson's (1938) progressive relaxation is often inferior because it does not utilize sensory recall to induce relaxation.
Tosi (1982) states that hypnosis maximizes the person's ability to concentrate and direct attention to behavioral processes above or below the awareness threshold, and minimizes distractions that inhibit and interfere with learning. The capability of hypnosis to effect processes above or below the awareness threshold emerges from the explanation of neurological functions.

Neurologically, cognitive restructuring initially occurs in the cerebral cortex, the structure that houses memory, and logical critical and evaluative thought. However, the subcortical areas (limbic system) of the brain may not be influenced by such activity. Ultimately higher and lower cortical functions need to operate together as does a horse and rider. The logical and critical operations of the cerebra cortex via the hypnotic modality are focused and directed to the psychological content of the more primitive areas of the brain to achieve a more comprehensive restructuring of thoughts, feelings, bodily states, and behavior (Tosi and Baisden, 1982).

Cognitive therapies have tended to ignore the unconscious processes (Arieti and Bemporad, 1978; Tosi, 1974; 1980; 1982).

Although several have utilized relaxation and Imagery to desensitize (Wolpe, 1969; Stampfl, 1970; Stampfl and Levis, 1967) or sensitize (Cautela, 1967) subjects the treatment of a behavioral dysfunction appears to be incomplete unless one can impact upon the inherent unconscious belief process of the subjects.

\[ A = \text{SITUATIONAL CONDITIONS} (a_1, a_2, a_3, a_4) \]
\[ B = \text{COGNITIVE FUNCTIONS} (b_1, b_2, b_3, b_4) \]
\[ C = \text{AFFECTIVE RESPONSES} (c_1, c_2, c_3, c_4) \]
\[ D = \text{PHYSIOLOGICAL RESPONSES} (d_1, d_2, d_3, d_4) \]
\[ E = \text{BEHAVIORAL RESPONSES} (e_1, e_2, e_3, e_4) \]

**FIGURE 3**

PERSON AND ENVIRONMENT INTERACTION

WITHIN A–B–C–D–E PARADIGM
Tosi's elaboration views the self, or person, depicted in the broken circle, as operating as an open system with the environment, labeled A. The Self is comprised of B) cognition, C) affect, D) physiology and E) behaviors relative to the social environment or other objects (real or imagined). The self or person is also in interaction with internal conditions such as bodily reactions, sensations or images, as well as to conditions external to the self. In addition, the A's, B's, C's, D's and E's operate as a network of relationships rather than as a linear function.

Note as seen in Figure 2 (Tosi, 1982) the A-B-C-D-E components are comprised of subsets which are experienced in a unitary but complex manner. Tosi conceptualizes the operations of B as somewhat sequential, whereas the subsets of the C, D, and E components are seen as response possibilities, with several responses being selected from a variety of possible responses, and with habitual patterns emerging.

Tosi places the A-B-C-D-E within an experiential context that places experiencing in developmental stages and along continua of awareness and time.
Figure 4

AWARENESS AND TIME CONTINUA IN THE EXPERIENTIAL LIFE SPACE
A) Event
   a₁ John calls Bill a dirty name

B) Cognitive
   Responses
   b₁ "I can't stand to be called dirty names." (Evaluation of situation)
   b₂ "I can't do anything about it" (Evaluation of response to situation)
   b₃ "I am a weakling" (Evaluation of self)
   b₄ "I must either fight or run away—I will run." (Cognitive-symbolic coping strategies)

c) Affective
   Responses
   c₁ Anxiety
   c₂ Hostility
   c₃ Self-doubt

D) Physiological
   Responses
   d₁ Peripheral vaso-constriction
   d₂ Gastric secretion
   d₃ Increased blood pressure

E) Behavioral
   Responses
   e₁ Avoidance of John
   e₂ Unassertiveness
   e₃ Cowardly behavior

Figure 5

THE ELABORATED A-B-C-D-E MODEL
Originally postulated by Quaranta (1971) the stages were modified and operationalized by Tosi (1974; 1980; 1982) and Tosi and Marzella (1975) for the RSDH model. Described more completely in Chapter I, the stages include awareness, exploration, commitment, implementation, internalization and behavioral stabilization. Within those stages the experiential themes associated with points A, B, C, D and E, occur along the continua of time and awareness (Tosi and Baisden, 1982).

The relaxation and imagery process operates as a catalyst to integrate the ABCDE model and to provide for optimum cognitive focusing. The role of relaxation as an effective adjunct to anxiety has been established (Fry, 1973; Gershman and Clouser, 1974; Nicoletti, 1972; Sherman, Mulac and McCann, 1974; Sherman and Plummer, 1973; Spielberger, Gorsuch and Lushene, 1970; Boutin and Tosi, 1982).
RATIONAL STAGE DIRECTED HYPNOTHERAPY VIS A VIS ANXIETY AS A MULTIDIMENSIONAL PHENOMENON

At this point the reader may wonder why the treatment model (RSDH) already discussed in toto and *vis a vis* counselor trainees and learners in general, is now being considered *vis a vis* anxiety as a multidimensional phenomenon.

The answer is that it is not supportable to view anxiety only as a unitary emotion emerging during a specific task. The broader perspective must also be presented along with a view as to the RSDH model as it interacts with and impacts upon the phenomenon both specifically and generally. Mandler in Spielberger's *Anxiety and Behavior* (1966) states:

...any attempt at a unitary concept of anxiety or a single theoretical attempt is doomed to failure.

and later:

I believe that stress on the state-trait distinction is both useful and necessary, but it must be made in the context of what are the situations or cognitions that lead to anxiety.
Therefore the following paragraphs will address a sampling of various theoretical stances regarding anxiety as an acknowledgement of the richness and complexity of human functioning, and also as an acknowledgement that while the RSDH model is being applied in a task specific manner, it is impacting more broadly.

The theory of general arousal propounded by Duffy (1941), Malmo (1959), Schachter and Wheeler (1962), Schachter and Singer (1962), Levi (1963), Korchin (1964), and Schachter (1964) holds that physiological arousal is emotionally nonspecific and that there are no particular physiological patterns correlative to particular emotional states. Rather as Levitt (1967) stated in his discussion of anxiety:

The physiological reaction is simply a general arousal or activation. The subjective experience of a specific emotion exists solely on the cognitive or psychological level.

Existential aspects of anxiety, that is, the ontology of anxiety of change, are addressed by RSDH through its stages of experiencing, and attention to timeliness of presentation.

Freudian concepts of reality anxiety (a reaction to threat from the external world), moral anxiety (a reaction to threat from the superego), and neurotic anxiety (a reaction to threat from the id
impulses, interface well with the RSDH model and its perspective of the continua of time and awareness as coordinates within the simultaneously occurring conscious and unconscious process from the past to projected future. In other words, it impacts the superego's maladaptive, constrictive "shoulds" regarding social, interpersonal expectations, and minimizes the threat of the external world by increasing the strength of the ego through cognitive restructuring that relabels and reinterprets past and present experiences. The hypnosis enables the person to develop interpersonal distance to minimize external threat, while heightening awareness, allowing for highly focused attention, and creating a semblance of functioning simultaneously within time dimensions for both conscious and unconscious processes.

However, the thrust of this research touches upon self-defeating thoughts, behaviors and feelings more closely related to moral anxiety and reality anxiety than neurotic anxiety, although it is understood that all three may interact simultaneously.

Finally, as RSDH interfaces with the aforementioned intrapersonal aspects of anxiety, its use in this study is to also alleviate anxiety in a Sullivanian sense (Sullivan, 1953). In other words, to improve upon an individual's opinion of self adequacy in an interpersonal
relationship, one in which one of the persons is being evaluated as to his general level of interpersonal functioning in a learning situation—the pre practicum lab.

THE ROLE OF SUPERVISION MODELS AND TRAINING OF COUNSELOR TRAINEES

The few early references to treatment of counselor trainee intrapersonal functioning indicated a therapy oriented approach with generalized objectives for outcome. For example, Truax and Carkhuff's 1967 training program included as one of three central elements a quasi-group therapy experience where the trainee could explore his/her own existence, allowing an individual therapeutic self to emerge (Garfield and Bergin, 1978). The belief that a more well adjusted therapist would effect more positive therapeutic outcome in the client was supported by substantial research (Bandura, Lipsher and Miller, 1960; Culter, 1958; Meltzoff and Kornreich, 1970; Rigler, 1957; Wogan, 1970; McNair, Lorr, Young, Roth and Boyd (1964). Not all studies, however, found therapy for counselor trainees to be facilitative (Holt and Luborsky, 1958; McNair, Lorr and Callahan, 1963; Mihalik, 1970; Garfield and Bergin, 1971). Parlow, Waskow, and Wolfe (1978)
summarized in a review of the literature that therapy for the counselor trainee may be helpful, but if received concurrently with learning to practice therapy with patients, it may interfere with optimal counselor performance.

Perhaps because of the mixed results emanating from studies on the effect of therapy for counselor trainees, supervision models thereafter were generally technique and skill oriented. Kagan and Krathwohl (1967) and Boyd (1973) utilized the Counselor Verbal Response Scale to measure success for his recall interrogation model. Ivey, Normington, Miller, Morrill and Haase (1968) included measures of eye contact, accurate reflection, total counselor talk time, and client ratings of outcome. The Matarazzo Check List of Therapist Behavior derived from a study by Matarazzo, Wiens and Saslow (1966) that found length of utterance and response delay to be related to interviewer skills was used in supervision research (Elsenrath, Coker and Martinson, 1972; Moreland, Ivey and Phillips, 1973). Even when the Truax human relations model was used in comparison with other models such as microtraining, only counselor skill was addressed (Toukmanian and Rennie, 1975). One notable exception was Fry (1973) who hypothesized that trainees as well as clients have conditioned anxiety responses to closeness and included a desensitization to closeness procedure as part of training. His findings indicated that
both the control and experimental benefited from training, but the experimental group benefited more in regard to communicating warmth, empathy, respect, concreteness, and genuineness.

As mentioned previously in Chapter 1, the anxiety of counselor trainees has been apparent to supervisors and authors throughout much of counselor supervision history (Bandura, 1956; Brams, 1961; Tyler, 1964; Hogan, 1969; Fry, 1973; Bowman and Roberts, 1979). However, there was a dramatic increase in the research and treatment of counselor anxiety as a specific focus of interest for supervision in the 1970's, which will be apparent in the content of the review of research on counselor anxiety in the text to follow.
SUPERVISION MODELS AND THE TREATMENT
OF ANXIETY IN COUNSELOR TRAINEES

A variety of treatment modalities utilizing the diverse models of supervision were incorporated as treatment levels.

Several approaches to the treatment of anxiety that were researched are: systematic desensitization (Monke, 1971; Carter and Pappas, 1975; Fry, 1973; Miller, 1971); behavioral rehearsal (Cook and Kunce, 1978; Henning, 1978); differential supervisory style (McIntire, 1973; Haymes, 1978; Bowman and Roberts, 1980) length of training (Preikshat, 1967; Pennscott and Brown, 1972) video playback and simulated client experience (Resnikoff, 1970) cognitive coping (Henning, 1978) microcounseling (Briggs, 1975) model reinforcement counseling and rational behavior therapy (Murphy, 1978) self and in vivo desensitization (Miller, 1970) assertive training (Jansen and Litwak, 1979) and alpha wave training (Fontaine, 1977).

However, the effect of lessened anxiety on enhanced skill performance varied from no significant change (Preikshat, 1967; Murphy, 1978; Haymes, 1978) to more effective performance (Sievers, 1969; McIntire, 1973) to mixed effect according to emotional tone of client (Roberts and Bowman, 1978).
Thus the results of the aforementioned treatment effects have not been consistent nor always significant but the tendency was toward lessened anxiety for all treatment groups.

DIFFERENTIAL ASPECTS OF COUNSELOR ANXIETY

In addition, attempts were made to empirically isolate causal factors in counselor anxiety.

Bowman, Roberts and Giesen (1978) used subjective and physiological measures of anxiety to compare anxiety levels of counselor trainees in a client interview and in a neutral situation of reading an article. Results indicated that counselor trainees were significantly more anxious on both subjective and physiological measures during the interview. Bowman and Roberts (1978) continued the exploration of counselor anxiety with a study that measured physiological and subjective anxiety to determine if counselors experienced greater anxiety during a counseling interview than during a conversation. Conclusions were that counselors experience comparable anxiety during counseling and conversing, that expectations accounts for most of the counselors anxiety, and that baseline
physiological and self report data may prove useful in identifying counselors who would experience anxiety during an interview. An interesting study by Bowman and Roberts (1979) measured the effects of tape recording and supervisory evaluation on counselor trainee anxiety levels. Results indicated that the tape recording and supervisory evaluation do not increase the anxiety levels of participants over the levels experienced while counseling without recording and for evaluation.

Counselor anxiety, therefore, has been empirically isolated as a factor in counselor training and its differential aspects explored.
Facilitative conditions as they are reviewed in this chapter will refer to those characteristics of a counselor that facilitate growth in a client and are teachable as specific skills or general attitude. It is not the purpose of this author to review every study of a facilitative condition, but to review broadly the many variables thought to be facilitative, and to specifically review those variables or facilitative conditions used in this study.

Truax and Mitchell (1971) appropriately comment that the facilitative conditions to positive human growth have been long recognized by philosophers, novelists, theoreticians in psychotherapy and others who study the broad areas of human relationships. However, a formalized systematic view of such variables, they propose, was offered by Shoben (1953) from a learning theory orientation, by Bordin (1955) from a counseling theorist perspective, but was finally brought to convergence in the mainstream of professional and scholarly thought by Carl Rogers in 1957.

From Rogers' concept of congruence emerged "genuineness," from unconditional positive regard, "nonpossessive warmth." His concept
accurate empathy, however, continued to be referred to as "accurate empathy" or just "empathy."

Research into the effect of therapist accurate empathy, nonpossessive warmth and genuineness grew out of studies by Whitehorn and Betz at Johns Hopkins Hospital (Betz, 1963; Whitehorn, 1964; Whitehorn and Betz, 1954) and the theoretical work of Carl Rogers (1967). Numerous studies followed a four year study of psychotherapy with schizophrenics conducted at the University of Wisconsin under the leadership of Rogers, Truax, Gendlin and Kiesler (Rogers, 1962; Truax, 1963; Truax and Carkhuff, 1963; Truax and Carkhuff, 1967; and Rogers, Gendlin, Kiesler and Truax 1967). Results showed that patients whose therapists offered high levels of nonpossessive warmth, genuineness, and accurate empathic understanding showed significant positive personality and behavior change on a wide variety of indices and patients whose therapists offered relatively low levels of these interpersonal skills exhibited deterioration in personality and behavioral functioning.

There were surprising results in several studies that found significance regarding positive outcome and core conditions: the Truax, Carkhuff and Kodman (1965) study of 40 chronic, hospitalized patients showed the data on therapist genuineness was directly opposite to the prediction and to the data on warmth and empathy,
which were similar; whereas in the Johns Hopkins study (Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash and Stone, 1966) data indicated identical, predicted, findings on empathy and genuineness, but a reversed tendency for warmth which led Truax and Mitchell (1971) to conclude that when one of the conditions is negatively related to the other two, predictions on outcome should be based on the two that are most highly rated.

An earnest attempt to test across populations included elementary, high school students, hospitalized outpatient subjects. Patient type comprised rehab, delinquent, and schizophrenic categories. In a comprehensive review of overall combined outcome measures significantly favoring the hypothesis, of warmth empathy and genuineness as important for positive growth, eleven of twelve hypotheses were supported.

The relationship between positive significant change and high levels of core conditions has also been validated cross culturally (Tausch, Eppel, Fittkau, and Minsel, 1969). Crossing therapeutic orientation boundaries, Horowitz (1969), psychoanalytic in training, offered an impressionistic validation of warmth and empathy. In addition, he suggested that high levels of therapist empathy included the capacity to tolerate some patient deterioration and the resultant
therapist anxiety, leaving the reviewers, Truax and Mitchell (1971) to comment that an important study would relate therapist levels of empathy to independent measures of therapist anxiety.

