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Inner Experiences of Experienced Therapists Derived by a Free Recall Method

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INNER EXPERIENCES OF EXPERIENCED THERAPISTS DERIVED BY A FREE RECALL METHOD

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CHAPTER I

INTRODUCTION

Overview

Psychotherapy process research has made headway in conceptualizing and measuring the in-session behavior of therapists and clients as well as their inner experiences. In terms of measuring verbal and nonverbal behavior, research has progressed through various stages including administering standardized questions after a session, having both the client and counselor keep records of their thoughts and feelings through notes and diaries, and through having the therapist and client state their thoughts and feelings through a structured recall method. In addition, methodological issues have been concerned with the unit of analysis, the selection of a session, how to train raters, and many other aspects.

In its early stages, process research referred to all or some part of the interpersonal interaction between a therapist and client. Now it seems to connote more of an intrapersonal, private operation in the mind of the therapist or client as they interact in counseling (Martin, 1991). It seems to represent a "to think about" or a "to reflect on" process (Martin, 1991). Hill & O'Grady (1985) added that the counseling approach includes two parts which

are the "how" and "why" parts of counseling. The how deals with the different ways of intervening and is operationalized in terms of response modes. The why part of counseling involves different reasons for intervening and is operationalized in terms of intentions.

Due in part to this type of thinking, a plethora of past studies reviewed the relationship of counselor intent, counselor behavior, client cognitive operations, and client response. For example, Russell and Stiles (1979) presented a framework for classifying behaviors that included coding schemas based on three categories. The semantic meaning of the language is captured in a content category. Such things as vocal noises, tonal quality, and pauses are reviewed by the extralinguistic category. Lastly, the intersubjective category examines the relation between counselor and client. This category is descriptive of interpersonal intentions and has been utilized to measure psychotherapeutic techniques, relationships in therapy, and the therapy process in general.

Another pioneering study was done by Kagan (1975) who developed the Interpersonal Process Recall method that involved playing back an audio or videotape immediately after a session and allowing the client and counselor to describe intents, perceptions, impacts, and other momentary experiences associated with interventions. Later, Elliot (1979) adapted Kagan's IPR method to explore the client's

subjective experiences and perceptions about the counselor's behavior. In this study, a counseling session was taped and after the session, three segments were reviewed (beginning, at 15 minutes, and at 25 minutes) from a 30 minute session. After the therapist spoke, the client was asked to describe the therapist's behavior and what they thought the therapist's intentions were. Seven intention variables were utilized which include guiding the client, reassuring the client, communicating understanding of client's message, explaining to client, getting information, using self to help client. Results of the study suggested that guiding and getting information were the most commonly perceived intentions while reassuring was the least (Elliot, 1979).

Later, researchers began to focus more on the internal processes of the therapist. In many studies a structured method of cued recall was employed to access the therapist's intentions. This approach entails audio or videotaping a session and then having the therapist either review the transcript or the videotape and state their intentions for each of their interventions. When focusing on intentions, researchers commonly have provided a predetermined choice list for a therapist to categorize their intentions.

Purpose

The current study is an exploratory study that attempts to access therapists' internal processes using a free recall method. Specifically, instead of cued recall that may

interfere with the therapist's ability to accurately remember his or her inner experiences at the time of the session due to the reprocessing information when cued by an audio or video tape (Wynne, Susman, Ries, Birringer, & Katz, 1994), free recall is used to access inner experiences. Free recall is defined as remembering verbatim dialogue and the accompanying inner experiences without taped cues. In this study, an intention list was not provided to the therapist to give the therapist flexibility in remembering their inner experiences. Although the current study includes intentions as one of the dimensions of therapists' internal processes, there is also an effort to assess all thoughts, feelings, and rationales as well as the metacognitions and self-talk of therapists.

Organization of Present Study

This thesis is organized into five chapters and references. Chapter 1 consists of the introduction, purpose, and organization of the present study. Chapter 2 contains a review of related literature. Chapter 3 includes the method and procedures employed in this study. Chapter 4 contains results of the study. Chapter 5 consists of the discussion.

CHAPTER II

REVIEW OF RELATED LITERATURE

Process & Outcome

Psychotherapy research studies both process and outcome variables separately as well as their influence upon one another. Psychotherapy process research concentrates on what happens during a counseling session whereas outcome research involves the post-session effects of psychotherapy. For example, in the past years, process researchers have investigated components of the therapy session such as the client's and therapist's verbal and nonverbal behaviors and the interaction between the two of them. Meanwhile outcome research specifically reviewed the client's behavior outside of the counseling session (Hill & Corbett, 1993). Then process and outcome researchers then began to be interested in revealing the different aspects of the psychotherapy process so that they could link what happened within the session to what happened outside of the session.

In general, three goals of process research emerged. These goals include describing what happened in a counseling session, describing and showing change within session behavior, and lastly, associating process and outcome (Hill & Corbett, 1993). The process of change became a major

focus of the researchers as change within the session was purported to be related to post change. Researchers were not simply able to examine how change occurs in the client because the client and therapist are dependent upon one another and change results from their interaction. The client and therapist influence one another and therefore their behavior began to be viewed as interactional units (Hill, 1982). In addition, it was thought that a therapist would be more effective at promoting change if the therapist understood what was happening within the session. Even though advances in this arena have been made, the causal links between process and outcome research are still in a germinal stage.

Process Research Variables

Process researchers examined many variables including how a client processes information from the therapist, the therapist's theoretical orientation, the client's specific problem, the therapist's and client's overt behaviors, and their interaction are just a sample of the variables that received attention (Greenberg, 1986). Efforts were made to observe these behaviors, develop new ways to measure the behaviors, and then to relate them to outcomes (Shoham-Salomon, 1990).

Researchers also began to delve into the issue of what constitutes a behavioral unit and how it can be measured. It became important to "segment therapy into

different therapeutic episodes or events in order to understand process in the context of clinically meaningful events" (Greenberg, 1986). Early on, a unit became dependent upon the researcher's interest and what he or she was trying to assess. Speech acts, context, and episodes were some of the initial variables measured by definable units. For example, therapeutic episodes represented units of therapeutic interaction and an event became a unit to assess the process of change.

In addition, verbal response modes became an important part of process research. To some extent, psychotherapy can be envisioned as a discipline that includes a language system (Shoham-Salomon, 1990). The therapist's language stems from his or her theoretical orientation. In other words, therapists are trained to use specific language with their clients based upon their school of thought. To understand the effects of language on the counseling process, researchers started investigating how to classify systems that would be able to categorize the therapist's language. Verbal response modes were developed as a way to assess the conceptual features of therapy and were one way of describing therapists' techniques (Stiles, 1987). Over the years, verbal response modes were frequently utilized for training and research purposes.

