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The Relationship Between The Basic Skills Proficiency Of Counselor Education Master's Level Students And Client Outcome

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THE RELATIONSHIP BETWEEN THE BASIC SKILLS PROFICIENCY OF
COUNSELOR EDUCATION MASTER'S LEVEL STUDENTS AND CLIENT
OUTCOME

by

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ABSTRACT

A review of literature on the history of psychology and counseling revealed a limited amount of research on counselor education training programs, specifically basic skills versus client outcome. The purpose of this study was to investigate the relationship between counselor educator student's basic skills and the effects these skills had on client outcome. By way of a multiple regression, two independent variables, the Global Scale for Rating Helper Responses (GSRR) and the Counselor Skills and Professional Behavior Scale (CSPBS) were analyzed in relation to the Outcome Questionnaire (OQ-45.2). Results indicated that there was no statistical significance between basic skills and client outcome.

The pursuit of this doctoral degree would have been extremely difficult, if not impossible, without the loving support of my husband and daughters. To my husband Ron, for the continued encouragement and commitment throughout my academic work, and to my daughters, Nicole and BreAnn, for their acceptance and understanding throughout my academic endeavor, go my love and most sincere appreciation. It is to them that I dedicate this work, for they are the ones that made this possible and all worthwhile.

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LIST OF ACRONYMS/ABBREVIATIONS

AAAP	American Association of Applied Psychology
AACD	American Association for Counseling and Development
ACA	American Counseling Association
ACES	Association of Counselor Education and Supervision
ACP	Association of Consulting Psychology
ACPCA	Academy of Clinical Psychotherapist Certification and Accreditations
AMHCA	American Mental Health Counselors Association
APA	American Psychological Association
APGA	American Personnel and Guidance Association
AVTMH	Americans View Their Mental Health
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CMHS	Center for Mental Health Services
COPA	Council on Postsecondary Education
CSPBS	Counselor Skills and Professional Behavior Scale
ES	Effect size
GSRR	Global Scale for Rating Helper Responses
GSS	General Social Survey
HAI	Human Affairs International

HRT/HRD	Human Resource Training/Human Resource Development
IPR	Interpersonal Process Recall
IRB	Institutional Review Board
MC	Microcounseling
MRA	Multiple Regression Analysis
NAACCMHC	National Academy of Certified Clinical Mental Health Counselors
NDEA	National Defense Education Act
NHSC	National Health Service Corps
NIMH	National Institute of Mental Health
NVGA	National Vocational Guidance Association
OQ-45.2	Outcome Questionnaire 45.2
PBH	Pacificare Behavioral Health
PRN	Practice Research Network
SCP	Society of Consulting Psychology
SD	Symptom Distress
SPSS	Statistical Package for the Social Sciences
SR	Social Role
TDCRP	Treatment of Depression Collaborative Research Program
USPHS	U. S. Public Health Service
VA	Veterans Administration

CHAPTER ONE: INTRODUCTION

There are over 57 million people in the United States diagnosed with a mental illness annually (National Institute for Mental Health, 2006). The growing need for highly trained counselors to address this demand is apparent. Moreover, in 1993, the Joint Commission on Mental Illness and Health was concerned about resource shortages. The commission suggested expansion in existing training facilities and the establishment of new training facilities to meet the demand for more mental health professionals (Joint Commission on Mental Illness and Health, 1993). As the counseling profession changes in response to the evolving needs of our society, relevant training programs need to be developed and implemented to prepare students in this profession. Students are required to, "… master the knowledge and skills to practice effectively" (CACREP, 2001, p.3). However, are counselors actually trained in such a manner, and what are the ramifications of their training on the client? This study examined the basic skills taught to counselors-in-training and the effects that these skills had on client outcome.

Chapter One will describe the following: (a) a brief history of training in psychotherapy, skills training modalities and prevalent research on training of basic skills, (b) rationale of the study, (c) the research question, (d) a brief methodology, data analysis, and limitations. The literature review in Chapter Two will focus on the history of training, research on training, and client outcome. Chapter Three will present the methodology including participant information, instruments, and procedures. Chapter

Four will report the findings of this study. Lastly, Chapter Five will summarize

observations, discuss limitations, and propose future directions for additional research.

<div align="center">History of Training in Psychotherapy</div>

As early as the 1900's, the effects of psychotherapy on clients were being

scrutinized and challenged. There was a limited amount of research at that time and what

was available indicated that clients diagnosed with neurosis had a better chance of

recovering without psychotherapy. Eysenck (1952/1992) posited that,

> They fail to prove that psychotherapy, Freudian or otherwise, facilitates the
>
> recovery of neurotic patients. They show that roughly two-thirds of a group of
>
> neurotic patients will recover or improve to a marked extent within about two
>
> years of the onset of their illness, whether they are treated by means of
>
> psychotherapy or not (p. 661).

He further added that psychotherapy had an inverse correlation; the more psychotherapy

received the smaller the chance of recovery (Eysenck, 1952/1992). Consequently,

Eysenck's evaluation of psychotherapy outcome generated over 500 outcome studies

(Bergin, 1971; Meares, Stevenson, & D'Angelo, 2002). These studies (1916 to 1970)

improved the opinion on psychotherapy slightly; however, it was still indicated that

psychotherapy had a mediocre effect that was only modestly positive (Bergin, 1971).

Bergin said, "It is only when we break therapy down into its components that we begin to

obtain clearer results" (p. 238).

As proposed by Truax and Mitchell (1971), these components consisted of the therapist's empathy, warmth, and genuineness. However, even with this discovery, a debate still ensued as to whether a therapist could be taught the skills of being empathetic, warm, and genuine or if these components were part of the therapist's innate attitude or personality characteristics. At the same time, the founder of humanism, Carl Rogers (1957/1992) believed that for sufficient change to take place in a client, a therapist needed to demonstrate the facilitative conditions of empathy, genuineness, and unconditional positive regard. In response, a study conducted by Truax and Carkhuff (1965), using Roger's conditions of empathy and unconditional positive regard, indicated that when a therapist lowered conditions of empathy and unconditional positive regard, there was a definitive drop in the client's ability to self-explore. Conversely, when the therapist raised the levels of empathy and unconditional positive regard, there was a consequential rise in the client's ability to self-explore. This study was the impetus of blending behaviorism and humanism. Roger's terms were operationalized, and research began on how these basic skills could be taught to counselors-in-training (Young, 1998).

Although there are numerous counselor training programs, only the ones most relevant to this study will be discussed. Rogers contributed a great deal to the training and development of counseling students. Even though he did not believe in a skills model per se, he had an enormous impact on the training of counselors. Therefore, his ideas will be included in this section. Specifically, there were several training models that eventually led to the skills-based approach, including Carkhuff's Human Resource Training model and Ivey's Microcounseling.

Rogerian Legacy

Although there was concern that psychotherapy was not effective, it appears that training of therapists may not have been a priority. Rogers (1957/1992) stated that,

> Considering the fact that one-third of present-day psychologists have a special interest in the field of psychotherapy, we would expect that a great deal of attention might be given to the problem of training individuals to engage in the therapeutic process… For the most part this field is characterized by a rarity of research and a plentitude of platitudes (p.96).

However, Rogers was innovative in his ideas and efforts, which he demonstrated in teaching his students. He was the first to make audio recordings of sessions and analyze them. He deemed that therapy should be a scientific pursuit and that research would help to improve the profession (Kahn, 1997). He taught students to role-play the therapist with peers, he had students observe live demonstrations by the supervisor, he would play recordings of his own therapy sessions, and he would have students participate in personal therapy (Matarazzo, 1971). As aforementioned, Rogers taught his students that as a condition necessary for a change to occur, the therapist would need to express unconditional positive regard and empathy while being genuine towards that client (Rogers, 1957/1992). He also emphasized that the supervisor must model these behaviors for experiential learning to occur (Matarazzo, 1971). Interestingly, Rogers did not focus on diagnosis and pathology in clients like his counterparts.

Carkhuff's Human Resource Training

Carkhuff's (1969) approach was more of a behavioral training model. One of the fundamental tenets of this model was that helping is a process that will lead to changed behaviors. If the effective helper demonstrated nourishing and responsive behaviors, then in turn, the individual would be helped. The belief was that as clients become fully functional and self-actualized, they become capable of helping others as well as themselves.

The model consisted of three goals for the client: self-exploration, understanding, and action. The helper assists the client in achieving these goals by (a) attending, (b) responding, (c) initiating, and (d) communicating. In these four categories, therapists learn numerous sets of skills that parallel each of these categories. The interaction between the counselor and client was what would lead to a client's changed behavior (Carkhuff & Pierce, 1975). Once the client had an understanding of this process, he or she would then be able to train and help others.

Ivey's Microcounseling Model

Ivey's microcounseling model emphasized more of an educational approach than a medical one, as had been the case previously. Ivey's hope was that there could be a reconceptualization of the psychotherapist's role where therapists could perceive themselves as being a teacher rather than a therapist. Ivey posited that if interpersonal skills could be taught to everyone, then this would be a good training approach as a therapeutic modality. Some success was had in teaching a modified version of

microcounseling to hospitalized mental patients, students, parents of emotionally

disturbed children, and psychiatric inpatients (Daniels, Rigazio-Digillio, & Ivey, 1997;

Ivey & Authier, 1971).

Microcounseling emphasizes the learning of basic clinical interviewing skills by

breaking these skills down into concrete behavioral units. In this training method, skills

are taught one at a time until the individual has mastered each specific skill. The aim of

microcounseling is to bridge the gap between that learned in the classroom and the actual

experience of counseling. The model consists of three basic steps: (1) a baseline

interview, (2) specific training of the single skill, and (3) a re-interview (Ivey & Authier,

1971). Microcounseling also utilizes videotaping as a teaching and research instrument.

To date, this skills-based approach has continued to be a popular training method for

counselors (Young, 1998).

Research on Training of Basic Skills

As previously mentioned, outcome studies measuring the effects of psychotherapy

on clients increased after Eysenck's article proclaimed psychotherapy to be ineffective.

Subsequently, Rogers made a call for research on the training programs of therapists.

However, ten years later there was still a limited amount of research published.

Matarazzo, Wiens, and Saslow (1966) concluded, "…that there is no published research

regarding the teaching of psychotherapy, the supervisory process, how learning of

effective psychotherapy takes place, and how to teach psychotherapy efficiently" (p.608).

Consequently, by the 1970's, more research had been done on microcounseling than on any other significant training model (Hill & Corbett, 1993). After conducting a meta-analysis on 81 microcounseling studies, Baker and Daniels (1989) reported that the mean effect size was .89. This analysis indicated that microcounseling was a more effective training program than no-treatment or attention control conditions and even more effective than other training programs. Populations sampled were undergraduate students, minors, counseling students, and adults. Of these four groups, microcounseling training was more effective on undergraduates in acquiring skills.

In 1990, a narrative and meta-analysis review was conducted on three training programs; Carkhuff's Human Resource Training/Human Resource Development (HRT/HRD), Kagan's Interpersonal Process Recall (IPR), and Ivey's Microcounseling (MC). Of the 41 studies, included were 8 studies on HRT/HRD, 10 studies on IPR, and 23 studies on MC that met the researchers' criteria. The participants in these studies were graduate-level counselor trainees in counselor education and counseling psychology programs. The effect size for HRT/HRD, IPR, and MC, were 1.07, .20, and .63 respectively (Bakers, Daniel, & Greeley, 1990). The findings led to favorable views of all the training programs; however, they indicated the need for more research. Specifically, for the particular study on microcounseling, even though the effect size was medium in comparison to the other training programs, teaching lower order skills was more effective than teaching higher order skills (Baker et al, 1990).

Additionally, McLennan (1994) reviewed 39 papers published between January 1968 and December 1989. He reported that in six studies, counselors-in-training that

completed a skills-based training program retained and practiced the skills they were taught. The results of the meta-analysis, when comparing skill-based training groups versus untrained control groups, showed an effect size of 1.04. However, the skills-based training group as compared to other types of training groups saw the effect size decreased to .78.

With over 300 empirical studies investigating microcounseling, it appears that this skills-based training program is effective in teaching graduate-students as well as many other different populations (Daniels et al., 1997; Hill & Corbett, 1993; Ivey & Ivey, 1999). Healthcare professionals in all walks of life have been trained successfully using microcounseling. Microcounseling has even been taught to psychiatric patients, mildly mentally retarded individuals, and couples with communication issues (Daniels et al., 1997). "However, the ultimate measurement of training adequacy, that of patient improvement, for the most part has continued to be relatively crudely measured, if at all" (Matarazzo & Garner, 1995, p.855). Young (personal communication, March 2006) describes the conundrum as watching a skilled surgeon perform a successful intricate surgery, but the patient dies. It is difficult to imagine that with all of the present day emphasis on counseling skills, the results of applying those skills toward client well-being is still lacking. Counselor educators should be held to a higher standard as those ultimately accountable to the client and responsible for the skills taught to the student. Therefore, the purpose of this research study was to examine the relationship between proficiency in using basic counseling skills and the effect this had on client outcome.

Rationale of Study

According to several health monitoring organizations, the burden of mental illness on the health of individuals in the United States has been vastly underestimated. The Global Burden of Disease study by The National Institute of Mental Health reported that mental illness accounts for over 15% of all disease in the United States, which is higher than all the cancers combined (National Institute of Mental Health, 2006). They estimate that approximately 20% to 25% of adults suffer from a mental illness. Translating this percentage into numbers of people would mean 57.7 million adults diagnosed with a mental disorder in a given year, making the United States psychologically sicker than all other developed nations (American Psychiatric Association, 2006; Holden, 2005; National Institute of Mental Health, 2006).

These staggering statistics clearly demonstrate the need for highly qualified, trained mental health professionals. This need was first recognized in 1957, when people in the United States participated in the Americans View Their Mental Health (AVTMH) survey, which investigated and examined participants' view of their own mental health. The AVTMH survey was given again in 1976 and then in 1996. However, the 1996 survey by the General Social Survey (GSS) replicated only some of the questions from the AVTMH survey (Swindle, Heller, Pescosolido, & Kikuzawa, 2000). Nonetheless, all three surveys contributed significantly to legislation regarding mental health. Specifically, the 1957 study set precedence and direction for the national mental health policy, which gave credence to the empirical underpinnings for the 1960's mental health and education training movement (Swindle et al., 2000). In 1961, the Joint Commission

on Mental Illness and Health was concerned about having enough skilled people to fulfill the need for mental health services. Again, in 1993, the same concern was discussed (Joint Commission on Mental Illness and Health, 1993).

The need obviously exists for more training facilities and better equipped mental health professionals; however, how should the counselor-in-training be educated, and what are the ramifications on the clients? It seems imperative that counselor education and training programs be exceptionally well developed and implemented expediently. One such advancement in this regard has been through the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Closely monitored CACREP programs provide a national operational standard for counselor training. Within that standard, there are several requirements that need consideration in assuring the quality of counselor education and counselors must continually monitor their effectiveness as professionals (ACA, 2005). Specifically, the American Counseling Association (ACA) Code of Ethics, Section A, stipulates that the counselor's primary responsibility is to respect the dignity and promote the welfare of the client. Section A.4 also states that the counselor must act to avoid doing harm to the client (ACA, 2005). In meeting these requirements, there not only needs to be a measure for effective training of the counselor, but the direct effects of this training on the counselor's client is paramount.

<u>The Research Question</u>

Is there a relationship between the basic skills proficiency of counselor education master's level students and client outcome?

Hypotheses

(1) There is a relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

(2) There is a relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypotheses

(1) There is no relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

(2) There is no relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Definition of Terms

Basic Skills

Basic skills, microskills, microcounseling, and microtraining are interchangeably used as are therapist, counselor, and helper. The basic skills that are measured in this study are listed on the CSPBS and definitions for these skills come from *Learning the Art of Helping (3rd ed.) (Young, 2005)*.

Outcome

In this study, outcome refers to change that occurs based on the therapy process. Typically, outcome is often a measure between pretherapy and posttherapy sessions (Hill & Corbett, 1993). In this study, the OQ-45.2 measured client outcome pretherapy and posttherapy.

Methodology

Participants

The participants in this study were master's level graduate students admitted to a counselor education program at a large southeastern university. The students were first and second semester practicum students with data collected during the summer and fall 2006 semesters. There were 37 students (60 cases) participating in the study. Additionally, this researcher asked clients of the above participants to allow access to their Outcome Questionnaire scores. The subjects who participate were comprised of a purposive, who examined specific phenomenon, in this case, master level students skills in practicum (Shadish, Cook & Campbell, 2002).

Instruments

The three instruments utilized in the study were the Outcome Questionnaire (OQ-45.2), the Counseling Skills and Professional Behavior Scale (CSPBS) and the Global Scale for Rating Helper Responses (GSRR). The scores from the OQ-45.2 were the

dependent variables in this study, and the scores from the CSPBS and GSRR were the independent variables.

Outcome Questionnaire

The purpose of the OQ-45.2 was to measure client progress in therapy. The self-report 45-item instrument can be repeatedly administered during therapy, often given pre and post therapy and intermittently during the course of treatment (Lambert, Morton, Hatfield, Harmon, Hamilton, Reid, Shimokawa, Christopherson, & Burlingame, 2004). The questionnaire is highly sensitive to client change and symptomology (Vermeersch, Lambert, & Burlingame, 2002; Vermeersch, Whipple, Lambert, Hawkins, Burchfield, & Okiishi, 2004). The instrument measures adult client progress according to three specific dimensions: symptom distress, interpersonal relationship, and social role performance (Lambert et al., 2004). This study utilized only the total score.

Counseling Skills and Professional Behavior Scale (CSPBS)

The CSPBS is a new instrument, developed by the faculty at the same southeastern university. The design of the instrument was as a tool for the practicum instructor to evaluate practicum student proficiency in basic counseling skills at mid and final semester. Part one of the instrument contains 25 items on a 4-point Likert scale. This study utilized the total score of part one.

Global Scale for Rating Helper Responses (GSRR)

As designed, the GSRR measures the overall effect of the counselor's communication skills (Gazda, Asbury, Balzer, Childers, Phelps, & Walters, 1999). A team of three counselor education doctoral students, trained on the GSRR, observed one practicum session towards the end of the semester. The doctoral students rated the student counselors on their specific responses given to clients. The ratings on this instrument are designed on an 8 point Likert scale (.5, 1, 1.5, 2, 2.5, 3, 3.5, 4), and the total score was utilized. The inter-rater reliability coefficient was .94.

Procedures

This ex post facto correlational design investigated the relationship between the counseling skills scores from the CSPBS and GSRR and client outcome scores from the OQ-45.2. The master's level practicum students were asked to sign an informed consent. The consent gave the researcher permission to access their scores on the CSPBS and the GSRR. The practicum instructor evaluated the CSPBS, and the counselor education program research associate collected those scores. The researcher was given those scores via the research associate. The scores from the GSRR were accessed toward the end of the semester by the team of doctoral students. Scores were given directly to the researcher.

Additionally, the researcher asked the practicum students to obtain informed consent from their clients. If the clients agreed, they signed an informed consent. OQ-45.2 scores were entered into the counseling clinic database. For the researcher to access

these scores, the clinic coordinator provided them for the approved Institutional Review Board (see Appendix A) researcher. The pretest and posttest scores were subtracted, and this score was utilized for the study.

Data Analysis

Once the data was obtained, it was entered and analyzed by the Statistical Package for the Social Sciences (SPSS) using a Multiple Regression Analysis (MRA). A MRA was used to examine the relationship of the total scores on the CSPBS, GSRR, and OQ-45.2. The sample size was determined to be 37 participants with each participant having at least one to two clients, which exceeds the requirement of one variable to 10 cases for a MRA (Shavelson, 1996).

Limitations

Since this study was investigating a relationship between variables, the results were a prediction instead of a cause and effect (Campbell & Stanley, 1963). Additionally, the CSPBS and the OQ-45.2 were determined by the counselor education program. The CSPBS is a new instrument and has not been validated, which is why it was used in conjunction with the GSRR. This researcher was not intending to validate this instrument. Also, there was no interrater reliability on this instrument. Moreover, the OQ-45.2 is a self-reporting instrument and there was a chance for bias. Since some master's level students have two semesters of practicum, there was an overlap of students in the sample. However, each student was considered a separate case because the students had different skill levels, different clients, and different instructors each semester. The researcher was

using a purposive sample, and the study may only be generalizable to a similar university

setting. Lastly, since this was a correlational design, there are always extraneous

variables that may be unaccounted for in the study.

CHAPTER TWO: LITERATURE REVIEW

Chapter Two presents the significant literature pertaining to the relationship between the basic skills proficiency of counselor education master's level students and client outcome. Specifically, included in this chapter are, (a) the history of training in psychotherapy, (b) research on psychotherapy training, and (c) a review of client outcome literature.

History of Psychotherapy Training

Psychology as a Science

In the last 100 years, psychotherapy has made incredible advances in its prevalence, pervasiveness, and popularity (Reisman, 1991). However, the education and training of psychotherapists has developed slowly and with considerable contention. The tone that was set for psychologists and graduate students in the United States in the late 1800's was led by some great pioneers in the field. These included men such as G. Stanley Hall at Johns Hopkins University and Clark University, James McKeen Cattell at the University of Pennsylvania and Columbia University, and Lightner Witmer at University of Pennsylvania, all of whom studied under Wilhelm Wundt (Reisman, 1991). Wundt founded the first psychology laboratory in Leipzig, Germany in the same year (1875) that William James established the first psychology laboratory in the United States at Harvard University (Peterson, 1992; Reisman, 1991). Wundt defined psychology as the study of consciousness. The substance of psychology would be similar to philosophy;

however, finding answers would be done through scientific method. Psychology became the study of the mind (Reisman, 1991). In general, the field of psychology was struggling for identity as a science and psychology was not yet considered a profession.

