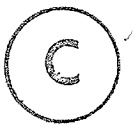
THE INFLUENCE OF PRE-TRAINING SELECTION FACTORS ON THE ACQUISITION OF HELPING SKILLS IN NONPROFESSIONALS

by



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Department of Psychology

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Abstract

The widespread shortage of mental health professionals has led to increasing recruitment of nonprofessionals to assume a wide variety of helping roles. Little has been done to evaluate the selection criteria for nonprofessionals, their trainability in learning helping skills or the utility of training devices such as videotapes. The present research consisted of two separate, independent studies. The first study examined the differential capacities of nonprofessionals to improve their helping skills as a result of training. The second study investigated the utility of videotaped "clients" as a training method. Specifically, the first study investigated the differential effects of a helping skills training program upon 84 nursing students pre-selected on the dimension of High versus Low interview skills. The students were assigned on the basis of a pretraining interview with a videotaped "client" which was itself videotaped and subsequently rated on several behavioral criteria. Half of each group was randomly assigned to five weeks of on-going didactic/experiential training in therapeutic interviewing skills and the remaining half was assigned to a delayed training control group. In the second study, the utility of videotaped clients was investigated by the comparison of students' responses to videotaped clients with responses

to live standardized and live free-responding clients. For the first study, the results indicated no significant differences in interviewing skill level between the experimental and control groups at posttraining and no evidence for differential change between the High and Low skill groups. In the second study, no significant differences were demonstrated in the comparison of students' responses to the videotaped and live standardized client. However, significant differences in interviewing behavior were demonstrated between videotaped clients and live free-responding clients. Both the mechanical nature and the prerecorded format of videotaped clients seem to be associated with poorer quality interviewing responses. The lack of differences between the experimental and control groups was discussed in terms of issues related to training. The use of videotaped interviews and monologues for training and research purposes was discussed with regard to possible variations in format in order to maximize the utility of videotapes.

Table of Contents

List of Tables

List of Figures

The widespread shortage of mental health professionals is well documented (Albee, 1959, 1963; Cowen, 1973) and the current short supply will likely continue because of training limitations. Broadening definitions of abnormal or maladaptive behavior and increasing needs for professional services in new settings and for new problems have created a demand for services that cannot be met using traditional methods and personnel. In addition, there is growing dissatisfaction with the effectiveness of traditional treatment approaches in preventing or alleviating psychological dysfunction, and new types of methods and personnel are being sought (Zax & Specter, 1974).

The current shortage of professional resources has necessitated the increased use of nonprofessionals. Nonprofessionals are defined by Sobey (1970) as any individual who is recruited to provide mental health services without having completed customary professional training in one of the traditional mental health disciplines. This includes lay volunteers as well as trained professionals in allied fields such as nursing or the ministry. The roles taken by nonprofessionals are varied and range from "taking over" where professionals are unavailable to providing new services in innovative ways. There is growing empirical evidence of the benefits gained through the use of nonprofessionals (Cowen, 1973; Sobey, 1970; Zax & Specter, 1974). Durlak (1979) reviewed 42 studies comparing the effectiveness of professional and nonprofessional helpers and con-

cluded that nonprofessionals achieve clinical outcomes equal to or significantly better than those obtained by professionals. Durlak concluded that professional training and experience are not prerequisites for an effective helping person. Further, it has been suggested that nonprofessionals will be the primary disseminators of direct psychological services in the years to come (Danish & D'Augelli, 1976).

In the initial phase of the nonprofessional mental health "revolution" (Sobey, 1970) the emphasis was on expansion of roles and settings. Currently, however, there is increased recognition of the need for evaluation and development of a theoretical base for evaluation of nonprofessional effectiveness (Cowen, 1973; Zax & Specter, 1974). At a time when accountability is increasing and financial support is decreasing, the evaluation of nonprofessionals and their contributions to the improvement of human services is a relevant and timely issue.

The present research consisted of two separate, independent studies. The first study examined the differential capacities of nonprofessionals to improve their helping skills as a result of training. In the second study, trainees' responses to videotaped and live clients were compared to investigate the utility of videotaped clients. Specifically, the first study investigated the differential effects of a helping skills training program upon nonprofessionals assessed on the dimension of high versus low pretraining

helping skills. Students involved in an ongoing training program were made available to the author for the purpose of investigating trainability. It is emphasized that no attempt was made to evaluate the training program itself. Videotaped "clients" were utilized during the assessment procedures in order to insure a standard stimulus situation while maximizing the degree of realism. In the second study, trainees' responses to videotaped and live clients were directly compared to investigate the utility of videotaped clients. Thus, while videotapes were used as an assessment device in the first study, here they were examined as a possible training aid.

Models for Effective Helping

Although some users of nonprofessionals rely exclusively on selection procedures to provide for maximal usefulness, others take the view that even well selected nonprofessionals can benefit from specific training in helping skills (Danish & D'Augelli, 1976). As a result, various programs have been developed by Ivey (1971), Truax and Carkhuff (1967), Danish and Hauer (1973), Goodman (1972) and others to screen and/or train nonprofessionals to be more effective helpers. These programs reflect the authors' unique perspectives on what constitutes effective helping.

Danish and D'Augelli (1976) described the overall goal of the Helping Skills Program developed by Danish and Hauer (1973) as that of training helpers in relationship

building skills. The six skills identified by the authors as being essential in learning relationship development are: (1) understanding one's needs to be a helper, (2) using effective nonverbal behavior, (3) using effective verbal behavior, (4) using effective self-involving behavior, (5) understanding others' communication and (6) establishing effective helping relationships. These six skills include the three essential components of an understanding of oneself, some knowledge of helping skills, and experience in applying these skills (Danish & D'Augelli, 1976).

Truax and Carkhuff (1967) identified three central elements in their training approach which is based on strengthening the trainees' inherent interpersonal skills. These elements are summarized as (1) a therapeutic context in which the supervisor communicates high levels of accurate empathy, nonpossessive warmth and genuineness to the trainees themselves, (2) a highly specific didactic training using scales for shaping trainees' responses toward high levels of empathy, warmth and genuineness, and (3) a focused group therapy experience that allows the emergence of the trainees' own idiosyncratic therapeutic self through self-exploration and integration of the didactic training with his personal goals and values.

Goodman (1972) developed a model for effective helping and a screening device derived from Rogerian concepts of therapeutic talent. Rogers (1957) defined the necessary

and sufficient components for effective therapist talents as: acceptance, empathy and genuineness. Goodman's (1972) Group Assessment of Interpersonal Traits (GAIT) screening device utilizes ratings of performance samples to assess such qualities as acceptance, understanding and openness.

Ivey (1971) utilized the concept of microtraining to develop a microcounseling model to train helpful counselor behaviors. His methodological approach attempted to first identify specific therapeutic counselor behaviors and then to systematically train the counselor in these behaviors. Ivey's (1971) approach to training utilized a shaping process involving didactic presentation of the target behavior, a modeling sequence involving a videotape of a brief counselor-client interaction demonstrating the behavior, followed by the opportunity for the counselor to practice the behavior with immediate feedback from the trainer. Ivey (1971) identified helpful interviewing skills that focus on the ability of the counselor to listen and attend to the client. Target skills for focused attention include attentive behavior, open invitation to talk and minimal encourages; target skills for focused listening include reflection and summarization of feeling and the summative paraphrase. In addition, Ivey (1971) identified skills of self-expression such as expression of feeling, expression of content, and direct, mutual communication.

In summary, the training programs have focused general-

ly on relationship building and specifically on behaviors involving listening and communication skills. In addition, the programs seemed to implicitly accept the idea of inherent helpfulness and attempted to maximize these qualities in trainees through guided self-exploration.

Selection of Nonprofessionals

One of the issues that has recently come under study is that of selection of nonprofessionals. However, few investigators even report their selection process and criteria (Durlak, 1979). Little work has been done in this area despite the fact that careful selection can potentially help identify the most effective helpers, maximize the usefulness of nonprofessionals, and minimize needs for professional supervision. In fact, given a surplus of candidates for a nonprofessional helping program, some suggest that careful selection could eliminate the need for training (D'Augelli & Danish, 1976). Selection procedures for identifying the best nonprofessionals are useful in at least two situations: (a) where the number of candidates exceeds the number of openings, and (b) when all the candidates cannot be trained to reach minimum performance levels in the available time or with the available resources.

Despite these benefits, Carkhuff (1969) concluded that the effort dedicated to the selection of both professional and nonprofessional helpers has been limited and in-

conclusive. Moreover, he suggested that selection indices be developed that will identify those individuals who are most capable of benefitting from training programs and providing effective services to their clients. Traditionally, the selection of nonprofessional helpers has been informal and haphazard. D'Augelli and Danish (1976) characterized early selection criteria:

> ...the paraprofessionals and nonprofessionals employed were individuals who have received little formal preparation for their jobs. It was implicitly assumed that careful selection of individuals with certain qualities would result in effective helpers. Picking an individual from the ethnic or subcultural group from which helpees would come was perhaps the most prevalent selection guideline. Equally important was the presence of an "ability to relate well to others" (p. 248).

The authors went on to note that even within subcultural and ethnic groups there are important individual differences in terms of ability to interact with others in a helpful way. In addition, it has been demonstrated that even adept individuals can benefit from training in specific helping skills (D'Augelli & Levy, 1978).

Selection methods have been developed as a means of tapping various criteria. The procedures used to select nonprofessionals have ranged from the very simple to the elaborate. On one hand, leaders of a project may simply rely on the volunteers' self-selection or may add a gross screening device to identify severely disturbed individuals. At the other extreme, nonprofessionals have been chosen on the basis of their performance in extensive evaluation pro-

cedures (Rioch, Elkes, & Flint, 1963).

From a survey of 185 programs utilizing nonprofessional workers, Sobey (1970) concluded that an individual interview was the most widely used selection method. This is based on the belief that certain personal qualities of an individual are the important criteria for selection and that professional judgment is an appropriate means of identifying the personal qualities. Sometimes the assessment of personal qualities is based on intuition and personal preferences. Cowen, Dorr, and Pockraki (1972) compared the personal characteristics of women selected to work as nonprofessional child aides with those who were rejected for the program. They found that the most significant factor in the individual's selection was how well the professional "liked" her.

Although an interview with a mental health professional seems to be the most common method for selecting nonprofessionals, there is evidence that it may be of limited usefulness. Taft (1955) reviewed the personal judgment literature and found no correlation between length of psychological training and ability to judge others. Mischel (1968) concluded that clinical training and experience usually does not improve the accuracy of global judgments and, in fact, may be a negative influence. This is due to systematic biases introduced through training. Kelly and Fiske (1951) conducted a well-known study with beginning graduate students in clinical psychology, relating information from an

extensive battery of objective and projective assessment instruments, situation tasks, and interviews to the prediction of later success in graduate training and professional functioning as clinical psychologists. They found that the interviews, although intensive and conducted by experienced clinicians, as well as the testing, made no contribution to the predictive validity of the assessment process. Judgments made by staff members on the basis of observing the individuals in situations did, however, have some predictive value.

Various written tests have been used to select trainees. As mentioned before, Kelly and Fiske (1951) found that traditional objective and projective personality tests did not predict success for clinical psychologists. Mischel (1968) extensively documented the lack of predictive accuracy demonstrated by traditional assessment techniques based on trait theories of personality. However, a recently developed selection measure (Anthony, Gormally, & Miller, 1974) showed promise in the prediction of human relations training based on the Truax and Carkhuff (1967) model. The authors compared the predictive power of various traditional academic and intellectual indices with a paper-and-pencil "trainability index" developed by the authors based on trainees' responses to a written task involving the understanding of the concept of empathy and subsequent performance in a written task involving responding in an empathic way and self-rating of their own responses. The results

supported previous studies indicating that traditional selection indices are not adequate predictors of an individual's ability to profit from helping skills training or of inherent human relations skills. However, the authors' trainability index contributed a significant portion of the variance in training outcome.

As mentioned previously, selection methods such as interviews and various tests have been utilized to identify personal qualities of the nonprofessional helper. Various personal qualities have long been associated with success for professional helpers. Matarazzo (1978, 1971) concluded that few personality characteristics consistently associated with being a good therapist have been identified, although the evidence suggests that psychological good health, flexibility, open-mindedness, positive attitudes towards people and interpersonal skill are associated with successful therapists. These characteristics are likely associated with any task in which personal interaction is involved. Further, Matarazzo (1978) suggested that individuals who are already interpersonally sensitive and skillful can more quickly learn to become therapeutic. Strupp (1975) emphasized that a therapist's maturity is essential in mediating the constructive experiences involved in therapeutic change.

