ANXIETY AND COPING OF FEMALE COUNSELLING STUDENTS:
RESPONSES TO SEXUAL, PHYSICAL ABUSE AND ROLE CONFLICT

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Abstract

The focus of this study was an examination of the anxiety level and coping processes of female counselling students when confronted with a client who has either been sexually abused, physically abused, or who is experiencing role conflict. It was hypothesized that students who were exposed to a sexually abused client would demonstrate a significant increase in anxiety and poorer coping processes than the comparison groups. Coping processes were construed as coping thoughts (the relationship between negative and positive self-statements), and operationalized as the proportion of negative self-statements to total self-statements. It was further expected that there would be a moderate, positive correlation between anxiety and relative negative self-statement scores after viewing the client videos. Sixty female volunteer counselling psychology students (M age 35.8) at the University of British Columbia were randomly assigned to one of three experimental groups: exposure to a video presentation of a client who had either been sexually abused, physically abused, or was experiencing role conflict. Each student completed the State Form of the State-Trait Anxiety Inventory and the thought-listing procedure before and after viewing the client. Data were analyzed by two repeated measures, 2-way (group x time) ANOVAs, with anxiety and relative negative self-statement scores as the dependent variables. A Pearson product-moment correlation was also conducted between these two variables at post-test. The ANOVAs revealed no significant differences between the three groups from pre- to post-video, and, unexpectedly, the relative negative self-statement scores decreased for all groups. A positive correlation but of low magnitude was found between anxiety and relative negative self-statement scores (r=.21, p<.05). Because of the unexpected results, and based on findings from the literature, post-hoc analysis was carried out. A repeated measures ANOVA with positive self-statements as the dependent variable revealed a group x time interaction that approached significance, F(2,60)=2.20, p<.12. Post-hoc
Scheffe's tests ($p<.05$) indicated that the sexual abuse group increased these positive self-statements more than the comparison groups. Data were also examined from the perspective of Schwartz and Garamoni's (1986) States of Mind model. These findings coupled with data from the ancillary questionnaires suggested that students were functioning from a position of grandiosity with respect to their counselling ability with adult survivors of sexual abuse. There was also some indication that at least some students who had been sexually abused themselves were in a state of denial in relation to the effects of their own abuse.
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Dedication

I would like to dedicate this thesis to all survivors of sexual abuse. Your courage and struggle in dealing with this issue has helped to bring this terrible secret to light and to propel people to become involved in the cessation of childhood sexual abuse.
Acknowledgments

I wish to thank Dr. Bonnie Long for her unceasing support and assistance in all matters related to this study, and for the extraordinary amount of time she made available to me throughout this period. Her encouragement and enthusiasm for this research project was also appreciated during those times when "spirits were flagging". I would also like to thank my other committee members, Dr. Kathryn McCannell, and Dr. John Allen for their review of my study and their constructive suggestions. I am also indebted to Liz Choquette, not only for having had the benefit of her professional expertise in the area of sexual abuse, but for her ongoing support and much-needed help with a myriad of tasks related to this study. I am, as well, grateful to those therapists who have freely offered their clinical wisdom in the formulation of various aspects of this study - Barb Messiah, Suzanne Kenney, John Saville, and Laurie Ross. Finally, I thank all those students who volunteered to participate in both the pilot project and the study itself; this thesis would not have been possible without your involvement.
Introduction

Child sexual abuse, including adults victimized as children, has recently become a focal point of investigation by a number of researchers (Baker & Duncan, 1985; Briere & Runtz, 1986; Finklehor, 1986; Hartman, Finn, & Leon, 1987; Russell, 1983). This has followed from an increase in the number of cases reported and growing acknowledgment by mental health personnel of the traumatic and overwhelming effects of sexual abuse. What has yet to be examined are clinicians' responses to clients who present with sexual abuse issues. Although child sexual abuse is far from a new phenomenon in our society and was identified by the research community as early as 1929 (Hamilton, 1929; Landis et al., 1940), the fact of its existence, as well as its pervasiveness, has only recently been accepted and begun to be addressed by the relevant systems and agencies of this society. As the issue of sexual abuse can thus be viewed as a newly emerging one, it is expected that many counsellors will have limited, or no, skill or training in this area and may, as a result, experience anxiety and difficulty coping when confronted with sexual abuse survivors. This study focuses on counsellors in training and how they cope with sexually abused clients.

Empirical studies that have documented long-term effects of sexual abuse have been largely restricted to women and no doubt reflect, at least in part, the preponderance of females as sexual abuse victims (Badgley et al., 1984; Finkelhor, 1986; Russell, 1983). These studies also support findings reported in the clinical literature (Briere, 1984; Finkelhor & Browne, 1985; Meiselman, 1978). In summarizing their review of the long-term effects of child sexual abuse, Browne and Finkelhor (1986) report that "Adult women victimized as children are more likely to manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse" (p. 72). They also note difficulty in trusting others and sexual maladjustment as further elements in this complex of sequelae.
It can be argued that more women are seeking treatment for prior sexual abuse and that many counsellors will encounter clients who have been sexually victimized as children. There are a number of factors that support this view. Reports of the prevalence rate for child sexual abuse have ranged from 6% to 62% for females (Finkelhor, 1986) with even the lowest rate indicating that child sexual abuse is far from an uncommon experience. Greater public awareness and media attention has resulted in the erosion of the barrier of silence surrounding this issue, a common factor in the perpetration of sexual abuse. Although there is little available data on the referral rate of adult sexual abuse survivors, the bourgeoning number of therapeutic workshops for survivors, and the waiting-lists that have developed at the few treatment centres that provide service in this area (e.g., VISAC, in Vancouver, British Columbia - personal communication, L. Doyle, January 18, 1989; The Women's Post-Treatment Centre, in Winnipeg, Manitoba - personal communication, B. Ball, January 20, 1989) testify to a demand for therapeutic assistance in this area. Given the deleterious consequences of child sexual abuse, counsellors need to be prepared to deal with this issue with clients who present as adult survivors of abuse. Researchers have yet to examine counsellors' readiness to do so, although Attias and Goodwin (1985) found in her survey of 108 private practitioners that 86% of these requested more training in this area.

Lack of information and training in the area of sexual abuse may act as threats to counsellors addressing this multi-faceted problem with their clients. There are other factors that may compound this situation and these too relate to limited information, exploration, and understanding of the problem of sexual abuse. The sexual nature of the abuse may be disconcerting to counsellors who are uninformed and uncomfortable about discussing sexual matters with their clients. Counsellors have been found to lack knowledge about sex and this has been related to high levels of anxiety and poor empathic responses with clients seeking help for sexual problems (McConnell, 1976).
Perhaps of greater import, the act of addressing sexual abuse issues with clients acknowledges the serious degree to which children are exploited by adults, a substantial number of whom are in caretaking roles and positions of trust and responsibility in relation to children. The repugnant nature of sexual abuse belies the belief of living in a civilized society and shatters the notion that the home is necessarily a place of safety and support for children -- concepts difficult for many people, including counsellors, to accept.

In advancing the premise that no, or deficient, training and experience with a presenting client issue may be stressful to a counsellor, it is necessary to examine how people respond when they feel threatened. Bandura (1977) has theorized that stressful and taxing situations not only elicit emotional arousal, but that this in turn is used as a cue in the person's judgment of their vulnerability to stress, and can thus affect that person's perceived self-efficacy to cope with a threatening situation. "People fear and tend to avoid situations they believe exceed their coping skills, whereas they get involved in activities and behave assuredly when they judge themselves capable of handling situations that would otherwise be intimidating" (p. 194). Lazarus and Folkman (1984) view Bandura's concept of self-efficacy as comparable to their "situational appraisals of control". These appraisals are viewed as resulting from a person's evaluation of the demands of a situation and his or her coping resources, which in turn influence emotion and coping. They contend that if a situation is appraised as threatening, stress is experienced, which, when extreme, generates intense negative emotion such as fear and anxiety. Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, p. 41). It is also seen as serving two functions: "managing or altering the problem with the environment causing distress (problem-focused coping) and regulating the emotional response to the problem
(emotion-focused coping)" (p. 179). High levels of threat are seen as preventing a person from using either of these coping mechanisms effectively.

Studies related to test anxiety, heterosocial anxiety, and assertiveness have demonstrated significant correlations between anxiety and negative self-statements, and a relationship between these and poor coping responses (Bruch, 1981; Caccioppo, Glass, & Merluzzi, 1979; Galassi, Friersen, & Sharer, 1981; Glass, Merluzzi, Biever, & Larsen, 1982; Safran, 1982; Schwartz & Gottman, 1976). Individuals characterized by high levels of anxiety in test and interpersonal situations were found to exhibit more negative self-statements and demonstrate more maladaptive behaviors or poorer performances than their less anxious counterparts. Interestingly, behavioral avoidance was found to be a frequent coping strategy in high anxiety individuals. Coping processes have also been construed as coping thoughts, or, the relationship between positive and negative thoughts in one's internal dialogue (Schwartz, 1986). Schwartz and Garamoni (1986) posit, from their review of the literature and as reflected in their "States of Mind" model, that functional and dysfunctional coping patterns can be differentiated by the nature of the proportions of positive to negative self-statements. This model proposes five distinct states of mind determined by the proportion of positive (P) cognitions to positive plus negative (P+N) cognitions (i.e., P/P+N). Each of these states of mind is seen to be either adaptive or maladaptive for the individual involved. It has also been demonstrated (Petty & Cacioppo, 1979a, 1979b) that issues particularly salient to the individual produce stronger associations among cognitive and affective responses than low-involvement issues.

Additionally, researchers (Bandura, 1956; Bergin & Solomon, 1970; Friedlander, Keller, Peca-Baker, & Olk, 1986; Hogan, 1969) have found that anxiety and subjective distress negatively correlate with factors related to counselling effectiveness. These factors include the therapist's ability to facilitate improvement in the adjustment of
patients, to develop a comprehensive treatment plan, and to empathize with the client. As well, it has been suggested that therapists who maintain emotional equilibrium in the therapeutic setting are more consistent in their responses to, and treatment of, clients (Ricks, 1974).

It was extrapolated, then, that client issues with which counsellors have some familiarity, knowledge, or expertise, would be less threatening than issues about which counsellors lack knowledge or training. Counselling students would be at risk of experiencing anxiety and poor coping processes when confronted with a client who had been sexually abused, when their training did not include a focus on sexual abuse issues. Given the prevalence of this problem many graduate students will undoubtedly encounter sexually abused clients in their work. They may not only be ill-prepared to deal with this issue, but, because of this, may experience emotional responses and coping strategies that are antithetical to good counselling practice (e.g., poor therapeutic rapport, denial, avoidance or minimization of the problem). Clients, already in turmoil and pain from the abuse, are then potentially exposed to further masking or distortion of the problem. Counsellors may perpetuate attitudes and approaches abused clients have previously encountered in relatives and their social circle, prior to coming to therapy, and which have hampered their ability to come to terms with their abuse.

Thus, the purpose of this study was to investigate female counselling students' anxiety levels and coping processes when confronted with a client who had been sexually abused as a child, and specifically one who was an incest survivor, and to determine whether these responses could be differentiated from responses generated by other issues, both familiar and not familiar to counselling students. This study focused on female counsellors because studies (Attias & Goodwin, 1985; Eisenberg, 1987) suggest that men may respond differently to sexual abuse issues and the limited number of male counselling psychology students precluded their inclusion.
Role conflict was determined to be a familiar issue to counselling students as it is a common client issue and one that counselling psychology students at the University of British Columbia have encountered as part of their course work. Additionally, many women entering the program are mature students who have themselves wrestled with the dilemmas of dual or multiple roles (e.g., wife, mother, homemaker, career woman, student) and the conflicts inherent in these. Physical abuse, like sexual abuse, is not generally addressed in the counselling program. Physical abuse and sexual abuse, accordingly, represent issues about which counselling students have been given little or no formal instruction and with which they are unfamiliar. Physical abuse is not, however, thought to be as threatening as sexual abuse due to the complex dynamics of the latter form of abuse. These presenting problems were documented on videotape in order to ensure consistency across problems.

Therefore, it was expected that counsellors exposed to a sexually abused client would experience greater anxiety and report a greater proportion of negative self-statements compared with counsellors exposed to a physically abused client, or a client experiencing role conflict. Furthermore, it was expected that counsellors who report greater anxiety after exposure to the client videos, would also report a greater proportion of negative self-statements.
Given the prevalence of child sexual abuse, the hazards it presents to mental health adjustment in adults, and the fact that more women are actively seeking therapy for this issue, counsellors in the field will undoubtedly encounter sexual abuse survivors in their caseloads. Lack of training or experience with this very complex and unsettling issue may induce feelings of anxiety and poor coping processes in counsellors and may compromise the counsellor's ability to provide therapeutic assistance.

The literature will now be reviewed as it pertains to the prevalence, long-term effects of, and counsellor responses to, childhood sexual abuse, and to theories that elucidate the emotional and cognitive responses to threat, and specifically those of anxiety and coping processes.

**Child Sexual Abuse**

The sexual abuse of children is now generally acknowledged as a pervasive and far too frequent phenomenon in our society (Haugaard & Repucci, 1988; Hechler, 1988). This awareness is due in large measure to the women's movement and its attendant concern and energy directed at the uncovering and cessation of the victimization of women and children (Asher, 1988; Courtois, 1988; personal communication - Roland Summit, May 12, 1989; Jon Conte, June 14, 1989). Research investigations into child sexual abuse were no doubt in response to this and followed on other studies examining child physical abuse and neglect, and other forms of violence in families, and the need to empirically validate clinicians' findings. Despite the inherent difficulties in studying such a problem as sexual abuse (e.g., ethical dilemmas, apprehensive research subjects) and the methodological weaknesses of many of these studies (Finkelhor, 1986; Haugaard & Repucci, 1988), sufficient evidence has accumulated over the course of the last decade that the following conclusions can be drawn:
(a) Child sexual abuse exists, has always existed and is more common than once believed (Hechler, 1988).

(b) The majority of victims are female, the majority of perpetrators are male (Russell, 1986).

(c) Children who have been sexually victimized are at risk of developing a host of problems both immediately and at subsequent life stages (Courtois, 1988).

(d) Research and training in the field of child sexual abuse is, for the most part, in its infancy (Hechler, 1988).

Each of these factors is germane to this study and together provide a broad overview of some of the dynamics of the problem. Aspects of these points will now be examined in greater detail. This study is concerned with female adult survivors of sexual abuse, therefore the literature was reviewed only as it related to female victims of childhood sexual abuse.

Child sexual abuse has been defined in various ways by researchers because of their use of differing criteria based on age, acts, and types of relationships. Browne and Finkelhor (1986) include in their review only those studies that addressed experiences bounded by two criteria: (a) forced or coerced sexual behaviour imposed on a child, and (b) sexual activity between a child and a person older than the child by at least 5 years. This description will also serve as this paper's definition of child sexual abuse.

**Prevalence and mental health services.** Information about the prevalence of child sexual abuse has been available since 1929 (Hamilton, 1929), and estimated from a volunteer sample of 100 married women at a rate of 20%. The scope of the problem of child sexual abuse has been difficult to estimate with any degree of accuracy with reported prevalence rates ranging from 6%, as reported by Burnam in 1985 (cited in Finkelhor, 1986), to 62% (Wyatt, 1985). Finkelhor (1986), in his comprehensive and methodical review of this area, identified several reasons for this. Studies examining
prevalence rates employed different definitions of sexual abuse, including contact and non-contact experiences; sampling techniques varied from probability samples that included household and mail surveys, self-administered and interviewer administered surveys and surveys with and without professional interviewers, to non-probability samples largely consisting of college student surveys; and the actual questions on sexual abuse varied widely in number and specificity. Haugaard and Repucci (1988), in their review, noted similar observations. One study that is extensively quoted in the sexual abuse literature and that includes many of the criteria that Finkelhor (1986) deems as important to sound methodological practice in this area is that of Russell (1986). Her study consisted of a random probability sample of 930 adult women in San Francisco where face to face interviews were conducted at households by specially trained female interviewers, matched to respondent ethnicity where possible. She found that 38% of the women reported at least one experience of intrafamilial and/or extrafamilial sexual abuse before they reached 18, and 28% reported at least one such experience before 14 years of age. When non-contact experiences are included these rates respectively rise to 54% and 48%. These are rather staggering statistics, and, when the deleterious effects of sexual abuse are considered, they have obvious implications for mental health services and providers.

What proportion of women who were sexually victimized as children ultimately seek therapy as adult survivors of abuse is not known. Studies do indicate, however, that a significant percentage of women who present as clients at mental health agencies have been sexually assaulted as a child. Golding, Stein, Siegel, Burnam, and Sorenson (1988) found in their survey of 2560 randomly selected community residents that approximately 30% of female respondents seeking care from a broad range of mental health services had a history of sexual assault compared to 15% of non-users. In addition, respondents assaulted during childhood were significantly more likely to seek mental health care than
those assaulted during adulthood. Prevalence of an incest history in adult women survivors has also been reported at 33% for psychiatric out-patients (Rosenfeld, 1979), and, in a Canadian study, at 44% for clients at a community mental health clinic (Briere, 1984). Although no direct causal link can be made between sexual abuse and utilization of mental health services, the evidence for such a relationship, when long-term effects of sexual abuse are examined, becomes rather weighty. Certainly, with more media and public attention directed at sexual abuse, more women have begun to speak out about their own abuse and are undertaking therapy specifically to deal with this issue (Courtois & Sprei, 1988). With the number of adult survivors of sexual abuse who have emerged in the mental health services and given those who are actively seeking professional assistance for childhood sexual victimization, it can be assumed that a number of therapists, at some point in their professional life, will encounter adult survivors of sexual abuse in their caseload.

**Long-term effects of sexual abuse.** There is compelling evidence that child sexual abuse has existed since recorded time and, for the preponderance of this time, has been viewed as either a positive, benign, or inconsequential experience for the child (Rush, 1980). Freud, in his work "The Aetiology of Hysteria" published in 1896 (cited in Miller, 1984) was one of the first health professionals to identify child sexual abuse as deleterious to emotional and psychological health. In his seduction theory he concluded that his adult female patients' "hysteria" was due to childhood sexual trauma. This was, however, quickly repudiated in light of his colleagues' lack of response and his own discomfiture at being ostracized for these postulates (Masson, 1984). In the subsequent development of his theories of infantile sexuality and the Oedipus complex which proposed that children fantasize this abuse in their projection of their own repressed aggressive and sexual desires, Freud interestingly emphasized that these theories did not invalidate his earlier findings. In an addendum to his earlier work and in reference to
sexual abuse of children he states: "All this is true but it must be remembered that at the time I wrote it I had not yet freed myself from my overvaluation of reality and my low valuation of phantasy" (cited in Miller, 1986, p.41). Freud, like many before him, did not deny the reality of sexual abuse so much as its being of any import. Freud's legacy in this area, as shall be examined later, is a distorted contribution to mental health professionals' understanding and response to child sexual abuse.

Although there are some authors who persist in viewing child sexual abuse as a largely harmless event (Constantine, 1980; Henderson, 1983), studies over the past decade that have investigated the impact of sexual abuse have essentially corroborated the impressions of those clinicians specializing in the field, that sexual abuse is indeed traumatic. Finkelhor's (1986) decade long review of the empirical literature pertaining to the long-term effects of child sexual abuse is perhaps the most systematic and thorough examination yet to be undertaken of studies that investigate the sequelae of child sexual abuse. His findings are impressive given that the studies were looking at differences associated with an event that occurred from 5 to 25 years previously and that broad definitions regarding the nature of sexual abuse were used including single incidents, experiences in which no physical contact occurred, and experiences with non-relatives. Finkelhor identifies eight non-clinical studies where women in the general population, who are survivors of sexual abuse, have evident mental health impairment compared to non-victims (Bagley & Ramsey, 1986; Briere & Runtz, 1985; Finkelhor, 1979; Fromuth, 1983; Peters, 1984; Russell, 1986; Sedney & Brooks, 1984; Seidner & Calhoun, 1984). Of note, the first two studies are Canadian in origin. Adult survivors of child sexual abuse were found to significantly exceed non-victims in the following areas: depression, hospitalizations for depression, self-destructive acts, with suicidal ideation and suicide attempts, somatic symptoms such as anxiety attacks, insomnia, dissociation, and feelings of unreality, feelings of isolation, alienation, and low self-esteem, fear of men and
women, difficulty trusting others, vulnerability to sexual assault and to marrying physically and sexually abusive men, sexual adjustment difficulties and decreased sex drive, and alcohol and drug abuse. Other studies found in Finkelhor and elsewhere also show links between child sexual abuse and parenting difficulties, prostitution, eating disorders, and psychiatric diagnoses of Post-Traumatic Stress Syndrome, Borderline Personality Disorder, and Multiple Personality Disorder (Briere, 1984; Goodwin, McCarthy, & DiVasto, 1981; Herman & van der Kolk, 1987; Putnam, Post, & Guroff, 1983; Silbert & Pines, 1981; Wheeler & Walton, 1987). Important to this study, survivors of incest have been found to be particularly at risk of long-term mental health impairment with markedly more severe problems than have been found in sexual abuse survivors as a whole (Courtois, 1979; Herman, 1981; Meiselman, 1978). In summary, as Finkelhor (1986) states: "... as evidence now accumulates, it conveys a clear suggestion that sexual abuse is a serious mental health problem, consistently associated with very disturbing subsequent problems in a significant portion of its victims (p. 163).

