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A COMPARISON OF TWO METHODS OF LISTENING SKILLS TRAINING  
FOR PARAPROFESSIONAL RESIDENCE HALLS ASSISTANTS:  
CARKHUFF'S MODEL VERSIS INTERPERSONAL PROCESS RECALL

By

M. Joan Hess

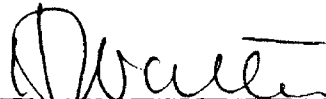
B.A., Kent State University, 1975

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Master of Arts

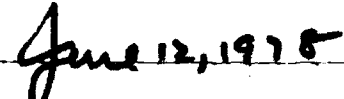
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A Comparison of Two Methods of Listening Skills Training for Paraprofessional Residence Halls Assistants: Carkhuff's Model versus Interpersonal Process Recall (103 pp.)

Director: Herman A. Walters



This study attempted to evaluate the comparative effectiveness of two models of paraprofessional training: Carkhuff's training model and Kagan's Interpersonal Process Recall model. Carkhuff's training program integrated a didactic and experiential approach and involved lectures on the important aspects of a helping relationship, training in discriminating facilitative from nonfacilitative responses and role-plays to practice these helping skills. Kagan's approach involved a minimal lecture presentation followed by affect simulation exercises to develop listening and communication skills and self-awareness, and finally, Interpersonal Process Recall, a structured role-play method which facilitated discussion of the underlying dynamics of the role-play communication.

In a between groups design with repeated measures, five Residence Halls Assistants were assigned to each of three groups: I) Kagan training group; II) Carkhuff training group; or III) Control group. The two training groups each received 12 hours of the appropriate listening skills training while the control group received no training. All 15 subjects were evaluated through ratings of three-minute segments selected from 15 minute pre-training and post-training behavioral role-plays. Two undergraduate students rated the segments with four dependent measures, the Counselor Effectiveness Scale, and Likert scale ratings of eye contact, verbal following and posture. As inter-rater reliabilities for all four dependent measures were quite low, ranging from +.18 to +.54, the results pointed to the need for more accurate measuring instruments and effective rater training in the evaluation of counselor behavior. In addition, the lack of significant differences between the three groups suggested the need for more rigorous and lengthy training in listening and helping skills for paraprofessionals. The implications of these findings bear directly on training requirements for professional counselor preparation.

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## CHAPTER 1

### INTRODUCTION

The purpose of the present study was to compare the relative effectiveness of two methods of listening skills training intended for use with paraprofessional counselors. Paraprofessionals are presently being widely used in direct client contact in the field of mental health (Grzegorek, 1975; Rioch, Elkes, Flint, Usdansky, Newman, & Silber, 1963; Shneidman & Mandelkorn, 1970). Several programs have been developed to meet the growing demand for training for this population (Carkhuff & Truax, 1965a, 1965b; Carkhuff, Piaget, & Pierce, 1968; Danish & Hauer, 1973; Egan, 1974; Ivey, 1971; Kagan, 1973; Kagan, Krathwohl, & Miller, 1963; Kagan & Krathwohl, 1967). Although these programs have individually been shown to be effective in some instances, little comparative research has been done to determine which is the best program, or to identify the most effective elements of any combination of programs.

The two training programs selected for examination in this study were those of Robert Carkhuff and Norman Kagan. These programs were chosen because of their popularity in existing training programs, and because they vary in terms of theoretical background and methods of training, which allows for the possibility that such a comparison may be of appreciable theoretical value.



### The Use of Paraprofessionals

A recent movement in psychology and related fields has been an increasing awareness of the need to rely more heavily on community resources in the treatment of mental patients. This community mental health movement has resulted in experimentation with changes in the roles which are played by mental health workers. Professionals were placed, in some cases, in more consultative positions to lay persons who were involved in more direct patient contact. This change, intended to include more community members in mental health care, was recommended by the Joint Commission on Mental Illness and Health (Ewalt, 1961) which proposed the following objectives for manpower in the mental health fields: 1) a substantial core of professionally trained individuals in many health-related professions; 2) an even larger group of subprofessional individuals to work with the professional staffs; and 3) citizens from the community to work with the professionals. This third manpower objective effected two major changes in the mental health field. The first change was the partial alleviation of the manpower shortage in mental health and related fields. In 1966, Rioch commented, "We are faced with a serious situation of huge numbers of mentally ill people, including or excluding delinquents, dropouts, criminals, and just plain troubled citizens, and a shortage of the professionals who claim to have some knowledge of how to cure, prevent or deal with such problems." (p. 290). In many mental health centers, the need for services was recently far outstripping the supply of such services, just as it was in 1966. At many clinics, the period of waiting before a prospective client requesting professional help

had even an initial session could be six weeks or longer. Professional schools were working at near capacity levels to meet this demand, but were still falling short. Lay mental health workers were increasingly being successfully used to close this gap between demand for services and actual available manpower.

The second effect of the community mental health movement was the involvement of the average citizen in the concern and care for his community's own mental health. "Roles are now being developed in which the citizen is an active positive force for the mental health of the community and its members, including direct therapeutic interaction with its emotionally disturbed members" (Heilig, Farberow, Litman, & Shneidman, 1970, p. 109). This could help dispel the widespread myths about mental health and illness held by the average citizen. In addition, participation by community members in the mental health field could lead to prevention, and earlier detection and treatment as people became increasingly aware of mental health issues and as education in this area became more pronounced. There were advantages for the individual lay person working in the mental health field in that, "they also tend to solve their own problems in helping to solve the problems of others - they become constructive, better integrated citizens themselves." (Rioch, 1966, p. 291).

The movement to use lay "paraprofessional" individuals in the delivery of mental health care was supported by many professionals, some having done research to support this view (Carkhuff, 1966c; Danish & Hauer, 1973; Gordon, 1965; Holzberg, 1965; Newton, 1974; Reiff, 1966). The results of such research have been extremely

encouraging. Many studies have shown that through short-term training, paraprofessionals were found to change positively on indices related to constructive client change (Carkhuff & Truax, 1965b; Gunning, Holmes, Johnson, & Rife, 1965). However, simply showing that paraprofessionals changed on indices related to client change did not provide evidence that they actually effected positive change in real clients. Further research, however, supported this idea (Brown, 1965; Carkhuff, 1969; Carkhuff & Truax, 1965a; Grzegorek, 1975; Heilig et al., 1970; Hurley, 1975; Lee, 1962; Philpott, 1975; Shneidman & Mandelkorn, 1970). Paraprofessionals have been used in such settings as crisis centers (Grzegorek, 1975; Lemole, 1974), suicide prevention centers (Resnik & Hathorne, 1973; Shneidman & Mandelkorn, 1970), university counseling centers (Hurley, 1975; McCarthy, Wasserman, & Ferree, 1975; Myrick & Paré, 1971; Wolff, 1969), mental hospitals (Carkhuff & Truax, 1965a; Cribb, 1972; Evans, 1955; Goldstein & Goedhart, 1973; Haddock & Dundon, 1951; Poetter, Alvarez, Van Den Abell, & Krop, 1974; Poser, 1966; Russell, Neuringer, & Goldstein, 1970; Wallach, 1974), police departments (Barocas, 1973; Danish & Brodsky, 1970; Driscoll, Meyer, & Schanie, 1973; Flint, 1974; Schreiber & Andrews, 1975), drug and alcohol rehabilitation and education programs (Cooke, Wehmer, & Gruber, 1975; Rudow, 1974; Volkman & Cressey, 1964; Wangen, 1972; Yablonsky & Dederich, 1963), schools (Askland, 1973; Ayllon & Wright, 1973; Carbonari Sant'Anna, 1972; Fabian, 1972; Laws, Brown, Epstein, & Hocking, 1971; Parsonson, Baer, & Baer, 1974), community psychiatric rehabilitation centers (Mosher, Reifman, & Menn, 1973), family and children's centers (Reid, Brown,

Hansen, & Sperber, 1973), welfare and health agencies in underprivileged areas (Gelfand, 1973; Gordon, 1965; Pines, 1965; Smith, 1973), medical hospitals (Felton, Wallach, & Gallo, 1974), community mental health centers (Gudowski, 1974; Painter, 1972; Rioch et al., 1963), rehabilitation centers for the physically handicapped (Felton, 1975; Scheffel, 1975), and in university residence halls (Dendy, 1971; Lubetkin, Rynearson, Grzegorek, & Ensign, 1973; Newton, 1974).

The paraprofessional workers in these settings performed a variety of functions, ranging from clerical duties, to implementation of behavior modification programs, to short-term therapy. They also varied in the amount of training received, some getting no training other than on-the-job training and others receiving one to two years of extensive training in therapeutic techniques.

However, the response to the use of paraprofessionals in the field of mental health was not always positive. Many people were opposed to the use of lay persons in the mental health field, except as aides and assistants to free counselors from clerical and other menial tasks (Odgers, 1964; Patterson, 1965; Rosenbaum, 1966; Schlossberg, 1967). Research seemed to show, though, that trained paraprofessionals had much to offer at almost all levels of mental health care delivery. The key to adequate service seemed to depend on the training received. Especially when paraprofessionals were involved in patient contact on an on-going basis, training and regular supervision became important factors determining the quality of services offered.

Several training programs were developed to meet the necessity for training geared to the needs of the paraprofessional worker.

Several of the major training programs that have been formulated were those of Robert Carkhuff and his associates (Carkhuff, 1966a, 1966b, 1966c, 1969a; Carkhuff, Piaget & Pierce, 1968; Carkhuff & Truax, 1965a, 1965b), Gerard Egan (1974), Allen Ivey (Ivey, 1971; Moreland, Ivey, & Phillips, 1973), Norman Kagan and his associates (Danish & Kagan, 1969; Kagan, 1973; Kagan et al., 1963; Kagan et al., 1967; Kagan, Schauble, Resnikoff, Danish, & Krathwohl, 1969; Kagan & Schauble, 1969), Steven Danish (Danish, D'Augelli, & Brock, 1976; Danish & Hauer, 1973; Danish & Brock, 1974; McCarthy, Danish, & D'Augelli, 1977), and Randolph, Howe, and Achterman (1968). These programs differed in theoretical background and in methods of training, but had in common the goal of improved human relationship skills which had broad applicability across a wide range of paraprofessional and professional roles.

Carkhuff's program, which combined didactic and experiential training, concentrated on the development of trainee responses which were at facilitative levels in the core conditions of therapy, as originally defined by Rogers (1957a). Egan proposed a developmental model of training based heavily on Carkhuff's work, which involved skill training in the context of an experiential group (1974). Ivey's Microcounseling technique was based upon a skill training model which utilized videotape modeling and videotape feedback to the trainees (1971). Kagan's Interpersonal Process Recall (IPR) and affect simulation models utilized videotapes to bring the trainees to self-awareness and to give them feedback which would aid them in understanding the underlying process of communication and help them improve their interpersonal communication skills. Danish also developed a skill

training program utilizing didactic knowledge, modeling and practice, to teach basic helping and relationship skills (Danish & Brock, 1974). Randolph, Howe, and Achterman's method of training, known as reflective listening, was a method whereby trainees learned to concentrate on demonstrating understanding of client statements through paraphrasing and then received feedback on the effects of their responses (DiMattia & Arndt, 1974).

Although each training program has been researched to some degree, there have been few comparative studies to determine the relative merits of each model. DiMattia and Arndt (1974), in one of the rare comparative studies, pitted Microcounseling against reflective listening as training programs for introductory counseling students. The results indicated that both training programs effectively imparted attending behavior skills to introductory counseling students. However, the authors concluded that, as the reflective listening technique was less expensive and complicated than the Microcounseling paradigm, it might be more useful.

VanderKolk (1973) compared a Carkhuff-type training approach with a "traditional" approach emphasizing lecture and discussion, but including some role-playing. The Carkhuff-type training group exhibited a significantly greater increase in empathy than the traditional group, and both increased significantly more than the control group. VanderKolk concluded that a structured, systematic approach with emphasis on practice was better than a didactic approach to training which did not seem to produce the specific skills desired.

Other studies comparing individual training programs with each other were rare. The question remained as to whether one training program was superior to the others. In the present study, a comparison was attempted between two of these programs, Kagan's Interpersonal Process Recall training model, and Carkhuff's training model. These two were chosen because of their present popularity and use in existing paraprofessional training programs and because of their theoretical and methodological differences.

#### Carkhuff's Training Model: An Historical Perspective

Carkhuff's training model was developed as an offshoot of his interest in facilitative therapist characteristics as defined by Rogers (1957a). The three necessary conditions for successful therapy and interpersonal relationships were as follows: 1) accurate empathy, or a sensitivity to and understanding of the client's current feelings, both those clearly expressed and those of which the client was barely aware, and the verbal facility to communicate this understanding; 2) nonpossessive warmth (unconditional positive regard) or an acceptance of the client and his feelings and experiences with no conditions placed upon this warmth; and 3) genuineness, or the ability of the therapist to be totally himself in the therapeutic relationship. Perhaps some of the first research in the area of therapist characteristics was performed by Whitehorn and Betz (1954) who found that successful therapists were warm and attempted to understand their patients in a personal, immediate and idiosyncratic way, while the unsuccessful therapists tended to be more impersonal with their patients and

focused more on psychopathology and an external type of understanding. In Betz's (1963a, 1963b) continuation of this research, the descriptions of successful therapists were similar to the facilitative conditions delineated by Rogers.

The development of the research scales of the therapeutic conditions (Truax, 1961, 1962a, 1962b) greatly aided research into the therapist characteristics correlating with effective psychotherapy. The Wisconsin studies, which involved several notable researchers and psychotherapists such as Rogers, Gendlin, Truax, and Kiesler, were among the first studies to demonstrate the relationship between accurate empathy, unconditional positive regard, therapist genuineness and positive therapeutic outcome (Rogers, Gendlin, Kiesler, & Truax, 1967). Truax (1963) summarized the results of several studies suggesting that patients who received high levels of accurate empathy usually improved and patients who received low levels either stayed the same or deteriorated. Similar results occurred when studying the effects of unconditional positive regard and genuineness. In studies comparing psychotherapy groups with no therapy control groups, the average improvement rates for the therapy groups were not much different from those of the control groups. These results were similar to Eysenck's data (1952, 1963). However, further analysis of the results with therapy patients demonstrated that patients receiving high levels of the facilitative conditions showed significant constructive personality change while those receiving low levels became significantly worse (Bergin, 1963; Carkhuff & Truax, 1966). Therefore, the positive results of the first group were cancelled out by the negative



results of the second group, making the total experimental group results no different from the control group results. Most data seemed to indicate that when high levels of facilitative conditions were offered, therapy could be helpful and clients could show improvement rates greater than 70%, which was the expectation for spontaneous improvement. When low levels of the therapeutic conditions were offered, improvement rates were less than 70%, exemplifying the deteriorative effects of low levels of therapeutic conditions (Truax & Wargo, 1966).