Research relating personal qualities of professional therapists with their therapeutic effectiveness has been contradictory and confusing. Initially, reviewers (Truax & Mitchell, 1971) demonstrated support for the views of

the client-centered school that therapists' interpersonal skills of accurate empathy, nonpossessive warmth and genuiness were directly related to client outcome, and that such skills were necessary and sufficient conditions for client change. Outcome studies demonstrated that high and low levels of these therapeutic skills led to improvement or deterioration, respectively, and the findings were held to be true for a wide variety of therapists, clients and therapeutic modalities. The skills, although considered personality characteristics, were viewed as responses that were trainable and that could be modified through practice (Truax & Mitchell, 1971). However, more recent reviewers (Mitchell, Bozarth, & Kauft, 1977) suggested that the emphasis on gross outcome in that body of research resulted in the lack of specificity in the relationships. They suggested that the relationships between empathy, warmth and genuineness with outcome are associated with other variables such as timing and that these important interactions should be identified. In addition, the validity of many of the studies was questioned because of the presence of methodological problems such as small numbers of therapists and therapists' knowledge of the research hypotheses, which may have confounded the results. Based on a review of recent outcome studies which included a wide sample of therapists of divergent orientations and assessed therapist characteristics in addition to empathy, warmth and genuineness,

Mitchell et al. (1977) concluded that:

> As outcome studies examine the relationships among therapist orientations, client predicaments, and therapist settings in increasing detail, it seems to us to be increasingly clear that the mass of data neither supports nor rejects the overriding influence of such variables as empathy, warmth, and genuineness in all cases. ... The recent evidence, although equivocal, does seem to suggest that empathy, warmth, and genuineness are related in some way to client change but that their potency and generalizability are not as great as once thought. (p. 483)

Another commonly used selection method is one based on behavioral samples. Mischel (1968) concluded that a wide variety of evidence supports the position that a person's relevant past and present behavior tends to be the best predictor of future behavior in similar situations.

Rappaport, Chinsky and Cowen (1971) studied nonprofessional college students who acted as group leaders for chronic hospitalized mental patients. Before the project started, the students were evaluated intensively using a battery of nine instruments which generated 85 predictor variables. This information was later compared to the patients' subsequent improvement. The tests of student attitude and personality were uncorrelated with patient outcome measures. However, the students' performance on

the Group Assessment of Interpersonal Traits (GAIT) (Goodman, 1972), a behavioral measure of interpersonal skills, was moderately predictive of patients' improved mood, ward cooperation and overall improvement. Briefly, the GAIT is a structured group situation developed by Goodman (1972) for the evaluation of interpersonal skills in a therapy analogue situation. The GAIT procedure consists of a series of five minute discloser-understander dyads. Each participant takes each role once. The discloser role entails sharing a personal concern about the person's relationships while the understander is asked to show understanding to the discloser. These GAIT communication samples are rated on nine scales, including such variables as Empathy, Openness, Acceptance, Quiet, Rigid, etc.

The GAIT shows promise as a selection procedure but the method has shortcomings. It was initially developed to utilize both peer and trained, nonparticipating observer ratings, but subsequent research has shown only trained observer ratings to be useful in predicting criterion performance (Chinsky & Rappaport, 1971; D'Augelli, 1973; Dooley, 1975). In addition, the structured group situation and the dyadic, interdependent nature of the participants' exchanges has been shown to distort individual performance. Lindquist and Rappaport (1973) suggested that peer modeling effects influence the performance of other group members. Further, Dooley (1975) suggested that the

lack of standardization in the discloser role may lead to distortion of individual performances in the understander role. For example, disclosers' responses may be highly variable in terms of affect or intimacy level and this, in turn, affects the degree of understanding the partner is able to demonstrate.

D'Augelli and Chinsky (1974) examined the effect of interpersonal skill level (high versus low "therapeutic talent") and pretraining (practice versus cognitive versus attention-placebo control conditions) with subsequent group performance using college students. The students' interpersonal skill level was assessed using several variables of the GAIT. Results indicated that individuals highly skilled interpersonally reacted differently to different types of pre-training and subsequently demonstrated significantly increased and decreased positive and negative target behaviors, respectively. Individuals judged as low skilled interpersonally demonstrated no change in subsequent group behavior regardless of type of pretraining. The authors concluded that a combination of behaviorally oriented selection and specific training is the best approach for nonprofessional helping programs.

Interpersonal skills have been viewed both as generalized tendencies within a person and as discrete behaviors. In general, the evidence suggests that interpersonal skills that are generalized tendencies, such as warmth, empathy

and genuineness, and interpersonal skills viewed as discrete behaviors such as open-ended questioning, are relevant individual characteristics associated with successful therapists (Mitchell et al., 1977; Rappaport et al., 1971). In addition, both types of interpersonal skills may influence an individual's performance in a training program (D'Augelli & Chinsky, 1974; Matarazzo, 1978). Either way, the literature suggests that behavioral samples are both an effective method of measuring the variables as well as the most predictive (Mischel, 1968).

Standardized Procedures for the Assessment of Trainee Performance

The effectiveness of training procedures designed to teach helping skills have been assessed in a variety of ways. Generally, samples of the trainees' performance are obtained from a standard client stimulus and then evaluated on criteria determined by the content of the training program. The trainee may be presented written or audiotaped standardized helpee stimulus expressions and asked to respond in writing or verbally (Carkhuff, 1969). Goldstein (1973) developed an audiotaped "standard client". The trainee was instructed to listen to the client and respond with a written statement when indicated by the trainer at various points in the client's monologue. Other researchers have used actors or confederates who role-played a standard client (Carkhuff, 1969; Toukmanian &

Rennie, 1975).

To investigate the operations of psychotherapists, Strupp and Jenkins (1963) developed sound motion pictures and videotapes of therapy interviews with stops at critical junctures where the viewer was asked for his response in writing. Although acknowledging the shortcomings of a film model, particularly the lack of true interaction between the film-patient and the therapist-viewer, the authors stated that "...extensive experimentation provided ample evidence that (1) a sound film closely approximates the patient's behavior in vivo, thus providing the viewer with a rich and relatively undistorted source of clinical data; (2) therapists become immersed in the interview situation, both intellectually and emotionally; (3) they find it relatively easy to give full sway to their clinical and therapeutic skills" (p. 320).

Eisenberg and Delaney (1970) utilized videotaped interview segments to model selected verbal behaviors to counselor trainees. After viewing the modeling sequence, the trainees were presented a series of brief videotaped "clients" and were instructed to respond at the end of each brief videotaped client monologue; their statements were audiotaped for later analysis. While results indicated that trainees demonstrated learning from the videotaped models, this did not generalize to responses subsequently made to live interviewees in an initial counselling contact. The authors suggested that the failure of the demonstration

of transfer effects was caused by the unsuitability of the target response which was a sophisticated response, the counselor tacting response lead, more suitable for a subsequent interview than an initial one.

Supporting the utility of videotape simulation, other researchers have found that client responses to a videotaped interviewer did not differ significantly from those given to a live, face-to-face interviewer (Dinoff, Stenmark, & Smith, 1970). In a follow-up study, Waters (1975) compared interviewees' reactions on a variety of measures, including galvanic skin response (GSR), interview length and several anxiety measures, to both a videotaped interviewer and a live interviewer who asked the same questions. He found that there were no differences in the interviewees' behavior between the two interview models and concluded that the interviewees responded to the videotaped interviewer as though in a face-to-face encounter. Further support came from Bandura, Ross and Ross (1963) who found that children exposed to filmed models portraying aggression did not demonstrate significant differences in subsequent aggressive behavior from children exposed to live aggressive models.

Although audio- and video-taped procedures have been used to simulate clients in counseling interactions, there have been no external validity comparisons to specifically assess the generalizability of these findings to subsequent

performance with live clients. As mentioned previously, videotape simulations of interview situations have been used because of the convenience for standardization purposes, although there is little research to assess the comparability of trainees' responses to videotaped versus live clients. As cited previously, a study by Eisenberg and Delaney (1970) demonstrated no transfer of learning from training using a videotaped client to subsequent responses to a live client but this finding was attributed to an inappropriate target response and not to inherent differences in the use of videotaped clients.

There are two obvious differences between a videotaped client as opposed to a live client. The first difference is in the mechanical nature of the videotape equipment: the interviewer responds to a machine and the novelty of the situation may be associated with self-consciousness and inhibition in the viewer. Work with a machine which necessitates some handling of the apparatus such as stopping and starting is distracting and may interfere with absorption in the material. Another major difference is in the prerecorded format of the videotape, which eliminates spontaneity and important client-counselor interaction. The interviewer can respond to the videotaped client but the reverse is not true. This lack of feedback and responsiveness may be discouraging to an interviewer who, for example, is unable to pursue a line of questioning.

On-Going Training Program Utilized in the Present Study

As mentioned previously, the purpose of the first study was to investigate the differential learning capacities of nonprofessionals selected on the basis of high versus low helping skills. It is to be emphasized that no attempt was made to evaluate the training program. However, because it was an integral part of the study, the program and the circumstances surrounding its inclusion in the study are described at this point.

Once the author had decided on a general research topic, she made arrangements to utilize an on-going program in a community setting that was available for her use. A helping skills training program located in a local School of Nursing provided part of the core curriculum for the nursing students. Access to the training program and the nursing students was provided to the author for research purposes by the trainer and the St. Boniface Hospital School of Nursing. The trainer was an experienced Ph.D. level counseling psychologist associated with the hospital. He had previously conducted research comparing various training techniques and had found Ivey's (1971) model to be the most useful for his purposes because it provided specific, immediate feedback on the trainee's performance (Dunn, 1975). The conceptual framework utilized by the trainer in designing the Therapeutic Interviewing Skills course is fully described in Appendix B. The program developed for the nursing students by the trainer was designed to teach therapeutic in-

terviewing skills and was a modification of Ivey's (1971) microcounseling model. The training for the nursing students consisted of ten hours of didactic and experiential instruction in specific skills taken from Ivey's (1971) model of helpful interviewing: (1) Nonverbal Attending Behavior, (2) Open Invitation to Talk, (3) Open-ended Questioning, (4) Reflection, and (5) Clarification. Briefly, appropriate Nonverbal Attending Behavior necessitated that the interviewer be relaxed, use varied eye contact and nondistracting gestures; Open Invitation to Talk necessitated minimal encouragement and a nondistracting tone of voice, appropriate Questioning necessitated attention to affect and open-ended structure; the use of Reflection necessitated accurate restatement of the problem with attention to affect; and use of Clarification necessitated a nonthreatening style while attending to ambiguous and/or related issues. For a more detailed description of these skills as taught in the Therapeutic Interviewing Skills course, see Appendix B.

The trainees met once a week for two hours. Each week during the five-week course a new unit of instruction was presented. Each two-hour block of training consisted of one hour of didactic cognitively oriented instruction from the trainer which included a videotaped modeling sequence demonstrating the target behavior. The second hour consisted of practice for the trainees. This consisted of roleplaying the target behavior with feedback. Because of

the size of the training group in the present study (39 trainees), four assistant trainers, all of whom were instructors in the School of Nursing, assisted in the role-playing segment. For each training session, the trainees were randomly divided into five groups of approximately eight students each and each group was supervised by the psychologist/trainer or one of the four assistants, all of whom had been previously trained by the psychologist and had assisted in previous groups of trainees. The practice sessions consisted of the trainer/assistant roleplaying a brief vignette of a client problem for each trainee, who was expected to "interview" the role-played client, with special attention to the target behavior just presented. After approximately five minutes of "interviewing", the trainer/assistant gave feedback to the trainee on her performance. All the interviewing was done in a group situation so that the trainees not engaged in interviewing could observe and learn from their peers' performance.

The author recognized the limitations of the relatively brief (ten hour) training period. No guidelines have yet been established for what constitutes adequate training in helping skills. Further, two years previous experience with the present training program suggested that the time involved was adequate and some training programs utilized even less than ten hours. For example, Fremouw and Harmatz (1975) used a five-hour training program, while Russell and Wise (1976) used five training sessions

in behavioral techniques for the reduction of speech anxiety. The results from the two studies indicated significant improvement for the helpees. In two other studies, student advisors were given six and four and one-half hours of training, respectively, and were as successful as faculty advisors in conveying information to their advisees (Brown & Myers, 1973; Zultowski & Catron, 1975). In other words, limited training has been shown to achieve limited goals. It was assumed that the present training would at least facilitate the extinction of obviously inappropriate interviewing behaviors and increase the skill level of trainees who already have appropriate skills in their repertoire.

