The Counseling Internship: A Trainee's Personal Report

Bullmer
THE COUNSELING INTERNSHIP:
A TRAINEE'S PERSONAL REPORT

by

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Carole Marie Bullmer
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CHAPTER I

Introduction

Internships are generally considered to be common practice in various training programs. A prescribed program of learning, such as an internship, is a procedure for acquiring proficiency in certain skills. Apprenticeship, internship, or participation in professional practice has been usual training practice in the fields of teaching, nursing, medicine, and social work. Other fields such as law, business, dietetics, government service and political science, library science, psychology, and public health generally have required some professional practice as well (Klopf, 1963, p. 1; Brammer and Shostrom, 1968, p. 18; Rosenbaum and Berger, 1963, p. 392).

There are also specific training procedures in the areas of the arts and crafts. The trades and skills are acquired by a process of conscious teaching and learning. Throughout history apprenticeships have been employed more than generally supposed. Mays (1927) suggests that "in nearly all ancient civilizations there was a tendency toward rigid hereditary, social, and economic stratifications . . . and the only thing to do was for the father to teach his son his own occupation" (p. 14). So the arts and skills attained in early civilizations were imparted through an experiential method, a learning-by-doing experience, and this practice has continued to the present.

Monroe (1906) gives a slightly different, but similar,
interpretation of the manner in which skills are acquired. He states that "in most primitive stages of society, skills are transmitted by the process of unconscious imitation" (pp. 10-11).

Mays (1927) perceived the process of obtaining skills in three stages:

First, it was an accepted custom for a father to teach his craft to his son. This led to the adoption of sons by some craftsmen who had no blood sons or needed more than he himself could provide. This adoption meant that a boy would be adopted for a period of months or years to be taught a craft in exchange for labor or pay. Lastly, this led to the practice of indentured apprenticeship, which meant that a person was bound by legal agreement to serve a craftsman for a fixed period of time, in order to learn the trade or craft. (p. 23)

Essentially, many of these ideas adapt well to the objectives of internships today.

Carkhuff (1971) defines the principle of internship as "an opportunity for the individual intern to have a close and intense study of the skills of his mentor" (p. 238). This idea is being explored as a possible alternative in the training of teachers. According to Tanruther (1967), this could be "a post-student teaching opportunity to orient a beginning teacher to a full-time teaching assignment or as a team effort, working with two experienced teachers for a period of one or two years" (p. 6). The latter would include supervision and assistance from both the local school and college personnel, a salary, and an enrollment in a seminar (Tanruther, 1967, p. 68).

Throughout history there has been continued practice and
acceptance of an internship experience. The basis of successful training, documented as far back as the craft guilds, was the special attention by the master craftsman or teacher and close supervision of the apprentice.

With internships being an effective learning procedure in so many fields, it seems imperative to include this type of experience in the development and training of a counselor. Brammer and Shostrom (1968) report that "the APA committee and the APGA Association of Counselor Educators and Supervisors stress the need for practicum training to give supervised experience in counseling and clinical psychology . . . to enable the student to synthesize many fragments of information from previous graduate work . . . and, internships have become common in training programs" (p. 18). Rosenbaum and Berger (1963) are also in agreement with the importance of experiential training in the counseling field. They state that "the direct employment of students in therapy sessions gives them a more intimate understanding of psychotherapy, while at the same time permitting continual supervision" (p. 392).

Prior to my internship, my counseling experience had been primarily in the public schools with sixth, seventh, and eighth grade students. My work with adults had been limited to clients worked with in two counseling practicums. This experience with adults, however, provoked an interest in broadening my exposure to and experience in working with a varied population in terms of age, sex, and nature of
problems. With this objective in mind, it was determined in consultation with my program advisor that I would do an initial Professional Field Experience in a community agency, and, if this proved to be successful, and if my interest continued, I would then do an intensive internship at a later time. St. Joseph's Lodge, which primarily operated as an out-patient clinic, was selected for this experience. This was completed during the summer of 1973, and served to confirm my interest in this area. As a result, an intensive internship was planned and completed the following year at the Kalamazoo State Hospital.

This report will deal with my experiences at St. Joseph's Lodge and the Kalamazoo State Hospital both located in Kalamazoo, Michigan. Each setting will be reported and reviewed individually and the meanings and learnings which resulted for me will be reviewed. This is a report of my internship experience and its influence on my development as a counselor and, also, an evaluation of the impact this experience had upon me.
CHAPTER II

St. Joseph's Lodge

Setting

St. Joseph's Lodge is an adult psychiatric day center affiliated with the Delano Clinic at Borgess Hospital in Kalamazoo, Michigan. The purpose of the Lodge's program is to aid people who are having problems in making personal and social adjustments in living. The Lodge is located in a former residence reconstructed to meet the needs of the day center. The facilities are adequate for the population of the Lodge.

The Training Program

My training program consisted of 160 hours of work over a period of eight weeks during the summer of 1973. During this time I participated in group and individual therapy and attended tri-weekly staff meetings. Since testing and report writing were not done by the staff, these experiences were not available at the Lodge.

Objectives

The main objective of my experience at the Lodge was to use this training as a transition from the school system to a community agency. To accomplish this, it was planned that I would receive training in individual and group psychotherapy; I would have opportunity to develop facilitating staff relationships and participate in staff consultations; and, I would receive regular supervision. With these experi-
ences, it was expected that I would receive a comprehensive perspective of the operation of a community agency and an understanding of the work of the individual therapist in this kind of setting.

**Group Psychotherapy Experience**

My first experience in doing group therapy occurred at the Lodge. While I had participated as a member in several groups during my training, I had never experienced the responsibility of leadership in a small group, nor had I been involved with groups where members presented problems which were severe enough to warrant intensive psychotherapy. Consequently, my initial feeling in the therapy group at the Lodge was that of being somewhat inadequate.

Each new patient at the Lodge was required to join an intake group to initiate him to group procedures. Since I felt much in the same category as the patients, in terms of having much to learn, and, therefore, anxious about group work, I discovered these meetings to be personally very worthwhile. The intake groups were small, four to eight members, with most of the members generating a great deal of inner motivation. After meeting two or three times on the basis of once a week, each patient joined a psychodrama group and had the option to belong to an on-going therapy group.