A final important aspect to the research on warmth, empathy and genuineness is the use of long term follow up (9 years) with the populations treated with high levels of core conditions exhibiting the highest levels of positive change and maintaining the highest level of functioning for all groups. The patients of therapists low in core conditions demonstrated less improvement and deteriorated more post study.

Research on appropriate therapist qualities has not only focused on warmth, empathy, and genuineness, but has also focused on other intuitively appropriate qualities. For example, Carkhuff included in his book, Helping and Human Relations, Volumes I and II, the following eight scales: (1) empathy, (2) respect, (3) genuineness, (4) self disclosure, (5) concreteness, (6) confrontation, (7) immediacy, and (8) self exploration. Egan (1975) in his book, The Skilled Helper, instructs regarding physical and psychological attending, social influence, and elicitation of client self exploration. Therapist style is seen as important as what is being said. Style includes a broad range of characteristics such as rate of speech (Matarazzo, Wiens, Matarazzo and Saslow, 1968) or attitudes towards managing the
session such as "laissez-faire," or "impersonal" (Lieberman, Yalom, and Miles, 1973).

Obviously, the counselor-client interaction is a richly complex one, which undoubtedly contributes to both the anxiety and excitement of training in the profession. The variables chosen to be used in this study as measure of counselor interpersonal skills are both quantitative and qualitative, but by no means inclusive. They are, however, all excerpted from variables already researched: empathy, concreteness, self-disclosure, genuineness and trustworthiness. The last variable, trustworthiness, was included on the basis of work by Strong and Schmidt, 1970; and Friedlander, 1970) but also on the basis of my own observations as a variable of importance within my counseling experience.

RESEARCH ON RATIONAL STAGE DIRECTED HYPNOTHERAPY
AND RELATED, COMBINATIVE APPROACHES

In a meta-analysis of psychotherapeutic effectiveness and differential orientations by Smith and Glass (1980), cognitive, cognitive-behavioral therapies hypnotherapy and systematic desensitization appeared most effective. Undifferentiated counseling
was reportedly least effective while psychodynamic, dynamic, dynamic-eclectic, Adlerian, client-centered, gestalt, rational-emotive therapies, transactional analysis, implosive therapy, behavior modification, eclectic-behavioral therapy and vocational-personal development counseling were reportedly close to the average effectiveness of all therapies. Relaxation therapy was included under placebo therapy along with mere attention from a therapist, both of which showed a positive effective large as one half standard deviation unit. Measures of fear or anxiety were associated with the largest effects.

Considering that Rational Stage Directed Imagery and Rational Stage Directed Hypnotherapy systematically combine cognitive, behavioral and hypnotherapeutic modalities within one approach it is not surprising that studies with both clinical and conclinical populations have shown significant treatment effects or at least improvement in psychological well being and in single case studies, at least, a higher level of social functioning. Single case studies included the following:

Howard and Tosi (1979) -- Male, age 19, intelligence dull-normal, involved in a work rehabilitation program referred for extreme levels of anxiety when in contact with women. Result
after six weeks of treatment and increased contact with females as high as 24 hours per week, with a decrease in subjective units of disturbance score from 75 to 10, and a Tennessee self concept score revealing improved positive self concept.

Reardon, Tosi and Gwynne (1977) — Male, age 45, severe psychiatric problems, on parole. After 20 consecutive weekly sessions, Minnesota Multiphasic Inventory (MMPI) results evidenced a controlled profile, the Tennessee Self Concept Scale (TSCS) showed increased self concept. Behaviorally he exhibited more social involvement and better work performance.

Tosi and Reardon (1976) — Female, age 25, experiencing acute periodic states of depression and guilt, migraine headaches. After 8 weeks of treatment self recorded guilt dramatically decreased, affect elevated, migraine headaches disappeared.
Tosi, Howard, and Gwynne (1982)— Female, age 21, in a work rehabilitation program referred because of incapacitating levels of anxiety, after 10 weeks of therapy significant improvement on the (TSCS) and the (MMPI) with a dramatic increase in work output and self report of reduced anxiety.

Howard, Reardon and Tosi (1978) — Female, age 30, of normal intelligence, could not maintain employment and suffered from severe and chronic migraine headaches. After 24 weeks of treatment migraines reduced from 7.5 per week to 0.2 per week during the last 5 weeks and a return to daily attendance and normal functioning in a classroom setting.

Rudy, Tosi, and Reardon (1977)— Male, age 25, manifesting greatly increasing hypertension and musculoskeletal pain, after 12 weeks of treatment significant decrease in blood pressure and disappearance of musculoskeletal pains.
Experimental group studies showing RSDH to be the most effective form of therapy included the following:

Boutin and Tosi (1981) test anxiety in nursing students; Corley and Tosi (1981) test anxiety in underachieving undergraduates; and Howard (1979) the modification of neuro-muscular performance, facilitation of muscular growth, reduction of anxiety and enhancement of self concept; Fuller (1981) reduction of depression and enhancement of self-concept in a geriatric population. Using a related therapeutic approach Reardon and Tosi (1977) published a study on the effect of Rational Stage Directed Imagery (RSDI) and Rational Stage Directed Therapy (RSDT) on the modification of self-concept and physiological stress with delinquent adolescent females. Rational Stage Directed Therapy differs from RSDH in that cognitive skills are developed within the stage directed framework, but all therapy is conducted during the normal waking state. In Rational Stage Directed Imagery cognitive skills are developed within the stage directed framework and enhanced by imagery and relaxation. The relaxation may comprise a progressive muscle relaxation procedure in combination with simply imagining a scene with the eyes closed and within a non-distracting environment.
Bessai (1976, 1977), developed a self-administered objectively scored instrument to measure specific levels of irrational thinking based on Ellis's theoretical framework of irrationality. The instrument represents the synthesis of nine already existing attitude surveys into one 54-item inventory, the Common Beliefs Survey III (CBS III). The CBS III contains six factors based on Ellis's irrational ideas: Importance of the past, Blame proneness, Self-downing, Importance of approval, Perfectionism, and Loss of Control of emotions. CBS III items are set in a 5-point Likert scale response format ranging from strongly agree to strongly disagree. In order to control for an acquiescent response bias, items are worded so that approximately one-half of the items are stated as rational beliefs (25) and one-half as irrational beliefs (29). The CSB III factor structure was replicated in two recent studies (Bessai, 1978) and Forman, Tosi and Rudy (1982). The following is a detailed description of the factors as explicated by Forman (1978):

Items comprising Factor I, previously labeled Importance of the Past included (a) Past experiences need not affect present behavior, (b) one can overcome the influence of the past, (c) a person's present behavior must be greatly influenced by his/her past.
Factor II labeled Blame Proneness included such items as (a) criminals are basically bad people and should be punished, (b) no one is evil, even though his deeds may be, (c) people are justified in refusing to forgive their enemies.

Factor III labeled Self Downing included such items as (a) if people don't meet their own standards, they are bound to think less of themselves, (b) a person can't help feeling guilty about wrongdoings, (c) people are bound to put themselves down when they fail.

Factor IV labeled Importance of Approval included such items as (a) being approved by others is very important, (b) people do not need to be loved in order to accept themselves, (c) being ignored by friends doesn't have to be upsetting.

Factor V labeled Perfectionism included such items as (a) there is a right way to do everything, (b) it is awful when things are not the way one would very much like them to be, (c) one must be perfectly competent, adequate and achieving to consider oneself worthwhile.

Factor VI labeled Control of Emotions included such items as (a) people can control their emotions, (b) how a person interprets an event determines his/her emotions, (c) emotions are not determined by outside events.
MEASUREMENT OF STATE–TRAIT ANXIETY

Since Spielberger was one of the primary creators of the State Trait anxiety scale, his conceptualization of State and Trait anxiety is appropriately quoted:

State anxiety (A-State) may be conceptualized as a transitory emotional state or condition of the human organism that varies in intensity and fluctuates over time. This condition is characterized by subjective, consciously perceived feelings of tension and apprehension, and activation of the autonomic nervous system. Level of A-State should be high in circumstances that are perceived by an individual to be threatening, irrespective of the objective danger, A-State intensity should be low in nonstressful situations, or in circumstances in which an existing danger is not perceived as threatening.

Trait anxiety (A-Trait) refers to relatively stable individual differences in anxiety proneness, that is, to differences in the disposition to perceive a wide range of stimulus situation as dangerous or threatening, and in the tendency to respond to such threats with A-state reactions. A-Trait may also be regarded as reflecting individual differences in the frequency and the intensity with which A-States have been manifested in the past, and in the probability that such states will be experienced in the future. Persons who are high in A-Trait tend to perceive a larger number of situations as dangerous or threatening than persons who are low in A-Trait, and to respond to threatening situations as dangerous or threatening than persons who are low in A-Trait, and to respond to threatening situations with A-State elevations of greater intensity.
An important qualification to the differentiation between A-State and A-Trait is that level of A-Trait does not absolutely influence the intensity of A-State responses to stressors, but only to those stressors that a person with high A-Trait would perceive as threatening. For example, if high A-Trait individuals are more self-deprecatory and fear failure more than low A-Trait individuals, then it might be expected that they will manifest higher levels of A-State in situations that involve threats to self esteem rather than physical danger (Spielberger, Gorsuch and Lushene, 1970). A study by Basowitz, Persky, Korchin and Grinker (1955) that evaluates anxiety in parachuting trainees supported that perspective.

The format of the State Trait Anxiety Inventory (STAI) provides the experimenter with a reliable, relatively brief report measure of both state (A-State) and trait (A-Trait) anxiety.

The STAI A-Trait scale consists of twenty statements that ask people how they generally feel. Subjects answer each item (for example, "I lack self confidence") by selecting one of the following: "Almost never," "Sometimes," "Often," "Almost always." The authors included items for the STAI A-Trait scale that correlated significantly with other anxiety scales that were widely accepted as measures of A-Trait, for example, the Taylor Manifest Anxiety Scale
and the IPAT Anxiety Scale. Items were also included on the basis of being impervious to situational stress and being stable over time.

The STAI A-State scale consists of twenty statements that ask people to describe how they feel at a particular moment in time; subjects answer an item by selecting one of the following: (1) Not at all, (2) Somewhat, (3) Moderately so, (4) Very much so.

The essential qualities that the STAI A-State scale attempts to measure are feelings of tension, nervousness, worry, and apprehension. Since the aforementioned feelings are correlated with the absence of feelings of calmness, security, contentedness, items such as "I feel calm," and "I feel content," were included to produce a balanced A-State scale. The STAI A-State scale thus is organized to define a continuum of increasing levels of A-State intensity.

For research purposes the STAI A-State scale may be administered with instructions that focus upon a particular time period, for example, just after an experimental task that has just been completed or while a specific stimulus situation was envisioned.

According to the authors (Spielberger, Gorsuch and Luschene, 1970), the STAI A-state scale may be given on each occasion for which an A-State measure is needed to measure changes in the intensity of
transitory anxiety over time.

Finally, for purposes of this study an interesting note is that the authors of the scales found that scores on the STA1 A–State scale increase in response to various kinds of stress and decrease as a result of relaxation training (Spielberger, Gorsuch and Lushene, 1970).

MEASUREMENT OF FACILITATIVE CONDITIONS

The facilitative conditions utilized were from an adapted scale by Tosi, Howard, and Fuller (1977). The authors based their scales on the work by Egan (1975), Carkhuff (1969) and Strong and Schmidt (1970). The differentiation of the various levels of those scales as described in their manuscript can be found in Appendix F.

It was the purpose of this author in using the adapted scales to rate the pre-practicum student on both specific verbalizations of empathy, concreteness and self disclosure and generalized attitudes of genuineness and trustworthiness. The selection of the five rater dimensions was arbitrary, and the general format of five levels for
rating each dimension was patterned after the early work of Carl Rogers and his associates (Rogers, 1959; 1961; Walker, Rablen and Rogers, 1960) and their process scale, which had seven levels, of Truax's (1967) Accurate Empathy Scale and on Carkhuff's (1969) Scales for Assessment of Interpersonal Functioning.

Although each of the five rating scales were rated separately, the scores were collapsed to produce a general facilitation score, since several studies have adequately cast doubt about the discriminate validity of facilitative conditions and similar dimensions (Avery, D'Augelli, and Danish, 1976; Boyd and Pate, 1975; D'Augelli, Deyss, Gurney, Hershenberg, and Sborofsky, 1974; Muehlberg, Grasgow, and Pierce, 1969). In addition, Boyd (1978) in his book Counselor Supervision: Approaches, Preparation and Practices, suggests that supervisors treat such as the aforementioned dimensions as overlapping ones that form a general facilitation factor.
RELAXATION/HYPNOSIS/IMAGERY

For the purpose of this study the author chose to utilize a process in conjunction with the rational stage directed model that included a more focused attention with relaxation technique (a hypnoidal state, rather than the deeper states of hypnosis). The distinction between relaxation and hypnosis of hypnosis and imagery is often blurred. Kroger (1963) described accepted differences of depth of hypnotic state using the Davis and Husband susceptibility scoring system, the rating scale most commonly referred to in the literature (see Figure 6).
<table>
<thead>
<tr>
<th>Depth</th>
<th>Score</th>
<th>Objective Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insusceptible</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hypnoidal</td>
<td>2</td>
<td>Relaxation</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Fluttering of lids</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Closing of eyes</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Complete physical relaxation</td>
</tr>
<tr>
<td>Light trance</td>
<td>6</td>
<td>Catalepsy of eyes</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Limb Catalepsies</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Rigid catalepsy</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Anaesthesia (glove)</td>
</tr>
<tr>
<td>Medium trance</td>
<td>13</td>
<td>Partial amnesia</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Posthypnotic anaesthesia</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>Personality changes</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Simple posthypnotic suggestions</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Kinesthetic delusions; complete amnesia</td>
</tr>
<tr>
<td>Somnambulistic</td>
<td>21</td>
<td>Ability to open eyes without affecting trance</td>
</tr>
<tr>
<td>(deep trance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>Bizarre posthypnotic suggestions</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>Complete somnambulism</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>Positive visual hallucinations, posthypnotic</td>
</tr>
</tbody>
</table>

Figure 6

DAVIS AND HUSBAND SUSCEPTIBILITY

SCORING SYSTEM
The depth of hypnosis used in this study would have to be considered no deeper than the hypnoidal range, with imagining a pleasant scene and incorporating positive self talk.

It is for the purpose as White (1941) stated, that if a subject is comfortably relaxed images and experiences tend to emerge in a vivid, concrete, and absolute manner.

MEASUREMENT OF HYPNOTIC SUSCEPTIBILITY

The Harvard Group Scale of Hypnotic Susceptibility (Shor and Orne, 1962) was utilized to test hypnotic responsiveness. It was patterned after Form A of the Stanford Hypnotic Susceptibility Scale and yields a single score (from 0 to 12) of susceptibility. The score obtained in a group session correlates .74 with an observer's score in a subsequent individual session (Bentler and Hilgard, 1963).

The subjects self report suggested levels of reaction at the termination of a standardized induction procedure comprised of twelve parts or tasks which the subject is asked to perform. The tasks arranged in a hierarchy of difficulty are as follows: (1) head
falling, (2) eye closure, (3) hand lowering, (4) arm immobilization, (5) finger lock, (6) arm rigidity, (7) moving hands together, (8) communication inhibition, (9) fly hallucination, (10) eye catalepsy, (11) posthypnotic suggestion and (12) hypnotic amnesia.

The procedure is administered by playing a standardized tape.
CHAPTER III

METHODOLOGY

This chapter addresses the research methodology of this experiment and is organized in the following manner: (1) experimental design; (2) treatment groups; (3) dependent measures (4) null hypothesis and alternate hypotheses; (5) selection of subjects; selection of the instruments; (7) procedure for rating of tapes; (8) training of raters; (9) reliabilities of tapes; (10) treatments; (11) treatment therapists; (12) statistics.