Consequently, the training of graduate research students in psychology found its basis in a design that was similar to the German model of master-student. Students would choose their area of interest and ask the professor for entrance into their lectures. The student would then study and learn independently all that they needed to know on that professor's particular research subject. Once the student felt that he was knowledgeable enough, the professor would question and examine the student. The professor would allow him to continue and study for their doctoral degree if the student demonstrated knowledge was acceptable. Under the guidance of the professor, the student would take the next logical step in the professor's research project. The student would apprentice under the professor and would become the professor's research assistant. Upon completion of the research, the student would write a report and defend their work to the faculty of the university. The awarding of a doctoral degree came if they could convince the faculty of their contribution to the research project. In this entire scenario, students did not have a curriculum to follow, but rather were led by their professors in a one-on-one relationship (Peterson, 1992). Research done in this manner helped to establish psychology as a science, but those thusly trained did not yet have distinct professions as psychologists and tended to remain in academia.

Psychology as a Profession

In 1892, Hall, along with seven other professors, founded the American Psychological Association (APA). At one of the APA meetings in 1896, Witmer delivered an address suggesting a different approach to train those in the field of psychology. He proposed that the "clinical psychologist," a term he coined, investigate mental or moral retardation in children and do so in a psychological clinic setting. Moreover, he said there should be specialized training for students in a new profession as psychological experts (French, 1992; Peterson, 1992; Witmer, 1907). Even though his colleagues did not receive his suggestions well, the University of Pennsylvania established the first psychological clinic. This innovation provided a great learning experience for students in that it allowed them to view the behavior of children first hand. The children at the clinic received both mental and physical examinations as part of the program (French, 1992; Reisman, 1991; Peterson, 1992). Witmer's suggestions on the training of students eventually lead to formal courses taught at graduate and undergraduate levels.

In 1910, for instance, the University of Pennsylvania developed a curriculum of psychology courses. Courses included a general psychology course, a genetic psychology course, a mind and body course, a character and conduct course, a growth and retardation course, as well as courses on evidence, feeling and appreciation, experimental psychology, abnormal psychology, and advanced experimental psychology. Most of the courses required a one-hour lecture and a total of 10 hours of additional lab work for the program (www.psych.upenn.edu/history/courses1910.htm).

Following Witmer's example, other universities began setting up psychological clinics. These clinics focused primarily on children with learning disabilities, which gave way to the child guidance movement. Services provided in these clinics integrated three fields: psychiatry, psychology, and social work (Peterson, 1992; Shore & Mannino, 1976). About the same time, Parsons realized the need for vocational counseling which was directed at the unemployed youth. In addition, he founded the Boston Vocational Bureau, which later became the National Vocational Guidance Association (NVGA) (Brooks & Weikel, 1996). Although these clinics revolutionized psychological services for children and the need for vocational services were adopted, the mentally ill were still not receiving appropriate services (Reisman, 1991). The manner in which those with a mental illness were treated was deplorable and unforgivable (Weir, 1992).

Prior to Pinel's reform, which was directed at the moral treatment of the mentally ill in France and all over Europe, individuals were chained, beaten, and starved (Weir, 1992). Sixty percent of them died within the first two years of confinement. Because of the belief that the mentally ill had lost the ability to reason, they were considered of animal status and were treated as wild beasts. The foremost diagnosis for the mentally ill was demonic possession. Men, women, and children were thrown together with criminals in cages or cells without heat or bathrooms (Peterson, 1992; Shore & Mannino, 1976; Weir, 1992).

In the United States, Dorothea Dix would make a plea for the mentally ill to the Massachusetts General Court calling, "…your attention to the present state of Insane Persons confined within this Commonwealth, in cages, closets, stalls, and pens! Chained,

20

naked, beaten with rods, and lashed into obedience" (Gollaher, 1993, as quoted in Dix,

1843, p.4). Subsequently, towards the end of the 18th century in France, Pinel finally

freed his patients, as Dix continued to push for reform in the United States. Converted

mad houses and asylums became hospitals (Gollaher, 1993; Weir, 1992). In 1909,

Clifford Beers published *A Mind that Found Itself,* describing the atrocities of what it was

like to spend his youth and part of his adulthood in an institution. Through the public's

interest concerning Beer's experience, he was able to found the National Committee for

Mental Hygiene, the forerunner of the National Mental Health Association (Brooks &

Weikel, 1996). As superstition waned and the mentally ill no longer considered

demonically possessed, better living conditions and psychological treatments were soon

forthcoming.

<center>The Beginning – Working with the Mentally Ill</center>

Over the next century, there were a great many contributions to the treatment of

mental illness. One major provider to the understanding of the mentally ill was Sigmund

Freud. Freud received his medical degree from the University of Vienna, specializing in

neurology. While studying under the famous psychiatrist Jean Martin Charcot, Freud

became intrigued with patients diagnosed with hysteria. Charcot's patients were often

paralyzed or blind, but had no apparent physical cause for this specific malady. Charcot

treated them through hypnosis to relieve their symptoms (Freud, 1961, 1965, 1966;

Moser, 2006). Freud, however, developed a different technique to treat hysteria, using

free association to reveal the unconscious process, which he believed to be the underlying

<center>21</center>

cause of the mental disorder. He also identified other mental processes, which he termed

repression and resistance. Repression was the process by which an individual disallowed

a traumatic event access to the conscious mind. Resistance was the defense against

awareness of the repressed experience, which produced the symptom (Freud, 1961, 1965,

1966; Friedlander, 1911). This new understanding of mental functioning led to a radical

change regarding the previous perceptions of mental illness, and eventually gave birth to

Freud's theory of Psychoanalysis.

Freud's childhood experiences, and later his own analysis of these events, was

additive to his theory (Wollman, 1984). As the very first analyst, partially because of his

own exploration and later that of others, Freud's new theory revolutionized the way

doctors interacted with their patients (Cushman, 1995; Freud, 1966). Psychoanalysis not

only permeated the medical field, but also influenced other scientific and educational

fields all over the world. In 1909, celebrating the 20th year anniversary of the founding of

Clark University, president G. Stanley Hall invited Freud and his new protégé, Carl Jung,

to lecture. Clark awarded honorary degrees in Doctor of Laws to both men. At this point,

Freud had gathered a substantial following. Prominent men such as Sandor Ferenczi,

Ernest Jones, and A. A. Brill represented advocacy for psychoanalysis at the convocation

(Freud, 1966; Peterson, 1992).

Freud was also one of the first to endorse a separation of psychoanalysis from

medicine, although physicians were opposed to relinquishing control of the practice.

Freud believed, "Psychoanalysis is not a specialized branch of medicine. I cannot see

how it is possible to refute this. Psychoanalysis is a part of psychology" (Peterson, 1992,

as quoted in Freud, 1959, p.232). Even though a lawsuit won in Austria proclaimed the viability of lay psychoanalysis, in the United States an article written by A. A. Brill refuted Freud's idea on the topic. Brill, a medical psychoanalyst, believed that only a physician could practice psychoanalysis. Consequently, in 1925, the New York state legislature passed a bill making it illegal for anyone except a psychiatrist to practice analysis (Peterson, 1992).

This controversy and the subsequent rulings made it very difficult for psychologists to receive training because now only a psychoanalyst could do the instruction and analysis. A student would be required to enter into full analytical therapy and remain in therapy until the senior psychoanalyst believed the scholar had sufficient skills to function independently. At one point, only foreign-born students that promised to only practice back in their own country could even enter analytic treatment. Treatment would last up to four years and cost an exorbitant amount of money (Frank & Frank, 1991; Peterson, 1992).

Finally, in 1929, the American Psychoanalytic Association allowed lay analysts to work with children (Peterson, 1992). This was the impetus for psychologists to receive training in psychoanalysis. Also during the 1920's, various types of assessments were created and implemented. There were tests for intelligence, aptitude, character, personality, temperament, and introversion-extroversion. Psychologists became psychometricians or mental testers (Reisman, 1991). The field of psychology was slowly growing in service, a slight step towards it becoming a profession, and the training of mental health professionals was just starting to take shape.

The 1930's – A Profession Evolves and Training is Required

As the 1930's approached, the world seemed to be spinning out of control. In the United States, the Great Depression had left the country in financial ruin, leaving millions unemployed. France and England had declared war against Germany. Hitler's regime had a devastating effect on humanity, affecting all walks of life, especially the field of psychology. In Germany, the communist party abolished psychoanalysis and the development and implementation of all psychological tests. Because Austria allied with Germany, Mussolini and President Roosevelt plead for Freud's safety and the government officials allowed him to leave Austria to live out the last year of his life in England (Reisman, 1991). Many psychologists fled to the United States for refuge.

During this time in the U.S., there were a plethora of psychological tests developed, Moreno began doing group therapy, and psychologists focused on and explored the therapeutic relationship. Freud, Jung, and Rank all believed in the importance of the therapeutic relationship to help the patient achieve their goals, even though they had different methods in accomplishing that end (Reisman, 1991). There was a great deal of literature written about the therapeutic relationship, and different opinions and therapies began to develop. For example, psychiatrist Levy believed that clients were apt to relate to the analyst in the same way they would relate in the outside world. Thus, it would be imperative for the therapist to act appropriately towards the client and remain calm and understanding. In turn, healthier behaviors replaced the client's maladaptive behaviors. Levy called his innovative approach relationship therapy (Reisman, 1991). Social workers often implemented another approach called supportive therapy. Here,

social workers gave the client direction and advice in lieu of the lengthy psychoanalytical

depth therapy (Reisman, 1991). However, Rank believed that supportive therapy might

create too much dependence on the analyst. Fredrick Allen agreed with Rank's idea and

developed a therapy specifically for children called passive therapy. Allen believed that

the therapist's position was one of respect and acceptance of the child in that moment

(Allen, 1934, 1942). He said:

> I am interested in creating a natural relation in which the patient can acquire a
>
> more adequate acceptance of himself, a clearer conception of what he can do and
>
> feel in relation to the world in which he continues to live… I am not afraid to let
>
> the patient feel I am interested in him as a person (Allen, 1934, p. 201).

Rank's and Allen's ideas about the relationship impressed many other psychologists and

professionals, especially Carl Rogers.

Unfortunately, during this period clinical psychologists were very discontent.

They loathed being just test givers (Reisman, 1991). Moreover, physicians often

received sought after positions as the heads of clinics with higher salaries. Even the

public was skeptical of psychologists because there were no standards, codes, or

approved training programs. The APA ignored their needs because it still believed

psychology was a science and did not want to be a part of nonacademic problems. In

1930, the Association of Consulting Psychology (ACP) formed outside of the APA. The

ACP later joined with the APA Clinical section and become the American Association of

Applied Psychology (AAAP) (O'Roarke, 1999; Reisman, 1991).

Eventually, through an AAAP subcommittee on psychotherapy, clinical psychologists were sanctioned to include therapy as part of their profession, and a much needed training program was developed. In 1936, Columbia University established a curriculum for psychology, and Boston Society of Clinical Psychologists followed one year later. James McKeen Cattell, in an address of 1937 stated that, "…in the end there will be not only a science but a profession of psychology" (1992, p.8). Doll (1939) and Rogers (1938) strove for better training programs for all psychologists. Moreover, Rogers (1938) suggested that clinical psychology students should have a desire to help others and build a positive relationship with the client, while gaining insight and awareness of themselves. With this new focus on education and training, the field of clinical psychology reached a new height of respectability, and qualified clinical psychologists were in high demand (Reisman, 1991).

The 1940's – Training Expands and New Theories Introduced

After World War II, the Veterans Administration (VA) and newly established National Institute of Mental Health (NIMH) needed more psychiatrists and more mental health specialists. The emphasis was no longer just on children and their needs, but on adults as well (French, 1992, Reisman, 1991). War veterans were in need of vocational training, psychological assessments, and psychotherapy. There were a total of 20 million veterans with only 1,000 vocational counselors available and 1,500 vacant counseling positions. The APA and the AAAP committees purposed a four-year graduate program to help alleviate this problem. Additionally, the VA and the U.S. Public Health Service

(USPHS) provided federal funds for graduate programs. Graduate training in clinical

psychology received $212,000 from the NIMH alone (Cohen, 1992; Reisman, 1991). In

1945, Connecticut became the first state to pass a law to certify psychologists, and by

1949, 11 states certified school psychologists (French, 1992; Reisman, 1991). In the VA

training program for clinical psychology, 210 students in 22 universities participated and

by 1949, 42 schools offered a doctorate in clinical psychology. Training in psychotherapy

received its guidance and direction through the 1949 Boulder Conference. Psychology

education focused on the doctoral level and an internship became a requirement of the

program (Cohen, 1992). Clinical psychology was now a blossoming profession.

As the psychology profession continued to develop, so did new theories. Inspired

by Otto Rank, Carl Rogers developed Client/Person-Centered therapy (Rogers, 1951).

Rogers had a profound and unique understanding of the nature of human beings,

believing in a holistic view of people. Where a psychoanalyst focused on diagnosis or

treatment of a patient, the person-centered therapist would focus on a more optimistic and

positive view of the individual. The theory stressed freedom of choice, responsibility for

oneself, and striving towards self-actualization. The therapist would focus on the client's

feelings more than on the content of the session. Rogers posited that in order for therapy

to be successful, a relationship needed to be formed so that the client was comfortable in

expressing himself or herself and able to gain insight through these expressions. The

more self-aware clients became, the easier they would be able to accept themselves (Hill

& Corbett, 1993; Reisman, 1991; Zimring & Raskin, 1992). Rogers' theory had four

phases. The first phase was a nondirective phase where the therapeutic role was broken

down into specific elements. The counselor was to encourage the clients to express themselves freely as the counselor accepted, identified, and clarified any positive, negative, or ambivalent feelings. The client's goals included gaining insight, becoming responsible for their decision-making and becoming more independent (Hill & Corbett, 1993; Rogers, 1940, 1942a; Zimring & Raskin, 1992). Rogers second phase would span the next decade, but controversy for the profession was at hand.

The 1950's – Strides Are Made

Turmoil filled this decade as international unrest again affected the world. North Korean invaded South Korea and the U.S. became involved. The U.S. lost 54, 246 men and there are 157,530 casualties in the undeclared war. Meanwhile, in the U.S., tranquilizers became miracle drugs and seeing an analyst became a symbol of status. In psychology, Hans Eysenck used factor analysis to gain understanding of personalities (Reisman, 1991).

To the psychologist's dismay, empirical outcomes on the effectiveness of psychotherapy indicated that one-third of the patients had not improved. To add insult to injury, Eysenck published a study claiming outright that psychotherapy did not work. There was a limited amount of research at this time, and what was available indicated that clients diagnosed with neurosis had a better chance of recovering without psychotherapy. Eysenck (1952, 1992) asserted that:

> They fail to prove that psychotherapy, Freudian or otherwise, facilitates the
> recovery of neurotic patients. They show that roughly two-thirds of a group of

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neurotic patients will recover or improve to a marked extent within about two

years of the onset of their illness, whether they are treated by means of

psychotherapy or not (p. 661).

He further added that psychotherapy had an inverse correlation; the more psychotherapy

received the smaller chance of recovery (Eysenck, 1992). Consequently, Eysenck's

evaluation of psychotherapy outcome eventually generated over 500 outcome studies

(Bergin & Garfield, 1971; Meares, Stevenson, D'Angelo, 2002).

During this decade, four training conferences convened. In 1951 at Northwestern

University, and in 1954 at Thayer, N.Y., meetings took place to develop a system of

training for counseling and school psychology (Cohen, 1992; Strother, 1957). A 1955

Stanford conference considered counseling and school psychology for training programs

and there was a discussion about opportunities for research in mental health. Moreover,

practicum internship sites considered using mental health clinics. In 1958, an Estes Park

conference focused on training in research in mental health and a Miami conference

focused on the potential of training non-doctoral personnel (Cohen, 1992).

In 1951, Roger's wrote *Client-Centered Therapy* during his second phase,

emphasizing understanding the client perspective and communicating this understanding

back to the client. Rogers (1951) asserted that, "…in a decade, client-centered therapy

developed from a method of counseling to an approach to human relationship" (p.12). In

his classic article on necessary and sufficient conditions, Rogers stipulated that a therapist

needed to form a relationship with the client. The therapist was to be congruent, genuine,

and empathetic, and extend unconditional positive regard (Rogers, 1957/1992). By the

late 1950s, Rogers' therapy became an international success. The psychological profession widely used his well recognized theory (Reisman, 1991).

However, the process of therapy was not Rogers only concern. He also advocated for more training programs because of the rapid growth in the field of psychotherapy. At this juncture, approximately 20% of APA members were doing psychotherapy (Rogers, 1951). In 1955, Rogers indicated that there was a gap in literature because very little research was forthcoming on training programs (Rogers, 1955). Rogers wrote a paper that was rejected for publication on the need for training in 1956. He was, however, undeterred, because his interest was not only in his students, but also in the profession as a whole.

Fortunately, Rogers was innovative in his ideas and efforts, which he demonstrated in his teaching. He believed that to train individuals, there needed to be a facilitation of experiential learning more than of cognitive teaching (Rogers, 1955). He was the first to make and analyze audio recordings of sessions (Rogers, 1942b), preferring that a transcript be included to review and re-experience interviews (Rogers, 1955). He taught students to role-play the therapist with peers, he had students observe live group demonstrations by the supervisor, he would play recordings of his own therapy sessions, and he would have students participate in personal and group therapy (Rogers, 1955; Matarazzo, 1971). Rogers taught his students that, as a condition necessary for a change to occur, the therapist would need to express unconditional positive regard and empathy while being genuine towards a client (Rogers, 1957, 1992). Furthermore, he also emphasized that, for experiential learning to occur, the supervisors themselves must

model these behaviors (Matarazzo, 1971). In addition, he deemed that therapy should be a scientific pursuit and that research would help to improve the profession (Kahn, 1997). His characteristics of the therapist served as the precursor for the future development of basic skills training models. However, Rogers (1955) emphasized that the:

…goal of training in the therapeutic process is that the student develop his own orientation to psychotherapy out of his own experience…Likewise, he does not put on certain attitudes because those are the attitudes expected of an analyst or client-centered therapist, or the Adlerain way. He discovers and uses certain attitudes in himself, which have been developed because they have been rewarded by the effective outcome of earlier experiences in carrying on therapy (p. 87).

By the end of the decade an ethical code was established, some states had passed laws for licensure and certification, and the number of psychologists in the profession increased domestically and internationally. The NIMH awarded over a million dollars in training grants to clinical psychologists. There were 27 counseling psychology and 56 clinical psychology APA approved doctoral training programs (Reisman, 1991). Moreover, the National Defense Education Act (NDEA) of 1958 provided funding for school-based counseling and for training counselors at universities, which resulted in a rapid growth of counselor education programs. Also during this decade, the American Personnel and Guidance Association (APGA) was founded (Brooks & Weikel, 1996; Seiler, 1996). The need for more psychologists and counselors was increasing. However, there were those still condemning psychotherapy and there was a black cloud hovering over the profession because of the question of whether or not it was effective (Reisman,

1991). A new profession in mental health had begun to slowly emerge despite all of this dismal controversy.

The 1960's – A Radical Need and Skills Training Introduced

The mantra of the 60's was sex, drugs and rock & roll. In many ways, it was an escape from a world that saw a president, a civil rights leader, and a senator all brutally assassinated, the Vietnam War raging, a rise in crime, and abundant civil protests. The need for psychological services was about to rise dramatically. The population was growing and traditional approaches could no longer meet the needs of the country. Individuals expressed an increase in tension and anxiety, and research studies indicated the need for more mental health professionals (Reisman, 1991).

The *Americans View Their Mental Health* (AVTMH) survey became the antecedent in defining United States national mental health policy (Swindle et al., 2000). In 1961, the Joint Commission on Mental Illness and Health was concerned about having enough trained professionals to fulfill the country's growing needs. The Community Mental Health Centers Act of 1963 provided federal funds to build and staff community mental health centers and integrate various professionals for treatment in these centers. Women and minorities began acquiring degrees in psychology and the Association for Black Psychologists came about in 1968. Four new treatment approaches were introduced including community psychology or psychiatry, behavior therapy, humanistic psychology, and drug therapy (Reisman, 1991). State hospitals saw a decrease in the number of patients and concurrently communities saw an increase in halfway houses and

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group homes. The NDEA programs declined and counselors began transitioning from guidance counseling to a broader arena of mental health. The APGA adopted the first Ethical Standards (Brooks, 1996). The counseling profession was able to grow and flourish, crossing over from an educational setting to a community setting. Graduates of Counselor Education programs found that their skills were effective for this population and within the community setting (Palmo, 1996).

For the psychologist, however, this was a time of uncertainty. Forty years had passed and there were still arguments about whether the psychologist was a scientist or a practitioner. There was a concern regarding whether the profession would become fragmented (Reisman, 1991). Carl Rogers (1964), still concerned about the unsatisfactory education and training of graduate students, wrote a manuscript entitled *Graduate Education in Psychology: A Passionate Statement,* which was rejected by the *American Psychologist.* However, the manuscript became so popular that Rogers asked the *American Psychologist* to inform readers about where they could obtain a copy. The 1965 Chicago conference for psychologists considered various training programs. One idea was to begin training undergraduate and master level students for sub-practitioner service. For instance, undergraduate level students could train to interview and administer basic tests. At the master's level, the student could train in counseling and statistics, qualifying them as mental health workers and statistician technicians (Cohen, 1992). Professionals suggested various ideas for doctoral training as well. One consideration was a new doctorate of psychology (PsyD) degree as an alternative to a PhD. In 1968, the University of Illinois graduate college accepted this degree. Another idea was for a

freestanding professional school and in 1969, the California School of Professional

Psychology began offering a 6-year PhD program (Cohen, 1992). As the psychologists

debated about training programs, exploration began on a psycho-educational approach to

therapy.

Previously, with the medical model approach, a patient was considered sick and in

need of a cure. However, in the psycho-educational approach, proponents thought the

client to be lacking in certain basic skills. The counselor's role was to teach the necessary

skills to the client (Brooks & Weikel, 1996). Robert Carkhuff developed one of these

skills-based training programs. Since Carkhuff's Human Resource Training model was

the impetus for the basic skills model in Young's *Learning the Art of Helping* utilized in

this study, a thorough description will be provided.

