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THE IMPACT OF A SUPERVISOR-GENERATED METAPHOR ON THE CLINICAL HYPOTHESIS FORMATION SKILLS OF COUNSELORS-IN-TRAINING

by

J. Scott Young

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the Faculty of the Graduate School at
The University of North Carolina at Greensboro
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Doctor of Philosophy

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Approved by

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The purpose of this study was to assess the impact that a narrative analogy metaphor, when generated by a counselor supervisor, would have on the clinical hypothesis formation skills of counselors-in-training. Thirty first year, second semester, masters level counselors-in-training (25 female and 5 male) comprised the sample which consisted of 27 Whites, 2 African Americans, and 1 Asian American.

A t test comparison between the two treatment groups (metaphorical communication versus literal communication) who viewed videotaped analogues of a counselor and supervisor discussing a client, revealed that there were no statistically significant differences in the groups ability to generate clinical hypotheses. There were also no significant differences in how the supervisors were viewed with regard to the social influence dimensions of Expertness, Attractiveness, and Trustworthiness. The p value for the Expertness subscale, however, did approach significance at .0544. Further, a power calculation indicated that the Expertness dimension had power of .766, suggesting that if a larger sample had been obtained, significant differences between the treatment groups may have been found.

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APPROVAL PAGE

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CHAPTER I

INTRODUCTION

"Wise men... are often distinguished by their gift for finding a few metaphorical words... that open new possibilities for the troubled person." (Lenrow, 1966,p. 145)

Metaphor as a Technique for Teaching Cognitive Counseling Skills

In clinical practice, the use of metaphorical communications has been widely cited as an effective intervention (Bandler & Grinder, 1975; Haley, 1987). It is believed that metaphors help clients gain new perspectives on their counseling concerns by generating a wide variety of associations among previously unrelated cognitive structures. As a result of creating new relationships between these structures, clients identify new possibilities for behaving and effecting change in a problem area (Fine, Pollio, & Simpkinson, 1973; Martin, Cummings, & Hallberg, 1992; Strong, 1989). In fact, Pollio, Barlow, Fine, and Pollio (1977) found that therapeutic insight often co-occurs with the production of novel metaphorical communications. They found this was true regardless of who generated the figurative theme, the therapist or the client. Therefore, metaphor is considered an effective means for helping clients achieve

alternative interpretations of situations and gain increased insight into self and others' functioning.

One reason metaphor is believed to be an appropriate means to promote clinical change is that it relies on communication at both the conscious and unconscious levels. It disrupts "the client's conscious frame of reference while generating an unconscious search for new or previously blocked meanings or solutions" (Matthews & Dardeck, 1985, p.12). In this way, metaphor promotes more complex thinking, as clients use divergent thinking patterns to develop alternative conceptualizations of difficult situations in their lives (Strong, 1989).

Such cognitive changes also have great relevance for counselor supervision. In particular, supervision goals include the encouragement of greater divergent thinking and reconceptualizations of difficulties, as ways to promote previously unrecognized strategies for change (e.g., Blocher, 1983; Loganbill, Hardy, & Delworth, 1982; Stoltenberg, 1981). According to Blocher (1983), characteristics of the highly functioning counselor include abilities to "take multiple perspectives," "differentiate among and manipulate a wide range and large number of relevant facts and causal factors," and "integrate and synthesize in creative and unusual ways large amounts of such information to arrive at an understanding of the psychological identity and life

situation of a wide range of other human beings" (1983, p. 28).

Despite rather widespread consensus on such cognitive skill goals, few authors have identified supervision methods specifically focused on producing such results. It is interesting to note that these desired outcomes of supervision are similar to the desired effects of the intentional use of metaphor. The potential of metaphorical interventions to effect such changes, however, has largely been ignored in the supervision literature.

In fact, only two published articles (Amundson, 1988; Ishiyama, 1988) exploring the use of metaphorical interventions in supervision were located. In both, the authors describe metaphorical drawing, a technique in which supervisees create drawings (i.e., metaphors) of the dynamics which they believe exist in their difficult cases. Consistent with other writings on metaphors, goals of the drawing approach include assisting supervisees in developing more complete conceptualizations and new hypotheses about their clients' functioning. A related goal of the drawing approach is to devise new intervention strategies as the supervisee symbolically displays perceptions of the client, the client's systemic situation, and the counselor's role in working with the client. Neither Amundson nor Ishiyama, however, provide empirical support for the effectiveness of their metaphorical interventions, although Ishiyama did

report that 13 of 19 participants in a supervision group preferred the metaphorical approach to case conceptualization "without reservation," considering it superior to the traditional case report method. Given the potential for metaphorical interventions as a method for enhancing supervisees' cognitive counseling skills, more stringent empirical support for metaphorical interventions is needed.

Importance of Cognitive Counseling Skills

To understand the potential usefulness of metaphorical communications to clinical supervision, it is also necessary to understand the importance of teaching cognitive counseling skills to counselors-in-training. Numerous researchers and theorists, in both counselor training and supervision, have argued that the development of counselor cognitive processes and strategies must be an integral component of counselor preparation (e.g., Borders, 1989; Fuqua, Johnson, Anderson, & Newman, 1984; Kurpius, Benjamin, & Morran, 1985). These experts argue that cognitive processes are central in counselors' attempts to formulate and select behavioral responses while engaged in a counseling interaction. Further, cognitive processes are important in understanding how counselors generalize attained skills to unique situations. Cognitive counseling skills include the ability to deftly collect information about a client, weigh alternatives, formulate viable clinical hypotheses, and select appropriate intervention strategies (Morran, Kurpius,

Brack, & Brack, 1995). Proficiency in these areas is of paramount importance to those who train counselors, as it is the counselors' effective utilization of these cognitive counseling skills that will ultimately determine the productiveness of the counseling process.

Given this emphasis on cognitive counseling skills, it seems ironic that most research to date has focused on counseling performance skills (e.g., empathy, self-disclosure, confrontation) rather than on cognitive counseling skills. However, as Fuqua, Johnson, Anderson, and Newman (1984) noted, the development of the cognitive counseling skills are equally, if not more, important in the development of the counselor-in-training. In fact, as early as 1980, Holloway and Wolleat noted that counselors with more developed cognitive abilities were better able to produce effective clinical hypotheses; subsequent work has supported their conclusion (e.g., Holloway & Wampold, 1986). Further, there is some evidence that counselors who produce better hypotheses are more effective clinicians (Morran, Kurpius, Brack, & Rozecki, 1994). Nevertheless, there is a noticeable deficiency of studies that examine the processes by which counselors formulate hypotheses and conceptualizations of their clients (Morran et al., 1995). In addition, there is a lack of studies exploring the appropriate supervision interventions which might impact development of these processes (Morran et al., 1995). Furthermore, most studies

that have examined cognitive counseling skills have focused on testing strategies and biases in hypothesis testing (Morran et al., 1995), which is a limited representation of requisite cognitive skills.

Recently, however, increased attention has been given to trying to measure directly the manner in which clinical hypotheses are formulated (e.g., Morran et al., 1994). Clinical hypothesis formation is viewed as the key component of the case conceptualization process whereby counselors accumulate information about a client, weigh the significance of various pieces of information, obtain missing pieces of information, and then formulate and subsequently test hypotheses about the client. Morran et al. (1994) noted that the clinical hypothesis approach is an appropriate means of studying case conceptualizations as hypotheses are a "synthesis of client data" and are a "tentative conceptual model of the client and the client's concern" (p. 655). They added that "clinical hypotheses thus serve as guides to subsequent counselor therapeutic interventions" (p. 655). Further, Morran et al. (1994) found that counselors who included multiple dimensions in their hypotheses (i.e., client's behavior, internal factors, external factors, and the relationship among factors) were able to perform in a manner that was consistently considered more positive by their clients.

Clearly, then, counselor educators and supervisors need to understand more about the processes by which counselors formulate their thinking about clients. In fact, Heppner (1989) proposed that researchers should examine how it is that "supervision affects the supervisee's ability to arrange information cognitively about counseling. In particular, how does the supervisee begin (as a result of supervision) to conceptualize clients differently or more effectively, diagnose clients, (and) learn intervention strategies...." (p. 234, Heppner, personal communication, cited in Bernard & Goodyear, 1992).

Heppner's proposal raises an important question; namely, how can supervisors promote the divergent thinking necessary for supervisees to consider alternate and perhaps previously unrecognized factors present in the counseling process so that more accurate and complete conceptualizations of a client may be developed? The intentional use of metaphor, because of its ability to promote divergent thinking and to integrate seemingly opposing pieces of information, may be an effective method to accomplish this.

Thus, the purpose of this study was to examine the impact of the use of metaphor on counselors' clinical hypothesis formation skills as a supervision intervention. Specifically, the impact of supervisor-generated metaphor on supervisees' formulation of a clinical hypothesis about a particular client was investigated.

To study the impact of supervisor-generated metaphorical communications on supervisee's formulation of clinical hypotheses, a methodological approach is needed that can manage the ambiguity inherent in variables such as metaphors and cognitive processes. In addition, metaphors need to be relevant to a particular client or issue, as it would not be appropriate to use the same metaphor across clients, across supervision sessions, or across counselors (Muran & DiGiuseppe, 1990). Therefore, conducting this study in a naturalistic setting would be difficult to manage, as the treatment (metaphor) could not be replicated exactly. The analogue approach is useful in controlling variables for specificity and allows for greater precision (Heppner, Kivlighan, & Wampold, 1992). Further, analogue research is an approach that provides more direct and unambiguous answers to research questions that are not always possible to investigate in naturalistic settings (Heppner et al., 1992). By isolating the variable of interest, it can be determined how the use of metaphorical communications in clinical supervision affects supervisees' clinical hypothesis formation as well as their perception of the supervisor.

Purpose of the Study

Recognizing the central importance of cognitive skills in counselors' effectiveness with clients, a number of writers (Borders, 1989; Fuqua et al., 1984; Kurpius et al., 1985) have cited the need for research in this area. Heppner

(1989) proposed that researchers should examine the impact of the supervision process on a supervisee's ability to organize cognitive information about counseling. In light of these calls for empirical work, the purpose of this study was to investigate the impact of metaphorical communications used in counseling supervision as a means to promote the development of cognitive counseling skills in beginning counselors. Specifically, this study examined whether the use of verbal metaphorical communications by supervisors, when supervisees were attempting to conceptualize a clinical situation, would aid the supervisees in developing more complete hypotheses. This was, therefore, one of only a handful of studies in which a method to enhance the teaching of cognitive counseling skills in counseling supervision has been tested empirically. Secondarily, this study investigated how the use of metaphor impacts counselor's-in-training perceptions of a supervisor's influence.

Need for the Study

Holloway and Wolleat noted as early as 1980 that there are few established approaches to teaching and supervising cognitive counseling skills, and, since that time, little significant progress has been made. Although metaphor is widely used in clinical work (Bandler & Grinder, 1975; Haley, 1987), as well as in all types of human communication (Ishiyama, 1988; Ortony, Reynolds, & Arter, 1978), its applicability in counseling supervision is virtually

unexplored. Descriptions of highly functioning counselors are quite similar to outcomes attributed to metaphor, particularly in terms of conceptual abilities. An understanding of how this intervention might be used to train new counselors to think more effectively about their clients is both academically desirable and practically useful. Further, it was hoped that this study might assist counseling supervisors in integrating metaphor into their work in a developmentally appropriate way, and might encourage them to do so if the use of metaphor was found to enhance their influence on supervisees. Therefore, this study was undertaken to address this notable deficiency in the field of clinical supervision and counselor development.

Statement of the Problem

This study investigated the impact of supervisors' use of metaphorical communications about clinical issues on supervisees' case conceptualization skills. Specifically, the research questions were the following:

1. What impact does a supervisor's intentional use of verbal metaphorical communications about clinical situations have on supervisees' generation of more varied and complete clinical hypotheses?
2. What impact does a supervisor's intentional use of metaphorical communications about clinical situations have on supervisees' perceptions of the expertness, attractiveness, and trustworthiness of the supervisor?

Definition of Terms

Metaphor - is a non-literal communication composed of literal meaning and figurative expression (Suit & Paradise, 1985) whereby one object is compared to another in a direct manner although in a literal sense the objects are not the same. Further, it functions as a non-literal communication that is an anomaly to the context in which it occurs, where the semantic tension created by its presentation can be eliminated by the receiver (Ortony et al., 1978).

Cognitive counseling skills - the cognitive processes whereby counselors a) attend to and seek information about self, client, and the therapeutic relationship; b) organize and integrate information into variable hypotheses and client conceptualizations; and c) plan, guide, and evaluate therapeutic interventions (Morran et al., 1995).

Clinical hypothesis formation - a synthesis of client data that provides the counselor with a tentative conceptual model of the client and the client's concern (Morran et al., 1994).

Expertness - the perception of a communicator as a source of true and accurate information. These perceptions are influenced by evidence of specialized training, rational and knowledgeable arguments, and a reputation as an expert (Strong, 1968).

Attractiveness - the degree to which a communicator is viewed as compatible to a hearer, such as perceptions of similarity in background and opinions (Strong, 1968).

Trustworthiness - a communicator's perceived honesty, social role, sincerity, openness, and perceived lack of motivation for personal gain (Strong, 1968).

Organization of the Study

The study is presented in five chapters. Chapter 1 is a brief introduction to the conceptual literature and empirical research findings on training supervisees in the use of cognitive counseling skills in supervision and what occurs when metaphorical communications are utilized. The purpose of the study, need for the study, research questions, definition of terms, and organization of the study also are described.

Chapter II is a complete review of the related literature and is composed of three sections. The first section describes metaphor, its functioning, its use in counseling, and implication of its use in supervision. Section two introduces conceptualization skills and links them to the developmental models of supervision. The third section reviews the clinical use of metaphor in supervision. In particular, the few studies that have used metaphor in supervision as a case conceptualization training method are discussed.

Chapter III describes the methodology used in the study. It also includes the hypotheses, participants, treatments, instruments, procedures, and data analyses.

Chapter IV describes the results of the data analyses. Discussion of the analyses and results parallel the research questions and hypotheses.

Chapter V includes a summary of the study, discussion of the conclusions, and implications for counselor education and supervision. An examination of the limitations of the study and recommendations for further research also is included.

CHAPTER II

REVIEW OF RELATED LITERATURE

The literature relevant to this study can be divided into three sections: (a) theories of metaphor and how it functions in communication and in counseling; (b) an exploration of cognitive counseling skills and how they relate to a developmental approach to supervision; and (c) a review of studies which address the use of metaphor as a supervision intervention, and how its use can promote cognitive skills development. Following a review of these, the chapter concludes with a discussion of the implications of the research reviewed, particularly as it relates to the purposes of this study.

The Use and Function of Metaphor

Metaphor, most simply, is a commonly occurring linguistic phenomena whereby one thing is compared to another (Ortony et al., 1978). Beyond this most basic of definitions, there are numerous theories regarding how best to explain the functioning of metaphors. To address these many perspectives, this discussion will be divided into two categories: linguistic conceptualizations of metaphors and psychotherapeutic conceptualizations of metaphors.

