8-2000

Changes In Counselor Intentions After Empathy Training

Dominic J. Barraclough

CHANGES IN COUNSELOR INTENTIONS AFTER

EMPATHY TRAINING

by

Dominic J. Barraclough
Master of Science, Central Washington University, 1994

A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy
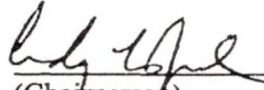
Grand Forks, North Dakota
August
2000
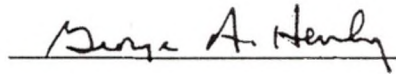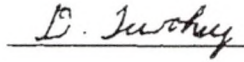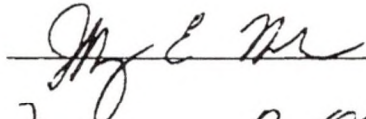
This dissertation, submitted by Dominic Barraclough in partial fulfillment of the requirements for the Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.
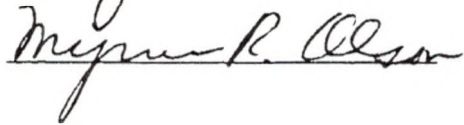
_____
(Chairperson)

_____

_____

_____

_____
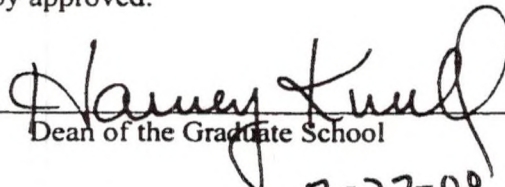
This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

_____
Dean of the Graduate School

7-27-00

_____
Date

ii

PERMISSION

Title   Changes in Counselor Intentions after Empathy Training

Department   Counseling

Degree   Doctor of Philosophy

In presenting this dissertation in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the library of this University shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my dissertation work or, in her absence, by the chairperson of the Counseling Department or the dean of the Graduate School. It is understood that any copying or publication or other use of this dissertation or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of North Dakota in any scholarly use which may be made of any material in my dissertation.

Signature   _Duane Barraclough_

Date   _7/17/00_

iii

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

ABSTRACT

Using Hill and O'Grady's (1985) model of assessing counseling intentions, this study examined the effects of a two-hour empathy training component in an introductory counseling methods course, as well as the relationship between intentions categories and the intention of being empathic. Participants also completed the Barrett-Lennard Relationship Inventory (BLRI) as a pretest measure, again immediately preceding the empathy training, and finally as a posttest measure. Due to unequal distribution within the control and treatment groups, gender was also examined. The results indicated that men responded more than women during role-play sessions as well as had more intentions. There was also a differential effect of the empathy training on men and women regarding their rate of intending to be empathic. Empathy training increased men's intention to be empathic while it decreased women's. Additionally, it was found that the intentions of Support and Assessment are reliable indicators of either the presence or absence of empathy in the counseling session. Implications for training and future research are discussed in light of these results.

In Memory of
Mary Foot
"Look Granny... I did it"

CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

Introduction

Empathy is a central concept in counseling. Without empathy, it is expected that clients will not feel comfortable sharing their thoughts and feelings. One author even argues that a therapeutic relationship cannot be established without empathy (Gladstein, 1987a). In what many consider to be a classic text on psychotherapy, Yalom writes, "The basic posture of the therapist to a patient must be one of concern, acceptance, genuineness, empathy. Nothing, no technical consideration, takes precedence over this attitude." (Yalom, 1995, p.106). In addition, ten experts who were asked to rank 22 personal characteristics of effective counselors put empathy as the most important (Pope & Kline, 1999). It is because of the importance of this concept to counseling that training programs attempt to facilitate the development of empathy in their students.

The question remains how successful these attempts are in increasing empathy among counselor trainees. Additionally, it is unclear whether increased empathy training results in any actual difference in counseling trainees' thoughts, feelings, and behavior with clients. The purpose of this study is to examine these questions by comparing measurements of self-reported empathy and counseling intentions during role-play counseling sessions between counseling trainees who did and those who did not receive additional empathy training.

Literature Review

What follows is a review of the literature most relevant to this study in the areas of empathy, empathy measurement, empathy training within counseling training, and finally counselor intentions. This review is followed by a conclusion highlighting the most important points. Based on this review, the rationale for this study is presented, along with the hypotheses of the study.

Empathy

Definitions and models of empathy

Since Rogers' (1957) early claim that empathy is one of three "necessary and sufficient conditions of therapeutic personality change" there has been an avalanche of research and literature addressing the concept. For example, below are just a few of the many attempts to define the concept of empathy. Chronologically listed, these definitions highlight the development of empathy, as well as the varied approaches to defining a complex phenomenon. Note that the initial definition not only qualifies empathy as being 'accurate' (vs. 'inaccurate'), but also foreshadows a later emphasis on the ability to communicate empathy back to the 'client'. It is no wonder that the researchers from whom this quotation comes became leaders in the field of empathy and empathy training.

Accurate empathy involves more than just the ability of the therapist to sense the client or patient's private world as if it were his (sic) own. It also involves more than just his ability to know what the patient means. Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility

to communicate this understanding in a language attuned to the client's current feelings. It is not necessary- indeed it would seem undesirable- for the therapist to share the client's feelings in any sense that would require him to feel the same emotions. It is instead an appreciation and sensitive awareness of those feelings. (Truax & Carkhuff, 1967, p. 46)

The next definition revisits the origins of the term and provides a much less precise clarification of the concept. In fact, it explicitly admits that the concept is "mysterious", thus relieving it of the responsibility of definition.

Empathy comes to us as a translation of the word of the German psychologist, "einfulung" which means literally "feeling into." It is derived from the Greek "pathos," meaning a deep and strong feeling akin to suffering, prefixed with the preposition "in."... It is in this profound and somewhat mysterious process of empathy that understanding, influence, and the other significant relations between persons take place. (May, 1967, p. 75)

Almost ten years later, Rogers himself revisits the concept with a definition which, while eloquent and obviously sensitive to the emotional experience of the client, provides only little clarification. Nor does it add any observable means for determining the presence of empathy in a counseling relationship.

It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or

tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensings of his/her world as you look with fresh and unfrightened eyes at elements of which the individual is fearful. (Rogers, 1975, P. 4)

Finally, a more recent definition includes the means, or verbal responses, used to facilitate empathy by a counselor. It also attempts to operationalize the concept by including a 'behavioral' means of identifying the presence of empathy in a counseling relationship. The difficulty remains however in identifying when a counselor "truly understands".

Another important quality is empathy - experiencing the client's world as if *you* were the client. This means moving into the client's frame of reference. The attending skills, particularly paraphrasing, reflection of feeling, and summarization, are deeply involved in developing basic empathy. Empathy manifests itself in the interview behaviorally when the interviewer or counselor truly understands the client and is able to paraphrase the client's main ideas accurately. (Ivey, 1994, p. 145)

As Hackney (1978) pointed out years ago, over time the emphasis of the definition of empathy has changed from a focus on the experience of the person

empathizing to a focus on the communication of empathy to another, specifically to the client. Regardless of this refinement of the definition, whether empathy actually is a communication skill, an inner experience of the counselor, or the perception of the client continues to be debated (Gladstein, 1983). Additionally, these issues obviously make measuring empathy, in the context of a relationship and as a personal trait, difficult.

In the 'early days' of empathy literature, Stewart (1956) stated that to study empathy scientifically would require breaking it into its parts, which would ruin it. From a clearly different perspective, and much more recently, Egan (1994) pointed out that, "If attending and listening are the skills that enable helpers to get in touch with the world of the client, then empathy is the skill that enables them to communicate their understanding of this world." (p.108). While Stewart sees empathy as holistic experience, Egan sees it as a communication skill.

This change in emphasis can also be seen in the number of different models attempting to operationalize the qualities of empathy (Stewart, 1956; Rogers, 1975; Barrett-Lennard, 1981; Gladstein, 1987c). These models of empathy have been used most extensively for research on improving counselor communication such that clients feel more fully understood, rather than for understanding the experience of the counselor attempting to empathize.

The earliest of these models is Stewart's' (1956), which, drawing upon Freud's ideas about identification, includes four stages: raw identification, deliberate identification, resistance, and deliberate reidentification. A year later came Rogers'

(1975) model which has only two stages: (a) temporarily living in the client's life, and (b) communicating the sensing of that life to the client. These two stages roughly translate into the ideas that the counselor experiences the feelings and thoughts that the client is having and then communicates what that experience feels like back to the client.

Probably the most widely known and used model of empathy is Barrett-Lennard's (1981) cycle of empathy, which consists of five different phases: empathic set, empathic resonation, expressed empathy, received empathy, and feedback. Only the middle three phases, however, are considered actual empathy phases, and it is these three that are focused upon in the literature. The first two of these three empathy phases are roughly equivalent to Roger's two stage model. It is the last of these three, the perception of empathy by the client, which was the unique, and important, component of this model at the time.

Gladstein's model of empathy (1987c) is based on the conclusion that although there is considerable theoretical literature concerning empathy's development, the empirical research minimally supports the major propositions. He proposes that we must have a broader understanding of empathy than our current multistage or different aspects theories. Based on this perspective, he proposes that there are at least eighteen different "kinds" of empathy that "have little relationship to each other." These eighteen "kinds" of empathy come from dividing empathy by whether it's a trait or state, whether it is in the affective, cognitive, or affective/cognitive domain, and whether it is recognized by the 'empathizer', the 'empathizee', or a third-party. More recently, Duan & Hill (1996) point

out that the research evidence shows that the cognitive and affective processes

unavoidably influence each other, thus making that distinction false. They propose that,

there are in actuality two different kinds of empathy: 'intellectual empathy' to refer to the

cognitive process and 'empathic emotions' to refer to the affective aspect of empathic

experience.

Bohart and Greenberg (1997) conceptualize empathy as being of three types. The

first type they call, "empathic rapport", and is "primarily kindliness, global understanding

and tolerant acceptance of the client's feelings and frame of reference". This type they

say most closely fits the average person's view of empathy. The second type,

"experience-near understanding of the client's world," includes an active attempt by the

therapist to "grasp the whole of the client's perceived situation." The two senses of this

include exploring factors involved in the client's present world, and exploring both

conscious and unconscious elements of the client's life history to attain a deeper

understanding of what it is like to be him or her. The third type of empathy,

"communicative attunement", "involves moment-by-moment attunement and frequent

understanding responses." The focus of this type of empathy is to consciously grasp what

the client is experiencing and trying to communicate "at that moment." The last two of

these three types of empathy are not mutually exclusive they explain, but differentiated

by their focus. While the second type, "experience-near understanding of the client's

world" focuses on understanding the client's life situation in addition to there-and then

experience, the third type, "communicative attunement" focuses on understanding the client's immediate experience.

Note how in each of these models, empathy doesn't simply occur; it's presence is considered a result of the counselor's active responses in the direction of understanding the client. The counselor, for empathy to be present, must intend for it to be present. This is a major proposition of the current study. Additionally, when viewed together, these models provide an example of how empathy can be considered in three different ways: as a personality trait, as a situation-specific cognitive-affective state, or as a multiphase experiential process (Duan & Hill, 1996). For the purpose of this study, we will be looking at two out of three of these approaches. Empathy as a personality trait, or 'dispositional empathy' as Duan and Hill (1996) refer to it, is presumed will increase as a result of empathy training. Additionally, empathy as a multiphased experiential process, or 'empathic process,' will be examined by looking at the intentions of the counselor while working with a role-play client.

Empathy in the counseling relationship

These different models of empathy have primarily been examined in the context of counseling relationships, specifically with regards to counseling outcome. Considering the importance of empathy within that context, in an early review of the literature, Truax and Carkhuff (1967) came to three conclusions. First, they concluded that empathy is "teachable", along with nonpossessive warmth and therapist genuineness. Secondly, they concluded that "nonprofessional people lacking expert knowledge in counseling can,

under supervision, produce positive changes in hospitalized patient populations after training in the communication of accurate empathy, nonpossessive warmth and therapist genuineness." (p. 112). Finally, they concluded that accurate empathy, nonpossessive warmth and therapist genuiness have "a causative relationship to outcome that is independent of expert knowledge." (p. 112).