It seems reasonable to believe that survivors of sexual abuse may experience a range of psychosocial problems that would either personally compel them to seek therapeutic assistance or, because of which, they would inadvertently or through advisement and referral gain entry to the mental health system. In addition, societal acknowledgement of and attention to child sexual abuse has precipitated the move by adult survivors to engage in therapy for the express purpose of dealing with their sexual abuse. It is assumed that many counsellors will be confronted with clients presenting with overt or covert sexual abuse issues. That therapy with this client population is a complex, arduous, and multi-faceted process has begun to be documented (Courtois, 1988; Evert & Bijkerk, 1987; Gil, 1988; Hyde, 1984). In relation to incest, Courtois (1988), for example, states: "Long-term treatment is often required due to the chronicity of the abuse, its impact on the developmental process and character of the victim, and the
time required to work with strong defenses and establish a therapeutic alliance" (p. 176). She further adds that incest treatment goals are rarely accomplished in less than two to three years particularly when survivors present with dissociative states, substance dependencies, and suicidal and self-destructive behaviors. Courtois also suggests that an incest survivor benefits from therapy that includes a range of treatment strategies and techniques drawn from theories of personality and psychotherapy and that therapists must be cognizant of, and prepared to work with, the multiple effects of the abuse dynamics on the therapy process. Of these effects, transference issues alone include survivors' fearing and mistrusting the therapist, projection of shame onto the therapist, self-sabotage by the client in order to bring about the expected rejection, the client double-binding the therapist, seductive and manipulative behaviors by the client, secretiveness due to feelings of guilt and responsibility, client's fear of abandonment and punishment, and rage and anger directed at the therapist. For therapy to even occur, however, a counsellor must initially acknowledge the sexual abuse of her client as a child with all of the ugliness and cruelty that that implies about some individuals in our society and particularly adults in care-taking positions or positions of authority. As suggested by Bass and Davis (1988), counsellors of survivors of sexual abuse must "be willing to believe the unbelievable" (p. 345). In addition, they must be open to, and capable of, in a non-judgemental fashion, working with the survivor. To what degree counsellors are prepared to do so is not clear as there are few empirical studies that have investigated counsellors' responses or readiness to work with adult sexual abuse survivors. There are, however, a number of reasons to suspect that many counsellors, and would-be counsellors, respond to sexual abuse survivors with anxiety, and poor coping processes and this will now be elaborated upon.

Counsellors and sexual abuse. There is, currently, an increasing amount of material devoted to the assessment, treatment and healing process of the adult survivor of
childhood sexual abuse that is being disseminated by clinicians specializing in the field (e.g., Bass & Davis, 1988; Courtois, 1988). That much of this material speaks to both the survivor and the counsellor would seem to indicate that as adult survivors are ready to engage in therapy, too few counsellors may be in a position to provide this service, and that counsellors, in general, may be particularly uninformed about working with survivors. In one of the few empirical studies that have investigated therapists' responses to adult survivors, Attias and Goodwin (1985) found, in their survey regarding professionals' knowledge and management strategies of child and adult cases of childhood incest, that although less than 20% professed the stereotypes of a few decades ago regarding sexual abuse, 86% of respondents said they wanted more training. As well the most common clinical problems cited in an open-ended question were problems managing the sequelae of incest in victims. In Hutchinson and McDaniel's experimental study (1986), therapists who worked with sexual abuse clients from a traditional framework (defined as "any therapist who may reinforce some of the societal attitudes and stereotypes which prevent women from gaining greater self-awareness, self-confidence and control over their lives" [p. 22]) were found to aggravate survivors' sense of guilt, shame and isolation. Twenty-one women who had been sexually assaulted and who had had therapy following this were interviewed as to the nature of their therapy and their satisfaction with it. It was found that, in the traditional therapies, which had been experienced by 13 women in the group, the abuse was hidden, redefined, and individualized, the survivor made to feel responsible, the therapist controlled the sessions, and that the woman's feelings of anger, shame, and vulnerability were either not discussed, or viewed as problematic. The 15 women who had experienced feminist therapies (defined as "any therapist that applies an awareness of the social, political, and economic constraints on women in her or his practice" [p. 22]), in contrast, reported that
they felt relieved of guilt, emotionally supported, their abuse validated, and confident that they had found a framework from which to understand their abuse.

The above mentioned authors, in addition to others (Courtois & Sprei, 1988; Haugaard & Repucci, 1988; Hutchinson & McDaniel, 1986; Miller, 1984), have expressed concern about counsellors' negative, and oftentimes psychologically damaging responses to sexual abuse survivors (e.g., dread and horror, minimization, denial, avoidance, unacknowledged countertransference reactions). Courtois (1988) has this to say about counsellors' reactions to a disclosure of incest:

Many therapists find themselves horrified when a client discloses incest because of the deviance it implies. The thought of a child being sexually coerced by and involved with a parent, in and of itself, is enough to be totally shocking. The details of the abuse are even more shocking, and those involving pleasurable, sadistic or violent aspects even more so. Thus, the most traumatic aspects of the incest and those most in need of ventilation and validation are the ones that cause the therapist the greatest degree of discomfort. Therapist discomfort often leads to defensive behavior, such as the therapist's changing the subject, subtly denying that the situation could have been that bad (even though doing so contradicts the therapist's emotional response), and encouraging the client to forget it and get on with her life. (p.230)

As presented within the context of her book, "Father-Daughter Incest", Herman (1981) reported that from her interviews with 40 sexually abused women who had sought treatment, including those with therapists who had worked with survivors of abuse, that many therapists were unsuccessful in accepting and treating the victim's problems. Therapists were commonly seen as resistant to raising the issue of sexual abuse with their clients: "Over and over we have heard the testimony of victims who longed for the opportunity to talk about their experiences with a helping person and who waited in vain
to be asked" (p. 178). Herman contends that the Freudian psychoanalytic tradition of
denial and disbelief in the face of clients presenting with a childhood sexual abuse history
has permeated the mental health professions. She also points out that most therapists not
only lack training in this area but are also resistant to asking questions about sexual abuse
with their clients because of personal discomfort in confronting their own feelings about
the issue. Additionally therapists do not like to feel helpless and for all these reasons too
often back away from this issue. She quotes two fully trained therapists confronted by a
client who talks about her incest: "I know I don't want to hear it. I have no idea what to
do with these cases. And I don't think I'm unusual." "When she told me about her father,
I didn't know what the hell to do with her. I felt I couldn't help..." (p. 181).

Herman also identifies defensive reactions that female therapists specifically may
be prone to when initially confronted by a sexual abuse victim. The female therapist, she
believes, is at risk of overidentifying with the victim and feeling overwhelmed by
feelings of helplessness and despair and of aggravating the patient's situation when the
therapist herself has a sexual abuse history that remains unresolved.

The female therapist who has not sufficiently mastered her feelings about
incestuous elements in her own childhood is not able to listen to an incest history
with the same calm curiosity with which she approaches other aspects of the
patient's experience. She communicates to her patients that the incest secret is too
special or too frightening to hear...(p.183)

Emerson (1985), as a counsellor educator, reports similar findings related to
female therapists and unresolved sexual abuse issues in a paper written for the
Department of Counselling at the University of Nevada. Otherwise competent
counselling students who were having difficulty in experiential classes and particularly in
working with families where sexual abuse had occurred were found to have their own
history of childhood sexual abuse. Among other signs of unresolved sexual abuse in
these counselling students, Emerson noted an unwillingness and fearfulness to discuss sexual issues with clients, excessive anxiety about practising being a counsellor, and an insistence upon staying on a more superficial, intellectual level with clients. Emerson (1988) also observed, in a follow-up article, that students, and particularly older students, generally required encouragement to discuss sexual issues with clients due to fears of being "rude" or "prying".

McConnell (1976) also reported that counsellors are uncomfortable discussing sexual issues with clients. In her study, 36 counsellor trainees who were approaching graduation, and who had a mean age of 32, completed the Sex Knowledge Inventory: Form X (McHugh, 1967), conducted a sex counselling interview, and completed the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1968) following the interviews. Trained raters were used to evaluate the level of empathy during the counselling session. Students were found to have intensive anxiety while sex counselling, very poor to inadequate knowledge about sex and an inability to express minimally facilitative empathic responses in relation to sex counselling. Pierce and Pierce (1985) concluded, from their analysis of sexual abuse hotline reports, that protective service workers were generally ill-equipped and uncomfortable with discussions of sexuality with the families of abused children. This study involved the analysis of 304 cases of childhood sexual abuse reports and was undertaken to increase the knowledge base of protective service workers. The authors suggested that service workers' discomfort with sexual matters could explain their finding that a large number of sexual abuse cases had been previously reported as physical abuse. As one third of these cases had been previously seen by protective services, and as 37% of the abusive families reported unsatisfactory sexual relationships, Pierce and Pierce note that "If discussing sex is avoided by the protective services workers, the family's need to protect and maintain a long-held family secret is supported and the abuse may have a greater
chance of continuing" (p. 43). Difficulties that counsellors experience in approaching clients about sexual concerns will obviously act as a further impediment to therapists' dealing with sexual abuse issues with their clients.

In summary, such factors as lack of training and opportunities for personal exploration of feelings and beliefs about child sexual abuse particularly as this relates to a personal history of sexual abuse, may contribute to therapists responding adversely to an adult survivor of sexual abuse. As has been noted by clinicians working in the field of sexual abuse, anxiety, varying degrees of discomfort, and avoidant-type coping responses are some of the ways in which therapists might react to a client who presents with sexual abuse issues. That a majority of therapists will undoubtedly encounter clients who have been sexually victimized as children seems clear given the high degree of prevalence of childhood sexual abuse and its demonstrably injurious outcomes for emotional and psychological well-being. As well, because of the nature of these sequelae (e.g., impairment in relationships and parenting, substance abuse, depression and suicide attempts) survivors are apt to become involved in mental health services through a variety of portholes--family services, social service agencies, community clinics, in-patient facilities, drug and alcohol centers. Thus, therapists may be poorly prepared to cope with this phenomenon and counsellors' responses to survivors of sexual abuse would seem to warrant further investigation.

In making the assumption that counsellors may feel threatened by clients who present with child sexual abuse issues, further exploration of the theoretical and empirical literature related to the effects of and responses to a situation that is viewed as threatening follows.

**Stress and Coping**

In his self-efficacy theory, Bandura (1977), a social learning theorist, proposed that perceived threats produce high emotional arousal and that people rely, at least in
part, on this physiological arousal in judging their level of anxiety and vulnerability to stress. One mediating factor, according to Bandura, is a person's appraisal of the instigating conditions for the arousal; if this arousal occurs in situations that are perceived as threatening then the visceral arousal is interpreted as fear. Perceived threats are seen as not only producing high emotional arousal but various defensive and avoidance manoeuvres as well, with anxiety and defensive behavior viewed as coeffects rather than causally linked. Because reactions of tension and visceral agitation are viewed as debilitating to performance this emotional arousal can elicit expectations of failure. As behavioural choices are governed in part by considerations of mastery and self-efficacy, "People will approach, explore, and try to deal with situations within their self-perceived capabilities, but they will avoid transactions with stressful aspects of their environment they perceive as exceeding their ability" (Bandura, 1977, p. 203).

Lazarus and Folkman (1984), whose theory of stress centers on cognitive appraisal and coping, view situational control appraisals as similar to Bandura's concept of self-efficacy. These appraisals refer to the extent to which a person believes that he or she can influence or alter a stressful encounter. What is drawn on, in the determination of this, are an evaluation of the demands of the situation, the person's coping resources and options, and ability to implement these. These "secondary" appraisals of coping options, with the "primary" appraisals of the "stakes" involved are seen to influence emotion and coping. Important to note, Lazarus and Folkman argue that emotion and cognition are inextricably linked, and causality is seen to be bidirectional. They also believe that cognitive appraisal not only underlies but is an integral feature of emotional states. They argue that: "cognitive appraisal always mediates emotional reactions to a greater or lesser degree, although emotions once generated can then affect the appraisal process" (p. 278).
These appraisal processes constitute important elements in "coping", defined by Lazarus and Folkman (1984) as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). They identify two forms of coping. Problem-focused coping is directed at managing or altering the problem causing the distress, and strategies here may be directed at the environment or the self. Of the former, coping efforts might include defining the problem, and generating, selecting, and implementing solutions. Related to the self, problem-focused coping might include learning new skills or behaviors, or shifting the level of aspiration. Emotion-focused coping, on the other hand, is leveled at regulating emotional responses to the problem and includes cognitive reappraisals or reframing, cognitive processes such as avoidance, minimization, distancing, selective attention, as well as processes that lend themselves to self-deception or reality distortion. Emotion-focused coping is seen to be more likely to occur when the threatening situation is perceived as not amenable to change or as outside of one's control. Lazarus and Folkman also suggest that people respond to stressful situations with both forms of coping and base this on findings from their investigation (Folkman & Lazarus, 1980) of the means by which 100 community adult residents coped with stressful daily living events. Both forms of coping, though, are seen to be hindered with increasing levels of threat: "The greater the threat, the more primitive, desperate, or regressive emotion-focused forms of coping tend to be and the more limited the range of problem-focused forms of coping" (p. 168).

Although Lazarus and Folkman (1984) make no predictions as to how problem- and emotion-focused coping may vary in frequency with differing levels of stress, they report a study by Anderson (1977) that suggests some possibilities. Anderson investigated the coping mechanisms of owner-managers whose businesses had been damaged by a flood. He found that with low levels of stress, both forms of coping
occurred with equal frequency, that problem-focused mechanisms were used with moderate ranges of perceived stress, and that emotion-focused forms of coping including defensive behavior predominated with high levels of stress.

To recapitulate, Lazarus and Folkman point out that the extent to which a person feels threatened is in part due to perceived adequacy of resources, and potential constraints limiting their use, and that, in a circular fashion, the level of threat in turn will affect how coping mechanisms will be utilized. The counsellor, then, who lacks training or experience in the area of childhood sexual abuse, and who is confronted by a client with a history of childhood sexual abuse, may not only appraise her situation as overwhelming and respond to it with anxiety, but this in turn may reinforce the tenuousness of her position and engender difficulties in coping. Further to this conceptualization, there is substantial empirical evidence (e.g., Glass et al., 1982; Safran, 1982; Schwartz & Gottman, 1976) that would seem to indicate that situations that are highly stressful or threatening do elicit negative affective and cognitive responses, specifically anxiety and negative self-statements, that interrelate with poor coping outcomes.

**Anxiety, self-statements, and coping.** It is widely accepted that most people respond to stressful situations with increased anxiety (Spielberger & Sarason, 1975). The state of anxiety has been described as "subjective, consciously perceived feelings of tension, apprehension, and nervousness accompanied by, or associated with, activation of the autonomic nervous system" (Spielberger & Sarason, p. 137). Studies have demonstrated significant correlations between this emotional state and certain types of cognitions, specifically those of negative thoughts or negative self-statements. An association between anxiety and negative self-statements and poor coping responses has also been demonstrated. Before proceeding to these studies some elaboration of the concept of negative self-statements is in order.
Meichenbaum (1977), Ellis (1973), and Beck (1970) were some of the first clinical researchers to demonstrate that internal cognitive processes could be accessed through an examination of a person's internal dialogue or "self-talk". This internal dialogue has been researched on a number of different dimensions but the most consistent findings are those elicited by the polarity dimension (Cacioppo & Petty, 1981). This classification comprises positive or favorable thoughts, negative or unfavorable thoughts, and neutral or irrelevant thoughts. Methods for assessing these thoughts or self-statements have variously included: recording methods where verbalizations are audio or videotaped; endorsement methods where inventories with sample self-statements are completed; sampling methods where a random sampling of thoughts is taken at pre-arranged times; and production methods where thoughts are retrospectively produced and usually in written form (e.g., thought-listing; Kendall & Hollon, 1981).

Studies employing a variety of cognitive assessment strategies have demonstrated significant correlations between negative self-statements, anxiety, and poor coping behaviors on such parameters as test anxiety, heterosocial anxiety, and assertiveness (Bruch, 1981; Cacioppo et al., 1979; Galassi et al., 1981; Glass et al., 1982; Safran, 1982; Schwartz & Gottman, 1976). In a sample of 231 male and female undergraduates in Galassi, Frierson, and Sharer's (1981) study, during an actual test situation at a North Carolina university, an analysis of variance revealed a significant main effect for level of test anxiety and negative thoughts. Test anxiety was measured by the Sarason Test Anxiety Scale (TAS; Sarason, 1978) and students' internal dialogue was assessed by the Checklist of Positive and Negative Thoughts (Galassi et al., 1981). It was found that negative thoughts increased in a linear fashion with test anxiety level (i.e., low, moderate, and high test anxiety). A significant main effect was also obtained on test grade and test anxiety, with low test anxious students receiving significantly higher test grades than high test anxious students.
With reference to assertiveness, in Schwartz and Gottman's (1976) study, 101 male and female college students were assigned to low, moderate, or high assertive groups on the basis of their Conflict Resolution Inventory (CRI; McFall & Lillesand, 1971) scores. In response to situations requiring refusal of an unreasonable request, low assertive subjects reported greater nervousness than high assertives, with moderate assertives falling midway between. Significant differences were also found among all groups on negative self-statements, as measured by the Assertiveness Self-Statement Test (ASST; Schwartz & Gottman, 1976), with low assertives reporting the most and high assertives the least. Safran (1982) and Bruch (1981) reported similar findings in their studies on assertiveness. In Safran's study 28 individuals role played nine interpersonal situations calling for assertive responses. Positive and negative self-statements were measured by the ASST. High negative self-statement subjects reported significantly more anxiety during role plays than did low negative self-statement subjects and were rated by judges as exhibiting significantly more non-verbal anxiety and performing significantly less assertively than low negative self-statement subjects. One interesting finding was that high positive self-statement subjects were rated as more irritable and brusque by judges. Safran suggests that these individuals may be coping with their anxiety by denying or distorting the impact of the threatening situation (i.e., role plays) where "a reduction in subjective anxiety is maintained at the cost of a general constriction of the experiential field" (p. 224).

In Glass et al.'s (1982) study into social anxiety, 40 high and 40 low socially anxious undergraduate women were presented with difficult social situations. Negative self-statements, as measured by the Social Interaction Self-Statement Test, which was developed and validated as part of this study, were found to correlate negatively with skill and positively with anxiety on subjects' self-evaluations. The same finding occurred with confederates' and judges' behavioral ratings of skill and anxiety. In Cacioppo et al.'s
study (1979), 137 male psychology students were screened to form high and low socially
anxious groups. They were subsequently told that they would be meeting a female
student although this in fact did not occur. Participants were administered the thought-
listing procedure, the state anxiety scale of the State-Trait Anxiety Inventory
(Spielberger, 1983) and semantic differential scales designed to assess subjects' attitudes
towards themselves and the impending interaction. The high socially anxious men
generated more negative self-statements and rated themselves more negatively, less
potent, and less active than did low anxious men. Although the men's actual social
performance was not assessed, the authors view their findings as consistent with prior
research that demonstrated that high and low socially anxious men differ less
behaviorally while interacting with women than in the frequency with which they expose
themselves to heterosexual interactions. They suggest that this behavioral avoidance acts
to reduce anxiety but ultimately reinforces nonrewarding asocial behavior.

In two recent studies that compared cognitive assessment methods (Halford &
Sanders, 1988; Myszka, Galassi, & Ware, 1986), negative self-statements, as measured
by the thought-listing procedure, were found to respectively differentiate maritally
distressed couples from non-distressed couples, and high heterosocially anxious women
from low socially anxious women. Halford and Sanders' (1988) study involved 16
distressed couples and 20 non-distressed couples who were instructed to engage in
problem-solving interactions. On both cognition measures used (i.e., thought-listing and
video-assisted recall) there were significantly fewer partner-referent and self-referent
positive cognitions, and more partner-referent negative cognitions reported by distressed
than by non-distressed couples. In Myszka et al.'s study, 32 high heterosocially anxious
and 32 low heterosocially anxious college women were given the experimental task of
engaging with a male confederate. Negative self-statements were measured by the
thought-listing procedure and the Social Interaction Self-Statement Test (SISST; Glass et
al., 1982), and subjective distress by a self-report comfort scale ranging from extremely panicked or anxious (1) to totally calm or relaxed (7). Significant correlations were found between negative self-statements and irrational beliefs, subjective discomfort, and self-evaluation on the SISST. With thought-listing, correlations were limited to a moderate, significant correlation ($r = .50$) between negative self-statements and subjective distress. There were significantly more negative self-statements made by the high heterosocially anxious women than the low socially anxious women on both cognitive measures.