The experimental design for this study consists of a 4x3, one between groups (RSDH, CR, H, AND C) and one within groups (measurements across time: pre-test; post-test I; and post test II) factorial. The purpose of this study was to determine the relative effectiveness of Rational Stage Directed Hypnotherapy, cognitive restructuring and relaxation with respect to the reported anxiety in interaction with irrational beliefs and acquisition of interpersonal skill.
The research design included one active control (no-treatment) group and three treatment groups: (1) Rational Stage Directed Hypnotherapy (RSDH); (2) Cognitive Restructuring (CR); and (3) Hypnosis (H). Each group met for seven sessions and was comprised of eight subjects.

<table>
<thead>
<tr>
<th></th>
<th>PRE</th>
<th>POST I</th>
<th>POST II</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSDH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**4 x 3 Model**

Figure 7

RESEARCH DESIGN
The dependent measures for this study were administered as pre-tests one week preceding treatment, again as posttest I upon termination of treatment and finally as posttest II, three weeks after termination of treatment. The instruments utilized in this study included: (1) The Common Beliefs Survey III; The State Trait Anxiety Inventory; and 20 minute cassette audiotapes of a counseling session.

The null hypothesis for the study was that group means on the dependent variables of state-trait anxiety, evaluation and locus of control measures on the Common Beliefs Survey III, and the collapsed interpersonal dimension score on the tapes will not differ significantly across time. Alternate hypotheses were: (1) group means of the dependent variables will be greater for the RSDH group as compared to the CR, H and Control groups across time of measurement; and (2) group means representing the five dependent variables will be greater for both CR and H groups as compared to the Control group across time of measurement.
SELECTION OF SUBJECTS

The subjects who participated in this study were students in an introduction to counseling class taught through the department of Education Special Services at the Ohio State University. The course was offered in the evening, and a majority of the thirty-two students were fully employed. As mentioned in the Limitations of the Study, the educational level of the students consisted of ten doctoral level, twenty master's level and two last quarter seniors. Regardless of the educational level, none self-reported more than minimal counseling experience, although several had experienced relaxation training. There were six male students and twenty-six female students.

The mean age of the group was 33 with a range of 21 to 52. (See Table 1.)

All of the subjects were administered the Harvard Group Scale of Hypnotic Susceptibility, and were scored as to either low or high susceptibility and randomly assigned to groups. They were not informed as to group membership (treatment level).

Subjects were informed that their performance would not be graded.
Table 1
RANGE, MEDIAN AND MEAN AGES FOR TREATMENT GROUPS

<table>
<thead>
<tr>
<th>TREATMENT GROUP</th>
<th>RANGE</th>
<th>MEDIAN</th>
<th>MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSDH</td>
<td>21-52</td>
<td>35</td>
<td>35.4</td>
</tr>
<tr>
<td>CR</td>
<td>25-37</td>
<td>34</td>
<td>32.5</td>
</tr>
<tr>
<td>H</td>
<td>22-37</td>
<td>28</td>
<td>29.4</td>
</tr>
<tr>
<td>C</td>
<td>22-45</td>
<td>35</td>
<td>34.5</td>
</tr>
<tr>
<td>TOTAL GROUP</td>
<td>21-52</td>
<td>33</td>
<td>32.9</td>
</tr>
</tbody>
</table>
The Common Beliefs Survey III (CBSIII) resulted from the efforts of Bard (1973), Lane, Bessai and Bard (1975), and Bessai (1976, 1977) who sought to develop an improved self administered and objectively scored diagnostic instrument to be used to measure specific levels of irrational thinking. Nine attitude surveys were combined and synthesized into the 54-item, CBSIII which was to reflect the theoretical framework of irrationality as proposed by Ellis. The pooled surveys included the Irrational Beliefs Test (Jones, 1968), Personal Beliefs Inventory (Hartman, 1968), Questions for Rating Reason (Argabrite and Nidorf, 1968), Adult Irrational Ideas Inventory (Fox and Davies, 1971), Ellis Scale (Macdonald and Games, 1972), A self Rating Scale for Rationality (Bard, 1973), Common Perception Scale (Maultsby, 1974), Common Belief Scale (Maultsby, 1974), and Common Trait Scale (Maultsby, 1974). A review of the instruments revealed inadequacies such as an insufficiency of items, an inadequacy of sample sizes and items focusing on symptoms and feelings rather than beliefs.
From the aforementioned scales and instruments, 49 items were selected to be reviewed by a panel of judges who insured that Ellis's 12 irrational beliefs were represented equally, and eliminated redundant items. The resultant Common Belief Survey I (CSBI) consisted of 189 items. Subsequently the authors further evaluated the instrument through factor analysis and a promax oblique rotation which yielded 10 first order factors, and developed a revised 100 item CBSII. Upon closer examination of the 10 factor solution they concluded that those factors accounted for 76% of the common variance. However, four of the factors were judged artifactual because of similar item wording or non-normal response distributions of the items.

Removing items based on the artifactuality of the factors yielded a 49 item matrix and a six factor solution accounting for 82.8% of the common variance. Those six first order factors included: Importance of the past, Blame proneness, Self downing, Importance of approval, Perfectionism and Control of emotions. The second order factors which accounted for 100% of the common variance included Evaluation and Locus of control. Bessai (1977) added five equivalent items to the 49 item matrix so that there would be 9 items for each of the six first order factors. The 54 items, CBSIII factor structure was replicated in recent studies: Bessai (1978) and Forman (1978).
Thus, CBS III consists of 54 items set in a 5-point Likert scale response format ranging from strongly agree to strongly disagree. In order to control for an acquiescent response bias, items are worded so that approximately one-half of the items are stated as rational beliefs (25) and one-half as irrational beliefs (29). Only 15 to 20 minutes is necessary to administrate the instrument.

STATE-TRAIT ANXIETY INVENTORY

The State-Trait Anxiety Inventory (STAI) is comprised of separate self-report scales for measuring two distinct anxiety concepts: state anxiety (A-State) and trait anxiety (A-Trait).

State anxiety (A-State) is conceptualized as a transitory emotional state or condition of the human organism that is characterized by subjective, consciously perceived feelings of tension and apprehension, and heightened autonomic nervous system activity. A-States may vary in intensity and fluctuate over time whereas Trait anxiety (A-Trait) refers to relatively stable individual differences in anxiety proneness, that is, to differences between people in the tendency to respond to situations perceived as threatening with
elevations in A-State intensity (Spielberger, Gorsuch, and Lushene, 1970).

In general, it would be expected that those who are high in A-Trait will exhibit A-State elevations more frequently than low A-Trait individuals because they tend to react to a wider range of situations as dangerous or threatening. High A-Trait persons are also more likely to respond with increased A-State intensity in situations that involve interpersonal relationships which pose some threat to self-esteem. It has been found for example, that circumstances in which failure is experienced, or in which an individual's personal adequacy is evaluated (for example, taking an intelligence test), are particularly threatening to persons with high A-Trait (Spence and Spence, 1966; Spielberger 1966; Spielberger and Smith, 1966).

The STAI A-Trait scale consists of 20 statements that ask people to describe how they generally feel. The A-State scale also consists of 20 statements, but the instructions require subjects to indicate how they feel at a particular moment in time. The STAI, designed to be self administering, may be given either individually or in groups. College students generally require only six to eight minutes to complete either the A-State or the A-Trait scale, and less than fifteen minutes to complete both.
In the standardization of the STA1 the A-state scale was given first, followed by the A-Trait scale, and this form is recommended when both scales are given together. Since the A-State scale was designed to be sensitive to the conditions under which the test is administered, scores on this scale can be influenced by the emotional atmosphere that may be created if the A-Trait scale is given first. In contrast, it has been demonstrated that A-Trait scales are relatively impervious to the conditions under which they are given (Johnson, 1968; Johnson and Spielberger, 1968; Lamb, 1969).

The range of possible scores varies from a minimum score of 20 to a maximum score of 80 on both the A-State and the A-Trait subscales. Subjects respond to each STA1 item by rating themselves on a four point scale. The four categories for the A-State scale are: (1) Not at all; (2) Somewhat; (3) Moderately so; and (4) Very much so. The categories for the A-Trait scale are: (1) Almost never; (2) Sometimes; (3) Often; and (4) Almost always.

Some of the STA1 items (for example, "I am tense") are worded in such a manner that a rating of (4) indicates a high level of anxiety, while other items (for example, "I feel pleasant") are worded so that a high rating indicates low anxiety.
In an attempt to reduce the potential of an acquiescence set, the authors balanced the A-State scale with equal numbers of items for which high ratings indicate high and low anxiety; however, the authors were at best able to incorporate seven reversed items and thirteen directly scored items.

Originally developed as a research instrument for investigating anxiety phenomena in "normal" (nonpsychiatrically disturbed) adults, the STA1 has been normed for male and female undergraduates, junior and senior high students, and male psychiatric, general medical and surgical patients, and male prisoners.

Test-retest reliability for the A-Trait scale evidenced correlations that were fairly high ranging from .73 to .86, while those for the A-State scale were lower, ranging from .16 to .54. The internal consistency of both STA1 subscales is reasonably good, as evidenced by the alpha coefficient which ranged from .83 to .92 for the A-State and .86 to .92 for A-Trait.

The STA1 has high construct and concurrent validity. Construct validity was established by sampling 977 undergraduates at Florida State University. The students were first administered the A-State
scale with the standard instructions (NORM condition). They were then asked to respond according to how they believed they would feel "just prior to the final examination in an important course" (EXAM Condition). All but one of the items significantly discriminated between those conditions for the males, and all of the items were significantly higher in the EXAM condition for the females. A study that contributed to construct validity of the STAI for the A-State involved administering the inventory under stressful and nonstressful conditions (Lazarus and Opton, 1966) induced through experimental procedures. Alpha coefficients ranged from .89 to .94 for the males and from .83 to .93 for the females, which led the authors to conclude that females may be more emotionally labile than males and/or that they are more willing to report their feelings.


Concurrent validity was assessed by administering the inventory to a sample of more than 300 Florida State University Undergraduates along with the Taylor Manifest Anxiety Scales (TMAS), the IPAT Anxiety
Scale, and the General and Today forms of the Affect Adjective Check List (AAACL). The STAI correlated from .75 to .77 with the IPAT, from .79 to .83 with the TMAS and from .52 to .58 with the AAACL (Spielberger, Gorsuch and Lushene, 1970).

FACILITATIVE DIMENSIONS SCALES

The following scales and descriptive levels of functioning are those chosen from the adapted helping dimensions scales of Tosi, Howard and Fuller (1977) as adapted from the work of Egan (1975) Carkhuff (1969) and Strong and Schmidt (1970).
GENUINENESS

Genuineness involves congruence between the counselor's words, expressions, tone, actions and feelings. This is done in a spontaneous, non-defensive, consistent and open manner.

RATING SCALE

5—The counselor emphatically shares feelings in an appropriate manner. He is freely and deeply himself in a non-exploitive way, and is spontaneous in sharing his feelings and is open to the feelings of the client. There is a scarcity of negative responses by the counselor.

4—The counselor responds in a genuine way with many of his own feelings and does so in a helpful manner.

3—The counselor does not seem insincere, but does little to indicate any real genuiness. He shows nothing of himself.

2—The counselor responds according to prescribed role, his verbalization seems slightly unrelated to his true feelings, or his only genuine responses are negative.

1—The counselor's verbalizations are clearly unrelated to what he is feeling at the moment, or he seems closed and defensive, his only genuine responses are negative and appear to have a totally destructive effect on the client.
TRUSTWORTHINESS

If the counselor is to help the client in a meaningful way, the client must develop a trust for the counselor. In order to develop trustworthiness the counselor must convey a feeling to the client that he will care and possess the skill to help the client. This involves the client feeling that the counselor will not directly hurt him and that the counselor will try to help the client in situations where the client might hurt himself.

RATING SCALE

5—The counselor respects the needs and feelings of the client. The counselor offers information and opinions for the other's benefit, generates feelings of comfort, and willingness to confide. The counselor is open and honest about his motives.

4—The counselor shows respect for the client most of the time. He tries to show his caring for the client by giving reinforcing comments on most of his constructive behavior. He is in general effective in developing feelings of trustworthiness on the part of his clients during the counseling process.

3—Although the counselor displays trustworthy behaviors most of the time, there are times in which the client may question the counselor's ulterior motives.

2—The counselor is minimally effective in displaying trustworthy behavior. He may talk about other clients and call them by name during the counseling session. He may also convey to the client that he has ulterior motives such as good pay instead of the client's best interests at heart.

1—The counselor is totally untrustworthy. He will display boastful behavior about things that the client has indicated he (the client) was poor at. The counselor will consistently break confidences and display ulterior motives for his behavior.
EMPATHY

Empathy involves the ability to perceive and communicate accurately the feelings of the client. An ability to see the world from the frame of reference of the client. Empathy enhances self-exploration by communicating to the client his behavior on a level unaware to him. It involves communicating implicit and explicit meaning and often summarizing the client's fragmented messages and feelings.

RATING SCALE

5—The counselor's responses add significantly to the feeling and meaning of the expressions of the client, in such a way as to accurately express feelings on a deeper level than the client was able to express. This encourages deep self-exploration on the part of the client. The counselor is fully with the client in his deepest moments.

4—The responses of the counselor add noticeably to the expression of the client in such a way as to express feelings he was unable to express previously.

3—The expressions of the counselor in response to the expressions of the client are essentially interchangeable with those of the client in that they express essentially the same affect and meaning.

2—While the counselor responds to the expressed feelings of the client, he does so in such a way that he subtracts noticeable affect from the communication of the patient.

1—The counselor's responses do not attend to or detract from the expressions of the client and communicate much less than the client was able to communicate.
SELF-DISCLOSURE

The counselor is willing to share his own experiences with the client if sharing it will actually help the client understand himself better. He is extremely careful, however, not to lay another burden on the client.

RATING SCALE

5—The counselor is ready to disclose anything about himself that will enable the client to understand himself better, but he actually discloses himself only when it will help rather than distract the client; he discloses himself in a way that keeps the focus on the client. He also discloses at an appropriate time.

4—The counselor discloses information about himself that is appropriate and timely, keeping the focus on the client, but doesn't draw the relationship to the situation as closely as he can.

3—The counselor discloses information about himself, is appropriately and timely, but is somewhat hesitant and defensive about his previous situation.

2—The counselor discloses information about himself but his manner of representation is unclear and he is somewhat defensive about his behavior, intimating that he was not in as difficult a situation as the client.

1—The counselor selfdiscloses, but gets involved in himself and carries on about his own previous difficulties; he also defends himself and is quick to point out that his difficulty was not as bad as that of the client.
CONCRETENESS

Concreteness is the ability of the counselor to identify specific behaviors, feelings and experiences in the counseling relationship and facilitate the same in the client. This can be done by modeling, by not letting the client ramble and by asking the client for more specific information.

RATING SCALE

5—The counselor is always able to facilitate the direct expression of all personally relevant feelings and experiences (regardless of concrete and specific terms).

4—The counselor is usually able to guide the discussion to personally relevant material in a specific and concrete manner.

3—The counselor at times encourages discussion of personally relevant material in specific and concrete terms; some areas of concern, however, are not dealt with concretely or developed fully.

2—The counselor leads or allows some discussion of personally relevant material, but mainly stays at a vague, abstract, or intellectualized level.