Carkhuff (1969b) postulated that graduate training programs had not

demonstrated their effectiveness towards insuring a positive client outcome. He

purported, in fact, that the field lacked the necessary research concerning their own

training programs. Ironically, he also asserted that a student's level of functioning

actually deceased over the course of the training program. Moreover, Carkhuff indicated

that perhaps Eysenck's results might have been correct in that two-thirds of clients

improve over a one to two year period whether in a treatment group or a control group

(Eysenck, 1992). Levitt (1963) also reviewed 22 studies and deduced that psychotherapy

did not facilitate children's psychological recovery. Consequently, Carkhuff developed a

new training model for nonprofessionals and professionals, or as he called them, helpers.

Carkhuff (1969b) based the development of this training model on three propositions. Proposition one stated that, "Training in the helping professions may have constructive and destructive consequences on trainee level of functioning on dimensions related to constructive change" (p.149). For traditional training programs, the limited amount of research suggested that trainees in a traditional program displayed no change or negative change whereas in lay training programs, the trainee demonstrated positive results. Proposition two stated that, "Constructive or destructive consequences in training may be accounted for in large part by the initial level of functioning of both trainer and trainee on dimensions related to constructive change" (p.150). In traditional programs, Burstein and Carkhuff (1968) indicated that the trainers or therapists were functioning at lower levels and this may have negative effects on the trainee. Carkhuff (1969) also concluded that this might have been because therapists often focused on diagnosis rather than their skills. Conversely, in lay training programs, the trainer was functioning at a higher level than the trainee. The last proposition said that, "The most effective programs appear to be those that (1) focus upon primary facilitative and action-oriented dimensions complemented by secondary dimensions involving potential preferred modes of treatment and (2) integrate the didactic, experiential, and modeling aspects of learning"(p. 151). Hence, Carkhuff (1969) believed that traditional training programs developed around secondary elements such as the current treatment mode. He also asserted that the didactic teaching based itself on a specific theory such as psychoanalytical, client-centered, or existential approaches. He said that in lay training programs, the focus was on integrated learning experiences.

Carkhuff's model consisted of three goals for the client: self-exploration, understanding, and action. Self-exploration enabled the helpee to have some sense of awareness of self and others, which helps him or her to define their problem. The aim of treatment is to clarify the problem, which leads to the helpee self-exploration for greater understanding. Next, during the phase of understanding, the helpee needs to understand where he or she is in relationship to where the helpee eventually wants to be. The final goal of the helpee is action. The helpee determines how to get to where he or she wants to be (Carkhuff & Pierce, 1975).

The helper assists the client in achieving these goals through four learning tasks: attending, responding, initiating, and communicating. In attending, the helper would communicate physically that he or she is aware of the client. These behaviors may include posturing, facing fully, moving forward, attending psychologically, maintaining eye contact, observing cues, or communicating interest. The key ingredient to an attending behavior is active listening. Responding can take many forms. For example, being empathetic to the client is essential if there is to be a connection. To help understand a client fully, the helper needs to observe the client's energy level, individuality, stereotyped behavior, congruent or incongruent behavior, presentation, and the client's feelings. The helper will provide empathy, respectfulness, and genuineness. The helper will develop interchangeable responses to help the helpee understand his or her feelings. Additionally, the helper will learn to respond to the client at a deeper level by understanding the underlying meaning behind the client's feelings. The helper may reflect back to the helpee the feeling and meaning to aid the helpee in understanding

himself or herself better. Once the helpee comes to a better sense of understanding, the helper is ready to begin the initiating stage (Carkhuff & Pierce, 1975).

In the initiating phase, the helper responses based on what the client is feeling within the context of the situation plus the underlying intent is evident. Later, the helper adds an accurate understanding of the client. Finally, the helper tells the helpee something additive that is not within the helpee's awareness. By recognizing common themes within the client's experience, this helps the client express his or her experience in relationship to his or her world. Lastly, the helper helps the client personalize and highlight the themes, and facilitates the client in understanding. Another additive response is a confrontation, which helps the client understand and explore discrepancies in his or her world (Carkhuff & Pierce, 1975). During the final learning task, communication is the objective and the goal is a form of action. At this point, the client should be able to fully respond and get response from the helper. The communication process includes immediacy and directionality (Carkhuff & Pierce, 1975). Once the helpee has an understanding and is able to apply the process, he or she will then be able to train and help others.

Toward the end of the 60's, many other skills training programs were developed (Egan, 2002; Gazda, Asbury, Balzer, Childers, Phelps, & Walters, 1999; Ivey & Ivey, 1999; Kagan & Kagan, 1990). The introduction of these programs had an enormous impact on graduate counseling training programs of the 1970's.

The 1970's – Skills Based Training Evolves

The 1970's were a confusing and bewildering time in history including an impeached president, abounding inflation, an all time high divorce rate, and continued civil unrest. The women's liberation movement was under way and some college students were killed on campus. American attitudes become self focused and, "Society was falling apart because people were looking out for 'Number One'" (Reisman, 1991, p.336). In the midst of this turmoil, there was growth in the field of psychology.

New psychological techniques and treatments were introduced including cognitive modification, behavior therapies, behavior modifications, cognitive insight, and affective insight. Also new were encounter groups, formed to help individuals expand their consciousness. However, employment for psychologists was now a major concern with approximately 95,000 psychologists and 24,000 graduate students either in the field or soon to enter the field (Reisman, 1991). The focus of the 1973 Vail Conference was on the appropriate level of training needed with regard to the population served. The Ph.D. programs still did not have significant training for the practitioner role. Psychology students continued to be educated in a research orientation manner. Admissions to university programs were high, but acceptance into the university psychology programs was low. Master's level professional graduate programs in psychology were discussed, and eventually 25 new programs were developed (Cohen, 1992). However, more focus on counseling was still required.

Mental health counseling emerged in November 1976 with the founding of the American Mental Health Counselors Association (AMHCA) by Nancy Spisso and Jim

Messina (Brooks & Weikel, 1996; Messina, 1999). The goal of AMHCA was to establish a clear identity for mental health counselors in the field of mental health. Some of the goals of the organization were to initiate a national membership, establish a national accreditation standard, establish a uniform state standard of licensure, and develop a national standard of professional competencies (Messina, 1999). Also in 1976, the state of Virginia passed a counselor licensure law establishing counseling as a distinct professional identity (Beck, 1999). In July 1978, AMHCA became the 13th division of APGA (Messina, 1985).

Concurrently, the Joint Committee on Education and Training for Mental Health Counselors was formed by the AMHCA and the Association of Counselor Education and Supervision (ACES) (Smith & Robinson, 1995). Dr. Robert Stripling and ACES developed a set of standards to train counselors based on the *Manual for Self-Study for a Counselor Education Staff*, authored by George Hill (Sweeney, 1992). Three sets of standards merged: (1) the Standards for Preparation of Secondary School Counselors, (2) Standards for the Preparation of Elementary School Counselors and, (3) Guidelines for Graduate Programs in Student Personnel Work in Higher Education (Sweeney, 1992). The programs were two years long with extended supervised field experience and approximately 60 semester-hours. ACES standards divided course curriculum into three elements: core courses, environmental emphasis courses, and specialized studies. In supervised field experience, students were to have a supervisor onsite, and an individual and a group supervisor assigned from the counselor education program. In 1976, the University of Florida's Counselor Education Department was the first to offer the ACES

standard plus a 72 semester-hour counselor education program (Seiler, 1996). The

standards were first set for master's degrees and then in 1977, ACES adopted standards

for the doctoral level (Brooks, 1996). Counselor education accreditation programs began

on July 1, 1978 (Sweeney, 1992).

The credentialing body for mental health counselors formed in 1979 as the

National Academy of Certified Clinical Mental Health Counselors (NACCMHC or The

Academy) which also started the AMHCA journal. The Academy board established a set

of procedures, guidelines, and code of ethics and in Maryland, 50 counselors sat for the

first examination (Messina, 1985). Despite improved structure, accreditation, and

credentialing, all was still not well in the mental health community (Goodyear & Derner,

1978; Smith & Robinson, 1995).

Disagreement began about what the appropriate approach or method was in

treating clients/patients, with mental health counselors and psychologists lining up

against each other. Many psychologists believed that counselors were not fully trained,

having only a Masters degree to do psychotherapy (Goodyear & Derner, 1978).

Moreover, psychologists believed that counselors were on their "professional turf" and

with limited job availability, began blocking their entrance into the field (Smith &

Robinson, 1995, p. 159). To add even more confusion, a different perspective arose on

what training approach would be most effective for the client. Traditionally, psychiatrists

and psychologists followed the analytical approach which emphasized the medical model

where the patients were seen as sick and needed to be cured (Palmo, 1996). Seiler and

Messina (1979) postulated that the mental health model was based, "…on the client's

strengths and on helping develop skills necessary for successfully dealing with life" (p.5).

Realistically though, the AVTMH study of 1976 revealed that American's emotional and

psychological health had declined since the 1957 AVTMH study, and something needed

to be done. More Americans were willing to seek help (Swindle et al., 2000). Fortunately,

more professionals from both fields were working on developing approaches, methods,

and treatments that would hopefully prove most efficacious for clients.

As previously mentioned, several basic-skills training programs were being

developed. Carkhuff developed the HRT model in the 60's and Ivey developed the

microcounseling model in the 70's. Ivey and Authier (1978) purported that,

"Microskilling is designed to bridge the gap between theory and practice, between

classroom and interview session, between what is said and what is done" (p.15). The

microcounseling model began as a behavioral training model that taught specific skills to

counseling students. Ivey's hope was that there could be a reconceptualization of the

psychotherapist's role, where therapists could perceive themselves as being teachers

rather than therapists. Ivey posited that if therapists could teach interpersonal skills to

everyone, then this would be a good training approach as a therapeutic modality. A

modified version of microcounseling, taught to hospitalized mental patients, students,

parents of emotionally disturbed children, and psychiatric inpatients, saw some success

(Daniels, Rigazio-Digillio, & Ivey, 1997; Ivey & Authier, 1978).

Microcounseling emphasizes the learning of basic clinical interviewing skills by

breaking these skills down into concrete behavioral units. This training method teaches

skills one at a time until the individual has mastered each specific skill. Skills were taught

in a six-step process. First, the trainee interviews a client on a video or audiotape for about five minutes. Following this baseline interview, the trainee completes an assignment in a manual that discusses the skill. Next, the trainee watches other professionals demonstrate the skill via videotape and then views his or her own videotape. The supervisor discusses with the trainee what behavior the trainee is demonstrating and what to do in the next session. Finally, the trainee tapes another interview and the supervisor reviews and eventually discusses this tape with the trainee. The supervisor's demeanor with the trainee is one of encouragement and of support (Daniels et al., 1997; Ivey & Authier, 1971; Ivey & Ivey, 1999). Once the trainee learns a skill, they repeated the model for other skills.

The concept of microtraining has several important propositions. The instructor introduces one skill at a time to the beginning counselor. Ivey, Ivey and Simek-Morgan (1997) noted that for a more advanced student, the instructor could teach several skills or counseling methods concurrently. Microcounseling has several approaches to teaching a skill such as modeling, cognitive-behavioral elements, social reinforcement, shaping, and constructivism. Another proposition that is essential in microtraining is for the trainee to be self observant and able to compare and contrast his or her own behaviors. Supervisors as well as supervisees should be aware that what may start as a role-play often takes the shape of a real life experience. Lastly, it is important that the trainee have the opportunity to practice these new skills in a clinical setting (Daniels et al., 1997; Ivey & Authier, 1971; Ivey & Ivey, 1999).

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Ivey and Ivey (1999) designed a hierarchical approach to systematically teaching the basic skills. At the bottom level of the basic listening sequence, the counselor learns to attend in order to help the client tell their story. Attending behaviors consist of eye contact, vocal qualities, verbal tracking, and attentive body language. At the next level, the counselor asks open questions to help the client talk more freely and closed questions to elicit information that is more specific. At the third level, the counselor observes verbal and nonverbal behaviors of the client and himself. Next, so that the client feels validated and understood, the counselor learns to encourage, paraphrase, and summarize. As the client discusses his story, there are implicit feelings expressed. The counselor reflects these feelings back to the client to help clarify what the client is feeling (Ivey & Ivey, 1999).

The next aspect in Ivey's hierarchy is the interview structure. Daniels et al. (1997) indicate that, "…the interview is understood as a five-step process: (a) establishing rapport and structuring, (b) defining the problem, (c) defining outcomes and goals, (d) confronting client incongruity and generating alternatives, and (e) generalizing and transferring learning to daily life" (p. 282). The next three levels include confrontation, focusing, and reflection of meaning. Confrontation points out inconsistency in the client's way the thinking, feeling, or behaving. Once the counselor points out a discrepancy, the client can then reframe or restructure his or her story. In reflection of meaning, the counselor may recognize deeper meanings, values, beliefs, and goals portrayed by the client. In turn, the therapist reflects this meaning back to the client in order to facilitate the client towards new possibilities (Daniels et al., 1997; Ivey & Ivey, 1999). The next

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six skills in the hierarchy are influencing skills and strategies. Interpretation and reframe provides the client with a different perspective than his own. Logical consequences enable the client to weigh other alternatives. Feedback gives the client a different perspective about himself while encompassed in a safe environment. Information, advice, opinion, instructions, and suggestions give the client new information. Lastly, directive enables the client to follow strategies and take action (Ivey & Ivey, 1999).

The next level is skill integration. At this juncture, to be the most effective therapist, all skills and strategies integrate to best develop an interviewing style and an effective treatment plan. At the apex of the hierarchy is personal style and theory of helping. Over time and with more experience, the therapist's style and theory will grow and change (Daniels et al., 1997; Ivey & Authier, 1971; Ivey & Ivey, 1999). To date, this skills-based approach has continued to be a popular training method for counselors (Young, 1998).

The 1980's – Counseling Accreditation

Ronald Reagan is president, there is a reduction in inflation, and the U.S. and Soviet Union relationship is improved. Society urges Americans to relax more. Physicians and the public began accepting the impact of psychological variables on medical conditions and medical variables on psychological conditions (Reisman, 1991). In 1984, the federal government recognized mental health counseling as a distinct profession and subsequently added it to the Occupational Outlook Handbook published by the U.S. Bureau of Labor Statistics (Beck, 1999). Reagan's policies promoted less

government support, hence there became less training for graduate students in

psychology. However, there were 155 doctoral training programs in clinical psychology.

Clinical psychology gets legal recognition as a profession and all 50 states have a

certification or licensure process. Clinicians received hospital admission privileges and

payment for their services from Medicare. In 1981, APA revised its Code of Ethics and in

1986, it added the office of professional practice (Reisman, 1991). The Salt Lake City

Conference in 1987 addressed four themes directed at the development of graduate

training programs: unity, diversity, quality, and humanity (Cohen, 1992). The hope was

to integrate these themes to create exceptional graduate level clinical psychology

programs.

Training programs were also the focus for the counseling profession. As

counseling professionals looked back on the history of psychology, they decided that

having a standardized training curriculum would not only quickly give the profession

credence, but would likely allow the public to feel more confident in the counselor's

skills. The American Association for Counseling and Development (AACD), formerly

APGA, and the Council for Accreditation of Counseling and Related Educational

Programs (CACREP) or The Council designed a modified curriculum in 1981 (Seiler,

1996). The Council's Board of Directors approved 44 counseling programs in 16

institutions (Bobby & Candor, 1992). The Council on Postsecondary Accreditation

(COPA), a gatekeeper of higher education accreditation programs, recognized CACREP

in April 1987. Concurrently, COPA also recognized 30 accredited doctoral programs by

the APA Committee on Accreditation. CACREP and the APA Committee on

Accreditation, so as not to overlap programs, reached an agreement that CACREP would accredit master's level counselor programs in counseling psychology and the APA would accredit only doctoral programs in psychology (Sweeney, 1992). By July 1988, CACREP adopted a modified version of the AMHCA training standards, which included at least 60 semester-hours and a minimum of 1,000 clock hours of supervision (Smith & Robinson, 1995). As significant as it was to standardize counseling programs, there was still concern about what basic skills to teach counseling students.

Carl Rogers disagreed with teaching basic skills, as evidenced by a letter written in 1980 to Edward H. Robinson, III (E. H. Robinson, personal communication, June 20, 2006). Rogers wrote to Robinson saying that, "I'm glad you found it to be effective but I have found skills training to be too mechanistic for me." However, as part of CACREP Standards, Section II – Program Objectives and Curriculum stipulates:

K. 5. HELPING RELATIONSHIPS - studies that provide an understanding of counseling and consultation processes, including all of the following:

b. an understanding of essential interviewing and counseling skills so that the student is able to develop a therapeutic relationship, establish appropriate counseling goals, design intervention strategies, evaluate client outcome, and successfully terminate the counselor-client relationship. Studies will also facilitate student self-awareness so that the counselor-client relationship is therapeutic and the counselor maintains appropriate professional boundaries (http://www.cacrep.org/2001Standards.html).

As more institutions become accredited, it becomes obligatory to teach techniques in basic counseling skills to counselors-in-training.

The 1990's to Present – Counseling Matures and Training Advances

In the 1990's much of the decade saw rapid advancements in world democracy, technology, and economic growth. Communism in Europe collapsed, the Gulf War ended, and personal computers and the internet became widely popular. Once the Y2K fears proved unfounded, the turn of the century and the new millennium offered a rapid expansion in telecommunications and technology, however, yet to come was the Iraq war, 9/11, hurricane Katrina, and a wave of controversy over illegal immigration. With a rise in terrorism, American's level of stress was perhaps higher than ever (http://en.wikipedia.org/wiki/1990's#Economics; Winum, 2005).

The General Social Survey (GSS) administered to Americans in 1996 indicated that mental health illnesses had increased 7% compared to the 1957 AVTMH survey. Specifically, depression and anxiety disorders had risen. However, instead of Americans seeking medical help for psychological issues, they sought out services from mental health professionals (Swindle et al., 2000). Furthermore, the Joint Commission on Mental Illness and Health was now concerned about the shortage of mental health professionals. The commission suggested that there needed to be more of a focus to stimulate students in pursuing careers in professional and public mental health service. Additionally, existing training facilities need to be expanded and new training facilities established to meet these demands (Joint Commission on Mental Illness and Health, 1993).

Further recognition finally came to the mental health profession in 1997. The National Commission on Quality Assurance recognized the mental health profession, as licensed professionals were included as mental health providers in managed care organizations (Beck, 1999). Then, in 1998, President Clinton signed the Health Professions and Partnership Act endorsing graduate students' eligibility for federal grants under the Clinical Training Program of the Center for Mental Health Services (CMHS). This act also mandated the recognition of professional counselors as core mental health providers (Beck, 1999). Subsequently, professional counselors became entitled to participate in the National Health Service Corps (NHSC) Scholarship and Loan Repayment Program.

In the field of psychology, Winum (2005), in his address to the Annual Convention of the APA, expounded on the accomplishments of Division 13, renamed the Society of Consulting Psychology (SCP). In the field of education, he reported the development of a training directory and a mentor list in support of the member's growth. In addition, Planning in the Education and Training Committee, pending approval from the APA Board of Educational Affairs, had a set of Principles for the Education and Training at the Doctoral and Post-Doctoral Level in Consulting Psychology. Lastly, along with Sandy Shulman, Winum expressed the need for strong leadership skills because clients were expected to develop these skills, however many graduate programs were lacking preparation for students in leadership skills.

In the counseling profession, the AACD was renamed the American Counseling Association (ACA) (Sheeley, 2002). The ACA was a major provider in educational

opportunities for counselors, with annual conferences providing over 500 sessions. The

membership was over 55,000, including the U.S. and 50 other countries (Kaplan, 2002;

Sheeley, 2002). AMHCA was renamed the Association of Clinical Psychotherapists

(ACP) (Seiler, 1999) and is still a division of ACA with 12,000 members. The

accrediting body for educational and training programs in this division is currently called

the Academy of Clinical Psychotherapist Certification and Accreditations (ACPCA).

In 1993, there were 195 programs at 72 institutions that received accreditation

through CACREP standards (Bobby & Kandor, 1992). By 2006, the CACREP Directory

showed that there were 448 master's level programs and 49 doctoral programs at 200

institutions (http://www.cacrep.org/directory-current.html). Research began to determine

the effectiveness and benefit of CACREP Curriculum (Bobby & Kandor, 1992; Hollis,

1998; McGlothlin & Davis, 2004). In one study, McGlothlin and Davis (2004) reported

that out of eight core curriculum standards, Human Growth and Development and

Helping Relationships were the most beneficial for counseling professionals. This came

as no surprise, since therapeutic techniques were the framework and foundation of

interviewing and counseling. The need for a comprehensive course in basic skills for

counseling professionals was evident to counselor educators.

In 1993, Mark Young authored *Counseling Methods & Techniques: An Eclectic

Approach.* This text integrated Carkhuff's model, Ivey's training of specific microskills,

and Jerome Frank's common curative factors, to establish a unique systematic approach

to teaching basic skills to master's level counseling students. During a brief interview,

when asked about the intentionality behind the skills, Dr. Young stated that he intended

the teaching of these skills to therapists, but implied that they were only basic skills. He further added that the real goal was to develop a relationship with the client and to help the client change, not to just develop counselor skills (M. E. Young, personal communication, June 21, 2006). Specifically, he contends that not enough emphasis was placed on the client's response to determine if the counselor was effective.

Young's basic skills-based approach has 21 therapeutic building blocks divided into six categories: (1) invitational skills, (2) reflecting skills, (3) advanced reflecting skills, (4) challenging skills, (5) goal-setting skills, and (6) solution skills. Additionally, the common curative factors taught through the acronym REPLAN provide the student with a way to organize and understand the purpose of the techniques that are being utilized. The acronym REPLAN stands for: R - maintaining a strong helper relationship, E - enhancing efficacy and self-esteem, P - practicing new behaviors, L - lowering and raising emotional arousal, A - activating client expectations, hope, and motivation, and N- providing new learning experiences (Young, 2005).