However, to conceptualize the therapy process in its entirety, researchers not only examined the explicit actions

of both the therapist and client, but also began to explore the covert processes of therapy (Hill, 1990; Hill & Corbett, 1993; Stiles, 1987). Intentions captured much of the focus on the implicit processes of psychotherapy and became an invaluable link in terms of understanding what brings change.

One way to understand the association between overt and covert processes of therapy is to conceptualize an overt behavior as meaningless until the corresponding covert process is known. In other words, the "observable process in and of itself is but a series of actions unless a certain psychological meaning is conceptually attributed to it on theoretical grounds or is empircally induced" (Pinsof, 1989). Thus, behavioral events were thought to have meaning due in part to the therapist's theoretical orientation and to the impact of the behavioral event on the interaction between the client and therapist (Shoham-Solomon, 1989).

The following two sections highlight the methodologies used in past studies for measuring overt and covert processes of the therapist and client.

Verbal Response Modes

Overall, there are approximately 30 systems assessing verbal response modes (Elliott, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987). In general, verbal response modes are defined as the "nominal categories that refer to the grammatical structure of the therapist's verbal

response, independant of the topic or content of the speech" (Hill, 1982). Verbal response modes are an intersubjective system that encompasses one aspect of the interpersonal counseling experience and have assisted researchers in getting at the interpersonal relationship.

One of the major questions researchers asked themselves when developing a framework for response modes was "what categories will best reveal the effect of therapist verbalizations?" (Goodman & Dooley, 1976). Researchers started to analyze the counselor's verbal behavior by classifying it into verbal response modes. Goodman and Dooley (1976) provided a criteria for response modes that included six points. In brief, the points emphasized that units should be easily identifiable, a response mode system should contain a small set of categories, the categories should organize behavior at the response level, the categories should be easily understood, the process and not the content should be emphasized and lastly, the response modes should be able to be utilized in various settings (Goodman & Dooley, 1976). This study served as a stepping stone for organizing and coding behavior units of help-intended communications and set out to integrate training and research objectives irrespective of a therapist's school of thought.

Early studies were also interested in the intent of the therapist, the effect of the verbal response mode, and how

to categorize verbal response modes as to best explicate the intent and effect. For example, Goodman & Dooley (1976) defined intentions as help-intended communication that emphasized what the therapist wished to communicate and not what was actually communicated. Helping intentions were defined as gathering information, guiding another's behavior, providing interpersonal space, explaining or classifying another's behavior, expressing empathy, and revealing one's personal condition. Moreover, Goodman and Dooley developed six response modes to communicate these helping intentions. The six modes are question, advisement, silence, interpretation, reflection, and self-disclosure. These categories dealt with the mode of the response rather than the content or focus and were able to combine to form associations with intentions.

In 1978, William Stiles developed a system that captured both the verbal response mode and the intent separately. He followed the premise that intentions provided a more complete picture of the therapist's behavior whereas verbal response modes were simply based on the grammatical structure of a response. Moreover, Stiles viewed that verbal response modes could code intentions in terms of their apparent overt meaning (Stiles, 1986). He purported that many measures had confused intent with the grammatical structure of the verbal response mode. As a result, when categorizing language, he stressed that each

utterance or response had a grammatical form and an interpersonal intent and these could either be the same or different.

Stiles unitized transcripts of counseling sessions with an utterance as the scoring unit. An utterance was defined as "each independent clause, each term of address of acknowledgement, each element of compound predicate, and each nonrestrictive dependent clause" (Stiles, 1979). In other words, an utterance was a linguistic unit that dealt with only one experience and that experience was thought of as meaningless by itself. When coding, a rater first looked only at the form of the utterance and then decided into what verbal response mode the utterance fell. While trying to assess the implicit intent, the rater took into consideration the context, the interpersonal relationship, and the tone of voice of the therapist. To hinder the raters from interpreting, the raters were instructed to confine their judgment to three forced choices. These choices were whose experience is the topic, whose frame of reference is used, and who is the response focused upon (Stiles, 1979).

Stiles (1979) then developed a taxonomy that included eight basic verbal response modes based upon and defined by the intersection of the therapist's or client's experience, the frame of reference (therapist's or speaker's viewpoint), and the focus (does therapist presume to know client's frame

of reference) (Stiles, 1979). In general, the modes defined the interpersonal roles as attentiveness, acquiescence, or presumptuousness (Stiles, 1978). The eight modes are disclosure, edification, question, acknowledgment, advisement, confrontation, interpretation, and reflection. The category "uncodable" was utilized for utterances that could not be heard or understood. Due to the way the taxonomy was set up, by answering the questions, the intent would fall into one of the eight mutually exclusive modes. When the form and intent modes were identical, then the mode was called a pure mode. When they differed, the mode was referred to as a mixed mode. As a result of having mixed modes and pure modes, there was a total of 64 possible modes (8 pure and 56 mixed).

In addition, Stiles analyzed the influence of therapists' different theoretical backgrounds. In brief, his study showed that therapists from different orientations used certain modes more often than other modes. Later studies also support this finding and reveal that there are favorite modes for each school of thought (Hill & O'Grady, 1985).

In 1978, Clara Hill developed Hill's Counselor Verbal Response Category System. Hill reviewed current systems and surmised that the different systems varied greatly in terms of the type and size of the categories. She also found that behaviors were not always being measured by similar

categories across the systems and that training protocols were not standardized. As a result, Hill set out to develop a more generalizable system.

Hill's study compared similarities and differences of 11 existing systems. After review, two judges collapsed the systems' categories into 25 distinct categories with specific definitions and examples for each category. Transcripts from an audiotaped practice therapy session were unitized. The judges then coded the units according to the new system for categorizing responses. Due to obtaining low interjudge reliability that did not reach 80-90% until the 3rd trial, the system was then used by three experienced counselors who were asked to match definitions of the categories with corresponding examples (Hill, 1978). After discussion and examination, the categories were again collapsed into 17 categories each with a definition and example. Further reviews were done that led researchers to believe that the definitions were easy to understand and that the system was sound.