Psychodrama is a form of group therapy that gives the patient the opportunity to re-create and act out certain troublesome real-life situations, so that more appropriate
social responses might be learned. The psychodrama group proved to be a kind of group I could adapt my counseling skills to most easily and I was readily accepted by the group members as a capable therapist. Being a co-leader in the group did not initially place heavy demands and responsibilities on me and I was allowed to participate and accept responsibilities in a developmental manner as I gained more confidence. My primary function in these groups was to help pattern the types of responses elicited by the group leader. With each succeeding group meeting, I became more active and more often I became one of the essential characters of the psychodrama. This gradual process of participation helped me immensely to combat some of my initial feelings of inadequacy, and soon I found myself feeling more and more confident.

This was also my introduction to working with different types of leaders and observing first hand the potential effect leadership style could have on a group. As Shaw (1971) states "effective leaders are characterized by task related abilities, to guide the group toward their goals; sociability, to have the interpersonal skills to deal with friction and conflict between group members; and, to have the motivation to be a leader" (p. 268). The various leadership roles I encountered at the Lodge enabled me to compare and contrast the outcomes and to understand more fully a leader's need for the characteristics noted by Shaw.

The psychodrama group seemed to have a positive effect
on those patients directly participating. This was true particularly if the patient's information and behaviors that were elicited in the group were followed-up with individual therapy. Unfortunately, the practice of following-up in this manner was not consistent among the various therapists. As for the group's non-participating patients, it was impossible to assess their learnings or possible insights gained from the group.

These groups also fluctuated in size and population and this adversely affected group cohesiveness and productivity. As Shertzer and Stone (1968) relate "as groups increase in size, the tendency is for the members to depend more on the counselor and not interact with other members, and for the counselor to speak increasingly to the group as a whole, rather than to the members as individuals" (p. 458).

The experiences I had with various group modalities employed at the Lodge were exceedingly beneficial and potentially useful for me. It provided an opportunity for me to observe different therapists as they worked with patients, and to compare and contrast their therapeutic models. Also, I had freedom to experiment with and develop some of my own ideas about work in groups with an adult population. And, most importantly, as my experience in groups progressed, I was able to overcome my initial feelings of inadequacy and gain confidence in my role as a therapeutic agent. These group experiences did fulfill my basic objectives which were to ameliorate my group leadership skills, as well as to
acquire additional experience with group treatment modalities.  

**Individual Psychotherapy Experience**

Individual therapy at the Lodge was less threatening to me than group therapy had been. I attributed this to my more extensive and more successful previous experiences with individual therapy. I was initially assigned two young female adults and met with them twice a week. In time I found that I was to learn much of value from these patient relationships.

The major learning I experienced from this individual work was very crucial for me. I was surprised to discover that I had difficulty dealing with a female patient's feelings toward me. I had previously encountered and dealt successfully with male transference, but I had not previously had to deal with female transference. Therefore, working through these relationships and doing therapy with these patients provided new learning for me that was both beneficial and meaningful.

Another important aspect of individual therapy had to do with the time element. This was short-term therapy which was also a new experience for me. The purpose of treatment at the Lodge was to make patients functional and have them discharged in as short a time as possible. This was very frustrating for me at times, since I was previously able to work at my own pace. In time, however, as I practiced, I became comfortable with this situation and found it enhanced my efforts and did not lessen my effectiveness as a therapist. Evidence to support my perception is available in the liter-
ature. Wolberg (1965) reported that "some persons after short-term therapy adapted and adjusted quite well and that if some of the main symptoms were eliminated, and the person was able to function, perhaps that should be measured as successful" (p. 54). In terms of Wolberg's definition, I felt I did have success with my patients.

As a result of my work with individual therapy, I was able to gain more experience and practice in working with adults. Exposure to a wider variety of patient transference provided new learning for me and individual therapy presented additional experience in structuring relationships. All of these experiences helped to fulfill my objective of developing personal confidence in my abilities as a therapist.

Staff Relationships and Consultation

Another of my goals was to develop good working relationships with the staff members. During the staff meetings that were held three times a week, patient histories were presented by individual therapists and patient progress was reviewed. A consulting psychiatrist and a psychological consultant were available once a week for consultation on difficult cases and to assist the staff with program development and evaluation.

I was surprised to find very varied backgrounds of staff members and their varied educational credentials. My credentials compared favorably with those of other staff, but I lacked their experience. My response was to feel extremely self-conscious since I was fully aware of the cohesiveness
of the staff and of being evaluated by them. Once I began
to learn the symbols of the new environment and I was able
to discuss patients with other staff, these feelings no
longer existed. Inquiring for their opinions and help and
attending the staff meetings provided a vehicle for gaining
acceptance from my colleagues.

The staff meetings were very valuable in providing an
opportunity to discuss cases, but they did seem to be exces­
sive and somewhat ill-planned, in that so much time was wasted
needlessly. It was an advantageous learning experience in
the necessity for budgeting time, however, and for preparing
agendas for meetings.

Report Writing

Since testing was not a function of the Lodge, the only
type of report writing required was recording in daily logs
for each of my patients. These logs were kept in folders in
file cabinets in the main office. When necessary, however,
I did have access to patients' psychological reports, which
were available at Delano Clinic and these occasionally proved
to be useful in diagnostic efforts. Writing the logs proved
to be good practice in obtaining, recording, and synthesizing
information.

Supervision

The major supervision of my work at St. Joseph's Lodge
was done by my advisor. I had hoped for some intensive super­
vision from Lodge staff members also, but circumstances made
that impossible. I received much informal positive feedback

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from staff members on my work there, but little formal supervision. On occasion I did meet formally with the director of training, but these sessions were very limited in number.

Since I was operating on a short-term basis, it would have been even more helpful to have received supervision from both sources. According to Tanruther (1967) "supervision . . . increases the opportunity to integrate theory and practice" (p. 7). Therefore, increased supervision would have provided me more opportunity for planning and evaluating new ideas and techniques. As I was to learn later, good supervisory relationships are not only personally rewarding, but essential for counselor development.

Supervision from my advisor was given in a very structured manner. It was on a weekly basis with the opportunity present for more consultations, if I felt the necessity. Kell and Mueller (1966) succinctly describe the type of supervision that I received. They state:

Supervision is a process in which the supervisor sensitively uses the stress that has been activated in the counselor as a consequence of his encounters with his clients, or he may introduce additional stress into the relationship, so that the counselor can grow professionally . . . the supervisory relationship becomes significant when the critical incidents that the counselor has introduced into the relationship are explored under stress. At those times in his professional and personal development, the counselor, like his client, is most vulnerable to change and growth. (p. 109)

I was appreciative of this approach to supervision and believe that it contributed greatly to my change and growth.