In the first stage of the helping process, invitational skills consisting of nonverbal and opening skills are required to build a good therapeutic relationship. Nonverbal skills include eye contact, body position, attentive silence, voice tone, gesture and facial expressions, physical distance, and touching. Opening skills consist of encouragers and questions. Encouragers such as door openers and minimal encouragers are brief interventions that help the client to disclose. Closed questions help clarify facts, whereas open questions are used to help clients express themselves more openly. Through paraphrasing and reflecting feelings skills, the client realizes that the counselor heard and

understood them. For the client to progress to a deeper level, the therapist will reflect meaning and summarize. The fourth category of building blocks is challenging skills. Challenging skills, through either providing feedback or confrontation, help the client identify discrepancies in his or her story. Goal-setting and solution skills are the last two building blocks. Goal setting helps the client focus on a particular area of concern whereas solution skills focus on alternative actions. Solution skills can include giving information, reframing, and brainstorming with the client (Young, 2005).

Once the counselor-in-training understands and practices these skills, they will learn about curative factors. Young (2005) states, "….a curative factor is a common or underlying element that explains why many different therapy systems seem to be effective" (p. 283), which in turn help the student understand the purpose of the chosen technique. The 21 basic skills or building blocks link with the six curative factors, identified by the acronym REPLAN. Additionally, a treatment-planning model also based on the REPLAN system is included in this techniques course. With a de-emphasis on the pathology of individuals and more on a, "… egalitarian view of the helping relationship" (Rigazio-Digillio & Ivey, 1994, p. 9), Young's treatment plan focuses not on a diagnosis, but on a few goals of the client at a time associated with the curative factors. This brief treatment model, plus an understanding of the REPLAN system and the 21 basic skills, provides a clearer understanding for beginning counseling students. This program, as with other training programs, still requires further research in determining the effectiveness on students and on client outcome.

Research on Psychotherapy Training

After an examination on the history of psychotherapy training, additional research is required on the effectiveness of such training, particularly in determining any measurements possibly related to client outcome. This research will include more on Roger's legacy, followed by discussions on several of the key training initiatives, including Carkhuff's model and Ivey's microtraining, and concluding with further discussion and research on basic skills.

Rogerian Legacy

As psychology and mental health programs adopted new training techniques and models, there was a need for research on whether these training programs were effective in producing a positive client outcome. As relevant and simplistic as this may seem, there was as scarcity of research done on the effectiveness of training programs (Doll, 1939; Rogers, 1938). Additionally, with all the discord about the effectiveness of psychotherapy, the research primarily focused on client outcome and the needed research on training programs remained neglected. However, in 1938, Francis Robinson began a project at Ohio State University (Hill & Corbett, 1993). Robinson began studying interview sessions and examined the results of counselors' responses on client's statements. As Robinson set the precedence, several other researchers began studying interviewing skills (Danskin, 1955; Kiesler & Goldston, 1988; Robinson, 1950, Rogers, 1942b).

In 1940, Carl Rogers began working at Ohio State University and developed a research program to assess the client-centered approach, formerly known as the nondirective theory (Strupp & Howard, 1995). His research on client-centered theory stimulated other researchers to investigate this theory, and by 1953, there were over 50 research investigations (Rogers, 1961). What made Roger's research significantly different was that he was measuring observable behaviors and attitudes of the psychotherapist, which he could teach to graduate students. "He and his students provided the strongest influence toward making psychotherapy observable, its practice and training techniques specifiable, and its results measurable" (Matarazzo & Garner, 1995, p. 853).

While at the University of Chicago Counseling Center, many of Rogers' graduate students and faculty continued the research on Rogerian theory. They defined several different measures used to test Client-Centered theory and many of Rogers' students worked on developing these scales. For instance, Stephensen developed the Q sorter to measure the client's self-perception (Rogers & Dymond, 1954), and Willoughby developed the Emotional Maturity Scale, which Bergman used to measure behavioral change. The Patient Experiencing Scale, designed for use with tape recordings or transcripts, measured client participation during sessions (Klein, Mathieu-Coughlan, Kiesler, 1986). Butler, Rice, and Wagstaff (1962) developed the Client and Therapist Voice Quality Systems, which was a client and therapist classification system that examined therapeutic relationship through a naturalistic observation. This system assessed level of expression, voice quality, and quality of participation in order to

identify vocal patterns (Rice & Kerr, 1986). Barrett-Lennard developed a Relationship Inventory to measure necessary conditions for change to occur such as empathy, level of regard, unconditionality of the regard, congruency or genuineness of therapist, and therapist willingness to disclose (Barrett-Lennard, 1986; Rogers, 1961). Many of Rogers' graduate students had innovative ideas and developed ways to measure the client-centered approach for research purposes.

While Rogers was working on researching his theory, he never stopped taking an interest in the needs of the graduate students. Rogers allowed several doctoral students to use the data from the research group to write their dissertations (Rogers & Dymond, 1954). In a paper presented to the Education and Training Institute, Rogers (1955) wrote that,

> Considering the fact that one-third of present-day psychologists have a special interest in the field of psychotherapy, we would expect that a great deal of attention might be given to the problem of training individuals to engage in the therapeutic process… For the most part this field is characterized by a rarity of research and a plentitude of platitudes (p.96).

Subsequently, Rogers made a call for research on the training programs of therapists. However, ten years later there was still a limited amount of research published. In 1964, Rogers submitted a manuscript to *American Psychologist* on the unacceptable graduate training programs in psychology, but unfortunately the *American Psychologist* rejected this article and the public never got to read *Graduate Education in Psychology: A Passionate Statement* (Rogers, 1964).

When Matarazzo, Wiens, Saslow (1966) reviewed the literature on training

programs research, they found only three studies which pertained, and these studies

focused on student's verbal behavior. Thus, with this paucity of research they:

> …concluded that there is no published research regarding the teaching of
>
> psychotherapy, the supervisory process, how learning of effective psychotherapy
>
> takes place, and how to teach psychotherapy efficiently. Many reports of training
>
> are available and it is evident that many psychotherapists talk about teaching, but
>
> few report systematic innovations, comparison of methods, and/or student skills
>
> before and after a course of instruction (p.608).

At the University of Wisconsin, Rogers, Genglin, Kiesler, and Truax began

testing Rogers' theory on patients with schizophrenia. The findings indicated that patients

who received warmth, empathy, and genuineness from their therapist improved at a faster

rate as compared to patients whose therapists did not demonstrate these skills. Patients

whose therapists had better interpersonal relationship skills also tended to leave the

hospital sooner, whereas therapists who lacked the skills saw their patients staying longer

with a higher recidivism rate (Matarazzo & Garner, 1995; Rogers et al., 1967; Truax &

Mitchell, 1971).

Truax and Carkhuff's Influence

A study conducted by Truax and Carkhuff (1965), using Roger's conditions of

empathy and unconditional positive regard, indicated that when a therapist lowered

conditions of empathy and unconditional positive regard, there was a definitive drop in

the client's ability to self-explore. Conversely, when the therapist raised the levels of empathy and unconditional positive regard, there was a consequential rise in the client's ability to self-explore. This study was the impetus of blending behaviorism and humanism. With Roger's terms operationalized, research began on how to teach these basic skills to counselors-in-training (Young, 1998).

A review of 14 studies measuring empathy, warmth, and genuineness from a client base of 992 participants indicated that therapists that had these interpersonal skills were very effective. This skill set measurement included several theoretical orientations as well as therapeutic contexts (Truax & Mitchell, 1971). However, even with this discovery, it was still debated as to whether a therapist could be taught the skills of being empathetic, warm, and genuine, or if these components were part of the therapist's innate attitude or personality characteristics. Furthermore, it may be that people with an inherent propensity towards warmth, empathy, and genuineness could benefit by additional training focused on these therapeutic skills. Inference suggested that individuals that are able to learn these skills may have already acquired them in early formative years through other venues, or perhaps the individuals learned the skills superficially. However, these therapeutic skills can evidently be learned by some individuals as evidenced by the results of a 100-hour training program (Truax & Mitchell, 1971). Unfortunately,

> From existing data it would appear that only one out of three people entering
> professional training have the requisite interpersonal skills to prove helpful to
> patients. Further, there is no evidence that the usual traditional graduate training
> program has any positive value in producing therapists who are more helpful than

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nonprofessionals…Moreover, the chances that a trainee will be taught by a

therapist who is himself either ineffective or harmful are two out of three (Truax

& Mitchell, 1971, p. 337).

Carkhuff (1969b) asserted that in graduate training programs, the trainees' level of

functioning decreased between the first and second year. Tragically, he suggested that

professional trainees never gained the original level of functioning they had before

graduate school. Furthermore, he reported that graduate training was a combination of

science, art, research, and practice, whereas in a lay program the training focused on a

didactic and experiential teaching that included teaching interpersonal skills.

Truax and Carkhuff (1967) had, in fact, suggested a didactic and experiential

approach to training that would foster growth in interpersonal communication skills for

professionals (Truax, Carkhuff, & Douds, 1964; Carkhuff, Collinwood, & Renz, 1969;

Truax and Mitchell, 1971). Their training approach began with the trainees reading a

selection of different theorists and learning the Accurate Empathy Scale, the

Nonpossessive Warmth Scale, and the Genuineness Scale (Truax & Carkhuff, 1967).

Moreover, they said the training program should include a supervisor that could model

empathy, warmth, and genuineness so that the student could emulate these characteristics.

Students should also be frequently examined on these scales to determine their level of

empathy, warmth, and genuineness. The scales help trainees identify high and low levels

of the characteristics by watching videotaped sessions and rating these sessions. Another

feature of the training was that students would listen and respond to taped sessions of a

client and a supervisor would provide immediate feedback as to the student's level of

empathy, warmth, and genuineness. Once students maintained high levels of the facilitative conditions, they met with clients. The sessions were tape recorded and reviewed by peers, the supervisor, and the trainee. Lastly, students should attend quasi-group therapy to experience self-exploration and assess their own goals, values, and beliefs. A spin off from this approach would lead Carkhuff to develop the Human Resource Training Model (Carkhuff & Pierce, 1975; Truax & Carkhuff, 1967).

The efforts of Truax, Carkhuff and their colleagues resulted in compiling an enormous amount of research. Research instruments were developed to measure Roger's client-centered theory, which prompted a renewed interest in the therapist's process (Matarazzo, 1971). Findings indicated that empathy, warmth, and genuineness were teachable to both professionals and nonprofessionals under certain conditions. Research studies concluded that counselors-in-training who learned the facilitating skills improved their interpersonal communication (Burstein & Carkhuff, 1968; Carkhuff et al., 1969; Collingwood, 1969; Friel, Kratochvil, & Carkhuff, 1968; Martin & Carkhuff, 1968; Matarazzo, 1971). Furthermore, it also appeared that trainees, clinical or non-clinical, might progress to the functioning level of their supervisor during training (Carkhuff, 1969a; Carkhuff, Kratochvil, & Friel, 1968). Carkhuff (1971) even suggested that training in interpersonal communication skills could be a mode of direct treatment for clients. Client-centered theory and the newly developed training programs had resulted in a copious amount of research with Roger's 1955 call for research largely fulfilled. Unfortunately, some researchers believed that there were several methodological limitations concerning Carkhuff's model, including lack of control groups, lack of data

on psychometric properties, and the use of only the Empathy Scale to measure therapy skills (Bakers, Daniel, & Greeley, 1990; Gormally & Hill, 1974; Hill & Corbett, 1993; Lambert, DeJulio, & Stein 1978).

Microtraining & Basic Skills Research

Similar to Carkhuff's model was Ivey's microtraining model, which emphasized teaching basic skills one at a time. This systematic training approach helped students to delineate effective helping skills during the interview process and in subsequent sessions (Ivey & Authier, 1978). Consequently, there was more research done on this model than on Carkhuff's Human Resource Training model (Hill & Corbett, 1993), with microtraining apparently found to be more effective in teaching counselors than the former model (Moreland, Ivey, & Phillips, 1973; Toukmanian & Rennie, 1975).

At the end of the 1980's and the early 1990's saw the evaluation of four meta-analyses of skills-based training programs. Baker and Daniels (1989) reviewed 81 research studies and the findings indicated that microcounseling was a more effective training program than a no-treatment group or a control group, and even more effective than other training programs. The overall effect size was .83, classified as a large effect. Populations sampled were undergraduate students, minors, counseling students, and adults. Of these four groups, microcounseling training was most effective on undergraduates in acquiring skills.

In 1990, a narrative and meta-analysis review was conducted on three training programs: Carkhuff's Human Resource Training/Human Resource Development

(HRT/HRD), Kagan's Interpersonal Process Recall (IPR), and Ivey's Microcounseling (MC). Of the 41 studies included, there were 8 studies on HRT/HRD, 10 studies on IPR, and 23 studies on MC that met the researchers' criteria. The participants in this study were graduate-level counselor trainees in counselor education and counseling psychology programs. The effect size (ES) for HRT/HRD, IPR, and MC, were 1.07, .20, and .63 respectively (Baker, Daniel, & Greeley, 1990). The findings indicated that the research led to favorable conclusions on the effectiveness of all the training programs, however, more research was suggested (Baker et al, 1990).

McLennan (1994) reviewed 39 published papers relating to the effectiveness of skills-based training programs between January 1968 and December 1989. Multiple studies were contained within the 39 studies. The data set therefore contained 43 outcome skills-based training studies. His findings indicated that the effect size was .94 when comparing the average trainee that completed a skills-based training program versus the no treatment group and alternative training group. When comparing the skills-based training group and other forms of training groups, the effect size decreased to .78, however, the effect size was 1.04 with the skills-based training group compared to no training. Moreover, McLennan found that in six studies, students retained their skills between one and twelve months after training. Only one study indicated that the skills transferred from training to interviewing actual clients (Roffers, Cooper, & Sultanoff, 1988). Overall, this meta-analysis concluded that in the classroom setting, training in a skills-based program is effective in improving the performance of the trainees as interviewers.

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In 1995, several Dutch researchers (Van Der Molen, Smit, Hommes, & Lang) analyzed 19 microcounseling studies covering the period of 1975 to 1994. These studies involved basic-skills training in various populations, including undergraduate psychology students, graduate psychology students, mentally deficient individuals, and paraprofessionals. The analysis showed an overall large effect size (1.41) found on three dimensions: knowledge (ES = 2.38), skills acquisition (ES= 1.28), and behavior (ES=.88). Compared to American studies, the authors concluded that the high effect size might relate to the trainers' proficiency (in Daniels, et al., 1997; Young, 1998).

Microtraining has also been shown to be efficacious in a number of other populations including work with children (Goshko, 1973; Poitras-Martin & Stone, 1977; Velsor, 2004), teachers (Ivey & Rollin, 1970), parents (Durrett & Kelly, 1974; Gluckstern, 1973), medical students (Moreland & Ivey, 1973; Lipsky, Taylor, & Schnuth, 1999), social workers (Barber, 1988) and various other professional and nonprofessional groups. Specifically, different components of microtraining such as attending behaviors and interviewing have also been examined and found to be effective (Barber, 1988; Kelley, 1971; Moreland & Ivey, 1973; Toukmanian & Rennie, 1975) as well as problem solving skills (Poitras-Martin & Stone, 1977) and reflecting feelings (Berg & Stone, 1980).

Specific Skills Research

Other researchers also looked at therapeutic efficacy through evaluating basic skills. Hill (1992) estimated the development of over 30 measures (verbal and nonverbal

response modes) of therapist techniques. However, she further explained that these

techniques lacked operationalization, although they had a small but significant influence.

Prior research had not adequately considered quality in terms of technique delivery nor

had it considered the characteristics of therapists and clients in context (Hill, 1992; Hill &

Corbett, 1993). Additionally, some studies contain additive designs or dismantling

designs. Additive designs add a specific component to the treatment (Ahn & Wampold,

2001). Dismantling designs involves dismantling or breaking down studies to determine

if the separate components are part of the effective treatment. This method has, however,

created conflicting results (Ahn & Wampold, 2001; Lambert & Arnold, 1987; Peters,

Cormier, & Cormier, 1978). Measured as well were rating systems on dimensions of

verbal action or response modes by the therapist. In a study, findings indicated there were

six primary modes (a) question, (b) advisement, (c) information, (d) reflection, (e)

interpretation, and (f) self-disclosure (Elliot, Hill, Stiles, Frielander, Mahrer, Margison,

1987). Researchers are, however, still exploring the best methodologies in measuring

basic skills.

In a series of studies on skills training, Orlinsky, Grawe, and Parks (1994)

indicated that they found no positive effect of reflections and clarifications on client

outcome and found self-disclosure seldom associated with client outcome. However, they

did not find reflections and clarifications to be harmful and they found the impact of self-

disclosure on client outcome to be insignificant.

In the assessment of interaction variables, verbal responses such as minimal

encouragers, reflections of feelings, and restatements, were beneficial in building rapport

at the beginning of an interview (Sharpley, Fairnie, Tabary-Collins, Bates, & Lee, 2000). Other researchers also found that beginning counselors used minimal encouragers and silence to promote clients to talk more at the beginning of a session, which helped the therapist to gather the needed information. Confrontation and information giving was seen later in the session, which indicated that the trainee was practicing what they had been taught in counselor training courses (Lonborg, Daniels, Hammond, Houghton-Wenger, Brace, 1991). Furthermore, Ridgway and Sharpley (1990) purported that when the trainee demonstrated empathy and focused on the client's concerns during the interview, the counselor increased the effectiveness of the session.

Hill and Gormally (1977) found that a client, who asked open questions instead of reflection of feelings or restatements, was better able to discuss his or her feelings. Open questions also helped to produce client awareness and cognitive restructuring (Elliott, 1985). Even though open questions led to more exploration, some clients felt more anxious when questioned. Therapists and clients rated closed questions as least helpful (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988). Additionally, the therapists considered paraphrasing and confrontation moderately helpful, but the client rated confrontation as low. Lastly, the therapists and clients rated self-disclosure high in usefulness (Hill et al, 1988). A microskills training program was an effective initial program for beginning counseling students, but was found less effective for advanced students (Fyffe & Oei, 1979).

Nonverbal behaviors such as head nodding and smiles did not increase the discussion of feelings (Hill & Gormally, 1977). However, nonverbal behavior such as

therapist-client distance and eye contact may be a successful means to extend empathy, warmth, and genuineness to a client (Sherer & Rogers, 1980). Tepper and Haase (1978) found that nonverbal cues played a significant role in empathy, respect, and genuineness. In addition, by changing nonverbal behaviors such as voice tone and distance, the client may self-disclose more information (Wiens, Harper, & Matarazzo, 1980).

Furthermore, the use of distance, especially in some cultures, affects people in different ways (Preston, 2005). Other studies on nonverbal behaviors considered subjects who leaned forward more attentive and better listeners (Genthner & Moughan, 1977). Female facial gestures (head nod, a smile, or a combination of both) evoked a more significant amount of feeling from participants as compared to male gestures (Hackney, 1974). Even though touch, when appropriately used, can have a powerful effect on a client (Willison & Masson, 1986), 90% of therapists rarely or never touch their clients, and when they do it is often no more than the traditional handshake (Stenzel & Rupert, 2004).

Overall, with more than 300 empirical studies investigating microcounseling and a few specific skills-based studies, it appears that the skills-based training program is effective in teaching graduate students, as well as many other populations (Daniels et al., 1997; Hill & Corbett, 1993; Ivey & Ivey, 1999). Healthcare professionals in all walks of life have been trained successfully using microcounseling (Daniels et al., 1997). "However, the ultimate measurement of training adequacy, that of patient improvement, for the most part has continued to be relatively crudely measured, if at all" (Matarazzo & Garner, 1995, p. 855).

Young (2005) explained that basic skills had very little research done on them, with most studies simply indicating that counselors could learn the skills. He also stated that research has shown that some training programs are better than others. "But very little is said about how clients react to these skills. In other words, research confirms that the operation is a success, but nobody asks whether or not the patient survived" (p. 265). At this juncture, in the interest of the client, and with managed care and insurance companies wanting to know if psychological treatment benefits the client, outcome research is no longer optional. This last section will define outcome, give an overview of outcome history, examine the utility of outcomes, and explain the different characteristics of appropriate client outcome instruments, ending with a brief description of the Outcome Questionnaire.

Outcomes in Psychotherapy

Defining Outcome

Client outcome can be very difficult to define. Rogers (1961) saw client outcome as rather nebulous, because he questioned how one could define a success or a cure. Did success mean a reduction in symptoms, or a solved conflict, or a goal attained? Was a disorder cured or was there just a new behavior learned? Outcome may also differ based on who is making the assessment. For instance, the assessor may be the client, the therapist, a family member, or even another objective party. To make matters even more complex, the final assessment may come at the end of a session, at the end of treatment, or even during a session (Orlinsky, Grawe, Parks, 1994). The pragmatic researcher

requires a more concrete definition that can be operationalized, analyzed, and evaluated. Simply stated, outcome research measures the change that occurs after the client has had therapy (Lambert & Hill, 1994; Sexton, 1996). Outcome research now focuses on, "…aspects, methods, and factors that make significant contributions to the changes clients make in psychotherapy" (Whiston & Sexton, 1993, p.43). For therapists to serve their clients in the best manner, it is important to have a thorough knowledge of the type of outcome research available (Whiston & Sexton, 1993). Interestingly, there was a time when the results of outcome research almost brought about the demise of psychotherapy.

History of Outcome

As early as the 1900's, the effects of psychotherapy on clients were being tested, scrutinized, dissected, and challenged. There was a paucity of research at that time, but unfortunately, the research that was available indicated that clients had a better chance of recovering without psychotherapy (Eysenck, 1952, 1992). Eysenck claimed that two-thirds of patients with neurosis would recover regardless of being treated or not. He further added that psychotherapy had an inverse correlation; the more psychotherapy received the smaller chance of recovery (Eysenck, 1952, 1993). As late as the 1970's, there were those who still challenged psychotherapy. Ellis (1977) in a speech to the Colorado State Legislature said:

> Are they [the legislators] also aware of the relatively primitive state of the art of treatment outcome evaluation which is still, after fifty years, in kind of a virginal state? About all we've been able to prove is that a third of the people get better, a

66

third of the people stay the same, and a third of the people get worse, irregardless

of the treatment to which they are subjected (Smith & Glass, 1977, as quoted in

Ellis, 1977, p.3).