Unfortunately, these results, most importantly the last, have not been strongly supported by the subsequent research. While Orlinsky et al (1994) conclude that 54% of 115 studies show a positive relationship between empathy and outcome, this finding does not take into account methodological weaknesses. Gladstein, in reviewing the research literature three different times (1970, 1977, and 1987a), concluded that the evidence concerning the relationship between empathy and counseling outcome is contradictory and inconclusive. In the most recent review of the literature, by Duan and Hill (1996), the same conclusion was drawn. They attempt to explain the inconsistent findings by pointing out that they are likely the result of interactions between intellectual empathy, empathic emotions, and dispositional empathy. They argue that not until the relationships between these three are examined will the impact empathy has on therapy be more fully understood.

Among the research findings that have been consistently supported is that client perception of empathy is more highly related to satisfaction with counseling outcome than any other variable (Gladstein, 1977). In addition to that, Duan and Hill (1996) point out that the research has shown that only client perceptions of empathy are related to

client-rated counseling outcome. These findings point to the idea that regardless of how one conceptualizes empathy, it's still the perception of the client which is most important when it comes to counseling satisfaction and outcome. Thus, it would seem beneficial to give the client the perception that one was attempting to be empathic. And in order to do this, one would either need to actually be empathic, or simply be trying to communicate empathy. As Duan and Hill (1999) put it, "It makes logical sense to study empathy as the therapist's contribution…"

Empathy Measurement

Throughout the literature on empathy, a recurring discussion of the difficulty of identifying and measuring it emerges, in fact it's one of the major criticisms of empathy research (Duan & Hill, 1996; Bohart & Greenberg, 1997). Several factors contribute to the difficulties of measuring empathy: weak construct validity, lack of an operational definition, limitations of observer and self-report methods of measurement, and the impact of changing technology in recording, measuring, and studying the counseling process.

As described above, our understanding of empathy has been continually refined over the years. With changing definitions come changing measurement tools and strategies. Initially external observation was the measurement strategy of choice. In 1967, Truax and Carkhuff emphasized the importance of using audiotape as a means for third-party observation and rating of empathy. More recently, Redfern, Dancey, & Dryden (1993), point out that because the client will be responding to more than spoken empathic

language, third-party audiotape review of counseling sessions is not sufficient. An important question not considered in this technological debate might be whether an outside observer can accurately assess the extent to which empathy is present in a counseling relationship.

And if a third-party can't be relied upon to be an accurate observer, could either the counselor or the client be relied upon? Obviously, if the only measurement of empathy were the counselor's self-report of perceived empathy in a counseling session or relationship, the measurement would be confounded by bias in the direction of rating more empathy than was actually there. Additionally, we can take from the literature above that counselor rated empathy isn't as important as client perceived empathy. And if the only measurement of empathy were the client's self-report of perceived empathy, we wouldn't get an entirely accurate picture as well. We wouldn't want a client focusing on how much, or how little, empathy was present during their session at the expense of their focusing on themselves. Additionally, they might not be aware of when the counselor is attempting to be empathetic with them. Given these concerns, an accurate measurement of empathy in a counseling session may best be achieved by considering the combination of perceptions from the client, the counselor, and an outside observer.

Despite these concerns about accurate empathy measurement, a number of assessment tools are available, with various limitations. The two most common are addressed here. The Carkhuff Empathic Understanding Scale (1969) uses third-person observations of a counseling session in order to measure in-session empathy. It requires

outside raters to either view or listen to tapes and rate the amount of empathy perceived. Besides the limitation(s) brought about by using a third-party observer/rater, this instrument is also limited in that the definitions used in the rating system are vague. Raters are expected to differentiate between empathic levels based upon some rather non-specific criteria.

The Empathy Scale of the Barrett-Lennard Relationship Inventory (BLRI, 1964) has addressed the issue of third-party observation by using observations by both the client and the counselor rather than a third-party observer, resulting in an instrument which takes into account both the client's and counselor's inner experience (Brennan, 1987). This instrument is based on a conceptualization of empathy as a state experienced by the therapist for his or her client. There are two versions of the BLRI: the client's version measuring his/her perceptions and feelings about the counselor (OS); and the counselor's version measuring his/her perceptions and feelings about the client (MO). Each has 64 items divided across four subscales: Empathy, Level of Regard, Unconditionality of Regard, and Congruence of Regard.

The BLRI is the most commonly used empathy measurement instrument due to it's inclusion of both counselor and client ratings of empathy, despite it's limitations. One of these limitations is that while it attempts to measure the amount of empathy in a counseling relationship, it doesn't do so in the context of how empathic the counselor is trying to be. It doesn't address whether the counselor is trying to be empathic, it simply assumes that the counselor values and intends to be empathic all the time.

Empathy Training Within Counseling Training

One would expect that counselor training programs would naturally facilitate the development of empathy. Counselors-in-training are in an environment where they are constantly asked to think about how to apply what they are learning to their future clients. Unexpectedly however, Carkhuff (1968) found that mean empathy levels may actually decline over the course of some professional counselor training programs. Ten years later, a review by Bath & Calhoun (1977) found the same thing: "The evidence reviewed, especially that from the most methodologically sound studies, indicates that professional training in counseling generally fails to increase trainees' empathy." (p. 98).

Those studies that found a positive effect for including empathy training in counseling training, have been criticized for methodological weaknesses (Bath and Calhoun, 1977). These weaknesses include lack of control groups, disproportionate numbers of subjects in personal therapy, invalid measures of empathy, and the use of correlations as being indicative of a cause-effect relationship. It may be due to these inconsistent findings that researchers have not been more active in examining the effects of empathy training programs.

Three separate reviewers (Bath & Calhoun, 1977; Ford, 1979; and Gladstein, 1987b) have raised the concern that empathy training programs, while improving students' empathy, are not improving it to the point of being facilitative, based on the proposition that there is a specific level of empathy as measured by the Carkhuff Empathic Understanding Scale (1967), at which a counselor moves from being non-

facilitative in the counseling relationship to being facilitative. Based on this concern, Gladstein (1987) urged that researchers work to develop better predictors of success in training with regards to empathy. In the same light, other reviewers (Bath & Calhoun, 1977; and Ford, 1979) suggest that in order to increase the final group mean on an empathy measure, trainers should match trainee needs to training program components and train to a specific criterion level.

Brennan (1987), in order to specifically study the experiential components of empathy training, compared two different empathy programs: Carkhuff's Human Relations Training (HRT), and Tubesing and Tubesing's Tune-In. He found that the combination of the two programs was more effective in training for Barrett-Lennard's empathic resonation than either of these programs alone, and is more effective than a lecture-discussion program. It should also be noted that in Brennan's review of the literature, he cited results from two dissertations (Aylward, 1981; and Corcoran, 1980, both in Brennan, 1987) which found that the addition of training components concerned specifically with the counselor's experience had not produced the expected results in terms of counseling outcome increases. These findings, along with his own, would appear to indicate that while some combination of empathy training components can be presumed to increase trainee's empathic resonation, increased empathic resonation doesn't necessarily result in increased positive outcomes.

Gladstein (1987b) presented a program based on Carkhuff's 1969 model that taught the verbal and nonverbal skills of empathy. This program, criticized for not

including an affective empathy component, was then proposed to be half of a larger program of which observing characters and their emotions in movies made up the other half. Although counselors-in-training reported enjoying the program, no other measures were made of it's effectiveness.

This study was consistent with the conclusions from Gladstein's review of the literature with regards to facilitating empathy development (1987c). He concluded in this review that didactic techniques are effective for developing beginning level communicative empathic skills, but are not effective for developing empathy to the level considered to be facilitative. This point is consistent with Ford's (1979) conclusion that brief empathy training using modeling, role playing, and feedback techniques in combination produces only initial levels of empathic skills. Based on these studies, Gladstein recommended that empathy training should utilize a comprehensive program that includes behavioral and experiential components.

In summary, the influence of empathy training remains unclear when overall counseling outcomes and behaviors are considered. While different programs might improve empathy to varying degrees, their effect on counseling outcome is not evident. What also remains unclear, though due to not having been examined rather than inconsistent research findings, is the impact empathy training has on the pieces of counseling behavior which contribute to the whole of the counseling experience. For this reason, counseling intentions are considered in the succeeding section.

Counselor Intentions

Counseling research originally focused on the outcome, or results, of counseling. This was referred to as counseling outcome research. More recently, researchers have begun to examine what happens within the process of counseling, which is referred to as counseling process research. Included in counseling process research are measures and rating systems of counselor and client variables. One counselor variable that has been studied is counselor intentions – assessing what the counselor is trying to do during the counseling session, specifically with each response she/he makes. The focus of counselor intentions is not what the counselor says, or in what form of counseling microskill it is in, but rather why the counselor said what he/she said. Is the counselor trying to gather information, to pass on information, or possibly trying to help the client explore some area of concern by simply following? Thus counselor intentions are not behaviors as much as they are reasons behind behaviors. For this reason, they may be expected to be more responsive to the effects of empathy training than are counseling outcomes.

Counseling intentions are currently best defined as "a therapist's rationale for selecting a specific behavior, response mode, technique, or intervention to use with a client at any given moment within the session" (Hill & O'Grady, 1985). Prior to the development of this definition though was an earlier model of intentions, proposed by Goodman and Dooley (1976). This model consisted of only six different types of intentions and unfortunately was never used in any research. Another model including only six intentions was Elliot's (1979). This model was based on a method in which

independent raters reviewed sessions and assumed, by the type of response(s) made by the counselor, that they knew the type of intention behind the response. Obviously this method of measuring intentions has a major limitation: independent raters can't know the reason(s) behind a specific counselor behavior; they can't read minds. This model did make a unique contribution to the intentions literature however by adding the idea that there can be more than one intention for, or reason behind, each counselor response.

This contribution was included in Hill and O'Grady's model (1985), categorization system which included 19 therapist intentions: set limits, get information, give information, support, focus, clarify, hope, cathart, cognitions, behaviors, self-control, feelings, insight, change, reinforce change, resistance, challenge, relationship, and counselor needs. This model was further refined by Hill, Helms, Tichenor et al. (1988) who suggested that only seven categories of Hill and O'Grady's 19 intentions are worth noting for research purposes. These seven categories of intentions include: assessment (get information, focus, and clarify), restructure (resistance, challenge, and insight), change, explore (cognitions, feelings, and behaviors), support (support, hope, reinforce change), set limits, and educate (give information). Hill and O'Grady (1985) developed a more direct method of measuring intentions as well. Based on Kagan's (1975, in Hill & O'Grady, 1985) Interpersonal Process Recall method of supervision, the authors developed the idea of reviewing tapes of a session with the counselor and asking, after stopping the tape with each counselor response, what was the purpose of the counselor's response. The rater then 'translates' the answer into one or more of the 19 different

intentions categories. This method relies much more on the reliability of the self-report of the counselor and much less on the ability of the rater, a major limitation of Elliot's (1979) previous method (Hamer, 1995). It is still worth noting however that the rater still plays a role by taking what the counselor says about her/his intention(s) and 'translating' it in terms of the intentions categories used.

Up to this point, the only study that has examined variation in counselor intentions as a function of training found that trained students used fewer 'assessment' intentions and more 'explore' intentions when compared to a no-training control group (Kivlighan, 1989). Hill and O'Grady (1985), studying experienced therapists, found that, within each session, there was a pattern of decreases in 'clarify' and 'get information' intentions and increases in 'cathart,' 'insight,' and 'change' intentions. This study is expecting that students who receive additional empathy training will not only score higher on measures of empathy, but will also differ from those students who didn't receive the empathy training with regards to their intentions. Specifically, it is expected that the treatment group will score higher on the intentions categories of 'Support' and 'Explore', while scoring lower on 'Assessment.'