The Present Research: Study 1

The first study assessed the differential capacities of High versus Low skill trainees to profit from training. Previous research suggested that High skill trainees would demonstrate greater increase in helping skill level as a result of training than would trainees of Low skill (D'Augelli & Chinsky, 1974). Videotaped clients were used as standard interview stimuli to assess the students' pretraining skill level and then again to assess the students' skill level following the training. The trainees' interviews were themselves videotaped and subsequently rated on a behavioral rating scale. On the basis of the ratings, the trainees were divided by a median split into High and Low skill groups. Half of each group were randomly assign-

ed to the training program and the remaining half to a no training control group. Although the present study did not attempt to evaluate the training program, it was necessary to include a no training control group to ascertain that post-training differences in the skill level of the trainees were indeed attributable to the training they received. The control group was a no contact control group. They were involved in other courses as part of their nursing education and their schedules did not allow for placebo or alternative treatment. The total time involved in educational activities was essentially equal for both the experimental and control groups. The trainees in the control group received equivalent training immediately following the data collection for the present study.

In order to assess the trainees' interviewing skill level, the author developed a five-point behavioral rating scale. The scale was derived from the specific skills taught in the Therapeutic Interviewing Skills training program because it was believed that a rating scale specifically designed to assess the specific skills taught in the training program would be the most sensitive to change in skill level. As described previously, the skills taught were based on Ivey's (1971) model and included (1) Nonverbal Attending Behavior, (2) Open Invitation to Talk, (3) Open-ended Questioning, (4) Reflection, and (5) Clarification. These skills were operationally defined to directly parallel the content presented in the training program. The

operational definitions of the target variables are described on the scale used by the raters, which is presented in Appendix D.

In addition to the five variables taken from the specific content of the training program, a sixth, Empathy, adapted from Goodman (1972), was added to the rating scale because of its widely recognized importance as a therapeutic skill. Empathy is considered to be a generalized tendency within a person (Truax & Carkhuff, 1967), as opposed to the specific behaviors identified by Ivey (1971). In addition, by including Empathy along with the target behaviors in the rating scale. the relationships between Empathy and the specific behaviors could be studied. Briefly, Empathy was defined as accurate understanding expressed with warmth and sensitivity; a more detailed explanation is presented in Appendix B and the operational definition for rating purposes is presented with the rating scale in Appendix D.

The rating scale was developed on a descriptive, ordinal scale so that appropriate qualitative factors such as appropriateness could be included. Marsden (1971) pointed out that, although frequency counts have typically been used to indicate quantitative aspects of behavior, important qualitative aspects may be lost. Therefore, the rating of each criterion variable included such aspects as quality and appropriateness of the response. For the first study, an overall increase in skill level attributable to train-

ing must be demonstrated for the experimental group in order to assess differential change in skill level for High and Low skill trainees following training.

The Present Research: Study 2

The second study compared the students' responses to videotaped clients and live clients and used only data collected during the post-training assessment. As previously mentioned, two obvious differences between a videotaped client and a live client are that of the mechanical aspect and the pre-recorded format. To examine these differences, two types of live (roleplayed) clients were used. A "standardized" live client roleplayed from a pre-arranged script, analagous to the pre-recorded format of a videotaped client but eliminating the mechanical aspect. The "free-responding" live client simulated a real counseling exchange and eliminated both the mechanical and standardized aspects. Although it would have been preferable to have each trainee interview both types of live clients, because of time limitations the trainees were randomly assigned to one of the live client conditions. The trainees' responses to the videotaped client were compared to responses to one of the two live client conditions. Responses to the two live client conditions could not be directly compared because each trainee did not interview both types of live clients, as described previously. This investigation was exploratory in nature, although previous research suggested that

there would be no significant differences in interviewers' responses to videotaped and live clients. The second study utilized data gathered in the post-training interviews only. The data was regrouped" the High and Low skill groups and the experimental and control groups were collapsed and comparisons were made between the responses to the videotaped clients and responses to each of the live client conditions, respectively.

The designs of the two independent studies are presented in Figure 1.

Hypotheses - Study 1

1. Both experimental groups (High and Low skill) would surpass their control group counterparts in post-training skill level on all six rating variables, based on ratings of interviews with the videotaped clients.
2. There would be an interaction between selection (High versus Low skill and treatment (Experimental versus Control) on all six rating variables, based on ratings of interviews with the videotaped clients following training. The High Interviewing skills experimental group would improve significantly more as a result of training.

No hypotheses were formulated for the second study because it was exploratory in nature.

Figure 1

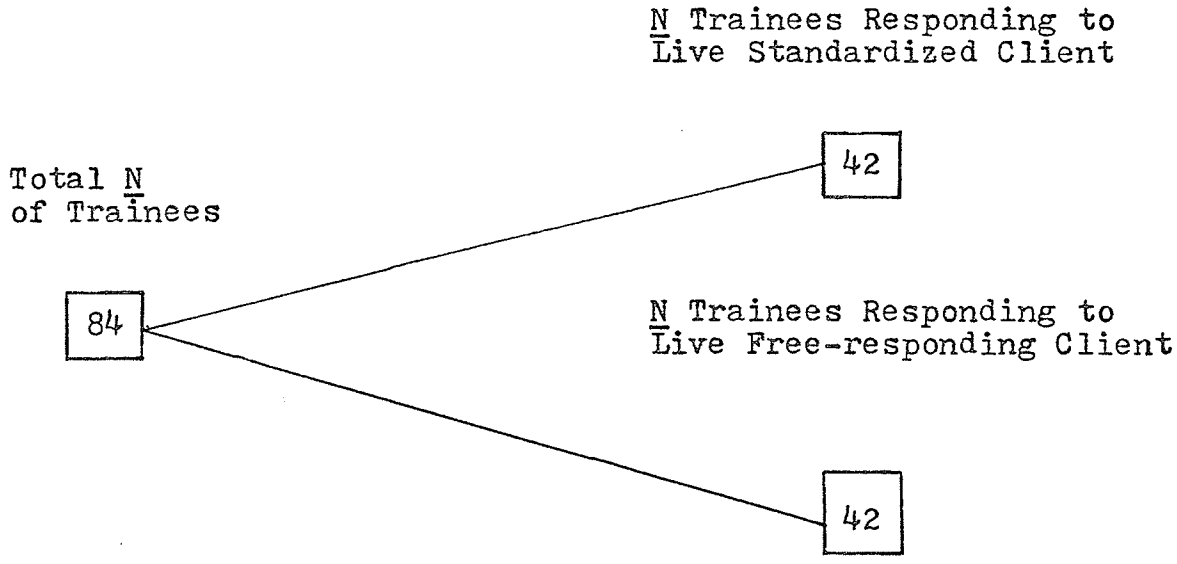
Designs of the Two Studies

Study 1

Pre-test

	N High Skill Trainees	N Low Skill Trainees		N High Skill Trainees	N Low Skill Trainees
Experimental	23	16	Training	23	16
Control	21	24	No Training	21	24

Study 2



Data Analysis: Study 1

Two by two (Selection X Treatment) multivariate (MANOVA) and univariate (ANOVA) analyses of variance were applied to the post-training ratings of the experimental and control groups with the videotaped client. The results of the MANOVA were given precedence, because it is the more conservative test. This assessed post-training differences in skill level between the experimental and control groups. To investigate the hypothesis of differential change between the High and Low skill groups following training, the interaction term of Selection X Treatment was inspected.

Study 2

Two pair-wise group comparisons were made utilizing multivariate and univariate analyses of variance. One comparison utilized the pairs of responses made by trainees who interviewed the live standardized client (as well as a videotaped client) and the other comparison utilized the pairs of responses of the trainees who interviewed the live free-responding client (as well as a videotaped client).

Method

Participants

The participants consisted of 84 students (82 females, 2 males) enrolled in their first year of training at the St. Boniface School of Nursing, Winnipeg, Canada, as of Spring, 1977, when the present study was conducted. The group originally consisted of the complete class of 91 students but seven were lost through attrition. Of the seven, four dropped out of nursing school midway in the study and three did not participate in their scheduled interviews because of illness. The students were required to take a five-week course in Therapeutic Interviewing Skills as part of their training. They were informed as to the purpose and requirements of the study prior to their participation and were assured that all individual data collected would be kept confidential and used only for research purposes. Written consent was obtained from all participants.

The groups were compared on intelligence because it may be a contributing factor in the acquisition of interviewing skills, at least the cognitive aspects of the training. The groups were also compared on age because an older average age may reflect greater overall experience, indirectly affecting interviewing or helping skills. Ages and Full-Scale IQ scores from the Wechsler Adult Intelligence Scale (W.A.I.S.) were obtained from the students' admission data. As can be seen in Tables 1 and 2, one-way

Table 1

Analysis of Variance of

Participants' Ages as of March, 1977

	$\bar{X}$ (years)	SD	F (df 3,87)	p
Experimental Group				
High Skill (N=20)	20.1	5.5	0.1	n.s.
Low Skill (N=26)	19.8	5.5		
Control Group				
High Skill (N=24)	19.4	4.1		
Low Skill (N=21)	19.2	4.7		

Table 2

Analysis of Variance of

Participants' IQs (Full-Scale W.A.I.S.)

	$\bar{X}$	SD	F (df 3,87)	p
Experimental Group				
High Skill (N=20)	117.1	5.7	0.3	n.s.
Low Skill (N=26)	117.8	6.5		
Control Group				
High Skill (N=24)	118.0	6.1		
Low Skill (N=21)	116.6	5.6		

analyses of variance using IQ and age as dependent variables demonstrated no significant differences between the groups. The mean age of the students was 19.6 years and the mean IQ was 117.4. Overall, the students were young and had above average intelligence.

Equipment

The equipment consisted of a videotape recorder and monitor in one room and a camera, recorder and monitor in an adjacent room separated from the first by a one-way mirror. The monitors had 21 inch (53.3 cm) screens.

Procedure

Videotaped Clients

Four videotaped "standardized" clients were developed following an adaptation of procedures developed by Eisenberg and Delaney (1970) and Strupp and Jenkins (1963) to simulate a counseling exchange. Two videotaped clients were used in the pretraining group selection procedure to determine the initial interviewing skill level of each trainee. The two remaining videotaped clients were used for the post-training videotaped client interview. In both interviews, the videotaped clients were presented to the trainees in randomized order. Thus any differences between the tapes would have no substantive effect on the results.

Four women ranging in age from 28 to 35 years were videotaped roleplaying the parts of clients. All were

experienced counselors. Women of equivalent ages were used throughout the present study to control for sex differences. They were presented in a similar format and followed different but comparable scripts of content developed by the author. The client was shown seated in a chair. She began her monologue by introducing herself and then describing why she had come for counseling. Her affect was depressed and she spoke slowly, with pauses. The four complete monologues are included in Appendix C. Each monologue lasted 15 minutes.

Live Clients

Two female graduate students in clinical psychology were hired to roleplay clients for the second interview in the post-testing procedure. The "standardized" client closely followed a prearranged script, similar to that used by the videotaped clients, and so simulated the experience of interviewing a videotaped client. The "free-responding" client was instructed to follow a comparable outline of content but interacted with the interviewer as if engaged in a counseling exchange. In other words, the free-responding client modified her script in response to interviewer questions and comments, while the standardized client essentially disregarded the interviewer as much as possible and engaged in a monologue, with pauses. Both the standardized and free-responding clients were role-played by both graduate students in randomized, counter-balanced order.

Pretraining Group Selection

Each individual student's pretraining interviewing skill level was assessed through ratings of a performance sample with a videotaped client. The same procedure was used to assess the student's post-training skill level. All trainees were instructed to sign up for a time period to do the pre-training interview. Upon reporting individually to the research room they were met by the author or an assistant, who briefly explained the procedure. First, the trainee was instructed to sit in front of the videotape monitor and the author demonstrated how to operate the video recorder. The trainee was instructed to imagine she was in a counseling situation and to respond to the videotaped client as if the client was in the room. The trainee was also instructed to stop the videotape and respond when it was appropriate to ask a question or make a comment. Then a videotaped modeling sequence was shown to the trainee to demonstrate the requested behaviors (i.e., a person "interviewing" a videotaped client). The instructions given in the videotaped modeling sequence are presented in Appendix A. The sequence lasted approximately five minutes. During the instruction period, the author was with the trainee to answer any questions. At the end of the videotaped modeling sequence, the author left the room and the trainee began watching the videotaped client.

After a "warm-up" period of ten minutes, the author began videotaping the trainee responding to the client on the monitor, thus recording the trainees' interviewing behavior. The trainee was filmed for five minutes and then rejoined by the author with instructions to stop. The total time involved for the instruction period and interview was approximately 20 minutes per trainee.

A composite score for pretraining interviewing skill level was derived from the mean of ratings on six criterion variables for each student. (A description of the raters and rating procedures is presented in a subsequent section). As described previously, these variables (see Appendix B) included Empathy, adapted from Goodman (1972) and five variables adapted from Ivey (1971) reflecting performance on the specific skills that were taught in the five content areas of the Therapeutic Interviewing Skills training program: Nonverbal Attending Behavior, Open Invitation to Talk, Open-ended Questioning, Reflection and Clarification.