Linguistic Conceptualizations of Metaphors

The intuitively obvious place to begin exploring the function of metaphor is with the literal linguistic occurrence of metaphor. In an extensive review of the literature, Ortoney et al. (1978) observed that linguistic theories of metaphor could be divided into two categories: comparison theory and interaction theory.

Comparison theory. In the comparison theory of metaphor, which began with the writings of Aristotle, metaphor is viewed as basically the comparison between or the juxtaposition of objects that, in a literal sense, are dissimilar (Ortony et al., 1978). Aristotle's view of metaphor consisted of two primary components. First, Aristotle described metaphor as basically an analogy, that is, the comparison of similarities among two or more objects. Secondly, he believed that a command of metaphor was a sign of genius, but that metaphors were used infrequently and for the purpose of making language more aesthetically pleasing rather than more meaningful.

Breal (1897, cited in Ortony et al., 1978), also an adherent to the comparison theory of metaphor, argued against Aristotle's notion that metaphor is an uncommon occurrence or a sign of genius. In fact, Breal proposed that metaphor is a basic component of language use, common to nearly all users of language. In addition, he posited the now accepted idea

that metaphors exist on a continuum between the poles of "novel" and "frozen." A frozen metaphor is one that has become so commonly used that it has become integrated into the language, such as "foot of the bed." The process where by metaphors are integrated into common usage suggests that metaphors are an important vehicle for language change. Unlike frozen metaphors, however, truly novel metaphors contribute something new to the expressive power of language.

More recently, adherents to the comparison theory of metaphor have offered a simple comparison view of metaphor (Barlow, Kerlin, & Pollio, 1971). These writers borrow from the definition of Corbett (1965), who described metaphor as "an implied comparison between two things of unlike nature that have something in common" (p., 4). Barlow et al. indicated that the attributes of the vehicle (i.e., the term being used metaphorically) are compared with those of the topic (i.e., the subject term) in order to generate the "meaning" of the metaphor. A more complex comparison theory of metaphor was offered by Campbell (1975), who suggested that all metaphors are implicitly oxymorons. In other words, the objects of comparison in a metaphor have opposite rather than simply different meanings (e.g., "the soft harshness of words"). Campbell believed that although the opposite nature of all metaphors may not be as obvious as the above example, they are still oxymorons, as the tension created by the

metaphorical comparison results from the discord of the literal meaning.

<u>Interaction theory.</u> Proponents of the interactionist theory of metaphor agree with the comparison theorists that metaphors can be used as a substitute for literal statements and can be comparisons between objects. They part with the comparison view, however, in that they argue that good metaphors involve forming a relationship between the topic and the vehicle, thus producing a synergistic meaning that is original and that surpasses the meaning of both components individually (Black, 1962; Haynes, 1975; Richards, 1936; Wheelwright, 1962). Interactionists, thus, consider the functional rather than the grammatical components of metaphor.

Black (1962) perceived the interactionist approach to metaphor as basically a process that emphasizes an interaction between the topic and vehicle. According to Black, metaphors work through a process which highlights or suppresses characteristics of the topic by using characteristics of the vehicle. Black further argued the interactionist position by suggesting that substitution and comparison metaphors could be dropped from our language with no loss of cognitive content. He believed that interaction metaphors, however, could not be dropped from language without a loss of cognitive content. This is because interaction metaphors obligate the hearer to discern implied

meanings and consider ramifications, rather than simply passively experience the metaphor.

The idea of active involvement by the hearer with an interaction metaphor includes what Ortony et al. (1978) described as the "eureka" effect. This effect occurs as the components of the metaphor merge and a new whole is perceived. Therefore, interactionists consider a metaphor as more than a simile without the word *like* or *as*. A true metaphor must be able to create new understanding in the hearer.

In discussing the interactionist perspective of metaphor, Muran and DiGiuseppe (1990) noted that metaphor is unique in that it impacts both language and cognition. In a characterization particularly relevant to this study, they described metaphor as "a basic component of language use which also has heuristic value (i.e., value in learning) and epistemic value (i.e., value in understanding new schemata of knowledge)" (p. 71).

Categorization of Metaphor

To have a proper understanding of the linguistic approach to metaphors, it is necessary to consider how metaphors are classified with regards to their functioning as a component of language. According to Perrine (1971), there are four categories of metaphors and comparisons that address the possible combinations of explicit and implicit topics and vehicles. The first category occurs when both the topic and

vehicle are stated explicitly. Perine offers the following example for this category, "*The issue of balancing the federal budget while addressing the concerns of special interest groups is a bramble patch.*" In this example, balancing the budget while trying to meet the needs of special interest groups is explicitly compared to a bramble patch. The second category of metaphor occurs when the real vehicle is not stated explicitly yet the real topic is. For example, Perrine offered the example, "*Sheath thy impatience.*" In this example, *impatience* is the topic and the implicit vehicle is *sword*. The third category of metaphor is one in which the vehicle is stated explicitly but the topic is not. An example of this would include the proverb, *Don't count your chickens before they hatch.* In this case the topic is some behavior that is premature for the situation to which the proverb refers. The final category of Perrine's classification system consists of metaphors in which neither topic or vehicle is stated explicitly. *Let us eat drink and be merry, for tomorrow we shall die*, is generally used to suggest that life is short and unpredictable so one should enjoy it, rather than a literal statement about a hedonistic life style.

Psychotherapeutic Conceptualizations of Metaphors

Unlike linguistic approaches to metaphor which focus on defining their grammatical properties, psychological approaches are concerned with how the processing of metaphor

brings about change in the thinking, feeling, and, ultimately, the behavior of an individual. As a psychotherapeutic devise, metaphors are traditionally divided into two groups, which can be labeled as the interpretive and the communicative groups (Muran & DiGiuseppe, 1990). The interpretive group has its foundation in the analytic traditions of Freud and Jung, in which it is considered the job of the analyst to interpret the metaphorical communications of the unconscious. Freud believed that dreams, which are masked fulfillments of an individual's deepest wishes or inclinations, are the primary metaphorical outlet of the unconscious. Jung also stressed the metaphorical aspects of dreams; however, he did not agree that they were representations of hidden wishes. Instead, Jung believed that archetypal images appeared from the dreamer's unconscious in an attempt to communicate with the conscious mind and serve a necessary life-sustaining function for the psyche (Muran & DiGiuseppe, 1990).

The second type of psychotherapeutic metaphor, those of the communicative group, also espouse the idea that metaphor is the language of the unconscious. There are, however, some important differences in this approach to using metaphor. Practitioners Erickson and Rossi (1976/80), for example, sought to speak directly with the unconscious by way of therapeutic metaphor, rather than interpret its communications consciously. Erickson used a variety of

metaphorical stories that he believed were capable of "two-level communication." That is, he believed they were able to speak to both the conscious and unconscious minds simultaneously. Erickson's theory about this process was that a story gives the conscious mind something to focus on while he communicated to the unconscious mind therapeutic messages through subtle statements and connotation. As a result, the unconscious mind makes associations and restructures meanings which collect and then "spill over" to consciousness, thereby interrupting old patterns of behaviors or affective response.

A neurological framework to explain how Erickson's therapeutic metaphors work was developed by Bandler and Grinder (1975). From observations of Erickson in his clinical work, they determined that metaphorical communications move through three stages as an individual processes their meaning. The surface structure stage involves the individual understanding the actual words spoken in the therapeutic story. This process activates the second stage in which associations with the deep structure of the metaphor are formed, although, at this level, the metaphor will possess only indirect relevance to the listener. Finally, in the third stage, directly relevant meanings of the deepest structures of the metaphor are created by the listener. In other words, a "transderivational search" is performed by the hearer so that a meaning is created for the

metaphor that is of most benefit to the individual (Bandler & Grinder, 1975).

Although the approaches to psychotherapeutic metaphor described above are widely accepted for use in counseling, important criticisms have been made about them. Muran and DiGiuseppe (1990), for example, argued that there is no clear evidence to support the idea that metaphorical communications require different neurological structures than other linguistic activity. Specifically, they rejected the idea that metaphorical-imagistic processes are solely the function of the right hemisphere and the unconscious, an idea which they suggested is not supported by research. Instead, Ehrlichman and Barrett (1983) suggested there is bilateral hemispheric involvement in imagistic processing such as metaphors. Muran and DiGiuseppe (1990) further argued that the assumption that clients will derive the same meaning from a metaphorical communication that was intended by a therapist is a dubious one. They suggested that just as there is much disagreement among scholars as to the meaning of symbols of literature, there is inconsistency among individuals as to the meaning of particular symbolic communications such as therapeutic metaphor.

Metaphor and Cognitive Restructuring

Cognitive psychotherapies seek to discover and challenge dysfunctional thinking patterns in their clients. This involves the use of techniques which assist in the

restructuring of cognitive processes. Many cognitive psychologists believe that language and thought, though not synonymous, are closely related. Language, they argue, is key to the expression as well as the structuring of thought. Therefore, for cognitive restructuring to occur, it is necessary to modify the language and the meaning that individuals use to organize and understand their worlds (Muran & DiGiuseppe, 1990). For this modification of meaning to occur in an intentional manner, cognitive psychologists argue, it is imperative that both the sender and receiver of a communication share the same meaning for it. As a result, traditional views of psychotherapeutic metaphors are problematic in that there is potential for a variety of interpretations, making their unconscious impact uncertain. From a cognitive perspective then, metaphors need to be reconfigured in more tangible ways.

Cognitive psychologists have offered such a reconceptualization. From within the cognitive perspective, metaphor is considered a system of specific symbols within language. These symbols are thought to operate in a manner similar to ordinary language. In other words, metaphor and literal language are viewed as continuous rather than as fundamentally different phenomena. Therefore, the same cognitive and linguistic properties are used in the processing of both (Muran & DiGiuseppe, 1990).

According to Muran and DiGiuseppe (1990), therapeutic metaphor is an important tool for the restructuring of cognitive processes, as language has a great influence on the manner in which cognitive processes are structured. Cognitive restructuring often involves a modification in both the language and meaning that clients utilize to organize and understand their world. Metaphor, therefore, can assist with cognitive restructuring, as it is seen as intricate to the development and transfer of new paradigms (Muran & DiGiuseppe, 1990). In fact, according to numerous writers (e.g., Boyd, 1979; Kuhn, 1979; Petrie, 1979) metaphor "lies at the heart of paradigm change" (Muran & DiGiuseppe, 1990, p.78). From the cognitive perspective, however, there is always the potential for misunderstanding. Therefore, to increase its memorability and to assure shared interpretations, the covert meaning of metaphor should be made overt.

Given this cognitive psychological perspective for the understanding of metaphor, there are two important implications for clinical practice. First, one cannot assume that a metaphor presented to a hearer will have the same meaning for the hearer as it does for the sender. Secondly, one cannot assume that metaphors are interpreted in a fundamentally different manner with different neurological structures (i.e., by the unconscious or the right brain). Therefore, it is necessary to discuss overtly the meaning of

a metaphor to insure that a hearer has derived the intended meaning.

Metaphor in Counseling

Upon reviewing the literature which addresses the use of metaphor in counseling, it is apparent that, to date, researchers have tended to take a general (i.e., atheoretical) approach to their study. Therefore, the articles discussed below are representative of the work in the area thus far, but none of these studies attend directly to the two considerations made above (i.e., the assumptions that individuals will interpret a metaphor in the same manner, and that the processing of metaphor involves different neurological structures).

Therapeutic metaphor is a common counseling intervention used to assist clients in developing new meaning for difficulties. It is believed that metaphorical interventions work by promoting divergent thinking patterns (Matthews & Dardeck, 1985). In addition, the usefulness of metaphor as a stimulus to new learning, understanding, and development has been suggested by theorists in psychology, linguistics, and philosophy (Ortony, 1979). Given the wide support for the use of therapeutic metaphor, it is surprising that empirical research to examine its impact as a counseling intervention is somewhat limited. In one of the few studies conducted to directly investigate the effects of metaphor in counseling, Martin et al. (1992) examined the impact of

metaphor on four desirable counseling outcomes. These outcomes included the memorability of events highlighted by metaphor, the impact of metaphor on clients' perceptions of counseling effectiveness, the possible epistemic effect (i.e., the acquisition of knowledge) and the motivational power of metaphor intentionally used by therapists.

The researchers were interested in three research questions related to therapists' intentional use of metaphor. The first concerned the extent to which clients would recall therapy events associated with therapists' intentional use of metaphor. They believed that significant therapeutic events which were highlighted by therapists' use of metaphor would be recalled by the clients on postsession questionnaires. Their second question involved whether clients would rate sessions during which they recalled events associated with therapists' intentional metaphor as more helpful and effective overall than sessions from which they recalled events other than those associated with therapists' intentional use of metaphor. The third question concerned whether therapists' intentional use of metaphor would impact the learning and motivation of counselees.

Therapists in the study (in four counselor-client dyads) were instructed to use and elaborate on metaphors in each therapy session, if possible, in an attempt to promote clients' recall of important therapeutic events. Clients and therapists completed the Episodic Memory Questionnaire (EMQ)

following each session. The EMQ, a pencil and paper instrument, was designed to solicit specific phrases or sentences recalled from a counseling session as well as why the events were seen as significant. Participants also were asked to complete a Likert rating of the overall helpfulness and overall effectiveness of the session. Interestingly, classification of metaphor (i.e., cliché, narrative analogy, complex) used by the therapists was not addressed by the researchers. This is significant as it effects the interpretations which can be made of the results.

Upon scoring the EMQ's for the 29 sessions (out of a total of 41 sessions) in which therapists found the opportunity to intentionally use therapeutic metaphor, 66% of the time (19 of the 29 sessions), clients did recall the therapists' use of metaphor. Martin et al. (1992) noted that this percentage may be slightly inflated in that, to be counted as a recall, a client needed document only one metaphoric vehicle, and in 9 of the 19 sessions more than one metaphor was used. Recall of events associated with therapists' intentional use of metaphor could not be statistically tested due to small sample sizes and the fact there was often little or no variability in the rating of sessions within dyads.

To address the second research question which involved the clinical impact of the therapists' intentional use of metaphor, a t test was conducted to compare the mean client

ratings of the helpfulness ("How helpful was this session?") of all 19 sessions in which metaphor was recalled with the mean of the 10 sessions in which other events were recalled. The result of this comparison was statistically reliable, t(27), one tailed p .001. Helpfulness ratings for sessions in which clients recalled therapists' intentional use of metaphor averaged 4.89 (SD = .31), compared to a mean of 4.20 (SD = .98) for sessions in which another event was recalled. A t test comparison of the means of overall effectiveness ("How would you rate this session overall?") did not reveal any statistically reliable difference between the sessions in which metaphor was recalled and those in which it was not, (t(27) = 1.42, one tailed p = .07). Even though the sample sizes were small giving the analysis low statistical power, there was a trend in the hypothesized direction.