Conclusion

The empathy models presented above provide an overview of different approaches to defining a complicated and sometimes confusing construct. The conclusion that it can be considered as either a personality trait, as a situation-specific cognitive-affective state, or as a multiphased experiential process (Duan & Hill, 1996) is important,

as is the differentiation between 'intellectual empathy' and 'empathic emotion.'

Additionally, the point was made that empathy cannot happen without the active intention

of the 'empathizer' or counselor in this instance. For the purpose of this study, we will

consider empathy to be both dispositional and a process.

Regardless of how one conceptualizes empathy, the effects of empathy training on

counseling outcomes remain unclear. The effects of empathy training on the counseling

process is also unclear, although this is due to the fact that it hasn't previously been

studied, not because results have been mixed. This study attempts to link these two

previously unrelated ideas. Counselor training focuses on not only developing certain

behaviors, but also on learning when and why to use those behaviors (Galvin, 1985;

Mahon & Altmann, 1977). Learning when and why to use a behavior is learning how to

use a behavior intentionally, with a purpose. As one would expect, counselor training has

been shown to have an effect on counselor intentions (Kivlighan, 1989). Empathy

training however has not been studied with regards to it's effect on intentions. The

current study attempts to link empathy training, as a specific part of counselor training,

with it's effect on counselor intentions.

There are additional reasons to use intentions as a measure of the effect of

empathy training. One of these reasons is because of the vagueness of the concept of

empathy. Whether empathy is a communication skill, an inner experience of the

counselor, or the client's perception, remains controversial (Gladstein, 1983). Rather than

becoming wrapped up in this controversy, this study will attempt to get to the heart of

counselor training: how does it effect what counselors think about during a counseling session? Additionally, an indirect measure of empathy, which minimizes social desirability effects, is recommended by reviewers (Duan & Hill, 1999). More specifically these reviewers encourage the use of counseling process measures "to infer communicated empathy" (Duan & Hill, 1999). I also like a point that Hackney (1978) states quite clearly: "Empathy cannot be seen. What is seen invariably occurs as a follow-up to the empathic moment and may be either a reflection of that moment or the anticipation of the next moment." (p. 38). The measure of intentions has little to do with what is seen, and much more to do with what was on the mind of the counselor at the moment he/she spoke or acted.

Rationale for Study

The primary hypothesis of this study is based upon the idea that empathy training should have some effect on what counselors-in-training try to do during their role-play counseling sessions. Specifically, based upon an examination of the 8 different intentions categories used, it would make sense that the "Support" and "Explore" intentions categories would be higher for the treatment group than for the control group, and vice-versa for the "Assessment" category.

However, the literature, as reviewed, indicates what can be expected as a result of including an additional empathy training component to an already complete counseling methods course. While intuitively one might expect that empathy training would increase students' scores on empathy measures, no consistent effects for empathy have been

found. Therefore, no overall effect on the Empathy subscale of the BLRI is expected as a result of the empathy training. However, empathy, as measured by the BLRI will be monitored to assure that there are no meaningful differences between the two groups.

Second, I expect students who received the empathy training to have a higher proportion of intentions that were empathic than students who didn't receive the training.

Third, because this study is partially dependent upon the fact that the counseling intentions are sensitive to the effect of increased empathy, it would seem important to assess how well related the intentions categories are to the empathy categories. Specifically, it would appear that intentions categories such as 'Support' and 'Explore' would have a positive relationship with the 'Empathy' category. Additionally, it would seem that the "Assessment" category would have a negative relationship with the 'Empathy' category.

Hypotheses

Specifically, the hypotheses for this study are as follows.

Hypothesis 1. The primary hypothesis of this study is that counselor intentions will change as a result of empathy training.

Hypothesis 1(A). The 'Support' intention will be significantly higher for those participants in the treatment group than it is for those participants in the control group.

Hypothesis 1(B). The 'Assessment' intention will be significantly lower for those participants in the treatment group than it is for those participants in the control group.

Hypothesis 1(C). The 'Explore' intention will be significantly higher for those participants in the treatment group than it is for those participants in the control group.

Hypothesis 2. The second hypothesis is that the training group will have a statistically significantly higher mean of intending to be empathic than the control group.

Hypothesis 3. The third hypothesis is that there will be correlations between the intentions measures and the additional empathy intention category.

Hypothesis 3(A). There will be a positive correlation between the 'Support' intention and the empathy category.

Hypothesis 3(B). There will be a positive correlation between the 'Explore' intention and the empathy category.

Hypothesis 3(C). There will be a negative correlation between the 'Assessment' intention and the empathy category.

Hypothesis 4. The fourth hypothesis of this study is that neither the treatment nor the control group will show an increase in their empathy over the course of a single semester. This will be indicated by there being no main effect for measures of empathy on the Empathy Subscale of the BLRI over the course of three measurements (Pretest, Pre-Intervention, and Posttest).

23

Research Questions. As well as the above hypotheses, I will examine differences

that may occur in counselor intentions due to age, gender, and amount of past

professional experience in the counseling field.

CHAPTER 2

METHOD

Participants

The participants in this study were beginning master's level counselors-in-
training. There were three different cohort class groups; students either began the
program in the Fall of 1997, 1998, or 1999. A total of 35 participants were included in the
analysis for this study. Of the original 48 students contacted to participate in the study, 12
failed to complete all of the data collection processes and 1 case was omitted from
analysis because of a negative response set on the BLRI. This resulted in a final
participation rate of 35/48 (73 %). The final participant pool consisted of 66% females
and 34% males. The mean age for participants was 28.9 years old (range = 22 - 54, SD =
8.1). 89% of participants self-identified as "White" or "Caucasian", and 3% each
identified as "Japanese", "Hispanic", "Native American", and "East Indian". The average
amount of counseling experience previous to enrollment in the course was .54 years
(range = 0 – 4, SD = 1.0). The average amount of supervised counseling experience was
.17 years (range = 0 – 1.5).

Instruments

Barrett-Lennard Relationship Inventory

Though Duan and Hill (1996) conclude that valid measures of empathy are still
lacking, they point out that the BLRI is the most commonly used self-report or other-

24

report instrument of counselor-therapist empathy. The counselor form (Form MO-64) of the BLRI is a paper-and-pencil, self-report instrument that is intended to assess the level of empathy in an individual counseling relationship. The instrument is composed of four subscales across 64 questions, each requiring a response of "never", "rarely", "sometimes". "often". or "always." In reviewing 24 reliability studies of the BLRI. Gurman (1977) noted a high degree of stability, with mean internal consistency coefficients across 14 studies of .84 for the Empathy subscale, .91 for the Level of Regard subscale, .74 for the Unconditionality of Regard subscale, .88 for the Congruence subscale, and .91 for the Total. Split-half reliability for the original form (MO) is 0.96, indicating acceptable reliability. Validity however, according to Brennan (1987), is questionable. He cites Lanning & Lemon (1974, in Brennan, 1987) in bringing up the point that the BLRI may not measure empathy as much as it does overall satisfaction with the counseling relationship. This particular issue of validity however relates to the client version of the BLRI used within a counseling relationship, not to the counselor version used outside of a counseling relationship. Thus, it was not considered a limitation in the use of the BLRI for this study. Additionally, in examining the intercorrelations between the four subscales of the BLRI across 16 studies, Gurman concludes that the four subscales "are consistently measuring different dimensions of the patients' perceptions of the therapeutic relationship" (p.511). Gelso and Fretz (1992) contend that the BLRI "continues to be the most effective method of measuring the facilitative conditions that is

true to Rogers' theory" (p.143). It is because of the high reliability and adequate validity

of this instrument that it was chosen for use as a measure of empathy in the current study.

The one limitation of this instrument for this study however is that both the

client's and the counselor's version are intended to assess empathy within a specific

counseling relationship, not to assess a person's overall empathic stance. In order to

rectify this problem, two steps were taken. The first step was to use a version of the

instrument that had previously been modified from the original by changing the language

of the items from specific to general terms for a study examining nurses' empathy

(Henley, 1997). The second step was to further refine that version by replacing references

to "patients" or "nurses" with references to "clients" or "counselors" respectively.

Unfortunately, the reliability figures for this revised version with the sample used

for this study are not very strong. Alpha-coefficients for the fours subscales, Level of

Regard, Empathy, Unconditionality, and Congruence, are .17, .50, .43, and .43,

respectively. These reliability figures are lower than expected, and indicate that any

conclusions based solely on the BLRI should be made cautiously.

<u>Intentions Rating System</u>

As addressed earlier, adapting a method used by Hill & O'Grady (1985) and a list

by Hill, Helms, Tichenor et al (1988), this study used a system of eight categories of

intentions: Assessment, Change, Educate, Explore, Miscellaneous, Restructure, Support,

and Set Limits. In the procedure for obtaining this information, research assistants meet

with each counselor-in-training (CIT), no longer than 24 hours after the relevant role-play

session, and review the videotape of their session using an Interpersonal Process Recall model developed by Kagan (1975). Using this model, after each response made during the session by the CIT, the tape is stopped and the research assistant queries her/him as to the rationale for their statement. Upon hearing this rationale, the research assistant rates which intention category/ies (up to 3) the counselor's thoughts fall. It is acceptable, and expected, for there to be multiple intentions for any single counselor response. These per response tallies are then added to get a raw score of how many times a counselor intended to, for example, educate, during the session. These raw scores are then divided by how many intentions there were total during that session, in essence providing a proportion, or percentage, of how much a single intention was present during a session.

The major limitation of this procedure with regards to empathy research has to do with how well the intentions categories are actually indicative of empathy. For this reason, an additional category system was developed. This system, referred to as Empathy categories for the purpose of this study, began simply as two mutually exclusive categories to be included when rating intentions. These two categories were 'Empathy' or 'No Empathy.' The 'Empathy' category was defined as any indication that the counselor's intent included trying to understand the client better or was actually feeling along with the client what was going on in session. The 'No Empathy' category was defined as the lack of a stated attempt to be empathic in the intention. The two categories were further refined after some initial testing by adding an additional category: "Communicated Empathy." This additional category was defined as an attempt at letting

the client know that he/she is empathizing with them. So, in addition to rating the stated counselor intent with regards to the intentions categories, the raters were also asked to rate it with regards to the three empathy categories. See Appendix A for instructions given to Research Assistants for rating and for definitions used in the two category systems.

Due to the importance of the rater's accuracy in using this system, inter-rater reliability was computed for the Counseling Intentions as well as for the Empathy Categories (See Table 1). In order to attain these figures, audio and video tape recordings were made of the tape review sessions. These tapes were then used by one of the other raters to independently rate the CIT's stated intentions within the category system. Correlation coefficients were then computed for the two raters raw intentions scores. These correlations ranged from -.284 to .954. Most were significant at the .05 level, with the most relevant intentions categories (Assessment, Exploration, and Support) being relevant at the .01 level. Additionally, both the number of intentions per role-play session, and the number of intentions per role-play session were significantly correlated at the .01 level. One intention category indicated a negative correlation (Educate, $r = -.039$), as did one of the empathy categories (Communicate Empathy, $r = -.284$). Upon viewing the raw data, no apparently significant outliers were observed. Due to the fact that neither of these categories have a direct impact on the hypotheses of this study, no further steps were taken to adjust for these findings.