In a review of approximately 20 studies comparing these therapeutic conditions to outcome, Truax and Mitchell (1971) concluded that the data suggested that therapists who were empathic, nonpossessively warm, and genuine were effective in psychotherapy and produced positive client change. These findings seemed to hold for therapists of many different orientations and for a wide variety of client types, including hospitalized schizophrenics, college underachievers, juvenile delinquents, mild to severe outpatient neurotics and a variety of others. In addition, the results held for both individual (Truax, 1963) and group therapy (Truax, Carkhuff, & Kodman, 1965). Other support for this view of the facilitative effects of empathy, nonpossessive warmth and genuineness was drawn from a study by Truax and Carkhuff (1965) in which they experimentally manipulated the levels of the three conditions. As expected, the results showed that the clients' depth of self-exploration (Dx scale) dropped when the conditions were lowered and returned to previous levels when the facilitative conditions improved. Other studies (Alexik & Carkhuff, 1967; Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, & Stone, 1966) showed

that the therapist was the main determiner of the level of therapeutic conditions, but the client's depth of self-exploration had differential effects on high and low functioning therapists.

The initial studies on the importance of the three facilitative conditions led Truax, Carkhuff and Douds (1964) to expand Rogers' (1957b) views of therapist training. Rogers emphasized the experiential aspect of training and the importance of a facilitative relationship between the supervisor and the trainee. Other training programs, such as those in medical schools, emphasized a more didactic training approach in which the supervisor taught the trainee his accumulated store of therapeutic knowledge. Truax, Carkhuff and Douds (1964) described a therapist training program which integrated the experiential approach to training with a didactic form of training. The authors felt that a totally didactic training program would not offer trainees the opportunity for self-exploration or the chance to experience a role-model of a therapist they could imitate in psychotherapy. Conversely, a solely experiential training approach would not teach the trainees what specific therapeutic behaviors were helpful to clients. Although experientially-oriented supervisors would shun the thought of "programming" trainee behaviors, they probably did so haphazardly by exposing the trainees to behaviors which they would probably imitate. In the integrated program, "the therapist supervisor brought to bear his knowledge of therapy accumulated from his own experience and the experiences and work of others in the context of a therapeutic relationship which provided for the trainee the conditions which research and clinical learning suggested were essential for psychotherapeutic

personality change." (p. 242).

The therapy supervision, then, was viewed as a special form of therapy; it was viewed as a learning process occurring under the auspices of a deep and meaningful relationship which would facilitate this learning. The three basic elements of the training program were: "1) a therapeutic context in which the supervisor himself provided high levels of therapeutic conditions; 2) a highly specific didactic training in the implementation of the therapeutic conditions; and 3) a quasi-group therapy experience where the trainee could explore his own existence, and his own individual therapeutic self could emerge" (Truax & Carkhuff, 1967, p. 242).

By 1967, the training program was modified as follows (Truax & Carkhuff, 1967):

1) Trainees were initially provided with an extensive reading list and also copies of the three scales, Accurate Empathy, Nonpossessive Warmth and Genuineness.

2) They were required to listen to 25 hours of individual and group therapy tapes and to attempt to rate specific excerpts, some of which had been rated by experienced raters, thus giving them feedback on their discrimination skills.

3) In empathy training, the trainees were presented as a group with a series of tape-recorded patient statements to which they were to respond by reformulating the essential communication of the patient. This was done initially in a "round-robin" format and later, on a random basis.

4) In warmth training, the trainees were asked to concentrate not only on what they said, but also on how they said it. The emphasis was on low pitched, full vocal tones in a slowed rate of speech, communicating the intentness and seriousness of the therapist's response, if appropriate.

5) At this point, trainees were asked to "put more of themselves" into the brief responses in order to make them less rehearsed and mechanical.

6) Trainees were then asked to pair off between the supervisory sessions and tape record role-plays of "therapy." These role-play tapes were brought into the supervisory sessions and random samples were selected to be rated on the therapeutic conditions by the supervisor and trainees as a group.

7) After the trainee achieved minimally high levels of therapeutic conditions in his role-playing, he was given experience in one-shot interviews with actual patients. The goal of these sessions was to establish a good therapeutic relationship. These interviews were recorded and later played back in supervisory sessions and rated by the trainee, other trainees, and the supervisor, providing concrete feedback to the trainee.

8) After the trainee achieved consistent minimally high levels of the therapeutic conditions in single interviews and was able to facilitate moderately high levels of the patients' self-explorations, he began to see patients on a continuing therapeutic basis. These sessions were tape-recorded, and segments were periodically selected for evaluation in the supervisory session.

9) The quasi-group therapy sessions were begun during the sixth week of the training program and met weekly for a two-hour session. In these supervisory groups, time was spent listening to and rating tapes, as was previously described, and also discussing theoretical and clinical issues such as the therapeutic conditions and techniques of various therapeutic orientations, examples being behaviorism and analytic therapies. However, these sessions were not quite as didactic as this would lead one to believe, and also included moments of deep human encounter. These groups provided the experiential base in which the trainees could experience high levels of the facilitative conditions.

Carkhuff and Truax experimented with the training program with two groups of trainees. The first was a group five lay hospital personnel and the second was a group of twelve graduate students. The training programs were short-term in comparison to existing programs and involved approximately 100 hours. Carkhuff and Truax (1965b) reported the results of the two training programs and compared them to the average levels of therapeutic conditions offered by several famous experienced therapists such as Ellis, Rogers, Gendlin, Truax and others. The results indicated that both lay personnel and graduate students could be trained to function at facilitative levels nearly commensurate with those provided by experienced therapists. The three groups performed in the following order on the empathy, unconditional positive regard and genuineness measures: 1) experienced therapists; 2) graduate students; and 3) lay personnel. On client depth of self-exploration, the order was: 1) experienced therapists; 2) lay personnel; and 3) graduate

students. However, the only significant difference between any of the three groups was between the lay personnel and the experienced therapists on the therapist genuineness dimension. On accurate empathy, all groups functioned near stage five (out of nine total). On unconditional positive regard, all functioned around stage three (out of five total) and on genuineness, all groups were near level five (out of seven total). The patients of all three groups functioned near level 4.5 (out of nine total) on the client self-exploration dimension.

In a study comparing the effectiveness of trained lay group therapists against a no-therapy control group, Carkhuff and Truax (1965a) found that on all ratings of patient behavior, the group receiving lay therapy functioned significantly better than the control group. Indeed, only one therapy patient deteriorated, while 12 control patients deteriorated. Thirty-eight therapy patients were rated as improved, while only twelve non-therapy patients were judged to have improved.

These studies would seem to indicate the effectiveness of this training program. Carkhuff's interest in this training program and in therapist training, generally, led him to question the effectiveness of training programs in the helping professions. He was quite vehement in his challenge that traditional training programs demonstrate their efficacy in terms of client benefit (Carkhuff, 1966c) and very definite in his statements about the ability of nonprofessionals to learn to offer the facilitative therapeutic conditions through a well-designed training program. Carkhuff recommended the development

of one to two year training programs designed to produce "therapeutic agents" who worked under supervision (p. 364).

Two studies have been made of the effectiveness of graduate training programs in clinical psychology (Bergin & Soloman, 1963; Carkhuff, Kratochvil, & Friel, 1968). Bergin and Soloman (as reported in Carkhuff, 1966c) found the level of empathic understanding of final year, post-internship graduate students in a long-standing well-known program to be positively correlated with therapeutic competence. However, they also found that the ratings of empathy were negatively related to the students' grade point averages and the students' practicum grade averages. Carkhuff, Kratochvil and Friel (1968) compared the levels of therapeutic conditions offered by various graduate students: 1) first year clinical psychology students; 2) first year non-clinical psychology students; 3) fourth year clinical psychology students; 4) fourth year non-clinical psychology students. They found that in their first year, clinical students were rated significantly higher than non-clinical students in the facilitative conditions. However, the clinical students' levels of therapeutic conditions dropped by their fourth year to approximate the levels offered by their professors, making the difference between the clinical and non-clinical students insignificant. In terms of discrimination skills or the ability to rate therapy excerpts as to the levels of conditions offered, fourth year students, in general, discriminated at significantly better levels than first year students. However, fourth year clinical students did not discriminate at significantly higher levels than first year clinical students. A second study reported ratings of graduate

students during their first and second years. Trainees who remained in school for the second year functioned at lower levels than they had in the first year. They also functioned at lower levels during the first year than did the trainees who dropped out following the first year. These differences, however, were not significant. Carkhuff, Kratochvil, and Friel (1968) also compared a group of graduate students who had gone through training in communication skills and found that these students functioned at significantly higher levels than did the students in the above studies. This group also discriminated at significantly higher levels than the students in the second study. The authors concluded that the results of these studies failed to establish the efficacy of these two graduate training programs. Even in terms of discrimination skills, on which clinical students improved from their first to their fourth years, non-clinical students also improved, suggesting that a clinical training program was unnecessary to bring about this change.

Carkhuff's contribution to the literature concerned with the training of professional and nonprofessional therapists has been voluminous (Carkhuff, 1969a, 1969b, 1973; Carkhuff & Berenson, 1967, 1976, 1977; Carkhuff, Berenson, & Pierce, 1976; Carkhuff & Pierce, 1976; Carkhuff, Pierce, & Cannon, 1977). In his two volume book entitled Helping and Human Relations (1969a; 1969b), he compared the effectiveness of lay and professional training programs and defined his model for human dysfunctioning and treatment. He then presented a comprehensive view of training in the helping professions, including his own newly refined and developed models for selection, training, practice,



and research.

Carkhuff's model of dysfunctioning viewed all interpersonal relationships as deteriorative or constructive. People functioning at deteriorated levels were thought to be the product of a series of negative and retarding relationships, whereas those functioning at constructive levels were thought to be the result of a series of positive relationships in which the other participant offered high levels of facilitative conditions. A large body of evidence indicated that the offering of high levels of facilitative and action-oriented conditions by parents, teachers, counselors, and therapists was related to constructive change or gain on the part of their children, students and clients on both emotional and intellectual indices. Similarly, the initiation of low levels of facilitative and action-oriented dimensions was related to the deterioration of children, students and clients on emotional and intellectual indices (Aspy, Carkhuff, & Douds, 1968; Carkhuff & Berenson, 1967; Kratochvil, Carkhuff, & Berenson, 1969; Rogers et al., 1967). Carkhuff expanded the original facilitative conditions (empathy, unconditional positive regard, and genuineness) to include initiative (action-oriented) facilitative conditions such as confrontation, immediacy of experiencing and concreteness. Carkhuff's model for selection and training flowed directly from the above-mentioned findings. In terms of selection, Carkhuff recommended choosing potential helpers on the basis of their pre-training level of functioning in the helping role. Carkhuff presented methods for assessing communication and discrimination skills through potential helpers' responses to standard

helpee statements and their rating of various levels of helper responses to helpee statements, respectively.

Training was thought to be related to psychotherapy; the principles applying in psychotherapy were hypothesized by Carkhuff to apply to training. He stated that the most effective training programs appeared to be those that: 1) focused upon primary facilitative and action-oriented dimensions complemented by secondary dimensions involving potential preferred modes of treatment, and 2) integrated the didactic, experiential, and modeling aspects of learning (Carkhuff, 1969a, 1969b). In summarizing research which compared trainer levels of facilitative conditions to pre- and post-training levels of trainees, Carkhuff stated: those trainees whose trainers were functioning 1) above minimally facilitative levels (level three); and 2) approximately one level or more above the trainees, demonstrated more positive changes.

As of 1969, Carkhuff's method of training included three subareas: 1) discrimination training; 2) communication training; and 3) training in the development of effective courses of action (Carkhuff, 1969a, 1969b). Training in discrimination of empathy, respect, concreteness, genuineness and self-disclosure and confrontation involved introduction to and training in the rating process and also clarification of the facets of the dimensions, and shaping of trainee discriminations of the levels of these dimensions. Training in communication skills involved three tasks for all of the facilitative conditions: 1) responding to taped material; 2) role-playing; 3) helpee contact. These three tasks were carried out in three environmental

contexts: 1) experiential; 2) didactic; and 3) trainer modeling. Courses of action were the means employed for attaining the goals focused upon in the helping process. Training in the development of effective courses of action involved the contexts of didactic information, trainer modeling and experiential practice of the following steps: I. definition and description of problem area(s); II. definition and description of direction(s) and/or goal(s) dictated by the problem area(s); III. an analysis of the critical dimensions of these direction(s) and/or goal(s); IV. a consideration of the alternative courses of action available for attaining the dimensions of the direction(s) and/or goal(s); V. a consideration of the advantages and disadvantages of the alternative courses of action; VI. the development of physical, emotional-interpersonal, and intellectual programs for achieving that course with the most advantages and fewest disadvantages in terms of ultimate success in goal achievement; VII. the development of progressive gradations of the programs involved. Behavior therapy methods were also presented to trainees in this portion of training.

As can be seen from the above description, Carkhuff's method of training gradually changed from the first description of it (Truax, Carkhuff, & Douds, 1964). The program as described in Helping and Human Relations (Carkhuff, 1969a, 1969b) still incorporated the basic didactic and experiential approach, but also included training in various techniques of therapy such as problem-solving and behavioral interventions.

Since the start of the 70's, Carkhuff made a drastic change in his views of training (Carkhuff, 1973; Carkhuff & Berenson, 1976, 1977; Carkhuff, Berenson, & Pierce, 1976; Carkhuff & Pierce, 1976; Carkhuff, Pierce, & Cannon, 1977). He aimed many of his publications toward a lay audience and became even more radical in his definition of adequate therapy and those who could provide therapy (Carkhuff & Berenson, 1976, 1977). His training program developed to depend more strongly on a didactic base with some experiential components. To the responsive and initiative skills which he identified (Carkhuff, 1969a) as those skills necessary for helping, he added attending and personalizing skills. Attending, the initial skill to be learned, involved attending physically through bodily positioning, observing and listening. The concept of responding was expanded to include responding to content and responding to feeling. Personalizing involved aiding the helpee in becoming aware of his part in the problem, his feelings, and his goals. The final step, initiating, included determining the small steps needed to reach a goal and taking action to accomplish each of the steps (Carkhuff, Pierce, & Cannon, 1977).

Although Carkhuff formerly emphasized discrimination skills and training, he reduced this emphasis greatly. In one of his most recent works, The Art of Helping III (Carkhuff, Pierce, & Cannon, 1977), no mention was made of discrimination skills. However, a discrimination task was used as a pre-post measure of helping skills, indicating that discrimination skills still held a place in his paradigm.

Overall, Carkhuff's recent works went far afield of traditional counseling and psychotherapy skills. In fact, he stated that most

of what occurs in typical counseling and psychotherapy is, at best, immediately irrelevant to human benefits and, at worst, harmful to human growth and development (Carkhuff & Berenson, 1977). Carkhuff emphasized the importance of training as the preferred mode of treatment (Carkhuff & Berenson, 1976). He made several assumptions in prescribing this form of treatment. The first was that human beings were inherently neither good nor bad. the second assumption was that the only way to really teach people how to grow, how to be effective, how to be constructive, or how to be good, was through skills-development. The third assumption was that the most efficient and effective means for teaching people how to develop their resources was through training. Carkhuff's goal for trainees was to turn them into explorative - understanding - actors who made use of all their experience to learn and grow to their limits. His method of bringing them to this was through training in skills which build human resources.

