Counselor intentionality as a variable in the psychotherapeutic process

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Abstract
A substantial body of research indicates that counselor behavior in the counseling/psychotherapeutic process is of great importance. Rogers (1957) suggested that counselor behavior must serve as a channel for fulfilling the necessary conditions of empathy, warmth and genuineness for client growth. Sloane et al. (1975) reported the potent 3 effect on outcome of therapist variables. Goodman & Dooley (1976) devised a response taxonomy to categorize counselor behaviors. Ivey & Authier (1978) proposed microcounseling training to teach specific counselor behaviors.
COUNSELOR INTENTIONALITY AS A
VARIABLE IN THE PSYCHOTHERAPEUTIC PROCESS

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Counselor intentionality as a variable in the psychotherapeutic process

A substantial body of research indicates that counselor behavior in the counseling/psychotherapeutic process is of great importance. Rogers (1957) suggested that counselor behavior must serve as a channel for fulfilling the necessary conditions of empathy, warmth and genuineness for client growth. Sloane et al. (1975) reported the potent effect on outcome of therapist variables. Goodman & Dooley (1976) devised a response taxonomy to categorize counselor behaviors. Ivey & Authier (1978) proposed microcounseling training to teach specific counselor behaviors.

Barak & LaCrosse (1977) noted that counselor behavior is the medium through which clients derive and organize perceptions about counselors and counselors acquire or experience perceptions about themselves. They also point out that though counselor behavior is an objective phenomenon, it is the base for subjective perceptions and interpretation (inference) by individuals directly involved as participants or less directly involved as observers.

The purpose of this paper is to explore counselor intentionality as a measure to examine and clarify counselor behavior. Issues addressed will include: a) what is meant by counselor intentionality; b) how do intentions fit into the
psychotherapeutic process; c) is there any relationship between orientation and usage of intentions; and d) do intentions differ across stages of treatment?

What is meant by counselor intentionality?

Goodman & Dooley (1976) discussed links between counselor intentions and interventions. They devised a response taxonomy to categorize counselor behavior. They assumed that various kinds of helping intentions exist: (1) gathering information, (2) guiding another's behavior, (3) providing interpersonal space, (4) explaining or classifying another's behavior, (5) expressing empathy, and (6) revealing one's personal condition. These six intentions can be carried out in the following language acts or "response modes": (1) question, (2) advisement, (3) silence, (4) interpretation, (5) reflection or paraphrase, (6) self-disclosure. This framework for help-intended communication is pantheoretical, or, inclusive of the most important categories employing various counseling theories. Many systems of classification have evolved from studies of this kind.

Elliott (1979) examined how clients used helper verbal behavior to arrive at an understanding of the helpers intentions. In a content analysis of the literature on how clients, helpers, and third-party observers (teachers and researchers) perceive particular helper behaviors, he found the following relations to be most typical and used these findings as a working hypothesis.
in his study: a) Advisements are perceived as guiding the client. b) Acknowledgements (uh-huhs') are perceived as reassuring the client. c) Reflections are perceived as communicating understanding of the client's message. d) Interpretations are perceived as explaining the client to himself or herself. e) Questions are perceived as gathering information or understanding of the client. f) Self-disclosures are perceived as using (the helper's) self to help the client. The results produced significant but modest support for using helper behaviors to predict corresponding client perceived helper intentions.

An earlier study done by Sloane et al. (1975) presented empirical evidence for measuring counselor behavior. They implied that should the therapist intention be to control the content of the interaction, he may wish to ask questions that 'set limits' on the range or array of possible client responses. Day & Sparacio (1980) also supported structuring the counseling session. In their article, they presented a rationale for its use in counseling.

Hill, Carter & O'Farrell (1983) defined intentions as reasons or purposes for what the counselor does in any given speaking turn. They developed a list of 15 counselor intentions (structure, fact finding, focus, support, ego strengthening, clarification, identification, effects of behavior, intensification of feeling, challenge, insight, reframing, direct change attempts, indirect change attempts, and analysis of relationship) representing the
counselors cognitive process as a measure to analyze 12 counseling sessions. They reported that counselor intentions seem to be a promising development in examining counselor behavior.