29

Table 1

Inter-rater Reliability of Counseling Intentions and Empathy Categories

Intention Category	r	sig.	
Assessment	.838	.000	
Change	.446	.037	
Educate	-.039	.862	
Explore	.857	.000	
Restructure	.724	.000	
Set Limits	.681	.000	
Support	.948	.000	
Miscellaneous	.310	.161	
Number of Intentions	.954	.000	
Number of Responses	.823	.000	
Empathy	.219	.328	
Communicate Empathy	-.284	.200	
No Empathy	.789	.000	

Intervention

While the primary focus of this study was not to develop and implement an entirely new approach to empathy training, a unique empathy training component was developed for implementation. The empathy training component attempted to integrate findings from the literature with the practical concerns of adding an educational component to an already full counseling methods curriculum. It was assumed that the existing curriculum already contained sufficient opportunity for the practice of communication skills involved in being empathic. What was added, based upon the empathy literature, was an additional opportunity to develop and refine the ability to recognize emotions in the client (Galvin, 1985). Additionally, the component was kept as short in order to facilitate ease of implementation and generalizability to other programs. The training interventions that made up the two-hour long empathy component were chosen due to their emphasis on empathy as a emotional process. In providing the training, facilitators were encouraged to focus on growth and improvement, rather than on instantaneously becoming an empathic person. It was also emphasized that the facilitation of the exercise, including role-modeling, was just as important as the content of the exercise. See Appendix B for a complete description of the empathy training component used in this study. Appendix C includes remarks made by the Teaching Assistant who first implemented the training component.

31

Procedure

The Masters of Arts in Counseling Program at the University of North Dakota requires taking a class in basic counseling methods, commonly called "methods class". This course includes weekly small group participation in which master's level counselors-in-training, supervised by doctoral counseling psychology students, discuss the lecture portion of the class and can practice, through role-playing counseling with each other, counseling microskills.

At the beginning of the course participants completed the modified version of the MO form of the BLRI and a brief demographic questionnaire. Approximately half-way through the semester (after 8 weeks of a 16-week semester) participants again completed the same instrument. Immediately after completing this second administration of the BLRI, the lab courses were divided into approximately equal halves and randomly assigned to either the treatment or control group. The treatment groups then received additional empathy training while the control groups continued with the practice and feedback protocol which was the norm. At the end of the semester, the effects of the empathy training were assessed using both the BLRI and by measuring the intentions participants report having during their last role-play counseling session of the semester (usually about 20 minutes long).

Finally, a follow-up assessment, including completing the BLRI and again assessing counseling intentions was administered at the end of the next semester, when students are typically in a Practicum working with 'actual' clients in a mental health

setting. This follow-up was intended to ascertain the amount of transfer that occurs past the role-paying experience. Unfortunately, due to the difficulty in obtaining the data in a setting involving actual clients, this portion of the study was discontinued. Results for any significant number of participants are not available, so will not be further discussed.

CHAPTER 3

RESULTS

Initial descriptive statistics were computed in order to assess equivalency of

treatment and control groups and to provide information about the potential

generalizability of these findings to other graduate counseling students. Descriptive data

for the two experimental groups is presented in Table 2 (See the Participants section for

descriptive statistics of the participant pool as a whole). Because the treatment group had

Table 2

Means and Standard Deviations of Control and Treatment Groups

Variable		Treatment Group	Control Group
Gender			
	# Males	9	3
	# Females	9	14
Age			
	$\underline{M}$	31.44	26.29
	$\underline{SD}$	10.09	4.07
Previous Counseling Experience (in Years)			
	$\underline{M}$	.68	.40
	$\underline{SD}$	.98	1.05
Previous Supervised Counseling Experience (in Years)			
	$\underline{M}$	.18	.16
	$\underline{SD}$	.34	.42

9 males and the control group had only 3 males. a Chi-square was performed which indicated that this difference between the two groups was statistically significant (X^2 = 4.063, $\underline{p}$ < .05). Because of this, further exploration was undertaken to ascertain the impact gender had on several important dependent variables. Table 3 presents the means and standard deviations, by gender, on these variables. Of particular interest is that the females had fewer intentions and responses per session ($\underline{M}$ = 23.22, $\underline{SD}$ = 9.31; $\underline{M}$ = 19.83, $\underline{SD}$ = 7.11; respectively) than did the males ($\underline{M}$ = 31.58, $\underline{SD}$ = 14.78; $\underline{M}$ = 27.25, $\underline{SD}$ = 10.21; respectively). ANOVA's performed indicated that the differences between the genders for these measures were statistically significant ($\underline{F}$ (1, 33) = 4.231, $\underline{p}$ < .05; $\underline{F}$ (1,33) = 6.347, $\underline{p}$ < .05; respectively). Because the number of intentions significantly

Table 3

Means and Standard Deviations of Pretest and Posttest Variable Measures by Gender

Variable	Males		Females	
	$\underline{M}$	SD	$\underline{M}$	SD
Pretest BLRI Empathy Scale	23.83	5.36	25.92	4.30
Pre-Intervention BLRI Empathy Scale	23.83	5.89	25.93	3.40
Posttest BLRI Empathy Scale	25.08	5.02	26.94	5.42
Number of Intentions	31.58	14.78	23.22	9.31
Number of Responses	27.25	10.21	19.83	7.11

effected the measurement of intentions (total intentions was used as the denominator in order to compute proportions), and the number of responses significantly effected the empathy categories (total responses was used as the denominator in order to compute proportions of empathic intentions), subsequent hypothesis testing using these measures will include gender as a covariate.

Additionally, in order to further examine how unequal gender composition may have effected group scores, means and standard deviations were computed by group and gender specifically looking for possible interaction effects (See Table 4). ANOVA's were calculated for each of the variables in order to ascertain whether observed differences were statistically significant. Due to the length of Table 5 it is presented separately in Appendix D. The only measures found to have significant interaction effects for group and gender were the Communicate Empathy category and the No Empathy category, both of which are presented in Table 6. Due to the fact that the interrater reliability was so low for the Communicate Empathy category, it's importance is discounted here. What is more important however is the effect gender and group membership had on the No Empathy category, a measure which indicates the percentage of time that there was no empathy present in a participant's rationale for a counseling response. According to these results, men who had the empathy training, by indicating that they had no empathy in the rationale for their responses less often than did the men who had no empathy training, provided evidence that supports the positive impact of empathy training for men. Conversely, the women who had the empathy training had no empathy more than did the

Table 4

Means and Standard Deviations of Dependent Variables by Gender and by Group

Dependent Variable		Treatment Group		Control Group	
		Male	Female	Male	Female
Assessment Intention	M	26.84	30.42	43.78	4.88
	SD	9.03	16.70	17.64	16.28
Change Intention	M	2.84	2.06	4.88	2.19
	SD	3.67	3.31	8.45	3.57
Education Intention	M	3.84	1.38	.00	2.01
	SD	3.57	2.84	.00	3.11
Explore Intention	M	15.14	15.14	19.77	14.35
	SD	10.25	9.11	9.64	13.83
Restructure Intention	M	15.52	12.89	11.59	12.34
	SD	6.62	12.75	12.60	8.47
Set Limits Intention	M	1.52	2.51	1.67	2.89
	SD	2.41	3.20	2.89	5.33
Support Intentions	M	21.10	22.15	8.33	23.53
	SD	12.45	14.08	10.41	13.27
Miscellaneous Intentions	M	13.20	13.45	10.00	12.76
	SD	9.62	11.74	13.23	10.65

Table 4 cont.

Dependent Variable		Treatment Group		Control Group	
		Male	Female	Male	Female
Number of Intentions	M	33.11	18.44	27.00	26.29
	SD	15.89	6.44	12.12	9.75
Number of Responses	M	28.33	15.89	24.00	22.36
	SD	10.91	4.11	8.72	7.59
Empathy Intention	M	8.89	8.84	5.56	15.90
	SD	9.83	8.36	9.62	10.59
Communicate Empathy Intention	M	11.60	4.48	.00	9.23
	SD	8.44	5.53	.00	12.40
No Empathy Intention	M	79.51	86.68	94.44	74.88
	SD	12.86	8.37	9.62	16.05
Post-test BLRI Empathy Subscale	M	24.89	26.22	25.67	27.39
	SD	5.82	5.17	1.53	5.72

women who didn't have the training, providing evidence that empathy training may have actually decreased the amount of empathy in women.

After examining descriptive data of the two groups, Hypothesis 4 was examined in order to assess whether the results from this study's self-report measure of empathy (BLRI) were consistent with what had been seen in the empathy literature. Means and

Table 6

Summary Table of Statistically Significant Analyses of Variance of Dependent Variables

by Group and by Gender

Variable and Source	df	SS	MS	F	sig.
Communicate Empathy Intention					
Group	1	74.91	74.91	.825	.371
Gender	1	7.03	7.03	.077	.783
Group x Gender	1	426.55	426.55	4.699	.038
No Empathy Intention					
Group	1	15.64	15.64	.090	.767
Gender	1	245.08	245.08	1.400	.245
Group x Gender	1	1140.47	1140.47	6.528	.016

standard deviations were computed for participant's scores on the Empathy subscale of the BLRI from the three times it was administered (Pretest, Pre-Intervention, and Posttest). Table 7 shows these results, which indicate that there was little variability in the groups' means on the subscale. This variability is not unexpected given the standard error of measurement of 1.93 (using the previously reported Empathy subscale alpha coefficient of .84 (Gurman, 1977)) or 3.40 (using the alpha coefficient of .50 calculated for this sample). Both of these calculations used the average standard deviation across all three administrations of this study of 4.8153. The results of a repeated measure ANOVA in Table 8 indicate that there were no significant differences in BLRI scores between the groups, over time, or due to an interaction between group and time. This makes it clear

39

Table 7

Means and Standard Deviations of Control and Treatment Group scores on the Empathy

Subscale of the BLRI

Group	Pretest	Pre-Intervention	Posttest
Control			
M	25.19	26.29	27.09
SD	3.62	2.78	5.23
Treatment			
M	25.22	24.18	25.56
SD	5.67	5.47	5.38

that there were no significant differences between the groups, nor over time, nor over

time between the groups.

While there are no significant differences between the groups or over time on this

measure, upon reviewing Table 7, the differences between the standard deviations of the

two groups stands out. Due to the size of these differences, tests of the homogeneity of

variance were performed for all three administrations of the BLRI in order to examine

Table 8

Summary Table of Repeated Measures Analysis of Variance for Empathy Subscale

Scores at 3 Different Administrations by Group

Variable and Source	df	SS	MS	F	sig.
Time	2	28.23	14.11	1.07	.346
Time x Group	2	21.53	11.38	.816	.441
Error	66	870.72	13.95		

whether it is appropriate to assume that the variances are equivalent enough to support analyses of variance (See Table 9). And though the second administration's group variances were found to be significantly different ($L = 9.21$, $p < .01$), the smaller variance is not less than one-ninth of the larger variance, indicating that the inflation of Type I error is not likely to be significant (Keppel, 1991, p. 98). So even though the difference isn't large enough to seriously threaten statistics using this figures, for the purposes of examining effects over time, the Pretest measure of the BLRI Empathy will be used rather than the more recent, though apparently less stable, Pre-Intervention measure.

The finding that the variances are not homogenous between groups for the second administration of the BLRI is important statistically, but difficult to explain. The standard deviations, as shown in Table 7, indicate that the variance for the Treatment group remained somewhat consistent across administrations, while the variance for the Control group remained low for the first two administrations and rose to be similar to that of the Treatment group for the last administration. No outliers were observed in the data that

Table 9

Tests for Homogeneity of Variance on the 3 Administrations of the Empathy Subscale of the BLRI by Group

Administration	Levene Statistic	df1	df2	sig.
Pretest	2.476	1	33	.125
Pre-Intervention	9.205	1	33	.005
Posttest	1.107	1	33	.300

would account for this finding. Because gender had been examined previously, descriptive statistics of participants' scores on the three administrations by gender were computed. Table 10 presents these and Table 11 presents the results of ANOVA's computed to assess the significance of apparent differences between the genders for each administration. None of the differences were statistically significant but, when a tests of the homogeneity of variance was computed due to the disparate standard deviations, it was found that the difference between genders on the Pre-Intervention measure was statistically significant (See Table 12). Apparently, women had significantly less variability in their scores on the Empathy subscale on the second administration than did men. This would indicate that the difference in variance found between the two groups on that second administration is related to gender.