Finally, the researchers' question regarding the epistemic and motivational power of metaphor when intentionally used by a therapist was supported. For sessions in which clients recalled therapist metaphors, responses on Questions 3 and 5 of the EMQ's indicated that the metaphors were associated with two learning factors and two motivational factors. The two learning factors where (a) enhanced emotional awareness and understanding, and (b) conceptual "bridging." This means that when therapists used metaphors associated with issues relating to clients' emotional awareness or a new conceptual understanding,

clients recalled these metaphors as significant events. In the same manner, two motivational factors were associated with the therapists' use of metaphor. These were (a) an enhanced relationship with the therapist and (b) goal clarification, both of which are viewed as fundamentally necessary to elicit client commitment to the counseling process.

An additional consideration regarding therapeutic metaphor is the impact their use may have on clients' perceptions of their counselors. In a study by Suit and Paradise (1985), the effect of counselor-generated metaphors which varied in complexity were compared to facilitative responses in terms of their relationship to participants' perceptions of counselor characteristics. The counselor characteristics under investigation included empathy, regard, expertness, attractiveness, and trustworthiness. Participants ($\underline{n}$ = 80) were crossed on levels of cognitive complexity and assigned to one of four audiotaped treatment conditions: complex metaphor, narrative analogy, cliché, or facilitative response. They were then asked to listen to an audiotaped portion of a role-played counseling session in which a 35-year-old man was having interpersonal communication problems with his parents. The tapes were equivalent except for the nature of the response (i.e., the four treatment conditions) which the counselor offered to the

client near the end of the tape; there was no client response to the experimental manipulation.

The researchers found that counselors who used narrative analogy metaphors or facilitative responses were rated as higher on empathy, regard, and expertness, than those who used a cliché or a complex metaphor. They also discovered that, for the complex metaphor, the more cognitively complex participants were better able to determine the intent of the complex metaphor than were the less cognitively complex participants. There were no differences in the ways various respondents understood other types of metaphor.

The findings of this study have important implications for using therapeutic metaphor to enhance the therapeutic relationship. First, the researchers determined that counselors' use of narrative analogy metaphors resulted in higher ratings of empathy, regard, and expertness, which suggests the potential usefulness of this type of metaphor for enhancing the therapeutic relationship. Secondly, the finding that not all individuals possess the cognitive capabilities necessary to interpret the intended meaning of more complex metaphors indicates that this type of metaphor is potentially problematic for clinical use. At the least, complex metaphors should be used only with appropriate (i.e., complex) clients. Finally, these findings lend support to the position of cognitive psychologists who have argued that

clarity and specificity are critical when using any metaphorical intervention.

Cognitive Counseling Skills and the Developing Counselor

Much like the assertions that clients' thoughts affect their behavior, a number of writers have asserted that counselors' cognitive processing plays a central role in their performance as a professional helper. In fact, it is reported that counselors' attempts to effectively formulate and adapt behavioral responses within the therapeutic situation and to generalize acquired skills to new situations, are directly impacted by their cognitive processes (e.g., Borders, 1989; Fuqua et al., 1984; Hirsch & Stone, 1983; Kurpius et al., 1985; Martin, 1984; Murdock, 1991). Therefore, writers and theorists in counselor training and supervision have stressed that for counselors to be effective their cognitive counseling skills must be developed as a component of preparation. A clear understanding, however, of exactly what these skills are remains illusive. Few have attempted to list specific skills and even fewer have sought to describe a complete taxonomy. Those who have offered definitions typically have listed a number of individual skills. The skills suggested cover quite a range, including counselor self-talk to manage anxiety and self-instructional processes, the sequence of which involves information manipulation,

conceptualization/hypothesis formation, and intervention planning. Other cognitive counseling skills, including competencies with the counseling process, conceptualization, and personalization skills (i.e., multiple perspective taking, the ability to understand numerous facts and causes, and the ability to creatively integrating large amounts of information so as to understand the psychological identity of many individuals), have all been discussed as necessary cognitive skills.

Case Conceptualization Skills

Although there is considerable diversity in the cognitive skills discussed in the literature, a review of their descriptions reveals that the ability to form accurate client conceptualizations is consistently included, either explicitly or implicitly, as a skill of great importance (Bernard, 1979; Biggs, 1988; Fuqua et al., 1984; Kurpius & Morran, 1988; Morran et al., 1995; Morran, Kurpius, & Brack, 1989). This consistency is notable, as it suggests that case conceptualization is an underlying cognitive skill necessary for effective counselor performance. Case conceptualization, in general, refers to a counselor's ability to formulate an accurate clinical picture of a client from available information. The benefit of good case conceptualization skills is evidenced by Biggs' (1988) suggestion that the process of formulating the conceptualization of a case forces the counselor to resolve existing cognitive conflicts by

attempting to reconcile contrasting perspectives of a client. This process, by its nature, forces the counselor to function at a higher level of cognitive complexity. This outcome has considerable significance for supervision, as it has been found that counselors who function at higher conceptual levels are better able to perform counseling-related tasks than counselors who function at lower conceptual levels (Holloway & Wampold, 1986).

Researchers and theorists have offered varying perspectives as to the process of case conceptualization and the sub-skills of which it is composed (Bernard, 1979; Biggs, 1988; Fuqua et al., 1984; Kurpius & Morran, 1988; Morran et al., 1995). Some writers have focused primarily on describing the sub-skills, while others have attempted to measure them or their impact on the counseling process. Understanding the cognitive counseling skills that inform accurate case conceptualization is of particular interest for counseling supervisors, as it is this process by which counselors use observations and inferences to give evidence for clinical judgments, perceive the dimensions of the counseling relationship, make assumptions about a client's personality and problem condition, and, subsequently, make treatment choices (Biggs, 1988).

As with any cognitive skill, case conceptualization skills can be difficult to recognize and measure. Bernard (1979) offered two important considerations in this regard.

First she indicated that case conceptualization skills fall under the general category of what she calls "covert behavior," which suggests the difficulty she believes is inherent in observing and evaluating the skills. Secondly, she suggested that case conceptualization skills indicate both "deliberate thinking and case analysis" by a counselor. Further, Bernard believed two types of thinking are involved in this process: conceptualization that takes place in the counseling session and conceptualization that takes place between sessions. Clearly, then, there are many components to this illusive skill area.

Although case conceptualization is complex, Bernard (1979) offered further evidence for its centrality as a primary cognitive counseling skill when she suggested that the general skill of case conceptualization actually consists of the grouping together of several related skills. These skills are: a) the ability to understand what a client is communicating; b) the ability to identify themes in a client's messages; c) the ability to determine appropriate and inappropriate client goals; d) the ability to select intervention strategies that are consistent with client goals; and e) the ability to recognize client improvements even if they are subtle. For the counseling supervisor to assist a counselor in the development of these skills, it is first necessary to understand both the interrelationship of

the skills involved in case conceptualization and how a developed counselor will function.

Case conceptualization, cognitive development, and supervision. Within the supervision literature, as with any field of inquiry, there are on occasion, seminal writings that have an on-going impact on work in the area. Blocher's (1983) discussion of counseling supervision from a cognitive developmental perspective is such a work. Although he did not specifically use the language of "case conceptualization" to outline the skills he believes necessary for adequate counselor performance, that Blocher was in fact describing such skills is apparent. Blocher offered a idealized heuristic of supervision goals for the cognitive development of a counselors-in-training which, bottom line, indicates that functioning at a very high cognitive level is the desired outcome of supervision. High cognitive functioning, according to Blocher, involves numerous skills pertinent to counseling. These skills include the ability to take multiple perspectives and operate from varying perspectives, which assists the counselor in developing empathic understanding for individuals holding differing world views, value systems, and personal constructs. Blocher further suggested that counselors must become capable of discriminating and managing numerous wide-ranging facts and causal factors. Finally, he indicated that counselors must learn to synthesize large amounts of information in ways that

are creative and unique, so that the psychological identities of a broad spectrum of human life situations may be understood.

Beyond his description of the cognitively developed counselor, Blocher (1983) outlined several factors that he believed must be present within the supervision context before a learning environment which allows cognitive growth to occur can be created. These factors are challenge, involvement, support, structure, feedback, innovation, and integration. Challenge occurs when there is an intentional (or controlled) level of mismatch between the coping resources of the counselor and requirements of the learning environment (i.e., the supervision and internship process). Involvement is the amount of psychological attachment counselors have to their performance. Support takes place when there is care, empathy, and warmth available in the supervisory and cohort relationships. Structure exists when a definite path is available for a trainee to follow to meet learning goals. Feedback is the offering of pertinent and usable information to a trainee by a supervisor. Innovation results when a counselor feels confident to implement, in a personalized manner, new strategies in the counseling session. Finally, Integration will follow when a pattern of interaction exists between supervisor and supervisee that serves to reinforce behaviors already learned.

Clinical Hypothesis Formation

In discussions of case conceptualization skills it is indicated that counselors must possess the ability to develop a clear and accurate understanding of a client's difficulty. A central component of the process of developing a case conceptualization involves the formation of clinical hypotheses. This is not surprising, as a clinical hypothesis results from the integration of relevant information about a client into a conceptual model of functioning and possible resolutions of difficulties (Morran et al., 1994). The formation of clinical hypotheses is considered a pivotal case conceptualization skill because development of hypothesis involves the counselor's attempt to synthesize all known information about a client into a single theme that is then used to guide all ensuing counselor behavior. According to Morran et al. hypothesis formation actually consists of the utilization of a series of three sub-skills. These skills are the ability a) to observe the client and formulate appropriate corollaries, b) to integrate information about the client into a hypothesis, and c) to test the validity of that hypothesis (Pepinsky & Pepinsky, 1954). Therefore, it should be apparent that counselors who do not possess adequate hypothesis formation skills will be severely limited in their ability to perform effectively in session.

The importance of hypothesis formation to effective counselor performance is evidenced by Morran et al.'s (1994) findings in a study which examined the relationship between counselors' clinical hypotheses and client ratings of counselor effectiveness. They reported that increases in the number of hypothesis units cited by counselor trainees, overall hypothesis quality, and the number of questions used for testing hypotheses were positively related to client ratings of counselor expertness, attractiveness, and trustworthiness. Further, Morran, Kurpius, and Brack (1989) suggested the importance of the skill when they found that more than 17% of all counselor self-reported in-session thoughts consisted of the formation of inference and hypotheses. Other researchers have examined the relationship of clinical hypothesis formation to any number of variables. For example, counselor effectiveness, self-talk, and cognitive strategy training have all been examined for their relationship to hypothesis formation (Kurpius et al., 1985; Morran, 1986; Morran et al., 1994).

To date there exist only a few methods to measure clinical hypothesis formation. Holloway and Wolleat (1980) provided one of these methods. They developed the Clinical Assessment Questionnaire (CAQ) which is an adaptation, in a pencil-and-paper format, of an interview method developed by Watson (1976). Watson indicated three aspects of information processing which are used in hypothesis formation, including

the content of hypotheses, the nature of information used in decision making, and the reasoning used by counselors to pursue additional information from clients. The CAQ procedures involve asking a counselor to develop and support two hypotheses about a client's problem by means of five written tasks. Counselor responses are then scored for inclusion of six categories of information. The categories are: a) elements in understanding the client, b) timeframes used in understanding the client, c) categories of information used to support conclusions, d) number of instances used to support conclusions, e) categories of information sought, and f) number of divergent questions asked. Although this approach includes important guidelines for the examination of hypotheses, the CAQ is cumbersome to score and has proven difficult for obtaining good interrater reliability (Borders, personal communication, May, 1995).

Using guidelines provided by Holloway and Wolleat (1980), Morran (1986) developed an instrument for rating clinical hypotheses, subsequently named the Clinical Hypothesis Exercise Form (CHEF). The CHEF consists of four items on which counselors describe and support a hypothesis about a specific client. The scoring dimensions of the CHEF have been revised by Morran through its use in several studies. Most recently, the instrument is being used to measure seven components of hypothesis formation: a) number of hypothesis units, b) the presence of key hypothesis

dimensions (i.e., client behavior, inferred client internal factors, external factors, and associations between these factors), c) number of support units, d) support statement dimensions, e) overall quality, f) number of questions, and g) new domain questions. Raters are used to divide counselors' responses into the units indicated above and to score those responses. The fact that high interrater reliability has been found for the instrument, along with its ease of use, make the CHEF an attractive research tool.

Summary. It should be apparent that for beginning counselors the development of hypothesis formation skills is of paramount importance. This is true because they do not yet possess the more complex conceptualizations of the counseling process and client issues that are found in more experienced counselors (Martin, Selmon, Hiebert, Hallberg, & Cummings, 1989). The ability to create good hypotheses, however, is a key factor in the conceptualization process that may facilitate new counselors' acquiring the abstract knowledge about counseling issues that allows experienced counselors to develop more complex conceptualizations. Therefore, the need for supervision strategies that can assist counselors-in-training in acquiring the ability to think more abstractly and systematically about the counseling process and about their clients is apparent.

Metaphor and Skill Development

Blocher's (1983) cognitive developmental model of supervision provides a clear understanding of how a counselor who possesses good case conceptualization skills should function, while Morran et al.'s (1994) research on clinical hypothesis formation provide a reliable and valid means to measure this development. These writers offer convincing evidence that beginning counselors need to develop more complex thinking patterns to function well in their role, which in turn suggests the need for the formal examination of methods used to facilitate the growth of cognitive skills. Metaphor may be one appropriate and effective method.

Blocher (1983), in his description of a developmental model of supervision, discussed two components of the developmental learning environment for which metaphor might be particularly appropriate. These environmental components are challenge and feedback. When discussing challenge, Blocher stated that supervisors should create "properties in the learning environment that tend to raise the level of complexity, ambiguity, novelty, abstraction, and intensity," (p. 31), all of which are fundamental characteristics of metaphorical communications. Further he stated, with regard to feedback, that "The major tasks of the supervisor are to help the counselor to be aware of or 'hear' the most relevant cues, and to develop a manageable number of themes or

constructs with which to organize this information" (p. 32). Again, as metaphor is used for similar purposes in other settings, a metaphorical approach in supervision offers a potentially effective means to bring important clinical themes to the awareness of supervisees. Therefore, the need for systematic investigation, in a supervision setting, of this potentially valuable intervention is apparent.

Metaphor and Case Conceptualization Skills

Within the current supervision literature one looks in vain for any discussion of verbal metaphor as an intervention strategy. The non-literal intervention of case drawing, however, which attempts to enhance case conceptualization skills, has been occasionally reviewed. Ishiyama (1988), for example, asked counselors-in-training to draw pictures of a case with which they were having some difficulty. This visual metaphorical interpretation was found to be the preferred means of understanding case dynamics for 13 of 19 participants, with only two individuals preferring a non-visual method of case conceptualization and the remainder finding the metaphorical method valuable under some circumstances. Amundson (1988) also suggested the effectiveness of metaphorical drawings as a means of teaching conceptualization skills to counselors-in-training. He gave a case illustration of a counselor working with 38-year-old female client who was experiencing numerous life stressors associated with being a single mother, having an alcoholic

boyfriend, and attending school full-time. The counselor was asked to create a case drawing of the client and the dynamics affecting her life. The drawing, according to Amundson, was used to assist the counselor in understanding better the numerous struggles in her clients' life. The drawing also provided insight into the counselor's feelings of helplessness about her client's many problems and, subsequently, how the counselor might be more effective in her work.