Consequently, with this kind of skepticism over psychotherapy effectiveness, over 500

outcome studies were generated (Bergin, 1971; Meares, Stevenson, D'Angelo, 2002). A

preponderance of research eventually found psychotherapy to be effective (Bergin, 1971;

Emrick, 1974; Smith& Glass, 1977; Lambert, 1986; Lambert & Bergin, 1994; Lambert &

Okiishi, 1997; Parloff, London, & Wolfe, 1986). During the 1970's, research findings

indicated that psychotherapy had a mediocre effect that was only modestly positive

(Bergin, 1971), but by the 1980's the findings indicated that the effect was "positive and

large" (Parloff et al., 1986, p. 324). The consensus is that psychotherapy works; we just

do not know how it works (Stiles, Shapiro, & Elliott, 1986).

Finding out how psychotherapy works has required enormous effort, thought, and

research. Should researchers look at the therapeutic process, client outcome, or both?

There are no definitive answers; however, history has indicated much of the focus has

been on comparing different psychotherapies more so than on focusing directly on the

client. Perhaps, there were prior positive client outcomes from other meta-analyses

studies similar to the studies conducted by Ahn and Wampold (2001), which is why the

focus was on the therapies and not on the client. Recently, two contradictory viewpoints

have emerged as to whether the therapist's relationship or techniques are more effective

on client outcome. This next section will focus on such topics.

Outcome Research

In a classic monograph, Saul Rosenzweig (1936) purported client outcome and

the efficacy of psychotherapy based on common factors involving the relationship and a

system of explanation. To emphasize the point, he used the classic statement from the

Dodo bird in *Alice in Wonderland,* "At last the Dodo said, 'Everybody has won, and all

must have the prizes'" (Carroll, 1989, p.43). Known as the "Dodo bird verdict," this

became synonymous with outcome studies (Duncan, 2002).

In later studies of outcome research, the focus was on the overall effect of

treatment because of validity issues (Cartwright & Roth, 1958). Even Rogers and

Dymond (1954) did not assess specific skills, but focused on a more global client

outcome. However, in 1957, after Rogers published his classic article on necessary and

sufficient conditions of therapy, researchers concentrated on the facilitative conditions

within a different methodological structure (Matarazzo & Garner, 1995).

Outcome researchers from varied theoretical orientations began reviewing the

proliferation of research studies on facilitative conditions, but found less optimistic

results (Gormally & Hill, 1974; Lambert, DeJulio, & Stein, 1978; Luborsky, Chandler,

Auerbach, Cohen, & Bachrach, 1971). Meltzoff and Kornreich (1970) concluded that the

results were ambiguous and that facilitative conditions were not proven effective. Bergin

(1971) indicated that the results might not generalize to other approaches of therapy.

Lambert et al. (1978) asserted that there was only a "modest relationship" between

Roger's facilitative conditions and client outcome, and further that Carkhuff's training

model had not been found efficacious (p. 486). Conversely, however, Patterson (1984)

found the reviews biased, and the reviewers were criticized for being inconsistent and ambiguous. He felt, as evidenced by the reviews, that the facilitative conditions were "supportive for the necessary, if not the sufficiency, of these therapeutic conditions" (p. 431). An overview of the research continued to demonstrate that there was no significant difference in outcomes among different modes of psychotherapy (the Dodo bird verdict) (Frank & Frank, 1991; Luborsky, Singer, & Luborsky, 1975).

During the 1980's, outcome research had a minimal impact on the practice of psychotherapy (Lambert, 1986). Much of the emphasis was on the "traditional clinical trial paradigm" (Lambert, 1989, p.481). Manualized treatments were being introduced and studying individual therapy style was at the bottom of the list to be researched. The NIMH established the Treatment of Depression Collaborative Research Program (TDCRP), which was to serve as a model for outcome research. The patients were randomized into one of four treatment modalities for sixteen weeks. Results indicated that patients improved significantly across all treatment modalities. This study was the beginning for all other studies that wanted funding to have a manualized treatment protocol (Rosner, 2005).

Based on empirical studies of outcome research conducted by Lambert, Shapiro, and Bergin (1986), it was indicated that patients' improvements were due to 40 % spontaneous remission, 30% common factors, 15% placebo effect, and 15% techniques. Eysenck (1952) found that patients improved without treatment (spontaneous remission) two-thirds of the time, however, Lambert (1986) concluded it was significantly below that level. Interpersonal skills and therapist's attitudes are one of the most highly

researched common factors (Lambert & Arnold, 1987). Common factors were grouped

into three categories: (a) support, (b) learning, and (c) action. Building a relationship and

working alliance were placed under the support category. The placebo effect (15%) is the

proportion of improvement based on the client's knowledge that he was being treated.

Techniques (15%) are not microskills, but factors that related to specific therapies such as

biofeedback, systematic desensitization, empty chair, hypnosis, etc. (Lambert, 1986).

Additionally, Lambert's extensive study also indicated that psychotherapy in general was

shown to have positive outcomes across a variety of theoretical orientations. By the end

of treatment, "…the average treated person was better off than 80% of the untreated

sample" (p.440). Smith, Glass, and Miller (1980) also found similar results. Based on 475

controlled studies and tens of thousands of clients, they also concluded that at the end of

treatment the client is better off than 80% of those untreated. Psychotherapy was

effective.

     During the 1990's, outcome and process research, according to Lambert and Hill

(1994), was still in its infancy. Process researchers could not agree on what process to

measure or what measures to use, even though their methodology was more advanced.

Whereas, outcome researchers, in order to measure change, identified what procedures to

use and the "general target" to measure, although they could not decide on specific

measures (p. 105). Consequently, Matarazzo and Garner (1995) added that patient

improvement was not being adequately measured. There was also a noticeable decrease

in outcome studies after 1994 (Sexton, 1996).

In the studies that were conducted, it was indicated that common curative factors such as the therapeutic relationship and the strength of the therapeutic alliance are the strongest predictors of client outcome (Duncan, 2002; Green & Herget, 1991; Horvath & Symonds, 1991; Weinberger, 2002; Whiston & Sexton, 1993). The client who was open was also identified as having a powerful impact on the therapeutic relationship and positive outcomes (Whiston & Sexton, 1993). Specifically, individual therapists having personal traits that were warm and genuine were found to have more positive client outcomes than those with just training in specific techniques (Lambert & Okiishi, 1997). Finally, clients who had a high expectation and viewed therapy positively had better treatment outcomes (Kirsch, 1985; Weinberger, 1995; Weinberger, 2002)

Different types of therapy produced similar outcomes; therefore, there was still truth in the Dodo bird verdict (Luborsky, 1995; Lambert & Bergin, 1994; Wampold, Mondin, Moddy, Stitch, Benson, Aha, 1997; Wampold, Mondin, Moody, Ahn, 1997; Weinberger, 1995). Shadish and Sweeney (1991) did indicate that perhaps mediator and moderator variables need to be included in the meta-analyses. This different methodology could change the interpretation of the results, indicating that there was a difference in therapeutic modalities on client outcome. However, Wampold et al. (1997) in their meta-analysis of outcome studies dispelled any notion that the Dodo bird verdict was not still valid.

According to Sharpley et al. (2000), the focus has been on outcome research for the last 15 years. Again, it has been established that after 17 meta-analyses reviewed and comparisons made with each other, the results indicated that there was a small effect size,

again confirming a positive Dodo bird verdict (Luborsky, Rosenthal, Diguer, Anadrusyna, Berman, Levitt, Seligman, & Krause, 2002). Furthermore, linked with positive outcome is the quality and strength of the therapeutic alliance, particularly the therapist's interpersonal communication skills (Hovarth, 2001). In a study conducted by Wampold and Brown (2005), they attributed 5% of the variation in considering the client's severity to the therapist; however, they did not assess the working alliance and facilitative conditions such as empathy. At the end of the 20th century, the APA Division of Psychotherapy appointed a task force to review research concerning therapeutic relationships. The findings indicated that empathy, therapeutic alliance, and agreement on goals were the top three areas demonstrated across different modes of therapy (Kirschenbaum, 2005; Norcross, 2001). Even with more research and data collected, the controversy continued on what causes change in psychotherapy.

> Although it has been suggested that the personality of a therapist is more important than techniques. Skills that are used specifically in an interview session or relationship building can be quite powerful with a therapist that has inherent interpersonal skills such as empathy, warmth, and genuineness (Truax & Mitchell, 1971, p341).

There is perhaps a third possibility that affects process and outcome research. Gelso (2005) articulated that two specific viewpoints have emerged: (1) specific technique or methods account for most of the variance in treatment outcome and, (2) the therapist relationship and alliance account for most of the variance in treatment outcome.

Now, after 70 years of controversy, Gelso espoused that it was *both*. He advocated that, "…what matters most in psychotherapeutic treatments is the interplay of the two, of techniques and the therapeutic relationship" (2005, p.419). Subsequently, the synergistic effects of the two influences on the course of treatment was also indicated by several researchers with different theoretical orientations (Freedheim, 2005; Geller, 2005; Goldfried & Davila, 2005; Hill, 2005; Holtforth & Castonguay, 2005; Lejuez, Hopko, Levine, Gholkar, & Collins, 2005). This then seems to be the current extent of this journey in progress on outcome research.

It is understandable why therapy outcome in graduate training programs, particularly the relationship between therapy courses and therapy outcome, remains largely neglected. Specifically, Hill and Kellems (2002) asserted that research on basic skills has declined over the past few years and if the teaching of courses is to continue, more research is required. Stein and Lambert emphasized the value of graduate programs and further articulated that, "…it is quite remarkable that more compelling evidence is not available that demonstrates that graduate training directly relates to enhanced therapy outcome. It is time to provide such documentation" (1995, p.194). The next section will further address client outcome in terms of usefulness and application.

<center>Utility of Client Outcome</center>

Francis Robinson (1950) indicated that, "… the best procedures or conditions for counseling must be evaluated in terms of the efficiency in helping the client" (p.15). This has not changed in over 50 years. "Today there is a burgeoning interest in client

outcome" (Young, 2005, p. 264). Therapists, clients, and counseling students all clearly

benefit from having an understanding of client outcome.

By monitoring client outcome and providing therapist feedback throughout

treatment, the therapist is better able to guide ongoing treatment. This process has

improved the number of positive outcomes and significantly helped clients who respond

negatively to the onset of therapy (Lambert, Whipple, Hawkins, Vermeersch, Nielsen, &

Smart, 2003). Furthermore, since managed health care providers are now looking at

outcome research to determine appropriate services and make financial decisions, it

would be efficacious for the therapist to have equal understanding in justifying purposed

treatments (Conte, 1997). Additionally, within our litigious society, treatment

interventions based on current research would provide for a more sound legal precedent

in court. The clinician's efficacy also improved when they were conducting research

(Granello & Granello, 2001).

With the inception of practice research networks on the horizon, several

organizations are considering ways and means to assess outcome data. Over five hundred

therapists from The PacifiCare Behavioral Health (PBH) managed care health

organization collected outcome data to help increase the benefits to their clients

(Wampold & Brown, 2005). Additionally, the APA has piloted the Practice Research

Network (PRN) asking a thousand clinicians to monitor their clients as to type of

treatment provided and outcome measures (Zarin, Pincus, West, & McIntyre, 1997). This

information can provide insurance companies and policy makers with the needed data to

establish practice guidelines, and help therapists provide the most effective services for healthcare.

Outcome research is equally important to the client. With a premature termination rate of 50% at outpatient clinics, it is important for clinicians to be able to understand and fulfill the clients' needs (Wierzbicki & Pekarik, 1993). Furthermore, the therapist has a responsibility to inform the client of their improvement or deterioration. It is interesting that just the client's expectation of therapy alone has shown improvement in client outcome (Kirsch, 1985; Weinberger, 1995, 2002).

The beginning therapist should be informed that, according to the American Counseling Association's (ACA, 2005) and Standards of Practice, counselors are "to continually monitor their effectiveness as professionals and take steps to improve when necessary" (p.9). An understanding of this responsibility from the onset may help to form positive habits for counselors in the future. In addition, counselors-in-training often feel anxious as to whether or not the client has actually improved. Measuring client outcome can increase counselor's self-efficacy and confidence (Young, 2005). Granello and Granello (1998) suggested infusing outcome research into the counselor's curriculum. Training students in outcome assessments and teaching them to select appropriate measures will not only benefit the student, but the client as well.

Characteristics of Appropriate Instruments

In the counseling profession, selection of the appropriate measures and outcome instruments are imperative to evaluate client outcome (Ogles, Lambert, & Masters,

1996). Some very basic methods used to assess outcome include progress notes, specific and global measures of psychopathology, subjective scales, an observer, client satisfaction scales, and a goal attainment scale (Young, 2005). Following the selection of a method, the next consideration is the particular instrument.

Outcome instrument classification is according to five dimensions: (1) content area, (2) social level, (3) time orientation, (4) source, and (5) technology (Lambert & Lambert, 1999; Ogles & Lunnen, 1996). The content area looks at the measurement of a psychological area, whereas the social level may include intrapsychic, interpersonal, or social roles. The time orientation dimension refers to the trait or state-like qualities of a particular construct (Ogles, Lambert, & Maters, 1996). Another consideration in selection of instrument is the source or who will be the reporter, the client, the therapist, a third party, a family member, or an employer. Of numerous studies researched, 25% of the studies reported that the client was the sole source of the assessment. Self-reporting by the client has become the most popular source for collecting outcome data (Lambert & Lambert, 1999). The last dimension, technology looks at methodology change. A final consideration when choosing an instrument is whether the instrument can detect change in a client after therapy (Vermeersch, Whipple, Lambert, Hawkins, Burchfield, & Okiishi, 2004). The sensitivity to change over a span of time is essential when determining client outcome.

In this specific study, the researcher utilized the Outcome Questionnaire (OQ-45.2) for various reasons. One important reason is that the clinic that collected this data already administered this assessment to their clients. However, the OQ-45.2 also meets

the requirements of what a good assessment should entail. A more thorough discussion on this instrument is included in chapter three.

Summary

In conclusion, training began with a German model, eventually found not only ineffective, but also actually harmful to students. Carl Rogers's innovative ideas in training and research created a different approach to educating graduate students. He was the first to use audio recordings and role-play interview sessions. He also was the first to explore the necessary and sufficient conditions of therapy. This method was refined, further developed, and researched by Carkhuff (1969). In 1970, Ivey instructed his students to break these skills down into concrete behavioral units using microcounseling, which was a hierarchical systematic approach. Most recently, Young developed a basic skills model by integrating curative factors with basic skills.

Historically, the psychological profession neglected research on basic skills and training programs. Rogers, in 1955, called for more research on training programs but by 1966 researchers had only conducted three studies. Truax and Carkhuff (1965) began exploring Roger's facilitative conditions and generated an abundant amount of research. However, years later a lack of control groups and a lack of psychometric properties faulted the methodology. The profession found Ivey's microcounseling model effective and after 300 research studies, clearly students were able to learn these skills. To date, Young (2005) indicated there was a very limited amount of research done on basic skills,

with most studies only implying that the skills are learnable. Finally, there is very little research on client outcome as it relates directly to training programs.

Outcome research initially focused on what worked in psychotherapy. Saul Rosenzweig, in 1936 indicated that different therapies produce similar outcomes and declared that, "…everybody has won and all must have the prize" (p. 412). However, in 1952, Eysenck proclaimed that patients had a better chance of recovery without any psychotherapy. The question of whether psychotherapy worked or not generated over 500 studies, which eventually concluded that therapy does work. In 1975, Luborsky returned to the initial focus and research focused on what specific therapies worked. Again, the answer was the same. Different therapies produce similar outcomes, yet the controversy continues. It appears that with researchers caught up in finding out what works, the client outcome in relationship to training programs for those doing the therapy remains largely ignored. Hill and Lambert, on separate occasions, stated that it was surprising that there was not more research on basic skills and graduate training programs related to client outcome.

There has not been an area of study, including the history of training, the research on basic skills, or the history and utility of client outcome, which has not pointed to the need to explore the effectiveness of basic skills on client outcome. Researchers, psychologists, counselor educators, clinicians, professors, and counseling students have all asked the same question. Is there a relationship between the basic skills taught in techniques class and client outcome? It was the intent of this researcher to contribute to that answer.

CHAPTER THREE: METHODOLOGY

Chapter three presents the relevant methodology pertaining to this study on the relationship between counselor education master level student's basic skills and client outcome. The methodology chapter includes a section on, (a) the participants, (b) the three instruments, and (c) the specific procedures. The instruments utilized in this study were the Global Scale for Rating Helper Responses (GSRR), the Counselor Skills and Professional Behavior Scale (CSPBS), and the Outcome Questionnaire (OQ-45.2). The GSRR and the CSPBS are the independent variables and the OQ-45.2 is the dependent variable.

<u>Participants</u>

The student participants attended a CACREP accredited southeastern university. The program tracks offered were Master of Art degrees in school counseling, mental health, and marriage and family. The requirements for the school counselor program consisted of 60 semester hours and one practicum experience, whereas the marriage and family and mental health tracks required 63 semester hours and two practicum experiences. Prior to enrolling in the practicum course, all of the Counselor Educator participants had taken three credit hours in a Techniques of Counseling course. The required text for this course was Young's *Learning the Art of Helping: Building Blocks and Techniques.*

The three-credit practicum class enabled the student participants to have a hands on clinical experience. The five hour class included 2 hours of group supervision with six students and the instructor. The students also had an opportunity for 3 hours of client contact. Students would meet with their client while being audio and visually monitored by their instructor. Students had a bug-in-the-ear so that the instructor could speak directly to them. All practicum participants had an additional hour of individual supervision during this course.

All of the adult client participants that were part of this study sought out counseling from the community counseling center, which is a training facility associated with the university. All clients who participated in this study were at least 18 years of age or older. There were 60 clients and 37 students that participated in this study. Each student participant had from one to three clients over the summer and fall semesters.

<u>Instruments</u>

Global Scale for Rating Helper Responses

The Global Scale for Rating Helper Responses (GSRR) (Gazda, Asbury, Balzer, Childers, Phelps, & Walters, 1999) has been efficacious in measuring interpersonal communication skills in various treatment modalities (Hayes, Taub, Robinson, & Sivo, 2002; May, Powell, Gazda, & Hauser, 1985; Robinson & Wilson, 1980, 1987). The instrument measures the effectiveness of the following basic counseling skills: open and

closed questions, paraphrasing, reflecting feelings and meanings, summarizing

confrontation, self-disclosure, and immediacy (Hayes et al., 2002).

A team of three doctoral students including the researcher received training on the

GSRR. To establish interrater reliability, a Cronbach's alpha was calculated (Patten,

2002; Shavelson, 1996). The results indicated that the team had a high level of

consistency with a Cronbach's alpha of .925 (See Table 1). The raters evaluated and

scored the student participants counseling responses on an 8-point Likert scale with

levels of .5 to 1 indicating not helpful or harmful, 1.5 to 2 indicating ineffective or not

helpful, 2.5 to 3 indicating facilitative or helpful, and 3.5 to 4 indicating additive or

helpful. Levels of .5 to 1 may indicate client ridicule or ignoring the feelings of the client,

control of the session, or imposing one's own values, beliefs, and opinions on the client.

In Level 1.5 to 2, the student participant may have given advice, asked numerous

questions, reflected content but not feelings or meaning, or the student counselor's

manner may have remained casual and mechanistic. In Level 2.5 to 3, the student

participant was respectful and caring of the client, and reflected feeling and meaning

accurately. In Level 3.5 to 4, the student counselor moved the client to a deeper sense of

awareness, confronted the client while remaining respectful, and the client began to gain

clarity of their issues (Gazda et al., 1999). A member of the team rated each verbal

utterance by the student participant with a rating of .5 to 4. The researcher then summed

the ratings and divided by the number of utterances, utilizing the total score (see

Appendix B).

The GSRR's development had its underpinnings in the Human Relations

Development Model and therefore substantiated the content validity (Gazda et al, 1999;

Hayes et al, 2002). Construct validity was supported through several studies. May et al.

(1985) indicated that patients who received training in communication skills versus the

control group received higher scores on the GSRR. This research established that the

GSRR detected a sensitivity to change between the two groups. Additionally, Hayes et al.

(2002) purported that student's counseling skills rated according to the GSRR were

higher after the treatment compared to pretest scores. Again, the GSRR was able to

identify change and growth in counseling skills, therefore supporting the construct

validity of the instrument.

Table 1: Cronbach's Alpha Calculation

Cronbach's Alpha	N of Items
.925	3

Counselor Skills and Professional Behavior Scale

The Counselor Skills and Professional Behavior Scale (CSPBS) evaluates

practicum students' basic counseling skills at mid-semester and post-semester. The

practicum instructor observed the student counseling responses and rated them on a 4-

point Likert scale. A level 1 response indicated the response was inappropriate,

excessive, or deficient; a level 2 indicated the response was somewhat effective; a level 3

indicated the response was effective; and a level 4 indicated the response was highly

effective. The 25-item instrument has the following categories: nonverbal, encouragers, questions, reflecting, advanced reflecting, challenging, goal setting, and solution.

Nonverbal skills are the use of appropriate eye contact, body position, attentive silence, voice tone, and facial expressions and gestures. In eye contact and body position, the therapist faces the client with an open posture and makes direct eye contact, occasionally looking away to maintain a comfort level for the client. The therapist's voice tone is measured according to pace, volume, warmth and supportiveness towards the client (Young, 2005). Attentive silence allows the client time to think and continue to speak about their issue or problems without the therapist interrupting to ask questions. In measuring facial expressions and gestures, the evaluator would assess for head nodding and other appropriate welcoming gestures (Young, 2005).

Opening skills are verbal encouragers and questions. Encouragers consist of door openers, which invite the client to speak, and minimal encouragers, which are supportive statements that express understanding (Young, 2005). The evaluator would also assess the effectiveness of open and closed questions. Open questions allow the clients to express themselves freely whereas closed questions ask for facts or details (Young, 2005).