In examining these studies as a whole, it is clear that positive and negative self-statements have varying associations with anxiety and coping outcomes. Although some studies found inverse correlations between positive self-statements and anxiety, and positive correlations between positive self-statements and performance ratings (Galassi, et al., 1981; Halford & Sanders, 1988; Myszka et al., 1986) these effects tend to be weaker than those associations found with negative self-statements. Other studies have found that positive self-statements have not been related to anxiety or coping processes (Bruch, 1981; Cacioppo et al., 1979; Heimberg, Chiauzzi, Becker, & Madrazo-Peterson, 1983) leading one researcher to conclude that "while the absence of negative self-statements is related to positive psychological adjustment, well-adjusted individuals do not necessarily employ a high frequency of positive self-statements" (Safran, 1982, p. 223). Others have viewed the seemingly more potent effects of negative self-statements in terms of "the power of non-negative thinking" and see this as central to coping, and positive adjustment (Kendall & Hollon, 1981).

Still other researchers have approached the positive-negative dichotomy in the internal dialogue from a different perspective, one that is more integrative, albeit more complex (Kendall & Korgeski, 1979; Schwartz, 1986; Schwartz & Garamoni, 1986, 1989; Schwartz & Michelson, 1987). What has been noted by these researchers is an
asymmetry in the frequency of positive and negative self-statements. What has emerged is Schwartz and Garamoni's (1986) "States of Mind" model. They propose that functionally optimal states of mind consist of a precise balance of positive and negative conditions that closely approximates the "golden section" proportion of .62 (i.e., positive cognitions constitute .62 of the total internal dialogue, negative cognitions, .38).

The golden section is defined as the ratio that is obtained between two parts when the smaller part is to the larger part as the larger part is to the whole, which occurs when the smaller part is 62% of the larger, and the larger part, 62% of the whole (Benjafield & Adams-Weber, 1976). Social psychologists Benjafield and Adams-Webber hypothesized that "Whenever subjects differentiate things into two, they will tend to do so in a way that approximates the golden section" (p. 12). Schwartz and Garamoni (1986) cite Adams-Webber's 1982 review of a number of authors' work with bi-polar constructs in proposing that the golden section proportion generalizes across various methods of measurement, and different age and cultural groups. In relation to psychopathology and coping with stress, Schwartz and Garamoni (1986) propose that the greater frequency of positive judgments (approximately 62% of the internal dialogue), in the functional mind set postulated by the golden section ratio, provides for a background of positive psychological bias; the less frequent negative thoughts (approximately 32% of the internal dialogue) prove to be maximally striking in standing out as a "figure" against a positive "background". This is seen as an adaptive way of processing information as it "allows the person to bask in the warm glow of moderate positivity, while being optimally set to notice and deal with threatening events" (Schwartz & Garamoni, 1986, p. 14).

Following their overview of 27 studies where functional and dysfunctional groups were compared on measures of positive and negative cognitions, Schwartz and Garamoni (1986) identified functional and dysfunctional groups as characterized by different ratios
of positive to negative cognitions. The States of Mind model, with its five distinct states of mind, reflects this. The "positive dialogue" (PD) is that internal dialogue that is seen to be functional, and is characterized, as has been stated, by an asymmetrically balanced structure of .62 mean proportion (positive/[positive + negative]) of positive statements to .382 negative statements. The PD range is construed as between .56 to .68, and defines the adaptive, flexible, and resilient coper. Positive and negative self-statements are relatively equal in the "internal dialogue of conflict" (IDC) and the range is defined as .45 to .55. This state of mind is viewed as mildly dysfunctional and is associated with ambivalence, conflict, indecisiveness, and stasis. In the "negative dialogue" (ND) the negative statements constitute .62 of the total dialogue, and the positive statements, .38, with the ND range defined as .32 to .44. This dialogue characterizes the moderately dysfunctional individual, one who is chronically tense, pessimistic, and avoidant. Positive self-statements predominate in the "positive monologue" (PM), forming over .69 of the total dialogue. This state of mind is exemplified by the hypomanic individual and is associated with grandiosity, denial, and unrealistic optimism. In an inverse fashion, negative self-statements predominate in the "negative monologue" (NM) and constitute over .69 of the total dialogue. This state of mind characterizes the very depressed, or panic stricken individual. Schwartz and Garamoni (1986) do note that brief periods of any of the maladaptive states of mind (i.e., ND, IDC, PM, NM) may be adaptive under certain circumstances.

Neutral self-statements are conspicuously absent from Schwartz and Garamoni's States of Mind model, and although they are included in some production methods and recording methods of measuring cognitions (e.g., thought-listing procedure, think-aloud), they are not included in endorsement methods of assessing the internal dialogue (i.e., structured questionnaires in which participants can only respond to positive or negative
self-statements). In relation to the States of Mind model, Schwartz and Michelson (1987) have this to say:

Conceptually, one could argue that neutral or task-irrelevant thoughts might be included in the self-monitoring process as individuals balance their positive and negative cognitions. However, the golden section and the cognitive-behavioral studies that have supported the SOM model typically have confirmed the predicted set-points when only positive and negative cognitions are considered. This suggests that the algorithm used by individuals to balance their cognitions is set to ignore neutral thoughts, not because they serve no other function in the internal dialogue but because (with respect to positive/negative balance) they appear to be cognitive noise. (p. 560)

Neutral thoughts are not, then, necessarily irrelevant in the internal dialogue, according to these authors, but do appear inconsequential with respect to functional and dysfunctional states of mind.

There is much evidence, then, to suggest that when an individual is threatened, likely responses will not only include anxiety, but a markedly more negative internal dialogue as well as coping responses that are maladaptive, and poorly serve the situation (e.g., individuals behave in a less assertive manner, perform more poorly on test situations, are less apt to engage with others in heterosocial situations). Although reports are somewhat mixed, there is some indication in the empirical literature that counsellors who are anxious and subjectively distressed when counselling are in fact less effective counsellors. Although this issue does not seem to have been extensively examined studies that have investigated this will now be discussed.

**Anxiety and Counsellor Effectiveness**

Using different counselling effectiveness parameters researchers have demonstrated negative correlations between effective therapy and counsellor anxiety.
Bandura (1956) was perhaps one of the first clinical researchers to examine the therapist's anxiety level and its relationship to therapeutic competence. Anxiety measures were obtained on 42 psychotherapists and were determined by averaging the ratings assigned to a therapist by associates on three separate conflict areas (i.e., dependency, hostility, and sexuality). Competence was defined in terms of the therapist's ability to facilitate improvement in the adjustment of patients, and was assessed by supervisors who had extensive contact with the therapists. Significant negative relationships of moderate degree ($r = -.69$) were found between the psychotherapists' anxiety level and ratings of psychotherapeutic competence. Anxious therapists were seen to be less competent than therapists who were low in anxiety. No significant relationships, however, were obtained between therapists' self-ratings of anxiety and ratings of their psychotherapeutic competence.

Hogan (1969), in the development of his empathy scale, was able to demonstrate that, among other qualities, the empathy scale was predictive of low anxiety. Correlations between empathy scale scores and MMPI scale scores led him to infer that "high scorers on empathy will be sociable, optimistic, and free from unnecessary doubts and worries" (p. 312). It can be easily extrapolated from this study that empathy, a requisite skill in counselling, may be seriously hampered by a distraught and anxious counsellor.

Friedlander, Keller, Peca-Baker, and Olk (1986) exposed 52 male and female counsellor trainees' to a situation of role conflict and examined its effects on their self-statements, anxiety level, and performance. Self-statements were measured by the thought-listing procedure, anxiety by the State-Trait Anxiety Inventory (STAI; Spielberger, Gorusch, & Lushene, 1970) and performance scores were determined by judges' ratings of the comprehensiveness of subjects' treatment plan for the client they were about to counsel. Although no correlation was found between anxiety and self-
statements, a significant inverse relation emerged between anxiety and performance, leading the authors to suggest that anxiety is an important predictor of trainees' counselling-related behaviour.

Kelly, Hall, and Miller (1989) examined the influence of clarity of counsellor-stated intention, and counsellor anxiety as mediators of counseling outcome. Thirty-eight male and female counselling students were asked to recall their intentions associated with specific therapeutic interventions following a counselling session with a client. They also completed the STAI, and the Depth scale of the Session Evaluation Questionnaire (a measure of the perceived value and power of individual counselling sessions; Stiles & Snow, 1984). The quality of counsellor performance, as measured by the Counselling scale of the Counsellor Evaluation Rating Scale (CERS; Myrick & Kelly, 1971), and the clarity of counselor-stated intentions were rated by independent judges. Although counselor anxiety did not seem to be a salient variable in ratings of quality of counselling, anxious counsellors tended to rate their counselling less favorably than their less anxious peers, with counsellor anxiety negatively related to counsellor-rated depth. Counsellor anxiety was also negatively related to clarity of stated intentions. These results led the researchers to conclude that anxiety in the counselling session interfered with counsellors' cognitive operations.

These studies generally seem to support the idea that counsellor anxiety acts as an impediment to good counselling practice in such areas as counsellor empathy and clear thinking, development of intervention strategies and comprehensive treatment plans, and facilitation of improvement in adjustment of patients. The present study does not intend to examine counsellor performance or, specifically, the student counsellors' therapeutic effectiveness with adult survivors of sexual abuse. However, it can be extrapolated from the above studies that counsellors, who because of lack of training are in a state of
...disequilibrium when confronted by adult sexual abuse survivors, may be at risk of poorly serving their clients.

Summary

Empirical research has clearly demonstrated that childhood sexual abuse is a pervasive phenomenon in our society and that it has multiple and far-ranging emotionally and psychologically traumatizing effects for the adult survivor. Incest victims have been shown to be particularly at risk in this regard. Counsellors from an array of mental health services are apt to encounter sexual abuse survivors in the course of their work, as, not surprisingly, studies indicate that a significant percentage of women who present for therapeutic assistance have been sexually assaulted as a child. Research investigations into counsellors' responses to and capacity to work with clients who present with this disturbing issue have been scant. Research and clinical documentation does suggest, however, that counsellors may not only lack information about sexual abuse and, of relevance, sexuality, but that those who lack experience in working with the sexual abuse survivor may be uncomfortable and poorly able to cope with this clinical situation. Herman (1981) and Courtois (1988) in particular have documented their clinical observations and concerns regarding the inexperienced therapist who is confronted by the adult survivor of sexual abuse.

The theoretical literature, as conceptualized by Bandura (1977) and Lazarus and Folkman (1984), supports the idea that threatening situations may not only elicit anxiety, but poor coping responses. Increasing levels of threat are viewed as impairing both emotion-focused and problem-focused coping mechanisms with emotion-focused coping, including defensive and avoidant responses, predominating with high levels of threat and when situations are appraised as outside of one's control.

Experimental research in the areas of assertiveness, heterosocial anxiety, and test situations, has shown significant correlations between anxiety, negative self-statements,
and maladaptive coping responses. Based on Schwartz and Garamoni's (1986) States of Mind model, coping responses can also be construed as coping thoughts which are defined as the relationship between the positive and negative self-statements in the internal dialogue. The nature of the asymmetry or symmetry of positive and negative self-statements has been found to be predictive of functional and dysfunctional coping patterns. The use of an anxiety measure (i.e., the State-Trait Anxiety Inventory; Spielberger, 1983), and a measure of cognitions (i.e., the thought-listing procedure; Cacioppo & Petty, 1981), seems appropriate in the determination of counselling students' anxiety and coping responses to a client who presents as a sexual abuse survivor. Counsellor anxiety has also been found to be correlated with factors that negatively impact on the counselling process. It can be surmised, then, that counselling students who respond with high anxiety and poor coping responses to clients with a history of childhood sexual abuse, may not only be in jeopardy of being ineffectual counsellors, but with a client population who can ill-afford this type of therapeutic treatment.

Although many researchers have now begun to investigate the diverse factors involved in sexual abuse (e.g., incidence, effects, risk factors), there are, as far as this author is aware, no empirical studies that have examined counsellors' responses, from the counsellors' perspective, to clients who present as sexual abuse survivors. Given the prevalence of sexual abuse, and the likelihood that many counsellors will encounter sexual abuse survivors in their caseload, counsellors need to be aware of personal reactions that could jeopardize the counselling process.
Hypotheses

**Hypothesis 1.** Of the sexual abuse, physical abuse, and role conflict scenarios, it is hypothesized that exposure to a sexually abused client elicits the greatest increase in anxiety, from pre- to post-scenario, in counsellors, and exposure to a client experiencing role conflict, the least.

**Hypothesis 2.** Of the sexual abuse, physical abuse, and role conflict scenarios, it is hypothesized that exposure to a sexually abused client elicits the greatest increase in the proportion of negative self-statements, from pre- to post-scenario, and exposure to a client experiencing role conflict, the least.

**Hypothesis 3.** It is hypothesized that there is a moderate significant positive correlation between anxiety and the proportion of negative self-statements to total self-statements for all participants post-video.
Method

Subjects

Sixty-three female counselling psychology students enrolled at the University of British Columbia served as participants. Eligibility criteria included being female, having had minimal or no training or experience in the area of sexual abuse, and completion of the basic interviewing skills course requirement to ensure a basic level of competency skills. The sample was delimited to women because the literature supports the concept that men may respond differently to sexual abuse issues or clients who present with this problem (Attias & Goodwin, 1985; Eisenberg, 1987). It was assumed that counsellors with training or experience in the area of sexual abuse would respond in a different manner than those without expertise.

Volunteers for the study were solicited in several ways. Eight counselling psychology classes were approached, with the permission of the instructors, and volunteers requested through the format of a questionnaire (see Appendix A). This questionnaire briefly explained the study, requested information regarding which counselling psychology courses students had taken, as well as any specialized training or experience they may have had. Of the latter request, students were asked to delineate prior training from a list of common client issues (e.g., substance abuse, suicide) within which were embedded the issues salient to the study, physical and sexual abuse. Twenty-three women were recruited in this manner. Forty participants were obtained via a counselling psychology department student list (see Appendix A for further details regarding recruitment breakdown). Students were informed of the study by telephone contact and those who indicated an interest in receiving information on the study were subsequently forwarded the questionnaire with a covering letter (see Appendix A). Students who decided to participate in the study returned the completed questionnaire in a self-addressed stamped envelope. Arrangements were subsequently made with them, by phone, for an appointment time for the study.
The incentive offered to students who participated in the study was a half-day workshop on a prevalent counselling issue, offered at the termination of the study. The nature of this workshop (sexual abuse) was revealed to each participant at debriefing.

The mean age of participants was 35.8 (SD=7.1), with a range of 22-50. Half of the participants were married or in a common-law relationship, a little over a third were ever single, and the remaining were widowed, separated, or divorced. Approximately 58% of participants were childless, with 36% having one or two children, and 6% having three to four children. Sixty-five percent of participants had no children living with them, while 32% had one or two children living in the same house and 3% had three or four children with them. Participants in the Master of Education (MEd) program and the Master of Arts (MA) program were approximately evenly distributed, with 42% and 47% respectively, and the remainder were in the diploma program or unclassified. Participants were distributed across the range of specialization available to them in the counselling program: 19% in adult, 23% in family, 10% in women, 13% in elementary, 5% in cross-cultural, 5% in higher education, 14% in adolescence, and the remaining 11% with no specialty area (i.e., unclassified or in diploma program). Participants enrolled on a full-time or part-time basis were approximately equal (47% and 53% respectively). Participants were also found in every year of the program: 38% in the first year, 20% in the second, 11% in the third, 6% in the fourth, 15% in the fifth, 5% in the sixth, and 5% with no designated year as they were unclassified students. One participant did not complete the demographic questions and for the category "year", data were missing on two participants. Table 1 contains the demographic and background data for each of the three groups (i.e., role conflict, physical abuse, and sexual abuse).

**Design and Procedures**

This study involved an experimental design wherein 63 female counselling student volunteers were randomly assigned to one of three experimental conditions, such
### Table 1

**Demographic Characteristics of Counselling Psychology Students by Group**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Role Conflict</th>
<th>Physical Abuse</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=21</td>
<td>n=20</td>
<td>n=21</td>
</tr>
<tr>
<td>Age</td>
<td>M  33.2, SD 7.2</td>
<td>M 36.7, SD 7.5</td>
<td>M 37.4, SD 6.2</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>42.9, SD 33.4</td>
<td>28.6</td>
<td></td>
</tr>
<tr>
<td>Married/common-law</td>
<td>38.1, SD 52.4</td>
<td>61.9</td>
<td></td>
</tr>
<tr>
<td>Divorced/sep/widowed</td>
<td>19.0, SD 14.3</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>61.9, SD 60.0</td>
<td>52.4</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38.1, SD 40.0</td>
<td>47.6</td>
<td></td>
</tr>
<tr>
<td>No. of children</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>61.9, SD 60.0</td>
<td>52.4</td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>38.1, SD 35.0</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td>-</td>
<td>14.3</td>
<td></td>
</tr>
<tr>
<td>No. living in same house</td>
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</tr>
<tr>
<td>None</td>
<td>71.4, SD 70.0</td>
<td>52.4</td>
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</tr>
<tr>
<td>1-2</td>
<td>28.6, SD 30.0</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td>-</td>
<td>14.3</td>
<td></td>
</tr>
<tr>
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<td>MA</td>
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<td>--------------------------------</td>
<td>----------------------</td>
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<td>-----------</td>
</tr>
<tr>
<td>Enrolled</td>
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<td>33.4</td>
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<tr>
<td>Specialty</td>
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<td></td>
<td></td>
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<tr>
<td>Unclassified</td>
<td>9.6</td>
<td>20.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Adult</td>
<td>19.0</td>
<td>20.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Family</td>
<td>23.8</td>
<td>25.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Women</td>
<td>9.5</td>
<td>10.0</td>
<td>9.6</td>
</tr>
<tr>
<td>Elementary</td>
<td>9.5</td>
<td>5.0</td>
<td>23.8</td>
</tr>
<tr>
<td>Cross-cultural</td>
<td>4.8</td>
<td>-</td>
<td>9.5</td>
</tr>
<tr>
<td>Higher education</td>
<td>4.8</td>
<td>5.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Adolescence</td>
<td>19.0</td>
<td>15.0</td>
<td>9.5</td>
</tr>
<tr>
<td>Enrollment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Full-time</td>
<td>52.4</td>
<td>40.0</td>
<td>47.6</td>
</tr>
<tr>
<td>Part-time</td>
<td>47.6</td>
<td>60.0</td>
<td>52.4</td>
</tr>
<tr>
<td>Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclassified</td>
<td>4.8</td>
<td>10.5</td>
<td>-</td>
</tr>
<tr>
<td>First</td>
<td>38.1</td>
<td>47.4</td>
<td>28.6</td>
</tr>
<tr>
<td>Second</td>
<td>14.2</td>
<td>21.1</td>
<td>23.8</td>
</tr>
<tr>
<td>Third</td>
<td>23.8</td>
<td>10.5</td>
<td>-</td>
</tr>
<tr>
<td>Fourth</td>
<td>9.5</td>
<td>-</td>
<td>9.5</td>
</tr>
<tr>
<td>Fifth</td>
<td>4.8</td>
<td>10.5</td>
<td>28.6</td>
</tr>
<tr>
<td>Sixth</td>
<td>4.8</td>
<td>-</td>
<td>9.5</td>
</tr>
</tbody>
</table>
\( n=20 \) as one participant in the physical abuse group did not provide demographic data except for that related to age, and marital status. \( n=19 \) for the physical abuse group as one participant did not respond to the specific question regarding year.
that 21 participants were in each experimental group. Participants were individually scheduled for the experimental procedure according to their availability and based on access to the clinic room that was used throughout the study. To ensure random assignation of students to groups it was determined that the first participant to undertake the study would be assigned to the role conflict group, the second participant, the physical abuse group, and the third, the sexual abuse group, with each participant thereafter assigned accordingly. This procedure was followed throughout the study.

Each experimental condition involved a video presentation of a client. In all three conditions the same client (an actress) speaks about problems for which she is seeking help. The variable that was manipulated and that differentiated each group was the client's inclusion of statements to the effect that she was sexually abused as a child, physically abused as a child, or was presently experiencing role conflict. The client's monologue was otherwise the same for each condition (see Appendix B).

