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# Predictors of relationship skills training in clinical psychology Ph.D. programs.

Phoenix Gillis  
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Predictors of Relationship Skills Training in  
Clinical Psychology Ph.D. Programs

By  
Phoenix Gillis

A Thesis Submitted to the Faculty of Graduate Studies  
through Psychology  
In Partial Fulfillment of the Requirements for  
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### Abstract

Ninety psychotherapy instructors from APA/CPA accredited clinical psychology Ph.D. programs were surveyed to examine the hypothesized effects of clinical/research orientations and instructor beliefs on relationship skills training. A path analysis indicated that instructors who believed that relationship skills are more trainable and more important and who perceived themselves more as clinicians than as researchers trained relationship skills more often. Programs' clinical/research orientations were not associated with relationship skills training. Post-hoc analyses indicated that instructor age was positively associated with relationship skills training and that this association was mediated by instructors' beliefs and instructors' clinical/research orientations. These findings have important implications for course assignment, program design, professional development seminars, and for the future of clinical psychology psychotherapy training.

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## CHAPTER I

### INTRODUCTION

After several decades of researching and practicing psychotherapy, we still do not know why it works (Keijsers et al., 2000). Although our understanding of the psychotherapy process has come a long way since the early days of psychoanalysis, the profession has yet to agree upon the particular actions of the therapist that are most important in promoting client change. Strupp (1998) suggested that the therapeutic influence embodies two factors: interpersonal (i.e., relationship) skills and technical skills. The literature has often been divided similarly. While many authors have advocated the importance of skilful use of specific therapeutic techniques (Calhoun et al., 1998; Chambless et al., 1998), others have contended that techniques are unimportant and that the person-to-person therapist-client relationship is the essential agent of change (Ahn & Wampold, 2001; Bambling and King, 2001; Rogers, 1957/1992). Despite progress in healing this rift since the 1960s, the debate continues.

Training programs have often emphasized technical skills over relationship skills (Shaw & Dobson, 1988), despite considerable research evidence that specific treatment models have little or nothing to do with therapy effectiveness (e.g., Ahn & Wampold, 2002; Smith & Glass, 1977; Wampold et al., 1997). However, results of meta-analyses have shown that the therapeutic relationship is a robust predictor of therapy outcome (e.g., Beutler, Machado, & Neufeldt, 1994; Lambert & Bergin, 1983; Orlinsky & Howard, 1986). The significance of the relationship “traverses theoretical schools, theory-specific concepts, and a diversity of measurement procedures” (Beutler et al., 1994, p. 244). Research has shown that the quality of the therapeutic relationship facilitates client improvement across a wide range

of treatment models, including short-term psychodynamic psychotherapy (Piper et al., 1991), interpersonal psychotherapy (Rounsaville et al., 1987), time-limited manualized drug therapy (Luborsky et al., 1985), manualized cognitive therapy (Safran & Wallner, 1991), and experiential psychotherapy (Greenberg, Elliott, & Lietaer, 1994). The majority of these studies were conducted in the 1960s and 1970s; since then, interest in the therapeutic relationship has declined substantially. The reason for this trend is disputable, but it is likely linked to professional and political influences of the last few decades.

### The History of the Therapeutic Relationship

The relationship of the client to the therapist as a fellow human being has long been recognized as an essential component of the psychotherapy process. Even early on, Freud (1913/1958) distinguished between the transference relationship, which is distorted by the client's neurosis, and the more reality-based interaction between patient and analyst that allows them to collaborate to heal the patient (Horvath & Symonds, 1991). Although other psychoanalytic authors would later expand on this idea (e.g., Greenson, 1967; Zetzel, 1956), these writers only gave passing mention to the positive, realistic aspect of the therapeutic relationship. Even in these cases, it was often viewed only as an important precursor to interpretive work (e.g., Freud, 1913/1958).

The shift toward examining the relationship as a healing element unto itself can mostly be attributed to a group of psychotherapy researchers at the University of Chicago in the early 1950's. This research team, led by Carl Rogers, was interested in the effectiveness of client-centred therapy, which is a therapy based largely on the personal connection between therapist and client. Rogers' team undertook a large-scale psychotherapy project investigating the effect of the client-centred model on a variety of therapy outcome measures.

Their results indicated that clients' self-perceptions, functioning, personal integration, and maturity of behaviour improved significantly as a result of the therapy. They concluded that client-centred therapy is indeed effective in improving therapy outcome.

Rogers' involvement in this research and his experience as a psychotherapist led him to clearly identify a theory about the essential ingredients of the therapeutic relationship that he believed were at the heart of effective psychotherapy. In 1957, he published his theory in a seminal article titled "The Necessary and Sufficient Conditions of Therapeutic Personality Change" (1957/1992). In his paper, he hypothesized that the only relevant components in psychotherapy are factors inherent in the therapist-client relationship. In particular, he postulated that the effectiveness of psychotherapy depends on three interrelated relationship conditions: *empathy*, *genuineness*, and *unconditional positive regard*. Rogers hypothesized that these core conditions are essential for client change and, if present, consistently result in successful outcome.