Finally, in examining group differences on the Posttest BLRI scores, Table 13 presents the results of an ANCOVA in which Pretest BLRI scores were used as the covariate. The results indicate that the groups are not different on this last self-report

Table 10

Means and Standard Deviations on the Empathy Subscale of the BLRI by Gender

Gender	Pretest	Pre-Intervention	Posttest
Females			
M	25.92	25.93	26.94
SD	4.30	3.40	5.42
Males			
M	23.83	23.83	25.08
SD	5.36	5.89	5.02

Table 11

Summary Table of Analyses of Variance for the Empathy Subscale Scores of the BLRI at

3 Different Administrations by Gender

Variable and Source	df	SS	MS	F	sig.
Pretest					
Between groups	1	34.39	34.39	1.571	.219
Within groups	33	722.27	21.89		
Pre-Intervention					
Between groups	1	34.54	34.54	1.79	.190
Within groups	33	636.63	19.29		
Posttest					
Between groups	1	27.03	27.03	.966	.333
Within groups	33	923.07	27.97		

Table 12

Tests for Homogeneity of Variance on the 3 Administrations of the Empathy Subscale of

the BLRI by Gender

Administration	Levene Statistic	df1	df2	sig.
Pretest	.359	1	33	.553
Pre-Intervention	6.85	1	33	.013
Posttest	.232	1	33	.633

Table 13

Analysis of Covariance of Posttest BLRI Empathy Subscale Scores as a Function of

Group, with Pretest BLRI Empathy Subscale as Covariate

Source	df	SS	MS	F	sig.
Pretest BLRI Empathy Subscale (covariate)	1	158.03	158.03	6.56	.015
Group	1	20.96	20.96	.869	.358
Error	32	771.53	771.53		

measure, unless differences in the Pretest measure of self-report empathy are taken into

account. Thus the Control group would appear to have increased in self-report empathy

more than did the Treatment group.

The second hypothesis was that the treatment group would attempt to be empathic

more often than the control group, thus scoring relatively higher on the Empathy

category. Actually the treatment group scored lower on the Empathy category (M = 8.87,

SD = 8.86) than did the control group (M = 19.96, SD = 23.06) (See Table 14), although

this difference was not significant when gender was used as a covariate (F (1,33)= 1.28, p

= .267). Table 15 shows the results of ANCOVA's, with gender as a covariate, computed

to examine the difference between the two groups on the Empathy categories, including

number of responses.

Correlation coefficients were computed on the raw data of the intentions measures

and the additional empathy categories in order to analyze the third hypothesis examining

Table 14

Means and Standard Deviations of Empathy Categories by Group

Intention	Treatment Group		Control Group	
	M	SD	M	SD
Empathy	8.87	8.85	14.07	10.92
Communicate Empathy	8.04	7.83	7.60	11.75
No Empathy	83.09	11.15	78.33	16.73
Number Responses	22.11	10.24	22.65	7.53

relationships between these two variable categories (See Table 16). These correlations were intended to indicate if the empathy categories were related to the counseling intentions categories in the expected manner. Hypothesis 3(A) was that there would be a positive correlation between the Empathy category and the 'Support' intention. This hypothesis was confirmed with a correlation of .37, which is significant at the .01 level (for a 2-tailed analysis). Hypothesis 3(B) was that there would be a positive correlation between the Empathy category and the 'Explore' intention. This hypothesis was not confirmed ($r = -.02$). Finally, Hypothesis 3(C) was that there would be a negative correlation between the Empathy category and the 'Assessment' intention. This hypothesis was confirmed with a correlation of -.18, which is significant at the .01 level (for a 2-tailed analysis). The trend of these findings would seem to indicate, as expected, that when participants intended to support it was related with empathy, and when they intended to assess, empathy was not present in the intention.

Table 15

Summary Table of Analyses of Covariance of Empathy Categories by Group with Gender

as a Covariate

Source and Variable	df	MS	F	sig.
Empathy				
Gender (covariate)	1	92.16	.94	.340
Group	1	125.53	1.28	.267
Error	32	98.36		
Communicate Empathy				
Gender (covariate)	1	12.34	.12	.729
Group	1	9.51E-04	.00	.998
Error	32	101.28		
No Empathy				
Gender (covariate)	1	37.05	.18	.674
Group	1	124.84	.61	.441
Error	32	204.89		

Additional significant correlations to note, though not included in the hypotheses,

include those between 'Support' and both 'Communicate Empathy' and 'No Empathy',

each of which are in the direction one would expect and are significant at the .01 level

(for a 2-tailed analysis). There was also a statistically significant positive correlation

between the 'Assessment' intention and the 'No Empathy' empathy category, which is

consistent with the results stated above.

Table 16

Intercorrelations Between Intentions Categories and Empathy Categories

Intentions Measure	Empathy	Communicate Empathy	No Empathy
Assessment	-.18**	-.17	.26**
Change	-.04	-.02	.05
Educate	-.06	.04	.01
Explore	-.02	-.07*	.08*
Miscellaneous	-.06	.09**	.11**
Restructure	-.05	-.09**	.09**
Set Limits	-.02	.06	-.03
Support	.37**	.50**	-.65**

** $p < .01$ (2-tailed); *$p < .05$ (2-tailed)

Finally, the primary hypothesis (Hypothesis 1) of this study was that counselor intentions would change as a result of empathy training. To analyze this, means and standard deviations of participants' intentions measures (ratios) were computed (See Table 17). As expected, the Control group used the Assessment intention more often and the Support intention less often than did the Treatment group. The difference between groups in terms of the Explore intention is minimal. ANCOVA's were computed, with gender as the covariate, in order to examine the differences between groups for these three measures (See Table 18). Hypothesis 1(A) was that the 'Support' intention would be significantly higher for those participants in the treatment group than for those

Table 17

Means and Standard Deviations of Intentions Measures by Group

Intention	Treatment Group		Control Group	
	M	SD	M	SD
Assessment	28.63	13.15	32.38	16.85
Change	2.45	3.41	2.67	4.51
Educate	2.62	3.38	1.67	2.91
Explore	15.14	9.41	15.30	13.10
Miscellaneous	13.33	10.41	12.28	10.73
Restructure	14.21	9.95	12.21	8.85
Set Limits	2.01	2.80	2.67	4.94
Support	21.62	12.90	20.85	13.86
Number Intentions	25.78	13.98	26.41	9.79

participants in the control group. This hypothesis was not confirmed as the ANCOVA indicates that the difference between the two groups was not statistically significant (F (1,32) = .34, p > .05). Additionally, hypothesis 1(B), that the 'Assessment' intention would be significantly lower for those participants in the treatment group than it is for those participants in the control group, was not confirmed, as the difference between the groups was not statistically significant (F (1,32) = .70, p > .05). And finally, hypothesis 1(C), that the 'Explore' intention would be significantly higher for those participants in the treatment group than it is for those participants in the control group, was not confirmed either as the group means indicate that the control group had a higher ratio of

Table 18

Summary Table of Analyses of Covariance of Intentions by Group with Gender as a

Covariate

Source and Variable	df	MS	F	sig.	
Support					
Gender (covariate)	1	256.63	1.45	.237	
Group	1	57.90	.34	.571	
Error	32	176.53			
Assessment					
Gender (covariate)	1	47.01	.20	.656	
Group	1	162.52	.70	.410	
Error	32	232.38			
Explore					
Gender (covariate)	1	25.70	.20	.662	
Group	1	4.80	.04	.850	
Error	32	131.96			

'Explore' intentions than did the treatment group ($\underline{M}$ = 15.3, and $\underline{M}$ = 15.14,

respectively). The difference between the two groups on this final measure was not found

to be statistically significant ($\underline{F}$ (1,33) = .850, $\underline{p}$ > .05).

Additional examination of the results of this study took place as well. Statistics

were also computed in order to further explore any possible effects gender may have had

on the results. Table 19 presents means and standard deviations, by gender, for the

Intentions Category measures. ANOVA's were calculated in order to accurately assess

Table 19

Means and Standard Deviations of Intentions Measures by Gender

Intention	Males		Females	
	M	SD	M	SD
Assessment	31.07	13.21	30.12	16.07
Change	3.35	4.86	2.14	3.39
Educate	2.89	3.50	1.77	2.96
Explore	16.30	9.88	14.66	11.97
Restructure	14.54	8.00	12.56	10.08
Set Limits	1.56	2.40	2.74	4.53
Support	17.91	12.87	22.99	13.29
Miscellaneous	12.40	10.06	13.03	10.83

the significance of any apparent differences between the means (See Table 20). There

were in fact no significant differences between the genders on the counseling intentions

categories. Table 21 presents means and standard deviations, by gender, for the Empathy

Categories. Again, ANOVA's were computed to assess the significance of differences.

Table 22 presents the results from these ANOVA's and indicates that none of the

differences were statistically significant as well.

Table 20

Summary Table of Analyses of Variance of Intentions Categories by Gender

Source and Variable	df	SS	MS	F	sig.
Assessment					
Between groups	1	7.15	7.15	.031	.861
Within groups	33	7598.53	230.26		
Change					
Between groups	1	11.52	11.52	.741	.396
Within groups	33	513.04	15.55		
Educate					
Between groups	1	9.90	9.90	.998	.325
Within groups	33	327.22	9.92		
Explore					
Between groups	1	21.15	21.15	.165	.687
Within groups	33	4227.64	128.11		
Restructure					
Between groups	1	30.96	30.06	.348	.559
Within groups	33	2938.82	89.06		
Set Limits					
Between groups	1	11.00	11.00	.704	.407
Within groups	33	515.35	15.62		
Support					
Between groups	1	203.97	203.97	1.179	.285
Within groups	33	5706.79	172.93		

Table 20 cont.

Source and Variable	df	SS	MS	F	sig.
Miscellaneous					
Between groups	1	3.16	3.16	.028	.868
Within groups	33	3692.30	111.89		

Table 21

Means and Standard Deviations of Empathy Categories by Gender

Empathy Category	Males		Females	
	M	SD	M	SD
Empathy	8.06	9.45	13.14	10.20
Communicate Empathy	8.70	8.90	7.37	10.38
No Empathy	83.24	13.52	79.50	14.57

Table 22

Summary Table of Analyses of Variance for the Empathy Categories by Gender

Source and Variable	df	SS	MS	F	sig.
Empathy					
Between groups	1	701.18	701.18	2.266	.142
Within groups	33	10210.86	309.42		
Communicate Empathy					
Between groups	1	14.05	14.05	.143	.708
Within groups	33	3240.81	98.21		
No Empathy					
Between groups	1	110.72	110.72	.547	.465
Within groups	33	6681.20			

CHAPTER 4

DISCUSSION

Hypotheses

The initial analysis of the demographic data indicated a difference between the treatment and control groups with regard to gender, with significantly more males in the treatment group (9) than in the control group (3). This imbalance led to further exploration of the differences between the genders, and some important findings for this study. Specifically, it was found that males had significantly more responses and intentions than females. This would indicate that males are either more active during their role-play sessions or that their role-play sessions are longer than those of their female classmates. Additionally, the finding that there was an interaction effect for gender by group in the Communicate Empathy category and the No Empathy category is important to clarify. While the finding with regards to the Communicate Empathy category can be disregarded to some degree due to the low inter-rater reliability found for that category, such is not the case for the No Empathy category. That result indicates that the effect of empathy training, at least with regards to in-session intentions, differs for the two genders. It would appear that while males increase in their intentions to be empathic as a result of empathy training, females actually decrease in their intentions to be empathic. The additional empathy training, by explicitly encouraging students to feel what the role-play client feels, may encourage men to not only be more focused on the affective side of

52

the client than they otherwise might be, but it may also increase the likelihood of sharing those affective reactions with the client. Empathy training may have the effect of implicitly giving men permission to be empathic, thus increasing their intentions to do so. It may also provide a structure for them to do so, which they many not previously have had. Conversely it would appear that empathy training inhibits women's intentions to be empathic. This result may be an artifact of the finding regarding men, or it may be that women's intentions to be empathic are actually decreased as a result of empathy training. Because the women in the treatment group actually included empathy as part of their rationale less than the men, it would appear that the latter of these two possible explanations is likely.