Summary

My work at St. Joseph's Lodge had been planned to provide
a basis for deciding my major professional interest area. To this extent, the experience was profitable in that I successfully made the transition from working with school children to working with adults. Also, my interest in community agency work was intensified, and while I did not think that I was ready for a final commitment, I was enthusiastic to gain more experience in this area.

Many things combined to contribute to my positive impression. I had an opportunity to work with an adult population in an agency setting, which was quite different from the school setting. My introduction to group therapy was gradual and afforded me an opportunity to develop confidence and skills at my own pace. It was profitable to observe "carry-over" behaviors of my individual patients. It was possible to see these patients attempt new behaviors in social situations and interpersonal relationships.

Although the staff welcomed me and I felt that my suggestions and ideas were considered seriously, they appeared to be resistant to evaluating their program and their individual therapy models.

Although I did not receive supervision from the Lodge staff, what I did receive from my advisor was very profitable. He was available to discuss my work and my personal integration.

My views on my ability to deal effectively in the Lodge context changed from what they had been when I started my work. At the end, I felt more capable of working with groups,
deciphering important information from daily logs, and in accepting criticism and guidance from my supervisors and fellow workers. This experience led to a decision to extend my training by doing an intensive internship at Kalamazoo State Hospital.
CHAPTER III

Kalamazoo State Hospital

Setting

Kalamazoo State Hospital is an institution for the mentally ill and is operated and funded by the Michigan Department of Mental Health. It serves an eleven county region with a current adult patient population of 900 to 940, not including a children's unit. The hospital services people with personal and social adjustment problems ranging from moderately disturbed to severely disturbed. Admissions to the hospital are on a voluntary or involuntary basis.

The Training Program

During the summer of 1974 I completed a 400 hour internship at the Kalamazoo State Hospital over a ten week period. The experience included work not only in the psychology unit of the hospital, but in the alcoholic unit as well. During this time I regularly participated in group and individual therapy, attended staff meetings and court proceedings held at the hospital, administered psychological tests and prepared reports, and experienced consistent and on-going supervision and consultation with the staff.

Objectives

My main objectives for the internship (see Appendix I for a complete prospectus) included the enhancement of my knowledge of a mental health agency, to gain experience of working in such an agency, and to further develop my clinical
skills in the following areas: individual and group therapy, testing, psychological report writing, and diagnosis. Also, I sought additional experiences in developing good professional interpersonal relationships with fellow staff members.

**Group Psychotherapy Experience**

My introduction as a group therapist at the hospital was as assignment to an alcoholic rehabilitation group. This program for alcoholics was based on a six week living in experience for patients. The overall goal of the program was to return the patient to a functional state as expeditiously as possible, so that he or she might be discharged at the end of the six week program. The group met twice a day for two hour periods for the entire six weeks.

The group was open-ended in that patients would be discharged and new patients would replace them. Group size varied from six to twenty-five members, including the staff therapists and visitors. Members from the patients' families, social workers, nursing personnel, students, ministers, and other therapists were sometimes permitted in the group as visitors. All of these factors combined to have various effects on group productivity.

The establishment of norms developed very quickly in this group. Norms, the acceptable behaviors in a group, are established only for situations that hold some significance for a group, and once norms are established, they serve to create pressures toward conformity to the norms (Lakin, 1972, p. 43). Some of the apparent norms developed in the
alcoholic group were avoidance of self-disclosure, intellectualization, and conformity. These norms had an observable effect on group productivity.

According to Shaw (1971), "conformity increases with the size of the group . . . probably because the larger the number of group members who give the same response simultaneously weakens the subject's confidence in his own judgments and strengthens his belief in the group norm" (p. 251). Also, Jones and Girard (1967, p. 605) in agreement with Shaw (1971) show that conformity is greater when individuals respond with others present than when they respond privately or anonymously.

The group lacked cohesiveness. Cohesiveness refers to all of the resulting forces influencing all of the members to remain in the group (Cartwright and Zander, 1960, p. 74). Group members did not share a common group goal, unless it was to achieve termination from the program after six weeks and/or to meet the requirement for participation (or attendance) in the therapy group. Since the group members were not attracted to the group work, their productivity was low and they were not satisfied with themselves or their accomplishments (Shaw, 1971, pp. 200-204). Having negative feelings about belonging to a group also reduces a member's participation in carrying out a group task (Lakin, 1972, p.42). As a result, patients often did not complete a task assigned, or did so to a minimumly acceptable level. These patients maintained this inner conflict within themselves which made
it difficult for them to approach group therapy in a proper frame of reference. On the other hand, when group members are attracted to the group, they will attempt to do what they think is expected. They will work harder to achieve goals, increase productivity, and be better satisfied with groups in general (Shaw, 1971, pp. 200-204).

Groups that have not yet acquired "valid communications" are not functioning at maximum effectiveness. Valid communications means that each member should be able to freely share his own feelings about himself and others and have the ability to accept that other individuals have the right to express their ideas, feelings, beliefs, and values (Shaw, 1971, p. 103). The alcoholic group did not demonstrate that they had acquired these skills.

Leadership style is also a major influence on group productivity (Applbaum, Bodaken, Sereno, and Anatol, 1974; Shaw, 1971; Feidler, 1964). While authoritarian leadership is sometimes the most productive leadership style, depending upon task and situation, it has been demonstrated to be the least productive for psychotherapy groups. The authoritarian model does not lend itself toward the development of group cohesiveness, and as a result, patients do not establish trust in each other and avoid self-disclosure. Since an authoritarian leadership style was advocated and practiced in the alcoholic group, it can be concluded that this factor discouraged self-disclosure and promoted the use of intellectualization by patients as an avoidance mechanism. This
group phenomenon was demonstrated many times when therapy sessions would be started with a question or statement by the leader, which patients were instructed to respond to. This type of direction invariably led to an intellectual discussion which was of low therapeutic value. It produced very little anxiety for patients, since it was not self-revealing, and, therefore, was minimally productive (Moxnes, 1974, p. 399).

In observing several of the therapists, it seemed that some were overly aggressive and punishing. Therefore, the leader was watched carefully by patients to see which of their responses would receive positive feedback, and in this manner expected responses were learned. The leader-follower dimension in group carries with it implications of varying degrees of acceptance by the group. The higher up in the hierarchy the more valued they become to the group (Jones and Girard, 1967, p. 415). So the group members who best copied the behaviors of the leader and received the most positive attention from the leader, received the highest degree of acceptance by the group.