Rogers' hypothesis was highly controversial. In many ways, it was the antithesis of the more directive, "therapist-centred" psychoanalytic and behavioural approaches that were popular at the time (Orlinsky & Ronnestad, 2000). Rogers (1957/1992) contended that the contemporary psychoanalytic and behavioural techniques espoused by many mental health practitioners were entirely dispensable, and he stated that professional expertise is irrelevant to the effectiveness of psychotherapy. According to Rogers' (1957/1992) theory, psychotherapy techniques are only useful to the extent that they "serve as channels for fulfilling one of the conditions" (p. 832).

This radical perspective stimulated considerable discussion and research on the therapeutic relationship in the two decades that followed (Barrett-Lennard, 1985). The large

body of literature published at that time was, in part, a reaction to Rogers' unorthodox ideas. In addition, Rogers (1957/1992) presented his model in the form of a testable hypothesis and offered suggestions for research designs that would either falsify or confirm it. Many early studies found that his theory held up under scrutiny (see Gurman, 1977; Truax & Mitchell, 1971). However, because some studies that should have demonstrated the effectiveness of Rogerian factors reported nonsignificant or negligible results (e.g., Garfield & Bergin, 1971; Jacobs & Warner, 1981; Mintz et al., 1971), several major review articles published toward the end of the 1970s concluded that the Rogerian conditions were not as important as researchers had previously thought (e.g., Bergin & Suinn, 1975; Lambert et al., 1978; Mitchell, Bozarth, & Krauft, 1977; see also Patterson, 1984).

Kirschenbaum and Jourdan (2005) identify several reasons for these inconsistencies. First, the therapists who participated in these studies often had poor relationship skills, and there was often not enough variance in their performance to yield significant results. Studies that controlled for this problem demonstrated a more consistent association between relationship skills and therapy outcome (Stubbs and Bozarth, 1994).

A second reason for the contradictory results relates to the measurement of Rogers' factors. Most of the studies investigating his theory used therapist or observer ratings of therapist relationship skills instead of client ratings; however, Rogers' (1957/1992) hypothesis was that the core conditions are only effective insofar as the client perceives them. Again, later studies using client ratings of psychotherapist relationship skills provided more consistent support for the effectiveness of these conditions (Farber & Lane, 2002; Orlinsky, Grawe, & Parks, 1994).

Finally, Kirschenbaum and Jourdan (2005) pointed out that researchers often investigated the effects of each condition separately. This was another methodological flaw based on a misconception of Rogers' hypothesis: Rogers stated that all three conditions must be present for client improvement. Once again, later research examining the three variables in combination provided more reliable support for Rogers' theory (Orlinsky et al., 1994; Sexton & Whiston, 1994). At the time, however, these inconclusive and inconsistent findings discouraged researchers from pursuing Rogers' hypothesis any further, and investigations on the Rogerian conditions began to wane (Cornelius-White, 2002; Duan & Hill, 1996).

While Rogers' theory had been gaining prominence, another influential figure had been emerging in the field of psychotherapy research. Ed Bordin, a psychoanalytic researcher, had read Rogers' early writings and supported Rogers' non-directive approach to therapy and his emphasis on the therapeutic relationship. However, Bordin felt that Rogers had taken too bold a position regarding the relative importance of the relationship. Instead, Bordin, "distressed by what he felt to be the rhetorical excesses of that Rogerian antithesis" (Orlinsky & Ronnestad, 2000, p. 842), appealed to his colleagues by linking the therapeutic relationship to psychoanalytic theory. He ultimately developed a three factor model of what he termed the *working alliance*: (a) agreement on goals, (b) collaboration between client and therapist in achieving these goals, and (c) the affective bond between therapist and client (Bordin, 1979). Bordin's development of this construct inspired a tremendous amount of research on the alliance in the two decades that followed, thereby rekindling interest in the therapeutic relationship (Beutler et al., 1994).

It may seem incongruous that researchers quickly adopted the alliance as a topic of investigation, when many of them had previously lost interest in the Rogerian factors. In fact,



many researchers did turn away from examining the relationship altogether, preferring to focus on specific treatments in the late 1980s and 1990s (Cornelius-White, 2002). The fact that interest in the therapeutic relationship did not dry up entirely may be due to findings from research on psychotherapy effectiveness that emerged around that time (Horvath & Bedi, 2002). In response to some earlier concerns regarding the effectiveness of psychotherapy (Eysenck, 1952), Luborsky, Singer, and Luborsky (1975) reviewed the literature and concluded that psychotherapy does have a significant impact on client outcome. Interestingly, however, they also discovered that all psychotherapies are equally effective. Subsequently, Smith and Glass (1977) conducted a meta-analysis to test this conclusion, and they obtained the same result (see also Landman & Dawes, 1982).