Hill & O'Grady (1985) defined intentions as a therapist's rationale for selecting a specific behavior, response mode, technique or intervention to use with a client at any given moment within the counseling session. Counselor intentions, therefore, are cognitive components and represent what the therapist wants to accomplish through his/her behavior within the counseling interaction. They also developed a list of therapist intentions. The list was revised through several stages. The final list contains 19 categories with minimal overlap between categories. Throughout the stages of development the list was used by practitioners from a wide variety of orientations and was seen to have face validity, to be inclusive of the range of intentions, and to have a neutral language with terms acceptable to all orientations. The final list is shown in Table 1, Appendix 1 (p.13).

Similar to the aforementioned definitions of intentions, Ivey & Simek-Downing (1980) described the intentional counselor as one who acts with a sense of capability, one who can generate alternative helping behaviors in any given situation, one who has several alternative helping modes available to respond to the needs of the client at the moment and one who has the ability to utilize these responses to assist others to reach long-term
goals. In addition, intentionality forms a part of the concept of communication competence and the culturally effective individual (Ivey, 1977).

The goal of intentionality can be achieved through the careful delineation and mapping of microskill units of the interview. Ivey (1982) stated that microskills are communication skill units of the interview that help counselors develop a more intentional and rounded ability to interact with a client. He presented a microskills hierarchy that summarizes the successive steps of intentional counseling. Attending behavior is the first microskill unit of this hierarchy. Ivey & Authier (1978) confirmed that the interviewers use of attending behavior in the counseling session determines the direction and content of the session. Day & Sparacio (1980) suggested that structure in the counseling process aids the intentional counselor in that it allows the counselor to feel more comfortable and confident. If the counselor has devoted some thought to the philosophy and methodology of his/her approach and has some idea of how to present these views and procedures to the client, then the counselor will be more self-aware and self-assured.

How does intentionality fit into the psychotherapeutic process?

Reviews of the literature (Ivey, 1982; Ivey & Simek-Downing, 1980) found that intentionality is not only a goal for the counselor, it is also a goal for clients. A client comes to the session stuck--having either no alternatives for solving a problem or a
limited range of possibilities. The task of the therapist in the psychotherapeutic process is to find specific areas where lack of intentionality exists in the client then develop programs to enable the client to increase his/her response repertoire.

Hill & O'Grady (1985) presented a theory of how intentions operate in the counseling/psychotherapeutic process. They proposed that therapists compute an enormous amount of data from global input variables (e.g., presenting problem, diagnosis, setting, attractiveness) as well as immediate stimulus variables (e.g., the behavioral observations, clinical hypotheses, personal reactions, overall treatment plan, and specific task engaged in at that point in treatment) in a quick and sophisticated manner. Based on their experience and training, therapists develop these data into intentions or goals for what they want to accomplish next in the session. These intentions guide the choice of interventions. An intention can be implemented by a range of interventions, both nonverbal and verbal. For example, if the intention is to intensify feelings, the therapist might choose from a range of behaviors to implement that intervention: leaning forward, touching, reflection of feelings, silence, confrontation, self-disclosure or an empty chair technique.

After each counselor intervention or turn, the client responds. The client goes through a similar process of integrating the immediate stimulus variables and choosing how to respond.
Based on the client's response, the therapist reacts and adjusts the subsequent intention and response accordingly. In agreement, Ivey (1982) noted that the intentional counselor can act decisively, note feedback in response to that action, and then act in accord with the new data.

However, Stiles (1979) pointed out that intentions don't always operate smoothly in the psychotherapeutic process. He argued that many measures of response modes confuse intent and grammatical structure and has recommended that these are constructs that should be determined separately by objective judges. For example, a therapist utterance such as "I want you to tell me whatever comes to mind" is in the form of a disclosure but has the intention of suggesting that the client reveal his thoughts. However, Hill & O'Grady (1985) contended that response modes generally refer to grammatical structure that can be observed behaviorally, whereas intentions refer to the internal processes of a therapist that might be quite undetectable to an outsider.