Another interesting aspect of the alcoholic group was that it had both male and female members. Shaw (1971) notes that different expectations exist for mixed sex groups than for same sex groups. Members are expected to conform more in mixed sex groups than in same sex groups. The high degree of conformity which existed in the hospital's alcoholic group would appear to be consistent with Shaw's thinking.
Nowicki and Hopper (1974) also suggest that differences exist between male and female alcoholics. In their recent study, they found that inpatient female alcoholics are relatively more disturbed than inpatient male alcoholics and that different treatment procedures should be considered with respect to sex differences. Although interpretations of these findings may be considered inconclusive, they do suggest that sex differences should be considered and evaluated in alcoholic group therapy sessions.

In summary, I experienced positive and negative thoughts about my work with the alcoholic groups. On the positive side, I was pleased to have an opportunity to work in a problem area that was new to me. It also provided an opportunity for me to observe group phenomena, which I had read about and studied in group dynamics class, but had never seen demonstrated in such an obvious manner. It was exciting and gratifying to see hypotheses about group behavior proven in the group.

On the negative side, I found myself in a situation whereby my past experiences and formal training in group dynamics and therapy were not compatible with the existing approach in the alcoholic groups. This in itself was not a source of conflict for me, but opportunities to exchange ideas and try new procedures were not available and this was a source of frustration.

In contrast, my following experiences as a group therapist in the psychology unit of the hospital were quite
different from those in the alcoholic unit. My impressions were far more positive and I felt that the learning experiences were far more beneficial for me. I discovered that open-ended therapy groups had many similar characteristics. Both groups had rapid turn-over in population, visitors in group, and variance in size. I observed that there were also marked differences between these groups in leadership styles and group productivity. The typical leader in the alcoholic group had been very confronting, and, at times, punitive; whereas the leaders in the psychology unit could best be described as confronting, but supportive. These leaders influenced group members in positive ways, were sensitive to changes within the group, and adapted their styles to changing situations. As a result, the usual problems often created by continuous groups, those of communication, support, and acceptance among group members (Shertzer and Stone, 1968, p. 458), did not readily develop in the psychology unit groups. They were, however, most apparent in the alcoholic groups, in that cohesive groups did not develop.

A factor contributing to greater cohesiveness in the psychology unit groups can be attributed to differences in the content of the discussions in the alcoholic and psychology unit groups. When group leaders encouraged the discussion of personal patient concerns, as was done in the psychology unit groups, it was possible to have a high-level of communication. When those behaviors were not directed
and nourished by the leader, as in the alcoholic group, a low-level of communication ensued. This observation is supported by research. According to Wilson and Rappaport (1974), "... subjects responded more personally to high-intimacy, personal topics than to low-intimacy topics, and low-intimacy topics produced more impersonal responses than high-intimacy topics" (p. 906). Vondracek (1970) also found that more personal disclosure was attained from personal items than impersonal items (p. 5230).

The lack of productivity in the alcoholic groups, as compared with the more productive groups in the psychology unit, might well be attributed to differences in leadership style and resulting cohesiveness. While cohesiveness is an important ingredient in all productive groups, it is particularly important in therapy groups (Shaw, 1971, p. 205). The essential condition in therapy groups is a willingness on the part of the group members to openly and freely expose their thoughts and emotions. In addition, they must be willing to accept suggestions from other group members for behavior change. Without a high degree of cohesiveness, group members find it difficult at best to communicate openly, and the result is rather superficial interaction. Also, relative to low-cohesive groups, high-cohesive groups exert greater influence over their group members and this condition is vital, if group members are to be influenced by the group to change behaviors. It was this difference in group cohesiveness which was most obvious as I worked with groups in
Intrapersonal conflicts may often disrupt a group. These conflicts arise when someone sees something differently from another person, but assumes they see it in the same way (Lakin, 1972, p. 240). Leaders in the psychology unit demonstrated good therapeutic responses to conflict, and by observing these therapists, I was able to develop new insights into various techniques. I gained deeper appreciation of the need to listen, understand, and empathize with the opposite viewpoint.

Role-playing was one of the techniques employed by therapists in the psychology unit. It was used often and in a variety of situations, and was usually an effective technique for allowing group members to experience their emotional states. Since I had experience in psychodrama at St. Joseph's Lodge, I felt quite comfortable with this technique, and was able to further develop my skills in this group procedure. Shertzer and Stone (1968) suggest some meaningful applications for role-playing, as noted by the following:

1) when a client is having difficulty describing a situation or communicating his feelings about it to others, 2) when a client wants to know how others perceive him and his situation, 3) when a client wants to know how others react to his proposed actions, and 4) when a client feels that he needs practice with social skills or that he needs to develop the confidence to act. (p. 465)

I found these suggestions useful and at various times found opportunities to make use of all of these role-playing applications.

Many valuable learning opportunities resulted from my group work in the psychology unit, and, as a result, I
definitely enhanced my skills as a group therapist. With the aid and encouragement of other therapists, I learned to utilize the group in setting group and individual objectives and working toward them. I also developed skills in exerting controls to unite the group into a cohesive unit.

An additional important experience for me was learning to utilize the leader/co-leader relationship more effectively. I found it productive in modeling behaviors or verbalizations, receiving additional insight and feedback on group activity, transferring leadership to become an observer, and in conflicting roles with a particular patient. Perhaps the most important experience for me was gaining added confidence in myself as a group therapist.

**Individual Psychotherapy Experience**

Because of the large population at the hospital, it was not possible to use individual therapy as a primary therapeutic procedure. As a result, group work took precedence as a means of dealing with as many patients as possible. When patients or their families would request individual therapy, an attempt was made to provide individual therapy. However, the majority of the patients did not receive individual therapy, but those capable of profiting from a group experience did receive group therapy.

Once again, as with my experience at St. Joseph's Lodge, I met with the frustration of working within strict time limits since individual therapy was on a short-term basis. My first patients were an adult male and an adult female,
with whom I met three times a week. Once again, I was to ex-
perience new and meaningful learnings from working with these
individuals.

A new experience for me was integrating individual ther-
apy with group therapy. Both of my patients had difficulty
interrelating the two modes of treatment, but according to
Gibbard, Hartman, and Mann (1974), that ambivalence is explain-
able. They state that "the basic antagonism is between the
individual's commitment to himself,—to his own needs, beliefs,
and ambitions—and his yearning for psychological submersion
in a group, for an obliteration of those qualities that make
him unique and thus distinct and separate from others" (p. 177).
My patients seemed to demonstrate this ambivalence in many
ways.