This finding, often referred to as the *Dodo bird verdict*, has since been substantiated by numerous meta-analyses showing that specific models or techniques only account for 5%-15% of outcome variance (Asay & Lambert, 1999; Lambert, 1992; Miller, Duncan, & Hubble, 1997; Shapiro & Shapiro, 1982). A frequently cited meta-analysis by Wampold and colleagues (1997) showed that even under the most liberal assumptions, the upper bound estimate of the effect size for type of treatment is .20. Meanwhile, Horvath and Symonds (1991) found an effect size of .26 for the therapeutic relationship, which they indicated is a conservative estimate. Other meta-analyses of studies on relationship variables have found similar results (e.g., Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000).<sup>1</sup>

The initial reports of the Dodo bird effect were met with charged responses from professionals harbouring strong opinions in both directions (Luborsky et al., 2002). Many authors refused to accept the notion that such divergent approaches to psychotherapy could

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<sup>1</sup> Although later studies would reveal that a small part of the variance in treatment outcome can be attributed to specific techniques, this influence disappears when we control for methodological biases due to therapist allegiance (Luborsky et al., 1999).

be more or less equivalent in facilitating client improvement (e.g., Rachman & Wilson, 1980). Since then, psychotherapy outcome studies have become increasingly pragmatic as researchers have attempted to demonstrate the superiority of one psychotherapeutic approach over another (Omer & Dar, 1992). However, other professionals took the Dodo bird effect as evidence that techniques were inconsequential to the effectiveness of psychotherapy, as Rogers had hypothesized (Duncan, 2002). For these individuals, this finding provided support for the significance of the therapeutic relationship. Due to the general disillusionment with Rogers' theory at the time, many professionals were quick to adopt the therapeutic alliance as the new hot research topic (Orlinsky & Ronnestad, 2000). Although interest in this area developed slowly at first, research on the alliance has increased considerably since the mid-1980s (Beutler et al., 1994).

#### Empirically Supported Treatments

Although findings on the equivalence of psychotherapies did influence some researchers to reconsider the significance of the relationship, many professionals continue to tout the benefits of the technical aspects of psychotherapy. Often, the relational aspects of therapy are overlooked due to an emphasis on specific techniques inherent to one treatment approach or another. This perspective has become more prominent in recent years as a result of the healthcare situation in the U.S.

Increasingly, the aspects of psychotherapy that are researched, practiced, and trained are influenced by the decisions of insurance companies and managed care organizations in the U.S. (Norcross, 2002). This trend has put pressure on psychologists to advertise the cost-effective, scientifically proven elements of psychotherapy in order to compete with drug companies for a prominent role in healthcare (Crits-Christoph et al., 1995). Unfortunately,

the elements of psychotherapy that are most amenable to rigorous testing tend to be more technical (Castelnuovo, Faccio, Molinari, Nardone, & Salvini, 2004). Therefore, this has been the side that the psychology profession has emphasized.

In 1993, The American Psychological Association (APA) diligently responded to these new demands by commissioning the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures to review the psychotherapy outcome literature and to publish a list of manualized, *empirically supported treatments* (ESTs) for specific disorders with the goal of informing training programs and promoting psychological interventions to third party payers and the public (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The authors of the report stated that “if clinical psychology is to survive in this heyday of biological psychiatry, the APA must act to emphasize the strength of what we have to offer – a variety of psychotherapies of proven efficacy” (p. 3). To achieve this goal, the task force proposed three categories of treatments: (a) *well-established*, (b) *probably efficacious*, and (c) *experimental*.

In order for a particular therapy to be considered *well-established*, research results must have demonstrated its effectiveness (Task Force, 1995). The task force’s criteria specify that these studies must be conducted using treatment manuals and must use clearly defined client samples. Furthermore, the research must have demonstrated that the treatment is either (a) superior to pill or psychological placebo or to another treatment, or (b) equivalent to an already established treatment. For a therapy to be classified as probably efficacious, the criteria are less strict; however, inclusion in either group is enough for a treatment to be deemed “empirically supported.” Members of the task force published a list of treatments

that met the criteria for classification in each group. Since then, two updates of this report have been published (Chambless et al., 1996; 1998).

In response to the initial Task Force (1995) report, the APA (1996) made changes to its Guidelines and Principles for Accreditation of Programs in Professional Psychology to emphasize the role of evidence-based practice to include the statement that

all programs should enable their students to understand the value of science for the practice of psychology and the value of practice for the science of psychology, recognizing that the value of science for the practice of psychology requires attention to the empirical basis for all methods involved in psychological practice (p. 3).