Implications of the Review of Literature for this Study

It has been suggested that metaphor, although a widely used and potentially powerful intervention in counseling, has been minimally researched. In addition, it was determined that the examination of metaphor as an intervention strategy for counseling supervision is virtually non-existent. Therefore, this study examined the use of metaphor in counseling supervision using an analogue design so that the impact of metaphor on the cognitive counseling skill of hypothesis formation could be studied closely and in a controlled manner.

This review of literature suggested that the therapeutic use of metaphors has the potential to promote more complex thinking patterns, which is a desired outcome of counseling supervision that has been called for by many experts in counselor education and supervision (e.g., Blocher, 1983).

Further, the connection between metaphorical thinking and the skill of case conceptualization in general and hypothesis formation specifically was stressed. Amundson (1988) supported this connection when he indicated that case conceptualization and metaphoric processes are similar, in that for both the focus is on integrating a variety of "cognitive, behavioral, and emotional interpretational information into a synthesis" (p. 391).

The literature reviewed indicated that for greatest therapeutic impact the use of metaphors should follow two criteria. First, metaphors should be used in the form of a narrative analogy which, according to Suit and Paradise (1985), means that they are moderately complex and include "explicit elements and subtle implications" (p. 24). Second, according to cognitive theorists, it is necessary to insure that no miscommunication occurs when using metaphors. To prevent this from occurring, it was suggested by Muran and DiGiuseppe (1990) that, when used in counseling, the intended meaning of an intentional metaphor should be made explicit and that therapist and client should discuss openly their interpretation of it.

Therefore, for the purposes of this study, the dependent variable, hypothesis formation was examined using the independent variable, type of supervisor communication (i.e., literal and metaphorical). In addition, the need for explicit discussion of metaphorical communications for

correct interpretation was examined in a supervision context, as participants were asked to interpret the intended meaning of a narrative analogy metaphor used by a counseling supervisor.

CHAPTER III

METHODOLOGY

A review of the related literature yields evidence that, in general, metaphorical communications facilitate divergent thinking patterns and more complex conceptualizations of situations. Whether and how metaphor affects supervisees' conceptualizations of clients is not known from this literature, however. Therefore, the intentional use of metaphorical communications by a counselor supervisor and the impact this use has on supervisees' formation of clinical hypotheses is the focus of this study. In this chapter, the design and methodology for the study are presented. Included are research hypotheses, participants, treatments, instruments, procedures, and statistical procedures used in data analyses.

Hypotheses

The following hypotheses were tested:

1. When a narrative analogy metaphor (Treatment 1) is used to discuss client dynamics in clinical supervision, the clinical hypotheses formulated by beginning counselors will be of significantly higher quality and complexity, as measured by the Clinical Hypothesis Exercise Form (Morran, 1986; Morran et al., 1994), than the clinical hypotheses

formulated when direct communication (Treatment 2) about client dynamics are present in clinical supervision.

2. Beginning counselors' ratings of a supervisor's levels of expertness, attractiveness, and trustworthiness, as measured by the Supervisor Rating Form-Short Version (Schiavone & Jessell, 1988), will be higher for the supervision treatment that includes a narrative analogy metaphor (Treatment 1) to discuss client dynamics than for the supervisor treatment (Treatment 2) that does not.

Participants

Participants in this study were counselors-in-training in their first year of a full-time, master's level counseling program in the CACREP-approved counselor education program at the University of North Carolina at Greensboro. Participants consisted of the entire first year masters class who were in their second semester of studies and had not yet begun their internship training (N = 30). Students from four specialty disciplines within counselor education (i.e., community counseling, student development in higher education, school counseling, and marriage and family) were represented in the sample.

Descriptive information concerning all the participants is reported in Table 1. Participants tended to be in their twenties or thirties; most participants were female (83%) and white (90%). The respondents were spread fairly evenly over the four specialty areas represented, with 26.5% in the

community agency track, 10% in the student development track, 30% in the school counseling track and 26.5% in the marriage and family specialty.

Table 1

Demographic Description of Participants

Characteristic	Frequency	Percent	Cumulative Frequency	Cumulative Percentage
Program				
M.A.	15	50	15	50
Ed.S.	13	43	28	93
Ph.D.	2	7	30	100
Age				
21-29	19	63	19	63
30-39	9	30	28	93
40-49	2	7	30	100
50-59				
60+				
Sex				
Female	25	83	25	83
Male	5	17	30	100

Table 1, continued

Characteristic	Frequency	Percent	Cumulative Frequency	Cumulative Percentage
Race				
White	27	90	27	90
Hispanic	0	0	0	0
African American	2	7	29	97
Native American	0	0	0	0
Asian American	1	3	30	100
Specialty				
Community Agency	8	26	8	26
Student Dev.	3	10	11	36
School Counseling	9	30	19	66
Marriage & Family	8	26	27	93
Gerontology	0	0	0	0
Other	2	7	30	100

$\underline{N}$ = 30

Treatment

Two 9-minute segments of supervision sessions were created and videotaped to serve as the experimental treatments for this study (see Appendix A for transcripts). The supervision sessions were designed to vary on one dimension only: the intervention selected by the supervisor in response to the counselor's work with a particular client. The two treatment conditions for the dimension were: a) a segment of supervision in which the supervisor used a narrative analogy metaphor (i.e., non-literal) to interpret clinical issues of the supervisee's client (Treatment 1), and b) a segment of a supervision session in which the supervisor used literal communications to clarify clinical issues of the supervisee's client (Treatment 2).

Each treatment condition was portrayed by the same female supervisor and female counselor. The supervisor, a current doctoral student, had received her M.A. in counseling from a CACREP-approved counselor education program, and had worked as a counselor for three years. She had received clinical supervision on a continual basis, assisted with supervision research, and was quite familiar with the dynamics of clinical supervision. The client, who had a M.S.A.T. in art therapy and was a National Certified Counselor, had received individual and group supervision during her training and for over two years since beginning

full-time work as a counselor in an agency in the southeastern United States.

In each supervision segment, the supervisor and counselor were discussing a female client who was experiencing difficulties in her relationship with her boyfriend. The scenario chosen (i.e., difficulty with a relationship) is a typical supervision topic. The concern the counselor brought to supervision was the client's resistance to following through on homework assignments and her general uncertainty as to the exact nature of the client's concern. In both treatments, the supervisor's intervention was offered in response to the supervisee's description and discussion of the client's behavior in and out of session. Before offering the narrative analogy metaphor or the direct communication, the supervisor explored how the counselor viewed the clinical situation as well as what areas of the client's life she had explored. Each segment of the supervision session represented a typical discussion of a counselor's audiotaped counseling session that had been reviewed by the supervisor. The session was meant to reflect a mid-semester supervision session.

Treatment 1

In the session in which the supervisor intentionally used metaphor as a supervision intervention (Appendix A), the supervisor offered a narrative analogy metaphor to assist the supervisee in understanding the psychological dynamics of the

client and her situation. The supervisor intentionally used a narrative analogy metaphor to facilitate the supervisee's consideration of alternate explanations for the client's clinical circumstances.

Treatment 2

In the supervision session in which the supervisor did not use a narrative analogy metaphor (Appendix A), the supervisor offered literal statements to assist the supervisee in understanding psychological dynamics of the client and her situation. The supervisor used the literal communication to facilitate the supervisee's consideration of alternate explanations for the client's clinical circumstances.

Development of the Treatments

First, to determine the characteristics of the metaphor intervention to be used by the supervisor, a matrix was completed for Treatment 1 that identified characteristics of metaphor drawn from the relevant literature (e.g., Ortony et al., 1978; Suit & Paradise, 1985). Based on the descriptions of metaphors in the literature, it was determined that for a communication to qualify as a metaphor, it must make a literal comparison between two objects which, in a literal sense, are not alike, by using a metaphoric vehicle to inform the subject being discussed. Further, it was determined that clichéd language was not effective for facilitating divergent thinking; therefore, this type of metaphor was avoided (Suit

& Paradise, 1985). Similarly, complex metaphors which offer an implied interpretation of the situation to which they refer, having subtle implications and being highly complex, were not used. Suit and Paradise (1985) found that the use complex of metaphors in clinical settings, like metaphors using clichéd language, were rated unfavorably. Instead, narrative analogy type metaphors, which have explicit implications for the situation to which they refer and are moderately complex were rated most favorably (Suit & Paradise, 1985).

Given these characteristics as defined in the literature, four dimensions of metaphorical communications were identified and used to construct and evaluate the two treatment transcripts. The four dimensions of interest were 1) the presence or absence of metaphorical communication, 2) the avoidance of a clichéd metaphorical expression, 3) the avoidance of a complex metaphor, and 4) the presence of a narrative analogy type of metaphor. These four dimensions represent characteristics of metaphor which should impact participants' reactions to the vignettes. Subsequently, a narrative analogy type of metaphorical communication was used in Treatment 1 and no metaphorical communication of any type was used in Treatment 2.

Second, the two transcripts of the supervision session were written to reflect the characteristics in the matrix and the identified metaphor and non-metaphor dimensions. In

order to control the stimuli in the two interventions, the two transcripts began and proceeded with verbatim dialogue until the final interchange (see transcripts for Treatment 1 and Treatment 2 in Appendix A) in which the supervisor used a narrative analogy metaphor to discuss the client dynamics in Treatment 1, while in Treatment 2 she did not.

Third, using the four dimensions, the two preliminary transcripts were rated by two counselor education professors who had training and experience as counseling supervisors and had conducted research in the area. The experts were provided definitions of metaphor, key components of metaphor, and examples of each type of metaphor (i.e., cliché, narrative analogy, complex) (see Appendix D). The expert raters used a 5-point Likert scale anchored by "statement is clearly a metaphor" (1) and "statement is clearly not a metaphor" (5) for the metaphor dimension. For the three types of metaphor dimensions, similar ratings were used, anchored, for example, by "statement is clearly a cliché" and "statement is clearly not a cliché metaphor." The experts reported similar ratings on the metaphor versus non-metaphor dimension and on the cliché versus narrative analogy dimensions. Based on feedback from the expert raters a portion of dialogue was added to make the metaphor clearly a narrative analogy. On the basis of these results, videotaping of the transcripts was begun.

The actors met to review and discuss the transcripts and the desired characteristics of their portrayal of each role. The supervisor was instructed to deliver both the metaphor and the non-metaphor statements with the same intensity and quality. Both actors were instructed on how to portray the supervisor and counselor behaviors, including voice inflection and disposition, such that their interactions would appear as natural as possible. Practice sessions were videotaped and reviewed jointly by the actors and researcher to identify any counselor and/or supervisor behaviors which might distract from the focus of the study. During practice and production of the videotaped version of the treatments, a natural flow of interchanges, except for the final supervisory statement, was the primary focus. In producing the two videotapes, the exact same tape was used except for the final statements of the supervisor, which were spliced onto the end of each videotape. Thus, the exact same stimuli are included in each treatment except for the final statements of the supervisor, which are the metaphor or non-metaphor interventions under investigation in this study. Due to the fact that the treatments were identical except for the supervision intervention, no additional ratings were deemed necessary to confirm their similarity.

Instruments

Beginning counselors completed the Supervisor Intervention Interpretation Form (Young, 1995), created

specifically for this study, the Clinical Hypothesis Exercise Form (Morran, 1986; Morran et al., 1994), and the Supervisor Rating Form-Short (Schiavone & Jessell, 1988), in that order. A demographic questionnaire was the last instrument completed by all participants.

Supervisor Intervention Interpretation Form

As indicated in Chapter II, a critical component of the effective therapeutic use of metaphor is whether the hearer is able to discern the intended meaning of a metaphor. In addition, the researcher wanted to compare participants' understandings of the two supervisor interventions used in the videotaped treatments. Therefore, the Supervisor Intervention Interpretation Form (SIIF) was created for this study to verify participants' ability to accurately interpret the intended meaning of the metaphorical communication offered by the supervisor in Treatment 1 and the direct language intervention in Treatment 2 (see Appendix B). The SIIF consists of the following statement: "Explain in your own words what you believe the supervisor on the videotape was trying to communicate to the counselor with her final statements. Please be as specific and detailed as possible." This SIIF was used to examine the ability of beginning counselors to accurately interpret the meaning of the two supervision interventions under investigation (i.e., metaphor/non-metaphor) when used by a clinical supervisor without any discussion as to their intended meaning. The

instrument was scored by comparing respondents' interpretations of the metaphor to its meaning as intended when developed as the treatment intervention as well as their understanding of the direct communication by the supervisor. Specifically, respondents' statement of the clinical difficulty, evidence of the clinical difficulty (i.e., Linda's inability to adjust her perspective towards her boyfriend and his mother), and the resolution for the clinical difficulties (i.e., accepting the paradoxical nature of her situation, that the harder she tries to change the things the worse they will become) were assessed using present/absent categories with each dimension rated as "Stated this" or "Did not state this" (see Appendix B).

Scoring of the SIIF was performed by two doctoral students who were trained to serve as raters. These individuals were trained in scoring the instrument, using practice materials, until an average of approximately 80% agreement was reached. Once actual scoring of the instrument began, periodic checks of interrater reliability was performed. Differences in ratings were resolved by discussions and/or a third rater.

Clinical Hypothesis Exercise Form

The Clinical Hypothesis Exercise Form (CHEF) (Morran, 1986; Morran et al., 1994) (Appendix B) is a self-report, 4-item instrument developed to measure a counselor's clinical hypothesis formation related to a client and the concerns of

that client. The intention of the CHEF is to measure thoughts that occur during an activity by using post-activity cognitive assessment. Support for this rationale can be found in Cacioppo and Petty's (1981) validity study of the thought-listing technique which, like the CHEF, is administered immediately following a session. Cacioppo and Petty (1981) cited agreement between post-activity cognitive measures and physiological responses measured during the activity as an indication that such post-activity assessment yields cognitive measures that are representative of thinking that occurred during the activity.

The three-page CHEF includes a cover page which defines a clinical hypothesis as: "the integration of the counselor's observations, assumptions, and inferences to establish a tentative explanation of the factors, and any relationships among such factors, involved in the client's concern or issue." The cover page also instructs counselors to complete the four items on the remaining pages and to use the back of the page if additional space is needed. The four items to be completed by the counselors are the following:

1. Based on your observations, hunches, and assumptions, write a hypothesis describing your client and his/her major concern or issue.

2. Describe any factors related to the client, the environment, the counselor-client relationship, etc., that you believe to be supportive of your hypothesis.

3. Formulate a list of questions you feel you would need answered to test the accuracy/validity of your hypothesis.

4. On the following scale, rate your present level of confidence concerning the accuracy of your hypothesis. (An 8-point rating scale with anchors of 1 [*not at all confident*] to 8 [*extremely confident*] is provided for responding to this item.)