Kagan's Interpersonal Process Recall and Affect Simulation:  
An Historical Perspective

Kagan developed Interpersonal Process Recall (IPR) from a technique first used by Bloom (1954). IPR utilized taped playbacks of various situations to stimulate recall of the underlying dynamics involved in an interpersonal interaction. More specifically, the procedure involved taping an interaction, such as a client-therapist session. The two members of the interaction were then separated, and the tape was played back to each one separately in the presence of a trained third party known as the interrogator or inquirer. The interro-

gator encouraged each member to describe the feelings, physical responses, thoughts or strategies, expectations, fantasies and other reactions which occurred at the time of certain verbal exchanges in order to discover the underlying messages each member of the interaction was sending or wanted to send. These were known as client and therapist recall sessions. Mutual recall occurred when both were involved in one joint recall session.

Initially, IPR was used to facilitate communication in therapy. Kagan et al. (1963) reported a case study in which IPR was useful in enabling both the therapist and client to explore in greater depth many of the subtle or semi-conscious meanings in the interview. They concluded that IPR permitted a breakdown of the usual defenses in an interpersonal interaction and also introspection by all parties involved in a given communication at critical points of the interaction process.

Four specific characteristics of client growth seemed to be most affected by IPR; 1) the client admitted his discomfort. IPR provided the client with extensive information about his own behavior, making it possible for him to see his own embarrassment, fear, or other discomfort in interpersonal situations, and to see the ways in which he maintained and perpetuated the painful experiences. 2) The client committed himself to change. Clients, while observing the replay of the counseling session, became aware of the manner in which they resisted the counselor's efforts, as well as the self-defeating nature of this resistance. 3) The client differentiated stimuli. As the client was confronted with the discrepancies between his

expectations and the counselor's actual behavior during the recall, he began to differentiate individual situations and people, and he learned to cope with one independent of the others. In essence, he learned to perceive the stimuli around him and reacted to them as discrete and separate rather than stereotyped factors. 4) The client behaved differently. IPR allowed the client to view himself as both subject and object and thus to perceive his behavior as others did. He became more able to evaluate his behavior in terms of its impact on both himself and on others (Kagan et al., 1969).

Counselor training was another area in which IPR has successfully been used. This was the use of IPR which was investigated in this study. Statistically significant results were obtained using IPR in controlled studies of counselor education and paraprofessional training (Archer & Kagan, 1973; Kagan et al., 1967). However, in other studies, the results were not quite so favorable (Bradley, 1974; Ward, Kagan, & Krathwohl, 1972). Even though the results in applying IPR to counselor and mental health paraprofessional training programs were equivocal, IPR was used by several programs for training purposes (Grzegorek & Rynearson, 1975; Hagen, unpublished; Lubetkin et al., 1973).

IPR offered a totally different model for therapist supervision than that usually found in therapist training programs. In traditional therapist training, supervision consisted of replaying an audiotape of a therapy session of the trainee. There were two problems involved in this method: 1) the inability to get a representative sample of the counseling experience and 2) the difficulty in recreating the behavior and emotions of the counselor and client.

IPR corrected for the second problem and seemed to provide the following: 1) cues for the recall of cognitive and affective behavior; 2) an immediate and/or delayed playback; 3) an opportunity to introduce a meaningful third person, the supervisor, into a didactic relationship with both the client and counselor; 4) an opportunity for the counselor and/or client to observe himself both subjectively and objectively; 5) an in-depth analysis of the meaning and incipience of both cognitive and affective dimensions through separation of the content into components, sequences, and responses; 6) a recording of the counseling relationship that helped the trainee recognize both his strengths and weaknesses more clearly than did a supervisor's comments; 7) a convenient method of introducing an individual into a previous experience so that this experience could be used for further development or for new insight; and 8) an authentic recreation of counselor behavior for subsequent analysis and evaluation (Ward, Kagan, & Krathwohl, 1972).

In order to intensify the effects of IPR, Kagan and Schauble (1969) explored the use of a technique known as affect simulation. In this technique the client or therapist, depending on the purpose of the session, was presented with a series of videotaped, threatening behaviors. The viewer's reactions were videotaped and IPR was used to aid the individual in recalling his feelings, etc. Four types of affect were originally played in affect simulation: 1) rejection; 2) affection; 3) fear of hostility towards counselor; and 4) fear of affection towards counselor (Kagan & Schauble, 1969). Later, standard films were made in which the actor/acresss looked



directly at the viewer and engaged him/her in intense rejection, pseudo-acceptance, seductiveness, guilt or affection (Archer, Fiester, Kagan, Rate, Spierling, & VanNoord, 1972). Affect simulation was found to be a potent tool when used in conjunction with IPR (Schauble, 1970) or as a treatment by itself (Danish & Brodsky, 1970) or in therapist or paraprofessional training (Lubetkin et al., 1973).

The advantages of adding affect simulation to a training program were three-fold. First, it provided sample cases exemplifying the range of problem severity. Secondly, it promoted desensitization of non-helpful tension or anxiety (Lubetkin et al., 1973). Thirdly, it offered an opportunity for the trainee to explore his reactions, affective, behavioral and verbal, to certain client statements. This self-exploration, prompted by supervisor comments and probes, could lead the trainee to insights concerning his reactions and the effects they would have on a client, had the process exemplified in the affect simulation occurred in therapy. In this fashion, the trainee could determine the therapeutic (or non-therapeutic) value of his reactions without actually taking a chance on harming a client or jeopardizing the therapeutic relationship. In this manner, the supervisor could also be somewhat directive in leading the trainee to more effective therapy behaviors.

In an attempt to increase the potency of IPR and affect simulation as aids in therapy and counselor training, Archer et al. (1972) reported adding another mode of feedback, physiological activity, to the package. They took measures of eccrine sweat rate and heart rate while the subject viewed an affect simulation film. During

the replay, the data on the subject's physiological responses were shown to him along with the videotape playback. They found that certain combinations of heart rate and eccrine sweat rate indicated that the subject was undergoing an intense emotional reaction. This knowledge was used by the interrogator to bring the subject to insights which might have previously been missed.

All these concepts and techniques were combined into a unified training program. Kagan described the general training program as:

"a sequential progression of lessons beginning with a didactic presentation of concepts, then to simulation exercises to interpersonal affective stress, to video and physiological feedback, to study of self-in-action, to feedback from clients and, finally, to understanding of and skill at dealing with the complex bilateral impacts which occur when two people are in relationship with one another." (Kagan, 1973, p. 44).

After years of study and research Kagan decided that counseling and therapeutic behaviors were too complex to be learned by most students through a single type of supervision. This led to the formulation of a supervisory strategy based on certain therapist developmental tasks. These tasks were specific enough so that the majority of students could grasp them, but broad enough to have relevance in therapy.

Kagan identified four characteristics of therapeutic responses which he felt trainees must learn: 1) exploratory; 2) affective; 3) listening; and 4) honest labeling (Kagan, 1973). In his mode of training, these were learned through the observation of different therapist response modes and trainee practice of those responses, in conjunction with affect simulation and both client and mutual recall IPR.

Kagan's goal for therapist training was that training programs consistently graduate effective therapists, as he saw few programs, regardless of orientation, which were able to do so. He advocated increasing the reliability of our training programs and developing methods that would increase the likelihood that most graduates would become effective mental health workers who were able to elicit client change (Kagan, 1973). He attempted to do this through the training program described above which, thus far, has proven somewhat successful (Goldberg, 1967; Spivack, 1972).

#### Rationale and Purpose

As could be seen from the above descriptions, Carkhuff's and Kagan's views of therapy and training differed greatly. Carkhuff's theoretical basis was that of Rogers' client-centered therapy, which Carkhuff expanded and modified until it was almost unrecognizable in comparison with its original form. Kagan's theory was based on the concept that there was a personal response underlying every interpersonal interaction, which, if shared between the interactors, led to more open communication and, subsequently, to client growth and change.

The therapist training programs of each were based on these widely divergent theoretical views of therapy. Carkhuff saw it essential to teach trainees Rogers' facilitative conditions of empathy, unconditional positive regard and genuineness. This was done through a didactic and experiential program which broke therapist skills into the more basic components of attending, responding,

personalizing, and initiating. Kagan's training program of Interpersonal Process Recall involved videotaping trainee counseling sessions (or role-plays) for recall, either by the client, therapist-trainee, or both together. Recall was done to prompt each person to explore the underlying responses, affects, cognitions, etc. which each had but did not express. Another portion of Kagan's training program, affect simulation, induced self-exploration of reactions to uncomfortable therapeutic situations.

So, it seemed that although both programs approached training from a skills development viewpoint, they had different theoretical backgrounds and quite different methods to train effective therapists. In addition, they had different success rates. Carkhuff and others demonstrated the effectiveness of his training program many times (Butler & Hansen, 1973; Carkhuff, 1969a, 1969b; Carkhuff & Truax, 1965a, 1965b; Truax, Carkhuff, & Douds, 1964; VanderKolk, 1973). In contrast, Kagan's program was sometimes shown effective, sometimes ineffective (Archer & Kagan, 1973; Bradley, 1974; Kagan et al., 1967; Ward, Kagan, & Krathwohl, 1973). However, though the research results were equivocal, Kagan's methods of training were widely used as supervisory and training tools (Gimmestad & Greenwood, 1974; Grzegorek & Rynearson, 1975; Hurley, 1975; Lubetkin et al., 1973), attesting to their usefulness for practical application.

However, although both programs were used in the training of professionals and paraprofessionals, one question yet to be answered was whether they were equally effective in performing their function of training or whether one program was more effective and trained

better counselors and therapists, either professional or paraprofessional. If the methods were equally effective, choice of which method of training to use was a matter of individual preference or of ease of implementation of the training program. If they were not equally effective, the less effective training program could be dropped in favor of the more effective program.

This study was an attempt to compare the effectiveness of the two training programs with a paraprofessional population, University Residence Halls Assistants (R.A.'s). This population was used because, although rarely given training in counseling or crisis intervention skills, the job of Residence Halls Assistants often demanded that they perform such functions. In past studies in which students were trained in helping skills they were found to have positive effects on their helpees (Gruver, 1971). More importantly, in a comparison of trained student paraprofessional and professional counselors, the students were rated as equal to or higher than the professionals in evoking self-disclosure from clients (Popi, Nudler, Norden, & McGee, 1967). In another study, students who received academic counseling from trained student advisers obtained higher grade point averages and quality point totals than students who received the same type of counseling from professional counselors (Zunker & Brown, 1966). Newton (1974) demonstrated that Residence Halls Assistants could successfully be trained in listening and helping skills. Training in helping skills, it was hoped, would aid the Residence Halls Assistants in responding more effectively to dormitory residents requesting such assistance and also give them more con-

confidence in dealing with the residents on an interpersonal basis. Therefore, dormitory Residence Halls Assistants were considered to be an appropriate paraprofessional population for use in this study.

## CHAPTER 2

### METHOD

#### Subjects

Subjects used in this study were Residence Halls Assistants from the University of Montana. The dormitories at the University of Montana employed 66 Residence Halls Assistants. All of these Assistants were contacted by phone and the seventeen subjects were those who volunteered to participate. Participation was encouraged as a means for the Residence Halls Assistants to improve their skills in an area of probable benefit to them because of the nature of their jobs. Six female and eleven male subjects from 20 to 26 years of age agreed to participate. Their educational levels varied from junior year in college to second year of graduate school. An attempt was made to randomly assign subjects to groups, however, assignment to groups was also dependent on subjects' schedules and was therefore not totally randomized. The three groups were: 1) Experimental Group I, which received Kagan's Interpersonal Process Recall and affect simulation training; 2) Experimental Group II, which received Carkhuff's model of helping skills training; and 3) Control Group, which received no training. Originally, six subjects were assigned to both Experimental Group I and the Control Group and five subjects were assigned to Experimental Group II. Data on one

control subject, however, was lost due to scheduling error. Subsequently, for ease of analysis, one subject was randomly dropped from Experimental Group I, leaving five subjects per group for a total of fifteen subjects.

#### Apparatus

Closed circuit video recorders and monitors were used in the pre- and post-testing and the training portions of this study. In pre- and post-testing, recordings were made of 15 minute behavioral role-play situations which were rated at a later time. In addition, videotapes were used to show identical pre-taped client presentations to both experimental groups during training. In Experimental Group I, this was done in the affect simulation portion of training. In Experimental Group II, this was done so the subjects could practice responding to client concerns. There were ten of these pre-taped presentations, which were about one to two minutes in length and depicted graduate students in client roles, making client statements with strong affective content. Experimental Group II also viewed pre-taped videotapes of client-therapist role-plays portrayed by graduate students in the discrimination training section of the program. Portable cassette tape players were used to audiotape trainee role-plays in the training portions for both Experimental Groups.

Stimulus Materials. Separate mimeographed handouts to supplement the didactic portions of training were given to each experimental group. The handouts given to Group I are shown in Appendix A. Those for Group II are shown in Appendix B and Appendix C.



Procedure

Design. Both experimental groups received four, three hour training sessions, for a total of twelve hours of training. A between groups design comparing the two training groups with each other and with a no-training control group was used in this study. Subjects in all three groups received both a pre-test and a post-test.

Training. Trainers for both experimental groups were experienced graduate students in clinical psychology at the University of Montana who had finished at least one and a half years of graduate work. They were students who had exhibited interest in the present study and agreed to participate as trainers. The lecture portions of training for both Group I and Group II were performed by the Experimenter, with the trainers being used for the remaining portions of training. Three separate trainers were used for each experimental group, for a total of six trainers. Both groups of trainers received two hours of training and practice in the techniques they were to use in training the Residence Halls Assistants.

Training sessions for Group I consisted of the following components:

1) Lecture. This was the didactic portion of training. For Group I this portion of training was based on Kagan's view of the important dimensions of listening. He described counselor responses in terms of four dichotomous dimensions: a) affective - cognitive; b) understanding - nonunderstanding; c) specific - non-specific; d) exploratory - nonexploratory. During the lecture portions

of training, these were explained in more detail to the trainees and examples of the dimensions were presented.

2) Affect Simulation exercises. This portion of the training involved the presentation of videotaped client statements of approximately one to two minutes in length. After these presentations, trainees were divided into small groups of two to four trainees and one trainer for discussion of the client statement. Discussion of each statement was limited to 13 to 14 minutes, making each simulation a total of 15 minutes in length. The basic goals of affect simulation were the development of listening and communication skills and also the development of self-awareness. To accomplish the first goal, the following questions were helpful for the trainers to ask:

a) What kinds of concerns or problems is the client expressing?  
b) What kinds of feelings are being expressed by the client?  
c) What needs is the client expressing? d) What kind of response would you feel is important for the client at this point? In order to accomplish the goal of self-awareness, the following questions were asked: a) What feelings do you have about the client statement? b) How do you verbally respond when you have these feelings? c) How do you act when you have such feelings: d) Is your behavior (reaction) likely to be helpful or not helpful to the communication process? e) (Optional) How else might you handle or express your own feelings? (Grzegorek, 1975; Hagan, unpublished).