The literature presents mixed evidence of the effect that these changes have had on clinical training (Daniels & Olivares, 2002). When the 1995 report was published, clinical psychology programs and internship sites were already training students to deliver ESTs (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). The limited research that has been published since then suggests that training in ESTs continues to be a major priority (Daniels, Alva, & Olivares, 2002; Karekla, Lundgren, & Forsyth, 2004). The extent to which these changes have affected mainstream practice is also unclear. Freiheit, Vye, Swan, and Cady (2004) found that psychologists in community and private practice have responded to the recommendations of the report; however, Castelnovo et al. (2004) wrote that “despite of [*sic*] the emphasis supported by APA, such empirically supported psychotherapies are not used widely by front-line practicing clinicians” (p. 210). The conflicting evidence suggests that practicing and training in ESTs may still vary across settings. However, if the health-care system continues to move in the same direction, ESTs will most likely become increasingly common (Sanderson, 2003).

Since its publication, the Task Force (1995) report has been widely acknowledged as a noble contribution to psychological science (Calhoun et al., 1998; Norcross, 2002; Sanderson, 2003). In addition to carving a niche for psychotherapists in the future of healthcare, the report echoes the basic foundation of the scientist-practitioner model of training by encouraging evidence-based practice (Morin, 1999). However, many psychologists objected to the content of the report, particularly to the criteria for inclusion in the EST lists.

One potent criticism of ESTs concerns the Task Force's (1995) criterion that the treatment be demonstrably superior to a pill or a psychological placebo. The idea of randomized placebo trials may be in line with the medical model for which they were originally used; however, psychotherapy research is different from medical research in several important respects (Chalmers, 1998). Baskin, Tierney, Minami, and Wampold (2003) list several essential conditions of placebo control group designs that are difficult to fulfill when conducting psychotherapy research. A first condition is that all factors except those hypothesized to be the active ingredients of the treatment must be held constant. This requirement may be relatively straightforward to implement in studies comparing different types of medication; however, it does not easily generalize to psychotherapy research, as the mere awareness of being treated can have a positive impact on outcome (Kirsch, 1997). A second requirement is that all participants, administrators, and examiners involved in the study must be blind to the treatment conditions (Baskin et al., 2003). However, as Castelnovo and colleagues (2004) observed, the therapist must have a good understanding of the treatment that he or she is delivering in order to follow the clinical protocol (Seligman, 1995; Wampold, 2001). Furthermore, the effectiveness of double-blind research requires that

participants' expectations regarding effectiveness be the same across experimental groups (Baskin et al., 2003). Again, it is difficult to fulfill this requirement in the context of psychotherapy research. Even if we manage to deceive participants about the effectiveness of the treatments, the rationales for the therapies will differ, and therefore the credibility and expectations of clients may vary across treatment groups (Castelnuovo et al., 2004).

Other commentators have criticized the Task Force's (1995) stipulation that a therapy may qualify for inclusion in the *well-established* group if it is superior to another treatment or equivalent to a previously established treatment. As noted earlier, psychotherapy effectiveness trials testing treatments against one another may be biased by researcher allegiances (Luborsky, et al., 1999). For instance, Wampold, Minami, Baskin, and Tierney (2002) meta-analyzed treatments for depression and found that although CBT appeared to have superior effects compared to the other therapies in their analysis, this was because their alternative non-CBT "treatments" were not bona fide treatments (e.g., supportive counselling). An additional problem is that clinicians involved in comparison studies may not be familiar with each of the treatments being tested, and this may result in the treatments being delivered inconsistently (Stiles et al., 1986). Finally, research results failing to support investigators' allegiances may be less likely to be submitted for publication (Luborsky et al., 1999).

Another concern regarding the criteria set forth by the Task Force (1995) report is that they required clinical trials to adopt standards that may lead to poor external validity as a result of testing treatments on atypical clients in artificially controlled environments (Ablon & Jones, 2004). For example, the Task Force (1995) requires that client samples be clearly specified; however, it is difficult to obtain homogenous treatment groups without biasing the

sample of participants. The clients included in these studies are often atypical, because they exclude individuals who do not fit into a specific treatment group (e.g., clients with substance abuse problems or comorbid diagnoses). It seems that the reliability of the evidence supporting the Task Force's recommendations is somewhat questionable.

### Empirically Supported Therapy Relationships

One of the most important criticisms of the Task Force (1995) report is that it disregarded the therapeutic relationship (Garfield, 1998; Norcross, 2002). Shapiro (1996) pointed out that by focusing exclusively on treatment variables, the report disregarded various other significant factors. As noted earlier, there is strong research evidence that the therapist-client relationship is a more significant predictor of therapy outcome than the specific factors that the task force authors identified in their publication; given their emphasis on evidence-based treatment, it is striking that they did not make reference to this literature. Moreover, even if choice of treatment does have a significant impact on client gains, this does not devalue the evidence for the effectiveness of the therapeutic relationship. The relationship should be the basis for any treatment, including ESTs (Calhoun et al., 1998; Keijsers et al., 2000).