They reported on their fear of the group and their hesi-
tancy to share their thoughts and feelings for fear of being
chastised or laughed at. These fears were rationalized by
deciding that their individual problems were not worth using
the time of the group. As a result, it was difficult to fa-
cilitate their using the group as they might have to develop
and ameliorate behaviors suggested in individual therapy.

As time progressed, however, I was able to model be-
haviors in group and my patients developed a degree of con-
fidence so that they could express themselves more profitably
in group. As a leader, I had control of my group and was
able to use the tendency toward conformity by my patients in
constructive ways. At the same time, I could intervene when-
ever group pressures were not contributing to patient growth or were actually detrimental to their condition. At those times, I saw it as my responsibility to protect an individual's autonomy against the groups' demand for conformity.

As my patients progressed in their ability to function in group, they found that they were able to use the group to practice new behaviors or verbalizations which had been suggested in individual therapy. In this manner, they had an opportunity to receive valuable feedback from other group members, before returning to their home environments.

Patients also expressed a change in their attitude toward group work. While they were initially fearful of the group and ambiguous in their feelings about group and individual therapy, in time, they found that being able to practice new behaviors in the group led to an ability to express themselves and be accepted by others.

Although it was difficult to foresee relationships between "back-home" situations and therapy group interactions, it was often possible to successfully uncover such relationships. Through role-playing and other techniques, patients were aided in perceiving and working through problems comparable to those which might develop at home.

The most frustrating aspect of individual therapy, however, was in returning the patients, primarily alcoholics, back to their home environments. Patients can learn to acquire new behaviors, practice verbalizations, and share their feelings as long as they remain in therapy with constant
reinforcements for their behaviors. However, the home situation does not change and the problems and people who were part of the original, motivating forces that sent them to the hospital have not changed. The predictions for success without a change in the home environment appear bleak. In some cases, patients' families were worked with, but without ongoing follow-up on a particular case, failure would usually result.

**Staff Relationships and Consultation**

In observing staff relationships and consultation roles at the hospital, I became very much aware of differences in methodology that were employed by different units and how these differing methods affected the therapy programs. One marked difference was that between the alcoholic and psychology units.

The alcoholic unit held no formal staffings on individual patients and there was very little communication among staff members. No time was set aside for periodic meetings and there were no daily accountings kept on individuals in the group. This appeared to be a shortcoming of the alcoholic unit. Some of the staff members verbalized discouragement, unhappiness in their jobs, and generally displayed a disorganized approach in their therapy. Plans for group were often made at the last minute and usually resulted in a didactic presentation by the leader.

The approach employed by therapists in this unit was to identify with the patients' problems and feelings, but not
to make interpretations about etiology. This approach led to many discussions, but few empathic group sessions as defined by Carkhuff (1971). He defines empathy as "the ability to recognize, sense, and to understand the feelings that another person has associated with his behavioral and verbal expressions, and to accurately communicate this understanding to him" (p. 266).

The consultant role, as practiced in the alcoholic unit, was practically non-existent. The therapists appeared to be defensive, and, therefore, it was quite difficult to ask questions or share ideas with them. This situation is in conflict with Lakin (1972, p. 20) who encourages talking through conflicts about values and methods, reaching a resolution, that allows the therapists to function as a team. Tyler (1969) also brings therapy back into alignment when stating that the purpose of counseling is for the welfare of the individual for whom the program exists and that it involves all the efforts of staff members to strengthen their own relationships (p. 204).

Since the alcoholic unit did not exhibit those characteristics in terms of staffing and consulting, I believe it affected their therapeutic program in a negative way. Dissatisfaction from within will surely affect the total structure.

In the psychology unit I learned the importance of a staff working together. In that unit, therapists, social workers, physicians, and ward nurses were all dependent on each other for information to aid patients. Their cooperation
with each other appeared to be based on mutual respect and they facilitated their communications with each other through joint staff meetings, as Tyler (1969, pp. 205-206) suggests.

There were weekly staff meetings for each ward which included representatives from the psychology unit, nursing staff, a physician, and the social workers. At this time, patients on the ward would be discussed. Their progress would be checked with requests for any suggested changes. The staff was very cooperative and welcomed ideas for treatment. In having an opportunity to work with the physicians, my clinical skills were sharpened and I very much felt a part of the staff. In addition to weekly staffing on the wards, the psychology unit had a staffing after every therapy group. This was an important aspect of the program, because patient's progress in group affected their total program release.

Consultation opportunities were endless in the psychology unit. I had access to a variety of people willing to give their time for discussion of a case or help on a report. The staff allowed me freedom to use the libraries, materials, sample reports, and any other supplies that I might need. I also had access to patients' confidential case books.

**Testing and Report Writing**

The psychology unit of the hospital provided extensive testing services for the medical staff. A usual battery of tests would be a Wechsler Adult Intelligence Scale, a Bender-Gestalt Motor Test, and a Rorschach. Dependent on the patient,
at times a Minnesota Multi-phasic Personality Inventory would be administered or the Thematic Apperception Test. It would then be the test administrator's responsibility to write a psychological report.

One of my objectives for my internship was to develop proficiency in administering tests, interpreting the data, and writing psychological reports. An office was designated for my use, so I was able to organize my materials and feel comfortable in having a base for operations. I had been trained in testing previous to my internship, but I soon discovered that the more I administered tests and became well-acquainted with them, the more confident I became in test interpretation. My reports were discussed and critiqued by my supervisors, and I soon realized that good report writing did not occur immediately, but through a process of continual practice and re-writing. My initial tendency was to be too wordy and too detailed. I was hesitant to commit myself to a definite diagnosis, so I attempted to include every possible aspect that might influence a diagnosis. Physicians, however, wanted a brief, concise, and easy to comprehend report. After much practice, I began to develop a knack for that type of writing. Since the major purpose of psychological report writing is communication between two people about another individual (Hollis and Donn, 1973, p. 3), it was crucial for me to learn how to write reports for the staff physicians.

In evaluating and interpreting tests, it is important to become aware of everything that may affect the results obtained.
from their use (Sundberg and Tyler, 1962, p. 139). The patients' behaviors and attitudes were extremely informative when they took the tests, particularly their non-verbal behaviors. Since some of the patients' initial and last introduction to me was in a testing situation, creating facilitating conditions was of the utmost importance. Their anxiety levels were very high, primarily because they were unsure of my function in their case. Talking with them for awhile and giving them an understanding of what was transpiring usually eased their anxiety. Administering individual tests gave me an opportunity to observe patients and to get clues about their attitudes toward tests.