After the system was developed, six psychologists were asked to audiotape intake sessions. Transcripts were made from the tapes and the counselor's and client's statements were coded into response units defined as grammatical sentences (Hill, 1978). After receiving training, three judges coded the units according to the 17 categories. Ratings were based on agreement by two out of the three

judges. After the judges' agreements on the categories were analyzed, the system was collapsed into 14 nominal, mutually exclusive categories that were minimal encourager, approval-reassurance, information, direct guidance, closed question, open question, restatement, reflect, nonverbal referent, interpretation, confrontation, self-disclosure, silence, and other (Hill, 1978). These 14 categories collapsed into 5 hierarchical groups and those were minimal encouragers, directives, questions, complex responses, and strange bedfellows.

One critic (Friedlander, 1982) surmised that some of Hill's categories dealt with semantic content and therefore only the text was referred to while other categories were more inferential and required raters to infer the therapist's intent. Later, Hill revised the list and this time it incorporated nine pantheoretical nominal mutually exclusive response modes. These modes were approval, information, direct guidance, closed question, open question, paraphase, interpretation, confrontation, and self-discourse (Hill, 1985)

In general, response modes operationalized therapist techniques, were shown to be associated with intentions, and were defined independently of theoretical orientations. As a result of the development of verbal response mode categories, it was possible to learn how counselors from various orientations used different language and different

response modes. However, some common modes were utilized frequently across theoretical orientations and these were advisement, reflection, interpretation, reassuring, information, and disclosure (Barkham & Shapiro, 1986). Moreover, these responses were found to be easily conceptualized and thoroughly specified.

Verbal response modes were also shown to be used at different frequencies as a function of timing within a session in terms of first, middle, and end (Hill, 1978). Across the studies, response modes measured only one aspect of the therapist's behavior and were not shown to predict outcome (Elliott, Hill, Stiles, Friedlander, Mahner, Margeson, 1987). Though, in one study, clients reported that interpretation and advisement were the most helpful and questions were the least helpful response modes (Elliot, Barker, Caskey, Pistrang, 1982). Another study found self-disclosure, interpersonal, approval, and paraphrase as the most helpful response modes (Hill, Helms, Tichenor, Spiegel, O'Grady, Perry, 1988). Interpretation was found to be effective whem immediate outcome was analyzed.

Again, counselor verbal response modes are only one aspect of the interpersonal counseling experience. Because attention shifted towards the covert processes of the therapist and client that are associated with response modes, researchers put their efforts towards the study of intentions.

Intentions

In most of these forementioned studies, another question continued to arise that was concerned with what are the most significant aspects of the verbal interaction? Capturing the elusive intentions or the meaning behind the verbal response became one of the major focal points (Russells & Stiles, 1979). In one sense, ambiguity arose because the meaning of a verbal response mode is not always the same. For example, two therapists can use the same intervention and mean completely different things. In addition, the same therapist can use one intervention in two different settings and the meaning of the underlying intention can be completely different. Also, Stiles (1987) pointed out that intentionality had many different levels in the sense that a therapist may be aware of his intention and would also like the client to be aware of it, that the therapist is aware but does not want the client to be aware of the intent, or that the therapist is not aware of the intent. In general, intentions are not overtly observable by another and imply an awareness of one's rationale for one's intervention.

Definition of Intentions

Intentions are the reason behind one's intervention whereas verbal response modes are how that intervention is communicated. The intended meaning of a response mode is more elusive than its literal meaning. When intentions and

verbal response modes are analyzed together, they provide a more in depth picture of therapist behavior. For example, a therapist says, "Oh, I don't think you ought to do too much--I advise you to take things slowly." The therapist may be hoping that the client resists and follows through or maybe the therapist really wants the client to go slowly. When raters looked at intentions, they realized that the actual intent could be very different than the apparent intent. Again, knowing the therapist's intent assists one in conceptualizing the therapist's behavior (Hill & Corbett, 1993).

Hill and O'Grady (1985) defined the therapist's intention as the "rationale for selecting a specific behavior, response mode, technique, or intervention to use with a client at any given moment within the session." For them, intentions imply an awareness of why one picks an intervention, are context bound, and dependent upon the interaction between the therapist and client. Moreover, this relational aspect is expressed through the therapist's and client's verbal and nonverbal behaviors (Shoham-Salomon, 1990).

Intentions are the reason behind why therapists say what they say and why they choose to say it in the fashion they do. Intentions can include either the "reason" why therapists did what they did or the therapists' "plan" that involves the client's cognition (Horvath, Marx, Woudzia,

1991). According to the reason perspective, the intention's target is the therapist's own subsequent behavior. While on the other hand, the target of the plan perspective is the client's cognition, affect, or behavior.

Moreover it has been suggested that intentions lead to certain counselor and client activities and are predictably related to response modes (Hill, 1992). For example, a counselor becomes aware of something and chooses a certain response mode to communicate an intent. The therapist's actions influence the client who then picks a response mode due to his or her own thought processes. The therapist then reacts to what the client said and intended. The cyclical process continues. Also, the therapist's intention is influenced by the therapist's self-instructions such as his or her view on what constitutes a problem, how problems arise, and what brings change.

Intentions are associated with metacognitions because the process of recalling them or being aware of them includes thinking about one's subjective experiences. Intentions are influenced by one's theoretical background and impact what intervention is implemented (Hill & O'Grady, 1985). For example, gaining insight is an intention most often associated with psychoanalysts whereas setting limits and bringing change are intentions most often associated with behaviorists. Many studies have shown that intentions are associated with one's theoretical orientation and change

over the course of treatment (Hill & O'Grady, 1985; Heppner, Rosenberg, & Hedgespeth, 1992).

Categorizing & Assessing Intentions

Due to their covert nature and not always being easily accessible, intentions are measured after a session as to not disrupt the session. In early studies, assessing intentions involved only one step. During the process of coding, raters would infer the psychological processes of the therapist and client. As time passed, many studies used video or audiotapes of the therapy session to assist in recalling in-session events. For example, researchers asked the therapist to view the tape and state his or her intentions for each of his or her interventions. This method of accessing by having the therapist state them has been established as an appropriate way of determing the therapist's subjective experience (Heppner, Rosenber, & Hedgespeth, 1992).

Categorizing characteristics of the communicator such as intentions became known as a pragmatic strategy. In the pragmatic strategy, inferences are made from observable behavior about psychological processes whereas in the classical strategy, judgments are simply based on observable behaviors (Russells & Stiles, 1979). In other words, the classical strategy is concerned with the characteristics of speech whereas the pragmatic strategy describes characteristics of the communicator (Russell & Stiles,

1979). It was also purported that many of the pragmatic content categories were used as theoretical constructs by the therapist (Russell & Stiles, 1979).