In addition, many authors have voiced their concern that increased use of ESTs will result in increased use of psychotherapy manuals, because manualization is mandatory for inclusion in the *well-established* group (Task Force, 1995). Although treatment manuals may have the benefit of providing "clear-cut guidelines for training and the evaluation of the consequences of training in very concrete ways" (Stein & Lambert, 1995, p. 194), manuals generally present a superficially defined approach to treating clients, and, therefore, adherence to such manuals does not necessarily imply competent practice (Follette & Beitz,

2003; Wampold et al., 1997). In fact, one study found that although manuals are effective at increasing therapists' adherence to particular treatment models, they can also decrease clinicians' relationship skills (Henry, Strupp, Butler, Schacht, and Binder, 1993; but see also Crits-Christoph et al., 1998). In addition, Morstyn (2002) suggested that manualization of mental health practices has "managed to eliminate something so centrally important as therapist sincerity from general consideration. Therapists who 'fake' sincerity may be very successful in adapting to current cultural conditions but they are ultimately 'just playing the game'" (p. 328). The fact that all *well-established* therapies must be manualized may pose a threat to competent delivery of healthcare services (Beutler, 1998; Castelnovo et al., 2004).

In response to the concern that the Task Force (1995) neglected the therapeutic relationship, in 1999 Norcross commissioned the APA Division of Psychotherapy Task Force to "identify, operationalize, and disseminate information on empirically supported therapy relationships" (Norcross, 2001b). In constructing their report, the Division 29 Task Force (Norcross, 2001a) had two goals: (a) identify which elements of therapy relationships were most effective, and (b) identify effective methods of customizing therapy to the individual client based on his or her (nondiagnostic) characteristics. I will focus on the first of these in this review.

Although the general idea behind this project was similar to the 1995 Task Force report, there are several important differences, including the use of both quantitative and qualitative studies in their reviews and the consideration of both short- and long-term impacts of treatment (Norcross, 2002). However, the later report paralleled the 1995 publication in that it classified relationship factors into three broad categories: (a) *demonstrably effective*, (b) *promising and probably effective*, and (c) *insufficient research to judge*. The factors from



the first two groups were included in the final reviews and recommendations published by the task force. The *demonstrably effective* category included therapeutic alliance, cohesion in group therapy, empathy, and goal consensus and collaboration. The *promising and probably effective* category included positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of counter-transference, and quality of relational interpretations.

The objective of the present study is to investigate the predictors of relationship skills training in clinical psychology programs. Because the Division 29 Task Force (Norcross, 2001a) report provides a well-considered and comprehensive review of empirically supported relationship factors, I have decided to base my selection of relationship variables on the findings from this publication. However, to include every relationship element identified in the report would be beyond the scope of this project. Therefore, I have narrowed the scope of this study to focus on several key elements.

The Task Force (Norcross, 2001a) report classified four relationship qualities as *demonstrably effective*: (a) the alliance, (b) cohesion in group psychotherapy, (c) empathy, and 4) goal consensus and collaboration. Positive regard and congruence were classified as *promising and probably effective* rather than as *demonstrably effective* because although the research evidence supported the importance of these variables as predictors of therapy outcome, the evidence reviewed by the task force authors was not strong enough to classify them as *demonstrably effective*. However, as Cornelius-White (2002) pointed out, the task force may have made an error in deciding to relegate Rogers' other two common factors to the *promising and probably effective* group. He argued that the task force mistakenly reviewed the research on positive regard and congruence/genuineness along with similar but

theoretically distinct factors (e.g., affirmation, support, the “real-relationship”). According to Cornelius-White, research findings from the Rogerian factors themselves “comprised data that would likely be included in the demonstrably effective category if extracted from the peripherally included research” (p. 221). Moreover, he contended that the task force made the common error of including research that used therapists’ and judges’ ratings of the Rogerian factors. As noted earlier, when they separately reviewed findings based on client ratings, the task force authors found that evidence for the effectiveness of all three factors was overwhelmingly positive (Norcross, 2002). Therefore, in light of these considerations, I decided to consider positive regard and congruence/genuineness in my investigation on training of relationship skills.

The present study focused exclusively on training in *demonstrably effective* relationship elements, including congruence and positive regard. This decision was based on the assumption that the factors that are most significantly associated with therapy outcome are also the factors most salient to effective graduate training. In addition, I chose to examine only those relationship factors that apply to individual psychotherapy; therefore, I did not examine cohesion in group psychotherapy. Finally, I decided to amalgamate two factors: the alliance and goal consensus and collaboration. Because goal consensus and collaboration are essentially two of the three components of Bordin’s (1979) definition of the alliance, i.e., agreement on goals, and collaboration between client and therapist in achieving these goals, it seem redundant to examine them individually. Therefore, this study featured four relationship elements: empathy, unconditional positive regard, congruence/genuineness, and the alliance.