Using the composite mean of their pretraining ratings, the trainees were divided through a median split of the total number of ranked composite rating scores into High Pretraining Interviewing Skills (High Skills) and Low Pretraining Interviewing Skills (Low Skills) groups. It was originally planned that the author would randomly assign trainees in each group to the experimental condition which received the training and the no training control condi-

tion. However, a random subgroup of trainees were unable to take part in the training program because of a scheduling conflict arising from work assignments made by the nursing school independent of the present study and so were assigned to the control group. This made the size of the groups slightly unbalanced but did not affect the random selection of the experimental and control groups. Thus two (High Skill, N=23; Low Skill, N=16) experimental groups and two (High Skill, N=21; Low Skill, N=24) control groups were selected.

Post-training Interviewing Skill Assessment

Upon completion of the training program, all students, including both the experimental and control groups, once again participated in an interview with a videotaped client, in a procedure identical to the one used in the pre-training group selection phase. In addition, each trainee was randomly assigned to interview a live, roleplayed client under one of two conditions described previously. In the first condition, the roleplayed client was instructed to respond freely, similar to a genuine counseling encounter. In the other condition, the roleplayed client followed a memorized prearranged script, designed to simulate the situation encountered with the videotaped client. The live clients are more extensively described in a following section. While the trainees were not told explicitly that the live clients were roleplayers, it was believed

that they were aware of it both because of their familiarity with roleplaying, as it was an integral component of their training, and because of the obviously controlled nature of the research.

The post-training assessment procedure was conducted as follows. Each student reported individually to the same research room used in the pretraining assessment procedures and was met by the author and/or research assistant. The student was refamiliarized with the videotape equipment and instructed to conduct an interview with a videotaped client in a duplication of the previous procedure, although the client would be different. Again, the student was encouraged to respond to the videotaped client as though engaged in a real counseling encounter. Again, there was a ten-minute warm-up period, followed by five minutes of videotaped film of the interviewer's behavior. At this point, the author rejoined the student and stopped the videotape. The student was instructed that the next phase involved interviewing a live client and the student was then informed as to what type of live client (either standardized or free-responding) would be interviewed. Any questions were answered and the author left the room. Immediately, the live client joined the student, introduced herself and initiated the subsequent interview. After a ten-minute warm-up period, the author videotaped five minutes of the interview and then rejoined the student and client to end the interview. The

total time involved was approximately 35 minutes for each trainee.

In summary, each student participated and was videotaped in three interviews. The first was with a videotaped client during the pretraining group selection procedures. The post-training included two interviews, one with a comparable videotaped client and another with a live client.

Raters and Rating Procedure

The raters were two advanced graduate students in clinical psychology who were hired for the present study.

The procedure for training the raters was as follows: After the rating criteria for a variable were explained to the raters, a videotape segment was randomly chosen from the actual data set and the raters made their ratings of the target variable independently. The rating scores were then immediately compared and where discrepancies in the ratings occurred, the author, her advisor and the two raters discussed the rating criteria until the raters reached consensus on the scoring. This procedure was carried out for each rating variable over a total training period of eight hours. A level of .80 of interrater agreement was reached on each rating variable.

After the raters were trained to criterion they were randomly assigned tapes of the trainees' interviews such that each rater rated half of the total number of tapes. The comparability of the two sets of ratings was then as-

sessed through multivariate and univariate analyses of variance. The calculation of per cent agreement was not possible since the raters did not rate the same tapes due to time and cost factors. However, a category by category comparison was conducted.

As described previously, each interviewing sample was five minutes long. For the rating procedure the five minute sample was broken down by the raters into four segments of 75 seconds each. During each 75 second segment the judge rated three of the six variables. Therefore, ratings were obtained for each five-minute sample as follows: Using a timer, the judge identified the first 75 second segment and immediately rated the first three variables. The judge went on to identify the second 75-second segment and then rated the last three variables. This procedure was repeated for the third and fourth 75-second segments and the six variables were re-rated. Thus, each of the six rating variables was rated twice and these ratings were averaged to yield an average score.

In addition to the initial training period, prior to the actual post-training ratings, the raters received four hours of additional training to correct for any rater drift prior to rating the post-training interviews.

Results

The results are grouped and presented in three sections, namely, inter-rater agreement, pre-training group selection and the experimental hypotheses.

Inter-rater Agreement

Rating variables for the three interview occasions are broken down into groups by rater, High and Low Skill level, and occasion, and are presented in Table 3. Multivariate (MANOVA) and univariate (ANOVA) analyses of variance of the rating variables for each interview occasion compared by rater are presented in Table 4. The composite mean of the ratings was analyzed independently from the individual ratings because it is a linear composite of the six rating variables and could not be analyzed using Finn's (1972) program. Throughout the study, the result of the MANOVA is given precedence because it is the more conservative test, taking into account the intercorrelations between the dependent measures.

The analyses of inter-rater agreement for the pre-training ratings indicated a significant difference between raters for the rating variables of Nonverbal Behavior, Invitation to Talk and Empathy with Rater 2 giving significantly higher ratings. No significant differences between the two sets of ratings were demonstrated for the variables of Questioning, Reflection and Clarification.

Pre-training Group Selection

The means and standard deviations of the pre-training

Table 3

Means and Standard Deviations of Rating Variables by Raters for Three Rating Occasions Within High and Low Skill Groups

	Pre-training						Post-training (Video Client)						Post-training (Live Client)					
	High Skill		Low Skill		Combined		High Skill		Low Skill		Combined		High Skill		Low Skill		Combined	
	(N=13)		(N=27)		(N=40)		(N=20)		(N=25)		(N=45)		(N=20)		(N=25)		(N=45)	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Rater 1																		
Nonverbal	2.2	.7	1.6	.4	1.8	.6	2.3	.8	2.0	.8	2.1	.8	2.6	.8	2.2	.8	2.4	.8
Inv.Talk	2.2	.3	1.9	.2	2.0	.3	2.3	.3	2.0	.5	2.1	.4	2.5	.3	2.3	.4	2.4	.4
Questioning	2.1	.4	1.9	.2	1.9	.3	2.1	.3	2.0	.3	2.0	.3	2.3	.4	2.3	.4	2.3	.4
Reflection	2.0	.1	2.0	.2	2.0	.2	2.1	.3	2.1	.3	2.1	.3	2.2	.2	2.2	.4	2.2	.3
Clarification	2.1	.3	2.0	.3	2.0	.3	2.1	.2	2.0	.1	2.0	.2	2.1	.2	2.1	.1	2.1	.1
Empathy	1.8	.6	1.3	.4	1.4	.5	1.9	.6	1.3	.4	1.6	.6	2.1	.6	1.6	.6	1.8	.7
Mean	2.1	.1	1.8	.1	1.9	.2	2.1	.3	1.9	.2	2.0	.3	2.3	.2	2.1	.3	2.2	.3
	(N=31)		(N=13)		(N=44)		(N=24)		(N=15)		(N=39)		(N=24)		(N=15)		(N=39)	
Rater 2																		
Nonverbal	2.5	.4	2.1	.3	2.4	.4	2.5	.5	2.4	.4	2.5	.5	2.8	.5	2.7	.4	2.7	.5
Inv.Talk	2.2	.2	2.0	.2	2.2	.2	2.3	.3	2.2	.2	2.3	.3	2.5	.4	2.5	.3	2.5	.3
Questioning	2.0	.2	2.0	.2	2.0	.2	2.0	.3	2.0	.2	2.0	.2	2.4	.4	2.3	.4	2.4	.4
Reflection	2.1	.3	1.9	.3	2.1	.3	2.1	.2	2.0	.1	2.1	.2	2.1	.2	2.1	.3	2.1	.3
Clarification	2.0	.1	2.0	0	2.0	.1	2.0	.1	2.0	.1	2.0	.1	2.1	.1	2.0	.1	2.1	.1
Empathy	1.9	.4	1.5	.4	1.8	.4	2.1	.3	1.9	.4	2.0	.3	2.0	.3	2.0	.4	2.0	.4
Mean	2.1	.1	1.9	.1	2.1	.1	2.2	.2	2.1	.1	2.1	.2	2.3	.2	2.3	.2	2.3	.2

Table 4

Multivariate and Univariate Analyses of Variance for Three Occasions of Ratings by Rater

Source	df	MS	F	p $<.01^{**}$ $<.05^{*}$
Pre-training Ratings				
Multivariate	6,75		16.8	**
Nonverbal	1,80	7.7	38.2	**
Inv. Talk	1,80	0.4	6.9	**
Questioning	1,80	0.1	2.6	n.s.
Reflection	1,80	0.0	0.5	n.s.
Clarification	1,80	0.0	0.3	n.s.
Empathy	1,80	2.0	12.0	**
Mean	1,80	0.8	56.3	**
Post-training Video Client Ratings				
Multivariate	6,75		0.8	n.s.
Nonverbal	1,80	0.2	0.4	n.s.
Inv. Talk	1,80	0.1	0.8	n.s.
Questioning	1,80	0.0	0.1	n.s.
Reflection	1,80	0.0	0.0	n.s.
Clarification	1,80	0.0	1.1	n.s.
Empathy	1,80	0.3	1.4	n.s.
Mean	1,80	0.0	0.1	n.s.
Post-training Live Client Ratings				
Multivariate	6,75		1.0	n.s.
Nonverbal	1,80	0.1	0.2	n.s.
Inv. Talk	1,80	0.6	4.5	*
Questioning	1,80	0.1	0.4	n.s.
Reflection	1,80	0.0	0.0	n.s.
Clarification	1,80	0.0	0.5	n.s.
Empathy	1,80	0.4	1.3	n.s.
Mean	1,80	0.1	2.0	n.s.

ratings are presented in Table 5. The MANOVA and ANOVA for the experimental and control groups are presented in Table 6. Consistent with the group selection procedures, the MANOVA indicated significant group differences between the High and Low Skill groups for both the experimental and control conditions and no significant difference between the experimental and control groups. The ANOVA of the individual variables indicated that the rating variable of Clarification was not significantly different between the High and Low skill groups within the experimental condition and likewise, the rating variables of Questioning and Reflection were not significantly different between the High and Low skill groups within the control condition. This may be explained by the uniformly low ratings of these variables to discriminate between the High and Low skill groups did not affect the significance ($p < .01$) of the composite mean, analyzed independently as previously mentioned.

Results Related to the Hypotheses

The MANOVA and ANOVA for the post-training ratings with the videotaped client are presented in Table 7. For the ratings of the interviews with the videotaped client, no significant differences between the experimental and control groups were demonstrated. The High skill group scored significantly higher than the Low skill groups as indicated by the MANOVA of the rating variables and the ANOVA of the composite mean ($p < .01$). However, the ANOVA

Table 5

Means and Standard Deviations of
Pre- and Post-training Ratings

	Pre-training		Post (Video)		Post (Live)	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Exp. High Pre-skill (N=23)						
Nonverbal	2.4	.6	2.5	.7	2.6	.6
Inv. Talk	2.2	.3	2.3	.3	2.5	.3
Questioning	2.0	.2	2.2	.3	2.4	.4
Reflection	2.1	.2	2.2	.3	2.2	.3
Clarification	2.1	.2	2.1	.2	2.1	.1
Empathy	1.9	.5	2.1	.4	2.1	.4
Mean	2.1	.1	2.2	.2	2.3	.2
Exp. Low Pre-skill (N=16						
Nonverbal	1.8	.4	2.1	.8	2.3	.8
Inv. Talk	2.0	.3	2.1	.4	2.4	.4
Questioning	1.9	.2	1.9	.3	2.4	.4
Reflection	2.0	.1	2.0	.3	2.1	.4
Clarification	2.0	.2	2.0	.2	2.1	.2
Empathy	1.3	.4	1.6	.5	1.7	.7
Mean	1.8	.1	2.0	.3	2.2	.3
Con. High Pre-skill (N=21)						
Nonverbal	2.5	.5	2.3	.7	2.8	.7
Inv. Talk	2.2	.2	2.3	.3	2.6	.4
Questioning	2.0	.3	1.9	.2	2.4	.4
Reflection	2.0	.3	2.1	.2	2.0	.2
Clarification	2.1	.2	2.0	.1	2.1	.2
Empathy	1.8	.4	1.9	.5	1.9	.5
Mean	2.1	.1	2.1	.2	2.3	.0
Con. Low Pre-skill (N=24)						
Nonverbal	1.7	.5	2.2	.6	2.4	.7
Inv. Talk	1.9	.2	2.1	.4	2.3	.4
Questioning	1.9	.3	2.0	.2	2.3	.3
Reflection	2.0	.3	2.1	.2	2.1	.4
Clarification	1.9	.2	2.0	.1	2.0	.1
Empathy	1.3	.4	1.5	.5	1.8	.5
Mean	1.8	.1	2.0	.2	2.2	.3

Table 6

Multivariate and Univariate Analyses of Variance on Ratings from Pre-Training Assessment for Group Selection of High and Low Skill Within Experimental and Control Conditions

Source	df	MS	F	p < .01** < .05*
(Experimental) High vs Low Skill				
Multivariate	6,75		10.9	**
Nonverbal	1,80	3.5	14.5	**
Inv. Talk	1,80	0.7	12.8	**
Questioning	1,80	0.3	4.6	*
Reflection	1,80	0.3	4.9	*
Clarification	1,80	0.0	0.2	n.s.
Empathy	1,80	3.0	17.3	**
Mean	1,80	0.9	54.8	**
(Control) High vs Low Skill				
Multivariate	6,75		11.3	**
Nonverbal	1,80	6.6	27.7	**
Inv. Talk	1,80	0.7	13.4	**
Questioning	1,80	0.0	0.3	n.s.
Reflection	1,80	0.1	1.5	n.s.
Clarification	1,80	0.2	4.3	*
Empathy	1,80	0.8	16.0	**
Mean	1,80	1.0	61.2	**
(High Skill) Exp. vs Con.				
Multivariate	6,75		0.4	n.s.
Nonverbal	1,80	0.3	1.2	n.s.
Inv. Talk	1,80	0.0	0.0	n.s.
Questioning	1,80	0.0	0.0	n.s.
Reflection	1,80	0.1	0.8	n.s.
Clarification	1,80	0.0	0.0	n.s.
Empathy	1,80	0.0	0.2	n.s.
Mean	1,80	0.0	0.3	n.s.