All participants completed a thought-listing procedure (Cacioppo & Petty, 1981) to assess coping processes, and second, the State Form of the State-Trait Anxiety Inventory (Spielberger, 1983), a measurement of anxiety, before and immediately after each condition. Anxiety and coping processes constituted the dependent variables in this study.

Prior to the video presentation and the distribution of the inventories, each participant signed a "Participant Informed Consent Form" (see Appendix C). The "Procedures" section of the form also served to further explain to each participant what would be expected of them in the study. They were told that they would be viewing a 5-minute videotape of a client, that they would be asked to imagine counselling that client, and to respond in writing to questions about the tape. Anonymity was assured by having students generate their own code which they were asked to use on each form they completed.
Two additional questionnaires, Questionnaire 2 and Questionnaire 3 (see Appendix C) were administered to each participant following completion of the second anxiety assessment and constituted sources of data ancillary to the findings. Questionnaire 2 asked questions regarding participants' comfort and ability to work with the client they had just viewed. Questionnaire 3 consisted of questions regarding participants' personal experiences of role conflict, physical and sexual abuse. Finally, all participants were asked to complete a demographic form to obtain further descriptive data about the participants (see Appendix C).

The procedure, then, involved each volunteer student arriving at the designated room at a pre-arranged time. Each participant initially signed the "Participant Informed Consent Form" and subsequently completed the first thought-listing procedure form and the first anxiety inventory. She was then given information regarding the nature of the videotape she was about to see (see Appendix D) and was left alone to watch this videotape. Each participant then completed the second thought-listing procedure and the second anxiety inventory, and, following this, Questionnaire 2 and Questionnaire 3, and finally the demographic form. As each form was administered to the participants, the instructions were read aloud by the researcher, and, where appropriate, statements were clarified or elaborated upon (see Appendix D). Following this, the students were left alone to complete the form, and would then put each form into a closed designated box. They then signalled the researcher by hitting a bell. The exceptions to this process were when the participants completed the two timed thought-listing procedures. Debriefing of participants (see Appendix D) occurred following participants' completion of all questionnaires and inventories used in the study and their viewing of the videotape.

A pilot study was undertaken prior to this experimental study to uncover, and, where appropriate, remedy, potential procedural flaws. Nine female counselling psychology students, two of whom had had extensive experience with sexually abused
clients, volunteered for this project. Each student was administered all of the questionnaires and was presented with one of the videotapes. Changes in the procedural format were made when students noted instructions were confusing, or following observations by the researcher that a procedure could be simplified.

Materials

Materials consisted of three 5-minute video presentations of a client (an actress). The use of a video presentation of a client was chosen to reduce the risks inherent in repeated live presentations where, despite duplication of the verbal monologue by the client, subtle changes in the client's expression could have affected the students' responses to her. Although an actual client was preferable in establishing an authentic scenario, ethical considerations precluded the use of a real client with this particular design. However, by using an actress, all students were therefore exposed to the same person in each experimental condition, thus ensuring that their responses could not be attributed to interpersonal biases. In each of these video presentations the client, who faces the screen, is seen talking with a counsellor. She lists specific complaints and problems (e.g., somatic complaints, problems with interpersonal relationships) for which she is seeking therapy. The only difference in each of the videos, and the variable that is manipulated is the inclusion, by the client, of statements to the effect that she has been sexually abused as a child, physically abused as a child, or is experiencing conflict in her roles as a mother and a woman working outside the home. The actress who played the part of the client was a slim, 38 year old Caucasian woman, well-groomed and dressed conservatively for the videotaping.

As reported by clinicians and as found on the intake forms of a local community mental health team, the video case presentations included symptoms and presenting problems common to women who have been physically or sexually abused, or who are experiencing role conflict. The actress was hired on recommendation and, as determined
by two outside reviewers, was consistent in her expression of the material common to all three video presentations. These videotapes were then independently presented to two clinicians working in the field of sexual abuse. As it became evident that the most significant issue in each of the three scenarios (i.e., role conflict, physical abuse, sexual abuse) was not readily identifiable to the reviewers, the videos were subsequently altered to include the client specifically stating, in response to the counsellor's question, what she would most like to work on. These tapes were then re-submitted to the reviewers and the client's issue was then determined to be clear. These reviewers, in addition to two other clinicians, also independently agreed that the client's presentation in the sexual abuse scenario was quite plausible.

**Dependent Measures**

**The thought-listing procedure.** The thought-listing procedure (Cacioppo & Petty, 1981), a self-report device for obtaining and assessing cognitions, was utilized to assess the counselling students' coping thoughts. In this procedure participants are asked to record their thoughts relevant to some stimulus situation and to subsequently rate these as positive, negative, or neutral (see Appendix E for detailed instructions). Positive thoughts are defined as a person's thoughts, when confronted with a personally significant stimulus, that are positive toward or supportive of the self (e.g., "I can do this") or the stimulus (e.g., "I like this person"). Negative thoughts are defined as a person's thoughts, when confronted with a personally significant stimulus, that are negative toward or in opposition to the self or the message. Neutral thoughts are those thoughts that are irrelevant to, or neither favor nor oppose the self or the message.

For this study the stimulus involved at the time of the students' initial completion of the form (see Appendix E) was that of the anticipation of viewing a client and of subsequently having to complete questionnaires related to the client's presenting issue. The stimulus involved at the second completion of the form (see Appendix K), which
follows the video presentation of the client, is that of completing questionnaires related to the presenting issue of the client the student has just seen and heard.

The thought-listing procedure has gained popularity in empirical research because of its flexibility, and because it does not present a risk of overlooking relevant thoughts, or of biasing the person by suggesting thoughts not previously considered (Tarico, Van Velzen, & Altmaier, 1986). Specific to the relationship pattern of positive and negative self-statements that characterize functional and dysfunctional groups, the thought-listing procedure has been found to be comparable to other methods of cognitive assessment such as talking aloud, and thought-sampling, and across diverse situations, such as test anxiety, social anxiety, and with high and low assertives (Kendall & Hollon, 1981; Schwartz, 1986). This procedure has been seen to have predictive validity (Heimberg, Nyman, & O'Brien, 1987; Myszka et al., 1986) in that stressful stimuli are found to activate equivalent frequencies of positive and negative self-statements and that negative self-statements correlate significantly ($r = .50$) with subjective distress.

Cacioppo et al. (1979) found that two judges' ratings of listed thoughts obtained by the thought-listing procedure correlated at .95, demonstrating high interrater reliability. As well, using the thought-listing procedure, significant correlations were found between expert ratings (with thoughts listed in, and out of "context" i.e., in and out of the order in which participants listed them) and participants' self-rating of listed thoughts in Tarico et al. (1986) study. Participants were 107 students enrolled in rhetoric classes who listed their thoughts prior to giving a speech and the expert raters were graduate students in counselling psychology blind to the participants' ratings. Correlations were significant between the participants' scores and the experts' "context" scores, $r = .53$, $p < .001$, and the participants' scores and the experts' "random" scores, $r = .46$, $p < .001$. 
Cacioppo and Petty (1981) cite Cullen's (1968) study in providing evidence for reliability of the thought-listing procedure. In comparing the thought-listing procedure with that of the Likert and Thurstone attitude assessment scales, she found an average split-half reliability of .78 for thought-listing, and an average test-retest reliability of .64 for this procedure, reliabilities that she viewed as moderately high.

"States of Mind" model. Coping thoughts have been previously defined in this study as the relationship between positive and negative self-statements. Each individual score is calculated by dividing the number of negative self-statements by the total number of self-statements (i.e., positive, negative, and neutral self-statements) to give a proportional score. Further descriptive analysis will aid in the interpretation of coping thoughts following Schwartz and Garamoni's (1986) model for assessing inner dialogue. In their model, coping thoughts ratios are calculated by dividing the mean positive self-statements by the mean sum of positive and negative self-statements to give a proportional score. A functional or "positive dialogue" range is defined as .56 to .68, and is characterized by adaptive, realistic, coping behaviour. A mildly dysfunctional range or "internal dialogue of conflict" is defined as .45 to .55 and is characterized by ambivalence, indecisiveness, uncertainty, self-doubt, worry, and procrastination. A moderately dysfunctional range or "negative dialogue" is defined as .32 to .44 and is characterized by pessimism, guilt, impaired self-esteem and avoidance behaviour. Proportions falling above .68 or a "positive monologue", and below .32 or a "negative monologue", are also viewed as dysfunctional and are respectively characterized by unrealistic optimism and undiluted pessimism. In this study, coping thought ratios will be calculated by dividing the mean negative self-statements (as opposed to positive self-statements) by the mean sum of positive and negative self-statements. This is in keeping with the way in which the scores will be initially analyzed (i.e., the mean negative self-statements divided by the total number of self-statements [positive, negative, and
neutral]). Schwartz and Garamoni's functional and dysfunctional ranges would then be
found in the mirror images of these ranges such that a functional or "positive dialogue"
range would now be represented by a range of .32 to .44. A mildly dysfunctional range
or "internal dialogue of conflict" remains unchanged at .45 to .55 and a moderately
dysfunctional range or "negative dialogue" range becomes .56 to .68. As well,
proportions falling above .68 become a negative monologue and proportions falling
below .32 become a positive monologue, respectively characterized by excessive
pessimism, and unrealistic optimism.

State-Trait Anxiety Inventory. The State Form (Form Y-1) of the State-Trait
Anxiety Inventory (Spielberger, 1983) which was used in this study, is an assessment of
state anxiety and is viewed as anxiety which a person experiences in response to certain
specific conditions. Form Y-1 consists of 20 brief items to assess "how you feel right
now, that is, at this moment". The following are representative items from the state
scale: "I feel calm", "I am tense", "I feel upset". Subjects respond to each item by rating
themselves on the following 4-point scale: (1) "not at all" (4) "very much so".

Norms have been developed for a number of different groups including male and
female college freshmen, and college students enrolled in an introductory psychology
course. Scores can range from 20 to 80 and define a continuum of increasing levels of
anxiety. The scoring keys reverse the direction of the non-anxiety items so that a high
score does indeed suggest high anxiety.

Validity has been established in a wide variety of studies, many of which are
summarized in the manual (Spielberger, 1983). Test-retest reliabilities are low, as might
be expected, and for females, following a one hour interval, have been reported at .16.
Alpha reliability coefficients, as measured by K-R 20, for the normative samples, range
from .83 to .92. The State Form has been found to be a reliable measure of increases in
the state of anxiety resulting from experimental manipulations.
**Ancillary measures**

Students were asked to complete two additional questionnaires (i.e., Questionnaires 2 and 3) following administration of the second thought-listing procedure and the second anxiety assessment. The purpose of Questionnaire 2 was to obtain descriptive information regarding the participants' sense of comfort and ability to work with the client they had been exposed to, how long they expected to work with the client, and how competent they generally felt about their counselling skills. Questionnaire 3 asked the participants questions about the degree of importance they attached to receiving further training or information in the areas of role conflict, physical abuse, and sexual abuse. It also inquired about whether they had experienced any of these issues as a child or adult, and if so, to what extent they had worked through these.

**Data Analysis**

Descriptive statistics were calculated for anxiety and coping statements and for responses to ancillary data (i.e., Questionnaires 2 and 3). In order to test the first and second hypotheses two, repeated measures, 2-way (group x time) ANOVAs were used to examine the change over time in anxiety and coping thoughts among the three groups (i.e., role conflict, physical abuse, and sexual abuse). Time was the repeated factor (pre-video and post-video). The BMD4V computer program was used (Dixon, 1985). Hypothesis three was tested with a Pearson product-moment correlation between post anxiety and post negative self-statement proportions.
Results

Descriptive Statistics

No significant pre-group differences were found among the role conflict, physical abuse and sexual abuse groups with regard to demographic characteristics. Group differences on marital status (single, divorced vs. married), parental status (yes vs. no), program (MEd vs. MA), and year (unclassified, first vs. second to sixth) were tested with Chi-square analyses. None of these Chi-squares were found to be significant, $X^2(2, N = 63) = 2.41, <1, 1.41, 3.51, \text{all } p's >.17$, respectively. Group differences on age were tested with ANOVA and found to be non-significant, $F(2,59)=2.14, p>.12$.

The means and standard deviations, by group, for anxiety, and for the proportion of negative self-statements to total self-statements (i.e., positive, negative, and neutral self-statements) pre- and post-video are shown on Table 2. The mean anxiety scores for each group and for the combined groups (33.9; SD=8.4, pre-video) are similar to a sample of female undergraduate students assessed at the beginning of an experimental session and described as the normal condition ($M=37.2, SD=10.3$; Spielberger, 1983). The mean anxiety scores post-video (combined group score was 32.8, $SD=8.3$) are lower than the mean for the same sample of undergraduate women during an experimental condition designed to invoke anxiety (43.7, $SD=11.6$). Only two studies have been found that used the thought-listing procedure such that the relative negative self-statement scores could be calculated. Cacioppo et al. (1979) examined the effects of heterosocial anxiety and anonymity on the cognitive responses of 137 male psychology students and found a relative negative self-statement score of .33 for the high anxiety, low anonymity group, and a relative negative self-statement score of .16 for the low anxiety, high anonymity group. The students in the high anonymity group had their interviews with women via an intercom system, the students in the low anonymity group had face-to-face interviews with the women.
Table 2

Means and Standard Deviations for Dependent Variables, Negative Proportions, and Self-statements by Group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Role Abuse n=21</td>
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<tr>
<td></td>
<td>Physical Abuse n=21</td>
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</tr>
<tr>
<td></td>
<td>Sexual n=21</td>
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</tr>
<tr>
<td>Anxiety pre</td>
<td>34.1 7.7</td>
<td>32.2 8.4</td>
<td>35.3 9.1</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Anxiety post</td>
<td>31.8 7.1</td>
<td>32.5 7.7</td>
<td>34.0 10.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/(N+P+NE)\textsuperscript{a} pre</td>
<td>.38 .29</td>
<td>.43 .25</td>
<td>.42 .27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/(N+P+NE) post</td>
<td>.22 .25</td>
<td>.18 .24</td>
<td>.21 .20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/(N+P)\textsuperscript{b} pre</td>
<td>.48 .34</td>
<td>.56 .30</td>
<td>.54 .32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/(N+P) post</td>
<td>.31 .33</td>
<td>.26 .31</td>
<td>.25 .21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive ss\textsuperscript{c} pre</td>
<td>2.48 1.89</td>
<td>2.00 1.48</td>
<td>1.76 1.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive ss post</td>
<td>3.29 2.51</td>
<td>2.48 2.23</td>
<td>3.86 2.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative ss pre</td>
<td>2.24 1.79</td>
<td>2.48 1.47</td>
<td>2.52 1.89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative ss post</td>
<td>1.76 2.14</td>
<td>1.24 1.79</td>
<td>1.52 1.47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral ss pre</td>
<td>1.33 1.35</td>
<td>1.38 1.02</td>
<td>1.43 1.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral ss post</td>
<td>2.67 1.98</td>
<td>3.05 2.73</td>
<td>1.71 1.98</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
\( \frac{N}{N+P+NE} \) = the proportion of negative self-statements to total self-statements (i.e., negative, positive, and neutral self-statements). 

\( \frac{N}{N+P} \) = the proportion of negative self-statements to negative and positive self-statements (Schwartz & Garamoni's [1986] formula for determining functional and dysfunctional states of mind). 

\( \text{css} \) = self-statements.
Myszka et al. (1986), in their analysis of cognitive assessment methods with 64 high and low heterosocially anxious college women, found a relative negative self-statement score of .37 for the high anxiety group, and .18 for the low anxiety group. As can be seen from Table 2 the relative negative self-statement scores for the role conflict, physical abuse, and sexual abuse groups pre-video (combined mean score is .41, SD=.27) are closer, for those same proportions, to the high anxiety groups in the two studies just mentioned. The relative negative self-statement scores for the three experimental groups post-video (combined mean score is .20, SD=.23) are closer to the mean proportions found for the low anxiety groups in the two studies just described.

**Hypotheses**

In order to test hypotheses 1 and 2, state anxiety and the proportion of negative self-statements to total self-statements were examined by computing two 2-way, repeated measures, analysis of variances (ANOVAs) with time as a repeated factor (pre and post). Differences were examined between the three groups (i.e., role conflict, physical abuse, and sexual abuse). The effect of interest, group x time interaction, was non-significant for both anxiety and negative proportions (bothFs<1; see Table 3). The group effects were non-significant (both Fs<1). The time effect was significant for the relative negative self-statement scores, F(1,60)=22.17, p<.0001. An examination of the mean scores from pre to post showed that, unexpectedly, the relative negative self-statement scores decreased for all groups.

The third hypothesis, that for all groups combined, a positive, significant and moderate correlation exists between anxiety and the proportion of negative self-statements to total self-statements post-video, was tested with a Pearson product-moment correlation. The correlation between anxiety post-video and the relative negative self-statement scores post-video, for all groups combined, was significant and in the expected direction but of lower magnitude than expected (r=.21, p<.05; see Table 4).
Table 3

**ANOVA for Anxiety and Negative Proportions Pre- and Post-Video**

<table>
<thead>
<tr>
<th>Effect</th>
<th>Variable</th>
<th>F</th>
<th>DF</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time(^a)</td>
<td>Negative Proportions</td>
<td>22.17</td>
<td>1,60</td>
<td>.0001</td>
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<tr>
<td></td>
<td>Anxiety</td>
<td>1.72</td>
<td>1,60</td>
<td>.19</td>
</tr>
<tr>
<td>Group</td>
<td>Negative Proportions</td>
<td>&lt;1</td>
<td>2,60</td>
<td>.97</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>&lt;1</td>
<td>2,60</td>
<td>.61</td>
</tr>
<tr>
<td>Time x Gp</td>
<td>Negative Proportions</td>
<td>&lt;1</td>
<td>2,60</td>
<td>.72</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>&lt;1</td>
<td>2,60</td>
<td>.48</td>
</tr>
</tbody>
</table>

\(^a\)Time = pre- and post-video.
Table 4
Intercorrelations for Dependent Variables, Negative Proportions, and Self-statements
(N=63)

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety pre</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Anxiety post</td>
<td>.68</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. N/(N+P+NE)(^a) pre</td>
<td>.40</td>
<td>.40</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>4. N/(N+P+NE) post</td>
<td>-.03</td>
<td>.21</td>
<td>-.00</td>
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</tr>
<tr>
<td>5. N/(N+P)(^b) pre</td>
<td>.31</td>
<td>.32</td>
<td>.88</td>
<td>-.06</td>
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<td></td>
</tr>
<tr>
<td>6. N/(N+P) post</td>
<td>-.06</td>
<td>.17</td>
<td>.04</td>
<td>.88</td>
<td>.04</td>
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<td></td>
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</tr>
<tr>
<td>7. Positive ss(^c) pre</td>
<td>-.22</td>
<td>-.20</td>
<td>-.52</td>
<td>.25</td>
<td>-.69</td>
<td>.16</td>
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<td></td>
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<tr>
<td>8. Positive ss post</td>
<td>.10</td>
<td>.01</td>
<td>-.03</td>
<td>-.16</td>
<td>-.10</td>
<td>-.29</td>
<td>.17</td>
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<tr>
<td>9. Negative ss pre</td>
<td>.46</td>
<td>.38</td>
<td>.86</td>
<td>.08</td>
<td>.74</td>
<td>.17</td>
<td>-.27</td>
<td>.03</td>
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<tr>
<td>10. Negative ss post</td>
<td>-.04</td>
<td>.18</td>
<td>-.03</td>
<td>.95</td>
<td>-.10</td>
<td>.84</td>
<td>.30</td>
<td>-.10</td>
<td>.10</td>
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<tr>
<td>11. Neutral ss pre</td>
<td>-.25</td>
<td>-.28</td>
<td>-.53</td>
<td>-.20</td>
<td>-.16</td>
<td>-.04</td>
<td>-.12</td>
<td>-.05</td>
<td>-.41</td>
<td>-.16</td>
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<td>12. Neutral ss post</td>
<td>-.04</td>
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<td>-.20</td>
<td>-.53</td>
<td>-.05</td>
<td>-.38</td>
<td>.26</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)N/(N+P+NE) = the mean proportion of negative self-statements to total self-statements (i.e., negative, positive, and neutral self-statements). \(^b\)N/(N+P) = the mean proportion of negative self-statements to negative and positive self-statements (according to Schwartz & Garamoni's [1986] formula for functional and dysfunctional states of mind). \(^c\)ss = self-statements.