One of the most common ways to categorize intentions is through predetermined choice lists. For example, a therapist is given a list of intentions to choose from when coding his or her thoughts and rationales. In addition, cued recall has often been the utilized method for accessing intentions. In this scenario, the therapist listens to an audiotape or watches a videotape. After each therapist's speaking turn, the tape is stopped and the therapist is asked to report his or her intentions. In brief, intentions have been examined by the perspective of molecular chunks such as subsentence thought units (Rice & Kerr, 1987), molar segments such as sentences (Fuller & Hill, 1985), and speaking turns (Elliot, 1986).

In 1975, Kagan developed the Interpersonal Process Recall (IPR) schema to help counselors and clients focus on what was happening in the session in terms of their feelings, aspirations, bodily sensations, and thoughts (cited in Hill & Corbett, 1993). Kagan felt that there was more going on than just overt behaviors in psychotherapy and that greater awareness of the covert processes would illuminate the therapy process.

In a "recall session", counselors reviewed videotapes of the counseling session and after each therapist comment,

the tape was stopped. The counselor was then asked to recall their internal cognitive and affective experiences (cited in Martin, Martin, Meyer, & Slemon, 1986). This procedure was used to allow both the client and therapist to immediately discuss their perceptions of their intentions and response modes. Since that time, many others have used the Interpersonal Process Recall method to investigate counselors' intentions, behaviors, and the client's perspective of counselor's intentions (Elliot, 1985; Martin, Martin, Meyer, & Slemon, 1986).

In another study, Elliot & Feinstein (1978) found verbal response modes to be related to intentions. They came up with an intention list that contains 10 nonmutually exclusive intentions that are concerned with the therapist's purpose (cited in Hill & O'Grady, 1985). Nonmutually exclusive means that more than one intention may be considered for each therapist response. These intentions are gather information, give information, communicate understanding, explain, advise, guide, reassure, disagree, share oneself, and other. Over the years, the list has been critized for not having a clear division between verbal response modes and intentions, for being incomplete and not representative of different theoretical backgrounds (Hill & O'Grady, 1985).

One of the most widely used intention studies was by Hill & O'Grady (1985). They developed an intention list

that included 19 therapist's intentions from a rationally derived method. The intentions are set limits, get information, give information, support, focus, clarify, hope, cathart, cognitions, behavior, self-control, feelings, insight, change, reinforce change, resistance, challenge, relationship, and therapist needs (Hill & O'Grady, 1985). The list was based on the premise that ideally, a therapist's verbal and nonverbal behaviors were thought to have to be consistent with the therapist's intention and a client must be able to perceive the therapist's behavior and act as the therapist intended (Hill & O'Grady, 1985). The therapist would then read the client's response and develop a new intention. Overall, the researchers set out to take into account various theoretical backgrounds and capture the inputing variables of the therapist that trigger or develop into intentions. The researchers utilized therapist intentions as a focal point for psychotherapy research and defined intentions as the therapist's reason for choosing a specific response or intervention in a session with a client (Hill & O'Grady, 1985).

In the beginning of the study, five therapists listened to audiotapes of a session and were asked to recall their intentions corresponding to each of their interventions without a pre-determined choice list being presented. These open-ended statements of the therapists were then used to revise a list of intentions. This list was then given to

seven therapists who listened to an audiotape of one of their sessions and were asked to use the list to categorize their intentions for their intervention. Then two raters listened to the same audiotape and judged the therapists' statements according to the intention list. The codings were compared and after the data was reviewed and analyzed, the list contained 19 categories that were nonmutually exclusive.

The researchers then conducted studies using the system. They utilized a case study approach to ascertain if intentions were associated with therapist and client verbal response modes. Results suggested that there was indeed a relationship between intentions and response modes. Another study's results indicated that therapist intentions do vary over the course of treatment with a decrease in the intentions of set limits, get information, and hope, and an increase in the integration of insight and change (Hill & O'Grady, 1985).

Many later studies utilized Hill & O'Grady's intention list. For example, a study by Fuller & Hill (1985) reviewed process events that might be related to session outcome. Specifically the study was interested in counselor intentions, helpee (client) perceptions of counselor intentions, and the association between what the counselor intended and what the client perceived the counselor to intend (Fuller & Hill, 1985).

The counselors in this study had experience with the intention list and therefore were not trained on how to use it and what the categories meant. However, the clients had no previous knowledge of the list and therefore practiced using the list and reviewed the list with the researchers. Immediately after a counseling session, the participants were interviewed in the same room with a partition between them so that they could not see one another but so both could see the videotape of the session. The videotape was played and after the therapist's speaking turn, the tape was stopped and both the counselor and client were asked to write down three intentions from the list that they perceived the counselor to have. The tape was then started and after the client's response to the intervention, the tape was stopped again and both participants rated the helpfulness of the counselor's statement.

Results indicated that the client perceived the most frequent intentions as clarify, get information, support, feelings, and focus. Counselors reported that the most frequent intentions were to get information, clarify, feelings, insight and support (Fuller & Hill, 1985). Results also suggested that some intentions were more easily detected such as get information and clarify while the harder ones to detect were relationship, resistance, and therapist need. No relationship was found between client's ability to perceive counselor's intention and the outcome of

the session. However, the client's did rate intentions such as therapist needs, resistance, insight, and challange as being helpful.

A later study (Hill, Helms, Tichenor, Spiegel, O'Grady, Perry, 1988) investigated intentions under the assumption that the best way to describe a therapist's technique was to view the verbal response mode in conjunction with the therapist's intent. In this study, the client and therapist watched a videotape of the session immediately following the counseling session. After each therapist statement, the videotape was stopped and the therapist was asked to recall what he or she was feeling at the time of the intervention and write down the numbers of up to five intentions that described their goals for the intervention. The numbers corresponded to the Hill & O'Grady's intention list. The client was asked to state five reactions to the intervention. In addition both the therapist and client were asked to rate the helpfulness of each response. Moreover, transcripts were made of the session and judges coded units according to the revised Hill's Verbal Response Modes Category System that included nine categories. Results suggested that when response modes were studied in conjunction with the therapist's intentions, more of the variance in immediate outcome was accounted for than when response modes were analyzed by themselves and a clearer picture evolved as a result of the two being incorporated

together. Also, the researchers found that a response mode could be used for various intentions. The most helpful interventions were shown to be when the therapist helped the client explore feelings and behaviors through confrontation, interpretation, and paraphrase.