3) Interpersonal Process Recall (IPR). This portion of training involved role-plays, again in small groups. Two trainees role-played a client-therapist interaction for five minutes. The interac-

tion was audiotaped, and subsequently played back for the recall. During the recall session, the trainer served as an inquirer (Kagan, 1975) and attempted to facilitate communication between the "therapist" and the "client" about the interaction. The inquirer acted as an objective third party, aiding the trainees in giving feedback to each other about how they related during specific exchanges. Only mutual recall was used and both the therapist and the client gave feedback to each other and attempted to recall their feelings, thoughts, motives and other covert processes during specific exchanges of the role-play (Kagan, 1975). A list of possible inquiry questions is presented in Appendix D. Normally, recall lasted about ten minutes, but it sometimes varied depending on the discussion which recall elicited.

Training sessions for Group I were scheduled as follows:

- Session 1. One hour of lecture on listening skills; one-half hour affect simulation (listening and communication skills); one-half hour affect simulation (self-awareness); one hour of lecture and demonstration of IPR.
- Session 2. One-and-one-half hour affect simulation (combined type); one-and-one-half hour IPR.
- Session 3. One hour affect simulation (combined type); Two hours IPR.
- Session 4. Three hours IPR.

Training sessions for Group II included the following:

- 1) Lecture. This portion of the training program involved didactic presentations of Carkhuff's model of listening skills. The lecture material was adapted mainly from Carkhuff and his associates' recent books, The Art of Helping III (1977), Teacher as Person

(1976), and The Skills of Teaching: Interpersonal Skills (1976).

Carkhuff divided helping behavior into four main skills to be acquired: attending, responding, personalizing, and initiating. Attending involved attending physically, observing, and listening. Responding was performed to both feelings and content. Personalizing involved enabling the client to understand where he stood in relation to his goal. Personalizing the meaning of the situation, the problem, the feelings and the goals were all important aspects of this step. The final step, initiating, involved formulating a goal and the small steps which could be taken to achieve the goal. In the lecture portion of training, these four skills were explained in greater detail and examples were presented.

2) Discrimination Training. This portion of training was performed in small groups of four to five trainees with a trainer. Trainees were trained to discriminate different levels of the facilitative conditions of therapy in this portion of training. They were trained to use the Carkhuff Empathy, Unconditional Positive Regard, and Genuineness Scales (Carkhuff, 1969b). Initially, the trainees used the rating scales to rate therapy tapes of graduate students role-plays and compared their ratings to those of the trainers. The second step in discrimination training involved the playing of pre-taped client statements to which each trainee formulated a response. The responses were then rated by the trainees. The final step involved the rating of role-plays between trainees. This portion of discrimination training was explained more fully in the section on role-plays.

3) Role-plays. In this portion of training, also performed

in small groups, one trainee role-played a client role and a second trainee performed a therapist role. The role-plays, which lasted about five minutes, were audiotaped. Afterwards, they were replayed and therapist statements were rated with the scales mentioned in the section on discrimination training. In addition, the trainers facilitated a discussion centering around Carkhuff's four skills, attending, responding, personalizing and initiating. The discussion and rating session lasted for about ten minutes per role-play.

Training sessions for Group II were scheduled as follows:

Session 1. One hour of lecture on attending skills; one hour training in the use of the rating scales; one hour rating of pre-taped client-therapist interactions.

Session 2. One hour of lecture on responding skills; one hour practice responding to pre-taped client statements and ratings; one hour role-plays, ratings, and discussion.

Session 3. One hour of lecture on personalizing skills; one-half hour practice responding to pre-taped client statements and ratings; one-and-one-half hour role-plays, ratings, and discussion.

Session 4. One hour of lecture on initiating skills; one-half hour practice responding to pre-taped client statements and ratings; one-and-one-half hour role-plays, ratings, and discussion.

#### Outcome Measures

The pre- and post-tests for all three groups consisted of fifteen minute behavioral role-play samples between the trainees and a female undergraduate student enacting a client role. The subjects

were instructed to treat the student as if she were a student on their floor who had come to them for help and to attempt to be as helpful to her as possible. For the pre-test, the undergraduate student role-played the part of a transfer student feeling depressed because of poor social relationships. In the post-test, the same undergraduate student role-played the part of a student feeling anxious because of difficulties in schoolwork. These situations were selected because of their relevance to the situations normally encountered by Residence Halls Assistants. The role-play student was dressed in casual student attire and was instructed to respond similarly to each subject, presenting the same situation to each and using the same affective range.

The role-plays were videotaped and a three minute segment was randomly selected from the latter seven-and-a-half minutes of each role-play. Ratings of the segments were made by two undergraduate students who had received three training sessions and two practice sessions in rating, for a total of five hours of training in the use of the four dependent measures. As in DiMattia and Arndt (1974), three five-point Likert-type rating scales for skills in eye contact, verbal following and posture (Appendix E) were used to evaluate the degree to which trainees acquired attending behavior. DiMattia and Arndt (1974) obtained inter-rater reliabilities of +.63, +.57, and +.85, respectively, in using these three scales.

Ratings on the Counselor Effectiveness Scale (Ivey, 1971) were used to evaluate overall helping effectiveness (Appendix F). This particular scale was chosen for use in the present study because

of its usefulness in prior studies evaluating the effectiveness of paraprofessional training programs (Ivey, 1971). In addition, its applicability in evaluating a counselor's effectiveness following only a short interview or role-play made the CES more appropriate for this study than other scales of counselor behavior, which required the development of a long-term therapeutic relationship before the scales could be used. Two parallel forms of the CES were developed and the parallel forms' reliability was found to be .975, significant beyond the .001 level of confidence. Validity was inferred because of the ability of both scales to significantly differentiate between a rationally defined good model and a rationally defined bad model of counselor behavior (Ivey, 1971). Inter-rater reliability when using undergraduate student raters was calculated by Ivey (1971) to be +.37. Only Form A of the CES was used in this study.

## CHAPTER 3

### RESULTS

#### Inter-rater Reliability

Inter-rater reliabilities were calculated using the Pearson Product Moment correlation coefficient. Raters were given two training sessions, and attained a reliability across all four measures of +.61 prior to rating the experimental segments. They were then given one additional training session, but, because of time constraints, were not re-tested prior to rating the experimental tape segments.

Inter-rater reliabilities for the experimental data were calculated separately for each of the four measures. The correlation coefficients ranged from +.18 to +.54 and are presented in Table 1. As none of the inter-rater reliabilities reached the minimal criterion of +.70, raters were included as a factor in the analysis of variance. This was done in order to separate the rater effects from the treatment and repeated measures effects.

#### Experimental Results

All four dependent measures were separately subjected to a 3 x 2 x 2 analysis of variance, including one between-subjects factor and two within-subjects factors. The first factor was the factor due to treatments and had three levels. The second factor



TABLE 1

INTER-RATER RELIABILITIES: N = 2

Counselor Effectiveness Scale	+ .18
Likert Scale Ratings	
Eye Contact	+ .48
Verbal Following	+ .32
Posture	+ .54

was the repeated measures factor and the last factor was due to raters. These latter two factors each had two levels. All main and interaction effects were analyzed through application of an F-test.

The analysis of the data from the Counselor Effectiveness Scale revealed no significant main or interaction effects (see Table 2). The first main factor, that due to treatments, approached significance ( $F = 3.046$ ,  $df = 2, 12$ ,  $p = .08$ ), but as these effects were not evident in the interaction of treatments x repeated measures, they were presumed to be due to initial differences between the groups (see Figure 1), and, therefore, not of concern to this study.

Analysis of the second dependent measure, eye contact, revealed two significant interaction effects, the repeated measures x rater interaction ( $F = 5.333$ ,  $df = 1, 2$ ,  $p < .05$ ) and the treatment x repeated measures x rater interaction ( $F = 6.333$ ,  $df = 2, 12$ ,  $p = .01$ ) (see Table 3, Figure 2). The latter will be interpreted as it includes the effects of the former. As is shown in Figures 3, 4, and 5, the raters varied depending on which group was being rated and also on which rating, pre- or post-, was being considered. For Group I, the Kagan model of training, Rater One increased her mean ratings from pre- to post-testing, and Rater Two, whose mean ratings were above those of Rater One on pre-testing, decreased her mean ratings from pre- to post-testing. For Group II, the Carkhuff model of training, Rater One did not change her mean ratings from pre- to post-testing, while Rater Two, whose ratings were initially lower than those of Rater One, increased her mean ratings at post-testing to equal Rater One's ratings. For the Control Group,

TABLE 2  
COUNSELOR EFFECTIVENESS SCALE ANOVA SUMMARY TABLE

Sources	SS	df	MS	F
Treatments	1937.63	2	968.817	3.046
S(Treatments)	3817.30	12	318.108	
Repeated Measures	18.15	1	18.15	0.056
Treatments x Repeated Measures	440.10	2	220.05	0.680
S(Treatments) x Repeated Measures	3883.50	12	323.628	
Raters	570.417	1	570.417	1.491
Treatments x Raters	56.2333	2	28.1167	0.073
S(Treatments) x Raters	4592.10	12	382.675	
Repeated Measures x Raters	22.8167	1	22.8167	0.103
Treatments x Repeated Measures x Raters	69.2333	2	34.6167	0.156
S(Treatments) x Repeated Measures x Raters	2660.70	12	221.725	

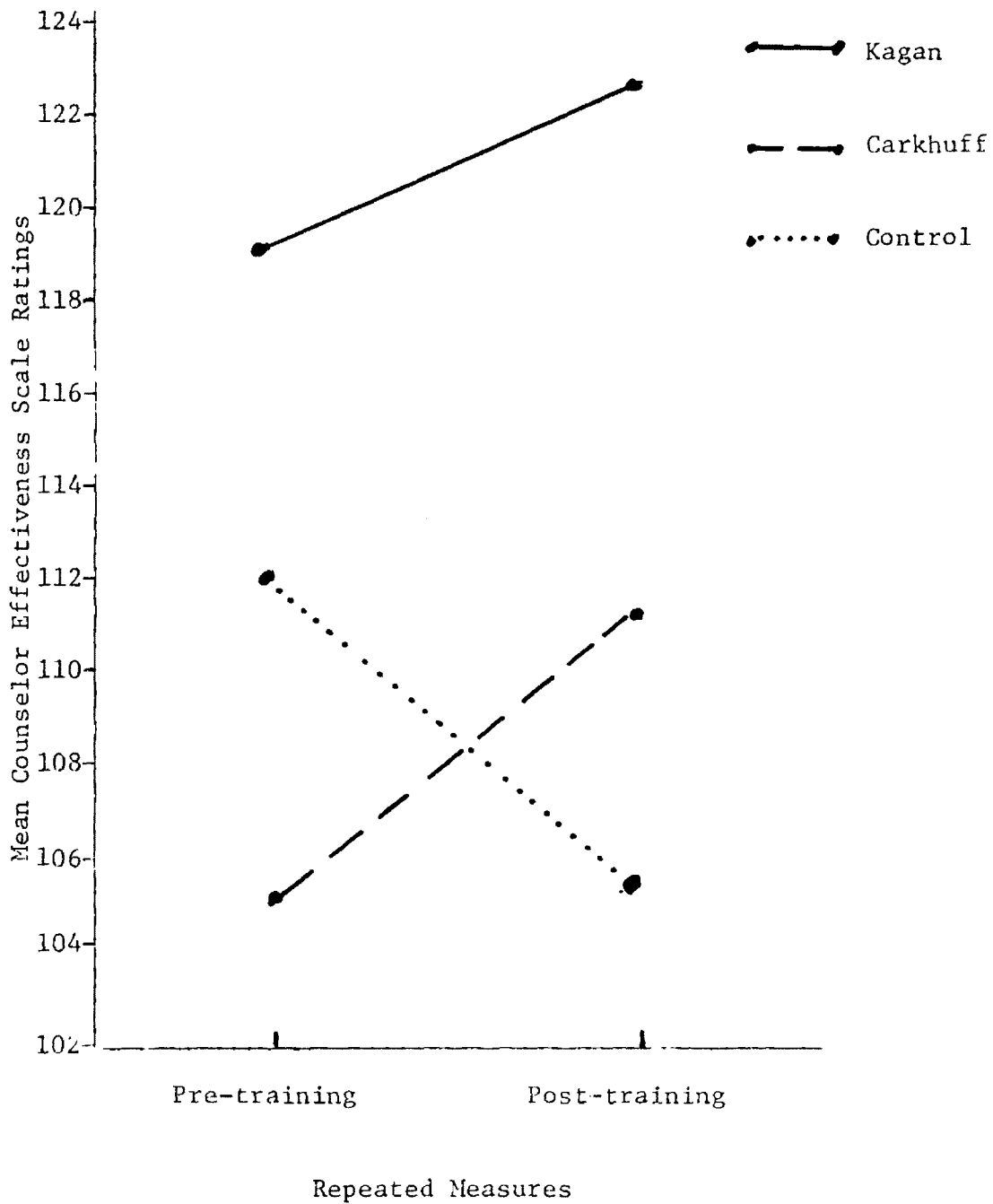


Figure 1. MEAN COUNSELOR EFFECTIVENESS SCALE RATINGS AS A FUNCTION OF TREATMENT AND REPEATED MEASURES

TABLE 3

## EYE CONTACT ANOVA SUMMARY TABLE

Sources	SS	df	MS	F
Treatments	5.73333	2	2.86667	2.000
S(Treatments)	17.200	12	1.43333	
Repeated Measures	0.06667	1	0.06667	0.211
Treatments x Repeated Measures	0.13333	2	0.06666	0.211
S(Treatments) x Repeated Measures	3.80000	12	0.31667	
Raters	0.60000	1	0.60000	2.400
Treatments x Raters	0.40000	2	0.20000	0.800
S(Treatments) x Raters	3.00000	12	0.25000	
Repeated Measures x Raters	1.06667	1	1.06667	5.333*
Treatments x Repeated Measures x Raters	2.53333	2	1.26667	6.333*
S(Treatments) x Repeated Measures x Raters	2.40000	12	0.20000	