### *Rogers' Three Factors*

Much of the research evidence for the effectiveness of empathy, unconditional positive regard, and genuineness comes from the years immediately following Rogers' (1957/1992) paper on the necessary and sufficient conditions for therapeutic personality change. One seminal study was conducted by Rogers' research team at the University of Wisconsin and investigated the effects of the core conditions on therapy outcome among chronic and acute schizophrenia clients (Truax & Carkhuff, 1967). Sixteen clients were randomly assigned to therapists, who were rated on empathic understanding, unconditional positive regard, and congruence. These ratings were found to be highly correlated with a composite measure of outcome (including hospitalization time and changes in scores on personality measures). Another frequently cited study was conducted by Barrett-Lennard (1962), who found that client ratings of the core conditions taken after the fifth therapy session and at termination were positively correlated with objective and therapist-rated measures of therapy outcome.<sup>2</sup> Other influential studies were conducted at this time as well (see Truax & Carkhuff, 1967; Truax & Mitchell, 1971 for a review).

As noted earlier, interest in Roger's (1957/1992) therapeutic conditions declined considerably after the 1970s. For instance, a recent review of the literature on congruence included 18 studies from the 1960s and 1970s, only two studies from the 1980s, and none after 1989 (Klein, Kolden, Michels, & Chisholm-Stockard, 2002). However, the research conducted over the past few decades has indicated that, overall, these factors are important to psychotherapy outcome.

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<sup>2</sup> Although results were all significant at the fifth session, only empathy and congruence were significant when assessed at termination. However, level of regard approached significance.

Unfortunately, a consistent challenge that researchers have faced when investigating relationship skills variables is that the contributions of the separate factors are difficult to tease apart. (Farber & Lane, 2002; Norcross, 2002; Rogers, 1961). Measures of the core conditions correlate highly with one another and with measures of the alliance (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Gurman, 1977; Salvio, Beutler, Wood, & Engle, 1992; but see Truax & Carkhuff, 1967). Nevertheless, these variables have been investigated extensively as distinct constructs.

### *Empathy*

Over the years, the word *empathy* has been used to refer to various concepts. The term is a translation of the word *Einfühlung* (literally, 'feeling into') originally used by Lipps and Wundt to denote the projection of emotion into people and things (Gribble & Oliver, 1973).

Duan and Hill (1996) discuss three separate constructs that have often been called empathy. First, some authors have defined empathy as person's ability to understand another person's internal world. This type of empathy, which Davis (1983) has termed *dispositional empathy*, is often studied in social psychology but is seldom used in psychotherapy process research (Bohart, Elliott, Greenberg, & Watson, 2002). Other investigators have defined empathy as a more transient state of emotional or intellectual understanding between two people (Barrett-Lennard, 1962). Finally, the term is often used to denote an experiential process involving several phases. Examples include Barrett-Lennard's (1981) three-stage model of empathy in which (a) the therapist resonates to the client's statement, (b) the therapist communicates this understanding to the client, and (c) the client receives the therapist's communication; Kohut's (1984) description of understanding followed by communication of the client's

message; and Gladstein's (1983) multistage model that includes emotional contagion, identification, and role taking (Duan & Hill, 1996).

For the purposes of this paper, I will use Rogers' (1961) definition of empathy as an experiential process. Rogers wrote that empathic understanding involves two sequential elements, wherein the therapist first understands the client's internal world, and then effectively communicates this understanding to the client. Rogers stated that empathy is present "when the therapist is sensing the feelings and personal meanings which the client is experiencing in each moment, when he can perceive these from 'inside,' as they seem to the client, and when he can successfully communicate something of that understanding to his client" (Rogers, 1961, p. 62). It is not enough for the therapist to understand the client's experience; the therapist must communicate this understanding so that the client can receive it.

Rogers (1959) pointed out that empathic understanding should not be mistaken for identification, wherein the listener may become overwhelmed by the other person's feelings because they are not clearly differentiated from his or her own. Although the type of understanding that Rogers alluded to involves fully experiencing the client's world, he also noted that you must have the ability "to sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it" (Rogers, 1957/1992, p. 829). In this sense, empathic understanding requires a degree of separation.

Empathic understanding also involves a deeper awareness than is present in most conversations. Rogers (1961) observed that empathic understanding is unlike the type of understanding that people usually communicate when speaking to each other. The latter often

takes the form of “evaluative understanding from the outside” (p. 62). This type of understanding is similar to other authors’ descriptions of empathy as the ability to introspect based on personal experience in order to know another person (e.g., Guntrip, 1969; Kohut, 1984). Some authors have referred to this as *external empathy*, as it requires that the therapist remain outside the other person’s experience (Mahrer, Boulet, & Fairweather, 1994). In contrast, Rogers’ (1961) notion of empathic understanding involves entering more deeply into another person’s experience. He wrote that when the therapist attempts to enter into and understand the client’s world from the inside without judgment, change is likely to occur.