The instructor assesses reflecting skills by measuring the effectiveness of paraphrasing and reflection of feelings. Paraphrasing is the reflection of content and thoughts about the client's message. Reflection of feeling identifies the client's emotion and states these feelings back to the client (Young, 2005). Advanced reflection skills include reflecting meanings, identifying and reflecting core beliefs or schemas, and

summarizing. Reflection of meaning is a deeper understanding of the client's worldview including content and feelings reflected back to the client. Reflection of meaning answers why this specific story is relevant to the client (Young, 2005). Core values or schemas are preferences, beliefs, and values. New schemas change the individual's view of the problem or perspective (M. E. Young, personal communication, June 21, 2006). Summarizing is a brief synopsis of everything the client has said thus far.

The challenging category contains the following building block skills: giving feedback, confrontation, self-disclosure, and immediacy. The evaluator can identify giving feedback by observing the student therapist supplying clients with specific information about themselves. Another helpful basic skill is confrontation, where the therapist points out discrepancies in the client's story (Young, 2005). Self-disclosure occurs when the therapist relates facts about his or her life for building the relationship. In addition, when assessing for immediacy, the student therapist and client remain in the present tense as recognized through language usage (Ivey & Ivey, 1999).

The last two categories include goal setting and solutions. Goal setting consists of keeping focus on the client, boiling down the problem, and identifying obstacles or preventing relapse. Keeping the focus on the client measures how well the clients are empowered to create change for themselves. Boiling down the problem and identifying obstacles is accomplished through summarizing and specifying the issues, identifying and selecting the most critical problems, and changing the problem to an agreed upon goal (Young, 2005).

The solution category consists of reframing and brainstorming. Reframing is identifiable by the evaluator when the student therapist changes the construction of the problem and defines the issue in a more palatable way without losing accuracy. Brainstorming is a method used to generate creative thinking so the client can learn to challenge assumptions, ask new questions, postulate new ideas, and finally select a solution (Young, 2005).

The CSPBS score is derived from the rating of each item from 1 to 4. The study uses the evaluator score for each item, sums the scores, divides by the total items or 25 and uses the resultant (see Appendix B).

A southeastern counselor education faculty who assessed their students on the CSPBS established face and content validity by a panel of experts related to counseling skills. Criterion validity as measured with the counselor educator master level student sample involved calculating the Pearson correlation (Cohen & Cohen, 1983) between the CSPBS and the GSRR. A preliminary finding of .48 was calculated based on 11 cases, whereas after the culmination of the data collection (60 cases), -.304 was found for criterion validity.

Table 2: Pre Criterion Validity

		GSRR	CSPBS
GSRR	Pearson Correlation	1	.480
	Sig. (2-tailed)		.135
	N	11	11
CSPBS	Pearson Correlation	.480	1
	Sig. (2-tailed)	.135	
	N	11	11

Table 3: Post Criterion Validity

		CSPBS	GSRR
CSPBS	Pearson Correlation	1	-.304(*)
	Sig. (2-tailed)		.018
	N	60	60
GSRR	Pearson Correlation	-.304(*)	1
	Sig. (2-tailed)	.018	
	N	60	60

* Correlation is significant at the 0.05 level (2-tailed).

<center>Outcome Questionnaire (OQ-45.2)</center>

In this study, the Outcome Questionnaire (OQ-45.2) was the dependent variable.
In 1996, Lambert and Burlingame designed the OQ.45 through funding from the College
of Family, Home, and Social Science at Brigham Young University. The purpose of the
OQ-45.2 was to measure client progress in therapy. The questionnaire is a self-report
instrument. The counselor may repeatedly administer the questionnaire during therapy,
often giving it pre and post testing and intermittently during the course of treatment
(Lambert, Morton, Hatfield, Harmon, Hamilton, Reid, Shimokawa, Christopherson, &
Burlingame, 2004). The questionnaire is highly sensitive to client change and
symptomology (Vermeersch, Lambert, & Burlingame, 2000; Vermeersch, Whipple,
Lambert, Hawkins, Burchfield, & Okiishi, 2004).

Description

The OQ-45.2 was specifically designed as a baseline-screening instrument, and
not intended for diagnostic purposes. Adults between the ages of 17 and 80 years old can
be administered the questionnaire. The instrument measures adult client progress
according to three specific dimensions: symptom distress, interpersonal relationship, and

social role performance (Lambert et al., 2004). The instrument looks at how a person is feeling, how they perceive their relationships, and how well they function in the work and school environment.

Symptom Distress

The impetus of the Symptom Distress (SD) subscale derived its measures from two sources: the 1988 National Institute of Mental Health (NIMH) epidemiological survey, and a review from Human Affairs International (HAI), a national managed care corporation (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996). The NIMH study surveyed 18,571 individuals across the United States and found that 15.4% of the population fulfilled diagnostic criteria from the DSM-III-R for mental disorders. The most prominent disorders that emerged were anxiety and affective disorders for approximately 12% of the population. Secondly, the Nationwide Insurance Company reported that of 2,145 patients, one-third reported affective disorders and another third reported anxiety disorders, including posttraumatic stress disorder. This data purported that the most common symptoms were anxiety and depression (Lambert et al., 2004). Therefore, the OQ-45.2 was heavily loaded with questions focusing on depression and anxiety disorders. Substance abuse was the next most common diagnosis and subsequently questions were included on the OQ-45.2 pertaining to that as well (Lambert et al., 2004).

The selection of items for the SD domain came from the DSM III-R, prominent symptoms discussed in literature, and statistical analysis. "Sample items are: I feel no

interesting things; I tire quickly; I have difficulty concentrating" (Lambert et al., 1996, p.250).

Interpersonal Relationship

Research on life satisfaction suggested that individuals consider positive relationships necessary for happiness (Blau, 1977; Veit & Ware, 1983). Therefore, items that measure relationship satisfaction were included in the OQ-45.2. The developed items were from marital and family therapy literature (Lambert et al., 1996). Additionally, the belief was that interpersonal issues might contribute to intrapersonal problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). Thus, items assessing friction, conflict, and withdrawal were included in the assessment (Lambert et al., 2004). "Sample items are: I feel loved and wanted; I have trouble getting along with friends and close acquaintances; I am satisfied with my relationship with others" (Lambert et al., 1996, p. 251).

Social Role

As a client develops intrapersonal dissatisfaction, this conflict will affect interpersonal relationships including their work and personal lives (Frisch, Cornell, Villanueva, & Retzlaff, 1992). Therefore, the items developed in the Social Role (SR) domain relate to three specific areas: work, school, and leisure. Assessment focused on a client's level of dissatisfaction, conflict, and distress relating to these areas (Lambert et al., 1996). "Sample items are: I enjoy my spare time; I feel that I am doing well at

work/school; I feel angry enough at work/school to do something I might regret"

(Lambert et al, 1996, p.251).

Administration

The OQ-45.2 is a pencil and paper self-assessment completed in 4 to 15 minutes,

depending on the reading ability of the client. The directions are simple and ask the client

to answer the question by placing a check in the box that best answers the question. The

assessment is a 5-point Likert scale ranging from 0 - never, 1 - rarely, 2 - sometimes, 3 -

frequently, and 4 - almost always. A narrative administration may be given under certain

circumstances such as the when a client is unable to read or write or on post testing over

the telephone (Lambert et al. 2004). There is a licensing requirement for individuals or

organizations that are administering the OQ-45.2 (see Appendix D).

Scoring

The OQ-45.2 provides a total score and three domain subtotals. Computerized

scoring simplifies this process as some items are reversed scored. However, the paper and

pencil version is still very easy to score (see Appendix B). The questionnaire's total score

is the sum of scores for the 45 items. The total score can range from 0 to 180. The higher

the score, the more distress the client is experiencing. There are three domain subtotals.

SD items are 2, 3, 5, 6, 8, 9, 10, 11, 13, 15, 22, 23, 24, 25, 27, 29, 31, 33, 34, 35, 36, 40,

41, 42, and 45. The SD scores range from 0 to 100. In the IR domain, the items are 1, 7,

16, 17, 18, 19, 20, 26, 30, 37, and 43. The IR scores range from 0 to 44. In the SR

domain, items are 4, 12, 14, 21, 28, 32, 38, 39, and 44. The IR scores range from 0 to 36.

There are also 4 critical items; item 8 pertains to suicide, items 11 and 32 pertain to drug

or alcohol abuse, and item 44 pertains to violence at work (Lambert et al., 2004). The

OQ-45.2 identifies critical items in the answer column by a circle with broken lines. The

therapist should discuss these topics with the client immediately if there is an answer

other than zero for any of these critical items.

Interpretation

Interpreting scores is just as important as accurately scoring the instrument.

Normative data, differences in gender, age, and ethnicity, and the cut off scores are

considerations in the interpretation of the OQ-45.2.

Normative Data

Several samples collected across the United States provided the normative data

with the undergraduate samples collected from Utah, Ohio, and Idaho. Another sample

was collected from a community in a Utah county as well as from a business setting in

Ohio. A University Counseling Center, outpatient clinics, and inpatient data from Utah

and Massachusetts provided additional patient or client samples (Lambert et al., 2004). It

was evident that there was a significant difference between the mean in client (42.87 to

49.92) versus non-client (22.96 to 25-43) samples (Lambert et al., 2004).

Differences of Gender, Age, and Ethnicity

There was no significant difference between the average male or female mean

scores. Moreover, the data sampled specifically from the business setting indicated there

is no significance difference based on age. In addition, the data currently available is not

sufficient to determine if there is a difference in ethnicity (Lambert et al., 2004). Further

research may be required.

Cutoff Scores

A comparison between clinical samples (treatment group) and community

samples (control group) determined the cutoff score. The cutoff total score was 63;

Symptom Distress was 36; Interpersonal Relationship was 15; and Social Role was 12. A

client total score decrease of 14 points indicated the client achieved clinically significant

improvement. Improvement also occurs if the client drops below a 63 and drops by 14

points. Deterioration occurs if the client increases their score more than 14 points during

the course of treatment (Lambert et al, 1996).

Psychometric Properties

Reliability

Sub-samples of 157 undergraduate students were assessed for test-retest (.84) and

internal consistency reliability (.93) (Lambert et al, 2004). A period of three weeks lapsed

between the first testing and the second testing of the OQ-45.2. Furthermore, a group of

EAP patients provided assessment of internal consistency. The total score and the

symptom distress subscale indicated a high correlation of internal consistency (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, Yanchar, 1996). However, the correlation in the Interpersonal and Social Role domains were lower.

Validity

Criterion validity was calculated using the Pearson Correlation coefficients for the total OQ-45.2 scores and the three domain scores against the following instruments: the General Symptom Index of the Symptom Check List 90 Revised, the Beck Depression Inventory, the Zung Self Rating Depression Scale, the Zung Self Rating Anxiety Scale, the Taylor Manifest Anxiety, the State-Trait Anxiety Inventory, the Inventory of Interpersonal Problems, the Social Adjustment Scale, and the Friedman Well Being Scale. Also calculated were correlations with the Mental Health Scale with the Symptom Distress domain, social functioning with the Interpersonal domain, and global functioning with the total of the OQ-45.2 on the SF 36. Overall, there is a high level of validity ranging from .51 to .88, depending on the specific instrument to which the OQ was compared (Lambert et al., 2004; Muller, Lambert, & Burlingame, 1998). Additionally, there is moderate to high levels of concurrent validity regarding the OQ-45.2, especially when the variables related to specific measures.

As for construct validity, the total OQ-45.2 score seems to reflect a closer measure to the Symptom Distress domain than to the Interpersonal domain and the Social Role domain (Lambert et al., 2004; Muller, Lambert, & Burlingame, 1998; Umphress, Lambert, Smart, & Barlow, 1997). The results from a factor analysis showed there was a

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low factor loading for several of the items on the OQ-45.2. It appears that the subscales may not be as distinct and the instrument is more of a global or Symptom Distress measure than an Interpersonal or Social Role measure (Muller, Lambert, & Burlingame, 1998). Therefore, it would be best to use the total score of the OQ-45.2 for client interpretation rather than relying on the domain subscale scores. This specific study utilized only the global score.

<div align="center">Procedure</div>

Upon obtaining Institutional Review Board (IRB) approval (see Appendix A) and committee review, the researcher asked permission from Practicum instructors via email to speak with the students. The researcher explained the purpose of the study and asked students for their consent to participate. The researcher then distributed informed consents (see Appendix C) to the student volunteers. The researcher specifically asked the master's level counselor education students for permission to utilize their CSPBS and GSRR scores. The researcher instructed the student participants to request their client's permission to participate and to explain to the client that the researcher only wanted their OQ-45.2 scores. Clients that agreed received client informed consents (see Appendix C) during the 2006 summer and fall semesters.

External evaluators assessed both the GSRR and the CSPBS because they are more objective than student self report or a client report (Loesch, 1995). The practicum instructors assessed the students' proficiency in basic skills using the CSPBS. The Counselor Education Research Associate collected the CSPBS at the end of each

semester and provided them to the researcher. To obtain the GSRR total scores, a team of three doctoral students assessed a single Practicum session at week 10 of the semester. The researcher requested permission from Practicum instructors via email prior to assessing the master level students counseling sessions. The counselor education program director trained the doctoral team, including the researcher, on the GSRR. To determine if the three team members rated the students' sessions equally, a Cronbach alpha (Cohen & Cohen, 1983) was calculated. The Cronbach alpha was .925.

To rate each student session, one team member would listen to the master level student at least 10 minutes into their session. The team member would listen for five minutes and record their observation according to the GSRR scale. The rater would then wait approximately five minutes or more and assess the next five minutes of the session. The team members rated ten minutes of each session. Summing the utterances and dividing by the number of responses provided the calculation for the GSRR scale. The researcher received the GSRR scores directly from the team members.

The researcher obtained a license (see Appendix D) in order to give and obtain results from the OQ-45.2. The student therapist administered the OQ-45.2 at pretherapy and thereafter every four weeks and finally at posttherapy. The master level students asked permission from their client's for the researcher to utilize their OQ-45.2 scores. The master-level counselor education students entered the OQ-.45.2 scores into the clinic database. The Clinic Director provided access to the client OQ-45.2 scores for the researcher. Subtracting the most recent posttherapy score from the pretherapy score provided the score utilized for this study. There was at least three weeks of therapy

between test and retest of the OQ-45.2 scores (Lambert et al., 1996, Lambert et al., 2003; Lambert et al., 2004).

After all the data was gathered and collected, the researcher entered the data into Statistical Package for the Social Sciences (SPSS) version 13. To enable the researcher to compile an exploratory analysis to determine a possible relationship, the researcher calculated a multiple regression to answer the question of whether basic skills predict client outcome (Hoyt, Leierer, & Millington, 2006; Petrocelli, 2003). The scores are interval and there are two independent variables; the CSPBS and the GSRR; and one dependent variable, the OQ-45.2 that is also indicative of a multiple regression analysis (Hair, Black, Babin, Anderson, & Tatham, 2006; Shavelson, 1996). Specifically, a simultaneous multiple regression was calculated because there was "… no basis for entering any particular independent variable prior to any other independent variable" and "….simultaneous regression is most often used in context of predication" (Wampold & Freund, 1987, p. 376). Since each master's level counselor education student may have more than one client, Table 4 was included for clarification.

Table 4: Sample Participant Table

Student X	GSRR Score a	CSPBS Score b	Client OQ.45.2 Score Y
X1	a	b	Y1
	a	b	Y2
X2	a	b	Y3
	a	b	Y4
	a	b	Y5
X3	a	b	Y6

Each master's level counselor education student's client was a distinctive case sample. Additionally, there were also a sufficient number of cases (60) to meet the

sample size minimum requirement of 10 times as many cases as independent variables (Shavelson, 1996) for calculating a multiple regression with two independent variables. Hair et al. (2006) also indicated a desired number of 15 to 20 cases per independent variable.

In sum, the methodology section consisted of three sections: the participants, the instruments, and the procedures. The participants included 37 master's level counselor education students who participated in either Practicum one or Practicum two over the summer and fall semester, 2006. The researcher utilized three instruments in the study: the GSRR, the CSPBS, and the OQ-45.2. The GSRR and the CSPBS were the independent variable whereas the OQ-45.2 was the dependent variable. The researcher collected the data, calculated a multiple regression analysis, and reports on the findings in the next chapter.

CHAPTER FOUR: RESULTS

Chapter four presents the applicable findings pertaining to this study regarding the relationship between counselor education master's level student's basic skills and client outcome. The chapter includes (a) the research question, (b) the hypotheses and the null hypotheses, (c) demographics (d) the descriptive analysis, (e) the hypotheses analysis and (f) the tables generated from the Statistical Package for the Social Sciences (SPSS) version 13. A simultaneous multiple regression analysis was performed because this statistical procedure is best for prediction (Hair et al., 2006; Wampold & Freund, 1987). Additionally, before calculating a multiple regression several established assumptions needed to be fulfilled such as the data was to be interval or ratio, have a normal distribution and demonstrate linearity. Through an examination of scatter plots (See Figures 1 & 2) and a histogram (See Figure 3) a preliminary analysis of the variables indicated the data met these requirements.
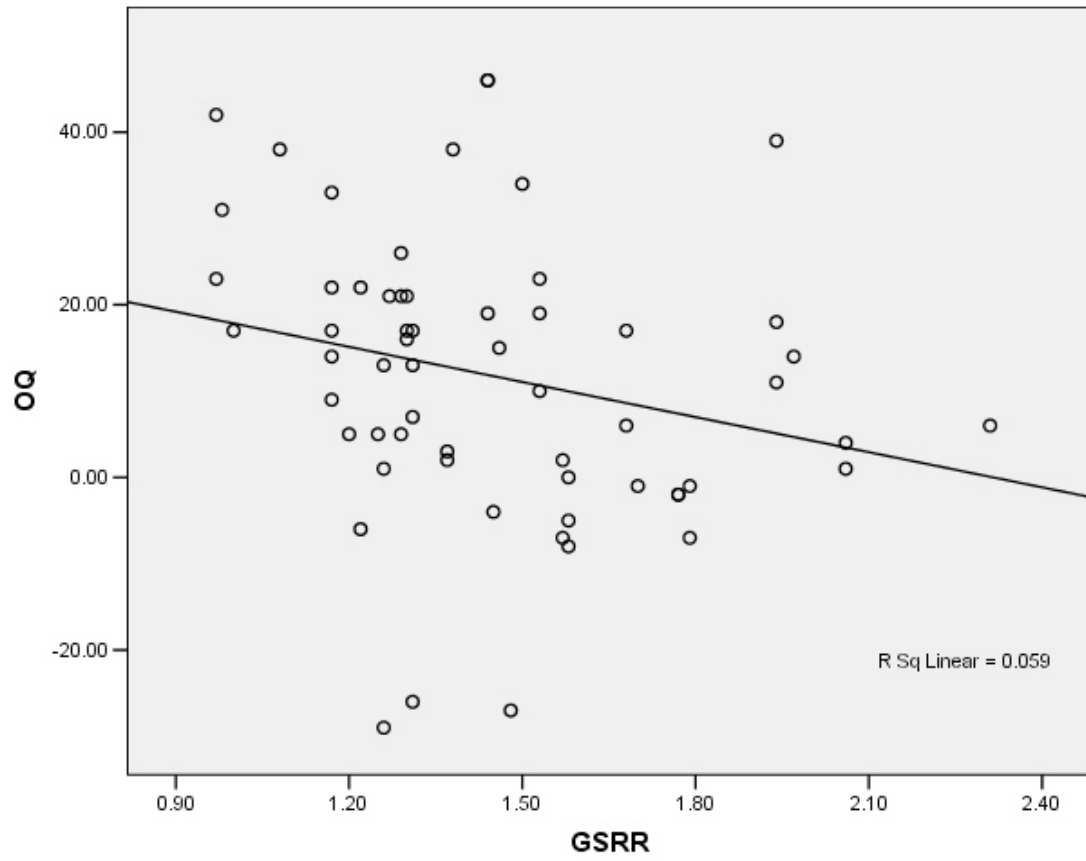
Figure 1: Scatter Plot – GSRR and OQ45.2
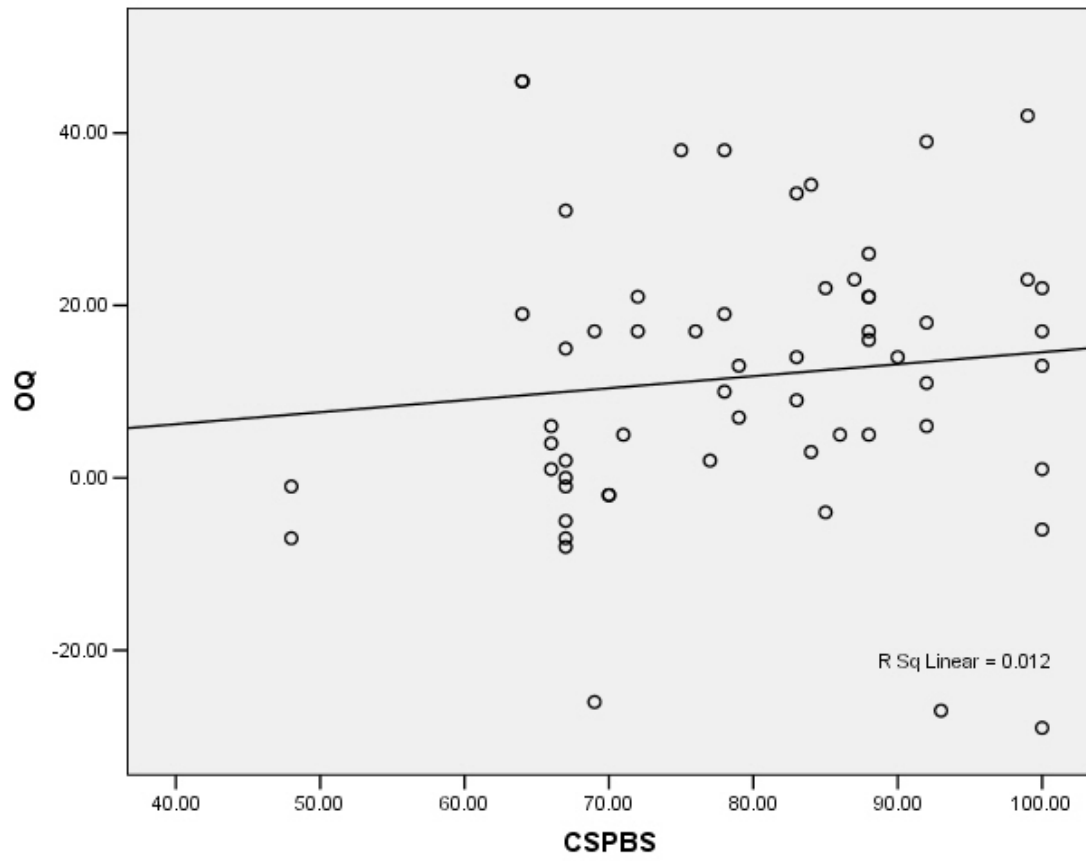
Figure 2: Scatter Plot – CSPBS and OQ-45.2