The mechanism for this occurring can only be guessed at at this time, although it could be a number of things. Carkhuff (1969b) pointed out the importance of having a model who is significantly more empathic than the trainee. The variation in facilitators' empathy was not measured in this study and could possibly explain some of the inconsistent results. Secondly, all three of the methods' lab facilitators were women, and there could be a confound there. Likewise, all three of the intentions and empathy category raters were men, which could have also been a confound. Finally, although it has not been reported in previous empathy training literature, women may simply have an adverse reaction to the intervention which diminishes their subsequent attempts to be empathic with their clients. What is important though is that this conclusion is new to the empathy literature and could lead to further exploration and additional findings. After

examining the demographic data, the next analysis assessed whether the empathy training component resulted in effects similar to those found in the literature which used post-test self-report empathy measures. While the Empathy subscale of the BLRI showed some variation across the three administrations, the difference between the treatment and control group at the posttest was only statistically significant when the pretest BLRI Empathy subscale score was used as a covariate. This finding is not inconsistent with what the literature predicted with regards to empathy training. As earlier noted, meta-analyses of empathy studies showed inconclusive and inconsistent results pointing in the direction of empathy training not having a significant effect on posttest self-report empathy measures.

The next analysis examined whether the treatment group would score higher on the Empathy category than would the control group. This difference was expected due to this measure being more responsive than the paper-and-pencil, self-report BLRI. A difference was found, although not in the direction hypothesized. The control group appeared to have empathic intentions a higher proportion of the time than did the treatment group, though this difference was not statistically significant after covarying for the influence gender may have had on it. The implication is that this empathy training did not increase CIT's conscious attempts at being empathic with their role-play clients, and may have actually been a factor in decreasing the number of those attempts. This conclusion may be premature however, taking into account that the control group had more women, who intended to be empathic substantially more than men, who were more

likely to be in the treatment group. Again though we have a result which indicates that gender is just as important a variable as the treatment.

The main purpose of this study was to see if counselor intentions, specifically the Support, Assessment, and Explore intentions, would change as a result of empathy training. I expected that the 'Support' intention would be significantly higher for those participants in the treatment group than it was for those participants in the control group. While the treatment group's mean was slightly higher than the control group's mean, the difference was not statistically significant, indicating that there was a likely probability that the empathy training had no effect on CIT's intentions to be supportive. An additional explanation for this finding is that the imbalance of having more women in the control group than in the treatment group produced the result due to the fact that women used the 'Support' intention more so than did men (See Table 19).

I also hypothesized that the 'Assessment' intention would be significantly lower for those participants in the treatment group than it was for those participants in the control group. While the difference between the groups on this score indicated that there was an effect as hypothesized, the difference was not statistically significant. Any difference between the groups on this score may simply be due to chance. Or, if the difference was due to an effect as expected, the treatment may not have been strong enough for this for this measure to respond to. Additionally, because little difference was found between the genders on this measure, there is no reason to suppose that gender played a part in the results obtained.

Finally, the 'Explore' intention was expected to be significantly higher for those participants in the treatment group than it was for those participants in the control group. In actuality, the two groups scored almost identically on this measure, indicating that there was little effect due to the empathy training. Interestingly though, there was a gender difference found on this measure, though it wasn't statistically significant. Male participants scored higher than female participants. Due to the fact that the treatment group had significantly more males than the control group, this might indicate that the empathy training may have actually decreased participants' scores on this measure, with the effect hidden because males in the treatment group scored high enough on the measure to offset any decreases.

All of the findings for the primary hypothesis of this study may additionally be due to at least two other reasons. The first, and probably most likely, is that the empathy training may have had the effects as expected, but that these effects were too small to produce a large enough discrepancy in the measures used. The two-hour component, in an already full semester curriculum, may have had the effects hoped for, but just as likely, may not have had those effects to the degree needed to show evidence of change. A longer, possibly more intensive, empathy training component may be required to produce the changes needed to show evidence of it's effects on intentions measures. The second reason may be due to the small sample size, which requires a large difference between groups' means to produce statistical significance.

Besides examining the effects of empathy training on counseling intentions measures, this study also examined the relationship between counseling intentions and a newly developed counseling process variable: empathy categories. This was intended to investigate the overlap between the intentions categories and attempts at being empathic, the criterion-validity if you would of both systems. It was expected that there would be correlations between specific intentions categories and specific empathy categories. The hypothesis that the empathy category would be positively correlated with the 'Support' intention was supported. Additionally, there was a statistically significant positive correlation between the 'Support' intention and the 'Communicate Empathy' category, as well as a statistically significant negative correlation between the 'Support' intention and the 'No Empathy' category. Combined, these results provide substantial evidence of the 'Support' intention being indicative of intended empathy in a counseling session. When a counselor intends to be supportive during a counseling session, most likely it is related with feeling empathy for the client.

The hypothesis that the empathy category would be negatively correlated with the "Assessment" intention was also supported. Further, there was a statistically significant positive correlation between 'Assessment' and the 'No Empathy' category. Again, strong evidence for drawing a conclusion about the empathy categories and the intentions categories. These correlations indicate that a counselor attempting to 'Assess' during a counseling session is not likely to be doing so out of empathy. It would seem more likely that a counselor intending to gather information during a counseling session is doing so

based upon his/her desire for information; not out of a desire to be more empathic with the client.

The hypothesis that was not supported with regards to the two category systems was that there would be a positive correlation between the empathy category and the 'Explore' intention. Not only was this hypothesis not supported, it was shown that the reverse was more likely true. The statistically significant correlations with respect to the 'Explore' intention were mixed. When 'Explore' went up, the 'Communicate Empathy' category went down. Conversely, when the 'Explore' intention went up, the 'No Empathy' also went up, indicating that when a CIT wanted to 'Explore' an area, it wasn't as a result of intending to be empathic.

Implications for Training and Future Research

The implications of the conclusions above for training and research are divided into three areas. First. and foremost. the implications of the results with regards to empathy training would seem to indicate continued theoretical and empirical work. With the inconsistent results in the literature, and in this study, it seems that there needs to be some redefining of the construct, how it manifests itself. and how it is best measured. Empathy training as part of counseling training will continue to be appealing to many counselor educators, despite inconsistent findings, including these. For this reason, it would seem prudent to continue exploring its effects on students not only at the end of their program, but also into their professional future. The effect empathy training has on

counseling intentions has only just been initially explored, and continued study is recommended, keeping in mind the limitations of this study mentioned below.

Second, the implications of the impact gender had on the results of this study are important, not only because of the strength of the impact, but also because this is a new finding in the literature. The fact that men and women react differently to empathy training is very important. Not only may it explain some of the inconsistencies found in previous studies, it may also facilitate more appropriate empathy training for future students. What is important at this time is to not only confirm this difference, but to start exploring the reasons behind this difference. As Bath & Calhoun (1977) and Ford (1977) pointed out, better predictors of an individual's success in empathy training (which aren't currently available) would enable matching trainee needs to training program components and would result in increased measures of post-training empathy. Once we can be more specific about the relevant difference between men and women, we can determine more effective means of increasing empathy in students.

Lastly, the implication of the relationship between the two category systems is that future counseling process research which uses intentions categories can include empathy, and lack of empathy, as dependent variables indirectly indicated using the 'Support' and the 'Assessment' categories. This provides the opportunity for empathy to be more widely studied, and possibly understood. Considering that there has been a decrease in the number of empathy studies since the 1980's, this is exciting for those of us who still consider it an important, and integral, part of the counseling process.

Other future research could also take advantage of qualitative research methods in gathering information about participants reactions to different portions of this study. Interviewing participants who took part in the empathy training component could provide additional information about the approach used. Interviewing the role-play clients about their reactions to different counselor statements could also provide important information.

Limitations

This study has some important limitations. The first and most important has to do with the strength of the intervention. The empathy training component used for this study was developed in order to be easily implemented into an already existing curriculum. Due to this consideration, its length was kept to a minimum. It also incorporated some 'generic' exercises that may not have been striking enough to catch and hold the students' attention, let alone raise their anxiety level sufficiently enough to facilitate any significant affective change.

Another area of weakness in this study has to do with the number of participants and the distribution of gender in the two groups. Additional participants in both groups would give the study more power both in terms of external validity and in terms of statistics. Having groups with equal gender proportions would have made the results less confusing and the conclusions more clear as well.

Additional measures could have been used as well, including having the facilitators complete BLRI empathy measures, pretest intentions measures, and perhaps most importantly, student evaluations and feedback regarding the empathy training

component and their reactions to it. Without this final assessment there is no way to assess the impact on the individual of the empathy training component. Are the results of this study due to it's effect, or due to some other experience which occurred during the semester long course?

Future research should address these limitations, most notably those that limit internal validity. Additionally, besides the recommendations made above regarding the construct validity of empathy, measurement instruments for empathy, as a personality trait, as a situation-specific cognitive-affective state, and as a multiphase experiential process need to be developed. The literature has been dominated by a measurement instrument, the BLRI, which deserves either updating or replacing. This would not only enable hopefully more accurate measurement, but may be the heuristic empathy studies need.

Conclusions

This study showed that a two-hour empathy training component had little effect on counseling intentions, although it did have a differential effect on men and women with regards to their rate of intending to be empathic with their role-play clients. Additionally, it was found that certain intentions categories are reliable indicators of either the presence or absence of empathy in the counseling session. While the controversy will likely continue with regards to the implementation of empathy training, and its effectiveness, the results of this study encourage future research which examines

the differential impact empathy training has on the two genders and which uses

counseling intentions as an indirect measure of empathy.

Appendix A

Handout for Assessing Counselor Intentions

Introduction

The assessment of counselor intentions is a relatively new counseling process research tool. The basic idea is to get behind what a counselor says to a client and get at what the counselor was attempting to accomplish is saying what he/she said.

This booklet is meant as a brief introduction to how to assess counselor intentions. It is organized so that you can learn a little about intentions and then learn how to be a rater of counselor intentions. At the end you should find a "Cheat Sheet" which you can use during videotape review to refer to should you need a reminder about the different categories.

Definitions

In the first published study of intentions research there were 19 different categories (Hill & O'Grady, 1985). Hill. Helms, Spiegal, and Tichenor (1988) suggested that for research purposes 7 categories were sufficient. They collapsed the original 19 categories into 7 categories, leaving out the intention categories of Cathart. Self-control, Relationship. and Therapist Needs. Because these 4 categories were left out, and in order to facilitate easy rating, an eighth category, Miscellaneous. has been included in this booklet. Below are the definitions of the now 8 different intentions categories:

I. **Assessment**
   A. **Get Information**: to gather specific facts about the client, such as history, functioning, or plans.
   B. **Focus**: to help the client get back on track or focus on the appropriate in-session task.
   C. **Clarify**: to provide or solicit continued explanation or more detailed explanation when the client or counselor has been vague.

II. **Change**
   A. **Change**: to help the client develop new and more adaptive skills, behaviors, or cognitions in dealing with the self or others; helping to instill more adaptive models, explanations, or conceptualizations.

III. **Educate**
   A. **Give Information**: to educate, give facts, or give reasons for specific counselor actions.

IV. **Explore**

A. **Cognitions**: to identify maladaptive or irrational thoughts or beliefs.

B. **Behaviors**: to identify or provide feedback concerning maladaptive client behaviors; to do a behavioral analysis.

C. **Feelings**: to identify, intensify, or promote the acceptance of feelings; to encourage the client to experience feelings at a deeper level.

V. **Restructure**

A. **Insight**: to aid in understanding of the underlying reasons, dynamics, or motivations for cognitions, behaviors, or feelings; for example, helping the client understand reactions to the behavior of others.

B. **Resistance**: to work on overcoming obstacles to change or progress; for example, may discuss failure to adhere to the terms agreed upon for counseling; discussion may involve anticipated obstacles or current obstacles.