The CHEF was originally constructed by Morran (1986) using guidelines provided by Holloway and Wolleat (1980). In developing the scoring procedures for the CHEF, Morran used the dimensions of hypothesis scoring outlined in Kurpius et al. (1985) and Holloway and Wolleat (1980). Morran did, however, modify the scoring process to assess the quality of the hypotheses offered by subjects rather than merely determine the presence or absence of each identified dimension (see below). During its first use, Morran (1986) evaluated participant responses to the CHEF by using 7-point quality scales, on five dimensions. These dimensions were a) definition of the major problem; b) identification of important internal and external factors; c) identification of important cognitive, behavioral, and emotional factors; d) conceptualization of the interrelationship between the key factors; and e) overall quality of thought and substantiation. Interrater reliabilities of .92 for the total hypothesis score were obtained by Morran.

In 1994, Morran et al. revised the scoring dimensions of hypothesis formation for the CHEF to the present form. The new scoring dimensions were selected from hypothesis evaluation scales used in previous studies of hypothesis formation (Hirsch & Stone, 1983; Holloway & Wolleat, 1980; Morran, 1986). In addition, Morran et al. (1994) adjusted the rating dimensions to reflect counselor skill level as related to the major hypothesis formation activities set forth by Pepinsky and Pepinsky (1954). This model of the development and testing of hypotheses involves the counselor a) making observations and inferences about a client's current status including related causal factors, b) integrating this information into a meaningful hypothesis, and c) testing the validity of the hypothesis.

The seven clinical hypothesis rating scales formulated by Morran et al. (1994) were used in this study. The new dimensions include: 1) number of hypothesis units, which is a frequency count of distinct, nonredundant, and relevant information units contained in an hypothesis; 2) hypothesis dimensions, which is the presence or absence of client behavior, inferred client internal factors, external factors, and associations between these dimensions; 3) number of support units, which is a frequency count of distinct, nonredundant, and relevant information units given as support for an hypothesis; 4) support statement dimensions, which is the presence or absence of the four supportive information

dimensions of client statements, kinesthetic behavior, social-psychological issues, and counselor-client relationship; 5) overall quality, which is a rating of the overall quality of thought and clarity of expression of an hypothesis as rated on a 5-point Likert scale anchored by low and high; 6) number of questions, which is a frequency count of distinct, nonredundant and relevant questions found in the application; and 7) new domain questions, which is a frequency count of questions representing exploration in a new or different domain from the stated hypothesis. With these modifications to the scoring categories, interrater reliablities for the CHEF remain strong, ranging from .82 to .99 across the seven elements (Morran et al., 1994).

For the purposes of this study, the directions and the first prompt of the CHEF were slightly modified to adapt the instrument to the videotaped treatments that were used to elicit responses. For example; the term "your client" in question one was changed to "the client discussed on the videotape."

Using an adapted version of the Clinical Hypothesis Ratings Worksheet developed by Morran et al. (1994) (Appendix B), scoring of the CHEF was performed by two doctoral students who were trained to serve as raters. These individuals were trained in scoring the instrument, using practice materials, until scores reached an average of 80% agreement. Once actual scoring of the instrument begins,

periodic checks of interrater reliability was performed. Disagreements in ratings were resolved by discussions and/or a third rater.

Supervisor Rating Form-Short

The Supervisor Rating Form-Short version (SRF-S) (Schiavone & Jessell, 1988) is an adaptation of the Counselor Rating Form-Shortened version (CRF-S) (Corrigan & Schmidt, 1983), which itself is an adaptation of the Counselor Rating Form (CRF) (Barak & LaCrosse, 1975). The CRF was developed by Barak and LaCrosse (1975) to coincide with the social influence dimensions proposed by Strong (1968). Factors related to opinion change research were suggested by Strong to be similar to factors in the counseling relationship. In fact, Strong stated that counseling was an attempt to change the opinion of the client. Barak and LaCrosse (1975) developed this theory into an instrument which measured the three particular dimensions of social influence: expertness, attractiveness, and trustworthiness. These three components of social influence are considered the bases of the working relationship between the counselor and the client. The therapeutic relationship, Strong indicated, would be influenced by the client's perception of the counselor on these three dimensions.

Originally, the CRF consisted of 36 adjectives, twelve of which described each of the three social influence dimensions. A 7-point bipolar response format was used for

each item, with the opposite descriptive adjective anchoring the other side of the Likert scale (e.g., experienced/inexperienced, attractive/unattractive, reliable/unreliable). To formulate the list of 36 adjectives, Barak and LaCrosse (1975) presented four experts with 83 adjectives that described the three scales of social influence. The experts were provided with a description of the scales and asked to classify each adjective into one of the scales or remove it from the list. Following this process, the remaining list consisted of 36 adjectives. Twenty-two of the adjectives received 100% agreement by the expert panel; the remaining 14 received 75% agreement, which was the lower limit of acceptability. A factor analysis revealed that 52% of the total variance was accounted for by the items.

A split-half method was used by LaCrosse and Barak (1976) to evaluate the internal consistency of the scales and produce an estimate of their reliability. Using the Spearman-Brown formula, reliability coefficients of .87 for expertness, .85 for attractiveness, and .91 for trustworthiness were determined for the three scales.

In a study of social influence in supervision, the CRF was used in a slightly modified format by Heppner and Handley (1981). To reflect the field of supervision, the word "counselor" was changed to "supervisor" on the instrument. In addition, the title was changed to the Supervisor Rating

Form (SRF), and the instructions were adjusted so that respondents were asked to rate their supervisor rather than their counselor. There were no other changes made to the CRF which might significantly impact its original psychometric properties.

In 1983 the CRF was adapted by Corrigan and Schmidt into a shortened version and named simply the Counselor Rating Form-Shortened version (CRF-S). The original 36 adjectives were reduced to 12, four adjectives per scale. Selection of the four adjectives was determined based on factor loadings of the items on the appropriate scales and the comprehension level necessary for understanding them. Listing the items in random order, the response format was modified, removing the opposite adjective from the Likert scale and anchoring each end of the scale with the words "not very" and "very." The removal of the opposite adjective was intended to reduce any negative associations with the descriptor so that greater variance in the responses could be obtained. Scoring of the instrument consisted simply of totaling the ratings for each of the scales. This produced a possible range of scores for each dimension from 4 to 28, based on the 7-point response format. The higher the total for a specific dimension, the more a respondent perceived that dimension in the counseling relationship.

Using a three factor oblique model, validation of the factor structure of each item was determined through

replication of the previous study (Barak & LaCrosse, 1975). An extension of the study to a separate clinical population also was conducted. Each item demonstrated high item loadings in the factor analysis, similar to the original loadings of the CRF.

Estimates of the reliability coefficients of the shortened version of the test were determined by using the Spearman-Brown formula. The expected values for each four item subscale, were .70 for expertness, .65 for attractiveness, and .77 for trustworthiness. The results, however, were much better than the estimates and were greater than the original reliability estimates for expertness (.90 compared to .87), attractiveness (.91 compared to .85), and were only slightly lower for trustworthiness (.87 compared to .91).

The CRF-S was further modified by Schiavone and Jessell (1988), although only slightly, for use in a supervision context. Their modifications resulted in the Supervisor Rating Form-Short version (SRF-S). The 12 items of the CRF-S were used in a 7-point format with the words "not very" and "very" as the anchors. The only alteration to the CRF-S occurred in the instructions to the respondent, which changed from "rate your counselor" to "rate your supervisor." No significant differences in the validity and reliability of the SRF-S were reported due to these slight changes to the CRF-S.

In the present study, the SRF-S was used to obtain information regarding beginning counselors' perceptions of the supervisor on the social influence dimensions. Specifically, counselors' perceptions of the expertness, attractiveness, and trustworthiness of the supervisor were examined when narrative analogy type metaphorical communications were used compared to when the same supervisor used direct communication.

Demographic Questionnaire

The demographic questionnaire (see Appendix B) was designed to elicit descriptive information about participants. Age, sex, race, and specialty area in the counselor education program (e.g., community counseling, student development in higher education, school counseling, marriage and family, and gerontology) was collected for counselors who participate in the study.

Procedures

The researcher was able to access eligible entry-level counselors via their CED 620 Counseling Theories and Practice course (two sections) during Spring 1996. During a class period, the researcher solicited participants by explaining the purpose of the study, procedures for gathering the data, and length of time required. Each counselor who agreed to participate was randomly assigned by the researcher into one of the two treatment groups. Participants then viewed one of the two videotaped treatments before completing the

instrument packets during the class period. Instructors for this course had given their permission for this use of class time prior to data collection.

Before any videotaped treatment was viewed, participants read and signed a release statement indicating his or her willingness to participate in the study (Appendix E). A packet containing a copy of the instruments and a demographic questionnaire was given to each participant. The researcher explained that participants would view a 9-minute videotaped segment of a supervision session (see Appendix C for script of instructions). No order effects were expected from the sequence of instrumentation, so that the instruments were presented in the same order for each treatment group. The instruments were ordered as follows: Supervision Intervention Interpretation Form, Clinical Hypothesis Exercise Form, Supervision Rating Form-Short, and the demographic questionnaire. Participants were told that the instruments were to be answered immediately after viewing a videotaped segment and that a response must be given for each question. Participants were urged to focus particular attention on trying to understand the nature of the client's concern. Participants were asked to imagine themselves as the counselor in the supervision session and to respond from that perspective when answering the questions. After providing verbal instructions, the researcher answered any questions before allowing the participants to begin. After the

participants had completed the instruments, the packets were collected.

Data Analysis

Descriptive Statistics

Descriptive scores (means and standard deviations) for the CHEF and the SRF-S were calculated for the entire group of participants as well as for each treatment group.

T-tests

In order to test the first hypothesis concerning the quality and complexity of the clinical hypothesis' developed by the counselors-in-training, a series of *t*-test comparisons for items one, three, six, and seven of the CHEF scoring dimensions was performed for the two treatment groups.

To test the second hypothesis regarding participants' perceptions of the supervisor's expertness, attractiveness, and trustworthiness, a series of *t*-tests was performed to compare SRF-S scores for each treatment group.

Chi-square

Due to the fact that item number five of the CHEF scoring dimensions yields categorical rather than continuous data, a Chi-square procedure was used to examine the hypothesis relative to this dimension (i.e., overall quality)

Qualitative Analysis

As a qualitative assessment of how well participants understood the dynamics discussed by the supervisor in the two treatment interventions, the results of the SIIF's for

the treatments groups were examined for exploratory purposes based on the qualitative criteria identified earlier. Based on the data, three Chi-square comparisons were performed to explore the responses of the groups in terms of three components of the participants discussios on this instrument. These Chi-squares were performed to examine the participants ability to interpret the purpose of the supervisors discussion of the case dynamics through the two intervention strategies (i.e., direct versus metaphorical communication) and the clinical implications for the case.

CHAPTER IV

RESULTS

This chapter contains results of the study, based on descriptive and inferential statistics used to examine relationships among the independent and dependent variables. Descriptive statistics, including means and standard deviations, were calculated to describe participant performance on each of the instrument scales. (Results of additional descriptive analyses were reported in Chapter III in the Participants subsection.) Inferential statistics (i.e., *t*-tests and Chi-squares) were used to address the research questions. Using the results of these analyses, overall findings relevant to the hypotheses were examined. Results are presented so that they parallel the research hypotheses and data analyses described in Chapter III.

Descriptive Results

Scores on each scale were calculated following procedures outlined in Chapter III. All scores were plotted for each treatment and distributions appeared normal. Means and standard deviations for each score are reported in Table 2 for the entire sample and in Table 3 by treatment group. Table 4 shows results of both treatment groups for scale two on the CHEF, which classifies the hypothesis elements contained in scale one. Similarly, Table 5 shows the results

of scale four on the CHEF, giving the classification for each supportive element (from scale three) for the two treatment groups.

Table 2

Descriptive Statistics for Each Measure for All Participants

Measures	Mean	Standard Deviation
Clinical Hypothesis Exercise Form		
Number of Distinct Elements	3.13	1.25
Number of Supportive Elements	2.60	1.22
Overall Quality	2.40	1.10
Number of Questions	4.93	2.23
Number of New Questions	2.93	2.03
Supervisor Rating Form		
Attractiveness	18.66	4.02
Expertness	22.99	3.73
Trustworthiness	23.26	3.76

N = 30

Table 3

Descriptive Statistics for Each Measure by Treatment Group

Measure	Mean	Standard Deviation
Treatment 1: Metaphorical Communication (n = 15)		
Clinical Hypothesis Exercise Form		
Number of Distinct Elements	3.07	1.16
Number of Supportive Elements	2.40	1.37
Overall Quality	2.47	1.06
Number of Questions	4.73	1.75
Number of New Questions	2.87	1.41
Supervisor Rating Form		
Attractiveness	18.93	3.71
Expertness	24.20	2.65
Trustworthiness	23.80	3.91

Table 3 continued

Descriptive Statistics for Each Measure by Treatment Group

Measure	Mean	Standard Deviation
Treatment 2: Direct Communication (n = 15)		
Clinical Hypothesis Exercise Form		
Number of Distinct Elements	3.20	1.37
Number of Supportive Elements	2.80	1.26
Overall Quality	2.33	1.18
Number of Questions	5.13	2.67
Number of New Questions	3.00	2.56
Supervisor Rating Form		
Attractiveness	18.40	4.42
Expertness	21.60	4.26
Trustworthiness	22.73	3.65

N = 30

Table 4

Descriptive Results for Hypothesis Dimensions (Scale Two, CHEF) by Treatment Group

	Metaphorical		Direct	
	Frequency	Percent	Frequency	Percent
Client Behavior	6	40.00	2	13.33
Client Internal Factor	10	66.67	10	66.67
External Factor	13	86.67	13	86.67
Association	8	53.33	10	66.67

Table 5

Descriptive Results for Categories of Information Sought in Supportive Elements (Scale Four, CHEF) by Treatment Group

	Metaphorical		Direct	
	Frequency	Percent	Frequency	Percent
Client Statement	1	6.67	5	33.33
Counseling/ Process Observation	9	60.00	10	66.67
Social-Psychological	10	66.67	10	66.67
Counselor-Client Relationship	4	26.67	1	6.67

In general, both treatment groups had relatively similar scores on the five dimensions used to evaluate responses for the CHEF, with less than a one point variation present between the two means on all five dimensions. The average hypothesis contained just over three distinct elements and was supported by nearly three supportive information units.

Participants also listed an average of just under five questions for testing their stated hypotheses and included, on average, nearly three questions that were judged to be exploring information in a new domain. The average overall quality of the hypotheses and supportive statements were judged by the raters to be somewhat below the midpoint of 3 on the 5-point rating scale ($M = 2.40$).

Compared to previous research, scores for this sample were generally low. Morran et al. (1995) reported that average hypotheses in their sample of 27 counselors-in-training contained 8.5 hypothesis units, with 6.2 information units given to support the hypothesis. In their study, counselors listed, on average, over six questions for testing their hypothesis, but only .05 of the questions were judged to be exploring in a new domain. The overall quality of this previous sample's hypotheses were judged to be slightly over the midpoint at 3.3. Therefore, means for the current study were lower than in this previous research, except for the number of new domain questions, with a mean of 2.93 for the current sample compared to just .05 in the previous study.