Another important aspect of my testing experience was interpretation of data. Since testing information was usually used in making dispositions or recommendations about a particular case, the purpose of testing and identification of potential users of test results had to be determined before test administration. Testing should be only one aspect of a total collection of data to confirm or deny hypotheses. According to Shertzer and Stone (1968), "diagnosis is a developing process, not a discrete event" (p. 409).

**Supervision**

Supervision of my work at the hospital was performed by staff members in the psychology unit. Daily conferences were held either formally or informally, and critiquing occurred after each group therapy session. With this amount of supervision, I felt as if my personal growth as a therapist made
many advantageous gains during my internship.

I was aware that my perceptions were always being checked by both myself and my supervisors. Because of the constant demand to validate my perceptions, I felt that my clinical judgment was being refined and honed to a keener degree. As a result, I was more able to quickly organize my thoughts and perceptions with a greater degree of accuracy than was previously possible. My supervisors provided well prepared sounding boards for my questions, ideas, and suggestions.

I was very pleased with the approach to supervision which was employed. I was never made to feel pressure to conform to suggestions and I did not feel compelled to rebel against suggestions and criticisms. I was given the freedom to grow and develop in my own way without emulating my supervisors, and, as a result, my confidence increased greatly. According to Kell and Mueller (1966, p. 18), this type of trainee-supervisor relationship is most profitable and my experience would lead me to agree with them. My ability to accept criticism and develop suggestions into something useful for myself was a progressive change from other previous supervisory experiences. I was now able to listen, internalize, and evaluate, and then accept or reject suggestions as they fit into my theory.

**Summary**

My initial feelings upon entering the internship experience at the Kalamazoo State Hospital were anticipation, excitement, enthusiasm, and curiosity. I was anticipating a
meaningful internship that would provide new experiences and learnings.

My experience at St. Joseph's Lodge provided a foundation for working in an agency and I had confidence in my ability as I began my internship at Kalamazoo State Hospital. My interest in agency counseling was still very strong, and I was greatly enthused about meeting new patients, new staff colleagues, and about gaining additional exposure to various individual and group therapeutic techniques. I felt prepared, particularly in working with groups, and I was eager to begin since this experience was to be a more intensive study of a mental health facility.

My initial work with the alcoholic unit of the hospital was both rewarding and frustrating. Most frustrating was a lack of individual therapy for patients and on-going follow-up for released patients. For this reason, I thought that the hospital's work with alcoholics was not as effective as it could have been. The philosophy of the alcoholic unit was that group therapy took care of patient needs, and patients received individual counseling if they requested it. It was my observation that when individual counseling did occur, it was primarily advice-giving without attempting in-depth personality reconstruction. I do believe that with the available staff and patient population of the alcoholic unit, it would have been possible for each patient to receive one hour of individual therapy per week during their six week minimum stay.
The psychology unit of the hospital, however, experienced a more serious problem, because the patient-therapist ratio was much larger and it was impossible to meet individually with all of the patients. Group therapy, therefore, was used primarily as a means of serving as many patients as possible. However, I do believe it would be feasible for each therapist to carry several patients on a regular basis and to work with a limited number of more serious disorders on a long-term basis.

Overall, my work at the hospital with individual therapy provided many learning opportunities and allowed for attaining my major goals in that area. I was able to increase my experience in short-term therapy. As I looked back on my work at St. Joseph's Lodge the summer before, I felt that my tolerance level had increased considerably, and that I was better prepared to deal with the expectations of the agency. I was exposed to a varied patient population, and was better able to understand the futility of changing behaviors and returning patients to their unchanged home environments. Also, I learned of the benefits that could come from proper use of concurrent individual and group therapy. I became aware of the need to be concerned with group and with individual development, ignoring neither, nor emphasizing one at the expense of the other.

My testing experience at Kalamazoo State Hospital fulfilled my objective of gaining experience in the testing area. I learned that if tests are to be used in diagnosis, it is
necessary for the therapist to be familiar with test material. This is crucial and has been stressed by authorities (Shertzer and Stone, 1968, p. 412; Sundberg and Tyler, 1962, p. 142).

Since testing and psychological reports can be written for various purposes, it is important to know for whom the reports are being written. It becomes increasingly important to concentrate on adhering clearly and simply to the specific purposes of each report (Hollis and Donn, 1973, p. 5).

I realized more fully the high anxiety level of patients taking a test and how this could affect their test results. The more clearly a patient knows what he is supposed to do, and the less he is disturbed about his own anxieties as well as anxieties provoked by outside forces, the more accurate the test is in doing what it is supposed to do (Sundberg and Tyler, 1962, p. 141). Interpretation of test data needs to be cautioned in several aspects. Brammer and Shostrom (1968) state:

1) The tendency of the counselor to overextend himself when data are incomplete or inaccurate, 2) the tendency to become preoccupied with the history of the patient and to neglect present attitudes and current behavior, 3) the temptation to utilize the tests too quickly to facilitate diagnosis, 4) the tendency to lose sight of the counselee's individuality and to become preoccupied with morbidity rather than healthy behavior, and 5) the tendency to show a judgmental attitude toward the patient. (p. 408)

As suggested, diagnosis and counseling should operate concurrently with one influencing the other. Affective changes need to be noted by therapists and the relationships between diagnosis and counseling could be close and meaningful (Shertzer
and Stone, 1968, p. 409). It is extremely important to be observant of patients in diagnostic procedures.

I was also able to experience the total assessment procedure at the hospital. It appeared to me that the hospital's assessment procedures very much followed those of Sundberg Tyler (1962). They reported assessment in four stages:

1) The preparation stage, in which early information and clinician's background of knowledge are used to make plans and decisions about how a case is studied;
2) the input stage, in which information is gathered by interviews, tests, and other procedures;
3) the processing stage, in which the information is collected, organized, and assigned meaning; and,
4) the output stage, in which the findings and interpretations are made and decisions are made about clinical actions. (pp. 86-89)

In reference to the hospital, these assessment procedures involve much time and the cooperation of a variety of people.

The supervision that I received at the hospital is described fittingly by Kell and Mueller (1966) as "involving a complex, yet understandable, interpersonal expression of qualities which enhance feelings of trust and security and, at the same time, allows those being supervised the freedom to learn, grow, and change" (p. 99). There had been a time when I was either completely defensive or completely accepting or criticism, because I lacked confidence in my judgment. The internship experience and the supervision it provided enabled me to test the accuracies of my judgments.