Furthermore, researchers found an overlap of Hill & O'Grady's intention list and therefore collapsed the previous list into seven categories. These seven categories are set limits, assessment (get information, focus, clarify), support (instill hope, reinforce change), educate (give information), explore (identify and/or intensify cognitions, behaviors, and feelings), restructure (insight, resistance, challenge), change, and a miscellaneous category (relationship, cathart, self-control, and therapist needs).

In another study, Martin, Martin, and Slemon (1989) explored the idea that there exists specific patterns between counselor intentions, counselor behaviors, client cognitive operations, and client responses. In general, it was assumed that some type of interactive behavior commonly occurs between the therapist and client. The researchers used the word "action" to refer to the relationship between the counselor's intentions and the counselor's behaviors. Because this relationship is not directly accessible, the researchers, similar to other studies, opted to use a structured method of cued recall. However, different from many studies, this study did not provide the therapist with

a predetermined choice list of intentions.

After a session, eight instances of the counselor's behavior were picked to be analyzed. Researchers felt that asking the therapist to recollect their thoughts for each of their interventions might make the interview too long. The researchers played the videotape of the session starting before the therapist's intervention and then after the intervention, the videotape was stopped. The therapist was asked to describe as completely as possible what he or she was thinking at the time of the intervention.

Transcripts of the dialogue and of the therapist's responses were made. Trained raters then unitized the transcripts into therapist's talking turns unless the segment was larger than a grammatical statement and moved from one verbal response category to another. In these cases, the therapist's talking turn was broken down. Raters coded the therapist's thoughts according to Hill & O'Grady's 19 category list of intentions, and counselor's behaviors were coded with the Counselor Verbal Response Category System (Hill et al., 1981).

An important aspect of this study is that the therapist's intentions were placed into intention categories by the researchers instead of by the therapist. The researchers did this because they found in their pilot study that therapists would code what appeared to be statements with the same intentions into different categories due to

their own understanding of what the categories were (Martin, Martin, & Slemon, 1989). Therefore, in the study, therapists watched the taped segments and were probed by the researchers by statements like "what thoughts accompanied your statement" and "what did you want to happen next ?" These counselor statements were then transcribed and judges coded the statements into intention categories.

Results indicated that feelings (to enhance awareness and experience of client feelings), give information (to educate or explain), and cognitions (to identify dysfunctional thoughts, attitudes, or beliefs) were the most commonly used intentions (Martin, Martin, Slemon, 1989). These results resemble Hill & O'Grady's (1985) findings concerning the most frequently used intentions, especially the feelings and clarify intentions. In addition, the researchers surmised that the results indicate distinct patterns of counselor behaviors with certain intentions. The therapist's intention "give information" was followed by the response mode of "get information" 47% of the time (Martin, Martin, & Slemon, 1989). In terms of the counselor's verbal and nonverbal behavior being consistent with his or her intentions and the client's accurate perception of the therapist's behavior, results suggested that a consistency between these stages was associated with session effectiveness.

In another study, the Counselor's Intention List (CIL)

was generated (Horvath, Marx, & Wondzin, 1991). In this study, the unit of analysis was the therapist's identified episode. A therapist determined the episode through reviewing the discourse by a cued method. In general, the list was developed to include the full domain of intentions, the use of a plan perspective of intentions (what the therapist plans for the client to do), and an immediate perspective in terms of client's understanding and processsing of intentions.

While developing the list, researchers surveyed old intention lists, combined the lists, and then added some new intentions. Intentions that were similar were grouped into clusters and then one intention was picked to represent the cluster. This list was then reviewed and revised into a new list. Because some of the past lists included descriptions that appeared to be theoretically based (Hill & O'Grady, 1985; Elliot & Feinstein, 1978) this schema stressed nontheoretical language. After final revisions, the list was comprised of 16 intentions with a category "other" making 17 categories. All items were in the form of "I want the client to...". A comparable list for the client read "My counselor wanted me to..." Both lists contained the following statements: recognize action, thoughts or feelings as my own, be aware of my feelings, make new connections, understand purpose of session, stop or do less of something, give him/her information, question my actions,

thoughts, or feelings, be more precise or focused, know what to do, feel good, experience or relive feelings, learn how to do something, do more of something, feel understood, have information, feel more hopeful, and other (Horvath, Marx, & Wondzin, 1991). An advantage of this study is that it clarified the definition of intentions and used a unitized episode that was defined by the therapist. Except for the category "feel understood" the system was found to be free of gender bias.

However, few studies have utilized this intention list and instead have used the Hill & O'Grady (1985) intention list. For example, in another study (Kivlighan & Angelone, 1991), researchers trained novice therapists to use Hill & O'Grady's intention list. This was done by giving the therapist examples of each intention and a definition of what the intention meant. Counselors were then given written statements and were asked which categories they would choose had this been their intention. Their answers were compared to another study that had already categorized these statements. Training continued until counselor reliability reached 90% agreement with the criteria category (Kivlighan & Angelone, 1991).

A counseling session was videotaped and immediately after the session, the novice counselor reviewed the tape. After each therapist turn, the counselor stopped the tape and categorized his or her intention according to the list.

One disadvantage of training the novice counselors to use the intention list is that they might have been influenced by the list. For example, the novice therapist might have learned to associate a question with a get information intention rather than examining the intention of the question in each specific case (Kivlighan & Angelone, 1991). Results suggested that some of the most common intentions in relation to the cognitive process of the client are to assist the client in making connections between old and new memorial information, monitor thoughts and feelings, consider new information, and retrieve information from memory.

In another study, (Hill, Thompson, Cogar, & Denman, 1993) the therapist and client reviewed the Hill & O'Grady list prior to the session. The therapist was asked to list up to three intentions for his or her intervention while cued by a tape. An interesting point to note is that the researchers this time collapsed the intention list into eight clusters for analysis. These clusters were derived from an earlier study already cited (Hill, Helms, Tichenor, & Spiegel, 1988). The therapist chose from the 19 category intention list but for analysis, the list was collapsed into the 8 clusters.

Results of the study reported proportions of .34 intentions in the assessment cluster, .19 in the support cluster, .18 in the exploration cluster, .16 in the

restructure cluster, .05 in the education cluster, .04 in the miscellaneous cluster, .02 in the change cluster, and .02 in the set limits cluster (Hill, Thompson, Cogar, Denman, 1993). These findings are similar to results from the Hill & O'Grady (1985) and the Fuller & Hill (1985) studies except that this study had fewer "change" intentions.