Table 6 (Continued)

Source	df	MS	F	$p < .01^{**}$ $< .05^{*}$
(Low Skill) Exp. vs. Con.				
Multivariate	6,75		0.7	n.s.
Nonverbal	1,80	0.1	0.3	n.s.
Inv. Talk	1,80	0.0	0.1	n.s.
Questioning	1,80	0.1	0.3	n.s.
Reflection	1,80	0.0	0.0	n.s.
Clarification	1,80	0.1	0.3	n.s.
Empathy	1,80	0.0	0.2	n.s.
Mean	1,80	0.0	0.1	n.s.

Table 7

Multivariate and Univariate Analyses of Variance of Post-Training Ratings With the Videotaped Client

Source	df	MS	F	p < .01** < .05*
Treatment (Exp. vs Con.)				
Multivariate	6,75		0.7	n.s.
Nonverbal	1,80	0.1	0.1	n.s.
Inv. Talk	1,80	0.0	0.2	n.s.
Questioning	1,80	0.1	1.4	n.s.
Reflection	1,80	0.0	0.2	n.s.
Clarification	1,80	0.0	1.1	n.s.
Empathy	1,80	0.6	2.8	n.s.
Mean	1,80	0.1	1.7	n.s.
Selection (High vs Low Skill)				
Multivariate	6,75		4.0	**
Nonverbal	1,80	1.4	2.9	n.s.
Inv. Talk	1,80	0.7	5.7	*
Questioning	1,80	0.1	0.8	n.s.
Reflection	1,80	0.0	0.8	n.s.
Clarification	1,80	0.0	1.7	n.s.
Empathy	1,80	5.2	24.9	**
Mean	1,80	0.7	13.3	**
Interaction (Selection X Treatment)				
Multivariate	6,75		1.8	n.s.
Nonverbal	1,80	0.1	0.3	n.s.
Inv. Talk	1,80	0.0	0.0	n.s.
Questioning	1,80	0.6	8.5	**
Reflection	1,80	0.1	2.0	n.s.
Clarification	1,80	0.0	0.0	n.s.
Empathy	1,80	0.1	0.4	n.s.
Mean	1,80	0.1	1.7	n.s.

of the individual rating variables indicated that the variables of Nonverbal Behavior, Questioning, Reflection and Clarification did not differentiate between the High and Low skill groups. Thus, although the experimental and control groups did not differ significantly following training, the groups selected before training on the basis of High and Low skills maintained those differences ($p < .01$). Although this finding was not unexpected given that the groups were selected on the basis of these differences, it supports the reliability of the ratings to discriminate between the groups.

To investigate the hypothesis of differential change between the High and Low skill groups following training, the interaction term of Selection X Treatment for the post-training analysis was inspected. This was not significant for the videotaped client condition, indicating no differential change in the High and Low skill groups. A MANOVA was subsequently applied to difference scores between the post-training videotaped client ratings and the pretraining ratings to determine whether uniform change may have occurred in the groups following the training period. However, the grand mean of the difference scores only approached significance, $F(6,75)=2.14$, $p < .06$. Thus, there was no differential change demonstrated between the High and Low skill groups following training or evidence that significant change for any of the groups occurred, although a nonsignificant increase was demonstra-

ted.

A correlation matrix of pretraining and post-training videotaped client ratings is presented in Table 8. The correlation matrices permit the reader to examine directly the relationships between the variables at the pre- and post-training occasions as well as the interrelationships between the variables for each rating occasion. Most of the rating variables were highly correlated with the composite mean in a positive direction. The variables of Nonverbal Behavior and Empathy showed the highest correlations (.70 and .70, respectively, for the pretraining ratings and .82 and .77, respectively, for the post-training ratings) with the composite mean.

Post-training rating variables for the two types of live clients (free-responding and standardized) are presented in Table 9. To investigate the differences between trainees' responses to a live client and the corresponding responses to a video client, a MANOVA and ANOVA were applied, shown in Table 10. Because each trainee conducted an interview with a videotaped client and either a live free-responding or live standardized client, only the two comparisons between the videotaped client and each of the live client conditions could be made. The analyses were applied to the pairs of rating scores from each trainee. As can be seen, the results indicated significant differences between responses to the videotaped and live client conditions.

Table 8

Correlation Coefficients for Pre-Training and Post-Training Videotaped Client Ratings

		Pre-Training							Post-Training Video Client						
	Rating Variables	Nonv.	Talk	Quest.	Refl.	Clar.	Emp.	Mean	Nonv.	Talk	Quest.	Refl.	Clar.	Emp.	Mean
Pre-Training	Nonverbal	1.00	.27*	-.02	.16	.11	.20	.70*	.28*	.35*	-.08	-.01	.08	.21	.29*
	Inv. Talk		1.00	.14	.11	.37*	.22*	.57*	.11	.36*	.10	.10	.23*	.40*	.34*
	Questioning			1.00	-.06	-.04	.15	.28*	-.09	-.09	-.12	-.04	.01	.02	-.09
	Reflection				1.00	.09	.21	.41*	-.14	-.11	-.02	.06	-.04	-.09	-.12
	Clarification					1.00	.31*	.45*	.11	.31*	.12	-.09	.17	.18	.22*
	Empathy						1.00	.70*	.11	.16	.09	.15	-.05	.34*	.25*
	Mean							1.00	.18	.33*	.01	.07	.10	.35*	.32*
Post-Training Video Client	Nonverbal								1.00	.58*	.14	.12	.08	.42*	.82*
	Inv. Talk									1.00	.13	.08	.14	.48*	.74*
	Questioning										1.00	.00	.23*	.19	.38*
	Reflection											1.00	-.15	.27*	.32*
	Clarification												1.00	.18	.27*
	Empathy													1.00	.77*
	Mean														1.00

$p < .05$*

Table 9

Means and Standard Deviations for Post-Training Ratings Broken Down by Type of Live Client

	$\bar{X}$	SD
Comparison 1		
Ratings of Responses to Live Free-Responding Client (N=42)		
Nonverbal	2.6	.6
Inv. to Talk	2.5	.4
Questioning	2.4	.4
Reflection	2.1	.3
Clarification	2.0	.1
Empathy	1.8	.6
Mean	2.3	.2
Ratings of Responses to Videotaped Client by Trainees who also interviewed Live Free-Responding Client (N=42)		
Nonverbal	2.2	.6
Inv. to Talk	2.2	.4
Questioning	2.0	.3
Reflection	2.1	.3
Clarification	2.0	.1
Empathy	1.7	.6
Mean	2.0	.3
Comparison 2		
Ratings of Responses to Live Standardized Client (N=42)		
Nonverbal	2.5	.8
Inv. to Talk	2.4	.3
Questioning	2.2	.3
Reflection	2.2	.3
Clarification	2.1	.1
Empathy	2.0	.5
Mean	2.2	.3
Ratings of Responses to Videotaped Client by Trainees who also interviewed Live Standardized Client (N=42)		
Nonverbal	2.4	.7
Inv. to Talk	2.2	.3
Questioning	2.0	.2
Reflection	2.1	.2
Clarification	2.1	.2
Empathy	1.8	.5
Mean	2.1	.2

Table 10

Multivariate and Univariate Analyses of Variance for Comparisons of Post-Training Client Conditions

Source	df	MS	F	p $<.01^{**}$ $<.05^{*}$
Comparison 1				
Videotaped vs Live Free-Responding (N=42)				
Multivariate	6,159		9.3	**
Nonverbal	1,164	4.1	8.4	**
Inv. to Talk	1,164	2.7	20.5	**
Questioning	1,164	3.8	35.6	**
Reflection	1,164	0.0	0.0	n.s.
Clarification	1,164	0.0	0.1	n.s.
Empathy	1,164	0.1	0.5	n.s.
Mean	1,164	1.0	16.3	**
Comparison 2				
Videotaped vs Live Standardized (N=42)				
Multivariate	6,159		1.8	n.s.
Nonverbal	1,164	0.3	0.6	n.s.
Inv. to Talk	1,164	0.5	4.0	*
Questioning	1,164	0.6	6.0	*
Reflection	1,164	0.1	1.8	n.s.
Clarification	1,164	0.0	0.8	n.s.
Empathy	1,164	0.5	1.8	n.s.
Mean	1,164	0.3	4.8	*

The MANOVA which compared the pairs of responses of the trainees who interviewed the live standardized client (as well as the videotaped client) indicated no significant difference between the pairs of responses. The ANOVA indicated that responses to the variables of Open Invitation to Talk, Questioning and the overall mean were rated significantly higher for the live standardized client; no significant differences between the two client conditions were indicated for the variables of Nonverbal Behavior, Reflection, Clarification and Empathy. The MANOVA which compared the pairs of responses of the trainees who interviewed the live free-responding client (as well as the videotaped client) indicated a significant difference between the pairs of responses. The ANOVA indicated that responses to the live free-responding client were rated significantly higher for the variables of Nonverbal Behavior, Open Invitation to Talk, Questioning and the overall mean; no significant differences were indicated for the rating variables of Reflection, Clarification and Empathy.

Correlation coefficients for the videotaped and live free-responding client ratings are presented in Table 11 and for the videotaped and live standardized client ratings in Table 12. As in the intercorrelations of the pre- and post-training ratings of the interviews with the videotaped client, most of the variables were highly correlated with the composite mean in a positive direction. The variables of Nonverbal Behavior and Empathy showed the highest correlations

Table 11

Correlation Coefficients for Post-Training Ratings
With the Videotaped and Live Free-Responding Client

		Videotaped Client							Live Free-Responding Client						
	Rating Variables	Nonv.	Talk	Quest.	Refl.	Clar.	Emp.	Mean	Nonv.	Talk	Quest.	Refl.	Clar.	Emp.	Mean
Videotaped	Nonverbal	1.00	.44*	.28*	.26*	.04	.49*	.81*	.40*	.28*	.05	.12	.20	.33*	.42*
	Inv. Talk		1.00	.25*	.14	.15	.49*	.70*	.30*	.47*	-.05	.09	-.03	.29*	.36*
	Questioning			1.00	-.05	.20	.36*	.53*	.27*	.06	-.01	-.12	-.19	.19	.16
	Reflection				1.00	-.20	.30*	.39*	.00	.02	.05	.30*	.32*	.45*	.27*
	Clarification					1.00	.05	.15	.18	.03	.12	.15	-.18	.13	.18
	Empathy						1.00	.82*	.33*	.38*	.13	.03	.08	.40*	.44*
	Mean							1.00	.43*	.39*	.07	.12	.10	.48*	.51*
Live Free-Responding	Nonverbal								1.00	.56*	.02	.07	.19	.35*	.74*
	Inv. Talk									1.00	.07	.15	.22*	.48*	.75*
	Questioning										1.00	-.11	.10	.21	.36*
	Reflection											1.00	-.12	.46*	.38*
	Clarification												1.00	.08	.26*
	Empathy													1.00	.78*
	Mean														1.00

$p < .05$*

Table 12

Correlation Coefficients for Post-Training Ratings With the Videotaped and Live Standardized Client

		Videotaped Client						Live Standardized Client					
	Rating Variables	Nonv.	Talk	Qest.	Refl.	Clar.	Emp.	Mean	Nonv.	Talk	Quest.	Refl.	Clar.	Emp.	Mean
Videotaped	Nonverbal	1.00	.70*	-.04	-.01	.09	.34*	.83*	.71*	.48*	.04	-.22*	.18	.20	.51*
	Inv. Talk		1.00	-.06	.02	.13	.48*	.80*	.72*	.60*	.02	.04	.09	.40*	.64*
	Questioning			1.00	.10	.30*	-.08	.15	.01	.11	.03	.01	.05	-.11	.00
	Reflection				1.00	-.12	.26*	.24*	.18	.19	.04	.38*	.11	.23*	.30*
	Clarification					1.00	.27*	.34*	.01	.15	.08	.05	.26*	.05	.11
	Empathy						1.00	.71*	.32*	.39*	.06	.21	-.03	.47*	.45*
	Mean							1.00	.70*	.61*	.07	.03	.16	.39*	.65*
Live Standardized	Nonverbal								1.00	.63*	.05	.00	.05	.53*	.83*
	Inv. Talk									1.00	.18	.13	.27*	.37*	.74*
	Questioning										1.00	-.08	.19	-.01	.27*
	Reflection											1.00	-.01	.54*	.39*
	Clarification												1.00	.05	.22*
	Empathy													1.00	.80*
	Mean														1.00

$p < .05$*

(over .70) with the composite mean.