1—The counselor leads or allows all discussion to deal with vague, impersonal generalities, avoids personally relevant specific situations and feelings, or stays at an abstract, intellectual level.
Reliabilities for only two of the scales utilized empathy and genuineness, are extensively reported in the literature. Moreover, the reliabilities are rater reliabilities rather than item reliabilities; with hours of training, educational level and therapeutic experience of raters varying. Accurate Empathy, the facilitative condition with the highest reported interrater reliabilities in Truax and Mitchell's (1971) review of the literature ranged from .42 to .95 with a mean score of 71.1 for forty-one studies. Scores for genuineness ranged from .20 to .95, with a mean of 53.7 for thirty-one studies. For the purpose of this study, however, all dimensions were collapsed to produce one overall measurement of interpersonal skill.

HARVARD GROUP SCALE OF HYPNOTIC SUSCEPTIBILITY

The most commonly employed tests of hypnotic susceptibility include the Stanford Hypnotic Susceptibility Scales (Weitzenhoffer and Hilgard, 1959, 1962) the Barber Suggestibility Scale (Barber and Glass, 1962) and the Harvard Group Scale of Hypnotic Susceptibility (Shor and Orne, 1962). Unlike the two former scales, the Harvard Scale can be administered in a group setting. In addition the individuals are permitted to score their own levels of susceptibility.
Since there is potential for inaccurate self evaluation, it was first thought that the scores might be invalid (Wallace, 1979), but that fear has been dispelled (Bentler and Hilgard, 1963) and determined that .74 is the correlation between individual and group-assessed hypnotic susceptibility levels. The average performance on the scale is 4.5 on a scale of 0 to 12.

In the present study, subjects ranged from scores of 1 through 10, with a median of 5 and mean score of 4.7. (See Table 2, for a breakdown by treatment groups.)

As was mentioned earlier in Chapter 2, the Harvard scale, like the Stanford scale consists of twelve tasks to be performed nine of which are exactly the same as those on the Stanford scale (Wallace, 1979). The other three are similar.

Table 2 provides the mean and ranges of scores on the Harvard Group Scale of Hypnotic Susceptibility for this study indicating that subjects would most likely operate at the hypnoidal or light trance stages. Erickson (1967) and Kroger (1977) both suggest that most significant therapeutic work can be accomplished in the hypnoidal, and other relatively lighter stages.
Table 2
RANGE, MEDIAN AND MEAN SCORES OF HYPNOTIC SUSCEPTIBILITY
FOR TREATMENT GROUPS: RSDH, CR, H, AND C.

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RATING OF TAPES

The tape raters consisted of three doctoral level students and two advanced master level students in counselor education. Raters met for a total of sixteen hours of training and rated six tapes in common to establish interrater and intrarater reliabilities.
Each tape was twenty minutes long and was rated on a five point Likert scale every two minutes. (See Appendix G for the rating scale format.) The ten rated segments were then averaged for each dimension for each tape. The final step was to collapse all five dimensions and arrive at an average measure of interpersonal skills for each tape. Every tape was rated by two raters except for the six tapes which everyone rated. The overall scores of the two raters were averaged for one final score entered into the data base for each separate tape. The raters were blind as to whether the tape was recorded at pre-test, post I or post II.

The reliabilities reported in Table 1, then, are interrater reliabilities (two raters evaluated each tape) and intrarater reliabilities for the collapsed dimension. The interrater reliabilities on the collapsed interpersonal dimension ranged from .40 to .90 with a mean of .62. Intrarater reliabilities ranged from .59 to .74 with a mean of .64.
Table 3

RATER RELIABILITIES

Interjudge: Time 1 with Time 1

<table>
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<th>C</th>
<th>D</th>
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Intrajudge: Time 1 with Time 2

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All four groups, the active control (C), hypnosis (H), cognitive restructuring (CR) and rational stage-directed hypnotherapy (RSDH), participated in a weekly pre practicum counseling skills group of eight students. The hour long pre practicum lab was utilized as an adjunct to a two and a half hour introduction to counseling class. The text for the class was *A Survey of Counseling Methods* by Osipow, Walsh, and Tosi (1980). In addition, a workbook text, *Exercises in Helping Skills*, which accompanies *The Skilled Helper* by Gerard Egan, was utilized by all four groups who progressed through the text at the same rate. Each week all groups discussed the workbook content then role-played client and counselor in dyads. The topic for counseling in dyads was the same each week, "Tell me about your day." The treatment therapist monitored the dyads, processed the content of the role playing and in all except the active control (C) delivered a treatment modality.
Rational Stage Directed Hypnotherapy (RSDH):

Rational Stage Directed Hypnotherapy (RSDH) is a systematic, therapeutic technique which makes use of relaxation and guided imagery procedures to facilitate the integration of cognitive restructuring and behavioral coping skills. During this procedure the student is directed through developmental stages through the use of relaxation and imagery.

In addition to utilizing the relaxation and guided imagery in a developmental sequence of stages of experiencing, the didactic/educational materials for cognitive restructuring were incorporated just as during the cognitive restructuring procedure. See Appendix I.

Cognitive Restructuring Only (CR):

The cognitive restructuring component is based upon the A-B-C paradigm developed by Albert Ellis (1962) in his Rational Emotive Therapy Model and later expanded upon by Donald Tosi in his Rational Stage Directed Imagery Model. The major premise of both models is that maladaptive emotional, behavioral and physiological states are associated with irrational thinking processes. The models provide a
means whereby irrational thinking may be confronted, evaluated and restructured in a scientific manner for the purpose of teaching clients more realistic, and rational thinking patterns. These more rational and realistic thoughts are then associated with more positive and functional, behavioral and physiological states. The procedure used in this treatment sequence was didactic/educational in nature and utilized the Self Directed Behavioral Change Instrument developed by Tosi (1975) and revised by Tosi and Black (1980). (See Appendix E. In addition, an introductory tape by Ellis was used to introduce the Rational Emotive Therapy Model. (See Appendix C for treatment.)

**Hypnosis (H):**

The Hypnosis treatment involved the following components:

1. The initial treatment session involved an explanation of the deep relaxation process, playing a tape of the process, and giving a tape to each of the subjects to play during the week.

The subjects were assigned to play the tape at least three (3) times a week. Questions
regarding the relaxation process were answered, and individual reactions monitored.

2. The relaxation procedure on tape consisted of the following steps:
   A. The subjects were requested to sit comfortably in their chairs, close their eyes, and focus on their breathing. They were then led through a deep breathing exercise.
   B. Next the subjects were guided through a progressive cognitive muscle relaxation procedure during which they were instructed to concentrate on relaxing their body, progressing from the toes to the forehead.
   C. The last step of the process was to encourage emergence of pleasant, peaceful images.
Control (C):  
This condition was a no treatment active control group. As such, subjects were administered pre-test, post-test I and post-test II measures and received no treatment.

THERAPISTS

The therapists providing the treatment were four advanced doctoral students in Counseling at the Ohio State University. All four had taught counseling skills in at least three pre practica experiences available through the Education Special Services department (Counselor Education). In addition all therapists were familiar with the rational stage directed hypnotherapy/imagery model through graduate course work and were skilled in the teaching of relaxation and imagery. Three of the therapists (RSDH, CR, and C groups) had thaken a graduate course that included the history and application of hypnosis, and utilized it during psychology internships. The other therapist (H group) had taught numerous classes to undergraduates utilizing deep relaxation as an adjunct to instruction. Therefore the therapists were randomly assigned to treatment level.
The therapists taught counseling skills and except for the active control group, delivered a treatment modality. In addition, they kept attendance and monitored assigned work, and usage of the relaxation tape (groups I and III).

STATISTICS

The data collected in this study were analyzed by the Multivariate Analysis of Variance (MANOVA) procedure with repeated measures. A discriminant function analysis was used as a follow up to compare all possible combinations of means of following significant F ratios for either main effects and interactions (Tatsuoka, 1971). The Duncan's Multiple Range test was performed to determine the differences between groups for each dependent variable.
Chapter IV

ANALYSIS OF DATA

The purpose of this study was to determine the effect of Rational Stage Directed Hypnotherapy (RSDH), cognitive restructuring (CR), hypnosis (H), and no treatment on the anxiety of pre-practicum students. In addition, the effect on anxiety was examined in relationship to irrational beliefs and interpersonal skill acquisition. The irrational beliefs were divided into categories related to either evaluation or locus of control; the anxiety dimension was divided into state or trait anxiety; however, the skill acquisition was collapsed for one score, referred to as TAPE.

The experimental design was a 4 X 3 one between groups (RSDH, CR, H, and C) and one within groups (pre-test, posttest I and posttest II temporal measurement) factorial. Five dependent measures were taken at the three temporal intervals: (1) state anxiety (A-State), (2) trait anxiety (A-Trait), (3) common beliefs regarding evaluation (CBS-E), (4) common beliefs regarding locus of control (CBS-L), and (5) interpersonal functioning (TAPE).
A repeated measures multivariate analysis of variance (MANOVA) procedure was chosen, incorporating four levels of treatment, three levels of testing and five dependent variables. The computations were performed by the Statistical Analysis System (SAS, 1981). SAS performs univariate and multivariate analysis of variance based on a least squares solution, a linear model.

In addition to the MANOVA performed on the dependent variables by SAS, individual ANOVA's are reported on each dependent variable for cell means, standard deviations and population for each level of treatment and the whole group for dependent variable at time of testing.

Tables 5, 6, 7
Table 4

SUMMARY OF MULTIVARIATE AND UNIVARIATE ANALYSES FOR THE FIVE DEPENDENT VARIABLES: EVALUATION, LOCUS OF CONTROL, STATE ANXIETY, TRAIT ANXIETY AND TAPES 
BY TREATMENT BY TESTING

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*p < .05
Table 5
ANALYSIS OF VARIANCE

CELL MEANS AND STANDARD DEVIATIONS FOR ENTIRE SAMPLE AT PRE-TEST

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Table 6

ANALYSIS OF VARIANCE

CELL MEANS AND STANDARD DEVIATIONS FOR ENTIRE SAMPLE AT POST-TEST 1

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Table 7

ANALYSIS OF VARIANCE

CELL MEANS AND STANDARD DEVIATIONS FOR ENTIRE SAMPLE AT POST-TEST II

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<td>P2STATE</td>
<td>RSD1</td>
<td>28.37</td>
<td>9.03</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>CR</td>
<td>28.12</td>
<td>6.79</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>27.57</td>
<td>4.33</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>CONTROL</td>
<td>35.37</td>
<td>10.05</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>ENTIRE SAMPLE</td>
<td>29.86</td>
<td>8.15</td>
<td>32</td>
</tr>
<tr>
<td>P2TRAIT</td>
<td>RSD1</td>
<td>31.50</td>
<td>6.41</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>CR</td>
<td>31.50</td>
<td>8.63</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>28.42</td>
<td>3.77</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>CONTROL</td>
<td>31.43</td>
<td>5.74</td>
<td>8</td>
</tr>
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<td>ENTIRE SAMPLE</td>
<td>30.71</td>
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<td>32</td>
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<tr>
<td>P2TAPE</td>
<td>RSD1</td>
<td>26.50</td>
<td>5.26</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>CR</td>
<td>29.00</td>
<td>4.92</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>28.25</td>
<td>4.46</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>CONTROL</td>
<td>28.87</td>
<td>7.07</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>ENTIRE SAMPLE</td>
<td>28.15</td>
<td>5.34</td>
<td>32</td>
</tr>
</tbody>
</table>
Follow up tests utilized for the MANOVA were the standard discriminant analysis function and Duncan's Multiple Range Test. The follow up discriminant analysis was performed for the testing main effects through the Statistical Package for the Social Sciences (SPSS, 1981). The Duncan's Multiple Range Test was performed for significant differences between groups for each dependent variable for treatment and testing.

The MANOVA performed on treatment for five dependent variables, showed the main effects for treatment were not statistically significant, \( \text{Pillai's } V = 5.75, \text{ approximate } F(15, 78) = 1.23, p < .27 \). The main effect for testing was statistically significant, \( \text{Pillai's } V = .676, \text{ approximate } F(10, 106) = 5.41, p < .0001 \), and the interaction of treatment by testing was significant \( \text{Pillai's } V = .824, \text{ approximate } F(30, 280) = 1.84, p < .0061 \).

Traditionally, a discriminant analysis would be performed as a followup to the treatment by testing interaction. It was inappropriate here because it would generate data for twelve groups which would be nearly impossible to interpret; also the N is too small to support using a discriminant analysis as a viable procedure (Tatsuoka, 1971).
Table 8 shows the group means for the treatments, testing, and times. In looking at change from pre-test to posttest II for treatment all four groups evidenced a decrease in irrational beliefs regarding locus of control, and decreased state anxiety. However, only the univariate F for state anxiety variable was significant and will be discussed.

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-test Mean</th>
<th>Posttest I Mean</th>
<th>Posttest II Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSDH</td>
<td>37.12</td>
<td>42.00</td>
<td>28.37</td>
</tr>
<tr>
<td>Hypnosis (H)</td>
<td>35.37</td>
<td>27.62</td>
<td>27.50</td>
</tr>
<tr>
<td>Control (C)</td>
<td>38.25</td>
<td>33.62</td>
<td></td>
</tr>
</tbody>
</table>

In looking at state anxiety, the group mean for Rational Stage Directed Hypnotherapy (RSDH) at pre-test was 37.12, and increased at posttest I to 42.00 then decreased to 28.37 at posttest II. The group mean for the cognitive restructuring group (CR) evidenced a continual decrease from 43.62 at pre-test, to 31.12 at posttest I to 28.12 at posttest II. The hypnosis (H) group mean also decreased across the three testing intervals but not to as great an extent as the CR group. At pre-test the H group mean was 35.37 decreased to 27.62 at posttest I, to 27.50 at posttest II. The control (C) group evidenced an initial group mean of 38.25 at pre-test, decreased to 33.62 at
Table 8

GROUP MEANS FOR TREATMENT BY TESTING BY TIME
FOR DEPENDENT VARIABLES: EVALUATION, LOCUS OF CONTROL, STATE ANXIETY
TRAIT ANXIETY AND TAPE

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Testing X Time 1, 2, 3</th>
<th>CBSE D1</th>
<th>CBSL D2</th>
<th>STATE D3</th>
<th>TRAIT D4</th>
<th>TAPE D5</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSDH</td>
<td>1</td>
<td>83.00</td>
<td>69.37</td>
<td>37.12</td>
<td>34.87</td>
<td>22.25</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>89.25</td>
<td>69.37</td>
<td>42.00</td>
<td>35.12</td>
<td>27.37</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>92.25</td>
<td>66.62</td>
<td>28.37</td>
<td>31.50</td>
<td>26.50</td>
</tr>
<tr>
<td>CR</td>
<td>1</td>
<td>93.25</td>
<td>70.75</td>
<td>43.62</td>
<td>32.75</td>
<td>25.62</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>94.62</td>
<td>79.12</td>
<td>31.12</td>
<td>31.62</td>
<td>28.75</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>96.37</td>
<td>62.37</td>
<td>28.12</td>
<td>31.50</td>
<td>29.00</td>
</tr>
<tr>
<td>R/H</td>
<td>1</td>
<td>88.62</td>
<td>68.50</td>
<td>35.37</td>
<td>34.62</td>
<td>28.62</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>89.12</td>
<td>62.12</td>
<td>27.62</td>
<td>33.50</td>
<td>27.75</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>91.75</td>
<td>63.37</td>
<td>27.50</td>
<td>28.37</td>
<td>28.25</td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td>90.87</td>
<td>71.25</td>
<td>38.25</td>
<td>31.37</td>
<td>26.87</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>99.50</td>
<td>67.50</td>
<td>33.62</td>
<td>33.87</td>
<td>25.12</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>96.87</td>
<td>68.00</td>
<td>35.37</td>
<td>31.37</td>
<td>28.87</td>
</tr>
</tbody>
</table>
posttest I, to 35.37 at posttest II. Thus, the CR treatment group showed the greatest overall decrease in state anxiety; the RSDH treatment group was the only one that increased from pre-testing to posttest I; the H group evidenced the least change from posttest I to posttest II; and the C group was the only one that increased in state anxiety from posttest I to posttest II. In addition, the C group evidenced the least change in anxiety across all times of treatment.