My supervisors reinforced this growth pattern by working to develop, understand, and achieve therapeutic objectives that were appropriate for me, even though my objectives might have been different from theirs.
Supervision aided me in developing objectivity in working with patients through questioning, discussing, and critiquing of my thoughts and emotions. I have definitely made progress in this area. My needs and emotions are much more in control and less likely to interfere with my work. I believe this to be a necessity for all therapists.
CHAPTER IV

Personal Development as a Counselor

Having concluded my internship at the Kalamazoo State Hospital, it is possible to look back at the steps along the way which led to this point and clearly see how each succeeding experience had contributed to my development as a professional counselor. After completing the Master's Degree program in counseling, I was very much aware that while I had acquired some knowledge about human behavior and some basic counseling skills, there was still much more to learn. Also, even though I had been engaged in school work for several years, I was still not sure that this was where my interest and abilities were best suited. This was the thinking which motivated my decision to seek experiences in the community agency area and to enter the Specialist's program.

My decision to do a Professional Field Experience at St. Joseph's Lodge was an important step toward determining the future direction of my training. I approached my placement at the Lodge with many doubts about the adequacy of my knowledge and skills, and, as a result, I was lacking greatly in confidence. As time progressed, however, I came to perceive myself differently. I quickly learned that much of what I had learned in the classroom had practical value and that I was more sophisticated than I had imagined. Much of what I had previously experienced in counseling practicum took on new meaning and I soon felt confident that I could "hold my own"
in a professional counseling setting. I also acquired a more realistic perspective of the knowledge I lacked and needed.

I believe the Lodge was an extremely good choice of setting for my initiation into community agency work. The setting was very informal which was helpful in allowing me to develop confidence in a day-by-day manner. Each new day provided new experiences and new opportunities to evaluate my efforts on a comparative basis with other staff members. As a result of this developmental approach, I completed my experience at the Lodge with the confidence necessary to move forward in my training program.

In the year following my work at St. Joseph's Lodge, I devoted my efforts to my work in the school and to additional study. I was surprised to find that the experience with adults at the Lodge was not wasted as I again worked with adolescents. In fact, my experience seemed to give me an even more realistic attitude and understanding of these young adults and I believe I was more effective in my efforts as a result of this change.

As I approached my internship at the Kalamazoo State Hospital, I was very much aware of my different feelings from those experienced the summer before when I began work at the Lodge. My experiences at the Lodge, and the additional classwork acquired during the preceding year, combined to give me much greater confidence in my professional abilities. I had approached the Lodge experience with apprehension, but I found I was eager to begin my new internship experience. This proved
very beneficial as I began my work in the more formal atmosphere of the hospital.

Group work at the hospital demonstrated for me the value of my past experiences. My initial introduction to group therapy had been at the Lodge and the emotions experienced at that time were also quite different than the ones I experienced at the hospital. My new confidence and expanded knowledge of group dynamics gave me a greater ability to observe and understand what was happening in my groups. As a result, I found I was better prepared to perceive differences in group leadership styles, and the effects these differing styles had on group productivity. Most importantly, I found I could more intelligently select therapeutic approaches and techniques which were compatible with my personality and skills.

Perhaps the most significant learning for me resulted from working with the more seriously disturbed patient population at the hospital. Initially, I was somewhat frightened and unsure of how effective I could be with these patients. The more exposure I had with these patients, however, and the more patient relationships I developed led to my discovery that the severity of patient problems lay more in my fears and perceptions than in actuality. This was an important insight for me to gain and it allowed me to deal with pathology with a new measure of confidence.

It was as a result of supervision that I believe much of my personal growth developed. It was in supervision that I received and evaluated feedback, asked questions, stated
opinions, made suggestions, and checked my perceptions about patients and my behaviors. The supervision that I received sharpened my cognitive abilities and developed and refined my clinical judgments. With my supervisors' encouragements, I was able to actively interact and view the improvement of my skills. This reinforcement enabled me to be more open and forthright in my thinking.

I have concluded that the sequence of my learning experiences has been most important for my professional development. If one is to fully profit from an internship, it is necessary that he or she be fully prepared to take an active role and work side by side with other staff members. The purpose of internship is to practice and without the prerequisite knowledge, skills, and experiences, this could not be possible. Nor, could it be possible without this preparation to have the respect of colleagues and patients that is so essential to the performance of effective therapy.

In deciding upon the setting for my first professional field experience at St. Joseph's Lodge, an important consideration was the nature of the demands that would be made upon me and my ability to fulfill these demands. The Lodge proved to be an ideal setting for me. The unstructured environment, the patient population, and the procedures practiced were well within the scope of my preparation.

In contrast, the more demanding situation at the Kalama-zoo State Hospital required a far more extensive background in knowledge of human behavior, psychoanalytic theory, testing
skills, diagnostic procedures, and therapeutic skill in dealing with severely disturbed patients. Without the experience at St. Joseph's Lodge and the additional studies that were accomplished prior to my internship at the hospital, I could not have profited from my internship to the extent that I did.

In summary, for anyone who would contemplate an internship in a setting such as Kalamazoo State Hospital provides, I would make the following recommendations:

1. Appropriate course work should be completed prior to the internship. Suggested courses would be in the following areas:
   a. Personality Theories
   b. Psychopathology
   c. Group procedures and dynamics
   d. Psychometrics—individual testing, personality measures
   e. Advanced practicums—individual and group
   f. Diagnostics and psychological report writing

2. Supporting field experiences should be a part of preparation to provide for proper integration of classroom studies and to allow the individual to feel competent in the practice of his skills.

3. The internship should be planned as a full-time experience, so that the individual may be accepted as a regular member of the agency staff.

At the completion of my internship, I was aware of feeling very satisfied. It was as if I had finally completed a
long journey and was happy where I found myself. Although there had been many fears and anxieties along the way, I had managed to deal with these and somehow had grown in personal confidence and felt stronger for having made the effort. I had a feeling of accomplishment and pride.
CHAPTER V

Summary

Throughout history learning-by-doing experiences have been employed to develop required skills for trainees. Today, as in the past, it is generally recognized by educators in fields such as law, medicine, business, psychology, and public health that professional practice should be included as part of the trainee's experience. Counselor educators are also in general agreement with this concept and counseling internships have become an accepted procedure for developing skills of trainees. This report details my internship and the impact the experiences had upon my development as a counselor.

Although my previous counseling experience had been with adolescents in a public school setting, I thought that my major interest was in community agency work. For this reason, a professional field experience was arranged at St. Joseph's Lodge in Kalamazoo, Michigan during the summer of 1973. This experience served to confirm my interest in the community agency area, and, consequently, an intensive 400 hour internship was arranged and completed at Kalamazoo State Hospital in Kalamazoo, Michigan during the summer of 1974.