Item scores on the Supervisor Rating Form-Short scales tended to be high and rather similar across treatment groups. Scores ranged from 4.33 to 6.20 (on a seven point scale) for the metaphor treatment group and from 4.33 to 6.07 for the direct communication group. The lowest overall mean among the subscales was Attractiveness at 18.66, although this mean indicates that the average item score for this subscale was over 4.5, which is still above the midpoint on the seven point scale. The Expertness subscale revealed a mean of 22.99, while the Trustworthiness subscale had the highest mean at 23.26. It also may be noted that although there were no statistically significant differences in the mean scores of the treatment groups, in each case scores were higher in the hypothesized direction (i.e., higher for the metaphor treatment group).

Correlations among scales are shown in Table 6 for the CHEF and Table 7 for the SRF-S. These analyses suggest that scales one and three of the CHEF are correlated (.62), a result that is not overly surprising as scale three is a continuation of ideas generated in scale one. In addition, scale five appears to be correlated to scales one and three (.83, .61). This finding is also understandable, as scale five is a rating derived from the quality of scales one and three. The final scales, six and seven, appear to be correlated with themselves but not the previous scales. This likely speaks to the fact that these two dimensions are

Table 6

Correlations among Dimensions on Clinical Hypothesis Exercise Form for Overall Group

	Dimen. 1	Dimen. 3	Dimen. 5	Dimen. 6	Dimen. 7
Dimen. 1 No. Dist. Elements	1.0000				
Dimen. 3 No. Support. Elements	0.6227	1.0000			
Dimen. 5 Overall Quality	0.8348	0.6103	1.0000		
Dimen. 6 No.Quest.	0.4855	0.3196	0.3625	1.0000	
Dimen. 7 No.New Quest.	0.3151	0.3501	0.1970	0.7681	1.0000

Table 7

Correlations among Supervisor Rating Form-Short Subscale Scores and Total Scores for Overall Group

	Attract.	Expert.	Trustworth.	Total
Attract.	1.0000			
Expert.	.3752	1.0000		
Trustworth.	.4738	.6985	1.0000	
Total	.7618	.8317	.8747	1.0000

derived from a single task of creating a list of questions which the respondent could use to test their hypothesis, which is not directly related to the tasks of the previous scales.

The correlation analyses for the SRF-S indicate that the Expertness and Trustworthiness scales are correlated. This finding might suggest the need to perform multivariate analyses in hypothesis testing; however, given the relatively small sample size, analysis of this instrument proceeded with a series of *t*-tests.

Main Analyses

Hypothesis 1

When a narrative analogy metaphor (Treatment 1) is used to discuss client dynamics in clinical supervision, the clinical hypotheses formulated by beginning counselors will be of significantly higher quality and complexity, as measured by the Clinical Hypothesis Exercise Form (Morran, 1986; Morran et al., 1994), than the clinical hypotheses formulated when direct communication (Treatment 2) about client dynamics are present in clinical supervision.

To address Hypothesis 1, *t*-tests were performed between scores for each treatment group on scales one, three, six, and seven of the CHEF (measures of number of hypothesis units, number of support units, number of exploratory questions, and number of new domain questions). A Chi Square comparison was performed on dimension five (overall quality), as this data was not of a continuous nature. Given that five analyses were performed, alpha was set at .01 for each test to reduce the experiment wise error.

Interrater reliabilities for the judges' ratings on scale one, three, six, and seven were calculated using the Pearson *r* formula. Results suggested a moderate level of interrater reliability, with coefficients of .78, .67,.81, and .64, respectively.

Results for the t-test analyses are shown in Table 8. There were no significant differences between the two treatment group scores for dimensions one, three, six, and seven at the .05 level (family wise error rate). The results of the Chi Square analysis is shown in Table 9. The comparison of overall quality between the treatment groups was not significant.

Table 8

T-tests between Treatment Group Scores for Dimensions One, Three, Six, and Seven of the CHEF

Source	*t*	*df*	*p*
Dimension 1			
No. of Distinct Elements	-0.2870	28	.7762
Dimension 3			
Number of Support. Elements	-0.8944	28	.3787
Dimension 6			
Total Number of Questions	-0.4853	28	.6312
Dimension 7			
Number of Quest. Exploring New Area	-0.1766	28	.8611

Table 9

Chi Square Analysis for Overall Quality Ratings of CHEF Responses by Treatment Group

Source	X^2	*df*	*p*
Dimension 5			
Overall Quality	0.3433	3	0.952

Hypothesis 2

> Beginning counselors' ratings of a supervisor's levels of expertness, attractiveness, and trustworthiness, as measured by the Supervisor Rating Form-Short Version (Schiavone & Jessell, 1988), will be higher for the supervision treatment that includes a narrative analogy metaphor (Treatment 1) to discuss client dynamics than for the supervisor treatment (Treatment 2) that does not.

T-test analyses were performed on the two treatment groups' scores for each of the three subscales of the SRF-S. Results of these analyses are shown in Table 10. The alpha was set at .017 for each test to maintain the overall alpha at .05. None of the analyses were significant at the .05 level. Although there were no statistically significant differences found between the treatment groups, the *t*-test comparison of perceived Expertness approached significance, with a *p* value of .0544. A power calculation indicated that the Expertness subscale had power of .766, suggesting that if a larger sample had been obtained significant differences between the treatment groups may have been found.

Table 10

T-test Comparison of Treatment Group Subscale and Total Scores on the Supervisor Rating Form-Short

Source	*t*	*df*	*p*
Total	1.227	28	.2298
Attractiveness	0.3578	28	.7232
Expertness	2.0082	28	.0544
Trustworthiness	0.7716	28	.4468

No hypothesis was stated for the Supervisor Intervention Interpretation Form. Instead, an exploratory post-hoc analysis of the responses was conducted. First, study of the responses yielded a meaningful categorical scheme that could be used reliably to classify the responses. Raters classified responses to the SIIF into three components which addressed the respondents' interpretation of the supervisors' intervention (i.e., metaphorical or direct communication) and discussion of case dynamics. Using Cohen's kappa, interrater agreement was calculated for the ratings of the three components addressed by the SIIF, yielding coefficients of .79 (Nature of Clinical Difficulty), .73 (Dynamics of Clinical Difficulty), and .85 (Resolution of Clinical Difficulty). Descriptive results are presented in Table 11.

The first dimension of the SIIF was labeled "Nature of Clinical Difficulty" and consisted of specific statements detailing the clinical problem as presented in the treatment. A sample response was; "Linda is stuck in her perspective that Mrs. Walters is completely responsible for she and Mike's problems." For both treatment groups, 40% of participants wrote statements classified in this dimension. The second component of the SIIF was labeled "Dynamics Supporting Maintenance of the Clinical Difficulty." This dimension consisted of direct discussion of psychological dynamics which supported the continuation of the problem (e.g., "Linda is unaware that Mike is allowing his mom to be

Table 11

Descriptive Statistics (Percentages) for Dimensions of the Supervisor Intervention Interpretation Form by Treatment Group

	Components of the Supervision Interventions		
	Statement of Clinical Difficulty	Evidence of Clinical Difficulty	Resolution of Clinical Difficulty
Treatment 1: Metaphorical Communication			
Identified this Component	40	46.7	86.7
Treatment 2: Direct Communication			
Identified this Component	40	33.3	53.3

overly involved in his life which is affecting his relationship with Linda"). Nearly 47% of the metaphor treatment group wrote statements classified in this dimension, but only 33.3% of the direct communication group included any discussion of this idea in their responses. The final component of the SIIF was labeled "Resolution of the Clinical Difficulty," and was comprised of specific discussions of how the clinical problem might be resolved (e.g., "Linda must come to realize that Mike has to take responsibility for his relationship with his mom and her closeness to him, if he really wants things to change"). Nearly 87% of the metaphor treatment group reported statements in this deminsion, but only 53.3% of the direct communication treatment group included such ideas in their reactions.

To investigate any trends in these results, a Chi-square comparison among the three intended components of the supervision interventions was performed. To maintain the overall experiment wise error rate at .05, the alpha was set at .017 for each test. The analysis revealed no statistically significant difference in the treatment groups at the .05 level of significance on any of the three dimensions (see Table 12). There was a trend toward significance, however, in participants' ability to state an appropriate resolution of the clinical difficulty. These results suggest that the supervisor's use of metaphorical

Table 12

Chi-square Comparison of Component Scores on the Supervisor Intervention Form-Short by Treatment Group

Component of SIIF	X^2	*df*	*p*
Clinical Difficulty	0.000	1	1.000
Evidence of Clinical Difficulty	0.556	1	0.456
Resolution of Clinical Difficulty	3.968	1	0.046

communications may have helped participants who received this treatment to generate ideas for how the difficulty might be resolved (i.e., what the client needed to do differently).

Overall, findings of this study seem to suggest that, although the metaphorical intervention did not significantly affect participants' ability to formulate a quality clinical hypothesis, as measured by the CHEF, it may have affected the content of their responses regarding a resolution of the clinical dilemma in a manner consistent with the goals of the study.

CHAPTER V

SUMMARY AND DISCUSSION, LIMITATIONS, AND IMPLICATIONS

This chapter consists of four sections: summary of the research, discussion of the results, recommendations for further research, and implications for supervision practice.

Summary and Discussion

The study was an examination of the impact of a supervisor-generated, verbal metaphorical communication on the clinical hypothesis formation skills of counselors-in-training. A review of the research suggested that metaphor has the ability to influence divergent thinking patterns (Matthews & Dardeck, 1985). Thus, it was hypothesized that the supervisor's metaphorical communication would lead to higher case conceptualization scores than would a nonmetaphorical communications. Further, it has been found that when counselors use narrative analogy metaphors, they are rated by their clients as showing greater empathy, regard, and expertness (Suit & Paradise, 1985). Extrapolating from this research, it was secondarily hypothesized that the supervisor using a metaphorical intervention would be rated higher on social influence dimensions (i.e., attractiveness, expertness, and trustworthiness) than the supervisor using direct communication.

In order to confirm a premise identified in the literature review, that is, that metaphorical discussions of case dynamics in supervision might facilitate the development of more complete hypotheses, an analogue design was used. Thirty master's-level counselors-in-training enrolled in a counseling theories course viewed a 9-minute segment of a supervision session. The concern the counselor brought to supervision was the same in both segments. In fact, the videotapes were identical except for the intervention used by the supervisor. In one segment, the supervisor discussed case dynamics by using metaphorical communications. In the second segment, the supervisor used direct communication to discuss the case with the supervisee.

Participants were asked to imagine themselves as the counselor in the supervision session and to report their reactions by responding to measures of three dependent variables of interest. The Clinical Hypothesis Exercise Form (CHEF; Morran, 1986; Morran et al., 1994) was used to measure counselors' ability to formulate clinical hypotheses about the case viewed. Relatedly, the Supervisor Intervention Interpretation Form (SIIF; Young, 1995) was used as a qualitative measure of participants' understanding of the metaphorical or literal discussions of the supervisor. Finally, the Supervisor Rating Form-Short Version (SRF-S; Schiavone & Jessell, 1988) was employed to measure

participants' perceptions of the Attractiveness, Expertness, and Trustworthiness of the supervisor in each segment.

The first analysis was conducted to determine if there was a relationship between clinical hypothesis formation skills and supervisor-generated verbal metaphorical communications. Second, the perceived expertness, attractiveness, and trustworthiness of a supervisor when direct and metaphorical interventions are used was explored.

Results of the study suggest that a single, brief exposure to a supervisor-generated metaphor has no significant impact on the ability of counselors-in-training to generate more varied and complete hypotheses. Likewise, this sample of counselors-in-training did not perceive the supervisor in the treatments in a significantly different manner with regard to her expertness, attractiveness, or trustworthiness, Nevertheless, the results did include several important trends.

Although no significant differences were found on any dependent variable for the two treatment groups, an interesting trend may be noted from the descriptive statistics for the CHEF. There was a tendency for the quantitative scores for the CHEF (i.e., counts of elements and questions; items one, three, five, and six) to be slightly higher for the group which did not receive the metaphor treatment. In contrast, the overall quality score for the responses on the clinical hypothesis formation

exercise tended to be higher for the metaphor treatment group. Although any speculation about these nonsignificant results must be viewed with great caution, it may be that the metaphor treatment group participants could offer fewer specifics but were better able to present their ideas in a clear and well thought out manner. In other words, the depth of their understanding about the case and the clarity of their articulation may have been enhanced by the metaphorical communication, even though this intervention did not help them pinpoint specific details to support their understanding. Such a speculation is, of course, in need of much further study. Students did, however, express such effects in follow-up interviews concerning their thoughts and feelings in reaction to the video tape they reviewed. Participants in the metaphor treatment group were able to state clearly their understanding of the supervisor's intervention and to discuss it as it applied to both the supervisee and the client. For example, one stated, "To back off was the main message I got from that. You're both so in the middle of the problem (Linda and the supervisee) you can't get a good perspective, yet both are capable of solving the problem if they'll just let go of the impulse to grab the fruit and yank it out of the jar. Relax... Let go and pullback a little bit and look at the problem from a different perspective." In contrast, when students in the direct communication group were asked to discuss what they

understood from the supervisor's intervention, one person indicated tentatively, "I think the feedback was the right stuff for the counselor to hear. The supervisor was giving her (the supervisee) other options for how to think about it." No students in this group, however, were able to expaned beyond such tenative responses.

A second trend involved results from the SIIF. One analysis, which was moving in the direction of significance, suggests that the supervisor's use of a narrative analogy may have impacted participants' ability to discuss changes in the case's dynamics that must occur for it to be resolved in a successful manner (e.g., Mike must begin to take responsibility for his relationship with his Mother). This trend is consistent with the intended goals of the study and therefore deserves further investigation. In addition, this trend may be consistent with the findings of Martin et al. (1992), who indicated that a counselor's intentional use of metaphor was associated with a learning factor they labeled "conceptual bridging." Presumably, in the context of their study, this learning involved clients gaining insight into their lives and difficulties. It may be that the counselors in the current study who received the metaphor were more likely to discuss the resolution of the clinical dilemma, may suggest a similar type of learning also taking place within the context of supervision.

A final notable trend from this study involves the expertness subscale for the SRF-S, which approached significance and was found to have power of .766, further suggesting its potential for significance. This trend is consistent with the findings of Suit and Paradise (1985), who found that counselors' use of narrative analogy type metaphors was associated with higher ratings of expertness. It may be, then, that there is some element involved in hearing metaphorical communications, including those in supervision, that leads the receiver of the communication to perceive the speaker as an expert, as particularly insightful about a clinical issue not based on what was said but how. Again, this speculation requires further investigation. It also should be noted that Suit and Paradise (1985) found that a counselor's use of a narrative analogy metaphor produced more positive ratings of empathy and regard. Although these variables were not under investigation in this study, they perhaps deserve inclusion in future research.