To follow up the significant testing effect, a discriminant function analysis was performed and was demonstrated to be significant (Wilks Lambda = .739, F (10, 178) = 2.900, p < .002). Normally, since the treatment by testing interaction was significant and disordinal, a main effect such as the testing effect in this study would not be interpreted. However, it was considered warranted since it may provide valuable information that may have been overlooked. The standard discriminant function coefficients and structure coefficients are given in Table 9. The structure coefficients are produced through a method of canonical correlation analysis (Tatsuoka, 1971) to support the discriminant function coefficients. A mathematical proof that the discriminant criterion and canonical correlation approaches yield similar results was given by Tatsuoka in 1953 (Tatsuoka, 1971).
Groups as referred to in Table 14 indicate the relative movement or change at three different temporal measurements for the entire sample for pre-test (group I), posttest I (group II) and posttest II (group III), the greatest difference occurring between group I and II, with a difference between group II and group III, but not as great.
### Table 9

**DISCRIMINANT ANALYSIS**

Standardized Discriminant Function and Structure Coefficients, and Group Centroids for Testing

<table>
<thead>
<tr>
<th>Standardized Discriminant</th>
<th>Standardized Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Function Coefficients</td>
<td>Coefficients</td>
</tr>
<tr>
<td>CBSE</td>
<td>-.23</td>
</tr>
<tr>
<td>CBSL</td>
<td>.44</td>
</tr>
<tr>
<td>STATE</td>
<td>.72</td>
</tr>
<tr>
<td>TRAIT</td>
<td>-.25</td>
</tr>
<tr>
<td>TAPE</td>
<td>-.44</td>
</tr>
</tbody>
</table>

Group Centroids:

- Pretest (Group I) = 2.55
- Posttest 1 (Group II) = 1.35
- Posttest II (Group III) = .98
The discriminant function and structure coefficients show the relative magnitude and signs of the several combining weights to determine if a meaningful psychological interpretation can be given.

From the coefficients, it appears that as state anxiety and locus of control load as positive weights in this theoretical concept, lessened state anxiety and increased locus of control would produce greater interpersonal skills. Thus, as state anxiety and locus of control score increased (locus of control irrational beliefs) interpersonal skills loaded negatively or decreased. However, the irrational beliefs loaded in the opposite direction, negatively for evaluation.

Trait anxiety loaded both positively and negatively, but without great magnitude in either direction.

As additional information the univariate F's were examined and graphed for interaction in a univariate sense (See Figures 8, 9, 10, 11, and 12). They were then tested for significance by the Duncan's Multiple Range test of significance as previously mentioned (See Tables 10, 11, 12, and 13).
Figure 8
TREATMENT EFFECTS OF GROUPS
ACROSS PRE, POST I, AND POST II ON EVALUATION SCORES ON THE CBS III
Figure 9

TREATMENT EFFECTS OF GROUPS ACROSS PRE, POST I AND POST II ON LOCUS OF CONTROL SCORES ON THE CBS III
Figure 10

TREATMENT EFFECTS OF GROUPS ACROSS
PRE, POST I, AND POST II
ON STATE ANXIETY SCORES ON THE STA I
Figure 11

TREATMENT EFFECTS OF GROUPS ACROSS PRE, POST I, AND POST II ON TRAIT ANXIETY SCORES ON THE STAI
Figure 12

TREATMENT EFFECTS OF GROUPS ACCROSS
PRE, POST I, AND POST II
ON TAPE SCORES
Table 10

DUNCAN'S MULTIPLE RANGE TEST BY TREATMENT

FOR EVALUATION, LOCUS OF CONTROL AND STATE ANXIETY

MEANS WITH THE SAME GROUPING LETTER ARE NOT SIGNIFICANTLY DIFFERENT

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Grouping</th>
<th>Mean</th>
<th>Levels of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation</td>
<td>A</td>
<td>95.75</td>
<td>(C)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>94.75</td>
<td>(CR)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>89.83</td>
<td>(H)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>88.16</td>
<td>(RSDH)</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>A</td>
<td>68.91</td>
<td>(C)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>68.45</td>
<td>(RSDH)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>64.66</td>
<td>(H)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>64.08</td>
<td>(CR)</td>
</tr>
<tr>
<td>State Anxiety</td>
<td>A</td>
<td>35.83</td>
<td>(RSDH)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>35.75</td>
<td>(C)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>34.29</td>
<td>(CR)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>30.16</td>
<td>(H)</td>
</tr>
</tbody>
</table>

\( p < .05 \)
Table 11
DUNCAN'S MULTIPLE RANGE TEST BY TREATMENT
FOR TRAIT ANXIETY AND TAPE
MEANS WITH THE SAME GROUPING LETTER ARE NOT SIGNIFICANTLY DIFFERENT

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Grouping</th>
<th>Mean</th>
<th>Levels of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trait Anxiety</td>
<td>A</td>
<td>33.83</td>
<td>(RSDH)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>32.20</td>
<td>(C)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>32.16</td>
<td>(H)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>31.95</td>
<td>(CR)</td>
</tr>
<tr>
<td>Tape</td>
<td>A</td>
<td>28.20</td>
<td>(H)</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>27.79</td>
<td>(CR)</td>
</tr>
<tr>
<td></td>
<td>B A</td>
<td>26.95</td>
<td>(C)</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>25.37</td>
<td>(RSDH)</td>
</tr>
</tbody>
</table>

p < .05
Table 12

DUNCAN'S MULTIPLE RANGE TEST BY TESTING
FOR EVALUATION, LOCUS OF CONTROL AND STATE ANXIETY
MEANS WITH THE SAME GROUPING LETTER ARE NOT SIGNIFICANTLY DIFFERENT

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Grouping</th>
<th>Mean</th>
<th>Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation</td>
<td>A</td>
<td>94.31</td>
<td>POST II</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>93.12</td>
<td>POST I</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>88.93</td>
<td>PRE</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>A</td>
<td>69.96</td>
<td>PRE</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>65.09</td>
<td>POST II</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>64.53</td>
<td>POST I</td>
</tr>
<tr>
<td>State Anxiety</td>
<td>A</td>
<td>38.59</td>
<td>PRE</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>33.59</td>
<td>POST I</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>29.84</td>
<td>POST II</td>
</tr>
</tbody>
</table>

\[ P < .05 \]
Table 13

DUNCAN'S MULTIPLE RANGE TEST BY TREATMENT
FOR TRAIT ANXIETY AND TAPE
MEANS WITH THE SAME GROUPING LETTER ARE NOT SIGNIFICANTLY DIFFERENT

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Grouping</th>
<th>Mean</th>
<th>Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trait Anxiety</td>
<td>A</td>
<td>33.53</td>
<td>POST I</td>
</tr>
<tr>
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<td>A</td>
<td>33.40</td>
<td>PRE</td>
</tr>
<tr>
<td></td>
<td>B</td>
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<td>POST II</td>
</tr>
<tr>
<td>Tape</td>
<td>A</td>
<td>28.15</td>
<td>POST II</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>27.25</td>
<td>POST I</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>25.84</td>
<td>PRE</td>
</tr>
</tbody>
</table>

$p < .05$
Finally the analysis of variance (ANOVA) for treatment groups for each dependent variable by repeated measures is shown in Tables 14, 15, 16, 17, and 18 for a better understanding of the main effects of treatment and treatment by testing.

Table 14

ANALYSIS OF VARIANCE FOR TREATMENT GROUPS BY EVALUATION REPEATED MEASURES SCORES

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>df</th>
<th>SS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>3</td>
<td>4529.9480</td>
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<td>.16</td>
</tr>
<tr>
<td>Subjects Within Treatment</td>
<td>28</td>
<td>2257.6250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td>2</td>
<td>572.2500</td>
<td>12.83</td>
<td>.01</td>
</tr>
<tr>
<td>Treatment X Testing</td>
<td>6</td>
<td>292.5833</td>
<td>2.19</td>
<td>.06</td>
</tr>
</tbody>
</table>
Table 15
ANALYSIS OF VARIANCE FOR TREATMENT GROUPS BY
LOCUS OF CONTROL REPEATED MEASURES SCORES

<table>
<thead>
<tr>
<th>SOURCE</th>
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<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
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<td>982.833</td>
<td>1.29</td>
<td>.30</td>
</tr>
<tr>
<td>Subjects Within Treatment</td>
<td>28</td>
<td>7127.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td>2</td>
<td>510.2500</td>
<td>6.68</td>
<td>.01</td>
</tr>
<tr>
<td>Treatment X Testing</td>
<td>6</td>
<td>243.1667</td>
<td>1.06</td>
<td>.40</td>
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</table>
Table 16
ANALYSIS OF VARIANCE FOR TREATMENT GROUPS BY
STATE REPEATED MEASURES SCORES

<table>
<thead>
<tr>
<th>SOURCE</th>
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<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>Treatment</td>
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<td>508.8646</td>
<td>1.37</td>
<td>.27</td>
</tr>
<tr>
<td>Subjects Within Treatment</td>
<td>28</td>
<td>3464.7917</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td>2</td>
<td>1233.3333</td>
<td>10.60</td>
<td>.01</td>
</tr>
<tr>
<td>Treatment X Testing</td>
<td>6</td>
<td>1023.4167</td>
<td>2.93</td>
<td>.01</td>
</tr>
</tbody>
</table>
Table 17

ANALYSIS OF VARIANCE FOR TREATMENT GROUPS BY

TRAIT REPEATED MEASURES SCORES

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>df</th>
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<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>3</td>
<td>54.2500</td>
<td>.14</td>
<td>.93</td>
</tr>
<tr>
<td>Subjects Within Treatment</td>
<td>28</td>
<td>3553.5833</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td>2</td>
<td>165.2708</td>
<td>5.00</td>
<td>.01</td>
</tr>
<tr>
<td>Treatment X Testing</td>
<td>6</td>
<td>118.8125</td>
<td>1.20</td>
<td>.32</td>
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</tbody>
</table>
Table 18
ANALYSIS OF VARIANCE FOR TREATMENT GROUPS BY TAPE REPEATED MEASURES SCORES

<table>
<thead>
<tr>
<th>SOURCE</th>
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<th>p</th>
</tr>
</thead>
<tbody>
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<td>1.00</td>
<td>.40</td>
</tr>
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<td>1049.833</td>
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</tr>
<tr>
<td>Testing</td>
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<td>86.8958</td>
<td>3.40</td>
<td>.04</td>
</tr>
<tr>
<td>Treatment X Testing</td>
<td>6</td>
<td>149.3541</td>
<td>1.95</td>
<td>.08</td>
</tr>
</tbody>
</table>
Chapter V

SUMMARY, INTERPRETATIONS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter is divided into four sections: summary, conclusions, recommendations and interpretations. An overview of the study is included in the summary, while the recommendations address further possibilities in the treatment of anxiety in pre-practicum students through the use of the rational stage directed hypnotherapy model (RSDH). Interpretation will help clarify some of the obscure effects of the treatment modalities.

SUMMARY

The purpose of this study was to examine the effects of rational stage directed hypnotherapy and its component modalities on the anxiety, irrational beliefs and interpersonal skills acquisition of pre-practicum students. The sample of thirty-two students was comprised of a range of students from fourth year undergraduate nursing students to beginning doctoral students enrolled in an introduction to counseling course. The hour long pre-practicum lab has historically been an adjunct to the counseling lecture. Each
subject was administered the Harvard Group Scale of Hypnotic Susceptibility to divide them into high and low hypnotically susceptible groups, which were later randomly distributed among the four treatment groups. All subjects were administered the State-Trait Anxiety Inventory (STAI), the Common Beliefs Survey III (CBS III), and were subsequently taped for a twenty minute counseling session. The treatment groups met for seven one hour sessions.

The experimental design for this study consisted of a $4 \times 3$, one between groups (RSDH, CR, H, and C) and one within group (measurements across time: pre-test; posttest I; and posttest II) factorial.

The statistical application consisted of a multivariate analysis of variance (MANOVA) procedure incorporating four levels of treatment, three levels of testing, and five dependent variables. A standard discriminant function analysis was used as a follow up for the MANOVA to compare all possible combinations of means with significant $F$ ratios for both main effects and interactions. A Duncan's Multiple Range follow up was utilized to test for significance among groups for treatment and testing in the univariate sense.
The null hypothesis for the study was that group means on the dependent variables of state-trait anxiety, evaluation and locus of control measures and the collapsed interpersonal dimension score on the tapes would not differ significantly across time. Alternate hypotheses were: (1) group means of the dependent variables will be greater for the RSDH group as compared to the CR, H and Control groups across time of measurement; and (2) group means representing the five dependent variables will be greater for both CR and H groups as compared to the Control group across time of measurement.

The null hypothesis for treatment main effects was supported. No significance was found for the treatment main effect. There was a main effect for treatment by testing; however, because of the large number of groups to consider for the interaction, and the relatively small N in the sample, no multivariate follow up test was appropriate.

There was a main effect for testing and a discriminant analysis was performed.
INTERPRETATION

Caution must be taken in interpreting the results and the results must be considered more descriptively than interpretively. The differences and groups were described according to the significant or nonsignificant differences between groups. Graphs of the differences between groups along treatment, testing and time illustrated the movement of the groups and several observations are worth noting. For example, all treatment groups were lower in state anxiety at post II. The curious result for state anxiety at post I was that the RSDH group increased from pre-test measurement. The cognitive restructuring group showed the greatest overall decrease in anxiety.

Since cognitive restructuring and relaxation showed a steady trend in decreasing anxiety, it appears that they can impact upon anxiety separately, but in combination in this study for the period of time allotted, the combined approach (RSDH) evidenced an increase at the second time of measurement. The trait anxiety variable, which should measure a stable characteristic, varied the least for all the dependent measures overall, and appropriately so.

The dependent variable, tape, evidenced improvement for all groups, but the greatest improvement was evidenced for the cognitive
restructuring and rational stage directed hypnotherapy groups. This dependent variable may have been greatly affected by the didactic—experiential aspect of the treatment.

Interestingly, the locus of control variable decreased also which illustrated that the subjects felt more in control as their anxiety decreased. Unexpectedly, all groups increased their scores on evaluation which shows that they were more stressed regarding evaluation, even though they were informed that they would not be graded on their performance.

The time allotted (1 hour) was undoubtedly too short to present the full model. The RSDH therapist occasionally voiced a concern that the full model plus skill presentation and processing could be presented. The other therapists rarely or never expressed concern.

The stimulus overload for the RSDH group was possibly exacerbated by the fact that their initial skill level was the lowest of the four groups, as determined by measurement on the five adapted scales (TAPE) at pre-test.
CONCLUSIONS

The stimulus overload of the RSDH group could contribute to the short term effect of elevated state anxiety at posttest 1. In addition, the RSDH model is designed to heighten awareness through its stages of experiencing and hypnoidal state of relaxation which may be threatening to ego defenses in a larger sense. As mentioned in Chapter 2, anxiety is a multidimensional phenomenon.

The RSDH model cannot be considered without merit, however, because the RSDH group evidenced the greatest increase in skill level (keeping in mind that because of their initial lower skill level, they could evidence the greatest overall improvement).

Cognitive restructuring was consistently effective in treating anxiety, lessening irrational beliefs regarding locus of control, and stabilizing the perceived threat of evaluation. It equaled or surpassed hypnosis only on all variables except for trait anxiety effect, which makes it a strong contender for treatment of choice when the training is of short duration.
RECOMMENDATIONS

1. Present the RSDH model and all its components over a longer period of time. The stages of experiencing in particular, need more presentation time. Only awareness and exploration were presented.

2. Utilize the more simplified cognitive restructuring model only for beginning practicum students, especially if time is short.