Discussion

Study 1

The hypotheses for the first study were not supported by the results. The ratings of the interviews conducted with the videotaped client following training demonstrated no significant differences between the experimental and control groups. Contrary to expectations, the training did not serve to increase the skill level of the experimental group. Thus, the present study did not provide an adequate test of the hypothesis of differential change in learning between the High and Low skill groups as a result of training. In order to draw any conclusion supporting or negating the hypothesis of differential change, the experimental group taken as a whole would have had to demonstrate a significant increase in skill level following training as compared to the no training control group, and this was not indicated. Rather, the experimental and control groups both demonstrated a tendency ($p < .06$) toward increased skill level at the post-training assessment.

The finding that all the groups demonstrated some improvement at post training could be due to such nonspecific factors as test-retest practice effects resulting from the pre-training interviews, or additionally, to informal generalization of training. Many of the students live together in a dormitory and socialized frequently. The students receiving training may have communicated the material to the students waiting to receive training.

Although the focus of the study was on differential learning, the lack of demonstrated change in interviewing skill level following training was an unexpected finding, for it was assumed that the training would at least serve to eliminate obviously inappropriate behaviors and hopefully increase the level of helpful behaviors already in the repertoire of some of the trainees. Although the training per se was only an incidental aspect of the study, issues relating to the training may help to explain the lack of demonstrable change in the experimental group.

Although there is no research data to support the usefulness of the present Therapeutic Interviewing Skills training, previous groups of nursing students who had participated in the training had verbally attested to its usefulness for them in their work with patients. Partially because of this positive response, the training program has been ongoing for several years as part of the nursing school curriculum. However, there was a major difference between the students participating in the present study and previous groups of trainees. All previous trainees have been in their second and final year of nursing school while the present group was composed of first-year students. The second-year students are actively involved in clinical work and interaction with patients; the emphasis during the first year is on didactic content typically presented in a classroom situation. After completion of the training, the trainer believed that the first-year students involved in the present study were less

motivated as a group to participate in the training than had been previous groups of second-year students. He reported that the trainees as a group demonstrated lower levels of interest and involvement in the teaching and roleplaying than had previous second-year trainees, and that they complained that the amount of time involved in the training and research conflicted with demands from other classes. As a result, some tended to be apathetic and passive in their participation. It was speculated that the lack of opportunity of the students to apply their skills in clinical practice contributed to a lack of involvement. Thus, the training may have been viewed only as an academic exercise as a result of being presented too early in the curriculum.

The lack of change in the experimental group is contrary to many studies on training. However, Authier and Gustafson (1975) conducted a study which compared the effectiveness of microcounseling training with and without supervision. The results showed microcounseling training ineffective in both conditions. The authors hypothesized that the negative results were due to poor motivation among their paraprofessional counselors both to participate in the training program and to conduct the videotaped pre- and post-training interviews.

Based on the current finding that the training program did not serve to increase the nursing students' helping skills, the author suggests ways in which the program could be changed.

First, the training should be presented to the students in their second year of nursing studies, not to first-year

students. Based on observation, it appears that second-year students recognize the usefulness of the training and this increases their motivation to learn.

In terms of changing the content of the training program itself, the author speculates that perhaps the "Helpful Interviewing Skills" training was not specific enough to be seen as useful by the trainees. In other words, perhaps the skills taught were viewed as either too general, or as unrelated to actual nurse-patient interaction. Perhaps graduating students could be surveyed and information collected on experiences of specific communication problems with patients. Based on this information, a training program could be designed with target behaviors based on specific communication skills for nurse-patient interaction.

Failure to recognize the potential usefulness of the training may have contributed secondarily to a lack of involvement in the tasks of interviewing for the data collection of the present study. Although the tasks of interviewing were presented as a useful practice experience for the trainees, there was reluctance from some to participate and some demonstrated hostility. While this was not true of all the students, many expressed the view that they did not accept the usefulness of the research or the tasks of interviewing, and appeared to resent the time demands involved. Many trainees expressed incredulity that they were to interview a videotaped client and a minority demonstrated their resentment in a passive-aggressive manner; for example, by viewing the videotape pas-

sively and totally disregarding instructions to respond to it. There was no way to anticipate that some of the trainees would react negatively although the majority of students co-operated. Everything possible was done to enlist the trainees' co-operation including talking with them on an individual basis. However, the negative results are informative and emphasize the importance of timing and context in training nonprofessionals.

Another possibility was that the trainees in fact did learn but were unable to demonstrate their skills because of limitations inherent in the use of a nonresponsive videotaped client. This was discounted, though, because no differential learning was demonstrated even under optimal conditions at the post-training interview, i.e., an interview with a live, free-responding client. It is interesting to note that the individuals roleplaying the parts of clients stated that, although they were blind to which students had received the training, they believed they could pick them out. Their questioning, particular, was more open-ended and they tended to give less advice. There is no data, however, to substantiate their impressions.

Another possibility was that the rater differences demonstrated for some of the variables in the pre-training ratings may have biased the study. To explore this hypothesis, the post-training ratings were broken down by High and Low skill groups and raters, and inspected to determine if any artificial leveling of actual post-training differences be-

tween the groups may have occurred because of pre-training rater differences for some of the rating variables.

As previously described, the raters rated different sets of data and differences between the sets were indicated for some of the individual variables in the pre-training ratings: Nonverbal Behavior, Open Invitation to Talk, Empathy and the overall mean. On the variables for which significant differences were indicated, Rater 1 gave lower and more variable ratings than Rater 2. There were no significant differences between sets of ratings for either of the post-training occasions. The possibility existed that some of the trainees may have been rated too "high" or "low" initially on some of the variables and perhaps assigned to the "wrong" skill group. Thus, some individuals may have obtained increased rating scores at post-training reflective only of a more "accurate" rating and not of any actual change in skill level. If enough of these individuals had been in the control group, for example, the group mean may have been raised at post-training due only to this artifact. This was not demonstrated, however.

The raters were trained to an 80% level of interrater agreement. The raters completed their work in a very short period of time and it was not thought that rater differences would occur. In a spot check before the post-training ratings, no rater drift was demonstrated and subsequently there were no significant differences demonstrated between sets of ratings for the post-training ratings. It should

also be emphasized that even on the individual variables for which no rater differences were demonstrated during the pre-training ratings (Open-ended Questioning, Reflection and Clarification) no significant differences in the results were noted between the experimental and control groups following training. This suggests that the rater differences demonstrated for some of the variables during the pretraining ratings did not significantly effect the results.

Johnson and Bolstad (1973) described the methodological problems that make research in naturalistic settings hazardous. Therefore, the task of the researcher becomes one of anticipating and countering the problems that arise in naturalistic settings. In the present study, potentially confounding problems arose from inconsistencies in the rating procedures. Rater disagreement occurred during a period when the raters were under time pressures to complete their work. What can be emphasized is the importance of allowing sufficient time for rating tasks such that more spot checks can be made and additional training provided to maintain sufficient levels of inter-rater agreement.

Although the present study did not provide evidence for absolute or differential change in skill level in the High and Low skill groups following training, the groups were still shown to be significantly different from each other. The stability of these group differences over time may lend support to the idea of helpfulness being an enduring character-

istic. These findings may relate to the notion of the "inherently helpful person" who may have been rewarded for being helpful starting in his early formative years (Truax & Mitchell, 1971). It has been suggested that focused training for helping skills may only serve to capitalize on these fairly permanent characteristics. Although there is considerable evidence that these skills can be taught in a relatively short time (Truax & Carkhuff, 1967) perhaps only receptive individuals can benefit, and conversely, only a great deal of training can increase helpfulness in individuals lacking in these inherent characteristics (D'Augelli & Chinsky, 1974).

In terms of future research, the question of differential change of high and low skill trainees is still unexamined. The author suggests that this topic be explored with different groups of nonprofessionals, for example, volunteer counselors in crisis intervention centers.

As previously mentioned, the Empathy rating variable was included because of its widely recognized importance in the psychotherapy literature and because its inclusion with the other helping behaviors would provide information on the interrelationships between the variables. At the time this rationale was developed, the literature indicated that empathy was directly related to client outcome and that it was necessary and sufficient for client change (Truax & Mitchell, 1971). However, these conclusions have recently been called into question and current reviewers have empha-

sized the importance of specifying precisely the conditions under which specific variables such as empathy are associated with client change; global outcome measures were seen as inadequate (Mitchell et al., 1977). Evaluating the effectiveness of a single therapist variable such as empathy is now seen as a highly complex task involving interrelationships with factors as therapist orientation, source of the rating, timing in therapy and client factors (Mitchell et al., 1977).

In terms of the present study, therefore, the author acknowledges the limitations of the data. The present study was designed to provide information on global relationships between the variables, which was appropriate at the time. However, more current literature has indicated that this was too simplistic an approach. Thus the following summary of the relationship between empathy and other helpful interviewing behaviors is presented, but the reader is advised to be cognizant of the limitations in the use of global measures. Only the intra-correlation coefficients from Tables 8, 11 and 12 were inspected because the important relationships were within each group. For example, on Table 8, the correlation coefficients within the pre-training and post-training ratings occasions were inspected, but not the correlation coefficients between the two occasions. This resulted in six sets of intra-correlation coefficients. Inspection of the significant correlation coefficients demonstrated that the variable Open Invitation to Talk correlated signifi-

cantly with the Empathy variable in five instances and Open-ended Questioning and Clarification each demonstrated a significant correlation in one instance. This suggests that facilitive behaviors such as appropriate nonverbal behavior and the use of open invitations to talk and reflection were significantly associated with high empathy ratings.

Study 2

The exploratory aspect of the present research compared trainees' responses to videotaped and live clients, presented under the conditions of a standardized or free-responding format. The multivariate analysis indicated no significant differences in the comparison of trainees' responses to the videotaped and live standardized client. That is, the trainees responded similarly to the videotaped client and the live standardized client. However, the univariate analyses indicated significant differences in the trainees' responses for the rating variables of Open Invitation to Talk, Open-ended Questioning and the overall mean, with higher scores indicated for the responses to the live client. Evidently, just the presence of a live client elicited higher quality responses in these areas, even though the live standardized client did not respond accordingly.

For the comparison of the responses of the trainees who interviewed the videotaped and live free responding client, the multivariate analysis indicated significant differences between the responses, with lower scores recorded for the

videotaped client. Low variability was demonstrated in the ratings for Reflection and Clarification and this may have accounted for the lack of differences. However, the lack of significant differences in the ratings of the Empathy variable is interesting to note. Of all the variables, Empathy was rated the lowest and this was true for all the rating occasions. This suggests that empathy may be a more complex and sophisticated skill than the other variables, at least for the inexperienced trainees in the present study. Overall, the results of the second study indicated that trainees responded differently to live clients and videotaped clients. Both the mechanical aspect of the videotaped client such as the experience of talking to a machine and having to manipulate the controls and the precorded format which results in a non-responsive monologue, may account for the lower quality of responses to the videotaped client.

As mentioned earlier, previous researchers have compared videotaped and live interviewers and found no differences in interviewees' responses. Other researchers have demonstrated the utility of both filmed interviews and brief monologues of clients for research and training purposes. As previously cited, Strupp and Jenkins (1963) used films and videotapes of interviews with patients and found them useful in studying therapists' behavior. They stated that the therapist/interviewers became interested and affectively involved in the talk. Eisenberg and Delaney (1970) utilized videotaped clients and found the format useful in teaching

counselor trainees. They attributed a lack of transfer of learning from the videotaped to live clients to unsuitability of the target response, which in their study was a specific verbal response.