Hart (1999) wrote about a type of empathy that requires direct intuition, which he calls *deep empathy*. He described the experience of deep empathy as a loosening of self-other boundaries to facilitate collaborative exploration. Hart noted that this experience does not occur as the result of introspection based on personal experience (Guntrip, 1969; Kohut, 1984), but instead comes about through intimate knowledge of the other person: “As the distance between subject and object – between therapist and client – is reduced, there opens up the opportunity to know the client more directly” (Hart, 1999, p. 116). According to Hart, techniques (e.g., logical inference based on personal history) are only helpful insofar as they engender the necessary shift in being or consciousness.

Other authors have written about the importance of moving beyond the manifest content of the client’s experience to create therapeutic change. Greenberg and Goldman (1988) stated that “effective empathy requires picking up the ongoing, growing edge of the client’s experience, the aspect that is developmentally moving the client forward to a greater sense of competence and mastery” (p. 697). In fact, research has shown that responses that are slightly ahead of the client are more effective than responses that paraphrase the client’s

statement or that are more general (Truax & Carkhuff, 1967). Greenberg and Safran (1989) suggested that affect is “an orienting system that provides the organism with adaptive information” (p. 20). Therefore, as Greenberg and Goldman (1988) noted, the therapist should not move the client’s experiencing in any direction; rather, he/she should try to respond to emotions that facilitate movement toward self-actualization: “Empathy thus involves selectively responding both to what is most alive in the client’s experience and to primary adaptive emotional responses” (p. 697). Furthermore, the authors contended that different types of empathy will be differentially effective at different times. They also suggested that focusing on a particular type of information may be adaptive at some times more than at others, which highlights the importance of moment-to-moment attunement.

*Research review.* Empathy is one of the most intensively researched variables in the process-outcome literature (Orlinsky & Howard, 1986), perhaps because it is one of the most robust predictors of therapy outcome (Barrett-Lennard, 1962; Bohart et al., 2002; Lafferty, Beutler, & Crago, 1989). In an early review, Orlinsky and Howard (1978b) surveyed the literature on the relationship between empathy and therapy outcome and reported that studies conducted during the 1960s and 1970s generally found a significant positive relationship between empathy and therapy outcome. This article was the first in a series of reports examining the literature on process and outcome in psychotherapy. Orlinsky & Howard (1986) built on their previous review by examining eight more years of process-outcome findings, and Orlinsky and colleagues (1994) followed suit by adding another eight years of results to Orlinsky and Howard’s (1986) review. The latter two surveys indicated that, overall, the research shows a significant relationship between therapist empathy and therapy

outcome. All three reviews reported that client ratings of therapist empathy are much stronger predictors of therapy outcome than are therapist or observer ratings.

As part of the Division 29 Task Force (Norcross, 2001a) report, Bohart and colleagues (2002) meta-analyzed 190 findings linking empathy to therapy outcome and obtained similar results. They reported an effect size of .32 for therapist empathy and concluded that “overall, empathy accounts for as much and probably more outcome variance than does specific intervention” (p. 96).

Alternatively, some research has focused on associations between empathy and other therapist variables. Peabody and Gelso (1982) discovered that counselling students who are open to countertransferential feelings are rated as more empathic by clients. Horvath and Greenberg (1986) found that client ratings of empathy are associated with client-therapist agreement on the goals and tasks of treatment. Finally, Lafferty and colleagues (1989) reported that effective therapists value intelligence and reflection more than less effective therapists do, whereas the latter are more likely to value comfort and stimulation.

Many of the methodological obstacles to obtaining accurate measures of empathy have been addressed above. A large number of these criticisms have focused on the validity of scales like Truax's Accurate Empathy Scale (Truax & Carkhuff, 1967) and the methodological flaws in studies using this instrument (see Jacobs & Williams, 1983, for a review). For instance, Greenberg and Goldman (1988) pointed out that observer ratings using these measures have more to do with the therapist's linguistic style than with how well the response addressed the client's preceding statement (Rennie, Burke, & Toukmanian, 1978). However, Jacobs and Williams (1983) have argued that the instrument is not the problem, and that the idea of operationalizing empathy is absurd. Some researchers have attempted to



design a scale to tap the more complex and phenomenological aspects of empathy (Klein, Mathieu-Coughlin, and Kiesler, 1986). However, Greenberg and Goldman (1988) contended that a more comprehensive measure would have to “measure empathy as a form of interactive communication in which the therapist uses a defined responsive style while selectively focusing on particular client processes at particular points in specific contexts” (p. 698). As of yet, it seems that the complexity of the interactions involved in the empathic process may have prevented researchers from obtaining accurate measures of this construct. The fact that the association between empathy and therapy outcome prevails despite the relatively crude nature of current empathy measures speaks to the therapeutic power of empathy.