Is there any relationship between orientation and usage of intentions?

Goodman & Dooley (1976) found that: 1) questions are the most frequently used response form by most orientations except client centered therapy; 2) advisements are rarely used by client-centered and analytic therapists; 3) existential advisement (here-and-now process instructions which guide the clients behavior during the therapy hour) is prominent in Gestalt approach, assertion
training and some forms of behavior modification; 4) in practice, psychoanalysts use interpretation 10% of the time which is more than client-centered therapists use it; 5) reflection is used by client-centered therapists 75% of the time; 6) disclosures are rarely used as primary or secondary responses in most current psychotherapies, but appears to be attracting interest in existential approaches.

Sloane et al. (1975) found that behavior therapists were more directive than psychotherapists. They more frequently gave explicit advice, instructions and provided information. They also exerted greater control over the content of the interaction by introducing new topics and seeking information. Psychotherapists played a more reflective role, allowing patients to select the topic of conversation and encouraged them to explore and express their thoughts and feelings. Only rarely did they let their personal opinions be perceived, much less put in the form of advice. Both groups showed similar levels of unconditional positive regard or warmth toward clients.

Hill & O'Grady (1985) compared therapists of psychoanalytic, humanistic and behavioral orientations for their usage of intentions and found: 1) set limits was positively related to behavioral ratings, focus was negatively related to psychoanalytic ratings, feelings were positively related to psychoanalytic ratings and negatively related to behavioral, insight was positively related
to psychoanalytic ratings, change was negatively related to psychoanalytic ratings and positively related to behavioral ratings and therapist needs were positively related to humanistic ratings. Furthermore, feelings and insight were more frequently associated with psychoanalytic; change, set limits and reinforce change were highly associated with behavioral and therapist needs were highly associated with humanistic. These intentions seem to represent the central differences between orientations and for the most part fit with the theoretical formulation.

**Do intentions differ across stages of treatment?**

A review of the literature indicated that intentions differ across stages of treatment. Edwards et al. (1982) analyzed 2 initial interviews by Carl Rogers and found that Rogers manifested moderate levels of empathy, respect and genuineness throughout both initial interviews. In a study by Hill, Carter and O'Farrell (1983) an analysis of intentions found more factfinding and focus in the first stage but more ego strengthening, reframing, direct and indirect change attempts, and discussion of relationship in the final stage of counseling.

Hill & O'Grady (1985) examined usage of intentions and found: 1) the most commonly used intentions in middle sessions were clarify, insight, feelings, get information, change, support and focus, in total accounting for 67% of the intentions. In addition, therapists across all orientations move through their middle sessions in a
fairly similar manner, such that the beginning of a session is characterized by intentions to clarify and get information, whereas the emphasis toward the end of the session shifts to intentions of cathart, insight and change.

Summary

Counselor intentionality has been presented as a variable in the counseling/psychotherapeutic process. Its potential value as a measure to examine and clarify counselor behavior has been explored.

Implications from this review suggest that the empirical evidence of associations between therapist intentions and response modes should be useful in training. Also, comments by the therapist involved in the Hill & O'Grady (1985) study indicated that reviewing their sessions with the aid of the intentions measure was quite useful in helping them clarify often unverbalized reactions, suggesting that this measure might be a useful supervision tool.