An important difference between the present study and previous ones is in the sophistication level of the interviewers. Strupp and Jenkins (1963) used as interviewers experienced psychotherapists and Eisenberg and Delaney (1970) used graduate level counseling students. First-year nursing students or other inexperienced interviewers may not find a videotaped client engaging enough to overcome limitations inherent in the use of a non-responsive machine.

One of the previously mentioned limitations of a videotaped client is in the non-responsiveness inherent in the pre-recorded format and the present study demonstrated that this is indeed associated with poorer quality responses. The MANOVA indicated that interviewers responded similarly to the videotaped and live standardized client and the responses were of comparatively poorer quality. Significant differences were demonstrated between responses to the videotaped and live free-responding client, with higher quality responses recorded for the live client. It appears, therefore, that the pre-recorded format of a videotape contributes to poorer quality responses. In responding to the videotaped client the trainees were less attentive generally and at times conducted themselves inappropriately, with distracting gestures, bored facial expressions and slack postures.

They made significantly poorer responses to the videotaped client as compared to either of the live client conditions for the variables of Open Invitation to Talk and Questioning evidently because they did not expect feedback. Eisenberg and Delaney (1970) utilized a more structured format than the continuous monologues of the present study in that they developed a series of videotaped client statements at the end of which the viewer was expected to respond.

Similarly, although long narrative passages were included in the films developed by Strupp and Jenkins (1963) to examine whether the viewer/therapist would interrupt the patient, clear interruptions were incorporated into the interviews at which points the viewer was requested to respond. The authors did not indicate the frequency of interruptions during the long passages. During the interviews of the present study, many of the trainees demonstrated indecisiveness and hesitance in stopping the videotape to make a statement and then, when the filmed client continued talking, seemed to "give up" and demonstrate discouragement with their own efforts. For some trainees, stopping and starting the equipment may have been a novel or threatening experience that distracted them from the task of interviewing. The use of a continuous monologue seems to be an impractical format when using videotaped clients and structured stopping points may be needed to involve the interviewers more effectively. Alternatively, a supervisor could sit with the trainee "interviewing" a videotaped client, stop the videotape at use-

ful junctures and subsequently explain the reason for the intervention.

Although the present research used videotapes as an assessment device, there are implications for training. However, one must be reasonably certain that skills learned with a videotape will generalize to interactions with a live client before one attempts to learn what skills are trainable through videotapes. When using videotaped monologues, for example, it appears that interviewer behaviors such as questioning, which are influenced by client feedback, are notably lessened.

The format of a filmed interview with an experienced interviewer has been found useful for purposes of modeling desirable interviewer behaviors, and previous research has demonstrated the superiority of videotaped modeling experiences over other training procedures (Dalton et al., 1973; Eisenberg & Delaney, 1970; Stone & Vance, 1976). A distinct advantage in the use of videotaped clients is that a wide variety of clinical problems, client characteristics, and client behaviors can be presented. The videotaped clients can be tailored to the needs of trainees, whether they are nonprofessionals or students in advanced clinical training. For research involving the study of therapist behaviors, videotaped clients insure a standard stimulus situation.

At any rate, certain types of videotaped presentations have been used successfully in training. The present research, however, indicated that trainees responded differently to a videotaped client. Future research is needed to compare dif-

ferent modes of videotape presentation to determine the kinds of films and content that are most engaging and useful for training and research purposes. For example, the failure of Eisenberg and Delaney (1970) to demonstrate transfer effects from a videotaped training procedure to subsequent performance with a live client may have been due to the use of the videotape procedure itself and not to the choice of an inappropriate target response. As well, there may be an interaction between the experience level of the viewer, the most effective mode of presentation and the material presented. Sophisticated interviewers may be able to utilize the experience of responding to a videotaped client monologue more effectively than naive beginners.

The present research examined the capacity to profit from training and the comparability of trainees' responses to live and videotaped clients. As Fleming (1967) pointed out, however, much more is known about the external conditions that facilitate increasing knowledge and learning new skills. Ultimately it is the learning process itself which needs to be examined.

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Appendix A

Instructions from Videotaped Modeling Sequence

Hello. I'm watching a videotape of a patient, just as you'll be doing in a couple of minutes. I'm pretending that the patient is really here in the room with me and I'm asking questions and commenting when I would with a real patient. My questions and comments are designed to find out more about the patient's problem. If it's a short question or comment I will leave the videotape running. If I want to ask a longer question or make a longer comment, I will stop the videotape by turning a switch. Let me demonstrate this for you now. Notice how my facial expression, gestures, and the tone of my voice change as if I were actually interviewing the patient. (At this point, there is two and one-half minutes of demonstration).

In a few seconds, another patient will appear on the screen in front of you. When she does, pretends you are interviewing a real patient in the same room. Don't be afraid to stop the videotape if you want to. Of course the videotaped patient won't answer you back, but don't let this keep you from asking questions or commenting when you would in a real interview.

Appendix B

Conceptual Framework for a Therapeutic Interview

I. Goals of an effective therapeutic interview:

Ideally, the interviewer creates an accepting, nonjudgmental helping atmosphere in which the client is maximally able to discuss his problem. This requires the interviewer to be relaxed, warm and nonthreatening. It also includes the appropriate use of facilitative techniques, where appropriate refers to the timing, frequency and intensity of the interviewer's communications. These techniques are intended to encourage the client to continue talking and to communicate understanding by the interviewer.

II. Facilitative Techniques

These include the appropriate use of: (1) nonverbal behavior, (2) open invitation to talk, (3) questioning, (4) reflection, (5) clarification, (6) communication of empathy.

(1) Appropriate use of nonverbal behavior. This includes posture, gestures, eye contact and facial expression.

Appropriate: the interviewer is seated comfortably and relaxed. The interviewer changes posture in a non-distracting manner. Gestures are open, inviting and non-distracting. There is varied use of eye contact.

The facial expression is used to augment verbal exchanges and coincides with the affective tone of the interview. All nonverbal behavior is appropriate to the verbal exchanges. The interviewer attends to the physical presence of the client.

Inappropriate: the interviewer is rigid or overly relaxed such that he calls attention to himself and is distracting. The interviewer does not give the impression of attending to the physical presence of the client. The gestures distract from the verbal communication. The interviewer stares at the client or uses no eye contact. The interviewer has a deadpan, unresponsive facial expression. The nonverbal behavior is inappropriate to the affect of the client.

(2) Open invitation to talk. This includes (a) minimal encourages, (b) pacing, (c) verbal modulation and (d) verbal attending.

(a) minimal encourages. This is the use of brief, facilitative phrases that encourage a client to continue talking, such as "please tell me more", "then what happened? and so on.

(b) pacing. This is interviewer style which regulates the tempo of the interview towards a moderate pace.

(c) verbal modulation. This is the utilization of the voice in a facilitative, non-distracting manner.

(d) verbal attending. This is demonstrated by phrases that follow directly from client statements, or staying "with" the client by showing awareness of his statements. For example, "I see..." .

Appropriate: the interviewer is following the client's statements and encourages the client to elaborate and explain. The verbal pace is neither unusually fast nor involves extended silences. The verbal modulation is varied and consistent with the content or affect of the client's communication. The interviewer acknowledges his understanding without disrupting the client's continuity.

Inappropriate: the interviewer monopolizes the interview. The interviewer makes statements unrelated to the client's previous statements. He rushes the client or interrupts. There are awkward pauses or extended silences. The verbal modulation is flat or forced and unrelated to the tone of the interview.

(3) Questioning. This includes open-ended and closed questioning.

(a) open-ended. This is questioning that provides alternatives for the client to express himself without imposed categories of the interviewer. For example, "Would you tell me more?"

(b) closed. These questions can be answered in a few words or with yes or no answers and tend to be factual. For example, "How old are you?"

Appropriate: the interviewer's questions are designed to help the client clarify his problems. The client has the opportunity to explore through the interviewer's limited use of structure and open-ended questions.
Inappropriate: the interviewer imposes artificial structure on the client's communications. The interviewer leads the client to topics of interest to the interviewer, not the client. The client is allowed to ramble. There is lack of structure or too much structure through the use of closed or brief answer questions.

(4) Reflection. This is a declarative statement which reflects or mirrors the feeling or content of the client's earlier statements. Reflective statements both summarize the client's thoughts or feelings and convey understanding. For example, "You felt sad over that."
Appropriate: the interviewer accurately restates the client's communications. The interviewer facilitates the client's movements towards deeper exploration of the problem.
Inappropriate: the interviewer makes an inaccurate restatement indicating lack of understanding of the client's communication. The focus is on irrelevant material. The interviewer neglects to label or explore important content or feelings.

(5) Clarification. The interviewer moves beyond the restatement skills of reflection towards more active

participation in the interview. This includes (a) the interviewer begins to direct the client in a nonthreatening manner towards conflicting or ambiguous statements with the goal of exploring and clarifying the conflict or ambiguity. For example, "You always smile when you sound angry". (b) the interviewer helps the client to begin recognizing related issues and themes. For example, "Do you feel that way towards other women?" (c) the interviewer gives feedback on the client's behavior during the interview in a leading, exploratory manner.

Appropriate: the interviewer uses clarification in an accurate, nonthreatening manner to direct the client towards exploration of a relevant issue or recurrent pattern.

Inappropriate: the interviewer directs the client towards an irrelevant issue. The interviewer confronts the client in a threatening manner.

(6) Communication of empathy. Empathy is the ability of the interviewer to understand the private thoughts and feelings of another person. The more empathic a person is, the more he is able to see through the other person's eyes, to assume the other's role and to think or feel as if he were the other person. In summary, the empathic interviewer (a) communicates interested attention, (b) accurately understands the client's

thoughts and feelings, and (c) communicates understanding to the client verbally, nonverbally, or both.

Appropriate: the interviewer focuses his full attention on the client and appears genuinely interested in what he has to say. The interviewer responds to the client's feelings in an accurate and sensitive manner. The interviewer shows his client that he is "with him" by communicating his understanding in language and voice that fits the client's expression.

Inappropriate: the interviewer shows lack of attention by frequently interrupting the client or with irrelevant remarks. The interviewer's attempts at understanding deal only with the factual content and not with the client's feelings. The interviewer makes little or no effort to communicate to his client that he understands the problem from the client's perspective.

Appendix C

Monologues of Videotaped Clients

1. Pre-training Client #1

I guess you want to know what I'm doing here. It's something I wanted to know, too. I'm just very depressed and I've been depressed, it seems like forever but it's only since my husband died which was six months ago. Something like that anyway. He had a heart attack and he died and I just can't cope. I can't really do anything. He used to do everything. He used to -- he took care of everything and without him, without him I can't do anything. I can't take care of the kids; we don't have enough money. I don't even get the house cleaned. A cleaning lady came in but we can't afford that anymore. When he was around, everything was good but now that he's gone... .

I still can't believe it. I know it's absolutely crazy but sometimes I think he did it on purpose. Sometimes I think, why did you go away and leave me like this? Why did you go away when you knew I couldn't handle it but you did it anyway. And I know it's crazy because he can't have a heart attack on purpose. Without him we don't have enough money now. I can't buy the kids just the little things that ... he used to take care of. How much money for this? He'd give me just the right amount to do it with. I get up in the morning and I say to myself, "Today is going to be different. Today I'm going to be different. I'm going to do

everything just like he would have done." Of course, the first thing, I don't even get breakfast made.

People come by to visit me. The couples we used to know - they say, "How are you doing?" but they never ask me over. They come out of pity. They don't come because they like me. They like him. Everybody did. When he was alive, I was somebody because I was married to him. Just because he loved me and now that he is dead I am nothing. I wish it had been me, not him. Why is the valued person taken and the one who can't do anything stays? I'm so lonely and so afraid and I don't know what to do and I don't want to do anything. My mother says, "Sell the house, dear, go out, meet new men, you'll feel better." Who wants anyone now? Who could find anyone like him anyway? Everyone's got terrific advice for me. They all know what they would do. Oh yes, they would go to a singles' bar. You know what I feel worst about? I wish I didn't have the kids. I just wish they weren't there. I can't do anything for them. I can't even do anything for myself. I can't even die. I can't even do that. So here I am. You know, it's really wierd how everything in your life can change in one day. And that's what happened to me. My days have no shape to them. They have no shape. My nights, I can't sleep and that's when I'm most afraid. I lie there at night and I think, "I've got to sleep tonight to make it through tomorrow" but I don't. I look at the clock and it's 11:30 and then it's 1:00, a quarter after 2. Sometimes I go to sleep around 4, 4:30 and

then the kids get me up. And then I could kill them. You know what I should do? I should either kill myself or pull myself together.

I should get a job but I can't work. I've never worked, why should I be able to work now? So, what are you going to do for me? Do you think you can help me cope with my life? Because if you can't, that's my last hope.

It's too late for me to change now. I've got to live differently now. My life was perfect before. I don't want anything different. I wish it was me. Sometimes I talk to him: "Why did you go? Why did you leave me like this? Why didn't you leave me with more money?" My mother says I should sell the house and buy one smaller. It's all I have left of him.