\(r_{.05,60} = .21\)
\(r_{.01,60} = .30\)
Post-hoc Analyses

It was expected that exposure to a sexually abused client would elicit the greatest increase in the proportion of negative self-statements to total self-statements from pre- to post-scenario. Repeated measures ANOVA revealed that the groups did not change differentially over time and, contrary to expectations, the relative negative self-statement scores decreased from pre-video to post-video. As these results were unanticipated it was decided to re-examine the data using the mean proportion of negative self-statements to negative and positive self-statements in lieu of the mean proportion of negative self-statements to total self-statements in the repeated measures ANOVA. Again, the effect of interest, group x time interaction, was non-significant (F<1). The only effect of significance was time, for the proportion of negative self-statements to negative and positive self-statements, F(1,60)=23.30, p<.0001. Again these relative negative self-statement scores decreased from pre- to post-video.

In light of the findings reported by Safran (1982) and Schwartz and Garamoni (1986), it was decided to test for differential change over time for the 3 groups using a repeated measures (pre, post) ANOVA with positive self-statements as the dependent variable. The effect of interest, group x time interaction, approached significance, F(2,60)=2.20, p<.12. Because of the exploratory nature of these data a post-hoc Scheffe's test was conducted and revealed that the sexual abuse group was different from the role conflict and the physical abuse groups with respect to an increase in positive self-statements from pre- to post-video.

It was also decided to examine the mean proportion of negative self-statements from the perspective of Schwartz and Garamoni's (1986) states of mind model. At pre-video the proportion of negative self-statements to positive and negative self-statements fall within the "States of Mind" range of an internal dialogue of conflict (see Table 5), for the role conflict, and sexual abuse groups. The mean score for the physical abuse group
Table 5  
Classification of Three Groups' Self-statements by Schwartz and Garamoni's States of Mind Model

<table>
<thead>
<tr>
<th>Classification</th>
<th>Group</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Role</td>
<td>Physical</td>
<td>Sexual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conflict</td>
<td>Abuse</td>
<td>Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Internal dialogue of conflict</td>
<td>.48</td>
<td>.54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(range .45 - .55)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative dialogue</td>
<td>.56</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(range .56 - .68)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive monologue</td>
<td>.31</td>
<td>.26</td>
<td>.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(range &lt;.32)</td>
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<td></td>
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</tbody>
</table>
at pre-video, although close to this range, is actually considered to fall within the
category of a negative dialogue (see Table 5). Of greater salience, the mean proportions
of negative self-statements to positive and negative self-statements for all three groups at
post-video was .31, .26, and .25 (see Table 2), and are considered to fall within the
category of positive monologue, represented by a range of <.32 (see Table 5), and
characterized by a state of mind that may be overly optimistic, grandiose, or in a state of
denial.

Given the above findings, further analysis of these data seemed warranted to
determine whether any significant differences in these functional and dysfunctional
categories could be found, with all groups combined, from pre- to post-video. Because
these proportions represent functional and dysfunctional states of mind and would thus be
classified as non-interval data, a Chi-square analysis was undertaken (see Table 6).
Although Schwartz and Garamoni (1986) identify five states of mind, only three are used
in this analysis as group size would have been too small for statistical comparison. Those
participants who had a negative monologue (> .68 proportion of negative self-statements),
a negative dialogue (within a range of .56 to .68 proportion of negative self-statements),
or an internal dialogue of conflict (within a range of .45 to .55 proportion of negative
self-statements) were collapsed into one category (labeled "negative"). Despite the
seemingly large changes noted by the drop from 38 participants with a negative dialogue
at pre-video, to 15 participants at post-video, and the increase from 13 participants with a
positive monologue at pre-video, to 38 participants at post-video, the Chi square analysis
showed no significant differences, $X^2(4, N = 63) = 3.95, p < .41$. Certainly the large
number of cells (i.e., four) with a frequency of less than five may account for this.
Because of the low magnitude found for the correlation between post anxiety and post
negative self-statement proportions, further associated correlations were examined (see
Table 4). The pre-video correlation between anxiety and the mean proportion of
Table 6

Crosstabulation of Functional/Dysfunctional Groups

<table>
<thead>
<tr>
<th></th>
<th>Post- Functional\textsuperscript{a}</th>
<th>Post- Negative\textsuperscript{b}</th>
<th>Post- Monologue\textsuperscript{c}</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Pre-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>5</td>
<td>9</td>
<td>24</td>
<td>38</td>
</tr>
<tr>
<td>Pre-</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Monologue</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>15</td>
<td>38</td>
<td>63</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Functional = a positive dialogue with a proportional range of .32 to .44 of negative self-statements to negative and positive self-statements.  
\textsuperscript{b}Negative = an internal dialogue of conflict, with a proportional range of .45 to .55 of negative self-statements to negative and positive self-statements, or a negative dialogue with a proportional range of .56 to .68 of negative self-statements to negative and positive self-statements, or a negative monologue with a proportional range of >.68 negative self-statements to positive and negative self-statements.  
\textsuperscript{c}Monologue = a positive monologue with a proportional range of <.32 negative self-statements to negative and positive self-statements.
negative self-statements to total self-statements was also found to be significant but at a
greater magnitude than that found at post-video (r=.40, p<.001).

Judges' Ratings

Because of the unexpected results related to the findings of higher proportions of
negative self-statements at pre-video than at post-video, and the generally high degree of
positive self-statements found at pre- and post-video it was further decided to have
judges rate the participants' self-statements as to their polarity (i.e., positive, negative, or
neutral). Two individuals in the counselling field were subsequently selected and trained
to rate self-statements according to the criteria set down by Cacioppo and Petty (1981).
Responses from the 9 participants in the pilot project were used as part of the raters'
preliminary practice session. Both judges rated all 126 thought-listing forms (pre- and
post-video), and an interrater reliability of 84% agreement was noted. Raters discussed
disagreements and mutually agreed upon classification. The pre- and post-video means
and standard deviations for judge-rated self-statements are found on Table 7.
Correlations between the participants' responses and the judges findings were calculated
using a Pearson product-moment correlation. At pre-video, significant and moderately
high correlations were found for positive self-statements (r=.68, p<.001), and negative
self-statements (r=.74, p<.001); a significant correlation of low magnitude was found for
neutral self-statements (r=.31, p<.01). At post-video, no significant correlation was
found between positive self-statements, as rated by judges and students themselves, and
correlations of lower magnitude were found for negative self-statements (r=.43, p<.001)
and neutral self-statements (r=.38, p<.01). The pre-video correlations compare favorably
with those of Tarico et al. (1986), r=.53, p<.001, when they compared scores from the
participants' responses in their study with those of the ratings of experts. Although the
post-video correlations were low or non-significant, an ANOVA using the judges'

Table 7

Means and Standard Deviations for Judge-rated Self-statements by Group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Role</td>
<td>Physical</td>
<td>Sexual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conflict</td>
<td>Physical Abuse</td>
<td>Sexual Abuse</td>
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<td></td>
<td>n=21</td>
<td>n=21</td>
<td>n=21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive self-statements pre</td>
<td>1.19 1.03</td>
<td>1.52 1.08</td>
<td>1.10 1.34</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Positive self-statements post</td>
<td>.95 1.24</td>
<td>1.00 1.30</td>
<td>.95 .97</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Negative self-statements pre</td>
<td>3.10 2.12</td>
<td>3.24 1.81</td>
<td>2.76 2.28</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Negative self-statements post</td>
<td>1.14 1.56</td>
<td>.95 1.36</td>
<td>1.71 1.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral self-statements pre</td>
<td>1.86 1.96</td>
<td>1.10 1.48</td>
<td>1.86 1.65</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral self-statements post</td>
<td>5.57 2.91</td>
<td>4.95 2.82</td>
<td>4.33 2.89</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
negative proportion ratings as the dependent variable found no significant differences between groups from pre- to post-video (F<1).

**Descriptive Statistics for Self-statements**

The means and standard deviations for negative, positive and neutral self-statements pre- and post-video, by group are listed in Table 2. The mean frequency of negative self-statements ranges from 1.24 to 2.52 across all three groups and is similar to that of the range found in the Cacioppo et al. (1979) study of 1.00 to 2.07 for, respectively, low socially anxious and high socially anxious men. However, for this study, the low end of the range, 1.24, was found post-video, where it was anticipated negative self-statements would be highest, and the 2.52 frequency was found pre-video where it was thought that negative self-statements would be lowest. In the Myszka et al. (1986) study described earlier, negative self-statements comprised 18.3% of the total self-talk for the low socially anxious women, and 36.5% for the high socially anxious women with negative self-statements rising with increased anxiety. When the mean frequencies of negative self-statements for each of the three groups in this study are converted to percentages, they are 37%, 42%, and 44% pre-video and 23%, 18%, and 21% post-video for, respectively, the role conflict group, physical abuse group, and sexual abuse group, with negative self-statements lower across all three groups post-video. This study's percentages can be considered in line with the Myszka et al. percentages if the pre-video condition is seen to be anxiety-provoking and the post-video condition non-threatening. This, of course, is the reverse of what was expected for this study.

In the only study found that actually reported the mean frequency of self-statements recorded by the thought-listing procedure, a range of 1.27 to 2.00 was found for positive self-statements for high and low socially anxious male students (Cacioppo et al., 1979). The upper end of the range of 1.76 to 3.86 for the present study is high in
comparison, and particularly when one considers that 3.86 represents the mean frequency of positive self-statements post-video for the sexual abuse group. In another study that reported the frequency of self-statements (as recorded by the thought-listing procedure) as percentages, positive self-statements constituted 23.8% of the internal dialogue for low heterosocially anxious women and 16.3% for high socially anxious women (Myszka et al., 1986). Positive self-statements decreased with increased anxiety. Calculating the mean frequencies of positive self-statements to percentages, for the present study, shows that for the role conflict group, physical abuse group, and sexual abuse group, the percentages are, respectively, 41%, 34%, and 31% pre-video, and 43%, 37%, and 55% post-video, with the greater frequency of positive self-statements occurring at post-video for all three groups. These percentages, and particularly the post-video percentages, are quite high in relation to those found in the Myszka et al. study, even when compared against the 23.8% found for the low socially anxious women. See Appendix F for a discussion on neutral self-statements.

**Correlations Between Variables**

When correlations between Schwartz and Garamoni's negative proportions, the self-statement variables, and the dependent variables, for all groups combined, were examined (see Table 3), a significant positive correlation was found between the pre-video proportion of negative self-statements to negative and positive self-statements and pre-video anxiety ($r=.31$, $p<.01$). Similarly, a significant positive correlation was found between pre-video negative self-statements and pre-video anxiety ($r=.46$, $p<.001$). When the relationships with these same variables were examined post-video, no correlations reached significance.

**Ancillary Data**

**Questionnaire 2.** The means, standard deviations and percentages, by group, for the responses to questions 1, 2, 3, and 5 of Questionnaire 2 are presented on Table 8.
Table 8

Participants' Responses to Client, and Sense of Competency, by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Role Conflict</th>
<th>Physical Abuse</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchor</td>
<td>%</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Not at all</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Only slightly</td>
<td>9.4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Somewhat</td>
<td>4.8</td>
<td>9.5</td>
<td>33.3</td>
</tr>
<tr>
<td>Moderately</td>
<td>42.9</td>
<td>52.4</td>
<td>47.6</td>
</tr>
<tr>
<td>Very</td>
<td>42.9</td>
<td>38.1</td>
<td>14.3</td>
</tr>
</tbody>
</table>

How comfortable do you feel about working with this client?\(^a\) (1-5)

<table>
<thead>
<tr>
<th>Anchor</th>
<th>%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.19</td>
<td>.93</td>
<td>4.29</td>
<td>.64</td>
</tr>
<tr>
<td>3.71</td>
<td>.78</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How likely is it that you have the skills to work with this client?\(^b\) (0-100)

<table>
<thead>
<tr>
<th>Anchor</th>
<th>%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.24</td>
<td>20.03</td>
<td>62.38</td>
<td>22.11</td>
</tr>
<tr>
<td>60.24</td>
<td>19.40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: \(^a\) Scale: 1 = Not at all, 5 = Very
Note: \(^b\) Scale: 0 = Not at all, 100 = Very
How likely is it that you have the skills to facilitate her working through her presenting problem? (0-100)

<table>
<thead>
<tr>
<th></th>
<th>75.10</th>
<th>17.44</th>
<th>64.29</th>
<th>22.49</th>
<th>66.19</th>
<th>17.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-</td>
<td>4.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>4.8</td>
<td>9.5</td>
<td>4.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>4.8</td>
<td></td>
<td>4.8</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>50</td>
<td></td>
<td>4.8</td>
<td>14.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>9.5</td>
<td>23.8</td>
<td>28.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>19.0</td>
<td>23.8</td>
<td>14.3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>72</td>
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<td></td>
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</tr>
<tr>
<td>75</td>
<td>4.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>23.8</td>
<td>23.8</td>
<td>14.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>19.0</td>
<td>4.8</td>
<td>19.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>9.5</td>
<td>4.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How competent do you generally feel about your counselling skills? (1-5)

<table>
<thead>
<tr>
<th></th>
<th>3.75</th>
<th>.72</th>
<th>3.57</th>
<th>.75</th>
<th>3.86</th>
<th>.73</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Only slightly</td>
<td>10.0</td>
<td>9.5</td>
<td>4.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat</td>
<td>10.0</td>
<td>28.6</td>
<td>19.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately</td>
<td>75.0</td>
<td>57.1</td>
<td>61.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very</td>
<td>5.0</td>
<td>4.8</td>
<td>14.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(a\) (1-5) = 1 denotes "Not at all", and 5 denotes "Very".

\(b\) (0-100) = 0 denotes "Very uncertain", and 100 denotes "Very certain". \(c\) = one participant in the physical abuse group did not respond to this question, \(n=20\).
Questions refer to participants' sense of comfort with the client they had just viewed, with their ability to work with that client, and with their competency about their counselling skills. The mean combined score of participants in response to "How comfortable do you feel about working with this client?" was 4.06 ($SD=.82$) from a range of 1-5, with the anchors of (1) Not at all, and (5) Very. The mean combined score in response to "How likely is it that you have the skills to work with this client?" was 64.29 ($SD=20.67$) from a range of 0-100, with anchors of (0) Very uncertain, and (100) Very certain. The mean combined score in response to "How likely is it that you would be able to work with this client to facilitate her working through her presenting problem?" was 68.52 ($SD=19.47$) with a range of 0-100 with anchors of (0) Very uncertain, and (100) Very certain. The mean combined score in response to "How competent do you generally feel about your counselling skills?" was 3.73 ($SD=.73$) from a range of 1-5, with anchors of (1) Not at all, and (5) Very. Standard deviations were determined to be too high to detect statistically significant differences between groups.

Of the 21 participants exposed to the sexual abuse scenario, 16 (76%) indicated in the comments section of Questionnaire 2 that they felt uncertain about the issue of sexual abuse and would require further information, experience, or outside assistance in order to work with this client. The following quotes are some examples of this: "Would need more background in sexual abuse"; "Would like experience specific to survivors of sexual abuse"; "More comfortable working with her than in working with the problem... I would be learning as I went. More likely that I would acquire what I needed than that I have what's needed."; "Basic counselling skills I feel confident in but specific skills to sexual abuse - no!". Despite indicating a need for more resources or skills in the area of sexual abuse, 7 (44%) of the 16 participants scored 70 or above (from a range of 0-100) in response to "How likely is it that you have the skills to work with this client? or "How likely is it that you would be able to work with this client to facilitate her working
through her presenting problem?" (see Appendix F for responses). Of the 5 participants who expressed no such concerns about working with a sexually abused client, 2 made no comments at all, 2 were encouraged by the client's self-motivation, and 1 indicated she would look at a group counselling format.

Of the 21 participants exposed to the physical abuse scenario, 3 (14%) indicated in the comments section of Questionnaire 2 that they would need more training in this area and 1 participant "would refer this woman to someone who is specialized in physical abuse counselling". No participants in the role conflict group made comments of concern about working with a client with role conflict.

The percentages, by group, for the response to the fourth item of Questionnaire 2 are displayed on Table 9. The question referred to the length of time participants believed it would take for the client to work through her problem. Although a minimum and maximum time range was not specifically requested of the participants, many included a range of time in their responses and this is reflected in the design of the table (i.e., the lesser time and greater time noted by participants have both been included as the "minimum" and "maximum"). What is of interest in reviewing these tables is the gradual increase in time, from the role conflict group, to the physical abuse group, and to the sexual abuse group, that participants expect the client to take in working through her problem (i.e., the greatest amount of time the role conflict group estimated was >6 months to a year, the physical abuse group, >1 year to 2 years, and the sexual abuse group, >2 years). Interestingly, the sexual abuse scenario also elicited the shortest expected time (0 - 2 months) from a greater percentage of participants in this group than in the others. The sexual abuse scenario, as can be seen, had the widest range of responses of all three groups.

These data were examined more closely with regard to participants' own sexual abuse experience. It was found that, in the sexual abuse scenario, 3 of the 4 participants
Table 9

Participants’ Responses to: How Long Would You Expect the Client to Take in Working Through her Presenting Problem?

<table>
<thead>
<tr>
<th>Group</th>
<th>Role Conflict n=21</th>
<th>Physical Abuse n=19&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Sexual Abuse n=20&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants’ Estimate of Time Needed</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Minimum Required:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 2 mths</td>
<td>3</td>
<td>14.3</td>
<td>3</td>
</tr>
<tr>
<td>&gt;2 mths - 6 mths</td>
<td>17</td>
<td>80.9</td>
<td>11</td>
</tr>
<tr>
<td>&gt;6 mths - 1 year</td>
<td>1</td>
<td>4.8</td>
<td>4</td>
</tr>
<tr>
<td>&gt;1 year - 2 years</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>&gt;2 years</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Maximum Required:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 2 mths</td>
<td>1</td>
<td>4.8</td>
<td>-</td>
</tr>
<tr>
<td>&gt;2 mths - 6 mths</td>
<td>16</td>
<td>76.2</td>
<td>12</td>
</tr>
<tr>
<td>&gt;6 mths - 1 year</td>
<td>4</td>
<td>19.0</td>
<td>5</td>
</tr>
<tr>
<td>&gt;1 year - 2 year</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>&gt;2 years</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<sup>a</sup>Two participants did not respond.  <sup>b</sup>One participant did not respond.
who had indicated that they expected the client to take 2 months or less (at a minimum) to work through her issue had in fact been sexually abused themselves as a child (participants' personal experience of sexual abuse is evenly distributed across all 3 groups and is discussed under Questionnaire 3). One of these participants had indicated that she had worked through her own sexual abuse to a moderate extent (score of 4 from a range of 1-5, from "not at all" to "very"); the other two participants indicated that they had worked through their sexual abuse to the extent of "very" (score of 5). Of the 8 participants who expected the client to take between 2 to 6 months to work through her presenting problem one had been sexually abused as an adult and indicated that she had worked through this to the extent of "moderately". One participant from the 6 who expected the client to take between 6 months to a year had been sexually abused as a child, and the sole participant who expected the client to take between 1 year and 2 years had been sexually abused as an adult. Both women stated that they had worked through their abuse only to the extent of "somewhat" (score of 3). The participant who fell into the 6 months to a year category had recorded that she expected the client to take, at a minimum, a year, and stated that her own experience had influenced her time span estimation, in that she herself had been seeing a counsellor for the past year and was primarily at the stage of simply recognizing her issues and beginning to be willing to work on these. The sole participant who expected the client to take more than 2 years (she stated 5) had been sexually abused as an adult and indicated that she had worked through this to a moderate degree. She also stated, as part of her listed thoughts in the thought-listing procedure at post-video, that she had a friend who had been sexually abused, and that she remembered a discussion with two sexual abuse victims. Thus, this student's potentially broader understanding of the issue of sexual abuse and her lengthy estimation of time for the client to work through her issue, is in contrast to students who estimated the client to take less than 2 months to do so.
**Questionnaire 3.** The first, second, and third questions of Questionnaire 3 asks the participant how important she considers further training to be in the areas of role conflict, physical abuse and sexual abuse. Participants were asked to score their responses from a range of 1-5 with the anchors of (1) Not at all, and (5) Very. The frequencies and percentages, by group, and combined, are presented on Table 10. As can be seen a majority of participants from all three groups considered it to be very important to have further training in the areas of physical abuse and sexual abuse. Over 65% of participants from all three groups considered it to be moderately to very important to have further training in the area of role conflict; over 85% of participants from all three groups considered it to be moderately to very important to have further training in the area of physical abuse; and over 90% of participants from all three groups thought it was moderately to very important to have further training in the field of sexual abuse. When the mean scores for all three groups are combined, 44.4% of participants indicated that it was very important to them to have further training in role conflict, 63.5% to have further training in the area of physical abuse, and 71.4% in the field of sexual abuse.
Table 10

Participants' Responses to: "How Important is it to You to Have more Training/Information about Role Conflict? Physical Abuse? Sexual Abuse?" by Group and Combined