Histogram

Dependent Variable: OQ

Mean = 3.76E-16
Std. Dev. = 0.983
N = 60
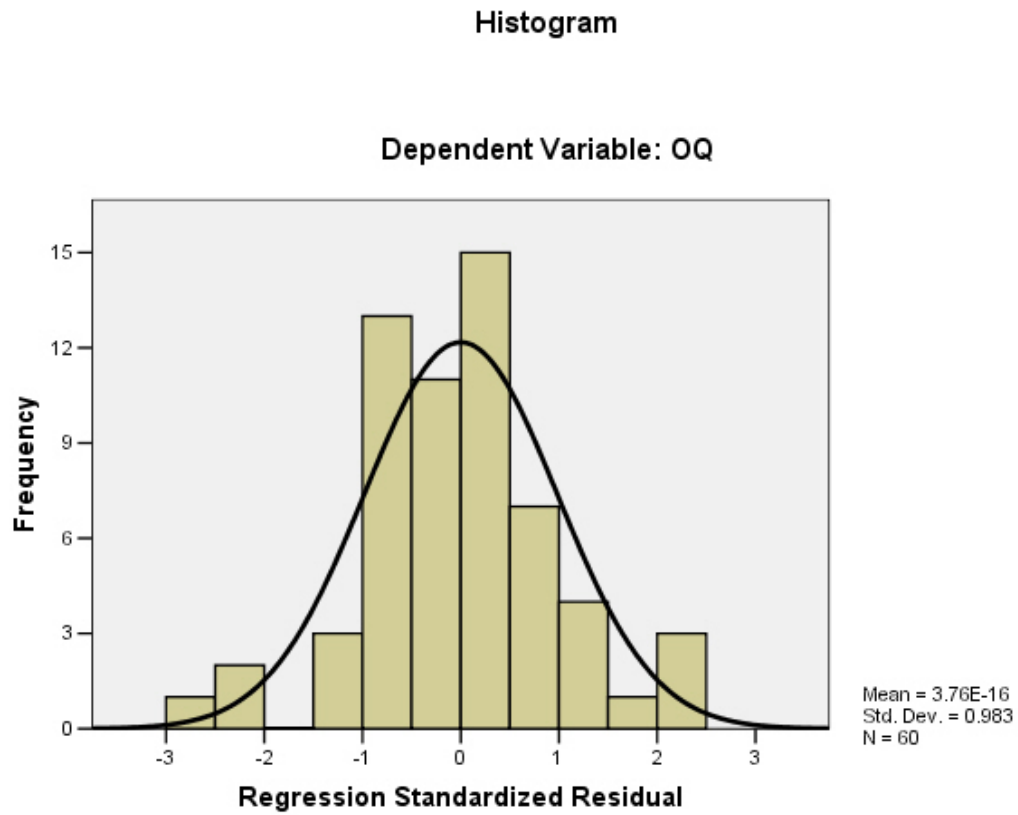
Figure 3: Histogram

The Research Question

Is there a relationship between the basic skills proficiency of counselor education master's level students and client outcome?

Hypothesis One

There is relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypothesis One

There is no relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Hypothesis Two

There is a relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypothesis Two

There is no relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

<u>Demographics</u>

As indicated by Table 5, there were 37 master level counselor education students
that participated in the study of which 34 were women and 3 were men. Eight students
were in the school counseling track, 22 were in the mental health track, and seven
students were undecided (See Table 6). There were a total of 20 Practicum one students
and 17 Practicum two students (See Table 7). Of the total practicum students, there were
11 Practicum One students and three Practicum Two students in the fall, 2006 semester.
Nine students were Practicum One students and 14 Practicum Two students in the
summer, 2006 semester (See Table 8).

Table 5: Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	female	34	91.9	91.9	91.9
	male	3	8.1	8.1	100.0
	Total	37	100.0	100.0	

Table 6: Track

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	school	8	21.6	21.6	21.6
	mental health	22	59.5	59.5	81.1
	undecided	7	18.9	18.9	100.0
	Total	37	100.0	100.0	

Table 7: Practicum

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Practicum one	20	54.1	54.1	54.1
	Practicum two	17	45.9	45.9	100.0
	Total	37	100.0	100.0	

Table 8: Semester

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Summer	23	62.2	62.2	62.2
	Fall	14	37.8	37.8	100.0
	Total	37	100.0	100.0	

Descriptive Analysis

There were 60 cases with no missing data. As Table 9 indicates, the mean for the CSPBS was 79.53 with a standard deviation of 13.02. The scores ranged between 48 and 100. The GSRR mean was 1.45 and the standard deviation was .29. The GSRR lowest score was .97 and the highest score was 2.31. The OQ-45.2 mean delta score was 11.73 with a standard deviation of 16.52. The range delta scores for the OQ-45.2 were from -29 to 46. The OQ-45.2 delta scores were the difference between the pre and post test results.

Analysis of Hypotheses One and Two

To investigate the hypotheses, a multiple regression was conducted with the OQ-45.2 as the dependent variable and the CSPBS and the GSRR as the independent variables. Overall, the linear composite of the independent variables entered into the regression procedure predicted 06% of the variation in the dependent criterion. At the .05 alpha level, the analysis yielded a nonsignificant $F_{(2, 57)} = 1.84$, $p = .17$ relationship between the variables (See Table 11). In other words, there was no statistical significant relationship between the variables.

All of the confidence intervals around each of the b weights included zero as a probable value (See Table 12). This also suggested that the results for each independent variable did not predict the dependent variable.

Table 9: Descriptive Statistics for Hypotheses One & Two

	N	Minimum	Maximum	Mean	Std. Deviation
CSPBS	60	48.00	100.00	79.5333	13.02080
GSRR	60	.97	2.31	1.4500	.29641
OQ	60	-29.00	46.00	11.7333	16.52206
Valid N (listwise)	60				

Table 10: Hypothesis One and Two Analysis of R

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.246(a)	.061	.028	16.29195

a Predictors: (Constant), GSRR, CSPBS

Table 11: Hypothesis One and Two Statistics

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	976.366	2	488.183	1.839	.168(a)
	Residual	15129.368	57	265.428		
	Total	16105.733	59			

a Predictors: (Constant), GSRR, CSPBS
b Dependent Variable: OQ

Table 12: Hypothesis One and Two Confidence Interval

Model	95% Confidence Interval for B	
	Lower Bound	Upper Bound
1	(Constant)	-13.492	66.399
	CSPBS	-.292	.392
	GSRR	-27.936	2.144

a Dependent Variable: OQ

Due to no statistical significant results, further analysis was conducted. Since the demographics of this study delineated specific subsections such as practicum and semester divisions, statistical tests were run on these variables. A multiple regression analysis and a descriptive analysis was calculated on Practicum one, Practicum two, summer semester, and fall semester students. The researcher examined whether there was a relationship between Practicum one students' counseling skills and client outcome or Practicum two students' counseling skills and client outcome. The researcher also examined whether there was a relationship between summer semester students' counseling skills and client outcome or fall semester students' counseling skills and client outcome.

Hypothesis Three

There is relationship between Practicum one students' basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypothesis Three

There is no relationship between Practicum one students' basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Hypothesis Four

There is a relationship between Practicum one students' basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypothesis Four

There is no relationship between Practicum one students' basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Descriptive Analysis of Practicum One Students

There were 32 Practicum one cases with no missing data. As Table 13 indicates, the mean for the CSPBS is 74.09 with a standard deviation of 11.26. The scores range between 48 and 92. The GSRR mean was 1.51 and the standard deviation was .30. The GSRR lowest score was .98 and the highest score was 2.06. The OQ-45.2 mean delta score was 13.66 with a standard deviation of 14.72. The range delta scores for the OQ - 45.2 were from -7 to 46.

Analysis of Hypotheses Three and Four

To investigate the hypotheses, a multiple regression was conducted with the OQ - 45.2 as the dependent variable and the CSPBS and the GSRR as independent variables. Overall, the linear composite of the independent variables entered into the regression procedure predicted 17 % of the variation in the dependent criterion. Table 15 indicated

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that at the .05 alpha level, the analysis yielded a nonsignificant F (2, 29) = 2.96, p = .07

relationship between the variables. In other words, there was no statistical significance

relationship between the variables.

All of the confidence intervals around each of the b weights included zero as a

probable value (See Table 16). This also suggested that the results for each independent

variable did not predict the dependent variable.

Table 13: Descriptive Statistics for Hypotheses Three and Four

	N	Range	Minimum	Maximum	Mean	Std. Deviation
CSPBS	32	44.00	48.00	92.00	74.0938	11.25757
GSRR	32	1.08	.98	2.06	1.5113	.30396
OQ	32	53.00	-7.00	46.00	13.6563	14.71801
Valid N (listwise)	32					

Table 14: Hypothesis Three and Four Analysis of R

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.412(a)	.170	.113	13.86538

a Predictors: (Constant), GSRR, CSPBS

Table 15: Hypothesis Three and Four Statistics

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1140.006	2	570.003	2.965	.067(a)
	Residual	5575.213	29	192.249		
	Total	6715.219	31			

a Predictors: (Constant), GSRR, CSPBS
b Dependent Variable: OQ

Table 16: Hypothesis Three and Four Confidence Interval

Model	95% Confidence Interval for B	
	Lower Bound	Upper Bound
1 (Constant)	-41.403	51.322
CSPBS	-..090	.829
GSRR	-29.360	4.671

a Dependent Variable: OQ

Hypothesis Five

There is relationship between Practicum two students' basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypothesis Five

There is no relationship between Practicum two students' basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Hypothesis Six

There is a relationship between Practicum two students' basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Null Hypothesis Six

There is no relationship between Practicum two students' basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2).

Descriptive Analysis of Practicum Two Students

There were 28 Practicum two cases with no missing data. As Table 17 indicates, the mean for the CSPBS is 85.75 with a standard deviation of 12.24. The scores range

between 67 and 100. The GSRR mean was 1.38 and the standard deviation was .28. The

GSRR lowest score was .97 and the highest score was 2.31. The OQ-45.2 score mean

delta score was 9.54 with a standard deviation of 18.4. The range delta scores for the OQ-

45.2 were from -29 to 42.

<p style="text-align:center">Analysis of Hypotheses Five and Six</p>

To investigate the hypotheses, a multiple regression was conducted with the OQ-

45.2 as the dependent variable and the CSPBS and the GSRR as the independent

variables. Overall, the linear composite of the independent variables entered into the

regression procedure predicted 07 % of the variation in the dependent criterion (See

Table 18). At the .05 alpha level, the analysis yielded a nonsignificant $\underline{F}$ (2, 25) = .94, p =

.41 relationship between the variables. In other words, there was no statistical

significance relationship between the variables.

As Table 20 indicates, all of the confidence intervals around each of the b weights

included zero as a probable value. This also suggests that the results for each independent

variable did not predict the dependent variable.

Table 17: Descriptive Statistics for Hypotheses Five and Six

	N	Minimum	Maximum	Mean	Std. Deviation
CSPBS	28	67.00	100.00	85.7500	12.24026
GSRR	28	.97	2.31	1.3800	.27638
OQ	28	-29.00	42.00	9.5357	18.39582
Valid N (listwise)	28				

Table 18: Hypothesis Five and Six Analysis of R

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.264(a)	.070	-.005	18.43903

a Predictors: (Constant), GSRR, CSPBS

Table 19: Hypothesis Five and Six Statistics

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	637.017	2	318.508	.937	.405(a)
	Residual	8499.947	25	339.998		
	Total	9136.964	27			

a Predictors: (Constant), GSRR, CSPBS
b Dependent Variable: OQ

Table 20: Hypothesis Five and Six Confidence Interval

Model	95% Confidence Interval for B	
	Lower Bound	Upper Bound
1 (Constant)	-39.872	110.719
CSPBS	-.643	.611
GSRR	-45.546	9.994

a Dependent Variable: OQ

Hypothesis Seven

There is relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the summer, 2006.

Null Hypothesis Seven

There is no relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the summer, 2006.

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Hypothesis Eight

There is a relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the summer, 2006.

Null Hypothesis Eight

There is no relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the summer, 2006.

Descriptive Analysis

There were 38 cases with no missing data. As Table 21 indicates, the mean for the CSPBS is 83.79 with a standard deviation of 11.23. The scores range between 66 and 100. The GSRR mean was 1.35 and the standard deviation was .26. The GSRR lowest score was .97 and the highest score was 2.31. The OQ-45.2 mean delta score was 11.42 with a standard deviation of 16.29. The range delta scores for the OQ-45.2 were from -29 to 42.

Analysis of Hypotheses Seven and Eight

To investigate the hypotheses, a multiple regression was conducted with the OQ-45.2 as the dependent variable and the CSPBS and the GSRR as the independent variables. Indicated by Table 22, the linear composite of the independent variables entered into the regression procedure predicted 08% of the variation in the dependent

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criterion. At the .05 alpha level, the analysis yielded a nonsignificant $\underline{F}$ (2, 35) = 1.48, p =

.24 relationship between the variables (See Table 23). In other words, there was no

statistical significant relationship between the variables.

All of the confidence intervals around each of the b weights included zero as a

probable value (See Table 24). This also suggests that the results for each independent

variable did not predict the dependent variable.

Table 21: Descriptive Statistics for Hypotheses Seven and Eight

	N	Minimum	Maximum	Mean	Std. Deviation
CSPBS	38	66.00	100.00	83.7895	11.23498
GSRR	38	.97	2.31	1.3453	.26160
OQ.45	38	-29.00	42.00	11.4211	16.29232
Valid N (listwise)	38				

Table 22: Hypothesis Seven and Eight Analysis of R

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.279(a)	.078	.025	16.08518

a Predictors: (Constant), GSRR, CSPBS

Table 23: Hypothesis Seven and Eight Statistics

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	765.605	2	382.802	1.480	.242(a)
	Residual	9055.659	35	258.733		
	Total	9821.263	37			

a Predictors: (Constant), GSRR, CSPBS
b Dependent Variable: OQ.45

Table 24: Hypothesis Seven and Eight Confidence Interval

Model	95% Confidence Interval for B	
	Lower Bound	Upper Bound
1 (Constant)	-19.406	92.724
CSPBS	-.513	.475
GSRR	-38.774	3.623

a Dependent Variable: OQ

Hypothesis Nine

There is relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the fall, 2006.

Null Hypothesis Nine

There is no relationship between basic counseling skills as measured by the Global Scale for Rating Helper Responses (GSRR) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the fall, 2006.

Hypothesis Ten

There is a relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the fall, 2006.

Null Hypothesis Ten

There is no relationship between basic counseling skills as measured by the Counseling Skills and Professional Behavior Scale (CSPBS) and client outcome as measured by the Outcome Questionnaire (OQ-45.2) during the fall, 2006.

Descriptive Analysis

There were 22 cases with no missing data. As Table 25 indicates, the mean for the CSPBS is 72.18 with a standard deviation of 12.83. The scores range between 48 and 92.

The GSRR mean was 1.63 and the standard deviation was .27. The GSRR lowest score was .98 and the highest score was 2.06. The OQ-45.2 mean score was 12.27 with a standard deviation of 17.29. The range delta scores for the OQ-45.2 were from -07 to 46.

Analysis of Hypotheses Nine and Ten

To investigate the hypotheses, a multiple regression was conducted with the OQ-45.2 as the dependent variable and the CSPBS and the GSRR as the independent variables. Overall, the linear composite of the independent variables entered into the regression procedure predicted 16% of the variation in the dependent criterion. As Table 27 indicates, at the .05 alpha level, the analysis yielded a nonsignificant $\underline{F}$ (2, 19) = 1.84, p = .19 relationship between the variables. In other words, there was no statistical significant relationship between the variables.

Indicated in Table 28, all of the confidence intervals around each of the b weights included zero as a probable value. This also suggests that the results for each independent variable did not predict the dependent variable.

Table 25: Descriptive Statistics for Hypotheses Nine and Ten

	N	Minimum	Maximum	Mean	Std. Deviation
CSPBS	22	48.00	92.00	72.1818	12.82719
GSRR	22	.98	2.06	1.6309	.26857
OQ	22	-7.00	46.00	12.2727	17.28523
Valid N (listwise)	22				

Table 26: Hypothesis Nine and Ten Analysis of R

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.403(a)	.162	.074	16.63275

a Predictors: (Constant), CSPBS, GSRR

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Table 27: Hypothesis Nine and Ten Statistics

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1018.042	2	509.021	1.840	.186(a)
	Residual	5256.321	19	276.648		
	Total	6274.364	21			

a Predictors: (Constant), CSPBS, GSRR
b Dependent Variable: OQ

Table 28: Hypothesis Nine and Ten Confidence Interval

Model		95% Confidence Interval for B	
		Lower Bound	Upper Bound
1	(Constant)	-41.316	81.811
	CSPBS	-.238	.949
	GSRR	-48.958	7.712

a Dependent Variable: OQ

For ease of reference, Table 29 and 30 were formatted and included to display the

totality of the calculations. Table 29 represents the overall descriptive statistics of

hypothesis one through ten. Table 30 represents the overall analysis of the multiple

regression statistical calculation of hypothesis one through ten.

Table 29: Descriptive Statistics Table of Hypothesis One to Ten

Hypothesis #	Mean	Standard Deviation	Range
One and Two (60 Cases)			
CSPBS	79.5	13.02	48 to 100
GSRR	1.45	.29	.97 to 2.31
OQ-45.2	11.73	16.52	-29 to 46
Three and Four (Practicum One)			
CSPBS	74.09	11.26	48 to 92
GSRR	1.51	.30	.98 to 2.06
OQ-45.2	13.66	14.71	-7 to 46
Five and Six (Practicum Two)			
CSPBS	85.75	12.24	67 to 100
GSRR	1.38	.28	.97 to 2.31
OQ-45.2	9.54	18.4	-29 to 42
Seven and Eight (Summer Semester)			
CSPBS	83.79	11.23	66 to 100
GSRR	1.34	.26	.97 to 2.31
OQ-45.2	11.42	16.29	-29 to 42
Nine and Ten (Fall Semester)			
CSPBS	72.18	12.83	48 to 92
GSRR	1.63	.27	.98 to 2.06
OQ-45.2	12.27	17.28	-7 to 46

Table 30: Statistical Analysis Table of Hypothesis One to Ten

Hypothesis	R Square	F	df	p
One and Two (60 Cases)	06%	1.84	2,57	.17
Three and Four (Practicum One)	17%	2.96	2,29	.07
Five and Six (Practicum Two)	07%	.94	2,25	.41
Seven and Eight (Summer Semester)	08%	1.48	2,35	.24
Nine and Ten (Fall Semester)	16%	1.84	2,19	.19

<u>Summary</u>

Chapter four reported results of the data analysis from this study. The researcher posited ten hypotheses. For all of these, the researcher failed to reject the null hypothesis. The following chapter will discuss implications of these results, limitations, and future direction of this study.

CHAPTER FIVE: DISCUSSION

Chapter five will summarize observations made from the above findings pertaining to this study on the relationship between the basic skills proficiency of counselor education master's level students and client outcome. Limitations of the study will be discussed and future directions for additional research will be proposed.

Observations

Multiple Regression Analysis

Results from the multiple regression analysis indicated no statistical significance however; with validated instruments and higher variance of instruments, it may have shown significance. It is also very possible that something other than the student's skills caused improved client scores. However, the student's practice of these basic skills did not cause harm to the clients and regardless of the student's basic skill level, client's scores did improve overall. Specifically, in 48 out of 60 cases there was a positive change in clients' scores. Additionally, of the 60 cases, improvement was clinically significant in 29 cases. In twelve cases, there was a negative change in clients total scores, however, only three cases decreased above 14 points. The other nine cases showed a minimal decrease where two cases decreased by one point, two cases decreased by two points, one case decreased by five points, one case decreased by six points, two cases decreased by seven points, and one case decreased by eight points. Overall, 80% of the clients seen at this clinic improved with 48.3% improvement clinically significant (See Figure 4).