\*  $p < .05$

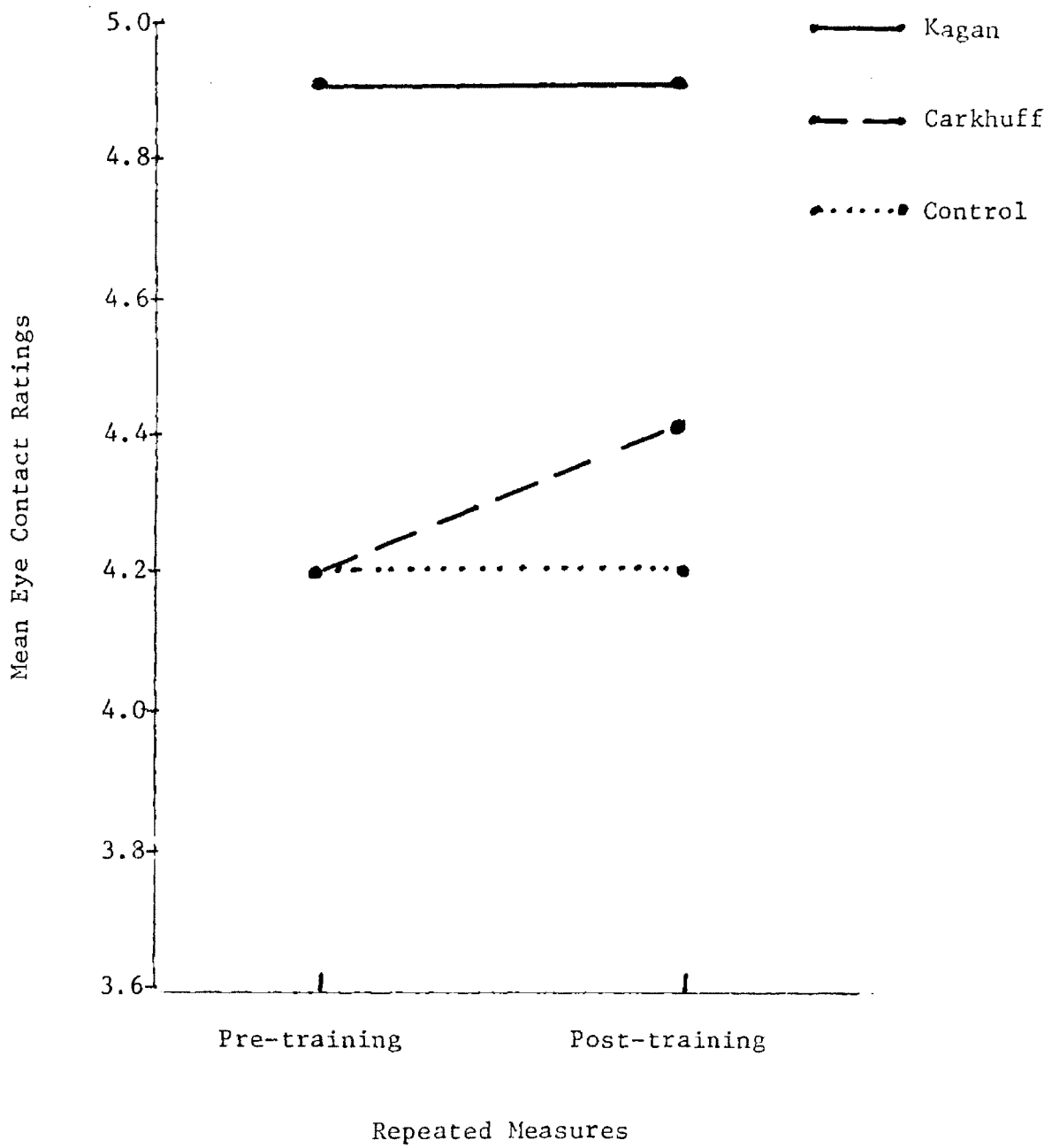


Figure 2. MEAN EYE CONTACT RATINGS AS A FUNCTION OF TREATMENT AND REPEATED MEASURES

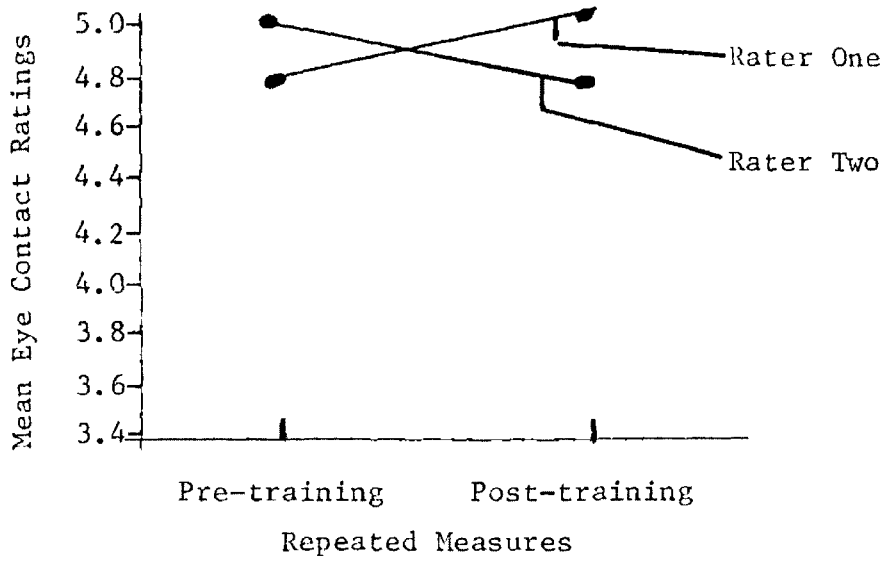


Figure 3. GROUP I: MEAN EYE CONTACT RATINGS

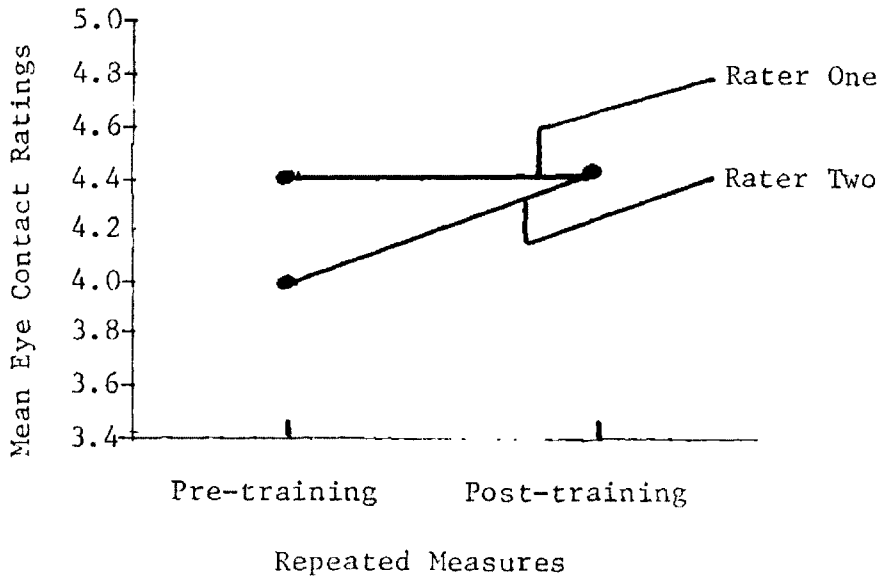
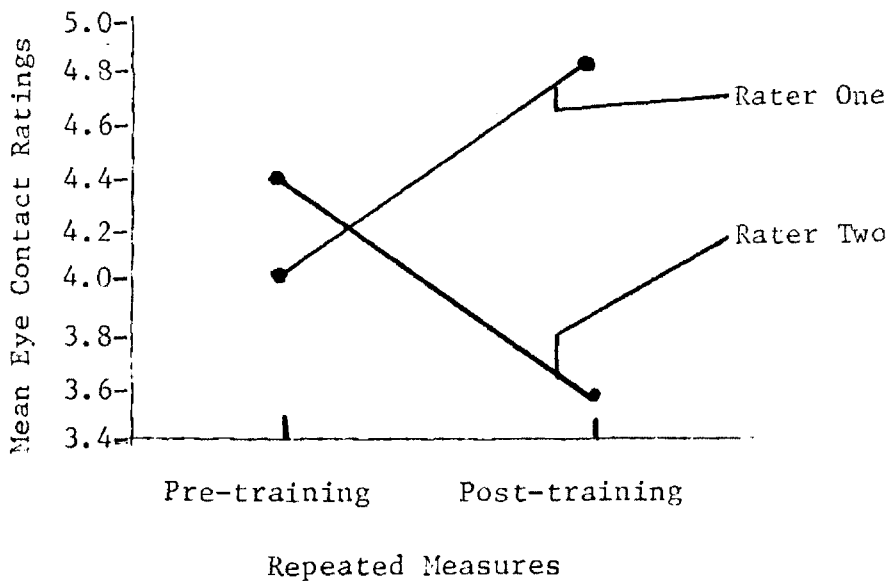


Figure 4. GROUP II: MEAN EYE CONTACT RATINGS



GROUP III: MEAN EYE CONTACT RATINGS

Rater One again increased her mean ratings from pre- to post-testing, while Rater Two again decreased her mean ratings from pre- to post-testing.

The analysis of the third dependent measure, Verbal Following, revealed two significant main effects (see Table 4). The first indicated pre- to post- differences ( $F = 4.745$ ,  $df = 2, 12$ ,  $p < .05$ ). As can be seen in Figure 6, the ratings for all three groups increased from pre- to post-testing on this measure. Although Figure 6 seems to indicate a slight tendency for both of the experimental groups to increase more from pre- to post-testing than the control group, the treatment x repeated measures interaction was nonsignificant ( $F = .745$ ,  $df = 1, 12$ ,  $p = .50$ ). The second significant effect was due to raters ( $F = 21.512$ ,  $df = 1, 12$ ,  $p < .001$ ). As is evident in Figures 7, 8, and 9, Rater One consistently rated subjects higher on this measure than did Rater Two.

Analysis of the fourth dependent measure, Posture, revealed no significant main or interaction effects (see Table 5, Figure 10).

Mean ratings on all measures for all experimental conditions are shown in Appendix G.



TABLE 4  
 VERBAL FOLLOWING ANOVA SUMMARY TABLE

Sources	SS	df	MS	F
Treatments	0.90000	2	0.45000	1.459
S(Treatments)	3.70000	12	0.30833	
Repeated Measures	2.01667	1	2.01667	4.745*
Treatments x Repeated Measures	0.63333	2	0.31667	0.745
S(Treatments) x Repeated Measures	5.10000	12	0.42500	
Raters	7.35000	1	7.35000	21.512***
Treatments x Raters	0.30000	2	0.15000	0.439
S(Treatments) x Raters	4.10000	12	0.34167	
Repeated Measures x Raters	0.15000	1	0.15000	0.783
Treatments x Repeated Measures x Raters	0.30000	2	0.15000	0.783
S(Treatments) x Repeated Measures x Raters	2.30000	12	0.19167	