3. Incorporate the RSDH model with more advanced practicum students.

4. Minimize threat of evaluation to the extent possible without jeopardizing the monitoring of tasks.

5. Add an additional therapist to each level of treatment if the RSDH model is used experimentally.
6. **Instruct students with a didactic experimental model not attached to a course to partial out classroom teaching effect.**

7. **Build in a larger population of practicum students into the treatment design utilized to resolve questions of significance.**

8. **Further investigate the relationship between measures of locus of control and anxiety in pre-practicum students.**

9. **Correlate the measure of locus of control of the Common Beliefs Survey III with other measures of locus of control.**
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APPENDIX A

COMMON BELIEFS SURVEY III
PLEASE NOTE:

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These consist of pages:

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166-178
APPENDIX B

HARVARD GROUP SCALE OF
HYPNOTIC SUSCEPTIBILITY
APPENDIX C

TRANSCRIPT OF ELLIS TAPE
OF IRRATIONAL BELIEFS
APPENDIX D

SELF DIRECTED BEHAVIORAL
CHANGE INSTRUMENT
SELF-DIRECTED BEHAVIOR CHANGE

IN THE COGNITIVE, AFFECTIVE, PHYSIOLOGICAL AND BEHAVIORAL DOMAINS

AN EXPANDED COGNITIVE-EXPERIENTIAL PERSPECTIVE

BASED ON RATIONAL EMOTIVE THEORY

DONALD J. TOSI, PH.D., & VIRGINIA BLACK, M.A.

THE OHIO STATE UNIVERSITY
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INTRODUCTION

The purpose of this instrument is to provide a structured exercises in self-directed behavioral change that focuses on the cognitive, affective, physiological, and behavioral functioning of a person. The exercise is especially valuable because it can be performed by using the actual instrument as well as through imagery. This self-directed intervention is an extension and revision of rational emotive theory that emphasizes the ABC model of human emotions and behavior.

Rational-emotive theory, developed by Albert Ellis, holds that most sustained negative emotions that interfere with effective behavior (problem solving, self-assertiveness, decision making, etc.) are the result of irrational ideas which take the form of biased, prejudiced, internalized sentences. Rarely do events external to us cause our discomfort; instead, it is our own perceptions, attitudes, or internalized sentences about those events that affect us most, especially when they are of an irrational nature.

Specifically, this exercise should (1) enable a person to explicate his thinking about significant events that are associated with areas of ineffective functioning, and (2) help that person to
generate more reasonable thoughts that would ultimately result in more effective and constructive behavior.

Thought and behaviors tend to be irrational when they (1) lead to distortion of reality, (2) interfere with the accomplishment of goals, (3) are not life preserving and (4) lead to significant personal and environmental stress. On the contrary, thought and behaviors are more rational when they (1) tend to consider reality, (2) facilitate the accomplishment of personal goals, (3) are life preserving and (4) reduce significant personal and environmental stress.

An elaborated ABCDE model of human functioning is presented next.
AN EXPANDED ABCDE MODEL OF HUMAN FUNCTIONING

A - Represents real or imagined events or situational conditions that are meaningful to individuals. These events may have occurred in the past, may be happening in the present, or may be about to occur in the future.

B - Represents the manner in which people perceive, appraise, or evaluate events, their responses to events, and themselves as human beings. B also signifies the internal dialogue people have with themselves—that is—how they talk to themselves. This internal dialogue or self talk may often escape one's awareness. B may be of a rational or irrational nature.

C - Represents the full range of emotional experiences people have in response to how they deal with significant events at point B. Sometimes people are unaware of their feelings and how they may relate to A and B. Emotional responses may be appropriate or inappropriate, constructive or destructive.

D - Represents the full range of physiological or bodily responses that result from emotional experiences or that go along with emotional experiences. D develops significantly with C and B. Physiological responses may be of a life enhancing or life inhibiting nature.

E - represents the way individuals translate their thoughts, feelings, and bodily responses into behavior that impacts on the self and the environment. Behavior may be constructive or destructive, appropriate, inappropriate, rational, irrational.
Some persons report that their physiological responses (D), behaviors (E), and feelings (C) are caused by external events (A). They appear to be unaware of how their thoughts give rise to their feelings and influence their behavior. Other people may report that their physiological responses (D), and behaviors (E) are the result of their thoughts (B) but are unaware of their emotions (C). Moreover, because of our social conditioning it is very easy not to make appropriate and meaningful connections between events (A), thoughts (B), feelings (C), physiological responses (D) and behavior (E).

Thus, appropriate psychological interventions assist persons initially to become fully aware of the entire ABCDE sequence. Once a person becomes fully aware of the sequence, the counselor or therapist can introduce the more sophisticated concept of "the proliferation effect," i.e., an irrational belief can become so integrated and ingrained into a person's conceptual system that a (B), (C), (D) or (E) can emerge as an event (A). For example, there is an (A) event:

A - Your mother tells you that you are a lazy, troublesome child.
B - You tell yourself, "My mother is an intelligent, powerful adult. She must be right. I'm worthless.
C - You feel angry and depressed.
D - You experience stomachaches, headaches, or bowel problems.
E - You withdraw from your mother or other critical people in a sullen way.
The aforementioned is a primary sequence. Once the pattern is set you may experience a proliferation of events initiated by any component of the ABCDE sequence. For example, (B) I'm worthless becomes an event at some moment that you are sitting in a group of people and unfavorably comparing yourself to them, which activates a (C) angry or depressed feeling, resulting in (D) headaches, stomachaches, etc., (E) sullen withdrawal. This may create another event (A), that is, critical evaluation by others who perceive you as unfriendly, setting off the whole primary ABCDE sequence again.

**ACTIVATING EVENTS**

Each one of us has experienced some unhappiness in our daily life in the context of school, work, home, and recreational environments. The unhappy event may have occurred in an interaction with family, strangers, or acquaintances or when we were by ourselves. Interactions with others would include such events as marital arguments, unreasonable demands by a boss, harassment by unruly students, separation from a loved one through work or divorce, etc. Unhappy events or situations which focus on the individual's interaction with self may include taking exams, deciding on a career, struggling with dieting, alcohol consumption, drug abuse or simply
procrastination with tasks.

Take a couple of minutes to try to think of several events that represent psychological discomfort to you. These may be events that occurred in the past, ones that you are involved in at present, or even ones that you expect to occur in the future. As you think of them, list each of them twice—once in the blocks under activating events on Form A and again in the blocks under Activating Events on Form B.
ACTIVATING EVENT EXAMPLES

1. You drink too much at an important social event, and have to sleep it off for several hours on the host's porch.

2. A student harasses you, the teacher, daily during the class period that you instruct the student and during the period she/he is in your study hall.

3. A driver cuts in front of your car unsafely, you blow the horn and get a very obscene gesture in return. You don't do anything because the other person looks tough and is driving a battered car.

4. You are a new employee and it is obvious that there are several cliques in the office. Furthermore, no one is making an effort to get acquainted with you.

5. You are a university student and an important exam has been returned to you. Unfortunately, the grade on the exam is much lower than you expected.

6. An important report, which you worked overtime to produce, has just sat on your boss's desk for several weeks. He barely acknowledged that you produced it.
PART I — THE IRRATIONAL SEQUENCE

UNDERSTANDING IRRATIONAL AND SELF-DEFEATING HUMAN TENDENCIES

Part I of this exercise shows how to become aware of and analyze self-defeating thoughts, emotions, physiological responses, and behaviors. This will be accomplished through the ABCDE model of human functioning just described.
THE IRRATIONAL BELIEFS OR IDEAS

The following are commonly held irrational ideas or beliefs that are direct sources of emotional disturbances. From the list, choose those irrational ideas that occur between the Activating Events and the negative emotions you generally experience. At first this may prove to be difficult because such thinking generally occurs in symbolic or shorthand form and may not be in one's awareness. The idea here is to bring into awareness those implied beliefs associated with situations or events and to focus on them. You may wish to translate the following ideas into words that are more familiar to you. Record those irrational beliefs you select under implied beliefs on Form A.

(1) I must be loved or approved by everyone for virtually everything I do, or, if not by everyone, by persons I deem significant to me.

(2) I believe that certain acts are sinful, wicked, or villainous and that people who perform such acts should be severely punished and blamed.

(3) I can't stand it when things are not the way I would like them to be.

(4) When I am unhappy it is because something external to me such as persons or events causes me to be that way.

(5) I should be terribly concerned about things that may be dangerous or fearsome to me.

(6) Although I want to face difficult situations and self responsibilities, it is easier for me to
(7) I need someone stronger or greater than myself on whom to rely.

(8) In order to have a feeling of worth, I should and must be thoroughly competent, adequate, intelligent, and achieving in all possible respects.

(9) If something once strongly affects me, it will always affect me.

(10) I don't have much control over my emotions or thoughts.

(11) I should never be angry or express my anger because such expression is bad and a sign of personal weakness.

(12) I should rarely confront other people or assert my own thoughts or feelings about another person because people are fragile and are hurt easily.

(13) Most of the time I must please other people even if I have to forego my own pleasure because it is the nice or right way to behave.

(14) I am happiest when I just remain inactive and passive.

(15) In order to be perfectly fulfilled as a human being I must have a close, personal, involved, and intimate relationship with another person.
UNDESIRABLE EMOTIONAL STATES
ASSOCIATED WITH PSYCHOLOGICALLY SIGNIFICANT EVENTS

The following list depicts emotional reactions that can be self-defeating when inappropriately associated with real or anticipated events. Identify those emotional reactions that accompany the activating events you already listed on Form A. Record the reactions in the space provided for Undesirable Emotions. Refer to page 3 for an example if necessary.

UNDESIRABLE EMOTIONS

1. Anger or great irritability 14. Stubbornness
2. Anxiety 15. Laziness
4. Worry 17. Self-hate
5. Boredom 18. Excessive shyness
6. Frustration 19. Hate towards others
7. Guilt or self-condemnation 20. Vulnerability
8. Hopelessness or depression 21. Dependency
9. Great loneliness 22. Mistrust
13. worthlessness or inferiority 26. Other (Specify)
**UNDESIRABLE PHYSIOLOGICAL RESPONSES**

While people vary in their physiological response to negative situations, some develop back trouble while others may develop headaches, fatigue, or rapid heart beat, there are symptoms that tend to cluster around particular emotional states. (This is not to say that a physical symptom is only indicative of an emotional state. There may be an organic cause.) Below is a list of responses or symptoms and associated emotional states. Record the appropriate one for you under physiological response on Form A.

<table>
<thead>
<tr>
<th>1. Thirst or hunger</th>
<th>17. Menstrual discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Loss of touch in fingers</td>
<td>18. Dry mouth</td>
</tr>
<tr>
<td>2. Lump in throat</td>
<td>19. Flushing</td>
</tr>
<tr>
<td>4. Excessive perspiration</td>
<td>20. Shortness of breath</td>
</tr>
<tr>
<td>5. Pains in heart or chest</td>
<td>21. Heart palpitations</td>
</tr>
<tr>
<td>6. Dizziness</td>
<td>22. Grinding teeth</td>
</tr>
<tr>
<td>7. Fatigue</td>
<td>23. Hair raising</td>
</tr>
<tr>
<td>8. Heaviness in arms or legs</td>
<td>24. Ringing in ears</td>
</tr>
<tr>
<td>10. Loss of memory</td>
<td>26. Hands trembling</td>
</tr>
<tr>
<td>11. Burning</td>
<td>27. Elevated blood pressure</td>
</tr>
<tr>
<td>13. Nausea</td>
<td>29. Pimples</td>
</tr>
<tr>
<td>14. Belching</td>
<td>30. Skin rashes</td>
</tr>
<tr>
<td>15. Diarrhea</td>
<td>31. Frequent urination</td>
</tr>
<tr>
<td>16. Loss of weight</td>
<td>32. Other (Specify)</td>
</tr>
</tbody>
</table>
UNDESIRABLE BEHAVIORS, ACTIONS, OR HABITS

This is a list of behaviors generally considered to be self-defeating or undesirable, especially when they are of a high frequency, intensity, and duration. From the list below, choose those behaviors that are most often associated with the activating event(s) you specified and the undesirable emotional or affective states you have already determined for yourself. Record these on Form A. You may need to be more specific than suggested by the below behaviors.

UNDESIRABLE BEHAVIORS

1. Avoiding responsibility
2. Acting unfairly to others
3. Being late to appointments
4. Demanding attention
5. Physically attaching others
6. Procrastinating
7. Telling people off harshly
8. Whining or crying
9. Withdrawing from activity
10. Excessive drinking of alcohol
11. Overeating
12. Undersleeping
13. Oversmoking
14. Excessively manipulating
15. Taking too many drugs or pills
16. Being sarcastic
17. Lying
18. Cheating
19. Overprotecting
20. Ruminating about failure
21. Other (Specify)
Part II of this exercise introduces you to the basis of cognitive restructuring. In this section you will learn how to challenge logically those irrational ideas you determined to be of personal significance in Part I. Additionally, you will see how more rational thinking can lead to more positive emotional, physiological and behavioral responses.
RATIONAL IDEAS OR BELIEFS

The following ideas are contrasted to those irrational ideas presented in the last section. When people substitute these ideas for their previously held irrational ideas, they eventually experience more desirable emotional, physiological and behavioral functioning.

This part of the exercise has two purposes: (1) to introduce persons to more rational ways of thinking about events associated with emotional, physiological, and behavioral disturbance and (2) to assist persons in the contradicting and challenging of those self-defeating ideas that support those negative behavioral states.

The following rational ideas or beliefs correspond to the irrational ideas or beliefs in the preceding section. Record the preferred rational belief in the designated column on Form b. While recording the rational belief, try to imagine yourself using them in real life settings which have become a personal source of disturbance.

(1) While it is desirable to be approved and accepted by others, it is not an absolute necessity. My life doesn't really depend upon such acceptance, nor can I really control the minds and behavior of other persons.
(2) Many persons do commit acts that are inappropriate, self-defeating, or antisocial, but needless blame and punishment rarely stops such persons who are usually ignorant, emotionally disturbed, or stupid from committing such acts. Demanding that persons should not commit stupid acts oftentimes is nothing more than a demand that reality be different.

(3) When things don't go the way I want them to go, it is too bad or inconvenient—but not catastrophic. And, it may be in my best interest to change them or arrange conditions so that they may become more satisfactory. But, if I can't change or modify situations to my liking, I would be better off accepting their existence rather than telling myself how awful they are.

(4) Human unhappiness is usually caused by one's thoughts, appraisals, evaluations, or perceptions of events. That is, I create my own disturbance. Since I am human, I can expect to disturb myself often. But, that doesn't mean I have to continually disturb myself forever.

(5) If something is or may be dangerous or fearsome, it is probably in my best interest to face it and try to render it less dangerous. I may even discover that most of the danger was imaginary.

(6) While it is humanly normal to want to take the easy way out of such things as avoiding life's difficulties and self-responsibilities, in the long run I would probably be better off confronting openly such difficulties, facing them squarely, and trying to solve them.

(7) Although the socio-cultural system teaches and reinforces one's tendencies to be dependent on others and things, I would be better off standing on my own two feet in facing life.
(8) Since I am a human being with biological, sociological, and psychological limitations, I cannot reasonably expect to be perfect in any endeavor. But, I certainly can strive to perform well in those tasks I deem as significantly contributing to my self-development. In those areas where I am deficient, I certainly can strive to improve those areas. If I fail, though—too bad.

(9) Although I have been influenced greatly by my past experiences and believe that specific instances of the past greatly affect me today, I can profit by such experiences but not be overly prejudiced or biased by them. Nor do I need to be dominated by them in the future.

(10) Human beings, including myself, are happiest when they are actively involved in creative pursuits or when they devote themselves to people or projects outside of themselves. Long term withdrawal from the world or inaction rarely are associated with happiness. Therefore, it would be in my best interest to force myself to productive or creative activity.

(11) I could probably develop the skills necessary to control enormously my own emotions or feelings if I decide to commit myself to that process. And, it would be in my best interest if I would take the necessary risks in order to achieve a greater control over my own destiny. Of course, I don't really expect to develop these skills overnight.