In addition, the findings suggested that clients are able to recognize therapist intentions with a match ratio of .50% and better on assessment, support, and restructure intentions. This might be due in part because these intentions are associated with specific grammatical nonverbal cues and occur frequently in daily life. There was no relation between overall match rate and session outcome as other studies have also purported (Fuller & Hill, 1985; Martin, Martin, & Slemon, 1987).

In summary, many studies have reviewed the relationship between intentions and verbal response modes, the impact of intentions within a session, the different uses of intentions across sessions, and the client's understanding of the intentions and therapeutic impact (Hill & O'Grady, 1985; Horvath, Marx, & Kamann, 1990; Martin, Martin, & Slemon, 1987). In general, research suggested that client characteristics effected the type of intentions and the response modes that were utilized (Hill, Helm, Spiegel, Tichenor, 1988). The client's covert reaction to the

therapist's intention was reviewed and it was suggested in some studies that the client's awareness of the therapist's intention was negatively related or not at all related to outcome (Fuller & Hill, 1985; Martin, Martin, & Slemon, 1987). These implications are valuable due in part because training has shown to influence the way counselors interact with their clients and how and what the therapist thinks about the counseling process (Kivlighan, 1989).

Free recall

In the following recall study (Wynne, Susman, Ries, Birringer, & Katz, 1994), researchers set out to obtain objective information about how much of a session is remembered when accessed through a free recall method. Specifically, the researchers explored free versus cued recall of molar and molecular ideas. After a session that had been audiotaped, researchers asked the therapist to freely recall the dialogue of the session. The interviewer then read back the dialogue and the therapist was asked to report his or her inner experiences that accompanied his or her interventions. The freely recalled dialogue was then coded according to molar (main) and molecular (supporting) ideas.

In brief, coders analyzed a transcript and identified any molar ideas. As a group, the coders then reported their designated molar idea without any discussion. If a molar idea received an interrater agreement of .50 or better, it

was then included in the later discussion phase (Wynne, Susman, Ries, Birringer, & Katz, 1994). During the discussion phase, each person stated their reason for selecting a molar idea. After arguments were heard, raters again voted on the molar. This time, if a molar received an interrater agreement of .80 or better, it was accepted as a molar idea. Molars not attaining high enough interrater agreement were later considered as possible molecular ideas. After all the molars were identified, the researchers then followed the same procedure for categorizing molecular ideas. Molecular ideas fell under molars and provided additional information and supported the molar idea. After coding was completed, therapist's recall percentages were calculated by using the total number of ideas on the verbatim transcripts as the denominator and the number of ideas recalled by the therapist as the numerator (Wynne, Susman, Ries, Birringer, & Katz, 1994).

Results suggested that therapists were able to freely recall 40% of the actual dialogue for the three time segments (first five minutes, most significant event defined by the therapist, and last five minutes) and that recall of molar ideas (45%) was better than for molecular ideas (34%) in both free and cued recall. It is significant to note that inner experiences obtained by free recall are therefore based upon 40% of the actual dialogue.

In another preliminary study (Susman, Wynne, Rezek,

Martin, Katz, & Ries, 1992) researchers compared free versus cued recall as a method for accessing inner experiences. The study intended to capture various inner processes by asking the therapist to report their thoughts, feelings, and rationales associated with their interventions. In brief, a counseling session was audiotaped and after the session, the therapist was interviewed. In the interview, the therapist was requested to recall as closely as posssible the exact dialogue and their accompanying thoughts, feelings, and rationales. Two weeks after the initial interview, the therapists were interviewed again. This time the therapists listened to the three segments of the session that they had freely recalled earlier from the audiotape. Again, therapists were asked to recall their thoughts, feelings, and rationales associated with their interventions.

The researchers analyzed the cued and free recall of inner experiences from the time segment identified as the most significant moment. Both cued and free recall transcripts were coded into thought units and then coded according to the collapsed version of the Hill & O'Grady intention list (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988). A supplementary list was then used to code inner experiences that fell off the Hill & O'Grady intention list. This supplementary list included the categories of therapist self-awareness of emotions, therapist self awareness of cognitions, therapist self-awareness of

behaviors, therapist emotional self-direction, therapist cognitive self-direction, therapist behavioral self-direction, criticism, praise, corrective self-feedback, therapist awareness of client's emotions, therapist awareness of client's cognitions, therapist awareness of client's behaviors, therapist awareness of client situational/interpersonal status, hypothesizing/formulating, client evaluation, setting/situation, relationship/process, tangential focus pertaining to client, tangential focus pertaining to therapist, and uncodable.

Results suggested that for cued recall, the therapist's inner experiences fell on the intention list and on the supplementary list 74% and 26% of the time, respectively. For free recall, the corresponding percentages were 53.2% and 43.8%, respectively. As indicated, the therapists' inner experiences tended to fall on the intention list more so than on the supplementary list for both recall methods. The categories assess, explore, and restructure were the most utilized categories on the Hill & O'Grady intention list. The categories therapist's evaluation of therapeutic situation and the collapsed category of therapist's awareness of the client's cognitions, emotions, and behaviors accounted for 66.2% of the responses for free recall and 39.15% for cued recall on the supplementary list. Overall, there were few self-direction statements for both conditions while self-awareness categories were more

frequently accessed in cued rather than free recall, 37.3% versus 16.1%, respectively.

CHAPTER III

METHOD

Participants

The sampling frame consisted of a list of over 1400 licensed psychologists in a large metropolitan area. Previous studies have utilized this sample and implemented the same protocol (Susman, Wynne, Rezek, Martin, Katz, Ries, 1992; Wynne, Susman, Ries, Katz, & Birringer, 1994). The final sampling frame consisted of 845 psychologists who received multiple mailing describing the present study and who were contacted by telephone. Out of the 23 therapists (2.72%) who initially agreed to participate, 20 were actually interviewed due to scheduling constraints. The final sample size consisted of 15 therapists who had completed all sections of the interview protocol and had tapes that were audible.

The therapists (12 women and 3 men) were in private practice either full or part-time and their theoretical orientations were either humanistic, psychodynamic, Adlerian, systems, or a combination of the four. Their ages ranged from 39 to 60 years (M=48.60, SD=6.90) and their post-doctoral clinical experiences ranged from 3 to 29 years (M=13.00, SD=7.20).

The therapists selected clients from their private practice and asked them to participate in the study. If a client agreed, he or she was asked to sign a consent form that the therapists retained and therefore, the clients remained anonymous to the researchers. The clients (9 women and 6 men) ranged in age from 27 to 57 years (M=38.67, SD=8.80) and were in therapy from 3 months to 5 years (M=2.30 years, SD=1.40 years).