C. **Challenge**: to confront the client to test the validity, reality, or appropriateness of client thoughts, feelings, beliefs, or behaviors; may be done to jolt or shake up the client.

VI. **Set Limits**

A. **Set limits**: to structure or establish guidelines concerning the nature of counseling, goals of counseling, methods for attaining goals, expectations about treatment, or parameters of the relationship.

VII. **Support**

A. **Support**: to provide warmth, support, or empathy for the purpose of establishing or strengthening the relationship; to help the client feel accepted, validated, understood; to provide a nurturing environment.

B. **Reinforce Change**: to provide positive reinforcement for client attempts at cognitive, behavioral, or affective change.

C. **Hope**: to let client know that change is both possible and likely to occur; to let the client know that the counselor is able to help.

VIII. **Miscellaneous**

A. **Other**: when the reason for the counselor statement doesn't fit any of the above categories. Examples could be: Cathart, Self-control, Relationship, Therapist Needs.

B. **Intuition**: when the explanation for the response is intuitive knowledge or that "it just seemed right".

C. **Not Sure**: when the rater is unsure as to which category the response belongs.

Procedure

In order to assess intentions, a counselor must either audio- or video-tape a session which is intended to be used. Within 24 hours after the actual session, the rater (you!) should have the opportunity to review the tape with the counselor. This review is likely to take up to 2 hours so be sure to schedule plenty of time.

To begin reviewing a session, explain to the research participant how this time will be used. Explain that the two of you will watch (or listen to) their tape. Make sure that you tell them that you are being held to the same expectations as to confidentiality as are they. As the two of you watch the tape, you, or if it is easier they, will stop the tape after each of their talk turns. A counselor talk turn is any counselor speech act which is surrounded by two client speech acts. Each time that the tape is stopped, the participant is to explain to you why they said what they did on the tape. Specifically you are asking for what they were hoping the immediate effect of their verbal response on the client would be.

With this information you are to rate which category, or categories, of intention(s) they are using. Try to determine which of the categories is the best fit for what they said. If they mention multiple reasons for saying something, you can record up to 5 different intentions categories for each talk turn. If you are unsure about anything, feel free to ask the counselor. You should also be aware that the Miscellaneous category is to be used sparingly. You should have no more than 8% of your talk turns include the Miscellaneous category.

You may want to ask the counselor to keep their explanations brief as there are likely to be a lot of talk turns to rate.

Additional Empathy Categories

In addition to rating/categorizing counselor responses in terms of intentions, you will also need to rate whether the stated intention shows any attempt at either having empathy, communicating empathy, or neither.

Participant responses should be categorized as being "Empathic" if the counselor indicates that he/she was either trying to understand the client better or was actually feeling along with the client what was going on in session.

Participant responses should be categorized as "Communicating Empathy" if the counselor indicates an attempt at letting the client know that he/she is empathizing with the them.

If neither of these two conditions occurs, than simply check the "No" box with regards to this area of rating.

QUICK SHEET

Possible Queries

"What were you hoping to do there?"
"What was your reason for saying that?" that?"

"Explain why you said that..."
"Can you tell me why you said

Definitions

I. **Assessment**

    A. **Get Information**: to gather specific facts about the client, such as history, functioning, or plans.

    B. **Focus**: to help the client get back on track or focus on the appropriate in-session task.

    C. **Clarify**: to provide or solicit continued explanation or more detailed explanation when the client or counselor has been vague.

II. **Change**

    A. **Change**: to help the client develop new and more adaptive skills, behaviors, or cognitions in dealing with the self or others; helping to instill more adaptive models, explanations, or conceptualizations.

III. **Educate**

    A. **Give Information**: to educate, give facts, or give reasons for specific counselor actions.

IV. **Explore**

    A. **Cognitions**: to identify maladaptive or irrational thoughts or beliefs.

    B. **Behaviors**: to identify or provide feedback concerning maladaptive client behaviors; to do a behavioral analysis.

    C. **Feelings**: to identify, intensify, or promote the acceptance of feelings; to encourage the client to experience feelings at a deeper level.

V. **Restructure**

    A. **Insight**: to aid in understanding of the underlying reasons, dynamics, or motivations for cognitions, behaviors, or feelings; for example, helping the client understand reactions to the behavior of others.

    B. **Resistance**: to work on overcoming obstacles to change or progress; for example, may discuss failure to adhere to the terms agreed upon for counseling; discussion may involve anticipated obstacles or current obstacles.

    C. **Challenge**: to confront the client to test the validity, reality, or appropriateness of client thoughts, feelings, beliefs, or behaviors; may be done to jolt or shake up the client.

VI. **Set Limits**

A. **Set limits**: to structure or establish guidelines concerning the nature of counseling, goals of counseling, methods for attaining goals, expectations about treatment, or parameters of the relationship.

VII. **Support**

A. **Support**: to provide warmth, support, or empathy for the purpose of establishing or strengthening the relationship; to help the client feel accepted, validated, understood; to provide a nurturing environment.

B. **Reinforce Change**: to provide positive reinforcement for client attempts at cognitive, behavioral, or affective change.

C. **Hope**: to let client know that change is both possible and likely to occur; to let the client know that the counselor is able to help.

VIII. **Miscellaneous**

A. **Other**: when the reason for the counselor statement doesn't fit any of the above categories. Examples could be: Cathart, Self-control, Relationship, Therapist Needs.

B. **Intuition**: when the explanation for the response is intuitive knowledge or that "it just seemed right".

C. **Not Sure**: when the rater is unsure as to which category the response belongs.

QUICK SHEET

Before the Tape Review

- Introduce yourself and explain that you are the research assistant.
- Help them feel comfortable, establish rapport, etc., etc..
- Remind about right to withdraw: *"You have the right to withdraw your participation in this research at any time without penalty."*
- Explain Confidentiality
  Only the research assistants will have access to the raw data.
- Because your identity is kept confidential, your individual results can not be reported except as part of the group data.
  "Before we get started any questions?"
- Explain procedure:
  "We're going to watch your tape together."
  "I'm going to stop the tape at times and ask you questions about your responses. There are no right or wrong answers, just be honest."
  "Typically I will be asking you about what you were thinking at the time you made the response you did."

Definition of a "Talk Turn"

Talk turns are defined as a spoken phrase between two of the other person's spoken phrases. Ignore "minimal encouragers". unless there's a pause which indicates the expectation of a response by the initial speaker. You're looking for direct communication between the two people.

After the Tape Review

- "To finish things up let me go over a few things."
- "First of, thank you for your participation."
- "Because next semester, or possibly summer semester, you may be asked to repeat this review process, I can't disclose to you at this time all of the details as to this research."
- "Are there any questions which I can answer?"
- "Thank you."

Appendix B

Empathy Training Program

Rationale

A major assumption in the development of the empathy training component used in this study is that the methods class already includes modeling of empathic communication skills followed by role-play practice and subsequent constructive feedback. Based on this assumption, this component will focus not on the didactic method of teaching empathy as a communication skill, but on the experiential method of teaching perceptiveness of other's feelings and thoughts instead. Although it is important to give trainee's an opportunity to spend time practicing a skill (Galvin, 1985), it is assumed that they will be given this opportunity as a normal part of the course. The additional component will have an emphasis on potential rather than on empathy as an end result, growth rather than product, as called for in Hackney (1978).

The difficulty will lie in making the intervention substantial enough to make a difference. This will require a focus on not only what to do, but probably more importantly, on how to do it. The role of the supervisor in implementing this component is crucial. For this reason I have included a small section on training the supervisor as part of this outline.

An additional consideration in the development of this component is easily integrating it into the average methods course. If it is to be generalizable, and potentially

69

useful in other training programs, it must not be either too difficult to implement nor so long as to take up time usually used for other purposes.

Outline-1st Hour

1. Introduction of Focus on Empathy

Let the participants know that they are now going to do something different than what they may have been doing up to this point in the group. For this hour the focus will be on learning to more accurately perceive another's thoughts and feelings.

2. Preview

Let participants know what they will be doing for the next hour. Roughly go over the outline below, explaining details as you see fit.

3. Activities

In order to get the group thinking about empathy, start a group discussion about what they already know about empathy. Do they think empathy is important, and why? Spend some time on this. Ask them to share with the group how empathic/perceptive they think they are.

Ask them to take out a blank piece of paper and a pen. Ask them how many emotions they think there are. Ask them how many emotions they think that they can name. Give them two minutes to individually write a list of as many emotions as they can. Process

this activity with them. Did they get as long a list as they thought they would? How do they think this activity relates to empathy?

Explain the basic idea behind the Barrett-Lennard cycle of empathy, which is that there are three phases to empathy. The first phase is empathic resonation in the listener, or the ability to perceive, understand, and possibly experience the feelings and thoughts of the speaker . The second phase is communication of that empathic resonation, or expressed empathy. The third phase is the speaker's perception of empathy, or received empathy. Explain that the group will be focusing on empathic resonation, or perception of feelings and thoughts in another.

Egan (1994). Exercise #9: Listening to Key Experiences, Behaviors, and Feelings (p.19). A number of client statements are presented with relative history. To each of these statements, participants are to state clearly what are the client's key experiences, key behaviors, and what feelings/emotions the experiences and behaviors generate. Have one participant answer the questions to one scenario. After the participant answers, ask the group if anybody sensed any different feelings/emotions. Occasionally ask another participant what her/his answer to the questions would be.

Review of Role-Play Tape. When it feels like the group members are ready, ask for a volunteer to share her/his role-play videotape with the group. Repeat the above activity substituting videotaped role-play client statements.

Repeat as needed.

4. Review

Review with participants what it was that you did different today. Review the activities briefly and be encouraging. Ask each participant what they learned from this experience.

Outline-2nd Hour

1. Introduction of Focus on Empathy.

Again, let the participants know that they are going to do something different. The focus will be on learning to more accurately perceive another's thoughts and feelings.

2. Review and Preview

Review with participants the last empathy session. Remind them of the concepts (the Barrett-Lennard cycle of empathy), and the activity.

3. Activities

Discuss briefly with the participants what they remember from the last time they focused solely on empathy and perception.

Review of Role-Play Tape. Ask for a participant who is willing to let the group review one of his/her videotapes. Explain that the group will not be judging the level of empathy in her/his responses, but will be focusing solely on the thoughts and feelings of the role-play client.

While watching the tape, ask the participants to write down the feelings/emotions that they perceive in the client. After an appropriate amount of time stop the tape and have the group share their perceptions. Were there any differences? Did anybody get something different than the others? Repeat this procedure until the group feels ready to move on. For the next portion of the tape, ask that participants listen while closing their eyes. This is meant to get rid of their primary sensory input and allow them to focus solely on what the experience of being that client is like. Again, stop the tape after an appropriate amount of time and share perceptions among the group. Repeat this procedure as much as needed.

4. Review

Review with participants what it was that you did different today. Review the activities briefly and be encouraging. Ask each participant what they learned from this experience.

Training of Supervisors

The supervisor(s) who will implement this component will have already received a master's degree in a psychology/counseling related field. They will also be supervised by a counseling faculty member.

The specific training involved for implementation of this component has little to do with actual mechanics. It is expected that the above outline is explanatory enough that

going over the rationale and the activities with the supervisor will be sufficient. The major focus of the supervisor training has to with an attitude towards developing empathy. The explicit focus will be on growth rather than product.

It will be pointed out that it is just as much the above activities as how the above activities are implemented that will increase CIT empathy.

Appendix C

Comments on the Empathy Labs

Background

Both of the Thursday labs received the specialized training in empathy on Oct. 23rd. Dom's typed instructions were followed as closely as possible, with even the questions being asked almost verbatim from the sheet. There was only one change made in the instructions and that was when we reviewed at the end of the session rather than in the middle. Also, (student) switched places with (student); thus, temporarily changing sections with one of the permanent Thursday lab members.