Limitations of the Study

This study was designed to examine the impact of metaphorical communications used in counseling supervision on the ability of counselors-in-training to create clinical hypotheses. Limitations of the study are identified in terms of their effect on the conclusions and in terms of their implications for further research.

One limitation is the analogue design of the study. Although analogue studies allow researchers to have greater control over the factors under investigation and greater flexibility in what can be examined, a major drawback is the uncertainty of the generalizability of the results (Heppner et al., 1992; Munley, 1974). In this study, counselors rated what they saw, heard, and felt in response to portions of a videotaped supervision session. Review of an entire supervision session might provide a more in-depth view of the supervisor's use of metaphorical or literal communication, and reveal more dynamics, thus allowing for different results. Even more, counselors' responses might be different if they rated a supervisor with whom they had been actively involved in a supervisory relationship over a period of time. For this topic to be studied in such a manner, however, a naturalistic design would be required, thus sacrificing control of numerous extraneous variables and affecting the outcomes in indeterminable ways. Nevertheless, the preliminary findings of Young and Borders (1996), using a naturalistic design to examine metaphor in supervision, indicate that this approach is possible. In addition, clinical observations of the impact that metaphorical approaches had on the thinking of supervisees in that earlier study suggest the approach may be fruitful, even though much control of variables is sacrificed. Additional studies in which data are gathered over a period of time (using a case

study or longitudinal design) from counselors and supervisors involved in an ongoing supervisory relationship may reveal more insights into any differential effects of metaphorical and nonmetaphorical communication. Such approaches also would allow researchers the flexibility needed to address use of contextually appropriate metaphors. In essence, the literature indicates that metaphors are most effective when they are created to fit a specific situation (i.e., a specific counselor, client, and counseling session). Analogue designs sacrifice the contextual power of metaphors for the power of control over variables. Systematic use of both approaches may be the best alternative, given their complementary nature.

It also may be that the treatment (one incidence of exposure to metaphor) was too faint (i.e., brief) to produce the desired results. Therefore, exposure to more than one instance of metaphor may be a better test of its impact. Given this perspective, the fact that this study yielded several trends after only one brief exposure is noteworthy.

An additional limitation of this study is the fact that participants were solicited from one university, and therefore are not a representative sample of all counselor education students. The sample was largely white (90%), female (83%), and young (63% in their 20's). Therefore, including students from a broader sample of counselor education programs (i.e., from other institutions) and from a

variety of racial and age groups of both sexes would allow the results to be more generalizable.

Relatedly, the small sample size yielded low power, limiting the possibility of significant results. This possibility was supported by the results of power calculations for the Expertness scale of the SRF-S, which indicated the trend may have been significant given a larger sample. Therefore, a larger sample size would be preferable in future studies.

An additional consideration for future research would be to examine the impact of a variety of figurative interventions rather than only one type. For example, complex as well as narrative analogy metaphors could be used by supervisors to examine their impact on supervisees' cognitive counseling skills. Also, the promising outcomes of the case studies conducted by Ishiyama (1988) and Amundson (1988) indicate that metaphorical drawings deserve controlled exploration.

Implications for Practice

The supervision literature lacks an empirical base to describe what actually happens within the cognitive structures of a supervisee when metaphorical interventions are used. This study is the only one to date that has attempted to investigate, in a controlled manner, the use of metaphor as a supervision intervention. The need for methods such as metaphors, that might impact counselors' cognitive

counseling skills, including clinical hypothesis formation, has been consistently cited in the counselor training and supervision literature (Borders, 1989; Fuqua et al., 1984; Kurpius et al., 1985). Therefore, this study was designed to investigate this need by examining the impact that supervisor-generated metaphorical discussions of case dynamics has on the clinical hypothesis formation skills of counselors-in-training, as well as counselors' perceptions of the expertness, attractiveness, and trustworthiness of a supervisor using this intervention. There are several ways that supervisors may benefit from these results.

First, supervisors may wish to include metaphorical interventions in their work as a possible means to assist supervisees with understanding how to approach clinical situations. Although the results of this study cannot be spoken of with certainty, the trend seems to be that exposure to a narrative analogy metaphor may benefit supervisees by helping them to discern the clinical variables which need to be addressed so that a clinical situation can be resolved. Further, supervisors may be able to use metaphorical interventions to impact the supervisory relationship in a positive manner. Specifically, the perceived expertness of a supervisor may be enhanced by the inclusion of figurative communication patterns.

It would be inappropriate to suggest a strong association among these variables, given the results of this

study. Nevertheless, it may benefit supervisors to consider the possible positive impact that metaphor may have in their relationships with supervisees. At the very least, supervisors could become more aware of the verbal metaphors they do use and begin to observe their impact on their supervisees' client conceptualizations.

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APPENDIX A

CLIENT DESCRIPTION

In the videotaped portion of a clinical supervision session you will view, the supervisor and supervisee will discuss a client whom this counselor has seen for four sessions. The client, whose name is Linda, has never been in counseling before. She is a 21-year-old college junior who is having difficulties in her relationship with her boyfriend of one year. Her boyfriend's name is Mike. Linda reports that Mike's mother is quite possessive of him and wants him to spend a great deal of time with her. Linda also reports that if she asks Mike not to do this he becomes angry with her. Therefore, Linda is left feeling as though she must compete with Mike's mother for his attention. Further, she states; "I think his mom is upset with me because she thinks I am trying to take Mike away from her. I don't know what to do!" Mike has told Linda that he is not comfortable talking with a counselor.

Script for Treatment 1
(Intentional Use of Metaphor)

1.1 S-ee: So, did you get a chance to listen to the tape of Linda? She's the girl who is concerned about her relationship with her boyfriend, Mike. His mother is so involved in everything he does, it's really affecting their relationship. Linda's really been having a hard time lately.

1.2 S-or: I did listen to the tape. This is the second tape I've listened to of you and Linda.

2.1 S-ee: That's right. This was the second tape you've heard, but it was our fourth session. She's an interesting client. I mean she is motivated to participate in counseling and seems to really want things to get better for her and Mike, but she just doesn't seem to know what to do to make that happen. It's like Mike's mom wants him to spend so much time with her that Linda feels she is less important to Mike than his mother is. By the way, his mother's name is Ms. Walters.

2.2 S-or: I heard you ask Linda on the tape about a homework assignment you had given her, to practice talking assertively with Mikes mom on the phone. I think you wanted Linda to tell Ms. Walters that she did not want to make plans to do something which involved all three of them.

3.1 S-ee: Yeah and she didn't do it. I was disappointed in her. I really thought that it would be helpful for her to do that. I wanted her to stand up to Ms. Walters and give her honest opinion.

3.2 S-or: Mmm. Could you describe for me the problems in Mike and Linda's relationship as you see them?

4.1S-ee: Well, I think that... Mike's Mom depends way too much on him. I mean, she thinks he should always be available to do what she wants him to do.

4.2 S-or: Uh huh

5.1 S-ee: Linda says that when she tries to talk to Mike about it he becomes angry and they end up having an argument. It's like Linda is stuck, she doesn't know how to change the situation. She just knows she isn't happy.

5.2 S-or: O.K., and what would you say has been your focus in counseling since you have been working with Linda?

6.1 S-ee: Well, at first I just tried to understand how she was feeling about the situation.

6.2 S-or: How would you describe Linda's feelings?

7.1 S-ee: I'd say she's hurt, confused, and at times sad. Mostly, though, she's just angry at Mike's mom.

7.2 S-or: What about how Linda sees the issues in the relationship? What do you believe she thinks is the primary problem?

8.1 S-ee: I think she doesn't exactly understand why Mom wants to be so close to Mike, who's now an adult, and why he doesn't choose Linda over his mom. I mean Mike's mom wants him to have dinner with her all the time, to go on vacations together, its really like she still wants him to be her little boy in a way. Of course Ms. Walters does tell Mike it's all right if Linda comes along, but Linda still feels kind of unwelcome. She thinks that mom needs to let him go. I guess Linda thinks his Mom just needs to back off!

8.2 S-or: I see... Do you agree with Linda?

9.1 S-ee: Well I think her assessment is a bit simplistic, but I do agree there needs to be more distance between Mike and his mom. I think that Mike's mother may be a bit jealous of Linda and not want to share Mike with anyone. You know Mike is an only child, and his parents have been divorced for years, so it has always been just Mike and his mother. At the same time, I find myself wondering why, if Linda is so upset about this, she won't tell Ms. Walters how she feels.

9.2 S-or: Yes..., she does say that what needs to happen is for Mike to be more separated from his mother.

10.1 S-ee: Yeah... (slowly, thoughtfully). That's true, and that's why you heard me talking to her about confronting Mike's mom. If this really does bother her so much, she needs to be willing to do something about it. I don't know if I told you, but Mike says that his mother sort of caused him and his last girlfriend to break-up. I mean, the girl got tired of his mom always being around. Plus, it sounds like she doesn't like anybody Mike dates. That's what is so <u>frustrating</u> to me, because I think that Linda <u>needs</u> to express her <u>feelings</u> to Ms. Walters! (speaking a bit more quickly and loudly).

10.2 S-or: I can hear the frustration in you voice.

11.1 S-ee: (Smiling) Yeah. It's just that I think it would really help if she did.

11.2 S-or: You might be right, but you can't force Linda to be ready to change. (Pause). I'm curious how you would describe Linda's primary issue or concern from your perspective. You indicated that she is having difficulty communicating assertively to Ms. Walters, but I haven't heard what you believe to be her primary difficulty.

12.1 S-ee: (Thinking for a moment, then slowly). I see this situation as one in which Linda, Mike, and even Ms. Walters need to mature and gain more self awareness. I think that because Linda and Mike don't agree on how to handle the problem, Linda is left feeling hurt. So, I think she needs to learn to communicate her needs in a more healthy manner. Also, I think that Ms. Walters is coming between Mike and Linda and that she needs to be less involved with her son.

12.2 S-or: Do you believe that Linda is gaining any self awareness?

13.1 S-ee: I don't know. I hope so. It's hard to tell since she mostly talks about Mike's mom and how upset she is with her.

13.2 S-or: Uh huh. Do you think that Linda talking about her frustration with Ms. Walters is getting any closer to resolving this difficulty?

14.1 S-ee: Well... (pause). I don't know... (pause). I guess it will be kind of hard for Linda to do much about it, really. I mean, how can she change Mike's mom?

14.2 S-or: I agree, there isn't much Linda can do about Ms. Walters. What about Mike and Linda? Is there any way you can help Linda with her part of their relationship?

15.1 S-ee: Well, I talked with her about expressing her feelings to Mike. Like how she feels as though Mike's mom is coming between them and, as I said, she has done this some. But it's just that it causes an argument so it doesn't really help.

15.2 S-or: Mmm. So when Linda confronts Mike directly, it causes Mike to get angry and it doesn't seem to help.

16.1 S-ee: Yeah, I mean Mike says he cares very much for Linda and wants their relationship to work; but Linda just feels like she sort of is a lower priority than Mom.

16.2 S-or: So what could Linda do differently?

17.1 S-ee: Hmm... (after a pause, thinking) I'm not sure if I know what you mean.

17.2 S-or: Well, you did say that when she confronts Mike directly about his Mom's involvement in their relationship it doesn't help. Also, it appears that Linda isn't able to confront Ms. Walters at all.

18.1 S-ee: Right. That right.

18.2 S-or: I guess I'm wondering how Linda might behave in a manner so that the struggle between Linda and Ms. Walters would change.

19.1 S-ee: Hmm... Well, maybe if Linda could express her concerns to both Mike and his mom together, then they could understand her better and then maybe his mom might back off.

19.2 S-or: True, but what does that say about Mike's responsibility in all this?

20.1 S-ee: I guess it sort of makes it easy on him.

20.2 S-or Yes. So is there a way Linda can get what she wants in a way that will not be so stressful on her?

21.1 S-ee: Mmm, that's a good question. I mean, that's really what needs to happen here. Linda needs to feel as though Mike is choosing her rather than feeling like she is struggling to get him and can't.

21.2 S-or: (pause) You know, Linda's approach to dealing with Mike and his Mom reminds me of a technique I once heard about for capturing a monkey. A piece of fruit is placed into a large heavy jar, the mouth of which is just large enough for the monkey's hand to pass through. Once the monkey reaches into the jar and grabs the fruit (simulating reaching) he cannot get his hand out because he has now made a fist. If, however, the monkey would relax (pause) and let go of the fruit (pause), he could remove his hand easily. Then, perhaps he could turn the jar over and shake it to remove the fruit. Anyway, the monkey entraps himself because he is unable to see how he is contributing to his own situation. (pause)
Similarly, Linda, is unhappy in her relationship with Mike because she holds to the view that Ms. Walters is the reason she and Mike are having problems. However, if Linda could relax and gain a new perspective, she may realize it is not her responsibility to force Mike and his mom to be more

separate. So, it seems important that Linda begin to look at what she is doing that enables the relationship to go on as it is rather than blame Ms. Walters for all of she and Mike's problems.

Script for Treatment Two
(Direct Communication Ending)

17.2 S-or: Well, you did say that when she confronts Mike directly about his Mom's involvement in their relationship it doesn't help. Also, it appears that Linda isn't able to confront Ms. Walters at all.
18.1 S-ee: Right. That right.

18.2 S-or: I guess I'm wondering how Linda might behave in a manner so that the struggle between Linda and Ms. Walters would change.

19.1 S-ee: Hmm... Well, maybe if Linda could express her concerns to both Mike and his mom together, then they could understand her better and then maybe his mom might back off.

19.2 S-or: True, but what does that say about Mike's responsibility in all this?

20.1 S-ee: I guess it sort of makes it easy on him.

20.2 S-or Yes. So is there a way Linda can get what she wants without this being so stressful on her?

21.2 S-ee: Mmm, that's a good question. I mean, that's really what needs to happen here. Linda needs to feel as though Mike is choosing her rather than feeling like she is struggling to get him and can't.

21.2 S-or: Yes, I agree and I suppose what I am suggesting is that you help Linda to look at the situation differently, so that she no longer believes that Ms. Walters is the reason she and Mike are having problems. Perhaps Linda may come to understand that it is not her responsibility to force Mike and his mom to be more separate. Also, it seems important that Linda begin to look at what she is doing that enables the relationship to go on as it is rather than blame Ms. Walters for all of she and Mike's problems.

APPENDIX B

SIIF

Explain in your own words, what you believe the supervisor on the videotape was attempting to communicate to the counselor with her final statements. Please use all the space you need to clearly relay your thoughts about the supervisors statements.

Scoring Criteria for the Supervisor Intervention Interpretation Form

To examine participants ability to discern the meaning of the interventions used by the supervisor in the videotaped treatments, you will evaluate their responses. Below is a description of the intended meaning of the metaphorical intervention as well as three components of the intervention which you are asked to rate. The intention is for you to rate if the participant included the particular components of the intervention that are outlined below.