Instruments

A protocol employed in the other studies (Susman, et al., 1992; Wynne et al., 1994) was used and consisted of three parts. Part 1 was concerned with client attributes and treatment issues. Part 2 consisted of the therapists' recall of the dialogue from the first five minutes, the most significant event as defined by the therapist, and the last five minutes. In addition, the therapists were asked to recall their thoughts, feelings, and rationales for each of their interventions. Part 3 focused on contextual elements of the therapy session.

Interviewers (4 females and 1 male) were graduate students and were extensively trained to ensure consistency across interviews. Interviewers memorized the protocol and field-tested it with practicing psychologists prior to data collection.

Procedures

After an appointment was arranged, an interviewer went

to the therapist's office prior to the counseling session and set up the audio recording equipment. The interviewer then left the office. After the session, the interviewer re-entered the office and collected the audio equipment. The researcher then interviewed the therapist according to the protocol. After taking a few minutes to complete Part 1 of the interview, in Part 2 the therapist was then asked to recall verbatim the dialogue of the first five minutes, the most significant event, and the last five minutes. The interviewer recorded the therapist's exact words on the protocol. The interviewer then read back verbatim the therapist's words and asked the therapist to state his or her thoughts, feelings, and rationales for each of their interventions. When the three distinct time segments had been recalled and inner thoughts recorded, the therapist was asked to complete Part 3 and a demographic questionnaire.

Procedures For Thought Units

The reported inner experiences of the therapist for each of the three time segments were separated by two female graduate students. Independently, the raters reviewed the therapist's written inner experiences and then separated them into distinct thought units. A thought unit was defined as one complete thought irrespective of sentence structure. Simple interrater agreement was 88%. Disagreements were resolved through discussions.

Coding Procedure For Inner Experiences

Hill & O'Grady (1985) developed an intention list that included 19 therapist's intentions from a rationally derived method. A later study (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988) collapsed the previous intention list into eight categories. These eight categories are set limits, assessment (get information, focus, clarify), support (instill hope, reinforce change), educate (give information), explore (identify and/or intensify cognitions, behaviors, and feelings), restructure (insight, resistance, challenge), change, and miscellaneous (relationship, cathart, self-control, therapist needs).

Two female graduate students who did not participate in unitizing were trained on Hill & O'Grady's collapsed intention list (Hill et al., 1988). Training consisted of coding inner experiences on practice transcripts according to the intention list and discussing agreements and disagreements until both raters understood the clusters and felt confortable with the list. A ninth category was created to categorize any responses that did not fit into one of the existing eight categories. Raters then coded the actual transcripts. Simple interrater agreement was 70% with Scott's π yielding a reliability value of .62. Disagreements were discussed until resolved.

After each transcript was coded and disagreements resolved, the raters then employed the Novice Therapist Pre-Intentional Coding Scale (Rezek, Susman, Wynne, Birringer, &

Gaubatz, 1994) to classify the inner experiences that were placed in the ninth category. This coding schema was data driven for the specific purpose of ascertaining the type and frequency of novice counselor's intentions (Rezek, Susman, Wynne, Birringer, & Gaubatz, 1994). This list consisted of 20 categories that were therapist self-awareness of emotions, self-awareness of cognitions, self-awareness of behaviors, therapist self-directive regarding emotions, self-directive regarding cognitions, self-directive regarding behaviors, therapist self-praise, therapist self-criticism, therapist corrective self-feedback, therapist awareness of client's emotions, therapist awareness of client's cognitions, therapist awareness of client's behaviors, hypothesizing/formulating, client evaluation/assessment, awareness of setting/situation, awareness of process/client-therapist relationship, tangential focus pertaining to client, tangential focus pertaining to therapist, and uncodable.

For this list, simple interrater agreement was 62% with Scott's π yielding a reliability value of .56.

CHAPTER IV

RESULTS

Frequency data were transformed into percentages by taking the total frequency of occurence in each category and dividing it by the total number of thought units on that transcript. The eight Hill & O'Grady intention categories were summed to form one percentage and compared to the "other" category that represent non-intentional categories.

Table 1 presents the mean percentage of therapists' use of Hill & O'Grady's collapsed intention list compared to the Novice Therapist Pre-Intentional Coding Scale (Rezek, Susman, Wynne, Birringer, & Gaubatz, 1994).

Table 2 shows a breakdown of mean percentages for the Hill & O'Grady intention list, and Table 3 displays a breakdown of the mean percentages for the Novice Therapist Pre-Intentional Coding Scale.

Table 1

Mean Percentages for Hill & O'Grady Collapsed Intention List and the Pre-Intentional List.

List	Mean %	St. Deviation
Hill & O'Grady	60.07	19.48
Pre-Intentional	39.93	19.48

Table 2

Percentages for Hill & O'Grady Collapsed Intention List Category Use.

Categories	Mean %	St. Deviation
Limit	.96	2.03
Assessment	20.64	14.06
Support	7.01	6.66
Educate	.70	2.72
Explore	13.55	10.75
Restructure	5.88	6.98
Change	3.92	6.35
Miscellaneous	7.42	9.03
Other	39.93	19.48

Table 3

Percentages for the Novice Pre-Intentional Coding Scale Category Use.

Categories	Mean %	St. Deviations
Ther. self-awareness of feelings	1.78	4.86
Ther. self-awareness of cognitions	6.98	13.19
Ther. self-awareness of behaviors	16.06	29.47
Ther. self-direction/ feelings	0	0
Ther. self-direction/ cognitions	0	0
Ther. self-direction/ behaviors	0	0
Ther. self-criticism	0	0
Ther. self-praise	0	0
Ther. self-corrective feedback	.95	.95
Ther. awareness of clt's feelings	8.49	14.13
Ther. awareness of clt's cognitions	13.79	16.80
Ther. awareness of clt's behaviors	3.26	6.44
Clt. situational/ interp. status	13.33	20.78

Table 3 (Continued)

Hypothesizing/formulating	8.24	25.91
Ther. evaluation/ assessment	13.36	16.31
Setting	7.46	12.86
Relationship/Process	3.27	6.98
Tangential--client focused	0	0
Tangential--ther. focused	0	0
Uncodable	3.02	7.46

CHAPTER V

DISCUSSION

Researchers have noted the value of understanding the association between counselor's thoughts, feelings, and behaviors and have suggested the central importance in understanding the therapy process for training therapists. Efforts have been made to directly assess counselor's and client's thought processes, especially intentions. Most of the past research has relied upon structured methods such as stimulated recall through the utilization of video and audiotapes and by providing a predetermined intention list to the therapist from which to choose his or her intentions. The current study utilized the term "inner experiences" to be inclusive of as many inner processes as possible. The study also employed a free recall method to access inner experiences. Discussion of findings, conclusions, and future suggestions follow.