Observations

The discussion on empathy in both labs was brief but thorough. Contrary to what I had expected, the 2 minute exercise to write down a list of words went well; yet, the majority of students claimed that they did not compile as many words as they had hoped. Only (student), with his disability, protested at the exercise. We processed that this was not for a grade - it was merely an attempt to start their creative juices flowing.

The usage of Egan's (1994) book was well worth the initial awkwardness. The students took turns reading the scenarios, asking the class for input, then passing it on. (The GTA did not give answers or guidance in this exercise.) Only (student) recognized the book as she commented that she owned it.

The usage of the tapes also went well but not nearly as smoothly as I had hoped. It took both time and patience to cue the tapes, which caused awkward breaks in the flow of the conversation. Everyone's tape (i.e. one of their complete sessions) was viewed for the exercises. Also, it initially took some effort to force the owners of the tapes to not focus on themselves but on the client. For the first part (where we were supposed to follow Egan's exercises) we watched approximately 3/5 of the tapes. However, for the second part (where we focused on the thoughts and feelings of the client) we used all 5/5 of the tapes. Discussions followed according to the guidelines provided by Dom.

The discussion after the students were asked to close their eyes was interesting. I believe that this went better than expected because of the awful counselor played the week before. During that session we had discussed tone in fluctuations, volume, and verbal cues which the students immediately picked up and discussed. I participated in some guidance during this but overall the students led and sustained the discussion.

At the end we discussed what we had covered in lab (i.e. topic, activities, purpose, etc.) and what we decided that we had learned from this experience.

General Comments & Suggestions

The two labs tended to last between 1 hour and 30-45 minutes long. The students had difficulty focusing on the task for (I believe) primarily two reasons: 1) it was very repetitious and therefore the novelty wore off quickly and 2) the subject matter was very theoretical and the majority of students in both labs are very concrete. I could also see that the students were really eager to practice, as that is why they rank the methods lab so highly, and by being denied this they had problems readjusting to the change. Also, the fumbling for the tapes broke the smoothness of the lab; thereby, causing more opportunities for the students to break their concentration and thus had some difficulties getting back on track.

If I were to offer suggestions I have only a few. First of all, in order to help smooth the delivery of the lab I would tell the students before-hand to rewind their tapes to a session before they come in the next week. Second, I would encourage some kind of concrete activity in order
to emphasize this lesson. Rather than full 10 minute sessions, perhaps an intensive 2-3 minute skit with the counselor (able to say nothing) just sits and experiences what the client is saying. Third, I would extend this so that if any questions are brought up after this lab experience (i.e. the next week) the students are able to process this further. Fourth, I would change the order of the tapes. I would go through tape by tape rather than section by section. It was harder to remember the storyline, identify' emotions, and more confusing/time-consuming when we kept flipping tapes. Finally, I would pass out a piece of paper specifically designed for this task. In this, I would leave space for them to write down insights that they might be experiencing during the lab and how this affects or changes their perceptions of their counseling skills. I would also encourage them to continue writing down ideas and thoughts about this lab throughout the rest of the week. We would then discuss this again (briefly) during the first 15 minutes of the next lab.

Table 5

Summary Table of Analyses of Variance for Intentions and Empathy Categories by

Gender and by Group

Variable and Source	df	SS	MS	F	sig.
Assessment Intention					
Group	1	431.74	431.74	1.925	.175
Gender	1	168.17	168.17	.750	.393
Group x Gender	1	484.59	484.59	2.161	.152
Change Intention					
Group	1	7.50	7.50	.462	.502
Gender	1	19.15	19.15	1.179	.286
Group x Gender	1	5.81	5.81	.358	.554
Educate Intention					
Group	1	16.55	16.55	1.758	.195
Gender	1	.328	.328	.035	.853
Group x Gender	1	31.94	31.94	33.394	.075
Explore Intention					
Group	1	23.40	23.40	.174	.680
Gender	1	46.72	46.72	.347	.560
Group x Gender	1	46.5	46.5	.345	.561

Table 5 cont.

Variable and Source	df	SS	MS	F	sig.
Restructure					
Intention					
Group	1	32.17	32.17	.344	.562
Gender	1	5.60	5.60	.060	.808
Group x Gender	1	18.24	18.24	.195	.662
Set Limits					
Intention					
Group	1	.446	.466	.027	.871
Gender	1	7.76	7.76	.467	.499
Group x Gender	1	8.48E-02	8.48E-02	.005	.943
Support					
Intention					
Group	1	206.61	206.61	1.202	.281
Gender	1	421.30	421.30	2.450	.128
Group x Gender	1	318.99	318.99	1.855	.183
Miscellaneous					
Intention					
Group	1	24.10	24.10	.204	.655
Gender	1	14.50	14.50	.123	.729
Group x Gender	1	10.05	10.05	.085	.773

Table 5 cont.

Variable and Source	df	SS	MS	F	sig.
Number of Intentions					
Group	1	4.77	4.77	.038	.847
Gender	1	377.32	377.32	3.012	.093
Group x Gender	1	310.49	310.49	2.478	.126
Number of Responses					
Group	1	7.27	7.27	.113	.7.39
Gender	1	316.52	316.52	4.935	.034
Group x Gender	1	186.09	186.09	2.902	.098
Empathy Intention Category					
Group	1	22.09	22.09	.230	.635
Gender	1	169.09	169.09	1.762	.194
Group x Gender	1	172.08	172.08	1.793	.190
Communicate Empathy Intention Category					
Group	1	74.91	74.19	.825	.371
Gender	1	7.03	7.03	.077	.783
Group x Gender	1	426.55	426.55	4.699	.038

Table 5 cont.

Variable and Source	df	SS	MS	F	sig.
No Empathy					
Intention Category					
Group	1	15.64	15.64	.090	.767
Gender	1	245.08	245.08	1.403	.245
Group x Gender	1	1140.47	1140.47	6.528	.016

REFERENCES

Bachrach, H. (1976). Empathy: We know what we mean, but what do we measure? Archives of General Psychiatry, 33, 35-38.

Barrett-Lennard, G. T. (1964). The relationship inventory (Form MO-64). Armidale, NSW, Australia: University of New England.

Barrett-Lennard, G. T. (1981). The empathy cycle: Refinement of a nuclear concept. Journal of Counseling Psychology, 28, 91-100.

Bath, K. E., & Calhoun, R. O. (1977). The effects of professional counselor training on empathy: Continued cause for concern. Counselor Education and Supervision, 16, 98-106.

Bohart, A. C., & Greenberg, L. S. (1997). Empathy and psychotherapy: An introductory overview. In A. Bohart & L. Greenberg (Eds.), Empathy reconsidered: New directions in psychotherapy (pp. 3-31). Washington, DC: American Psychological Association.

Brennan, J. (1987). Effects of four training programs on three kinds of empathy. In G. Gladstein (Ed.), Empathy and counseling: Explorations in theory and research (pp. 95-107). New York, NY: Springer-Verlag.

Carkhuff, R. R. (1987). The art of helping IV. Amherst, MA: Human Resources Development Press, Inc..

Cormier. W. H.. & Cormier. L. S. (1991). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions. Pacific Grove, CA: Brooks/Cole Publishing Company.

Duan. C., & Hill. C. (1996). The current state of empathy research. Journal of Counseling Psychology, 43, 261-274.

Egan. G. (1994). The skilled helper: A problem-management approach to helping (5th Ed.). Pacific Grove. CA: Brooks/Cole Publishing Company.

Egan, G. (1994). Exercises in helping skills: A manual to accompany the skilled helper (5th Ed.). Pacific Grove. CA: Brooks/Cole Publishing Company.

Elliott. R. (1979). How clients perceive helper behavior. Journal of Counseling Psychology, 26. 285-294.

Ford, J. D. (1979). Research on training counselors and clinicians. Review of Educational Research, 49. 87-130.

Galvin. M. (1985). Skills training for professional helpers. In L. L'Abate & M. A. Milan (Eds.), Handbook of social skills training and research (pp. 527-538). New York, NY: John Wiley & Sons.

Gelso, C. J., & Fretz, B. R. (1992). Counseling Psychology. Fort Worth, TX: Harcourt Brace Jovanovich.

Gladstein, G. A. (1970). Is empathy important in counseling? Personnel and Guidance Journal, 48, 823-827.

Gladstein, G. A. (1977). Empathy and counseling outcome: An empirical and conceptual review. The Counseling Psychologist, 6, 70-79.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental and social psychology perspectives. Journal of Counseling Psychology, 30, 467-482.

Gladstein, G. A. (1987a6). Counselor empathy and client outcomes. In G. Gladstein (Ed.), Empathy and counseling: Explorations in theory and research (95-107). New York, NY: Springer-Verlag.

Gladstein, G. A. (1987b8). Issues and methods in counselor empathy training. In G. Gladstein (Ed.), Empathy and counseling: Explorations in theory and research (121-134). New York, NY: Springer-Verlag.

Gladstein, G. A. (1987c11). What it all means. In G. Gladstein (Ed.), Empathy and counseling: Explorations in theory and research (173-188). New York, NY: Springer-Verlag.

Goodman, G., & Dooley, D. (1976). A framework for help-intended communication. Psychotherapy: Theory, Research, and Practice, 13, 106-117.

Gurman, A. S. (1977). The patient's perception of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapy: A handbook of research (pp. 503-543). New York, NY: Pergamon Press.

Hackney, H. (1978). The evolution of empathy. Personnel and Guidance Journal, 57, 35-38.

Ham M. A. (1987). Counselor empathy. In G. Gladstein (Ed.), Empathy and counseling: Explorations in theory and research (31-50). New York, NY: Springer-Verlag.

Hamer, R. J. (1995). Counselor intentions: A critical review of the literature. Journal of Counseling & Development, 73, 259-270.

Henley, S. (1997). [Women's roles and empathy in nurses]. Unpublished raw data.

Hill, C. E., & O'Grady, K. E. (1985). List of therapist intentions illustrated in a case study and with therapists of varying theoretical orientations. Journal of Counseling Psychology, 32(1), 3-22.

Ivey, A. E. (1994). Intentional interviewing and counseling: Facilitating client development in a multicultural society. Pacific Grove, CA: Brooks/Cole Publishing Company.

Keppel, G. (1991). Design and analysis: A researcher's handbook. Englewood Cliffs, NJ: Prentice Hall.

Kivlighan, D. M. (1989). Changes in counselor intentions and response modes and in client reactions and session evaluation after training. Journal of Counseling Psychology, 36(4), 471-476.

Mahon, B. R., & Altmann, H. A. (1977). Skill training: Cautions and recommendations. Counselor Education and Supervision, 17, 42-50.

May, R. (1967). The art of counseling. Nashville, TN: Abingdon Press.

Orlinsky, D. E., Grawe, K., & Parks. B. K. (1994). Process and outcome in psychotherapy – noch enmal. In A. E. Bergin & S. L. Garfield (Eds.). Handbook of psychotherapy and behavior change (4th ed., pp. 270-378). New York, NY: Wiley.

Pope, V. T., & Kline, W. B. (1999). The personal characteristics of effective counselors: What 10 experts think. Psychological Reports, 84, 1339-1344.

Redfern. S.. Dancey. C. P.. & Dancey, W. (1993). Empathy: Its effect on how counselors are perceived. British Journal of Guidance and Counselling, 21(3), 300-309.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.

Rogers, C. R. (1975). Empathic: An unappreciated way of being. The Counseling Psychologist, 5, 2-10.

Stewart, D. (1956). Preface to empathy. New York, NY: Philosophical Library.

Truax, C. B., & Carkhuff, R. R. (1967). Toward effective counseling and psychotherapy: Training and practice. Chicago, IL: Aldine Publishing Company.

Truax, C. B., Carkhuff, R. R., & Douds, J. (1964). Toward an integration of the didactic and experiential approaches to training in counseling and psychotherapy. Journal of Counseling Psychology, 11(3), 240-247.

Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York, NY: Basic Books.