\*  $p < .05$

\*\*\*  $p < .001$

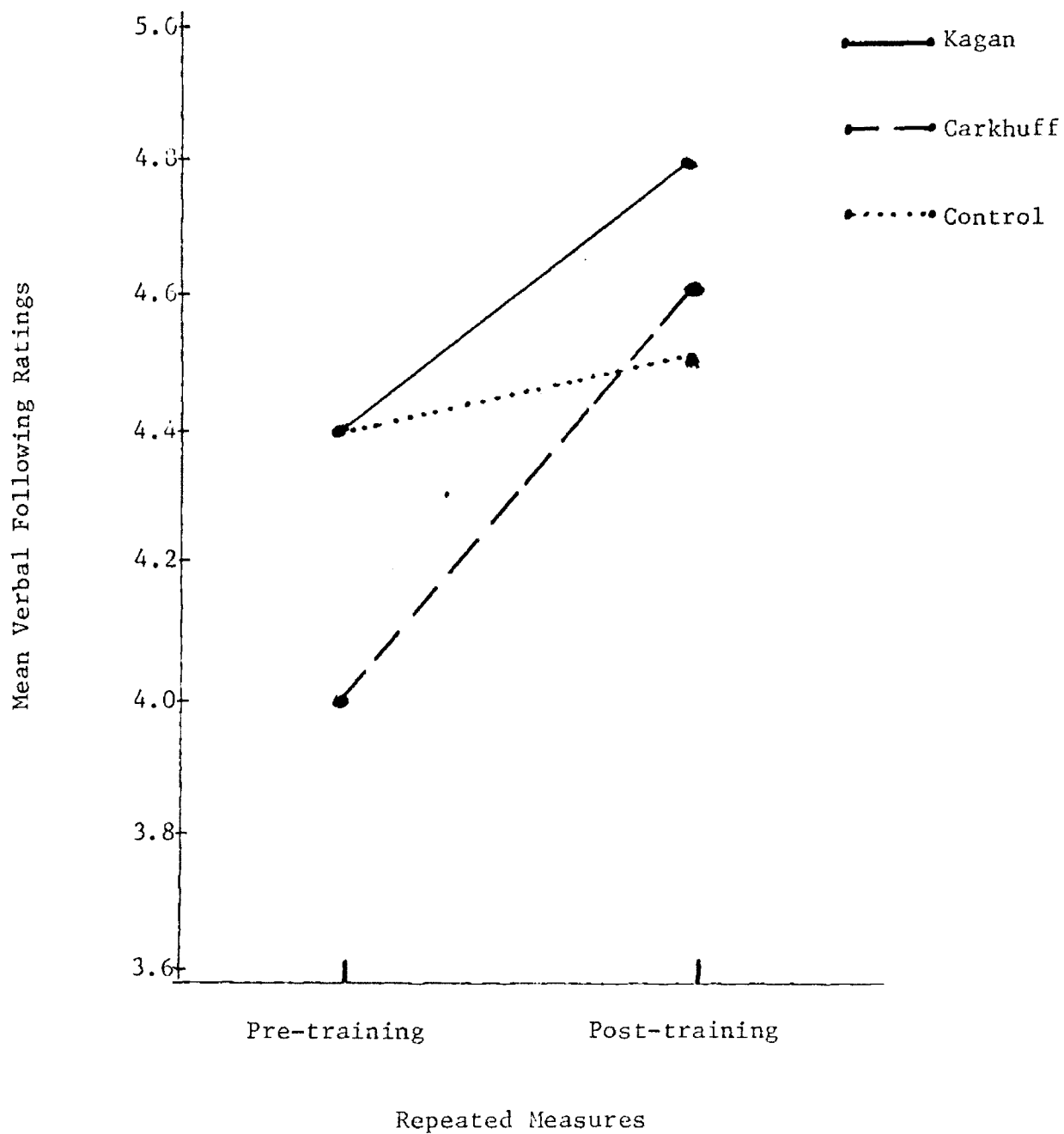


Figure 6. MEAN VERBAL FOLLOWING RATINGS AS A FUNCTION OF TREATMENT AND REPEATED MEASURES

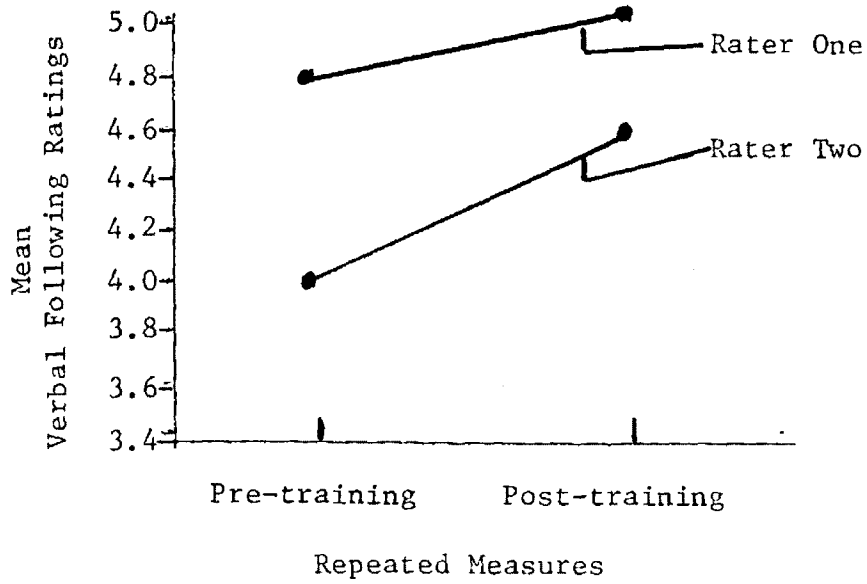


Figure 7. GROUP I: MEAN VERBAL FOLLOWING RATINGS

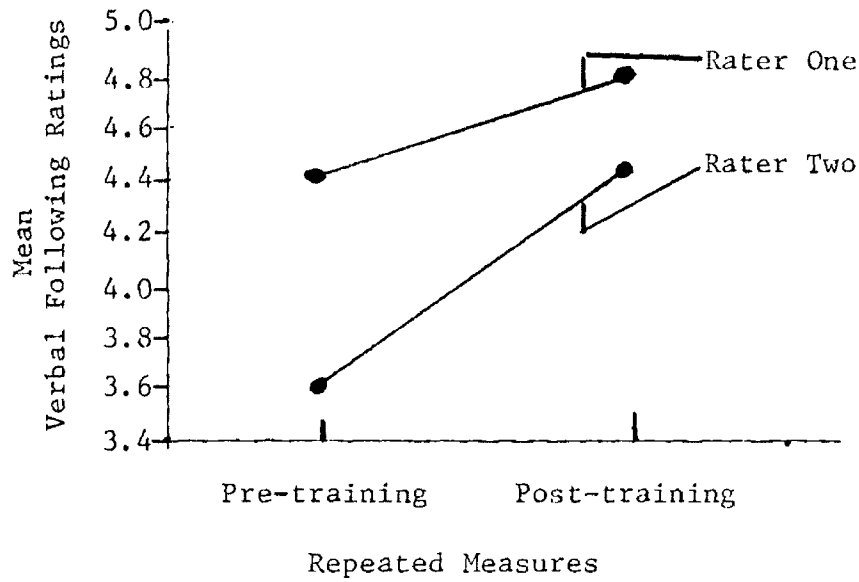


Figure 8. GROUP II: MEAN VERBAL FOLLOWING RATINGS

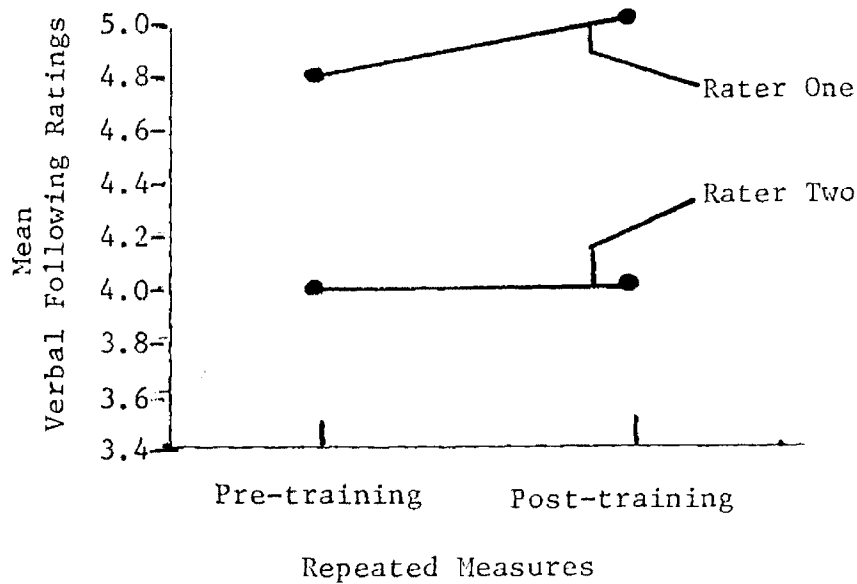


Figure 9. GROUP III: MEAN VERBAL FOLLOWING RATINGS

TABLE 5  
POSTURE ANOVA SUMMARY TABLE

Sources	SS	df	MS	F
Treatments	2.10000	2	1.05000	0.933
S(Treatments)	13.5000	12	1.12500	
Repeated Measures	0.15000	1	0.15000	0.234
Treatments x Repeated Measures	1.90000	2	0.95000	1.481
S(Treatments) x Repeated Measures	7.70000	12	0.64167	
Raters	0.41667	1	0.41667	1.351
Treatments x Raters	0.63333	2	0.31667	1.027
S(Treatments) x Raters	3.70000	12	0.30833	
Repeated Measures x Raters	0.15000	1	0.15000	0.947
Treatments x Repeated Measures x Raters	0.70000	2	0.35000	2.211
S(Treatments) x Repeated Measures x Raters	1.90000	12	0.15833	

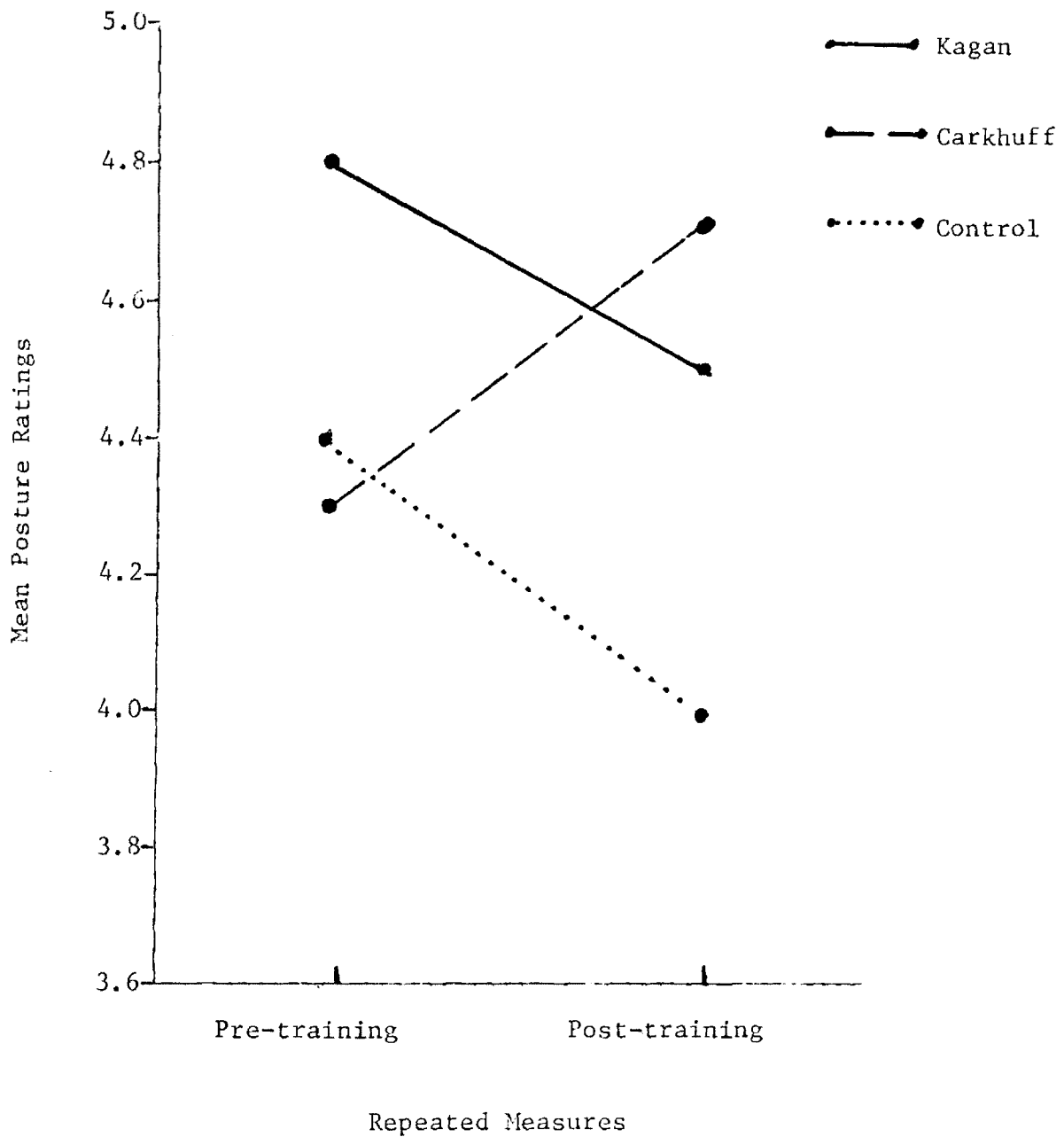


Figure 10. MEAN POSTURE RATINGS AS A FUNCTION OF TREATMENT AND REPEATED MEASURES

## CHAPTER 4

### DISCUSSION

The results of this study indicated no significant differences between the three groups on any of the four dependent measures. In addition, there were no significant pre- to post- changes on three of the four dependent measures. These findings could lend support to two interpretations of the data. The first interpretation was that neither of the two training programs was more effective than the other. This point was obvious, but warranted elaboration as it related to the original purpose of the study. The study was proposed in the hope of demonstrating that one of the two training programs, Carkhuff's or Kagan's, would prove to be more effective. As neither program led to any appreciable changes from pre- to post-testing, neither was shown to be effective and, consequently, neither could be more effective than the other. This latter statement relates to the second interpretation of the data, which is that neither of the two training models led to a significant increase in the trainees' levels of listening skills and that both training models were, therefore, ineffective in the present study. This interpretation was based on the lack of differences between the training groups and the control group on any of the four dependent measures. This view was further supported by the repeated measures analysis, which indicated that on

three of the four measures, the subjects performed similarly on both the pre- and post-tests. On the fourth measure, Verbal Following, all three groups, including the control group, increased from pre- to post-testing, indicating that the increase was probably due to nonspecific measurement effects rather than to training effects. The ineffectiveness of both training models in the present study may be due to the short length of the present training program. Perhaps the skills being taught were too complex to be adequately mastered in twelve hours of training. This point will be elaborated further later in this chapter.

Perhaps one of the most striking findings of this study was the difficulty in obtaining adequate inter-rater reliabilities. Four hours of rater training resulted in an inter-rater reliability over all four measures of  $+0.61$ . A final one-hour training session was then held in an attempt to raise the reliability to the pre-set criterion of  $+0.70$ . The raters were not re-evaluated prior to rating the experimental segments, though, because of lack of time. For the experimental segments, the inter-rater reliabilities dropped from this previous level and ranged from  $+0.18$  to  $+0.54$  for the four measures. Although this low level of inter-rater reliability was statistically controlled by including the raters as a factor in the analysis of variance, the effects of the low reliabilities on the experimental results could not be assessed totally, and it is impossible to determine if the results were due to lack of treatment effects or to measurement error. The low reliabilities of the ratings would seem to indicate inaccurate measurement of the dependent variables and perhaps

the training groups did improve their listening skills, but these positive findings were obscured by this inaccuracy in measurement.

The drop in reliability from the training segments to the experimental segments could possibly be due to the nature of the segments. The 20 training segments consisted of role-plays between two pairs of graduate students. As there were only two different counselors to be rated, it was easier for the raters to develop an internal "standard" or criterion for comparison upon which they based their ratings, causing the ratings to be non-independent (Gormally & Hill, 1974). The experimental segments, which were taken from the subjects' pre- and post- role-plays, were more variable and it was thus more difficult for the raters to arrive at an internal "standard" of comparison in rating these segments.

Findings which related to the inter-rater reliability problem were also indicated in the analysis of variance. On the Eye Contact measure, there was a significant treatment x rater x repeated measures interaction. This indicated a tendency for the raters to differ from each other depending on which measurement, pre- or post-, was being rated and also depending on which group the subject being rated was from. For the Kagan training group, Rater Two decreased her mean ratings from pre- to post-testing while Rater One, who originally rated the segments lower than did Rater Two, increased her mean ratings from pre- to post-testing. When rating the Carkhuff subjects, Rater One's pre- and post- ratings were equal, but Rater Two, who rated the pre-test segments lower than did Rater One, increased her mean post-test ratings to equal those of Rater One. For the



Control Group, Rater One again increased her mean post-test ratings over her pre-test ratings, while Rater Two did the opposite, and decreased her mean ratings from pre- to post-testing. The conclusion derived from these results was that a rating of eye contact was a particularly difficult evaluation to make from videotapes of role-plays. It may be that, as the "counselor" and "client" were facing each other directly in the role-plays and the rater viewed the interaction from a 90° angle, it was hard for the raters to discern where the counselor was looking, leading to increased probability of error in making this measurement.

On the dependent measure of Verbal Following, rater differences were again prominent. There was a highly significant difference between the raters on this measure and Rater One consistently rated subjects higher than did Rater Two. However, since their ratings were somewhat parallel (see Figures 7, 8, and 9), it would seem that the difference was due to consistent differences in the personal criterion each rater used in rating subjects on this dependent measure.

Knauss (1978) also had difficulty in obtaining adequate inter-rater reliabilities when training undergraduate raters to evaluate counselor behavior. It may be that it is difficult for undergraduates to rate counselors on variables selected as important in therapy. This could occur because of the complexity of counselor behaviors, which cannot be broken down into sufficiently discrete components to be easily evaluated by students who have only minimal experience with, and knowledge of the aspects of therapy which are usually conceded to be most important. Knauss (1978) came to essentially similar conclu-

sions and stated that undergraduate raters of counselor behaviors are required to make difficult judgments about a very complex human interaction on the basis of a brief sample of taped behavior. It is difficult for undergraduates with little clinical experience to make ratings with a scale which has no specified counselor behaviors to use as anchoring points. Raters who are also experienced therapists may rate segments differently than non-therapist raters, simply because of their increased knowledge of the potential range of facilitative responses (Gormally & Hill, 1974), knowledge which raters who have no therapy experience do not possess.

A second reason for the lack of positive findings may be due to the type of subjects used. It is possible that, as the subjects were fairly young, ranging in age from 20 to 26 years, they were not mature enough to be able to grasp the nature of the desired skills. This explanation would be based on the premise that a certain amount of maturity is necessary for an individual to be able to attend properly to the needs of another person and, more importantly, to be able to put oneself "into the other's shoes," a component of empathy. It is quite possible that age functioned as a mediating factor and that some or all of the trainees did not have the necessary maturational predispositions and, thus, could not take advantage of the potential benefits of the training program, particularly in the time frame allowed by this particular program.

As mentioned previously, the lack of positive results in this study may have also been partially due to the short-term nature of the training program. The length of training chosen for this program was

initially felt to be appropriate for two reasons. The first, although not the most important reason a short-term training program was chosen was because of the volunteer nature of the study. Several potential subjects reported that they could not participate because 12 hours was too much time for them to commit to the program. It was clear that, had the training time been lengthened, more subjects would have found the time constraints imposed by the training program to be too extensive, preventing them from participating. The second and most important reason for choosing a short-term training program was that there have been several successful programs of a similar length reported in the literature. Goldstein and Goedhart (1973) reported that, after a ten-hour training program in empathy skills incorporating lecture, modeling and reinforced practice, trained subjects scored higher than control subjects on measures of empathy. In a study comparing a 16-hour Carkhuff training program with a no-training control group, the overall results showed the Carkhuff group to score significantly higher than the control group on empathy measures (Berenson, Carkhuff, & Myrus, 1966). Similar findings were obtained in a ten-hour Carkhuff training program conducted by Butler and Hansen (1973). Spivack (1972) compared a 15-hour Interpersonal Process Recall graduate student training group with a training group receiving a more traditional didactic form of training. The IPR group scored significantly higher than the control group on three out of five measures. Short-term training was also reported to be effective with Residence Halls Assistants: Newton (1974) found that a 12-hour communication skills training program resulted in trained Residence Halls Assistants' obtaining significantly higher empathy scores

than non-trained Residence Halls Assistants. Therefore, it seemed likely that a short-term listening skills training program would be effective with Residence Halls Assistants, and would provide a reasonable basis for testing the hypotheses which were of interest in the present study.