Supervisors have reported that typically, they review the supervisee's intentions to enable the supervisee to become more aware of what he or she is trying to accomplish. Reviewing intentions enables trainees to examine their motivations more carefully. After questioning and understanding their own intentions, trainees can more systematically examine their interventions and subsequently client reactions.
Table 1

Instructions

To judge intentions, the therapist should review the tape within 24 hours so that the session is as fresh and vivid in memory as possible. The therapist should stop the tape after each therapist turn (everything the therapist says between two client speech acts, excluding minimal phrases) and indicate as many intentions as applied for that turn. You should strive to remember exactly what was going through your mind right at the time of the intervention and be as honest as possible in reporting what you were actually thinking. Remember that there are no right or wrong answers; the purpose is simply to uncover what you planned to do at that moment. Also remember that you should indicate your intentions only for that immediate intervention, rather than report global strategies for the entire session. Note that not every phrase in the definition for each intention needs to fit to judge that the intention applies. In general, the therapist should choose those intentions that best apply, even if all the phrasing is not exactly applicable to the current situation or does not fit the way he or she would say it.
Intentions

1. Set limits: To structure, make arrangements, establish goals and objectives of treatment, outline methods to attain goals, correct expectations about treatment, or establish rules or parameters of relationship (e.g., time, fees, cancellation policies, homework).

2. Get information: To find out specific facts about history, client functioning, future plans, and so on.

3. Give information: To educate, give facts, correct misperceptions or misinformation, give reasons for therapist's behavior or procedures.

4. Support: To provide a warm, supportive, empathic environment; increase trust and rapport and build relationship; help client feel accepted, understood, comfortable, reassured, and less anxious; help establish a person-to-person relationship.

5. Focus: To help client get back on the track, change subject, channel or structure the discussion if he or she is unable to begin or has been diffuse or rambling.

6. Clarify: To provide or solicit more elaboration, emphasis, or specification when client or therapist has been vague, incomplete, confusing, contradictory, or inaudible.

7. Hope: To convey the expectation that change is possible and likely to occur, convey that the therapist will be able to help the client, restore moral, build up the client's confidence to make changes.
8. Cathart: To promote relief from tension or unhappy feelings, allow the client a chance to let go or talk through feelings and problems.

9. Cognitions: To identify maladaptive, illogical, or irrational thoughts or attitudes (e.g., "I must be perfect").

10. Behaviors: To identify and give feedback about the client's inappropriate or maladaptive behaviors and/or their consequences, do a behavioral analysis, point out games.

11. Self-control: To encourage client to own or gain a sense of mastery or control over his or her own thoughts, feelings, behaviors, or impulses; help client become more appropriately internal rather than inappropriately external in taking responsibility for his or her role.

12. Feelings: To identify, intensity, and/or enable acceptance of feelings; encourage or provoke the client to become aware of or deepen underlying or hidden feelings or affect or experience feelings at a deeper level.

13. Insight: To encourage understanding of the underlying reasons, dynamics, assumptions, or unconscious motivations for cognitions, behaviors, attitudes, or feelings. May include an understanding of client's reactions to others' behaviors.

14. Change: To build and develop new and more adaptive skills, behaviors, or cognitions in dealing with self and others. May be to instill new, more adaptive assumptive models,
frameworks, explanations, or conceptualizations. May be to give an assessment or option about client functioning that will help client see self in a new way.

15. Reinforce change: To give positive reinforcement or feedback about behavioral, cognitive, or affective attempts at change to enhance the probability that the change will be continued or maintained; encourage risk taking and new ways of behaving.

16. Resistance: To overcome obstacles to change or progress. May discuss failure to adhere to therapeutic procedures, either in past or to prevent possibility of such failure in future.

17. Challenge: To jolt the client out of a present state; shake up current beliefs or feelings; test validity, adequacy, reality, or appropriateness of beliefs, thoughts, feelings, or behaviors; help client question the necessity of maintaining old patterns.

18. Relationship: To resolve problems as they arise in the relationship in order to build or maintain a smooth working alliance; heal ruptures in the alliance; deal with dependency issues appropriate to stage, in treatment; uncover and resolve distortions in client's thinking about the relationship that are based on past experiences rather than current reality.

19. Therapist needs: To protect, relieve, or defend the therapist; alleviate anxiety. May try unduly to persuade, argue, or feel good or superior at the expense of the client.
References