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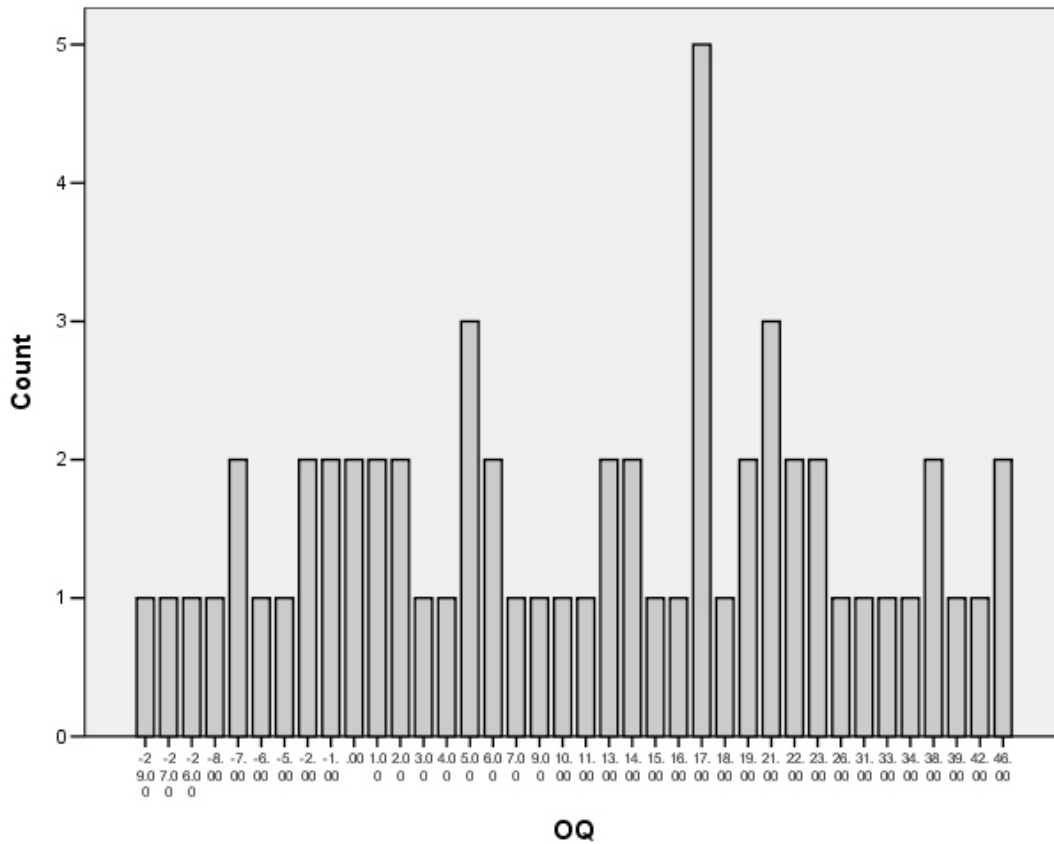
Figure 4: OQ Scores Bar Chart

Descriptive Statistics

The scatter plot (See Figure 1) showed the GSRR and OQ-45.2 had a negative linear relationship which indicated that the lower the student's score, the more the client improved. This may indicate that students with a lower skills level are demonstrating more relationship skills (lower level basic skills) which support other findings on the importance of therapeutic alliance and lower ordered skills (Baker et al., 1990; Norcross,

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2001). Client improvement may be based on the lower basic skills and not on the more

advanced skills (i.e. reflection of feeling, reflection of meaning).

However, the scatter plot (See Figure 2) with the CSPBS and OQ-45.2, showed a

positive linear relationship, which indicated that, the higher the student scores, the more

the client improved. This may imply that the practicum professors that rated the CSPBS

have a better understanding of their students' ability.

In reviewing the descriptive statistics of the data, Practicum one students had

lower mean score (74.9) on the CSPBS compared to Practicum two students (85.75)

mean score. However, the reverse was indicated on the GSRR where Practicum one mean

score was 1.51 and Practicum two mean score was 1.38. OQ.45 scores for Practicum one

students showed higher client improvement scores (13.66) compared to Practicum two

scores (9.54). The GSRR and the OQ-45.2 both indicated the same result. Perhaps,

Practicum one students are given more direct guidance than Practicum two students.

Scores may be higher because practicum professors speak to students through the "bug in

the ear" or perhaps the raters rated the instructor response. Regardless, this method also

may lead to the increase in client improvement.

At this university, the summer semester (12 weeks) is four weeks shorter than the

fall semester (16 weeks). The OQ-45.2 client improvement delta scores were lower

during the summer semester (11.42) compared to the fall semester (12.27). The GSRR

scores were also lower during the summer semester (1.34) than the fall semester (1.63).

This trend may imply that during the additional four weeks, students' skills improve and

clients' symptomology declines. However, the CSPBS scores were higher during the

summer semester (83.79) than the fall semester (72.18). In this instance, one professor taught two practicum classes (9 students) and many of her scores were extremely high. There was no inter-rater reliability reported between professors with the CSPBS. Even though professors were asked to rate the student on one specific session, several professors scored the CSPBS based on the student's overall ability. Also, some of the practicum professors were adjuncts that graduated in a similar field to counselor education and therefore may perceive basic skills differently. Lastly, the GSRR and the OQ-45.2 indicated the same directionality in clients and students' scores.

Instruments

CSPBS

CSPBS needs to be validated and inter-rater reliability needs to be established if this instrument is utilized for research. On the CSPBS, it is indicated that students need to perform at the level identified by the asterisk (See Appendix B). However, if this instrument is to be used for data collection than only a student's skills on one tape should be rated. The tendency of some professors was to rate the student's overall ability and not just the tape. For instance, even though goal setting was not included in the session, the professor would check the box because he or she saw the student perform this task in other sessions. This needs to be clarified between professors because inflated and inaccurate scoring resulted from this misunderstanding.

GSRR

Although the GSRR is a validated instrument (Hayes et al., 2002; May et al., 1985), there is a limited variance of 8-point on a Likert scale. Even though there was a high inter-rater reliability of .92, the scores of the 60 cases that were rated ranged between .97 to 2.31, which reduced the variance even more. The team that rated these students seldom saw advanced basic skills performed. Thus, the scores were low. In addition, some practicum students that had children for clients were more directive during their session and their GSRR scores were lower. Perhaps, if they were rated with adult clients, their skill level would have been rated higher. Also, for student's scores to increase, clients' response would need to indicate an inner awareness or an understanding of what the student therapist was indicating. For instance, when a therapist reflected meaning back to the client, the hope is that the client would gain insight into themselves and response in such manner. However, since clients develop at different rates, the lower scores may also reflect the client's lack of self-awareness or introspection.

OQ-45.2

The researcher observed that when some student therapists asked their clients to complete the OQ-45.2, they did not always explain to them that the assessment was based on how the client was functioning during the last week. This could cause inconsistency between clients' scores because this is a self-report assessment. Clients' scores were subjective and at the end of a semester, they may rate themselves with higher symptomology in order to come back to the free clinic the next semester. Some clients

also have a tendency to please their therapist (Kelly & Kahn, 1996) and scores may reflect that inclination. There was also no system in place to know if clients that have improved and terminated continue to remain stable after therapy. There was also no consistency between a students' skill level and clients' improvement. One student that had a moderate GSRR of 1.44 had two clients with the highest improvement rating of 46 points for each client. Another student with the highest GSRR at 2.31 had a client who improved by only 6 points, which is not clinically significant. Potentially when advanced skills were utilized, the client may have begun struggling with core issues, reducing their delta scores. Clients may get worse before they get better. Overall, the free clinic population may not be representative of the larger populations. Their coping skills may be sublevel to the general population since some clients were court mandated.

<u>Limitations</u>

There were several limitations to this study based on the results and observations of the data. They are as follows:

- Threats to internal validity in this study consist of maturation, instrumentation, and testing (Campbell & Stanley, 1963). Maturation occurs when clients emotionally and cognitively develop over a span of time. In this study, all clients took the OQ-45.2 over several weeks where scores may have been affected due to development.

- Testing was another threat to internal validity (Campbell & Stanley, 1963). Clients took the OQ-45.2 several times and could easily familiarize themselves with the answers.

- The OQ.45 is subjectively scored and the student therapist did not always explain the directions to the clients.

- Client attrition was not always attributed to formal termination. Some clients would drop out and the therapist would have no way of knowing if the client improved.

- Instrumentation was also a threat to interval validity. Measurement procedures were inconsistent on the CSPBS leading to instrumentation measurement error (Patten, 2002).

- The CSPBS should have inter-rater reliability and validation to be used again. All faculty should be trained.

- The GSRR, although valid, had very limited variance. It may be better to include another validated assessment.

- It may be best for consistency to only rate student therapists on adult sessions and not children sessions.

- The sample size met the requirements, but having a larger sample size would be more efficacious.

- Students also used the "bug in the ear" and the rater may have rated a professors' response instead of an original response of the student.

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- For the most part, only one student participated in both the summer, 2006 practicum and the fall, 2006 practicum. However, in the mental health counseling track, the students need two practicums and when collecting data from several semesters it would be quite possible to involve the same student more than once. This would violate the independence of error term.

- A threat to external validity is generalization. In this study, the results can only be generalized to a similar sample.

- As in all correlational designs, there are extraneous variables not accounted for.

Future Direction

Several recommendations can be proposed for the future direction of this study. They are as follows:

- This study should be replicated with both instruments that are validated and have inter-rater reliability.

- This study should be replicated with a larger sample size.

- A similar study should be conducted to compare Practicum one and Practicum two groups. Exploring the need for two practicums instead of one, after some of the results of this study, may lead to interesting findings.

- A similar study rating internship students on basic skills should be done to see if basic skills are continued and more advanced skills are utilized.

- The CSPBS has 25 items that measure specific basic skills. It would be interesting to find out which specific skills contribute the most to the improvement of the client.

- A future study could also include other instruments that measure client improvement. Clients assessment of the counselor performance may also be additive such as the Client Satisfaction Scale.

- It may also be advantageous to explore whether the GSRR or the CSPBS are measuring basic skills or perhaps some other construct. It is possible that the synergy of basic skills plus the counseling environment may facilitate client growth and change; therefore it is important to effectively measure this new construct.

<u>Concluding Summary and Comments</u>

In sum, even though the results of the study showed no statistical significance of basic skills having a relationship with client outcome, the exploration of this topic has only just begun. These findings bring into question what types of skills are needed for training of master's level counseling students. Currently, counselor educators teach basic skills to students. It maybe more worthwhile to investigate curative factors instead of basic skills. Some research has indicated that building a therapeutic alliance is most beneficial to a client (Norcross, 2001). Perhaps the focus should be on what skills this entails. Carl Rogers (1980) expressed to Edward H. Robinson that skills are too mechanistic (E. H. Robinson, personal communication, June 20, 2006). Perhaps we

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should revisit teaching and measuring empathy, unconditional positive regard, and genuineness. Eysenck (1952, 1992) stated that two-thirds of clients would improve regardless of what the therapist does. However, as the counseling field progresses, what is being taught to students regarding basic skills does not harm their clients. Furthermore, there is evidence that clients do improve when counseled by students with these skills. Obviously, there are still more questions than answers; however, this study has provided more insight into the struggle towards understanding, which ultimately adds to the body of knowledge.

APPENDIX A: IRB APPROVAL LETTER

University of
Central Florida

April 11, 2006

Lorie Welsh
1149 Bishop Avenue
Oviedo, FL 32765

Dear Ms. Welsh:

With reference to your protocol #06-3417 entitled, **"Is there a Relationship between Master's Level Counselor Education Practicum Student's Microskills and Client Outcomes?,"** I am enclosing for your records the approved, expedited document of the UCFIRB Form you had submitted to our office. **This study was approved on 4/10/06. The expiration date will be 4/9/07.** Should there be a need to extend this study, a Continuing Review form must be submitted to the IRB Office for review by the Chairman or full IRB at least one month prior to the expiration date. This is the responsibility of the investigator. **Please notify the IRB office when you have completed this research study.**

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board through use of the Addendum/Modification Request form. Changes should not be initiated until written IRB approval is received. Adverse events should be reported to the IRB as they occur.

Should you have any questions, please do not hesitate to call me at 407-823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

Barbara Ward

Barbara Ward, CIM
UCF IRB Coordinator
(FWA00000351 Exp. 5/13/07, IRB00001138)

Copies: IRB File
        Edward H. Robinson, III, Ph.D.

BW:jm

THE UNIVERSITY OF CENTRAL FLORIDA
INSTITUTIONAL REVIEW BOARD (IRB)

IRB Committee Approval Form

PRINCIPAL INVESTIGATOR(S):   **Lorie Welsh**   **IRB#: 06-3417**
            Supervisor: Edward Robinson III, Ph.D.

PROJECT TITLE: Is there a Relationship between Master's Level Counselor Education Practicum Student's Microskills and Client Outcomes?

[X] New project submission   [ ] Resubmission of lapsed project #
[ ] Continuing review of lapsed project #_____ [ ] Continuing review of #
[ ] Study expires: [ ] Initial submission was approved by expedited review
[ ] Initial submission was approved by full board review but continuing review can be expedited
[ ] Suspension of enrollment email sent to PI, entered on spreadsheet, administration notified _____

Chair   **IRB Reviewers:**
[X] Expedited Approval

    Dated: 4/10/06
      Cite how qualifies for   Signed: _____
      expedited review: Dr. Jacqueline Byers, Chair
      minimal risk and # 4 4 # 7

                               Signed: _____
[ ] Exempt   Dr. Sophia Dziegielewski, Vice-Chair

    Dated: _____   Signed _____
      Cite how qualifies for   Dr. Tracy Dietz, Vice-Chair
      exempt status:
      minimal risk and _____

                          Complete reverse side of expedited or exempt form
[X] Expiration   [ ] Waiver of documentation of consent approved
    Date: 4/9/07   [ ] Waiver of consent approved
                           [ ] Waiver of HIPAA Authorization approved

NOTES FROM IRB CHAIR (IF APPLICABLE): _____

_____

_____

_____

_____

_____

_____

APPENDIX B: ASSESSMENTS

GLOBAL SCALE FOR RATING HELPER RESPONSES (GSRR)

Name:
Practicum:
Instructor:

Interactions	**Interactions**
1_____	**1**_____
2_____	**2**_____
3_____	**3**_____
4_____	**4**_____
5_____	**5**_____
6_____	**6**_____
7_____	**7**_____
8_____	**8**_____
9_____	**9**_____
10_____	**10**_____
11_____	**11**_____
12_____	**12**_____
13_____	**13**_____
14_____	**14**_____
15_____	**15**_____

Subtotal _____

Subtotal_____

Total = _____
(sum of scores/ # of interactions)

Total =_____
(sum of scores/ # of interactions)

Counselor Skills and Professional Behavior Scale (CSPBS)   Part I Basic Skills

No.	Category	Specific Building Block Skill	1 inappropriate excess or deficiency	2 somewhat effective	3 effective	4 highly effective
1	Nonverbal	Eye contact			*	
2	Nonverbal	Body position			*	
3	Nonverbal	Attentive silence			*	
4	Nonverbal	Voice tone			*	
5	Nonverbal	Gestures and facial expressions			*	
6	Nonverbal	Physical distance			*	
7	Encouragers	Minimal Encouragers			*	
8	Encouragers	Door Openers			*	
9	Questions	Open Questions			*	
10	Questions	Closed Questions			*	
11	Reflecting	Paraphrasing			*	
12	Reflecting	Reflecting feelings			*	
13	Advanced Reflecting	Reflecting meaning Values and Meanings		*	**	
14	Advanced Reflecting	Identifying and reflecting core beliefs or schemas		*	**	
15	Advanced Reflecting	Summarizing		*	**	
16	Challenging	Giving feedback		*	**	
17	Challenging	Confrontation		* **		
18	Challenging	Self-Disclosure		*	**	
19	Challenging	Immediacy		* **		
20	Goal Setting	Keeping Focus on the client		*	**	
21	Goal Setting	Boiling down the problem		*	**	
22	Goal Setting	Identifying Obstacles and Relapse Prevention		*	**	
23	Solution	Refraining from Advice Giving		*	**	
24	Solution	Reframing		**		
25	Solution	Brainstorming		*	**	
		*skill required at this level for passing grade				

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OUTCOME QUESTIONNAIRE (OQ45.2)

DMBA

NAME: _____ SOCIAL SECURITY NUMBER: _____

AGE: _____ SEX: M ☐ F ☐ SESSION #: _____ DATE: _____

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item and mark the answer that best describes your current situation. For this questionnaire, "work" is defined as employment, school, housework, volunteer work, and so forth.

		Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
							DO NOT MARK BELOW		
1.	I get along well with others.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
2.	I tire quickly.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
3.	I feel no interest in things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
4.	I feel stressed at work/school.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
5.	I blame myself for things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
6.	I feel irritated.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
7.	I feel unhappy in my marriage/significant relationship.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
8.	I have thoughts of ending my life.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
9.	I feel weak.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
10.	I feel fearful.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
11.	After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never.")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
12.	I find my work/school satisfying.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0			☐
13.	I am a happy person.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
14.	I work/study too much.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
15.	I feel worthless.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
16.	I am concerned about family troubles.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
17.	I have an unfulfilling sex life.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
18.	I feel lonely.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
19.	I have frequent arguments.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
20.	I feel loved and wanted.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
21.	I enjoy my spare time.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0			☐
22.	I have difficulty concentrating.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
23.	I feel hopeless about the future.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
24.	I like myself.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
25.	Disturbing thoughts come into my mind that I cannot get rid of.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
26.	I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "Never.")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
27.	I have an upset stomach.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
28.	I am not working/studying as well as I used to.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
29.	My heart pounds too much.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	☐	
30.	I have trouble getting along with friends and close acquaintances.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
31.	I am satisfied with my life.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
32.	I have trouble at work/school because of drinking or drug use. (If not applicable, mark "Never.")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
33.	I feel that something bad is going to happen.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
34.	I have sore muscles.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
35.	I feel afraid of open spaces, of driving, or being on buses, subways, etc.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
36.	I feel nervous.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
37.	I feel my love relationships are full and complete.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
38.	I feel that I am not doing well at work/school.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
39.	I have too many disagreements at work/school.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
40.	I feel something is wrong with my mind.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
41.	I have trouble falling asleep or staying asleep.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
42.	I feel "blue."	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
43.	I am satisfied with my relationships with others.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
44.	I feel angry enough at work/school to do something I might regret.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		☐
45.	I have headaches.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		+	+

Developed by Michael J. Lambert, Ph.D. and Gary M. Burlingame, Ph.D.

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APPENDIX C: INFORMED CONSENTS

STUDENT INFORMED CONSENT

Dear Participant:

I am a doctoral student at the University of Central Florida. For my dissertation, I am conducting a study over the next two semesters entitled "Is There a Relationship Between a Master's Level Counselor Education Practicum Student's Microskills and Client Outcome? The purpose of the study is to examine the effectiveness of microskills in predicting client outcome. All participants' confidentiality is guaranteed.

As you are routinely assessed with these instruments during your Practicum course, I am requesting that you allow me access to your scores on the Counselor Skills and Professional Behavior Scale (CSPBS) and the Global Scale for Rating Helper Responses (GSRR). The CSPBS and the GSRR are evaluated by the Counselor Education faculty and staff and the scores are collected by the Research Associate. An identification number will be assigned to you and your name will NOT be used in this study. Your participation in this research has no bearing on your grade.

You are being invited to participate because you have been identified as a registered student in this class. Please understand that you are not required to participate in this study and you may discontinue your participation in this study at any time without penalty.

Again, your identity will be kept confidential. Your scores will be analyzed and reported anonymously to protect your privacy. Records will be kept in a locked filing cabinet in the Counselor Education Department.

There are no risks and no direct benefits; no compensation will be awarded. You are free to withdraw your consent to participate and may discontinue your participation in the study at any time without consequence. This research study has been reviewed and approved by the UCF Institutional Review Board. If you have any questions about this research project, please contact the researcher or my faculty supervisor:

Lorie J. Welsh, University of Central Florida (UCF)
College of Education, Suite 322 d; Orlando, Florida 32816-1250
Telephone: (407) 823-4511

Edward H. Robinson III, University of Central Florida (UCF)
College of Education, P. O. Box 161250; Orlando, Florida 32816-1250
Telephone: (407) 823- 3819
Information regarding your rights as a research volunteer may be obtained from:
Barbara Ward, Institutional Review Board (IRB) University of Central Florida (UCF)
12201 Research Parkway, Suite 501, Orlando, Florida 32826-3246.
Telephone: (407) 823-2901

If you decide to participate in this research study, please sign and return this copy of the consent form.

A second copy is provided for your records.

Sincerely, _____ (researcher signature)

_____ (printed)

Principal Investigator signature: _____, Ph.D., Professor, College of Education

Project title: Is There a Relationship Between a Master's Level Counselor Education Practicum Student's Microskills and Client Outcome?

___   I have read the procedure described above. I have read the "Informed Consent to Participate" and agree to allow the researchers to use the information I provide for related presentations and publications.
___   I voluntarily agree to participate and state that I am over 18 years of age.

/

Participant   Date

CLIENT INFORMED CONSENT

Dear Participant:

I am a doctoral student at the University of Central Florida. For my dissertation, I am conducting a study over the next two semesters entitled Is There a Relationship Between a Master's Level Counselor Education Practicum Student's Microskills and Client Outcome? The purpose of the study is to examine the effectiveness of microskills in predicting client outcome. Participants' confidentiality is guaranteed.

As part of your treatment at the University of Central Florida Counseling Clinic you will be given the Outcome Questionnaire (OQ.45). I am requesting you let me utilize your OQ.45 score for research purposes. An identification number will be assigned to you and your name will NOT be used in this study. Your participation in this research has no bearing on your treatment.

Your identity will be kept confidential. Your scores will be analyzed and reported anonymously to protect your privacy. Records will be kept in a locked filing cabinet in the Counselor Education Department.

There are no risks and no direct benefits; no compensation will be awarded. You are free to withdraw your consent to participate and may discontinue your participation in the study at any time without consequence. This research study has been reviewed and approved by the UCF Institutional Review Board. If you have any questions about this research project, please contact the researcher or my faculty supervisor:

Lorie J. Welsh, University of Central Florida (UCF)
College of Education, Suite 322 d; Orlando, Florida 32816-1250
Telephone: (407) 823-4511

Edward H. Robinson III, University of Central Florida (UCF)
College of Education, P. O. Box 161250; Orlando, Florida 32816-1250
Telephone: (407) 823- 3819

Information regarding your rights as a research volunteer may be obtained from:
Barbara Ward, Institutional Review Board (IRB) University of Central Florida (UCF)
12201 Research Parkway, Suite 501, Orlando, Florida 32826-3246.
Telephone: (407) 823-2901
If you decide to participate in this research study, please sign and return this copy of the consent form.
Sincerely, _____ (researcher signature)

_____ (printed)

Principal Investigator signature: _____, Ph.D., Professor, College of Education

Project title: Is there a Relationship between Master's Level Counselor Education Practicum Student's Microskills and Client Outcome?

____ I have read the procedure described above. I have read the "Informed Consent to Participate" and agree to allow the researchers to use the information I provide for related presentations and publications.

____ I voluntarily agree to participate and state that I am over 18 years of age.

                                                        /
Participant signature   Date
_____ (printed)

_____
Counselor

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