Although there was evidence in the literature favoring short-term training programs, the results of the present study would seem to indicate that the counselor and helper behaviors which were being trained in this procedure were too complex to be taught through either of the two training programs in 12 hours. Danish and D'Augelli (1976), in describing their paraprofessional training program, recommended at least 25 hours of training as they felt that this was the minimum time necessary for most trainees to attain the level of skill required for helping. Carkhuff's program was originally designed to involve 100 hours of training (Carkhuff & Truax, 1965b) and this length was also suggested when Carkhuff modified the program (Carkhuff, 1971). Other existing Kagan-type training programs have also been longer in length. The crisis intervention training program described by Grzegorek and Rynearson (1975) was 48 hours long and the peer counseling training program designed by Hurley (1975) was over 80 hours long. In a training program designed for a population similar to that in the present study, the length of a Residence Hall Staff training program using a Kagan model was 64 hours (Lubetkin, et al., 1973).

Perhaps the length of training necessary to teach paraprofessionals basic listening skills needs to be addressed more carefully as a separate research issue. The results of the present study seemed

to indicate that a longer training period is necessary, even though other studies have demonstrated success with short-term programs. Further research addressing this issue directly would seem to be necessary to resolve this conflict, though the results of this study indicated the ineffectiveness of short-term training and pointed to the need for longer training programs.

This finding, that short-term paraprofessional training did not seem to increase the participants' levels of listening skills, has implications for professional counselor training. Counselor and paraprofessional training programs are similar in certain respects. Both have as their goal the development of helping and listening skills. However, counselor and therapist training usually rely more heavily on intellectual training in psychopathology and related topics while paraprofessional training relies more heavily on experiential training designed to promote understanding. In addition, counselor and therapist training both lay heavy emphasis on the "expert" role of the therapist, while paraprofessional training emphasizes the indigenous nature of the paraprofessional, which has been found to lead to greater rapport and understanding, but without the sophistication and smoothness of technique which professional counselors possess (Pope et al., 1976; Zunker & Brown, 1966). The results of this study would seem to indicate the need for more rigorous and lengthy training programs for paraprofessionals. This recommendation is doubly important in the training of professional counselors and therapists who are required to possess a broader base of knowledge and who usually deal with more severe mental health problems than do paraprofessionals. In addition,

the professionals are usually required to supervise the paraprofessionals, necessitating a thorough familiarity with counseling and therapeutic behaviors and problems.

The second recommendation suggested by the results of this study is that evaluations of the effectiveness of training programs for both professionals and paraprofessionals be made more carefully. Further, closer attention needs to be paid to the adequacy of the evaluation procedures, which proved inadequate in this study because of the difficulty in obtaining adequate levels of inter-rater reliability. This variable has, all too often, been overlooked in previous studies, which made gross assumptions about the reliability and validity of the outcome measures being used. Further attempts to assess training effects are wasted without sound instruments and scales for use as outcome measures.

## CHAPTER 5

### SUMMARY

A recent movement in psychology and related mental health fields has been the increased reliance on community resources in the treatment of mental patients. This movement was motivated by two factors: 1) the increased demand for mental health services, which professionals have difficulty meeting; and 2) the involvement of the average citizen in the concern and care for his community's mental health. One result of the community mental health movement was the use of paraprofessionals or nonprofessionals who were usually indigenous to the population being served. The increasing use of paraprofessionals led to the development of programs to train the paraprofessionals to provide mental health services. Two of the most interesting and widely used programs were the training model of Robert Carkhuff and Interpersonal Process Recall, developed by Normal Kagan. Carkhuff's program combined a didactic and experiential approach and involved lectures on the important aspects of a helping relationship, training in discriminating facilitative from nonfacilitative responses and role-plays to practice these helping skills. Kagan's approach involved a minimal lecture presentation followed by affect simulation exercises to develop listening and communication skills and self-

awareness, and finally, Interpersonal Process Recall, a structured role-play method which facilitated discussion of the underlying dynamics of the role-play communication.

Although both programs were individually shown to be effective, there were no comparative studies attempting to demonstrate the superiority of one program over another. This study was performed in an attempt to compare the effectiveness of Carkhuff's training program and Kagan's Interpersonal Process Recall program in training paraprofessional Residence Halls Assistants listening skills.

Five Residence Halls Assistants were assigned to either the Carkhuff training group, the Kagan training group or a no-training control group. The two training groups each received 12 hours of the appropriate listening skills training. Pre- and post-ratings were based on 15 minute behavioral role-plays between each of the 15 trainees and a bogus "client." Random three-minute segments from the role-plays were rated by two undergraduate raters on four measures, the Counselor Effectiveness Scale, an eye contact rating, a verbal following rating, and a posture rating.

Inter-rater reliabilities for the four measures were quite low and ranged from +.18 to +.54, so raters were included as a factor in the analysis of variance. Results on all four dependent measures were separately subjected to a 3 x 2 x 2 analysis of variance, including the factor due to treatments, the repeated measures factor, and lastly, the factor due to raters. The analysis indicated no treatment effects.



These results seemed to show that neither training program was more effective than the other and, further, that neither was more effective than the control group. The ineffectiveness of the training groups was postulated to be the result of two factors: 1) the low inter-rater reliabilities which may have biased the results; and 2) the short-term nature of the training programs.

The difficulty in obtaining adequate inter-rater reliabilities in this study would seem to indicate the necessity for more extensive training for raters of counselor behaviors and also the need for closer attention to the assessment procedures used in studies evaluating paraprofessional and professional training programs. A further implication of the present study stemmed from the finding that short-term training did not increase Residence Halls Assistants' levels of listening skills. Although previous studies using short-term training programs were successful, the lack of positive results in the present study did not provide support for the notion that short-term paraprofessional training increases the participants' levels of listening skills.

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## APPENDIX A

### IPR COUNSELOR VERBAL RESPONSE SCALE

The Counselor Verbal Response Scale is an attempt to describe a counselor's response to client communication in terms of four dichotomized dimensions: (a) affective-cognitive; (b) understanding-nonunderstanding; (c) specific-nonspecific; (d) exploratory-nonexploratory. These dimensions have been selected because they seem to represent aspects of counselor behavior which seem to make theoretical sense and contribute to client progress. A fifth dimension -- effective-non-effective -- provides a global rating of the adequacy of each response which is made independently of the four descriptive ratings.

The unit for analysis is the verbal interaction between counselor and client represented by a client statement and counselor response. A counselor response is rated on each of the five dimensions of the rating scale, with every client-counselor interaction being judged independently of preceding units. In judging an individual response the primary focus is on describing how the counselor responded to the verbal and nonverbal elements of the client's communication.

#### Description of Rating Dimensions

##### I. Affective-cognitive dimension

The affective-cognitive dimension indicates whether a counselor's response refers to any affective component of a client's communica-

tion or concerns itself primarily with the cognitive component of that communication.

A. Affective responses -- Affective responses generally make reference to emotions, feelings, fears, etc. The judge's rating is solely by the content and/or intent of the counselor's response, regardless of whether it be reflection, clarification, interpretation. These responses attempt to maintain the focus on the affective component of a client's communication. Thus they may:

- (a) Refer directly to an explicit or implicit reference to affect (either verbal or nonverbal) on the part of the client.

Example: "It sounds like you were really angry at him."

- (b) Encourage an expression of affect on the part of the client.

Example: "How does it make you feel when your parents argue?"

- (c) Approve of an expression of affect on the part of the client.

Example: "It doesn't hurt to let your feelings out once in a while, does it?"

- (d) Present a model for the use of affect by the client.

Example: "If somebody treated me like that I'd really be mad."

Special care must be taken in rating responses which use the word "feel." For example, in the statement "Do you feel that your student teaching experience is helping you get the idea of teaching?", the phrase "Do you feel that ..." really means "Do you think that ...?" Similarly the expression "How are you feeling?" is often used in a matter-of-fact, conversation manner. Thus, although the verb "to feel" is used in both these examples, these statements do not represent responses which would be judged "affective."

B. Cognitive responses -- Cognitive responses deal primarily with the cognitive element of a client's communication. Frequently such responses seek information of a factual nature. They generally maintain the interaction on the cognitive level. Such responses may:

- (a) Refer directly to the cognitive component of the client's statement.

Example: "So, then, you're thinking about switching your major to chemistry?"

- (b) Seek further information of a factual nature from the client.

Example: "What were your grades last term?"

- (c) Encourage the client to continue to respond at the cognitive level.

Example: "How did you get interested in art?"

## II. Understanding-nonunderstanding dimension

The understanding-nonunderstanding dimension indicates whether a counselor's response communicates to the client that the counselor understands or is seeking to understand the client's basic communication, thereby encouraging the client to continue to gain insight into the nature of his concerns.

A. Understanding responses -- Understanding responses communicate to the client that the counselor understands the client's communication - the counselor makes appropriate reference to what the client is expressing or trying to express both verbally and nonverbally - or the counselor is clearly seeking enough information of either a cognitive or affective nature to gain such understanding. Such responses:

- (a) Directly communicate an understanding of the client's communication.

Example: "In other words, you really want to be treated like a man."

- (b) Seek further information from the client in such a way as to facilitate both the counselor's and the client's understanding of the basic problems.

Example: "What does being a man mean to you?"

- (c) Reinforce or give approval of client communications which exhibit understanding.

Example: CL: "I guess then when people criticize me, I'm afraid they'll leave me."

CO: "I see you're beginning to make some connection between your behavior and your feelings."

B. Nonunderstanding responses -- Nonunderstanding responses are those in which the counselor fails to understand the client's basic communication or makes no attempt to obtain appropriate information from the client. In essence, nonunderstanding implies misunderstanding. Such responses:

- (a) Communicate misunderstanding of the client's basic concern.

Example: CL: "When he said that, I just turned red and clenched my fists."

CO: "Some people don't say nice things."

- (b) Seek information which may be irrelevant to the client's communication.

Example: CL: "I seem to have a hard time getting along with my brothers."



CO: "Do all your brothers live at home with you?"

(c) Squelch client understanding or move the focus to another irrelevant area.

Example: CL: "I guess I'm really afraid that other people will laugh at me."

CO: "We're the butt of other people's jokes sometimes."

Example: CL: "Sometimes I really hate my aunt."

CO: "Will things be better when you go to college?"

### III. Specific-nonspecific dimension

The specific-nonspecific dimension indicates whether the counselor's response delineates the client's problems and is central to the client's communication or whether the response does not specify the client's concern. In essence, it describes whether the counselor deals with the client's communication in a general, vague, or peripheral manner, or "zeros in" on the core of the client's communication. NB: A response judged to be nonunderstanding must also be nonspecific since it would, by definition, misunderstand the client's communication and not help the client to delineate his concerns. Responses judged understanding might be either specific (core) or nonspecific (peripheral) i.e. they would be peripheral if the counselor conveys only a vague idea that a problem exists or "flirts" with the idea rather than helping the client delineate some of the dimensions of his concerns.

A. Specific responses -- Specific responses focus on the core concerns being presented either explicitly or implicitly, verbally or nonverbally, by the client. Such responses:

(a) Delineate more closely the client's basic concerns.

Example: "This vague feeling you have when you get in tense situations, is it anger or fear?"

- (b) Encourage the client to discriminate among stimuli affecting him.

Example: "Do you feel \_\_\_\_\_ in all your classes or only in some classrooms?"

- (c) Reward the client for being specific.

Example: CL: "I guess I feel this way most often with someone who reminds me of my father."

CO: "So as you put what others say in perspective, the whole world doesn't seem so bad, it's only when someone you value, like Father, doesn't pay any attention that you feel hurt."

B. Nonspecific responses -- Nonspecific responses indicate that the counselor is not focusing on the basic concerns of the client or is not yet able to help the client differentiate among various stimuli. Such responses either miss the problem area completely (such responses are also nonunderstanding) or occur when the counselor is seeking to understand the client's communication and has been presented with only vague bits of information about the client's concerns. Thus such responses:

- (a) Fail to delineate the client's concern and cannot bring it into sharper focus.

Example: "It seems your problem isn't very clear. Can you tell me more about it?"

- (b) Completely miss the basic concerns being presented by the client even though the counselor may ask for specific details.

Example: CL: "I've gotten all A's this year and I still feel lousy."

CO: "What were your grades before then?"

- (c) Discourage the client from bringing his concerns into sharper focus.

Example: "You and your sister argue all the time. What do other people think of your sister?"

#### IV. Exploratory-nonexploratory dimension

The exploratory-nonexploratory dimension indicates whether a counselor's response permits or encourages the client to explore his cognitive or affective concerns, or whether the responses limits a client's exploration of these concerns.

A. Exploratory responses -- Exploratory responses encourage and permit the client latitude and involvement in his response. They may focus on relevant aspects of the client's affective or cognitive concerns but clearly attempt to encourage further exploration by the client. Such responses are often open-ended and/or are delivered in a manner permitting the client freedom and flexibility in response. These responses:

- (a) Encourage the client to explore his own concerns.

Example: Cognitive - "You're not sure what you want to major in, is that it?"

Affective - "Maybe some of these times you're getting mad at yourself, what do you think?"

- (b) Assist the client to explore by providing him with possible alternatives designed to increase his range of responses.

Example: Cognitive - "What are some of the other alternatives that you have to history as a major?"

Affective - "In these situations do you feel angry, mad, helpless, or what?"

(c) Reward the client for exploratory behavior.

Example: Cognitive - "It seems that you've considered a number of alternatives for a major, that's good."

Affective - "So you're beginning to wonder if you always want to be treated like a man."

B. Nonexploratory responses -- Nonexploratory responses either indicate no understanding of the client's basic communication, or so structure and limit the client's responses that they inhibit the exploratory process. These responses give the client little opportunity to explore, expand, or express himself freely. Such responses:

Discourage further exploration on the part of the client.

Example: Cognitive - "You want to change your major to history."

Affective - "You really resent your parents treating you like a child."

V. Effective-noneffective dimension

Ratings on the effective-noneffective dimension may be made independently of ratings on the other four dimensions of the scale. This rating is based solely upon the judge's professional impression of the appropriateness of the counselor's responses, that is, how adequately does the counselor's response deal with the client's verbal and nonverbal communication. This rating is not dependent on whether the response has been judged affective-cognitive, etc.

A rating of 4 indicates that the judge considers this response among the most appropriate possible in the given situation while a 3 indicates that the response is appropriate but not among the best. A rating of 2 indicates a neutral response which neither measurably affects client progress nor inhibits it, while a rating of 1 indicates a response which not only lacks basic understanding of the client's concerns but which in effect may be detrimental to the specified goals of client growth.

This scale was developed as a part of a project supported by a grant from the U. S. Department of Health, Education and Welfare, Office of Education, "Exploration of the Potential Value of Interpersonal Process Recall Technique (IPR) for the Study of Selected Educational Problems" (Project Nos. 7-32-0410-216 and 7-32-0410-270).

## APPENDIX B

### CARKHUFF'S SCALES FOR ASSESSMENT OF INTERPERSONAL FUNCTIONING\*

Scale 1: Empathic Understanding in Interpersonal Processes: A Scale for Measurement.