<table>
<thead>
<tr>
<th>Issue</th>
<th>Group</th>
<th>Anchor</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Conflict</td>
<td>Role</td>
<td>Not at all</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Only slightly</td>
<td>1</td>
<td>4.8</td>
<td>1</td>
<td>4.8</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n=21) Somewhat</td>
<td>5</td>
<td>23.8</td>
<td>2</td>
<td>9.5</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderately</td>
<td>2</td>
<td>9.5</td>
<td>2</td>
<td>9.5</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Very</td>
<td>13</td>
<td>61.9</td>
<td>16</td>
<td>76.2</td>
<td>18</td>
<td>85.6</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>Physical</td>
<td>Not at all</td>
<td>1</td>
<td>4.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Only slightly</td>
<td>1</td>
<td>4.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n=21) Somewhat</td>
<td>2</td>
<td>9.5</td>
<td>2</td>
<td>9.5</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderately</td>
<td>10</td>
<td>47.6</td>
<td>7</td>
<td>33.4</td>
<td>8</td>
<td>38.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Very</td>
<td>7</td>
<td>33.3</td>
<td>12</td>
<td>57.1</td>
<td>12</td>
<td>57.1</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Sexual</td>
<td>Not at all</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Only slightly</td>
<td>5</td>
<td>23.8</td>
<td>1</td>
<td>4.8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n=21) Somewhat</td>
<td>4</td>
<td>19.0</td>
<td>1</td>
<td>4.8</td>
<td>2</td>
<td>9.5</td>
</tr>
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<td>----------------</td>
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<td>---</td>
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<td>----</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately</td>
<td>4</td>
<td>19.0</td>
<td>7</td>
<td>33.3</td>
<td>4</td>
<td>19.0</td>
<td></td>
<td></td>
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<tr>
<td>Very</td>
<td>8</td>
<td>38.2</td>
<td>12</td>
<td>57.1</td>
<td>15</td>
<td>71.5</td>
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<tr>
<td>Combined</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(n=63) Not at all</td>
<td>1</td>
<td>1.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Only slightly</td>
<td>7</td>
<td>11.1</td>
<td>2</td>
<td>3.2</td>
<td>1</td>
<td>1.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat</td>
<td>11</td>
<td>17.5</td>
<td>5</td>
<td>7.9</td>
<td>4</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately</td>
<td>16</td>
<td>25.4</td>
<td>16</td>
<td>25.4</td>
<td>13</td>
<td>20.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very</td>
<td>28</td>
<td>44.4</td>
<td>40</td>
<td>63.5</td>
<td>45</td>
<td>71.5</td>
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<td></td>
</tr>
</tbody>
</table>
Participants' responses to the fourth question from Questionnaire 4 are found in Table 11. This question asked the participant if she had ever personally experienced role conflict, physical abuse, or sexual abuse, either as a child or as an adult. Over half the participants had experienced role conflict as a child, and over 80% had experienced role conflict as an adult. The experience of role conflict as an adult was fairly evenly distributed across all groups, with 18 or 86% of participants in both the role conflict group and the sexual abuse group reporting this experience, and 16 or 76% of participants in the physical abuse group stating they had had this experience.

One fifth of all participants had been physically abused as a child, with 3 of these women found in the role conflict group, 6 in the physical abuse group, and 4 in the sexual abuse group. Approximately one seventh of participants reported having experienced physical abuse as an adult: 3 women in the role conflict group, 2 in the physical abuse group, and 4 in the sexual abuse group. Two of these women had also been physically abused as a child. In effect 20 (32%) women had experienced physical abuse as a child or adult.

Almost one quarter of the women involved in the study stated that they had been sexually abused as a child with 6 women from the role conflict group, 5 in the physical abuse group, and 4 in the sexual abuse group. Over one seventh of all participants reported having experienced sexual abuse as an adult: 4 in the role conflict group, 2 in the physical abuse group, and 4 in the sexual abuse group. Seven or 70% of the 10 women who had reported having been sexually abused as an adult had also been sexually abused as a child. In otherwords 18 (29%) women were sexually abused either as a child or adult or both.

One third, or 5 of the 15 women who had been sexually abused as a child had also been physically abused as a child. Nine or 45% of the 20 women who had either been sexually abused as a child or as an adult had also been physically abused as a child or as
Table 11

Participants' Personal Experience of Role Conflict, Physical Abuse, and Sexual Abuse

<table>
<thead>
<tr>
<th>Experience</th>
<th>Yes</th>
<th>% of responses</th>
<th>No</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role conflict as a child</td>
<td>36</td>
<td>57.1</td>
<td>27</td>
<td>42.9</td>
</tr>
<tr>
<td>Role conflict as an adult</td>
<td>52</td>
<td>82.5</td>
<td>11</td>
<td>17.5</td>
</tr>
<tr>
<td>Physical abuse as a child&lt;sup&gt;a&lt;/sup&gt;</td>
<td>13</td>
<td>20.6</td>
<td>49</td>
<td>77.8</td>
</tr>
<tr>
<td>Physical abuse as an adult</td>
<td>9</td>
<td>14.3</td>
<td>53</td>
<td>84.1</td>
</tr>
<tr>
<td>Sexual abuse as a child</td>
<td>15</td>
<td>23.8</td>
<td>47</td>
<td>74.6</td>
</tr>
<tr>
<td>Sexual abuse as an adult&lt;sup&gt;b&lt;/sup&gt;</td>
<td>10</td>
<td>15.9</td>
<td>51</td>
<td>81.0</td>
</tr>
</tbody>
</table>

Note. One participant denied that she had experienced either physical or sexual abuse, but then responded to the question "To what extent have you worked through the physical abuse? sexual abuse? (her response, "only slightly" to both).

<sup>a</sup>One participant did not respond to the questions of experience of physical or sexual abuse, as a child or adult.  
<sup>b</sup>Another participant did not respond to the question of whether she had experienced sexual abuse as an adult.
an adult. In effect, 30 (48%) women in the study had experienced some form of violence either as a child or adult.

The frequencies and percentages of participants' responses to questions 5, 6, and 7 of questionnaire 3 are found on Table 12. These questions ask the participant to what extent they have worked through the issues of role conflict, physical abuse, and sexual abuse. Responses could range from not applicable to 5, with the anchors of (1) Not at all, to (5) Very. The most common response across all three issues was that of having worked through these issues to a moderate degree (score of 4 from a range of 1-5). Of those participants who had experienced role conflict, 43% reported that they had worked through this to a moderate degree, and 24% to the degree of "Very" (score of 5). Of those participants who had been physically abused, 62% stated that they had worked through this to a moderate extent, and 19% to the extent of "Very". Fifty-two percent of participants who had been sexually abused as a child or adult reported that they had worked through this to a moderate degree, and 19% believed they had worked through this to the degree of "Very". It is interesting to note that of those participants who had experienced any of the issues of role conflict, physical abuse, and sexual abuse a greater percentage of those who had been physically or sexually abused responded that they had worked through these issues to a greater degree than that reported by participants who had experienced role conflict.

**Correlations And Ancillary Data Variables**

When the interval data variables from the questions of Questionnaire 2 and 3 for all groups combined were correlated (Pearson product-moment correlation) with pre- and post-video anxiety, no significant correlations were found, not surprisingly, between these variables and pre-video anxiety. A significant negative correlation was found between the degree of comfort the participant felt about working with the client (#1 of Questionnaire 2) and post-video anxiety (r=-.39, p<.001). When this correlation was
Table 12

Extent to which Participants Worked through Issues (N=63)

<table>
<thead>
<tr>
<th>Anchor</th>
<th>Role Conflict</th>
<th>Physical Abuse</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% of total (n=63)</td>
<td>n</td>
</tr>
<tr>
<td>Not applicable</td>
<td>9</td>
<td>14.3</td>
<td>42</td>
</tr>
<tr>
<td>Not at all</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Only slightly</td>
<td>3</td>
<td>5.5</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat</td>
<td>15</td>
<td>27.8</td>
<td>1</td>
</tr>
<tr>
<td>Moderately</td>
<td>23</td>
<td>42.6</td>
<td>13</td>
</tr>
<tr>
<td>Very</td>
<td>13</td>
<td>24.1</td>
<td>4</td>
</tr>
</tbody>
</table>
examined for each of the experimental groups, significance was found for the sexual abuse group (r=-.56, p<.01) but not for the role conflict group or the physical abuse group. That is, greater comfort was associated with less anxiety for the sexual abuse group. A significant inverse correlation was also found between the extent to which participants thought they had the skills to work with the client that had just been presented to them (#2 of Questionnaire 2) and post-video anxiety (r=-.34, p<.01). This correlation did not, however, reach significance for any of the individual experimental groups. As well, a significant inverse correlation was found between the extent to which participants thought they would be able to work with the client to facilitate her working through her presenting problem (#3 of Questionnaire 2) and post-video anxiety (r=-.39, p<.001). When this correlation was examined for the individual groups, significance was reached in the sexual abuse group (r=-.56, p<.01) but not in either of the role conflict or physical abuse groups.

From Questionnaire 2 significant positive correlations were found between the degree of comfort the participant felt about working with the client, and how likely the participant had the skills to work with the client (r=.55, p<.001); between the degree of comfort the participant felt about working with the client, and the likelihood that the participant had the skills to facilitate the client working through her problem (r=.41, p<.001); and between the likelihood that the participant had the skills to work with the client, and the likelihood that she could facilitate the client's working through her problem (r=.84, p<.001). When individual groups were examined, significant positive correlations were found between the degree of comfort participants felt about working with the client and their ability to work with the client, for the role conflict group (r=.62, p<.01) and for the sexual abuse group (r=.73, p<.001). When the correlations between the degree of comfort the participant felt about working with the client, and the likelihood the participant had the skills to facilitate the client's working through her
presenting problem for the different groups were examined, a significant positive correlation was found for the sexual abuse group only ($r=.62, p<.01$).

When all the participants were considered as one group, significant positive correlations were found between the participants' sense of general competency about their counselling skills (#5 of Questionnaire 2) and the participants' sense of their ability to work with the client ($r=.33, p<.01$), and the participants' sense of their ability to facilitate the client's working through her problem ($r=.33, p<.01$). When the correlations for general competency, and ability to work with the client were examined within the three groups, significance was reached for the role conflict group only ($r=.76, p<.001$). For the correlation between general competency, and ability to facilitate the client working through her problem, significance again was only found for the role conflict group ($r=.67, p<.001$).
Discussion

This study examined counselling students' anxiety and coping processes when confronted with a video of an adult client who either presents with childhood sexual abuse, physical abuse, or role conflict. It was expected that exposure to a sexually abused client would elicit the greatest increase in anxiety and relative negative self-statement scores, compared with a client reporting physical abuse, or role conflict. It was also expected that there would be a moderate, positive correlation between anxiety and the relative negative self-statement scores in response to the client videos.

The following discussion focuses first on the relative negative self-statement findings, and next on the results related to anxiety. Contrary to expected findings the relative negative self-statement scores decreased, rather than increased, from pre- to post-video across all three groups. Differential change across time was not found for the three groups. As these findings were unforeseen and because of Safran’s (1982) and Schwartz and Garamoni’s (1986) suppositions regarding positive self-statements (i.e., that an excess was dysfunctional) post-hoc repeated measures ANOVA was conducted with positive self-statements as the dependent variable. A significant follow-up Scheffe's contrasts indicated that the sexual abuse group increased their positive self-statements, compared with the physical abuse, and role conflict groups.

To shed more light on these unanticipated findings I will explore the pre-video, then post-video negative proportion scores and positive self-statements, and provide an interpretation of these results based on Schwartz and Garamoni’s (1986) States of Mind model, and from ancillary findings.

Pre-video Coping Processes and Self-statements

At pre-video the negative self-statement proportions were found to be similar to that of high anxious groups in the Cacioppo et al. (1979) and Myszka et al. (1986) studies. Evidence that supports the idea that students were feeling threatened and stressed at pre-video is found in the statements listed in the first thought-listing
procedure, and in unsolicited comments made by the students at debriefing. Thoughts listed at pre-video included fears related to counselling performance and competency, to being judged, to being confronted with a client whose issue would be overwhelming to the student, and uncertainty and trepidation about the possibility, and nature, of deception used in the study (see Appendix F for examples). At debriefing, students also commented that the study setting, occurring as it did in an education clinic room, had reminded them of when they had been previously assessed and tested for their counselling skills and of how uncomfortable and stressful this had been. It could be surmised, then, that students' anticipatory distress regarding what they might be faced with in the study led to a disproportionately high ratio of negative self-statements to total self-statements pre-video. Although the mean anxiety score indicated low anxiety ($M=33.9$), there was a significant correlation between pre-video anxiety and pre-video negative self-statement proportions ($r=.41$, $p<.001$) providing some support for this notion.

Schwartz and Garamoni's "negative dialogue" and "internal dialogue of conflict". In light of the decrease in negative self-statement proportions from pre- to post-video, and the increase found in positive self-statements for the sexual abuse group, Schwartz and Garamoni's States of Mind model was explored to determine the usefulness of their classification system in explaining the change in positive self-statements and the high pre-video negative self-statements. The application of their model to this study does seem to strengthen the idea that students' coping processes were compromised pre-video. Using Schwartz and Garamoni's formula for classifying functional and dysfunctional states of mind (i.e., the proportion of negative self-statements to positive and negative self-statements) the negative proportions for the role conflict, physical abuse and sexual abuse groups were found to fall within the category of "negative dialogue" and "internal dialogue of conflict" ranges. The former dialogue is representative of moderate anxiety
and fear. The latter dialogue is characterized by ambivalence and uncertainty and a certain degree of stress, although it is understood that a modicum of doubt and even contradiction is needed in the processing of difficult situations (Schwartz & Garamoni, 1986). Students' pre-video recorded thoughts are reflective of this ambivalence and "pro and con" evaluation of their situation. One participant wrote the following statements: "Then I'm curious about what the client issue would be. Then wondering if I'd be evaluated with my response to the client. Then remembered that this is for Lynne's research and what the heck. Then curiosity again, hoping it wouldn't be an abuse situation. Then thought I'd just role with it and see what came. Then...".

Both dialogues are considered dysfunctional by Schwartz and Garamoni (1986) and are compatible with the finding of high proportions of negative self-statements to total self-statements pre-video and serve to reinforce the assumption that participants felt threatened or, at the very least, challenged, prior to actually seeing the videotape of the client. As noted by the recorded thoughts, students were not sure that they would not be deceived, judged or overwhelmed by the experimental procedure. Students' coping responses pre-video are in keeping with Lazarus and Folkman's (1984) view that both event uncertainty and uncertainty about receiving a noxious stimulus can be stressful and can lead to conflicting thoughts and feelings.

**Post-video Coping Processes and Self-statements**

The proportions of negative self-statements to total self-statements for all three groups at post-video were lower than those found at pre-video and similar to those found for low-anxiety groups in the Cacioppo et al. (1979) and Myszka et al. (1986) studies. There are a number of factors that may have contributed to these unexpected findings. It is conceivable that as students seemed in the process of "imagining the worst" pre-video that, short of exposing them to "the worst", they might have responded to any experimental procedure with some relief. It may also be that the design of the
experimental procedure was such that students did not feel threatened, as they might have in a real situation, given that they were only asked to "imagine" counselling the client. Too, it must also be asked whether students might have responded differently had, for instance, the client spoken more about her experience of having been physically or sexually abused, thus bringing her situation home, as it were, to the counselling student.

Schwartz and Garamoni's "positive monologue". Schwartz and Garamoni's (1986) States of Mind model offers another means by which these data can be interpreted. The application of their formula for classifying states of mind showed that all three groups fell into the "positive monologue" range at post-video. This is a range in which positive thoughts and feelings exceed what Schwartz and Garamoni have postulated as the optimal balance of approximately two-thirds positive cognitions to one-third negative cognitions. This state of mind is characterized by such features as grandiosity, denial, impulsiveness, and unrealistic optimism. There is some evidence to support the idea that counselling students', and particularly those in the sexual abuse group, may have been functioning with many of these features. First, the concepts of grandiosity and unrealistic optimism, and then denial, will be reviewed, initially as these apply to the sexual abuse group, and then to the physical abuse and finally the role conflict group.

Despite the fact that students lacked training and counselling experience with the issue of sexual abuse, and acknowledging that well over a majority commented that they would seek out additional aid in the process of working with a sexually abused client, close to 45% of those participants exposed to the sexually abused client were 70% to 100% sure that they had the skills to work with her. This figure rises to 76% if those participants who were 60% certain are included. Perhaps even more striking, close to half of these participants were 70% to 100% certain that they had the skills to enable the client to work through her sexual abuse. Again this percentage rises to 76% when
participants who were 60% sure are added. When one considers that work with incest survivors is a complex and demanding process for both client and therapist, involving transference and countertransference issues that the therapist should be cognizant of and prepared to address, a majority of students seem overly confident about their counselling abilities with respect to sexual abuse survivors.

Students' lack of awareness of the dynamics involved in working with an incest victim is exemplified by their estimation of the time it would take for the sexually abused client to work through her problem. Almost one-fifth of the students in the sexual abuse group believed that the client would have worked through her problem within 2 months, while over 50% of students thought that this would occur within 6 months, at both a minimum and maximum estimation. This time span falls alarmingly short of Courtois' (1988) clinical judgment that therapeutic goals for incest survivors are rarely accomplished in less than 2 to 3 years. The above findings do seem to suggest that many participants in the sexual abuse group were functioning from a position of grandiosity, in relation to counselling a sexual abuse survivor, borne out of being poorly informed about sexual abuse.

There is some indirect evidence that suggests that participants in the sexual abuse group may have also been in a state of denial with respect to their true feelings about working with a sexually abused client. The statistical evidence lends credence to the idea that the sexual abuse group responded differently than the other two groups. The ANOVA revealed an increase of positive self-statements, from pre- to post-video, for the sexual abuse group, compared with the other groups. It is difficult to explain why the sexual abuse group would, as a whole, increase their positive cognitions more than the other two groups unless one considers that this group may have been particularly sensitive about presenting themselves as non-judgmental and accepting counsellors. This would enable them to defend against personal feelings of discomfort related to working
with a sexual abuse survivor, and of judgments that they were insufficiently empathic as counsellors. Denial with awareness has been found to occur, and has been related to low stress levels (Heilbrum & Pepe, 1985). In Heilbrum and Pepe's study, 99 male and female college students' cognitive defenses were investigated. Use of these defenses was related to the amount of stress reported for the previous year. Denial scores were derived by initially asking students to indicate, categorically, whether listed traits were characteristic of them, and later to review the list and select those that had been arbitrary choices. The finding that the conscious use of denial was related to a distinctly low level of stress was unexpected. In noting that denial is considered an immature defense, the authors speculated that "there is something of value in retaining some of the deliberate magical thinking of children to hold in reserve for last-ditch obliteration of unpleasant realities" (p. 16). Whether or not these students are in a state of denial, it is in any case troubling that participants exposed to a sexually abused client, an issue about which they are relatively untrained, should be the participants who are the most optimistic about their ability to do the demanding and circumspect work involved in counselling such a client.

Participants in the physical abuse group could perhaps also be said to be overconfident with respect to working with a client who had been physically abused as a child. Over half of the these participants were 70% to 100% sure that they had the skills to work with that client despite having had no training or experience in this area. This fraction rises to three-quarters when those participants who were 60% sure are included. Over 55% of these participants were also 70% to 100% certain that they had the skills to enable the client to work through her problem. When the participants who were 60% sure about their skills are included the figure rises to 81%. Although not the focus of this study, childhood physical abuse has been documented to have such long-term effects as alcohol problems, depression, violent relationships, and physical and eating disorder problems with aspects of therapy involving trauma resolution work (Gil, 1988). Whether
participants actually have the skills necessary to work with this type of client is questionable; that they believe they do, given no prior training in this area, is a matter of some concern.

It can be proposed that the classification into which the sexual and physical abuse groups fall (i.e., positive monologue), according to Schwartz and Garamoni's model, is a viable way of interpreting the students' coping processes. What is not as clear is why the participants in the role conflict group should also fall into this category.