(12) Anger is a normal human emotion and its expression is not a sign of personal worthlessness. Moreover, being aware of my anger and expressing it as a communication of current feelings without indiscriminately attacking the personal worth of others may be in my best interest.

(13) If I share most of my thoughts and feelings (negative or positive) honestly and openly, it will probably help me communicate more effectively with others in the long run—even though in the short run I might experience some temporary
Striving to know and to accept others for their humanness is a reasonable goal. Moreover, it is in my best interest to try to act fairly with others so I may receive the full benefit of their humanness. However, trying to please others at the expense of my own well-being is not personally growth-enhancing. Therefore, I can only do my best in trying to please others. If I fail—

It is desirable for me to be able to develop meaningful and intimate relationships with other people. However, if I demand intimate and satisfying relationships with others, I will tend to focus on the outcome of such interpersonal relationships rather than the process of getting to know and accept another person. Therefore, I would be better off not demanding but trying to be spontaneous, responsive, and accepting towards significant persons.
DESIRABLE EMOTIONS

This list consists of emotions that are generally positive or desirable. Although persons do not experience these always, these emotions are experienced under a variety of conditions with varying degrees of frequency, intensity, and duration. From this list, choose those emotional responses that would be more desirably associated with those activating events and rational ideas you have already listed. Also, it is important that you imagine these more positive feelings as emotional responses to those activating events and rational beliefs.

Record your choices under C on Form b.

DESIRABLE EMOTIONAL STATES

1. Relaxed  
2. Joyful  
3. Worthwhile  
4. Loving  
5. Hopeful  
6. Warmth  
7. Guiltless  
8. Shameless  
9. Elation  
10. Gentle  
11. Energetic  
12. Merry  
13. Cheerful  
14. Confident  
15. Self-Accepting  
16. Dependable  
17. Caring  
18. Able  
19. Lively  
20. Happy  
21. Patient  
22. Trusting  
23. Satisfied  
24. Stable  
25. Pleasant  
26. Other (Specify)
Below are some examples of desirable physiological responses that suggest a decrease in frequency, intensity, and duration of those undesirable physiological responses listed and reported in Part I. Record the appropriate physiological response on Form B.

<table>
<thead>
<tr>
<th>Desirable Physiological Responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Normal thirst and hunger</td>
<td>8.  Normal heart rate</td>
</tr>
<tr>
<td>2. Less dizziness</td>
<td>9.  Lowered blood pressure</td>
</tr>
<tr>
<td>3. Fewer pains</td>
<td>10. Normal vision</td>
</tr>
<tr>
<td>4. Fewer headaches</td>
<td>11. Normal breathing</td>
</tr>
<tr>
<td>5. Less menstrual discomfort</td>
<td>12. Fewer stomach symptoms</td>
</tr>
<tr>
<td>7. Normal bowell and bladder</td>
<td>14. Other (Specify)</td>
</tr>
<tr>
<td>functions</td>
<td></td>
</tr>
</tbody>
</table>
DESIRABLE BEHAVIORS, ACTIONS OR HABITS

The following behaviors are generally considered desirable or self-enhancing. Choose those behaviors that are associated with more reasonable ways to thinking and feeling. You may need to be more specific than suggested below. Again, try to imagine yourself utilizing these more self-enhancing behaviors as a response to those (?) you have already determined: Record them on Form B.

DESIRABLE BEHAVIORS

1. Taking responsibility
2. Acting fairly
3. Being punctual
4. Asserting myself
5. Behaving spontaneously
6. Drinking alcohol in moderation
7. Being kind
8. Performing in an honest manner
9. Being considerate
10. Helping others
11. Being reliable
12. Expressing tenderness
13. Developing a responsive style of communication
14. Being frank with others
15. Eating normally
16. Sleeping normally
17. Cultivating patience
18. Minimizing dependence on people, drugs, etc.
19. Taking decisive actions
20. Efficiently managing responsibilities
21. Other (Specify)
### The Irrational Sequence

<table>
<thead>
<tr>
<th>Activating Event</th>
<th>Irrational Belief</th>
<th>Undesirable Emotions</th>
<th>Undesirable Physiological Response</th>
<th>Undesirable Behavior</th>
</tr>
</thead>
</table>

203
<table>
<thead>
<tr>
<th>Activating Event</th>
<th>Rational Belief</th>
<th>Desirable Emotions</th>
<th>Desirable Physiological Response</th>
<th>Desirable Behavior</th>
</tr>
</thead>
</table>

FORM B
THE RATIONAL SEQUENCE

Desirable Physiological Response | Desirable Behavior
ADDITIONAL COMMENTS

Thoughts, emotions, physiological responses, and behaviors you would like to change as a result of completing this exercise:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Strategies or solutions you might develop and use in achieving desirable cognitive behavioral outcomes.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
APPENDIX E

STATE TRAIT ANXIETY INVENTORY
# Self-Evaluation Questionnaire

**Developed by C. D. Spielberger, R. L. Gorsuch and R. Lusheh**

**STAI Form X-1**

**Name** ________________________________  **Date** ________________________________

**Directions:** A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

<table>
<thead>
<tr>
<th>Statement</th>
<th>[ ]</th>
<th>[ ]</th>
<th>[ ]</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel calm</td>
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<td>8. I feel rested</td>
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<td>19. I feel joyful</td>
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<td>20. I feel pleasant</td>
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**Consulting Psychologists Press**

577 College Avenue, Palo Alto, California 94306
SELF-EVALUATION QUESTIONNAIRE
STA! FORM X-2

NAME________________________________________________________ DATE________________________

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

21. I feel pleasant _____________________________ 0 0 0 0 0
22. I tire quickly ______________________________ 0 0 0 0 0
23. I feel like crying ___________________________ 0 0 0 0 0
24. I wish I could be as happy as others seem to be ______________________ 0 0 0 0 0
25. I am losing out on things because I can't make up my mind soon enough ________ 0 0 0 0 0
26. I feel rested __________________________________________ 0 0 0 0 0
27. I am "calm, cool, and collected" __________________________________________ 0 0 0 0 0
28. I feel that difficulties are piling up so that I cannot overcome them ________ 0 0 0 0 0
29. I worry too much over something that really doesn't matter ________________ 0 0 0 0 0
30. I am happy ____________________________________________ 0 0 0 0 0
31. I am inclined to take things hard ________________________________________ 0 0 0 0 0
32. I lack self-confidence ___________________________________________ 0 0 0 0 0
33. I feel secure _____________________________________________ 0 0 0 0 0
34. I try to avoid facing a crisis or difficulty ________________________________ 0 0 0 0 0
35. I feel blue ________________________________________________ 0 0 0 0 0
36. I am content ________________________________________________ 0 0 0 0 0
37. Some unimportant thought runs through my mind and bothers me ________ 0 0 0 0 0
38. I take disappointments so keenly that I can't put them out of my mind ______ 0 0 0 0 0
39. I am a steady person ___________________________________________ 0 0 0 0 0
40. I get in a state of tension or turmoil as I think over my recent concerns and interests ___________________________________________ 0 0 0 0 0
APPENDIX F

ADAPTED HELPING

DIMENSIONS INSTRUMENT
Important Helping Dimensions in the Counselor-Client Relationship

Donald J. Tosi, Lee Howard, and Jocelyn Fuller

The Ohio State University

Based on the work of Egan, Carkhuff, and Strong
Important Dimensions in the Helping Process

Introduction

Several researchers (Eagan, 1975; Carkhuff, 1969; Strong, 1970, 1971; and Ivey, 1971) have identified a number of conditions which seem to be central to most successful counseling interchanges. These once ambiguous conditions have been operationally defined in an attempt to systematically teach these "core conditions" to counselors in psychology and other related disciplines. Recent research indicates that counselors who demonstrate high levels of core conditions seem to be more effective. These conditions also help form a base from which the counselor can move from to utilize more active techniques.

The first two conditions (physical and psychological attending) are prerequisites to all others. The next three conditions (expertness, trustworthiness, and attractiveness) are how the client perceives the counselor. They are very much governed by the behavior of the counselor and the effect the client's level of suggestibility may have. The last conditions (empathy, genuineness, confrontation, concreteness and respect) are most commonly called the "core conditions" and are the essence of the counseling process.
Accompanying each of these conditions is a rating scale based on five factors.

**Directions for Use of Scale**

Trained observers will rate the counselor on each important dimension based on the counselor's ability to follow the established criteria. This process will provide each counselor with immediate evaluative feedback. A rating of 5 on the scale is equated with outstanding performance; 4, 3, and 2 represent lessening performances; while 1 indicates a total inability to perform the indicated dimension.
A. **Physical Attending**

How the counselor presents himself physically communicates how he feels toward the client and whether he cares.

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**Important Factors of Physical Attending**

**EFFECTIVE ATTENDING**

**Eye Contact**
Looking at the client communicates, "I'm concerned." Maintaining consistent eye contact says the same.

**Posture**
Open posture, leaning forward says, "I'm open and interested." Relaxed posture says, "I'm relaxed with you."

**Using of Extremities**
Using hands to express self and nodding affirmingly says, "I understand and I'm involved."

**Use of Voice Tone and Facial Features**
Moderate, modulated voice indicates, "I'm relaxed and interested."

**INEFFECTIVE ATTENDING**

**Eye Contact**
Looking elsewhere communicates "I don't care." Looking away often says, "I'm uncomfortable."

**Posture**
Closed posture, facing away says, "I'm closed and not interested." Slouching says, "I'm too tired to get involved."

**Using of Extremities**
Fidgeting, picking nose, playing with things says, "I'm impatient or uncomfortable." Rigid body orientation may say, "I'm not open."

**Use of Voice Tone and Facial Features**
Voice too soft indicates, "I'm not sure of myself." Loud voice indicates, "I want to impress you."
The above conditions help to establish interest and rapport. They can also be used to reinforce self-directed talk with the client talks about irrelevant subjects or avoids discussing his problems. Discriminate use of these conditions involves attending to relevant talk while discriminantly ignoring irrelevant conversation.

Observer Comments
B. Psychological Attending

This involves attending to both verbal and nonverbal behavior of the client. The face and body of the client often are very communicative. For instance one study (McCroskey, Larson, Knapp, 1971) found that client communication of feeling was 35% verbal and 65% nonverbal. By attending to both verbal and nonverbal cues, the client can discover resistance, inconsistencies and surfacing of some unconscious processes that the client may be totally unaware of. All of these help the counselor in his diagnosis and treatment of psychological disorders. Not mentioned above but equally important, is the ability of the counselor to listen to his own internal processes (his attitudes, prejudices, and feelings).

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Attending to verbal and nonverbal cues of the client. Observing and acting on inconsistencies, resistances and repressed affect.

5 - The counselor is able to perceive all verbal and nonverbal cues, inconsistencies, resistances, etc., are acted upon. The counselor is equally tuned to his own internal processes.

4 - The counselor consistently perceives verbal and nonverbal cues. He monitors his own internal processes effectively.

3 - Although the counselor picks up some of the psychological cues, others are not perceived.

2 - The counselor is minimally effective in monitoring the client's and his own psychological systems.

1 - A total inability to perceive verbal and nonverbal cues is demonstrated. Ineffective monitoring of the counselor's own internal psychological processes causes interference.

Observer Comments
C. Counselor Expertness

The client who sees his counselor as an expert will be more amenable to his influence. Clients judge expertness from the counselor's overt appearance and behavior (dress, speech, name, title office, diploma, manner, etc.). Schmidt and Strong (1970) and Goldstein (1975) have experimentally demonstrated the importance of this dimension.

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5 - The counselor is neatly dressed, he looks comfortable and listens carefully to the client. His approach is clear, confident, logical and he appears intelligent and well prepared.

4 - The counselor is seen as an expert the majority of the time.

3 - Although the counselor appears expert at times it is not consistent. For example he may sound confident and intelligent but dress sloppy or his appearance may be good, but he is ill prepared.

2 - The counselor displays minimal expertness, has not prepared, his dress is questionable and his presentation is not totally logical.

1 - The counselor is sloppily dressed, he moves around nervously and is unable to focus on the client. His verbalizations are illogical, has not come well prepared and appears to be of average intelligence. The client has little hope for change.

Observer Comments
D. Trustworthiness

If the counselor is to help the client in a meaningful way the client must develop a trust for the counselor. In order to develop trustworthiness the counselor must convey a feeling to the client that he will care and possess the skill to help the client. This involves the client feeling that the counselor will not directly hurt him and that the counselor will try to help the client in situations where the client might hurt himself.

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5 - The counselor respects the needs and feelings of the client. The counselor offers information and opinions for the other's benefit, generates feelings of comfort, and a willingness to confide. The counselor is open and honest about his motives.

4 - The counselor shows respect for the client most of the time. He tries to show his caring for the client by giving reinforcing comments on most of his constructive behavior. He is in general effective in developing feelings of trustworthiness on the part of his clients during the counseling process.

3 - Although the counselor displays trustworthy behaviors most of the time, there are times in which the client may question the counselor's ulterior motives.

2 - The counselor is minimally effective in displaying trustworthy behavior. He may talk about other clients and call them by name during the counseling session. He may also convey to the client that he has ulterior motives such as good pay instead of the client's best interests at heart.

1 - The counselor is totally untrustworthy. He will display boastful behavior about things that the client has indicated he (the client) was poor at. The counselor will consistently break confidences and display ulterior motives for his behavior.

Observer Comments
E. Counselor Attractiveness

An attractive person is one toward whom you feel similarity, liking or compatibility. He has some experiences in common with you and does not talk up or down to you.

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5 - Counselor meets the client at the door, greets him, offers coffee, etc. He leans toward the client and during conversation looks for points of similarity, he is skillful and enthusiastic about the client's interests.

4 - The majority of the time the counselor is seen as attractive and attempts to find similarities between himself and the client.

3 - Although attractive at times, the counselor is not seen as always attractive. He may occasionally criticize the client for his or her interests or likes.

2 - Seldom is the counselor attractive. He finds few similarities between himself and the client. He may talk down to the client and may look bored when talking with the client.

1 - The counselor holds no beliefs in common with the client and openly criticizes the client's values. No attempt is made to see similarities or common points of reference between the counselor and the client. When meeting the client he does not shake hands and does not introduce himself.

Observer Comments
F. Empathy

Empathy involves the ability to perceive and communicate accurately the feelings of the client. (An ability to see the world from the frame of reference of the client.) Empathy enhances self-exploration by communicating to the client his behavior on a level unaware to him. It involves communicating implicit and explicit meaning and often summarizing the client's fragmented messages and feelings.

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5 - The counselor's responses add significantly to the feeling and meaning of the expressions of the client, in such a way as to accurately express feelings on a deeper level than the client was able to express. This encourages deep self-exploration on the part of the client. The counselor is fully with the client in his deepest moments.

4 - The responses of the counselor add noticeably to the expressions of the client in such a way as to express feelings he was unable to express previously.

3 - The expressions of the counselor in response to the expressions of the client are essentially interchangeable with those of the client in that they express essentially the same affect and meaning.

2 - While the counselor responds to the expressed feelings of the client he does so in such a way that he subtracts noticeable affect from the communication of the patient.

1 - The counselor's responses do not attend to or detract from the expressions of the client and communicate much less than the client was able to communicate.

Observer Comments
G. Genuineness

Genuineness involves congruence between the counselor's words, expressions, tone, actions and feelings. This is done in a spontaneous, non-defensive, consistent and open manner.

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5 - Counselor is freely and deeply himself in a non-exploitive way. He is spontaneous in sharing his feelings and is open to the feelings of the client.

4 - Counselor responds in a genuine way with many of his own feelings and does so in a helpful manner.

3 - Counselor does not seem insincere, but does little to indicate any real genuineness. The counselor shows nothing of himself.

2 - Counselor responds according to prescribed role, his verbalization seems slightly unrelated to his true feelings, or his only genuine responses are negative.