St. Joseph's Lodge is an adult psychiatric day center serving members of the community who have difficulty in making personal and social adjustments in living. During my eight week training program at the Lodge, I participated in group
and individual therapy, attended staff meetings, and, in general, functioned as other regular staff members.

The objectives for my training at the Lodge included: gaining experience in group and individual therapy, developing staff relationships and consultation, and receiving regular supervision.

Overall, I thought my experience at the Lodge had been very profitable. I had accomplished my goals and gained considerable confidence in my professional abilities. This led to my decision to do an internship at the Kalamazoo State Hospital.

Kalamazoo State Hospital, an institution for the mentally ill and serving an eleven county region, is operated and funded by the Michigan Department of Mental Health. During my ten week internship at the hospital, I participated in individual and group therapy, administered and interpreted tests, wrote psychological reports, and attended staff meetings and court proceedings.

All objectives for my internship at the hospital were met successfully. I greatly enhanced my skills as a group and individual therapist and gained a significant amount of skill and experience in testing, test interpretation, diagnosis, and psychological report writing. I was exposed to a variety of staff relationships and thus had the opportunity to experience a truly professional work experience. Supervision was personally meaningful and helped to contribute to my development as a counselor.
In retrospect, I was able to see continuity and inter-
relationship between my experiences at St. Joseph's Lodge
and the Kalamazoo State Hospital. The combined experiences
made possible more meaningful learning than might have been
possible for either experience by itself. This led to the
conclusion that a planned sequence of professional field ex-
periences make each succeeding experience more beneficial for
a trainee, since an additional basis for interpretation of
the experience is provided.
References


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APPENDIX I

Prospectus of Kalamazoo State Hospital Internship
MAJOR INTERNSHIP: PROSPECTUS

Submitted by Carole M. Bullmer, Department of Counseling and Personnel

A. Identifying Information

Institution: Kalamazoo State Hospital
Supervisors: Jim Burchell, Beverly Freet, Philip Teitelbaum
Time Period: June 17, 1974 to August 23, 1974
Description: This is a 40 hour week study for a 10 week period at the Kalamazoo State Hospital. The internship will be divided between the alcoholic unit and the psychology unit. During that time I will be working with and be supervised by Beverly Freet, Phil Teitlebaum, with Jim Burchell as my major supervisor during my internship.

B. Professional Development

To date my professional background has been in schools and school counseling. My interests and studies have now shifted to community agencies and the services they provide. I feel that this experience will add depth and breadth to my knowledge and understanding of some of the services that are available to communities. This internship offers me a comprehensive overview of a variety of these services. It also provides a variety of learning situations that I want to take advantage of such as, administering and interpreting tests, report writing, exposure to various personality disorders, and individual/group contact with patients.
I will have the opportunity to work in two different units of the hospital and be exposed to several treatment modalities and therapists. Also, I will be working with a cross-section of a community population, in terms of age, sex, race, etc. I will have an opportunity to observe and to work with many different therapists and be critiqued by them. I see all of these broad experiences as being beneficial to me and my professional growth.

C. Internship Goals

1. To gain experience and knowledge about a mental health organization.
2. To develop interpersonal relationships with the members of the hospital staff.
3. To develop clinical skills through providing clinical evaluations and counseling to groups and individuals.
4. To gain experience and develop proficiency in administering and interpreting tests.
5. To gain experience and develop proficiency in psychological report writing.

D. Method of Achieving Goals

1. Attending and participating in staff meetings.
2. Partaking in the activities of the alcoholic unit and the psychology unit.
3. Visiting the various units of the hospital and learning the hierarchy and importance of each unit to the other.
4. Working as a co-leader and leader with various therapists and being exposed to various techniques.
5. Conferring with different therapists about certain group or individual.

6. Partaking in frequent supervision of group activities in both units with different therapists.

7. Keeping detailed records of individual and group meetings.

8. Engaging in couple counseling and working with the families of patients with another therapist.

9. Engaging in counseling with individuals and groups in both units.

10. Writing up group reports and individual verbatims.

11. Administering the Wechsler and Rorschach tests and being supervised on interpreting them.

12. Writing psychological reports on patients and being critiqued on them by my supervisors.
APPENDIX II

Application for Permission to Elect
Specialist's Project
APPLICATION FOR PERMISSION TO ELECT
720 Specialist Project 2 hours
Winter 1974

Name: Carole M. Bullmer  Student Number: 352-40-3929
Address: 728 South Drake Road #8  Kalamazoo, Michigan 49009
Degree Program: Specialist/Counseling and Personnel
Description of Independent Study:

The purpose and intent of my Specialist Project is to present a detailed account of my experiences at St. Joseph's Lodge and Kalamazoo State Hospital, and how they directly related to and influenced my growth and development as a counselor. The internship experiences primarily consisted of a 400 hour program at the Kalamazoo State Hospital with an initial introduction to agency work in a 160 hour program at St. Joseph's Lodge. The project will include an evaluation of myself in terms of accomplished objectives of my internships, growth and development of my emotions and ideas in relationship to being a counselor, and how the internship experiences will relate to any school or agency counseling job.

William A. Carlson  Carole M. Bullmer
Signature of Faculty Sponsor  Signature of Student

William A. Carlson  William Martinson
Signature of Faculty Advisor  Signature of Department Head
APPENDIX III
Application for Permission to Elect
Professional Field Experience
DEPARTMENT OF COUNSELING AND PERSONNEL  
Western Michigan University  
Kalamazoo, Michigan 49001  

Date: May 31, 1973

APPLICATION FOR PERMISSION TO ELECT  
712 Professional Field Experience 3 hours  
Summer 1973

Name: Carole M. Bullmer  
Student Number: 352-40-3929

Address: 728 South Drake Road #8 Kalamazoo, Michigan 49009

Degree Program: Specialist/Counseling and Personnel

Description of Independent Study:

St. Joseph's Lodge is an adult psychiatric day center for adults affiliated with the Delano Clinic at Borgess Hospital. The program helps people with personal and social adjustments and problems associated with those adjustments. Individual and group therapy will be included in the study program, as will staff relationships, consultations, and daily log writing.

William A. Carlson  
Signature of Faculty Sponsor  
Carole M. Bullmer  
Signature of Student

William A. Carlson  
Signature of Faculty Advisor  
William Martinson  
Signature of Department Head