Role conflict is an issue with which participants were personally familiar and is indicated by the high percentage of participants who stated that they had experienced role conflict as an adult - 83%. This was also borne out by the numerous comments that participants made to that effect in the comments section following "To what extent have you worked through the role conflict". The following are only a few examples of these: "I am constantly working through role conflict - i.e., traditional female roles through socialization and my own feministic philosophy. It is probably a major theme in my life..."; "I believe that role conflict is a part of most women's lives..."; "Role conflict - I believe it to be a natural women's phenomenon"; "I feel role conflict is very pervasive - everyone experiences it but to varying degrees and in different ways". The correlations found, for the role conflict group alone, between the students' sense of general competency in counselling and both their ability to work with the client (r=.33, p<.01) and their ability to facilitate the client working through her problem (r=.33, p<.01) also perhaps suggests that students' basic counselling skills were deemed sufficient to work with a client presenting with role conflict. Thus, students could be viewed as being realistic in their appraisal of their abilities to work with this type of client. This group's scores did however fall into the positive monologue range although these scores are one decimal short (i.e., score of .31) of being within the "functional dialogue" range (i.e., .32 to .44). It may be that these participants were particularly pleased with the familiar
scenario with which they were presented given what they, and the other participants, were anticipating at pre-video. Their positive monologue could then reflect a temporary over-exuberance and even perhaps sense of elation. It must also be remembered that, as stated by Schwartz and Garamoni (1989), "temporary swings into the positive monologue are not necessarily dysfunctional" (p. 278).

It is also understood that students' faith in their counselling abilities with respect to sexual and physical abuse could, in fact, serve to insure that they would avail themselves of all personal and material resources necessary to work with clients presenting with these problems. As Bandura (1977) states: "...expectations of personal mastery affect both initiation and persistence of coping behaviour. The strength of people's convictions in their own effectiveness is likely to affect whether they will even try to cope with given situations" (p. 193). However, he also states: "Expectation alone will not produce desired performance if the component capabilities are lacking" (p. 194).

In reviewing this material, Schwartz and Garamoni's States of Mind model was helpful in illuminating broad differences from pre- to post-video, whereas ANOVA was useful in delineating differences between groups and over time.

Anxiety Scores

The hypothesis that anxiety would increase the most from pre- to post-video for the sexual abuse group was not supported. The anxiety scores in fact remained unchanged from pre- to post-video across all three groups and were similar to those scores of female students in a "normal" experimental condition. It is difficult to interpret these findings in light of the findings related to coping processes. The low anxiety scores pre-video are in some contrast to the high negative self-statement proportions found at pre-video. It is possible that students appraised their situation as both threatening and challenging, the latter in effect acting as a check on feelings of anxiety stemming from their uncertainty of what they could expect from the study. Lazarus and Folkman (1984)
include threat and challenge as components of what they term "stress appraisals" and do not see these as mutually exclusive. They both call for the mobilization of coping efforts but "challenge appraisals focus on the potential for gain or growth inherent in an encounter and they are characterized by the pleasurable emotions such as eagerness, excitement, and exhilaration, whereas threat centers on the potential harms and is characterized by negative emotions such as fear, anxiety, and anger" (p. 33). They also believe that the relation between these appraisals can change as the situation unfolds.

Appraisals of coping options and of the stakes involved are seen to be mediating factors in the nature of the emotional response. In relation to being in a position of having to first consider one possible outcome and then another, Lazarus and Folkman also have this to say: "When one cannot decide on a path of action, and closure is unavailable, fear, excessive worrying and rumination, and eventually [italics added] anxiety can result" (p. 92).

The low anxiety scores at post-video are in keeping with the interpretation accorded to the findings of low relative negative self-statement scores at post-video. If students are functioning from a position of overconfidence or denial it is assumed that, generally speaking, they will not be experiencing anxiety.

The third hypothesis, that there would be a significant positive correlation of moderate strength between anxiety and the proportion of negative self-statements to total self-statements at post-video, was partially borne out. This correlation was significant at p<.05 for a one tailed test but was not of the magnitude expected (r=.21). With regard to anxiety and negative self-statement proportions at pre-video there was a moderate significant positive correlation (r=.41, p<.001), but this was not found at post-video. This could perhaps be explained by the high frequency of positive self-statements at post-video which some authors have found to be inversely correlated with anxiety (Galassi et al., 1981; Halford & Sanders, 1988; Myszka et al., 1986).
Ancillary Data

The ancillary data have proved to be useful not only in clarifying or reinforcing findings related to the hypotheses, but in providing additional information relevant to the study, and particularly the area of sexual abuse. It is clear from the descriptive statistics and comments made in the Questionnaires, and from thought-listing statements, that at least some students from all groups were uncomfortable about the issue of sexual abuse, or working with a sexual abuse victim. In some cases they spoke in more general terms about concerns related to "abuse". In response to the question "How comfortable do you feel about working with this client?", 38% of the sexual abuse group stated they were not at all, only slightly, or somewhat comfortable compared to 10% of the physical abuse group, and 14% of the role conflict group for the same categories. Significant and moderate inverse correlations found between post-video anxiety and both degree of comfort about working with the presenting client, and ability to help the client work through her presenting problem, for the sexual abuse group only, does seem to suggest that at least some participants were affected by the presentation of a sexually abused client and felt constrained in their ability to effectively counsel her. Comments made by participants in the role conflict and physical abuse groups, in relation to sexual abuse, include the following: "I find the area of sexual abuse repugnant and I fear I would have difficulty listening to and hearing a client because I was upset..."; "I anticipated it might be an unpleasant or uncomfortable situation, e.g., child abuse" and "I realized that this was not about sexual abuse and that I was calm with this subject material"; "afraid of hearing a victim's story about sexual abuse which was physically damaging or disgusting, afraid that I may respond inappropriately to such stories due to my emotional reaction"; "Then curiosity again, hoping it wouldn't be an abuse situation". It seems clear that some students from all groups were distressed or at the very least uneasy by the idea of working with a sexual abuse survivor.
One out of 5 participants indicated that they had been physically abused as a child and almost one out of 4 participants reported that they had been sexually abused as a child. This latter statistic is in keeping with Finkelhor's (1986) review of prevalence rates but lower than that found by Russell (1986) although her sample involved women from the general population. There is some evidence to support the idea that at least some of the women who had been sexually abused had not sufficiently worked through their abuse and were possibly in a state of denial with respect to its effects. This can perhaps be deduced when one examines the differences in the extent to which all participants who had been sexually abused believed that they had worked through their abuse, compared to participants who had experienced role conflict. Sexual abuse, it can be assumed, has greater far-ranging and deleterious consequences than the issue of role conflict. Participants who had, however, been sexually abused, believed that they had worked through this problem to a greater degree than those participants who had experienced role conflict. The experience of role conflict was perceived as less resolved than having been sexually abused. Although the severity of the students' sexual abuse was not explicated, this finding is difficult to understand unless one considers that students had not as yet personally addressed this issue for themselves. What must also be considered, however, in the interpretation of students' lesser resolution with role conflict issues, is that role conflict may have been perceived by these women as an on-going issue in their lives, a socio-cultural issue not amenable to personal resolution.

What is of particular concern in relation to the concept of students functioning from a state of denial is the 3 (of 4) students who estimated that the sexually abused client would take 2 months or less to work through her problem. These students had been sexually abused as children and reported that they had worked through their sexual abuse to a moderate or "Very" degree (i.e., 2 participants reported "Very", or score of 5 from a range of 1 to 5, and the other reported "Moderate", or score of 4). It can be assumed that
had that been the case, these students' estimation of the time involved to work through sexual abuse would have been far greater. That these students are in a state of denial with respect to their own abuse and its effects upon them can be inferred. The same inference could perhaps be made of the single participant of 8 who had been sexually abused as an adult and who had estimated that the client would take between 2 months and 6 months to work through her problem. She believed that she had worked through her problem to a moderate (or score of 4 from a range of 1 to 5) extent. These responses are in some contrast to those of the 3 other women in the sexual abuse group who reported that they too had been sexually abused, one as a child and the other two as adults. Their estimation of the time it would involve for the client was from a minimum of 1 year to a maximum of 5 years. Two reported having worked through their abuse only to the extent of "Somewhat" (or score of 3) and one of these commented on how her own progress in therapy had influenced her suggested time span for the client. The other reported having worked through her sexual abuse to the extent of "Moderate" (or score of 4). This latter participant estimated that the client would take between 2 to 5 years. As these participants' time estimation for recovery from abuse were close to, or in keeping with Courtois' (1988), it can be extrapolated that these participants were more fully aware of the ramifications of their abuse and the time required for healing, both their own and that of the client's.

It is clear from the descriptive statistics of the ancillary data that students from all 3 experimental groups were greatly interested in obtaining further training and information in the areas of physical and sexual abuse, and particularly sexual abuse. Any comments made by participants to this effect generally referred to both physical and sexual abuse (i.e., neither physical nor sexual abuse tended to be singled out in the students' comments). This may at least in part be due to the design of the question sheet as students were asked to comment, as a whole, on the separate questions of the students'
interest in receiving more training in role conflict/physical abuse/sexual abuse. Comments generally related to the need for more training in the area of abuse because of the type of work participants were involved in, or because students believed them to be common, and therefore important counselling issues (see Appendix F for examples). Only two participants specifically commented that they were not interested in training related to the areas of physical and sexual abuse.

**Summary**

The hypotheses that female students confronted with a sexual abuse survivor would experience greater anxiety and poorer coping processes, as measured by relative negative self-statement scores, than colleagues confronted by issues both familiar and unfamiliar to them was not borne out. Post-hoc analysis did however reveal that the sexual abuse group reported more positive self-statements following the presentation of the client than either of the comparison groups. One interpretation of these results is afforded by the application of Schwartz and Garamoni's (1986) States of Mind model which considers that students were functioning from a position of grandiosity in relation to their ability to counsel a sexually abused client. That students were overly optimistic about their abilities may not in itself be construed as a maladaptive coping strategy. As noted in an article by Taylor, Collins, Skokan, and Aspinwall (1989), people with positive illusions of themselves not only feel happy but tend to show more creative thinking, react less adversely to stressful situations and exhibit more effective ways of dealing with these. Future research that focuses on positive self-statements and its relation to coping seems warranted. An examination of how positive illusions about counselling abilities may affect therapeutic performance could help to elucidate whether, and in what contexts, excessive positivity is effective or ineffectual.

Certainly there is much statistical and descriptive evidence that does demonstrate that despite a lack of training in this area many students perceived themselves as capable
of addressing this issue with their clients. Notwithstanding the above statements, this can be viewed with some concern given the complexities of working with a sexual abuse survivor and the many counselling pitfalls that can befall the uninformed therapist. Other students were obviously uneasy with the issue of sexual abuse even to the point of expressing revulsion at the idea of counselling a client with this issue. Most students did however identify a need for further training in this area. Certainly even minimal opportunities to explore this area with knowledgeable personnel could help students feel more comfortable with this issue, develop a more realistic appraisal of their skills and help ensure that students would undertake the necessary training prior to working with sexually abused clients.

Female counselling psychology students, like other women in the general population, were also found to have been sexually abused as children. What is of consternation is that at least some of these students can be seen to be unaware of, or, in a state of denial related to, the potential effects of their abuse. One can surmise that this would impact on their therapeutic approach with sexual abuse survivors, as they would be at risk of poorly appreciating, and underestimating, the effects of this developmental trauma. The concept that there may be a serious gap in these counsellors' ability to be sensitive to the distress experienced by these clients warrants further investigation.

Limitations

There are a number of limitations to this study which could in part explain the lack of support for the hypotheses. Many aspects of the design of the study could have diluted the overall impact of the client's presentation. An actress, as opposed to a real client, and a video performance, as opposed to a live performance, were used. Many students did comment at debriefing that they had considered that the client might be an actress although they denied that this had interfered with their ability to imagine counselling her. The participants were only asked to "imagine" counselling the client and
realized that they would not be called upon to do any actual counselling. This could have allayed their fears sufficiently that their responses were actually unrepresentative of thoughts and feelings in a comparable, but genuine, counselling situation.

Another limitation included the use of the author to conduct the experiment. This was done because of cost and time considerations. Independent research assistants blind to each participant's experimental group would have limited the possibility of prejudicing the participants' responses.

Results might have been biased given that responses from first year students and students at the completion of their studies were not differentiated due to insufficient numbers. Furthermore, results can only be generalized to female counselling students with little or no training in the area of sexual abuse. Inadequate numbers of male counselling students precluded their involvement in the study and this was unfortunate given that there is evidence that suggests that male and female counsellors respond differently to the issue of sexual abuse (Attias & Goodwin, 1985; Eisenberg, 1987).

**Recommendations and Implications**

Findings from this study suggest many areas for further study and some of these have been previously alluded to. The endorsement method of assessing internal dialogue may be more appropriate for a study of this design. For example, a coping inventory with items representative of thoughts and feelings of students confronted with familiar and unfamiliar client issues may be more effective than the thought-listing procedure in eliciting responses more amenable to statistical analysis. Further utilization of The States of Mind model in the assessment of counsellors' coping processes and performance, and using an array of cognitive assessment methods from which to apply this, could be helpful in delineating the extent to which Schwartz and Garamoni's classification system is a useful interpretive mechanism.
Counselling students might also respond differently to client issues dependent upon the actual presentation of the client. For instance, client presentations that are emotionally-laden may elicit quite different responses than those without affect despite identical content. According to clinicians who specialize in the field of sexual abuse, clients present with this issue in a variety of ways, from a range of covert to very direct, and from a presentation without affect to one that is guarded, filled with rage, pain, ambivalence, and/or confusion. There are at present no empirical studies that document this, and certainly no studies that examine counselling students' and counsellors receptivity to working with sexual abuse survivors based upon the client's initial delivery. This could have important ramifications in the training of students about sexual abuse.

Research that investigates counsellors and their responses to, and interactions with, sexual abuse survivors is, at best, at a preliminary stage. As there is some controversy about male therapists working with female survivors of father-perpetrated incest (personal communication - Jon Conte, June 14, 1989), empirical studies that examine male and female counsellors' attitudes and therapeutic approaches to sexual abuse victims are needed. Given the increasing numbers of survivors who are seeking therapy there is a need to empirically document this and to ascertain, within individual communities, the knowledge base and skill level of therapists in the area of sexual abuse. This could serve to substantiate the need for the implementation and public funding of sexual abuse training programs and the development of resources that could best address these clients' needs.

This study also has important implications for the training of counselling psychology students. There is an identifiable need, at least in the Counselling Psychology program at U.B.C., for students to be provided with sexual abuse training and instruction on violence-related issues, particularly as these affect women in our society. Students, minimally, need to be sufficiently informed about sexual abuse to be aware of
the complex dynamics involved in counselling those who present with this issue. Didactic educational sessions coupled with informal discussions with knowledgeable and non-judgmental faculty could not only provide students with much needed information but could help to allay students' fears about sexual abuse. Clinic supervisors should also be prepared to help students address this issue with clients who present, overtly or covertly, with sexual abuse. This would naturally have implications for the professional development of faculty who function as clinic supervisors.

It could be speculated that counselling students who have been sexually abused themselves and who have not had the benefit of counselling for this issue, may be at risk of minimizing or denying their clients' abuse. Certainly, as Courtois (1988), Herman (1981), and Emerson (1988) note, counsellors who are survivors of sexual abuse must be helped to seek counselling before counselling others. The trauma of sexual abuse, they report, especially when unrecognized, can impede effective counselling. However, the process of supervisors encouraging students with unresolved sexual abuse issues to seek therapeutic help is potentially fraught with difficulties, not least of which is the identification of these students, the possibility of discrimination, and students' resistance to such an approach when their readiness to deal with this very difficult process is at issue. Certainly, students may be more prepared to consider personal counselling when faculty deliver a clear, consistent, and constant message about the benefits, and oftentimes necessity, of counsellors' undertaking their own therapy as part of their preparedness for counselling others. Encouraging and supporting students in this process is vital to their sense of safety in bringing forward or acknowledging personal issues that may be interfering with their ability to respond effectively to their clients in clinic or supervised practicum.

As mentioned previously, informal discussion opportunities could also potentially serve as the means by which students, and particularly those who have been sexually
abused, could, in a manner similar to that described by Emerson (1988), develop their own support group. At the University of Nevada the counselling department established a support group for students. Instructors volunteered supervision support and advanced students led the weekly group. As group safety and trust were established students became more relaxed and felt supported in discussing such issues as childhood abuse. This format was seen as providing a starting place for student survivors to begin their own work, and of enabling counsellor educators to facilitate their students' engagement in personal therapy without becoming involved themselves in attempts to "fix" the student.

As stated at the outset of this paper, research in the area of sexual abuse is in its infancy. Given the devastating consequences of childhood sexual abuse and that mental health personnel are necessarily and increasingly involved in facilitating survivors' recovery, it is incumbent upon clinicians and researchers to investigate all aspects of this counselling process.
References


Appendix A

Student recruitment breakdown
Covering letter
Questionnaire 1
**Student Recruitment Breakdown**

Forty-five students were contacted through six counselling psychology classes. Of these, 15 women were subsequently recruited for the study: 10 were males and were thus ineligible, 14 women declined, and of the 21 women who were interested in participating, 6 had either had too much training or experience in the area of sexual abuse to be considered eligible for the study.

Two student orientation classes, one for part-time students and one for full-time students were approached. Eight women were recruited for the study from 17 completed questionnaires: 7 students were ineligible as they were male, and all 10 women agreed to participate but 2 were ineligible due to too much experience.

Students were also contacted via the counselling department student telephone list and 40 students were recruited in this manner. Of the 477 students listed, 108 (22.6%) were males, 171 (35.8%) could not be contacted due to incorrect telephone numbers, or because they lived out of town, 63 (13.2%) were ineligible because they had either left the program, did not have the necessary prerequisite, were doctoral students, knew about the study or had participated in the pilot project, 27 (5.7%) had too much experience or training in the field of sexual abuse, and 68 (14.3%) were unable or unwilling to participate in the study.
Dear (name of student)

I am presently seeking volunteers for my thesis research and would really appreciate any consideration you might give to being involved in this study. This study is designed to examine students' responses to different issues that clients may present with. It would involve approximately one hour of your time, at your convenience, and by using a code name known only to you, your responses would be completely anonymous.

If you are interested in volunteering for this study I would ask that you complete the attached questionnaire and forward it to me in the self-addressed stamped envelope. The information requested on the questionnaire is required for screening criteria and should take approximately 5 minutes of your time to complete. As the attached questionnaire was designed for use in a classroom setting I would ask that you ignore statements to the effect of "pretending to complete the questionnaire ..." (third paragraph).

I can appreciate that you may be involved in a number of classes and/or work activities at this time of year. However, if you can manage the time to participate in this study, in addition to being personally very grateful, you will be offered a half-day workshop on a topical client issue not presently addressed in the counselling psychology program.

Thank you for your time in this matter.

Sincerely,

Lynne Parisien
tel#
The researchers in this study are interested in how counselling students respond to particular types of clients. If you decide to participate in this study you will be asked to use a code name known only to you so that your responses can remain anonymous throughout the study. The study would involve approximately one hour of your time, at your convenience.

As a possible incentive to participating in this study we are offering a half-day workshop on a topical client issue not presently addressed in the counselling psychology program. The speakers at this workshop will be two individuals who work within the Mental Health community and who have substantial experience and knowledge in this area. Participants will be informed about the nature of this workshop at the completion of their involvement in the study. Findings from the study will be made available to all participants upon request.

If you are interested in volunteering for this study, please complete the following questions. If you are not interested in volunteering we ask that you pretend to complete the questions to help ensure your confidentiality and the confidentiality of those who wish to volunteer.

Please begin and where appropriate please print or place a checkmark ( √ ) beside your responses.

<table>
<thead>
<tr>
<th>Course</th>
<th>completed:</th>
<th>in progress:</th>
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</thead>
<tbody>
<tr>
<td>CNPS 362 (Basic Interviewing skills):</td>
<td>YES _ NO _</td>
<td>YES _ NO</td>
</tr>
<tr>
<td>CNPS 363 (Career Counselling):</td>
<td>YES _ NO _</td>
<td>YES _ NO</td>
</tr>
<tr>
<td>CNPS 365 (Introduction to Theories of Counselling):</td>
<td>YES _ NO _</td>
<td>YES _ NO</td>
</tr>
<tr>
<td>CNPS 578 (Counselling Theories and Interventions):</td>
<td>YES _ NO _</td>
<td>YES _ NO</td>
</tr>
<tr>
<td>CNPS 588 (Supervised Clinic):</td>
<td>YES _ NO _</td>
<td>YES _ NO</td>
</tr>
<tr>
<td>CNPS 598 (Field Experience - i.e. Practicum):</td>
<td>YES _ NO _</td>
<td>YES _ NO</td>
</tr>
</tbody>
</table>
Please indicate if you have received specialized training in any of the following areas. If yes, please indicate the time involved in this training, e.g., 3 hours, 1 day, 1 week, 6 months, etc. (Do not include any training that you may have acquired in this program.) We are asking you to identify any additional training you may have had because prior training in some of these areas may not make you eligible for this study.

We are also interested in any counselling experience you may have had where the client(s) has presented with any of the following issues. Where you have had counselling experience in any of the following areas, please indicate the number of clients seen (where this is a large number an approximation is quite adequate).