1 - Counselor's verbalizations are clearly unrelated to what he is feeling at the moment or he seems closed and defensive, his only genuine responses are negative and appear to have a totally destructive effect on the client.

Observer Comments
H. Confrontation

Confrontation involves the responsible unmasking of games, smoke screens, and discrepancies that the client may use in order to manipulate his environment. These behaviors are usually responsible for self-defeating actions on the part of the client. Confrontation also involves the challenging of undeveloped or unused skills which the client possesses.

5 - The counselor is always able to confront the client in a manner which is based on his deep understanding of the client's feelings, behavior, and past experiences. The counselor is very effective in helping the client identify his self-defeating thoughts, beliefs, and behaviors.

4 - The majority of the time the counselor is effective in identifying and confronting behaviors which are self-defeating on the part of the client.

3 - Although the counselor confronts the client on many of his self-defeating games and defenses, some of his very significant self-defeating behaviors go unchallenged.

2 - The counselor confronts the client in a manner which much of the time may indicate that the counselor does not care or that he may at times be enjoying attacking the client. The counselor may also rarely confront any of the client's self-defeating behavior or the counselor may be afraid of confronting the client.

1 - The counselor never confronts anything that is significant in the client's self-defeating behaviors. When he does confront he does so in a vicious attack which is highly negative and very punitive. This is usually designed to fill the needs of the counselor rather than to help the client.

Observer Comments
1. **Concreteness**

Concreteness is the ability of the counselor to identify specific behaviors, feelings and experiences in the counseling relationship and facilitate the same in the client. This can be done by modeling, by not letting the client ramble and by asking the client for more specific information.

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5 - Counselor is always able to facilitate the direct expression of all personally relevant feelings and experiences (regardless of concrete and specific terms).

4 - Counselor is usually able to guide the discussion to personally relevant material in a specific and concrete

3 - Counselor at times encourages discussion of personally relevant material in specific and concrete terms; some areas of concern, however, are not dealt with concretely or developed fully.

2 - Counselor leads or allows some discussion of personally relevant material, but mainly stays at a vague, abstract, or intellectualized level.

1 - Counselor leads or allows all discussion to deal with vague, impersonal generalities, avoids personally relevant specific situations and feelings, or stays at an abstract intellectual level.

**Observer Comments**
J. Respect

Respect involves communicating to the client that he has worth or value because he is human. Communicating that the client is unique, self-determined, has the ability to grow and his feelings and behaviors are worthy of consideration is accomplished by the counselor in both a verbal and nonverbal way.

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5 - Counselor communicates the very deepest respect for the client's worth as a person and potentials as a free individual.

4 - Counselor communicates a very deep concern for the feelings, experiences and potentials of the client to feel free to be himself and to be valued as an individual.

3 - Through nonverbal attending behavior and attempts to ****stand the client, the counselor shows concern for t#88 feelings, experiences and potentials.

2 - In many ways the counselor communicates disregard f*** feelings, experiences and potentials of the client, *** example the counselor responds passively or mechan**** ignores many of the client's feelings.

1 - Counselor does not pay attention to the client. The c*** communicates a total disregard for the feelings, experi**** and potential of the client.

Observer Comments
References


APPENDIX G

RATING SCALE
RATING SCALE

SSN ________________________
CODE # ______________________

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GROUP I AND GROUP II

Session 1

1. Take attendance.
2. Review basics of counseling relationship, warmth, empathy, unconditional positive regard, genuineness, respect.
3. Comment on physical attending such as good eye contact, other nonverbals.
4. Discuss role-playing, refer to pages 4 thru 9 in workbook. Assign those pages for homework.
5. Do attending exercises on pages 10 through 13 in workbook, but stop at exercise 7 on page 13. Process the exercise.
6. Play Ellis tape for 10 minutes. Comment very briefly on the application of RET to counseling.
7. Explain that Tosi has expanded the Ellis A-B-C model to A-B-C-D-E. Introduce SDBC instrument and assign that students read through the SDBC and have 3 to 5 comments about the format and content of the instrument. Students should not fill in the SDBC.
COMMENTS:

8. Role play "Tell me about your day."


GROUP III
Session 1

1. Take attendance.

2. Review basics of counseling relationship: warmth, empathy, unconditional positive regard, genuineness, respect.

3. Comment on physical attending such as good eye contact, other non-verbals.

4. Discuss role-playing, refer to pages 4 through 9 in workbook. Assign those pages for homework.

5. Do attending exercise on pages 10 through 13 in workbook, but stop at exercise 7 on page 13. Process the exercises.

6. Tell students before you begin the relaxation tape, that at the end of the tape you will gradually bring them back to awareness. They are to just listen for your voice. Play relaxation tape. Process how the students responded to it and ask how it compared to their relaxing on the hypnosis tape.
NOTE:

When the tape is over, the leader says, "As you begin to open your eyes now you will gradually feel more refreshed, not sleepy."

7. Give students tapes to take home to use as often as once a day if possible, but at least three times a week, spaced evenly through the week.

8. Role play, "Tell me about your day."


GROUP IV

Session 1

1. Take attendance.

2. Review basics of counseling relationship: warmth, empathy, unconditional positive reward, genuineness, respect.

3. Comment on physical attending, good eye contact, etc. To what all do they attend in physical attending?

4. Discuss role-playing referring to pages 4 through 9 in workbook. Assign filling in those pages.

5. Do attending exercises on pages 10 through 13 in workbook but stop at exercise 7 on page 13. Process the exercise.

6. Role play "Tell me about your day."

GROUP I

Session 2

1. Take attendance.

2. Check homework.

3. Review what has been done so far regarding relationship and attending to nonverbals.

4. Do exercise 7 on page 13 and 14. Note to students that the exercise may seem artificial or overly simple, but it will help in attending to what the client says.

5. Introduce exercise 8 and 9 on pages 15 through 18 and assign for homework.

6. Review RET, then ask for comments on the SDBC instrument. Point out the Ellisonian focus on language, e.g., shoulds musts, always, never, everyone, perfectly.... Note that the shorter, irrational beliefs need to be counteracted with longer rational beliefs.

7. Give students an example of an "Irrational sequence" in counseling and have everyone fill in that sequence in the SDBC. Assign students to fill in one irrational sequence regarding counseling.

8. Tell students before you begin the relaxation tape, that at the end of the tape you will gradually bring them back to awareness. They are to just listen for your voice. Play
relaxation tape. Process how the students responded to it and ask how it compared to their relaxing on the hypnosis tape.

NOTE:
When the tape is over, the leader says, "As you begin to open your eyes now you will gradually feel more refreshed, not sleepy."

9. Give students tapes to take home to use as often as once a day if possible, but at least three times a week, spaced evenly through the week.

10. Role play "Tell me about your day."


GROUP II
Session 2
1. Take attendance.
2. Check homework.
3. Review what has been done so far regarding relationship and attending to nonverbals.
4. Do exercise 7 on pages 13 and 14. Note to students that the exercise may seem artificial or overly simple, but it will help in attending to exactly what the client says.
5. Introduce exercise 8 and 9 on pages 15 through 18 and assign for homework.

6. Review RET, then ask for comments on the SDBC instrument. Point out the Ellisonian focus on language, e.g., shoulds, musts, always, never, everyone perfectly.... Note that the shorter, irrational beliefs need to be counteracted with longer, rational beliefs.

7. Give students an example of an "irrational sequence" in counseling and have everyone fill in that sequence in the SDBC. Assign students to fill in one irrational sequence regarding counseling.

8. Role play "Tell me about your day."


GROUP III
Session 2

1. Take attendance.

2. Check homework.

3. Review what has been done so far regarding relationship and attending to nonverbals.

4. Do exercise 7 on pages 13 and 14. Note to students that the exercise may seem artificial or overly simple, but it will help in attending to exactly what the client says. Process
what students experienced during the exercise.

5. Introduce exercise 8 and 9 on pages 15 through 18 and assign for homework.

6. Play relaxation tape.

7. Process reactions to relaxation tape.

8. Role play "Tell me about your day."


GROUP IV

Session 2

1. Take attendance.

2. Check homework.

3. Review what has been done so far regarding relationship and attending to nonverbals.

4. Do exercise 7 on pages 13 and 14. Note to students that the exercise may seem artificial or overly simple, but it will help in attending to exactly what the client says. Process what students experienced during the exercise.

5. Introduce exercise 8 and 9 on pages 15 through 18 and assign for homework.

6. Role play "Tell me about your day."

1. Take attendance.
2. Check homework.
3. Discuss exercise on concreteness pages 15 through 18.
4. Give examples of irrational cognitions found in everyday conversation and during the counseling process. Review entire A-B-C-D-E model. Relate concreteness and pointing to irrational cognitions.
   For example:
   "I must appear perfectly competent and intelligent while role-playing."
   "The client should quickly accept me and my every suggestion and interpretation as brilliant and growth producing."
5. Play relaxation tape.
6. Role Play "Tell me about your day."
8. Briefly introduce stages of experiencing: awareness, exploration, commitment, internalization, implementation, change (or redirection). Relate them to the counseling process.
GROUP II

Session 3

1. Take attendance.
2. Check homework.
3. Discuss exercise on concreteness pages 15 through 18.
4. Give examples of irrational cognitions found in everyday conversation and during the counseling process. Review entire A-B-C-D-E model. Relate concreteness and pointing to irrational cognitions.
   For example:
   "I must appear perfectly competent and intelligent while role-playing."
   "The client should quickly accept me and my every suggestion and interpretation as brilliant and growth producing."
5. Role Play "Tell me about your day."
7. Briefly introduce stages of experiencing: awareness, exploration, commitment, internalization, implementation, change (or redirection). Relate them to the counseling process.
GROUP III
Session 3
1. Take attendance.
2. Check homework.
3. Discuss exercise on concreteness pages 15 through 18.
4. Play relaxation tape.
5. Role Play "Tell me about your day."
7. Assign pages 19 through 29.

GROUP IV
Session 3
1. Take attendance.
2. Check homework.
3. Discuss exercise on concreteness pages 15 through 18.
4. Role Play "Tell me about your day."
6. Assign pages 19 through 29.

GROUP I
Session 4
1. Take attendance.
2. Check homework.
3. Review skills covered to date.

4. Elicit one irrational belief regarding the counseling situation. Note the purpose of integration RET, and the learning of counseling skills.
   a. To understand irrational beliefs and their application to the counselor as an individual.
   b. To understand the counselee's irrational beliefs about themselves.
   c. To understand irrational beliefs about the counseling situation while functioning as the counselor in training.

5. Play relaxation tape. At end of relaxation sequence have students imagine the rational growth enhancing thought "It's not necessary that I perform perfectly and adequately during every role playing session, only that I try to learn. If I don't spend time and energy putting myself down, I may learn more." After introducing that thought, bring students to awareness. This is the first incidence of cognitive restructuring.

6. Role play "Tell me about your day," focusing on feelings and emotions as explained on pages 23 through 29.

8. Reintroduce stages of experiencing: awareness, exploration, commitment, internalization, implementation and change (or redirection). Relate them to the counseling process.


GROUP 11
Session 3
1. Take attendance.
2. Check homework.
3. Review skills covered to date.
4. Elicit one irrational belief regarding the counseling situation. Note the purpose of integration RET, and the learning of counseling skills.
   a. To understand irrational beliefs and their application to the counselor as an individual.
   b. To understand the counselee's irrational beliefs about themselves.
   c. To understand irrational beliefs about the counseling situation while functioning as the counselor in training.
5. Role play "Tell me about your day," focusing on feelings and emotions as explained on pages 23 through 29.
7. Assign pages 29 through 38, stopping at exercise 16.
GROUP III
Session 3
1. Take attendance.
2. Check homework.
3. Review skills covered to date.
4. Play relaxation tape.
5. Role play "Tell me about your day," focusing on feelings and emotions as explained on pages 23 through 29.
7. Assign pages 29 through 38, stopping at exercise 16.

GROUP I
Session 4
1. Take attendance.
2. Check homework.
3. Review skills.
4. Point out similarities of A-B-C-D-E model and page 30 in workbook.
5. Review stages of experiencing and how the stages relate to counselors-in-training and clients.
6. Relaxation exercise with cognitive restructuring and suggestion of awareness and exploration stages of experiencing.

7. Give suggestion that from now on they, the counselors, think in terms of client situations and the A-B-C-D-E model.

8. Role play "Tell me about your day."

9. Process. (Were they able to be relaxed and alert? What was happening to the counselor and client physiologically?)

10. Assign pages 38-43.

GROUP II
Session 4

1. Take attendance.

2. Check homework.

3. Review skills.

4. Point out similarities of A-B-C-D-E model and page 30 in workbook.

5. Suggest that from now on everyone be aware of A-B-C-D-E sequence regarding themselves as the counselor or client. Especially point out that students also be aware of what is happening to them physiologically.
GROUP III

Session 4

1. Take attendance.
2. Check homework.
3. Review skills.
4. Play relaxation tape, at end of tape give suggestion for a relaxed, alert and focused state of being.
5. Instruct students to attend to what both they and the client are experiencing physiologically during the role play.
6. Role play "Tell me about your day."
7. Process. (Were they able to be relaxed and alert? What was happening to the counselor and client physiologically?)

GROUP IV

Session 4

1. Take attendance.
2. Check homework.
3. Review skills.
4. Role play "Tell me about your day."
5. Process. (Were they able to be relaxed and alert? What was happening to the counselor and client physiologically?)
GROUP I
Session 5
1. Take attendance.
2. Check homework.
3. Review skills assigned to date.
4. Play relaxation tape with cognitive restructuring and of the awareness and exploration stages of experiencing.
5. Role play "Tell me about your day."
6. Assign pages 43 through 49. Stop at exercise 22. Instruct students to review skills assigned to date and to continue use of tape.

GROUP II
Session 5
1. Take attendance.
2. Check homework.
3. Review skills assigned to date.
4. Review A-B-C-D-E model incorporating activating events in students own lives. Instruct students to attend to language of shoulds, musts, everyone, always, while role-playing client and counselor. Also, instruct students to be aware of own emotional and physiological reactions during daily events and during the counseling process.
5. Role play "Tell me about your day."
6. Assign pages 43 through 49. Stop at exercise 22 and instruct students to review skills assigned to date.

GROUP III
Session 5
1. Take attendance.
2. Check homework.
3. Review skills assigned to date.
4. Play relaxation tape.
5. Role play "Tell me about your day."
7. Assign pages 43 through 49. Stop at exercise 22. Instruct students to review skills assigned to date.

GROUP IV
Session 5
1. Take attendance.
2. Check homework.
3. Review skills assigned to date.
4. Role play "Tell me about your day."
6. Assign pages 43 through 49. Stop at exercise 22. Instruct students to review skills assigned to date.

GROUP I

Session 6
1. Take attendance.
2. Check homework.
3. Play tape that now covers the awareness and exploration stages of experiencing, cognitive restructuring, and pairs the counseling situation with the relaxation response.
4. Role play "Tell me about your day."
5. Process, especially the ability to relax, counsel, and counter self-defeating thoughts.
6. Assign pages through 57. Stop at section 5, page 58.

GROUP II

Session 6
1. Take attendance.
2. Check homework.
3. Discuss one student's activating event of the last week.
4. Role play "Tell me about your day."
5. Process. Relate the A-B-C-D-E model to each client and counselor interaction wherever possible. Increase level
awareness of counselor and client physiological reactions and emotional response.

6. Assign pages through 57. Stop at section 5, page 58.

GROUP III
Session 6
1. Take attendance.
2. Check homework.
3. Play relaxation tape. Discuss how students are experiencing relaxation now.
4. Role play "Tell me about your day."
5. Process, especially the ability to relax, counsel.
6. Assign pages through 57. Stop at section 5, page 58.

GROUP IV
Session 6
1. Take attendance.
2. Check homework.
3. Role play "Tell me about your day."
5. Assign pages through 57. Stop at section 5.