Intended Meaning for the Metaphor:

The metaphor was intended to suggest that Linda's situation is like the monkey who is stuck because he wants the piece of fruit so badly he cannot see another way to solve the problem (i.e., Linda wants Mike to give her more attention than he does his mother, so she is unable to see that he is making a choice to allow his mother to be so involved in his life). Further, Linda's situation is like the monkey's in that the monkey thinks it is the jar that is preventing him from getting what he wants when in fact he is causing himself to be stuck by refusing to let go of the fruit (i.e., Linda believes it is Mike's mom that is preventing her from getting Mike's full attention rather than admitting she is unhappy because she is focusing on Ms. Walters to avoid the reality that Mike is choosing to allow his mother to be so involved). Therefore, the metaphor implies that for Linda to get what she wants (greater attention from Mike) she must be willing to let him go, stop blaming his mother for their relationship problems, and allow Mike to take responsibility for his relationship with Ms. Walters.

1) Linda's situation is like the monkey because they are both stuck.

overtly made this comparison		somewhat made this comparison		did not make this comparison
5	4	3	2	1

2) Linda's situation is like the monkey's in that they both view something other than their own behavior as the cause of their unhappiness (i.e., the jar/Ms. Walters).

overtly made this comparison		somewhat made this comparison		did not make this comparison
5	4	3	2	1

3) Linda's situation is like the monkey's in that to solve their dilemma both must be willing to let go of what they want.

overtly made this comparison		somewhat made this comparison		did not make this comparison
5	4	3	2	1

Intended Meaning for the Direct Communication:

The direct communication by the supervisor was intend to inform the supervisee that Linda is stuck in her situation because she is so focused on not being able to relate to Mike in the way she wants to. Further, because Linda is blaming Ms. Walters for all of she and Mike's problems, she does not see that she is facilitating the problem by trying to force Mike and his mom to be more separate. Finally, the direct communication attempted to show that Linda, to solve her problem, needs to gain a new perspective as to the nature of the problem and how she is helping to maintain it.

1) Linda is unhappy because she is focused on not being able to relate to Mike, because of his mom.

overtly stated this		somewhat stated this		did not state this
5	4	3	2	1

2) Linda sees Ms. Walters as the source of the problem, rather than how she is contributing to the problem.

overtly stated this		somewhat stated this		did not state this
5	4	3	2	1

3) Linda needs to look at the situation in a new way to understand that by focusing on Ms. Walters she is taking responsibility for Mike's relationship with his mom and is facilitating the problem.

overtly stated this		somewhat stated this		did not state this
5	4	3	2	1

CLINICAL HYPOTHESIS EXERCISE

The formation of a clinical hypothesis involves the integration of the counselor's observations, assumptions, and inferences in order to establish a tentative explanation of the factors, and any relationships among such factors, involved in the client's concern or issue. The formation of such a "working model" of the client is useful because it can provide direction for the counselor's attempts to facilitate client growth and change. By thoughtfully responding to the following tasks, you will develop a clinical hypothesis that should aid you in understanding and facilitating the client discussed on the videotape, if you were actually her counselor.

If additional space is needed for your response to any of the following tasks, please continue on the back of the page.

1. Based on your observations, hunches, and assumptions, write an hypothesis describing the client discussed on the videotape and her major concern or issue.

2. Describe any factors related to the client, the environment, the counselor-client relationship, etc., that you believe to be supportive of your hypothesis.

3. Formulate a list of questions you feel you would need answered in order to test the accuracy/validity of your hypothesis.

4. On the following scale, rate you present level of confidence concerning the accuracy of your hypothesis:

Not at all confident 1 2 3 4 5 6 7 8 Extremely confident

CLINICAL HYPOTHESIS EXERCISE WORKSHEET

1. Number of distinct, relevant , and nonredundant elements in the hypothesis statement.

   Frequency count = _____

   a. # of distinct elements ____
   b. # of relevant elements ____
   c. # of nonredund. elements ____

2. Hypothesis dimensions. Judge the hypothesis statement for presence or absence of each of the following: Not present = 0 Present = 1

   _____ a. client behavior
   _____ b. client internal factors
   _____ c. external factors
   _____ d. associations between a, b, and/or c

3. Number of supportive elements. Frequency count of relevant and nonredundant facts listed as substantiation for hypothesis.

   Frequency count = _____

   a. # of relevant elements ____
   b. # of nonredund. elements ____

4. Categories of information used to support hypothesis. Judge the supportive facts for presence or absence of each of the following: Not present = 0 Present = 1

   _____ a. client statements
   _____ b. counseling process/observation
   _____ c. social-psychological issues
   _____ d. counselor-client relationship

5. Overall quality of hypothesis and supportive elements.

Low level of overall quality of thought & clarity of expression	1 2 3 4 5	High level of overall quality of thought & clarity of expression

6. Total number of questions. Frequency count of distinct and nonredundant questions.

   Frequency count = _____

   a. # of distinct ques. ____
   b. # of nonredund. ques. ____

7. Number of questions judged as representing exploration in a totally new or different domain.

   Frequency count = _____

Supervisor Rating Form

In the following statements, a characteristic is followed by a seven-point scale that ranges from "not very" to "very." Please circle the number that best represents how you view your supervisor. Though all of the following characteristics are desirable, supervisors may differ in their strengths. We are interested in knowing how you view these differences.

		Not Very						Very
1.	Friendly	1	2	3	4	5	6	7
2.	Likable	1	2	3	4	5	6	7
3.	Sociable	1	2	3	4	5	6	7
4.	Warm	1	2	3	4	5	6	7
5.	Experienced	1	2	3	4	5	6	7
6.	Expert	1	2	3	4	5	6	7
7.	Prepared	1	2	3	4	5	6	7
8.	Skillful	1	2	3	4	5	6	7
9.	Honest	1	2	3	4	5	6	7
10.	Reliable	1	2	3	4	5	6	7
11.	Sincere	1	2	3	4	5	6	7
12.	Trustworthy	1	2	3	4	5	6	7

Demographic Questionnaire

ID= ______________

1. Please indicate the academic program in which you are enrolled: (check only one)

_____ Masters

_____ Educational Specialist

2. Age

_____ 21-29

_____ 30-39

_____ 40-49

_____ 50-59

_____ 60+

3. Sex

_____ Female

_____ Male

4. Race

_____ White

_____ Hispanic

_____ African American

_____ Native American

_____ Asian American

_____ Other (please specify)

5. Please indicate your specialty discipline (track) in the counselor education program:
(check only one)

_____ Community Agency

_____ Student Development in Higher Education

_____ School Counseling

_____ Marriage and Family

_____ Gerontology

APPENDIX C

INSTRUCTIONS FOR PARTICIPANTS

The purpose of this study is to determine counselors' perceptions of various supervision interventions. You will watch a 9 minute segment taken from of a supervision session. As you view the videotape, imagine yourself as the counselor in the supervision session being portrayed, and imagine you are being supervised by the person to the right of the screen. Focus on the supervisor's feedback as well as how you would consider working with the client given the discussion you observe. Be aware of your thoughts, perceptions, questions, and hypotheses about the client. It is acceptable to write down your thoughts and feelings as they occur to you on this instruction sheet as you are viewing the videotape.

After viewing the videotape, please complete the instruments in the packet. Include all responses that best describe how you would be thinking if you were the supervisee at this moment.

APPENDIX D

TRANSCRIPT RATING PROCEDURES

To collect data for my dissertation study, I am creating videotaped analogs of a counseling supervisor and supervisee discussing a client with whom the supervisee is currently working. The dialogue of the two tapes are identical except for the supervisor's last series of statements (i.e., intervention). In one of the analogs the supervisor intentionally uses a metaphor to address clinical dynamics, while in the other she does not. Attached is a transcript of this conversation. Please read the transcript, the enclosed information regarding the components of metaphor, and types of metaphor, before giving your response to any questions. After reading this material, rate the dimensions requested on the enclosed form which begins on page 5. Also, include any feedback you might have regarding the interaction of the speakers, how representative this session is of supervision interactions, or any other reactions/suggestions you may have. While reading the transcript consider that this is intended to be a mid-semester supervision session of a master's- level counselor-in-training who is participating in a community-based internship.

Components of a Metaphor

The components necessary for a statement to qualify as a metaphor as well as explanations of the types of metaphor are provided below. Operationalized definitions of a metaphor as well as the types of metaphor are given. Please use these criteria in answering the questions regarding the metaphor used by the supervisor in the transcript.

For a communication to qualify as a metaphor it should contain the following components:

1) A metaphor should use an indirect communication pattern, so that its intended meaning is not perfectly clear (Muran & DiGiuseppe, 1990).

2) A metaphor should consist of comparisons among the similarities of two or more objects that, in a literal sense, are dissimilar (Ortony, Reynolds, & Arter, 1978).

3) For a metaphor to function, it must be possible to eliminate the semantic tension created by its use (Ortony, Reynolds, & Arter, 1978).

FOR EXAMPLE:

a) "The ship plowed the seas." The tension from this metaphor can be eliminated by interpreting it to mean that the ship pushed through waves much as a plow pushes through dirt.

b) "Regardless of the wavelength, some anger programmed the bus sandwich." In theory, there is no meaningful way to resolve the semantic tension created by this statement; therefore, it is not a metaphor.

4) A metaphor must allow for the assembling of a complex array of information into a relatively simple visual image (Rule, 1983).

Types of Metaphor

Metaphors vary in complexity based on their information processing difficulty, from subtle to explicit interpretation. There are three types of metaphor: the cliché, the narrative analogy, and the complex metaphor (Suit & Paradise, 1985).

To illustrate these three types, the following three metaphors were developed from scripts of a counseling session with a 35-year-old man having interpersonal communication problems with his parents.

1) Cliché- Have minimal implications to the situation to which they refer, are minimally complex, and rigid in form. For Example

Anytime you want to make a change, those having relationships with you must also face change. But you've got to make a choice. Do you try to teach an old dog new tricks or keep your finger in the emotional dam and avoid biting the hand that feeds you.

2) Narrative Analogy*- Have explicit implications to the situation to which they refer, are moderately complex, with explicitly stated elements and implications.

Anytime you want to make a change, those having relationships with you also face change. Think of it as if you relied upon an old watch, handed down within your family. Suppose you have a great deal of sentimental attachment to that watch. You don't feel comfortable with the idea of discarding it, yet it no longer works to your satisfaction. Sometimes it's fast, other times it's slow. Occasionally it stops working without forewarning. As a result, you find yourself missing appointments and having interpersonal difficulties you'd rather avoid. So you're faced with a dilemma: trying to repair it, knowing that you cannot guarantee the outcome, or leaving it as is and putting up with the personal difficulties. So it is in your relationships with those important in your life. You can avoid addressing the important issues, and the consequences are likely to prevail. But you can choose to intervene, although again there is no guarantee on outcome.

3) Complex Metaphor- Offer an implied interpretation to the situation to which they refer, are highly complex, having explicit elements but subtle implications.

I am reminded of an anecdote I recently heard. The story involves an incident at the San Diego Zoo. This is a especially progressive zoo- a pioneer in matching the environment to the captive animal's needs and natural habitat. Well, the zoo officials had requested a polar bear to complement their menagerie of animal. Unfortunately, the bear was delivered much sooner than expected. Renovations on the enclosure were

only half completed. Rather than sending the animal back, they decided to build a temporary cage. And so the animal was caged while the construction was completed. Now, if you have ever seen a caged animal, you know that they do not adjust well to the confinement. They pace repeatedly forward and backward. Over and over again, paces are measured. Since the polar bear was relatively large in relation to his cage, he could only take 10 paces before he was forced to turn around and repeat the paces. This occurred day in and day out until the new quarters were ready. At last, construction was completed. The environment awaited. Workmen were called who ever so carefully removed the smaller barred enclosure. Zoo officials watched with high expectations. The polar bear looked around cautiously and waited-before he resumed the same 10 paces, forward and backward.

*As narrative analogies were found by Suit and Paradise (1985) to elicit the most favorable impressions of therapists and because they were more easily interpretable than complex metaphors, I have attempted to use this type of metaphor in the script.

Now go to next page and begin answering questions about the content of the transcript.

With regards to the <u>metaphorical intervention</u> used by the supervisor in Treatment 1:

1) The metaphorical statements would likely be helpful to the supervisee.

Very Helpful	Helpful	Neutral	Unhelpful	Very unhelpful
5	4	3	2	1

2) The final series of statements used by the supervisor were, in fact, a metaphor.

Yes
No

3) The metaphor used by the supervisor was a cliché.

Yes
No

4) The metaphor used by the supervisor was a narrative analogy metaphor.

Yes
No

5) The metaphor used by the supervisor was a complex metaphor.

Yes
No

With regards to the non-metaphorical intervention used by the supervisor in Treatment 2:

6) The non-metaphorical statements would likely be helpful to the supervisee.

Very helpful Helpful Neutral Unhelpful Very Unhelpful

5 4 3 2 1

The following questions pertain to the performance of the supervisor and the supervisory interaction, excluding the supervisor's final intervention. In rating the following dimensions, use the scoring criteria outlined below. Circle your response:

5 = strongly agree
4 = agree
3 = neutral
2 = somewhat disagree
1 = strongly disagree

7) The interaction of the supervisor and supervisee in the transcript was representative of an actual supervision session.

5 4 3 2 1

8) The supervisor displayed appropriate supervisory skill.

5 4 3 2 1

9) The supervisor was supportive.

5 4 3 2 1

10) The supervisor was directive.
5 4 3 2 1

11) The supervisor was realistic.
5 4 3 2 1

12) The supervisor was warm.
5 4 3 2 1

13) The supervisor was sincere.
5 4 3 2 1

14) The supervisor was likable.
5 4 3 2 1

15) The supervisor provided appropriate structure.
5 4 3 2 1

Please add your comments regarding the following questions:

16) Was any portion of the dialogue difficult to understand or follow? If so which part?

17) Were any important issues of the case not addressed by the dialogue?

APPENDIX E

CONSENT TO ACT AS HUMAN SUBJECTS

The University of North Carolina at Greensboro

Short Form

Project Title: ______________________________

Project Director: ______________________________

Subject's Name______________________________

Date of Consent______________________________

______________________ has explained in the preceding oral presentation the procedures involved in this research project including the purpose and what will be required of you. Any benefits and risks were also described. ______________________ has answered all of your current questions regarding your participation in this project. You are free to refuse to participate or to withdraw your consent to participate in this research at any time without penalty or prejudice; your participation is entirely voluntary. Your privacy will be protected because you will not be identified by name as a participant in this project.

The research and this consent form have been approved by the University of North Carolina at Greensboro Institutional Review Board which insures that research involving people follows federal regulations. Questions regarding your rights as a participant in this project can be answered by calling Dr. Beverly Maddox-Britt at (910) 334-5878. Questions regarding the research itself will be answered by ______________________ by calling ______________. Any new information that develops during the project will be provided to you if the information might affect your willingness to continue participation in the project.

By signing this form, you are agreeing to participate in the project described to you by ______________________.

____
Subject's Signature

____
Witness to Oral Presentation and Subject's Signature

11/95