Grief and Bereavement: specialized training: YES ____ NO ____
if YES: ____________________________
        : counselling experience: YES ____ NO ____
if YES, no. of clients seen: ____________________________

Suicide: specialized training: YES ____ NO ____
if YES: ____________________________
        : counselling experience: YES ____ NO ____
if YES, no. of clients seen: ____________________________

Substance abuse: specialized training: YES ____ NO ____
if YES: ____________________________
        : counselling experience: YES ____ NO ____
if YES, no. of clients seen: ____________________________

Physical abuse: specialized training: YES ____ NO ____
if YES: ____________________________
        : counselling experience: YES ____ NO ____
if YES, no. of clients seen: ____________________________

Sexual abuse: specialized training: YES ____ NO ____
if YES: ____________________________
        : counselling experience: YES ____ NO ____
if YES, no. of clients seen: ____________________________

Juvenile Delinquency: specialized training: YES ____ NO ____
if YES: ____________________________
        : counselling experience: YES ____ NO ____
if YES, no. of clients seen: ____________________________
<table>
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<tr>
<th>Eating Disorders</th>
<th>: specialized training:</th>
<th>YES ____ NO ____</th>
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<tr>
<td>if YES:</td>
<td>: counselling experience:</td>
<td>YES ____ NO ____</td>
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<td>if YES, no. of clients seen:</td>
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<tr>
<th>Stress/Burn-out</th>
<th>: specialized training:</th>
<th>YES ____ NO ____</th>
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<td>: counselling experience:</td>
<td>YES ____ NO ____</td>
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<tr>
<td>if YES, no. of clients seen:</td>
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<tr>
<th>Remarried/step-families</th>
<th>: specialized training:</th>
<th>YES ____ NO ____</th>
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<tbody>
<tr>
<td>if YES:</td>
<td>: counselling experience:</td>
<td>YES ____ NO ____</td>
</tr>
<tr>
<td>if YES, no. of clients seen:</td>
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</table>

Please indicate whether you are interested in participating in this study:

YES ____ NO ____

If you have chosen to participate in this study then you will be contacted by phone within the week.

The following information is requested so that the researchers can contact you regarding the details of the study.

Name:  ___________________________

Sex:  F ____  M ____

Telephone number(s) where you can be contacted:
  Home  ______________  Work  ______________
Appendix B

The Client’s Monologue

Counsellor: "So how are you today Carol?"

Client: "Not great. I don't know exactly what's wrong --- all I know is I feel lousy and nothing seems to be going right in my life right now. I've got migraine headaches all the time and I don't sleep very well. The doctor gave me some pills and they're helping me a little. I also break out in rashes a lot and I've tried all different kinds of creams but they don't really seem to do anything. Actually it was my doctor who suggested I come here. It's weird too, everything seems to be going fine, and then all of a sudden nothing seems to work out. The people I work with aren't very friendly and my boss is driving me nuts, it doesn't seem to matter what I do, it's never good enough for him. Nobody else puts in as much overtime as I do, it just doesn't seem fair. Nobody listens to me either, they don't really want to hear about my problems."

Counsellor: "You're feeling really unsupported."

Client: "Yeah. My friends just say to me, "Oh Carol, don't be so sensitive," or "stand up for yourself," well, everytime I do that I seem to get into a fight with someone. Like with Paul, he's my husband, we're always getting into big arguments, and, of course, I always seem to lose. He thinks he's such a know-it-all most of the time, and, he's not often on my side, so my kids don't seem to listen to me either. I've got two kids, Sarah, she's seven, and Mike, he just turned ten. They're pretty good kids but I'm worried about Mike --- he always seems to be getting into trouble at school. His teacher seems nice, but, I don't know. And then, of course, there's my parents. They were over the other day for dinner, I just hate it when they come over, I only invited them 'cause it was Mom's birthday...."
[ . . . I don't know, maybe I just feel guilty about going back to work while the kids are still young and nobody at home has really been happy about me working, but I really needed to get working again, it was driving me crazy staying at home, but my mother was always home for me. I'm not sure what's right any more, staying at home, or working like I am now. (Role conflict scenario) . . . ]

[ . . . I don't know, maybe it's because my father is so aggressive; he still scares me. He used to beat us when we were little --- it didn't seem to matter how good we were, he'd always find some reason to hit us. He stopped doing it when I got older but I'm still afraid of him, his word is always the "law." (Physical abuse scenario) . . . ]

[ . . . I don't know, I've never gotten along very well with my parents, especially my father. He sexually abused me when I was younger. I saw an Oprah Winfrey show last month when I was home from work sick; it was about women who had been sexually abused, and I started remembering things . . . So, I'm not very comfortable now when I'm around my father. (Sexual abuse scenario) . . . ]

. . . So, I don't know what else to tell you, my friend's been telling me to get some help for a long time now and I kept thinking I could work things out myself, but, I just can't seem to do it and I'm tired of feeling lousy all the time . . .

Counsellor: "Carol, you've talked about alot of things, what's the most important thing you'd like to look at now?"

Client: [ ..."Well, I really want to sort out what it is I should be doing - staying at home and taking care of the family and the house like I did before, or working at my job like I
am now - I just keep going back and forth in my mind and I just don't know what's right. (Role conflict scenario)

[..."Well... that my father beat me when I was little. I often have bad dreams about that and sometimes when Paul and I fight, I sometimes think that he's going to hit me - even though I know he wouldn't, I still get scared. (Physical abuse scenario)

[..."Well... that I was sexually abused - I've never really talked to anyone about it and more and more I know that I have to somehow deal with it ... I can't seem to stop thinking about it or get it out of my mind... (Sexual abuse scenario)
Appendix C

Participant informed consent form
Questionnaire 2
Questionnaire 3
Demographic form
Questionnaire II

Please be as honest as you can in responding to the following two questions and take as much time as you need.

Circle the appropriate response.

1) How comfortable do you feel about working with this client?

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<th>3</th>
<th>4</th>
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<tr>
<td></td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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Comments: ____________________________________________

2) How likely is it that you have the skills to work with this client?

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<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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Comments: ____________________________________________

3) How likely is it that you would be able to work with this client to facilitate her working through her presenting problem.

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<th>10</th>
<th>20</th>
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<td>very uncertain</td>
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Comments: ____________________________________________

4) Approximately how long might you expect the client to take in working through her presenting problem (assume the client is seen once a week). ____________

Comments: ____________________________________________

5) How competent do you generally feel about your counselling skills?

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<tr>
<td></td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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* Please enter your code name here: ________________________
Questionnaire III

Please be as honest as you can in responding to the following questions and take as much time as you need.

Circle the appropriate response.

1) How important is it to you to have more training/information about role conflict?

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<th>5</th>
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<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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</table>

2) How important is it to you to have more training/information about physical abuse?

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<th>3</th>
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<tr>
<td></td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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</table>

3) How important is it to you to have more training/information about sexual abuse?

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<th>3</th>
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<tr>
<td></td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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</table>

Comments: __________________________________________
____________________________________________________
____________________________________________________

4) Have you ever experienced:

<table>
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<th></th>
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<th>As an adult</th>
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</thead>
<tbody>
<tr>
<td>Role conflict</td>
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</tr>
<tr>
<td>Physical abuse</td>
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<td>YES / NO</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>YES / NO</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>
5) To what extent have you worked through the role conflict?

<table>
<thead>
<tr>
<th>N/A</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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</table>

6) To what extent have you worked through the physical abuse?

<table>
<thead>
<tr>
<th>N/A</th>
<th>1</th>
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<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Not applicable</td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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</table>

7) To what extent have you worked through the sexual abuse?

<table>
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<tr>
<th>N/A</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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<tbody>
<tr>
<td>Not applicable</td>
<td>Not at all</td>
<td>Only slightly</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
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</table>

Comments: 

__________________________

__________________________

__________________________

* Please enter your code name here: _____________
Demographic Data

Code Name: 

Age: _____ years

Marital situation (circle one of the following):

1. single 2. common law/ married 3. divorced/separated/ widowed

Children (circle one of the following): 
If yes, number

1. YES 2. NO

Program you are presently enrolled in (circle one of the following):

1. MEd. 2. MA

Area of speciality (circle one of the following):

1. adult 2. family 3. women 4. elementary 5. cross-cultural 6. higher education 7. adolescence

Nature of enrollment (circle one of the following):

1. Full-time 2. Part-time

Year of the program you are presently enrolled in (circle one of the following):

1st 2nd 3rd 4th 5th 6th
Appendix D

Instructions to participants
Debriefing of participants
Instructions to Participants

Participant informed consent form:

The form is read to each participant. Under "procedures" and following "You will also be asked to view a 5 minute videotape of a client, to imagine yourself counselling that client, and to respond in writing to questions about the tape", I stated: "Some of these questionnaires will ask you about how you might counsel clients who present with the same issue as the videotaped client you are about to see".

Under "procedures" and following "The forms that you complete will be identified by a code name known only to you", I stated: "It is preferable to both of us that your responses can in no way be identifiable to you so it's important that you choose a code name that cannot be associated with you. You may wish to take a moment to think about one now. As you finish each questionnaire I will be asking you to fold up the questionnaire, like this (I demonstrate), and to put it in this box. As you can see it is sealed and will not be opened until all of the participants have gone through the study".

At the end of reading the form I stated: "Do you have any questions?"

* In response to the question: "How much anxiety might I experience in this study?" I stated: "Only as much as you might experience counselling a client".

Thought-listing 1:

Before reading the form to each participant I stated: "I'll be leaving the room each time you fill out a questionnaire. When you've completed the questionnaire please remember to make sure your code name is down, then fold the questionnaire and put it in this box, and hit this bell to let me know you've finished. Don't be afraid to hit it hard because this room is very soundproof. This form that I'll be asking you to complete now has 2 parts and it's the only form that is timed as you'll see when I read the instructions".

The first page of the form was read to each participant. Following "We are now interested in everything that went through your mind as you were told that you would be viewing and imagining counselling a client, and responding to questionnaires related to counselling" I stated: "and this refers to counselling clients who present with the same issue as the client you are about to see".

At the end of reading the first page I stated: "So turn to the next page now and at the end of 2 1/2 minutes I will come back into the room. Please don't turn to the last page as I will go through this second part with you when I come back into the room. Also, I'd ask you not to put your code name down until you've finished the second part of this form. Any questions?"

The second page is read to each participant and at the end I state: "Take as much time as you need to do this rating and when you've finished please be sure your code name is down, fold the paper and put it in the box before you hit the bell. Any questions?"

* In response to the question "What do favorable and unfavorable thoughts mean?" I said: "Favorable (unfavorable) thoughts are thoughts that you see as positive (negative) towards yourself, your situation, or another person, or that leave you feeling positive (negative) or good about yourself, your situation, or another person. Neutral thoughts are
thoughts that are irrelevant to the situation, or that are neither favorable nor unfavorable toward yourself, the situation, or another person”.

Instructions prior to watching the videotape

"Before you watch the videotape of the client I'd like to tell you a little bit about it. By the way I'll be out of the room when you are watching this videotape. The client that you will see is a woman who came into the clinic to get some help for herself, and after an initial interview with a counsellor she agreed to participate in this study. She was then videotaped and asked to summarize the reasons for which she was coming to the clinic. The counsellor she is talking to in this tape was given strict instructions about not interacting with her, and to just allow her to tell her story, and it's important that I tell you this because the scene may seem a little strange to you inasmuch as the counsellor says so little. The client was also aware that this would happen. The client was also more nervous when she was videotaped than she had thought she would be and you need to know that because she may come across as a little stilted. You may also need to know that the counsellor spoke with this woman after the videotape and that the client is presently getting therapy for herself.

I would now like to ask you, as you are watching this videotape, to imagine, as vividly as you can, that this is your client, and that following this 5-minute videotape you would be counselling this client. You may want to imagine, for instance, that you are at work and that you are given an intake form that has the same information on it that this client is saying on the videotape, and that she is waiting to be seen by you. You may want to take a moment now to get yourself in that frame of mind. Please ring the bell when the videotape ends”.

Thought-listing 11

Participants were told: "This form is the same as the first thought-listing form except for the following sentence: "We are now interested in everything that went through your mind as the client was presented to you and as you imagined counselling this client, and anticipated responding to questionnaires related to counselling". Following this I stated: "And this refers to counselling clients who present with the same issue as the client you just saw. Any questions?"

Participants were again reminded of the procedures as per thought-listing 1.

For the Self-Evaluation Questionnaires, Questionnaire 1, and Questionnaire 11, the directions were read to each participant. Each participant is then asked: "Any questions?" The participants were then reminded each time to write down their code name, and to put the questionnaire in the box before ringing the bell.
Debriefing of Participants

Following completion of the last questionnaire I stated, "The study is now over and I'd like to take a few minutes to talk with you about it. I'd first like to ask you how you're feeling right now and if there's anything that you want to say or ask of me".

Part of the debriefing also included the following statements, and may or may not have been in response to questions asked about the study: "I need to tell you that the client you just saw on the videotape was an actress. We felt that it was important that you believe that she was a client so that you could perhaps more easily imagine yourself counselling her."... "In case you're interested this study was designed to determine the various responses that counselling students might have to three different issues - role conflict, physical abuse, and sexual abuse."... "It is extremely important that you keep any information about the study confidential. I know that you might wish to talk about it with friends and I'd like to enlist your help in asking you to wait to do that until the study is over. You'll be contacted when that happens because I'll be getting back to you at that time to tell you about the date of the workshop that is being offered to everyone who has participated in this study. This workshop will be on sexual abuse and will be given by two counsellors who have worked extensively with sexual abuse survivors. It is designed to give participants some basic information about sexual abuse and to respond to questions that participants might have about sexual abuse.".... "Any other questions or comments?"
Appendix E

Thought-Listing 1
Thought-Listing 2
We are now interested in everything that went through your mind as you were
told that you would be viewing and imagining counselling a client and responding to
questionnaires related to counselling. Please list these thoughts, whether they were about
yourself, the situation, and/or others; whether they were positive, neutral and/or negative.
Any case is fine. IGNORE SPELLING, GRAMMAR, AND PUNCTUATION. You
will have 2 1/2 minutes to write. We have deliberately provided more space than we
think people will need, to insure that everyone would have plenty of room. Please be
completely honest. Your responses will be anonymous. The next page contains the form
we have prepared for you to use to record your thoughts and ideas. Simply write down
the first thought you had in the first box, the second in the second box, etc. Please write
only one idea or thought in a box.

* Please enter your code name here: ____________________
We would now like you to turn back to the page on which you wrote down your thoughts. We would like you to go back and rate each of the ideas that you wrote down. In the left margin beside each idea that you wrote down, we would like to know if that idea was (+) favorable toward yourself or your situation, (-) unfavorable toward yourself or your situation, or (0) neither favorable nor unfavorable toward yourself or your situation. If the idea that you wrote down seems to be favorable toward yourself or your situation, you should place + (plus) in the left margin beside the idea; if the idea you wrote down seems unfavorable toward yourself or your situation, you should place a - (minus) in the left margin beside that idea; and if the idea was neither favorable nor unfavorable, or had nothing to do with yourself or your situation, you should put a 0 (zero) in the left margin. Please go back now and rate each idea listed by putting a +, -, or 0 in the left margin. Be sure to rate each thought that you wrote down. Please be honest with your rating.
Thought-Listing II

We are now interested in everything that went through your mind as the client was presented to you and as you imagined counselling this client and anticipated responding to questionnaires related to counselling. Please list these thoughts, whether they were about yourself, the situation, and/or others; whether they were positive, neutral and/or negative. Any case is fine. IGNORE SPELLING, GRAMMAR, AND PUNCTUATION. You will have 2 1/2 minutes to write. We have deliberately provided more space than we think people will need, to insure that everyone would have plenty of room. Please be completely honest. Your responses will be anonymous. The next page contains the form we have prepared for you to use to record your thoughts and ideas. Simply write down the first thought you had in the first box, the second in the second box, etc. Please write only one idea or thought in a box.

* Please enter your code name here: ____________________
We would now like you to turn back to the page on which you wrote down your thoughts. We would like you to go back and rate each of the ideas that you wrote down. In the left margin beside each idea that you wrote down, we would like to know if that idea was (+) favorable toward yourself or your situation, (-) unfavorable toward yourself or your situation, or (0) neither favorable nor unfavorable toward yourself or your situation. If the idea that you wrote down seems to be favorable toward yourself or your situation, you should place + (plus) in the left margin beside the idea; if the idea you wrote down seems unfavorable toward yourself or your situation, you should place a - (minus) in the left margin beside that idea; and if the idea was neither favorable nor unfavorable, or had nothing to do with yourself or your situation, you should put a 0 (zero) in the left margin. Please go back now and rate each idea listed by putting a +, -, or 0 in the left margin. Be sure to rate each thought that you wrote down. Please be honest with your rating.
Appendix F

Neutral self-statements
Participants' pre-video statements
Comments re: sexual abuse training
Neutral self-statements

The range of neutral self-statements for this study across all three groups and pre- and post-video is from 1.33 to 3.05; the range found in Cacioppo et al.'s study is that of 2.67 to 3.40. The frequency of neutral self-statements for this study is generally lower than that found in Cacioppo et al.'s study when one considers that the groups had 1.33, 1.38, and 1.43 frequency of neutral self-statements pre-video, and the sexual abuse group, 1.71 post-video (see Table 2). In Myszka et al.'s study low anxious women recorded 57.9% of neutral self-statements, and high anxious women 47.2% of neutral self-statements. In that study approximately half of all self-statements were neutral with the greater percentage found in the low anxious group; this was also found in the study by Cacioppo et al. (1979). In this study the percentages of neutral self-statements for the role conflict group, the physical abuse group, and the sexual abuse group were, respectively, 22%, 24%, and 25% pre-video, and 35%, 45%, and 24% post-video. These neutral self-statement percentages are closer to representing a quarter to a third of total self-statements with the greater percentages generally found at post-video, when anxiety was expected to be higher than at pre-video. The lower percentage of neutral self-statements found in this study, as compared to those studies mentioned, is undoubtedly due to the higher proportion of positive self-statements, generally from a third to a half, found across all groups and particularly at post-video, as well as the higher proportion of negative self-statements found at pre-video.
Participants' pre-video statements

Examples:
"I had mixed feelings on the confidentiality because I was afraid it would be exposed to the department professors" and "Concerned about the sentence 'Jeopardizing your student status'" (i.e., from the consent form).

"afraid that I may respond inappropriately to such stories (i.e., violent client, or physical and sexual abuse) due to my emotional reaction".

"wondering if I'll be able to do the test correctly or appropriately".

"fear that her problem would be overwhelming"

"I became anxiously briefly in thinking how I would 'perform' in terms of 'good' counselling or 'bad' counselling responses"

"I wonder if the study is really about anxiety and coping or is that trying to throw me off".

"Anxiety - am I going to fail? Feel like a fool?" and "Will I find the client undesirable/repulsive?"

"Am I going to be videotaped?" and "The word anxiety on the consent form, how much anxiety? as bad as my first counselling session."

"Anxiety about whether I will do alright - will my performance be ok".

"Wondered if there is a covert purpose - what the up-front wording might be diverting from?"

"Wondering if I would be viewing difficult, extreme or shocking cases".

"Concerned re how realistic situation will be with video".

"Will I be able to do this?" and "Feeling of incompetence" and "Maybe I'm really not counsellor material".

"Is it a heavy-duty problem" and "How will I respond?" and "Do I want to continue or not with this study or project".

"Would I feel anxious?" and "Would I appear anxious?" and "Am I going to seem competent?" and "Is there any element of deception here?" and "Will someone be watching behind the glass?"

Comments re: sexual abuse training

Examples:
"Working with behavior-disordered children I need to know as much as possible about these issues".
"Physical and sexual abuse are crucial areas as they come up so frequently when counselling women and I need more training and information".

"With the increase in people presenting (sic) physical and sexual abuse it is important to have the training to be able to work effectively with clients".

"During counselling training these specific areas were not addressed. I feel it is very important to have workshops or in-services to deal with these areas as there are particular ways to deal with clients with those presenting problems".

"I've recently been hired to be a part-time counsellor in a private school where sexual and physical abuse issues have come to teachers' and that community's attention".

"From my past clinic had several cases with physical abuse, difficult, realize I need more training, and sexual abuse seems to be more exposed now, with people needing help".

"I feel that the above areas are only indirectly approached in counselling psych. As well since these areas frequently affect women, and since women likely statistically represent a larger part of a hypothetical caseload, I think that these areas should be concentrated on".

"In response to physical and sexual abuse I don't think one could ever get enough information/training in these 2 areas".

"...I need to understand more fully the results of abuse...in order to better understand the pathway that leads to healing".

"As a school counsellor very important to have training re: physical/sexual abuse".