2. Pre-training Client #2

Well I guess you want to know what's happening with me? Why I'm here? Well, just before Christmas my husband died of a heart attack. You know, it's just terrible -- just 32 years of age. I don't like to talk about it. It's no use talking about it. Anyway, nobody cares about me. Life's not worth living anymore. I'm just a big nothing. I'm thinking seriously of suicide. I don't feel like doing anything anymore. I can't do my housework. I'm left alone and I just can't stay alone. I'm left with three children. My children, they don't need me anymore. I'll never get out of this place. I know I'm going crazy. I know, I know.

Anyway, my children are safe. They're with my parents. I live in Brandon. My parents are quite close. They're safe there, with my Mom and Dad. They don't need me anymore. I'm just no good. I'm just a big nothing.

When I think I was so happy with my husband. He was such a good husband. The day it happened, you know, it was in the afternoon. He came in and he ... I don't really want to talk about it. Well, he came in and told me he had chest pains. I blame myself because I told him, "I hope you feel better today because I want to go shopping". He was such a good husband. He would even choose all my clothes like my mother used to do. I got married at 20. I'd finished my Grade 12. My mother was so nice to me and my dad, too. They used to do everything for me, babysit my children, help me with cooking, I didn't even have to go grocery shopping. He did everything. He was such a good husband. That night as usual I asked him to go downstairs and get me something from the freezer. He fell downstairs.

I kind of blame myself -- thinking of going shopping to get a new pantsuit. Now everything is finished. I've nothing to live for. I tried to get better. I'm tired of trying. But, we have money problems. I don't blame my husband. He left me with some money but not enough. For three kids it costs so much and I don't have any left for leisure. What can I do? Do you expect me to find a job the way I feel? I get up in the morning so tired -- pain all over. My neck is aching. Around my neck, my forehead, right now

I feel like crying. It's the way I feel all the time. How can I go to work? I can't even cross the street. I have jellylegs. I always feel as if I'm going to faint.

What's the use? My kids are safe at home with Mom and Dad. I'm really seriously thinking about suicide. I recall going to socials and parties with my husband. My husband was well known in the community. I used to go anyplace with him. With him gone, I am dead. His dad tells me it's stupid to see a psychiatrist. He says, "You're not crazy". My friend, she's getting fed up with me. A very close friend. I don't even know why.

I try to go shopping but as soon as I get in a crowd I get all those symptoms - my heart is palpatating, I'm sweating all over, I feel like running out. I can't even go to church -- I have to sit in the last pew, right across from the exit. I can't stay long at home. I'm scared of the dark. I can't even go to the washroom without locking the door.

We had such a nice car that my husband bought just a month before he passed away. I'd like to drive the car but my dad says I'm too nervous. There isn't a thing I can do. Even if I try they tell me I can't. What's the use of trying anymore? I can't. I'll never get better. With my husband I had some potential. I could do something. Now I can't. I've no self-confidence. I guess I never had. I relied on my husband. I'd like to get better. I guess that's why I'm seeking help. I'm getting deeper and deeper in the gutter. I don't really want to get better. I feel I'll

never be able. I've never done anything.

My husband used to handle all the money matters. He'd give me everything I'd need. I'm a big nothing. May I please go, I think I'm going to faint. I feel nauseated. See, that's the way I feel all the time. May I go please?

3. Post-training Client #1

Well, my name is Gail and ... and well they told me I should come here and talk to you today. Because I've really been feeling awful lately and I guess they thought that if I talked to someone it would help but I don't know if it will or not. I don't know if there's anything I can do about how I feel. Well, see I ... I've got this sort of like a problem with my boyfriend, I guess or he used to be my boyfriend and now he doesn't love me anymore and I just, I just don't know what to do. I don't know if talking to you can help or not. I just feel so depressed all the time. All I want to do is just stay in bed all day long and maybe never wake up in the morning. I just cry all the time. I feel so empty without George. When we broke up it was like my life just ended. I don't know exactly why it happened, either. I just don't understand. He was the very first person -- boy I ever went out with and I loved him so much. I still do and I felt that he loved me, too. He always said he did and I really believed him because we were so happy and I thought we were going to get married and everything and that's all I wanted. I was so happy with George. We were in school together and everything and we did everything together -- all

the friends we saw together and stuff like that. And then, well after we finished Grade 12 he decided to go to University and I was going to work and I thought everything would be the same as it always was except that it didn't work that way. I guess after he went away, after he went to University it was like -- it was like he went away sort of -- it was like we weren't so close anymore and he said that we should go out with other people and we shouldn't go so steady anymore like. And I didn't want to do it that way. I didn't understand why he wanted to do it that way but I didn't want to lose him so I said OK.

It doesn't work so well because whenever I was with him I just would cry all the time and I'd think about him being with other girls and maybe not loving me anymore and I'd just cry and that just made him mad or something. I don't know -- it did something because then he stopped calling altogether. I was trying so hard to make it right between us. I just wanted to make it right between us. I just wanted to make him happy and I just wanted him to love me the way he used to. There's just nothing anymore without him. Nothing. I don't even know why I bother going on.

My parents, well they think that I'll meet somebody else and it'll all be OK but I don't know. I don't want to meet someone else I don't want. I just want to be with George. He's my whole life. He's everything to me. I think I'm starting to worry my parents, too, because I cry so much. It's like I never smile anymore and -- I don't know. I guess

I'm worrying them. I don't want to do that. They've got enough to worry about. They've got their own problems. They don't need mine to worry about. They don't understand. They always say that I should go to this church group that I used to go to with George and sometimes I still go but somehow It's not the same without him 'cause all my friends there were our friends and I just don't feel as though I belong anymore. Well, I don't know what to do. I don't know if there's anything a person can do. Maybe I should just give up. I love George so much and I just want to be with him. I think about being in his arms again and I don't know.

Maybe if I just had some real close friends, someone like that. I wouldn't have to think about him all the time. But I don't. At the place where I work, there are all sorts of nice people, I guess, but they're not really my friends. They wouldn't understand. Nobody understands at all. I kept trying to figure out what I did wrong -- how he could stop loving me. I must have done something wrong. Maybe there's something wrong with me. Maybe I'm just not any good. The only thing he ever said about me was that I was been too dependent and I don't even understand that because I was working at my own job and everything like that and earning my own money. I don't think that's really what the problem is. I think it's just me. It's just that I'm no good.

You know I used to think about us getting married. I used to be so happy. It's all I wanted was to get married to him and have babies with him. I guess that's never going

to happen now. So what else is there? I don't think there's anything else. I wouldn't want to start all over with someone else either. I could never go out with anyone, any other boys or anything like that. I don't even want to be with other boys. I don't know what I want. I don't want anything. I don't even want to be alive. I just want George. That's all I want. I don't see that that's asking too much. He said he loved me.

We were really happy all the time. I don't know why those girls at University are better than me. When he likes them better. Maybe they're smarter than me or something like that. I don't know. I guess there's not much you can do for me? I guess there's nothing anyone can do really.

I don't know if it's worth going on anymore. I just feel so empty, like there's a big hole inside me where George used to be -- a big hole, and it hurts so bad. I just can't think about anything else. It's like, he doesn't even know what it's like -- it seems so easy for him. He's having a good time and I don't know if he even misses me or anything or if he cares. Maybe he never did care at all. But then why would he say he did? But, I don't know. Can people just fall out of love like that? I never thought it could happen. I never fell out of love with him. I just don't understand.

4. Post-training Client #2

I guess I should tell you why I'm here. I guess I'm here because my parents are worried about me. I don't think

there's anyone who can do anything. But everyone keeps telling me that if I talk to somebody I'll be OK and make things better and so I thought I would do that. I don't know, I guess. I guess my parents are worried about me because I'm just not in very good shape. I feel terrible all the time. It doesn't seem fair, you know. I just feel so bad. Nobody should have to feel this bad. I didn't do anything.

I don't know. I guess you want to know why I'm feeling so bad. It started when -- well, this guy and I have been going together for a really long time and ever since the beginning of high school. We were going steady and everybody knew us like, you know, like Cathy and George and he broke up with me awhile ago. It's just not going to be the same without him. He was all that I had in the whole world and now he's decided that he doesn't love me and I always thought that he did. He always told me that he did. Was I supposed to think that he was lying or something? It doesn't make sense. If he doesn't still love me then he probably never did love me. I was I guess just a food -- just a stupid girl or something to believe that. When he started out saying that he wanted to date other girls, he didn't say that he wanted to break up with me or anything so I said OK because I didn't want to lose him. He was all I had. I should have known it wouldn't work and it didn't work. He just got more and more mad at me because I was crying all the time. I just couldn't stand it, you know. He was going out with

other girls and he's never done that before. I kept asking him what I could do to be different and know what was wrong with me.

I figures something must be wrong with me because it wasn't the same as it was before. I don't understand because he would say that nothing was wrong with me. He just got further and further away and I felt worse and worse and it just made him mad. I guess there's nothing that I can do. The only thing I can think of to do is to get back with him, but it just seems like the harder I tried to do that the worse everything got. I guess it's not going to happen but if that doesn't happen there's just nothing for me anymore.

We always talked about getting married. We would plan about what we were going to do and about having a new house and having kids. That's all I wanted. I just wanted to be with him and be a mother. Take care of him and take care of our kids and then he always said that's what he wanted, too. I guess he doesn't want that anymore. He doesn't want me anymore. I guess that's it but still, you know, I still think about what it would have been like. You know, we'd get married and have a really nice wedding and invite all our friends and stuff and everyone would be so happy for us. We would be so happy with each other and everything would be just great. He should never have let me think that stuff if it wasn't going to happen because now it's just worse.

I wish I'd never met him. I wish I'd never been born at all if it could end up like this because it's useless. You know, I go to school, graduate from high school and get this job and ... I'm helpless. I just wanted to be a mother. I just wanted to be a wife. I wanted to be with Beorge and that's gone. There's just nothing for me.

My parents -- they just make it worse. Well they have their own problems and I guess they can't take too much time to try and understand what ... . They don't understand. They just keep telling me it's going to be OK, that there'll be other boys. I can't even think about other boys. Every-time I think about other boys I just want to be with George again. That just makes me feel worse. So I don't know. It's not going to be OK.

George and I used to be in stuff together, like we were in this church group together. We had friends there and we used to go bowling, go out with these guys and I don't want to go there anymore because it doesn't feel right without George being there anymore. I guess he doesn't care about me at all.

I don't know why anyone should care about me. I'm not very important and, in fact, my parents have enough problems as it is without me all the time. I'm just -- I just make things worse for them. They have lots to worry about be-sides me. They'd be better off if I weren't around. I feel like I'm not around. I don't want to be around. I

don't want to get out of bed in the morning because there's nothing to get up for. There's nothing to do. I had this job I could go to but that's never any good. I don't have any friends because I work for this place that sends me around to different companies. Even if I did it wouldn't make any difference. Maybe I'll just quit my job. Why should I do anything different? My parents keep telling me to do this and do that.

Appendix D

Trainee Rating Scale

Trainee name & number_____

Rater initials_____

Please rate each behavioral category on the following scale:

1 - Behavior opposite to category predominant
2 - Mixed behavior or absence of behavior (neutral)
3 - Behavior slightly consistent with category predominant
4 - Behavior moderately consistent with category predominant
5 - Behavior highly consistent with category predominant

Nonverbal Behavior	1st 75 Sec.	3rd 75 Sec.	Overall
* Moderately relaxed, varied posture	_____	_____	_____
* Varied eye contact	_____	_____	_____
* Encouraging, nondistracting gestures	_____	_____	_____
Open Invitation to Talk			
* Minimal encourages to talk (e.g., tell me more)	_____	_____	_____
* Nondistracting, conversational tone of voice	_____	_____	_____
* Verbal attending statements (e.g., I see)	_____	_____	_____
Questioning			
*Questioning at pauses	_____	_____	_____
*Open-ended structure	_____	_____	_____
*Affect related	_____	_____	_____

Trainee Rating Scale, p. 2

Please rate each behavioral category on the following scale:

1 - Behavior opposite to category predominant
2 - Mixed behavior or absence of behavior (neutral)
3 - Behavior slightly consistent with category predominant
4 - Behavior moderately consistent with category predominant
5 - Behavior highly consistent with category predominant

Reflection	2nd 75 Sec.	4th 75 Sec.	Overall
*Accurate restatement	_____	_____	_____
*Affect related	_____	_____	_____
Clarification			
*Nonthreatening, nonconfrontative	_____	_____	_____
*Draws attention to ambiguous statements	_____	_____	_____
*Draws attention to related statements or issues	_____	_____	_____
Empathy			
*Accurate understanding expressed with warmth and sensitivity	_____	_____	_____