The majority of practicing therapists' reported inner experiences fell on the Hill & O'Grady collapsed intention list (60.07%) while 39.93% fell on the Novice Therapist Pre-Intentional Coding Scale. On the Hill & O'Grady collapsed intention list, the categories assessment (20.64%) and explore (13.55%) were the most used categories followed by

miscellaneous (7.42%), support (7.01%), restructure (5.88%), change (3.92%), limit (.96%), and educate (.70%).

Another study (Hill & Fuller, 1985) that utilized the original Hill & O'Grady intention list found the most frequent intentions reported by the therapists to be get information, clarify, feelings, insight, and support. These intentions appear to correspond to this study's categories of assess (20.64%), explore (13.55%), and support (7.01). Results suggest that these categories are indeed used frequently. In addition, Martin, Martin, & Slemon (1989) found the categories feelings (to enhance awareness and experience of feelings), get information (to educate or explain), and cognitions (to identify dysfunctional thoughts, attitudes, or beliefs) were most frequently used. These categories seem to relate to the current study's categories of explore (13.55%), restructure (5.88%), and educate (.70%). The educate category, however, was a rarely used category in the current study.

A comparion with the Hill, Thompson, Cogar, & Denman (1993) study's proportions that were changed into percentages for comparison purposes with the current study's mean percentages follow: assessment (34%, 20.6%, respectively), support (19%, 7.01%, respectively), explore (18%, 13.55%), restructure (16%, 5.88%), educate (5%, .7%), miscellaneous (4%, 7.42%), change (2%, 3.92%), and set limits (2%, .96%). It is important to note that the Hill,

Thompson, Cogar, & Denman (1993) study did not use an "other" category while the current study had 39.93% of the responses falling into this category which makes true comparisons difficult. It appears though that the categories assessment, explore, and support were frequently utilized in both studies.

The mean percentage that fell on the Novice Therapist Pre-Intentional Coding Scale was 39.93%. It is important to note that since this list was not empirically developed for experienced therapists, the number of categories does not represent these therapists' particular inner experiences. For example, had the scale been developed for experienced therapists, there would be fewer categories that were not used at all. The categories that were unused are disregarded in the tabulation of the data while the non-intentional inner experiences that were reported by the therapists are documented.

When the mean percentage was broken down, the highest mean percentages fell into the categories of therapist self-awareness of behaviors (16.06%), therapist awareness of client's cognitions (13.79%), therapist evaluation/assessment (13.36%), and client situational/interpersonal status (13.33%). Results suggest that when viewing the inner experiences that fell specifically on this list, the therapists tended to be aware of their own behaviors and tended to assess and evaluate the

client's interpersonal status and overall situation quite frequently.

The categories therapist's awareness of client's emotions (8.49%), therapist's awareness of client's cognitions (13.79%), and client's situational/interpersonal status (13.33%) were reported with moderate frequency as expected. It seems that experienced therapists would be aware of the client's status. However, it is somewhat surprising that the experienced therapists were also very self-focused. The categories therapist self-awareness of cognitions (6.98%) and the therapist self-awareness of behaviors (16.06%) had surprisingly high mean percentages. Due to the very large corresponding standard deviations (13.19%, 29.47%, respectively), however it appears that a few therapists may account for these findings.

The experienced therapists also seemed to be reporting with moderate frequency inner experiences that fell into the categories hypothesizing (8.24%) and awareness of setting (7.46%). The setting category may have had a moderate mean frequency in part due to the taping of the session and the interview process. The smallest mean percentages fell into the categories of relationship process (3.27%), therapist awareness of client's behavior (3.26%), uncodable (3.02%), therapist awareness of feelings (1.78%), and therapist self-evaluation (.95%). The rest of the categories had a mean percentage of zero. The low mean percentage in the category

therapist awareness of client's behavior may be an artifact of coding since this type of inner experience may have been captured in terms of the category client's situation/interpersonal status (13.33%) that could also include awareness of client's behavior.

Overall, mean percentages on the Hill & O'Grady (1985) collapsed intention list seemed to be in agreement with past studies that utilized this list or the original intention list (Fuller & Hill, 1985; Martin, Martin, & Slemon, 1989). The collapsed version of the intention list was sufficient for capturing a major portion of the reported inner experiences. Moreover, it appears that the inner experiences that were not coded on the Hill & O'Grady intention list were for the most part adequately represented by the categories on the novice pre-intentional coding scale.

This study attempts to be more inclusive than just intentions and yet uses an intention list for categorizing inner experiences. In addition, the study employed a pre-intentional list that was developed for novice therapists and yet this study's participants were experienced therapists. Some critics may view the usage of these lists as a weakness of the study. However, reported inner experiences did appear to fit into most of the categories.

Inner experiences include intentions and those inner experiences that were not coded on the Hill & O'Grady list

may be representing a broader conceptualization of the therapists' inner processes. The inner experiences that fell on the pre-intentional list for novice therapists may be thought of as representing processes that occur prior to the therapist developing an intention.

Free recall as a method for accessing inner experiences appeared to be adequate. It seems there are many avenues concerning free recall and inner experiences that could be further researched. For example, it would be interesting to categorize novice therapists' reported inner experiences on these lists and compare results with the current study. The present study provides a foundation for further utilization of free recall as a method of accessing inner experiences as well as other in-session variables. The study also brings to the forefront the usage or conceptualization of inner experiences versus intentions while doing research in this area.

A suggestion would be to replicate this study with a larger sample size. However, one pervasive problem is how much of the therapist's internal processes can be adequately reported by the therapist in either a free or cued recall method as a result of part of these internal processes occuring on an unconscious level. If the thinking process of the therapist becomes a natural or instinctual phenomena as one gains experience and expertise, then it would be advantageous to explore inner experiences of therapists who

have different levels of experience and compare results. By focusing on experienced therapists rather than developing therapists, researchers may be missing some of essential elements of the internal processes due to the processes becoming almost habitual for the experienced therapists and therefore not as easily self-reported.

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VITA

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of Master of Arts.

March 25, 1994
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