#### Level 1

The verbal and behavior expressions of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated himself.

Examples: The first person communicates no awareness of even the most obvious, expressed surface feelings of the second person. The first person may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the other person(s).

In summary, the first person does everything but express that he is listening, understanding, or being sensitive to even the feelings of the other person in such a way as to detract significantly from the communications of the second person.

#### Level 2

While the first person responds to the expressed feelings of the second person(s), he does so in such a way that he subtracts noticeable affect from the communications of the second person.

Examples: The first person may communicate some awareness of obvious surface feelings of the second person, but his communications drain off a level of the affect and distort the level of meaning. The first person may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the second person.

In summary, the first person tends to respond to other than what the second person is expressing or indicating.

### Level 3

The expressions of the first person in response to the expressed feelings of the second person(s) are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.

Example: The first person responds with accurate understanding of the surface feelings of the second person but may not respond to or may misinterpret the deeper feelings.

In summary, the first person is responding so as to neither subtract from nor add to the expressions of the second person; but he does not respond accurately to how that person really feels beneath the surface feelings. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

### Level 4

The responses of the first person add noticeably to the expressions of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express himself.

Example: The facilitator communicates his understanding of the

expressions of the second person at a level deeper than they were expressed, and thus enables the second person to experience and/or express feelings he was unable to express previously.

In summary, the facilitator's responses add deeper feeling and meaning to the expressions of the second person.

#### Level 5

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

Examples: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wave length. The facilitator and the other person might proceed together to explore previously unexplored areas of human existence.

In summary, the facilitator is responding with a full awareness of who the other person is and a comprehensive and accurate empathic understanding of his deepest feelings.



Scale 2: The Communication of Respect in Interpersonal Processes:  
A Scale for Measurement

Level 1

The verbal and behavioral expressions of the first person communicate a clear lack of respect (or negative regard) for the second person(s).

Example: The first person communicates to the second person that the second person's feelings and experiences are not worthy of consideration or that the second person is not capable of acting constructively. The first person may become the sole focus of evaluation.

In summary, in many ways the first person communicates a total lack of respect for the feelings, experiences, and potentials of the second person.

Level 2

The first person responds to the second person in such a way as to communicate little respect for the feelings, experiences, and potentials of the second person.

Example: The first person may respond mechanically or passively or ignore many of the feelings of the second person.

In summary, in many ways the first person displays a lack of respect or concern for the second person's feelings, experiences and potentials.

Level 3

The first person communicates a positive respect and concern for the second person's feelings, experiences, and potentials.

Example: The first person communicates respect and concern for the second person's ability to express himself and to deal constructively with his life situation.

In summary, in many ways the first person communicates that who the second person is and what he does matter to the first person.

Level 3 constitutes the minimal level of facilitative interpersonal functioning.

#### Level 4

The facilitator clearly communicates a very deep respect and concern for the second person.

Example: The facilitator's responses enable the second person to feel free to be himself and to experience being valued as an individual.

In summary, the facilitator communicates a very deep caring for the feelings, experiences, and potentials of the second person.

#### Level 5

The facilitator communicates the very deepest respect for the second person's worth as a person and his potentials as a free individual.

Example: The facilitator cares very deeply for the human potentials of the second person.

In summary, the facilitator is committed to the value of the other person as a human being.

Scale 3: Facilitative Genuineness in Interpersonal Processes:

A Scale for Measurement

Level 1

The first person's verbalizations are clearly unrelated to what he is feeling at the moment, or his only genuine responses are negative in regard to the second person(s) and appear to have a totally destructive effect upon the second person.

Example: The first person may be defensive in his interaction with the second person(s) and this defensiveness may be demonstrated in the content of his words or his voice quality. Where he is defensive he does not employ his reaction as a basis for potentially valuable inquiry into the relationship.

In summary, there is evidence of a considerable discrepancy between the inner experiencing of the first person(s) and his current verbalizations. Where there is no discrepancy, the first person's reactions are employed solely in a destructive fashion.

Level 2

The first person's verbalizations are slightly unrelated to what he is feeling at the moment, or when his responses are genuine they are negative in regard to the second person; the first person does not appear to know how to employ his negative reactions constructively as a basis for inquiry into the relationship.

Example: The first person may respond to the second person(s) in a "professional" manner that has a rehearsed quality or a quality concerning the way a helper "should"

respond to that situation.

In summary, the first person is usually responding according to his prescribed role rather than expressing what he personally feels or means. When he is genuine his responses are negative and he is unable to employ them as a basis for further inquiry.

#### Level 3

The first person provides no "negative" cues between what he says and what he feels, but he provides no positive cues to indicate a really genuine response to the second person(s).

Example: The first person may listen and follow the second person(s) but commits nothing more of himself.

In summary, the first person appears to make appropriate responses that do not seem insincere but that do not reflect any real involvement either. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

#### Level 4

The facilitator presents some positive cues indicating a genuine response (whether positive or negative) in a nondestructive manner to the second person(s).

Example: The facilitator's expressions are congruent with his feelings, although he may be somewhat hesitant about expressing them fully.

In summary, the facilitator responds with many of his own feelings, and there is no doubt as to whether he really means what he says. He is able to employ his responses, whatever their emotional content, as a basis for further inquiry into the relationship.

## Level 5

The facilitator is freely and deeply himself in a nonexploitative relationship with the second person(s).

Example: The facilitator is completely spontaneous in his interaction and open to experiences of all types, both pleasant and hurtful. In the event of hurtful responses, the facilitator's comments are employed constructively to open a further area of inquiry for both the facilitator and the second person.

In summary, the facilitator is clearly being himself and yet employing his own genuine responses constructively.

\* (from Carkhuff, 1969b)

## APPENDIX C

### HANDOUTS FOR CAR KHUFF TRAINING GROUP

#### Attending

Attending establishes the basis for helping someone and prepares the person for a helping relationship. Attending means to give your attention to the helpee. This is done through the following skills:

##### Attending physically

- Informing the helpee of your availability and readiness

- Encouraging

##### Attend personally

- Attending to helpee's immediate needs

- Physical posture

- Eye contact

##### Observing

- Context or environment

- Appearance and behavior

##### Listening

- Resist distractions

- Suspend your judgment

- Listen for cues to feelings and the SWH of the situation

- Look for common themes

## Responding

Responding involves entering the helpee's frame of reference and communicating an understanding of the helpee's experience. It aids the helpee in exploring where he or she is and gives the helpee the feeling that you are "with him" in his exploration of his experience and feelings. Responding involves:

## Responding to Content

Format: "You're saying \_\_\_\_\_." or "In other words \_\_\_\_\_."

## Responding to Feeling

Format: "You feel \_\_\_\_\_."

## Responding to Feeling and Content

Format: "You feel (feeling) because (content)."

Categories of Feelings

Levels of Intensity	Happy	Sad	Angry	Scared	Confused	Strong	Weak
Strong	Excited	Hopeless	Furious	Fearful	Bewildered	Potent	Overwhelmed
	Elated	Sorrowful	Seething	Panicky	Trapped	Super	Impotent
	Overjoyed	Depressed	Enraged	Afraid	Troubled	Powerful	Small
Mild	Cheerful	Upset	Annoyed	Threatened	Disorganized	Energetic	Incapable
	Up	Distressed	Frustrated	Insecure	Mixed-Up	Confident	Helpless
	Good	Down	Agitated	Uneasy	Foggy	Capable	Insecure
Weak	Glad	Sorry	Uptight	Timid	Bothered	Sure	Shaky
	Content	Lost	Dismayed	Unsure	Uncomfortable	Secure	Unsure
	Satisfied	Bad	Put Out	Nervous	Undecided	Durable	Soft



## Personalizing

Personalizing moves beyond simply responding to the helpee's experience and adds the helper's perspective on why the helpee's experience is so important to him and what his personal deficits are that are contributing to the problem. Personalizing aids the helpee in understanding where he or she is in relation to his or her goal. Personalizing involves:

Laying a base of interchangeable responses

Personalizing the meaning

Format: "You feel \_\_\_\_\_ because you \_\_\_\_\_."

Personalizing the problem

Format: "You feel \_\_\_\_\_ because you cannot \_\_\_\_\_."

Personalizing the feeling

Format: "You feel \_\_\_\_\_ because you cannot \_\_\_\_\_."

Personalizing the goal

Format: "You feel \_\_\_\_\_ because you cannot \_\_\_\_\_ and you would like to \_\_\_\_\_."

## Initiating

Initiating involves developing a specific plan to reach the goal. It helps the helpee act to get from where he or she is to where he or she wants to be. Initiating involves:

Operationalizing goals in observable and measurable terms

Format: "You want to (personalized goal) as indicated by (operational definition of the personalized goal)."

Initiating steps to the goal

define the goal

first step

intermediary steps

Initiating a schedule

start dates

completion dates

Initiating reinforcements

## APPENDIX D

### IPR QUESTIONS\*

- (1) What are you thinking at this point?
- (2) What are you feeling at this point?
- (3) Do you think the counselor is understanding your thoughts and feelings at this point?
- (4) What did you want the counselor to think about you at this point?
- (5) What did you want the counselor to feel about you at this point?
- (6) What would you have rather heard at this point?
- (7) What would have been more helpful at this point?
- (8) What do you think about the counselor/client at this point?
- (9) What do you feel about the counselor/client at this point?
- (10) What is the counselor/client telling you here?
- (11) What was your physical response?
- (12) Did you have any strategies?
- (13) How did you want to react? What were the risks involved?
- (14) What did you think the caller wanted of you?
- (15) Did you have any fantasies?
- (16) Have you ever been in this position before?
- (17) Is there anything else you wanted to share with the counselor/client?

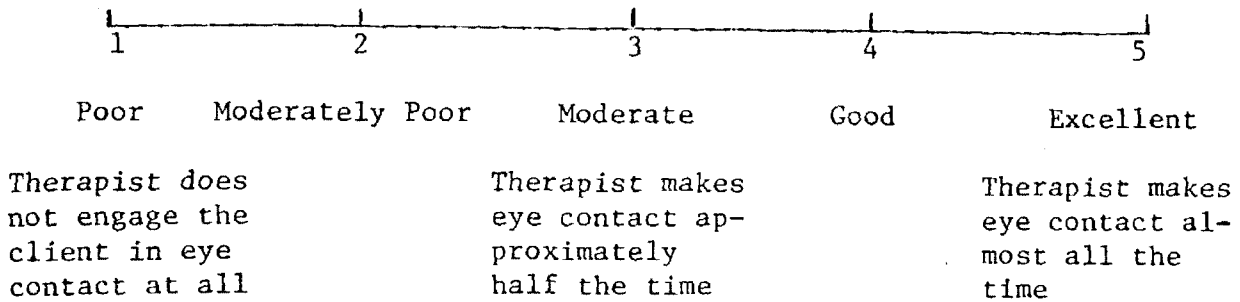
In general, the questions used by the inquirer are noninterpretive and facilitate communication between the counselor and client about the interaction process that occurred between them.

\* (from Lubetkin et al., 1973; Kagan, 1975)

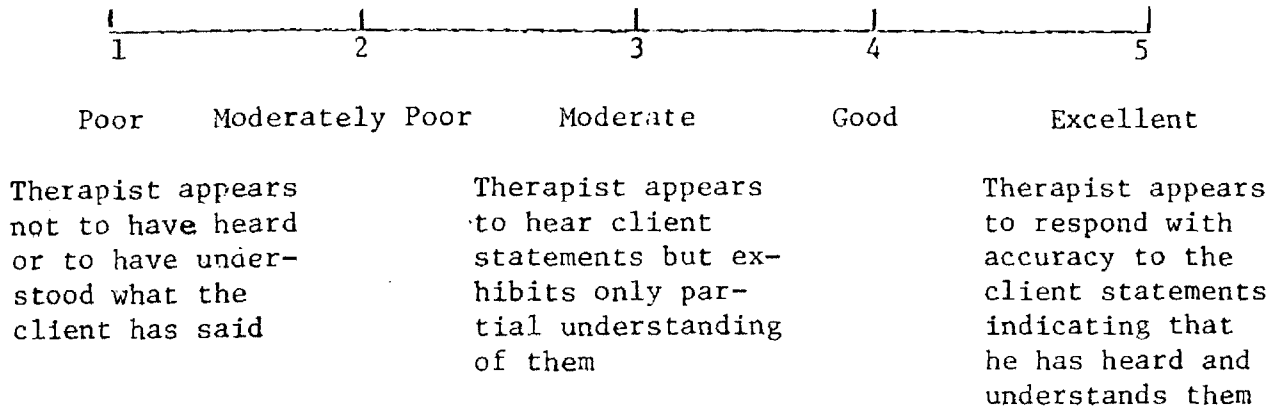
APPENDIX E

RATING SCALES

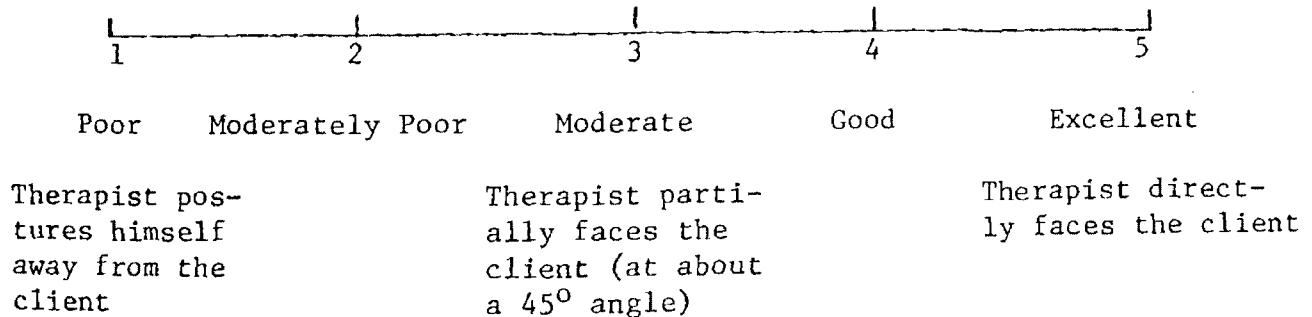
Rating of Eye Contact:



Rating of Verbal Following:



Rating of Posture:





APPENDIX G

MEAN RATINGS FOR ALL MEASURES UNDER ALL EXPERIMENTAL CONDITIONS

	PRE-TEST								POST-TEST							
	Rater 1				Rater 2				Rater 1				Rater 2			
	CES	EC	VF	P	CES	EC	VF	P	CES	EC	VF	P	CES	EC	VF	P
Kagan	122.0	4.8	4.8	4.6	115.4	5.0	4.0	5.0	124.4	5.0	5.0	4.6	120.6	4.8	4.6	4.4
Carkhuff	109.0	4.4	4.4	4.6	101.8	4.0	3.6	4.0	116.8	4.4	4.8	4.8	106.4	4.4	4.4	4.6
Control	116.0	4.0	4.8	4.4	108.2	4.4	4.0	4.4	106.0	4.8	5.0	4.2	105.4	3.6	4.0	3.8

CES - Counselor Effectiveness Scale

EC - Eye Contact Rating

VF - Verbal Following Rating

P - Posture Rating