#### *Unconditional Positive Regard*

Since his earliest reflections on the process of client-centred therapy, Rogers focused on unconditional positive regard and warmth as essential ingredients of client change (Farber & Lane, 2002). Rogers (1961) defined *unconditional positive regard* as “a warm caring for the client – a caring which is not possessive, which demands no personal gratification. It is an atmosphere which simply demonstrates ‘I care;’ not ‘I care for you if you behave thus and so’” (p. 283). He described the concept as a valuing or prizing of the client in a holistic sense and an “acceptant attitude toward the client...an outgoing positive feeling without reservations, without evaluations” (p.62). Several terms have been used to refer to this construct, including *positive regard*, *acceptance*, and *nonpossessive warmth*. In his early writings, Rogers (1951) distinguished between positive regard and acceptance; however, later in his career he used these terms interchangeably (Farber & Lane, 2002). In this paper, I will use the phrase unconditional positive regard to refer to all of these terms.

Much like empathy, unconditional positive regard can be construed as a cluster of interrelated conditions. Lietaer (1984) wrote that factor analytic research has identified a number of relatively independent dimensions within this construct (Gurman, 1977; Lietaer, 1976). Specifically, he suggested that unconditional positive regard represents three separate concepts: (a) positive regard, or the therapist's warmth, valuing, and nonpossessive caring for the client; (b) nondirectivity, which refers to an attitude of respect for the client as an independent and self-sufficient person; and (c) unconditionality, which denotes constancy in accepting the client, or "the extent to which the therapist accepts his client without 'ifs'" (Lietaer, 1984, p. 42).

Lietaer (1984) also noted that therapists operating from within and without the client-centred arena have been sceptical about the practical implications of unconditional positive regard. He enumerated several problems that arise in adopting this attitude in therapy. First, there is a potential conflict between congruence or genuineness and unconditionality, as there may be times when the therapist does not feel accepting toward the client. At these times, the therapist must decide whether to feign acceptance, thereby failing to be genuine, or else display the lack of acceptance, thereby failing to provide unconditional positive regard. Second, Lietaer noted that most therapists would not be able to provide constant acceptance for any client. He suggested that although unconditionality is not impossible, it is realistically improbable. Rogers (1957/1992) addressed these issues by clarifying that the unconditionality is a matter of degree:

The phrase 'unconditional positive regard' may be an unfortunate one, since it sounds like an absolute, an all-or-nothing dispositional concept...I believe the most accurate statement is that the effective therapist experiences unconditional positive regard for

the client during many moments of his contact with him, yet from time to time he experiences only a conditional positive regard – and perhaps at times a negative regard, though this is not likely in effective therapy. It is in this sense that unconditional positive regard exists as a matter of degree in any relationship (p. 829).

Third, Lietaer (1984) wrote that unconditionality requires the therapist to engage in “devoted self-effacing that often leads to a compensatory reaction in which confrontation becomes a form of self-assertion” (p. 41). In other words, unconditionality may be possible to maintain for a short while, but in the long run it may be harmful.

Interestingly, Lietaer’s (1984) statement that an attitude of unconditionality entails “devoted self-effacing” on the part of the therapist seems contrary to his description of unconditional positive regard as part of a more basic attitude of openness that he offered later in his chapter:

As a matter of fact, congruence and acceptance are thought to be closely related to one another; they are parts of a more basic attitude of ‘openness’ (Truax & Carkhuff, 1967b, p. 504): openness toward myself (congruence) and openness toward the other (unconditional acceptance). The more I accept myself and am able to be present in a comfortable way with everything that bubbles up in me, without fear or defence, the more I can be receptive to everything that lives in my client (p. 44).

This description suggests that unconditionality is less about effacing oneself and more about accepting both the therapist and client as fully as possible. It also suggests that unconditional positive regard facilitates empathy. If the conditions of worth that obscure our understanding of human existence are removed, the therapist is free to explore all aspects of the client’s experience.

Some authors have suggested that unconditional positive regard is the curative factor of the three conditions (Bozarth, as cited in Ridge, Campbell, & Martin, 2003) and a major curative factor in any therapeutic approach (Wilkins, 2000). Although it might seem that fully accepting a client as he or she is would encourage stagnation, this is not the case (Rogers, 1961). Rogers (1959) believed that the conditions that parents place on their love for their children cause the children to internalize parental expectations. Because they are taught to believe that they are only valued when they behave in certain ways, children learn to deny parts of themselves and to present a false self, thus creating a state of incongruence that may persist into adulthood (Kohn, 2005). If a therapist is able to accept aspects of a client's personality that had previously been denied, they become free to integrate themselves into the rest of the client's personality. In this way, unconditionality "enables evolution of 'frozen' aspects of ourselves" (Lietaer, 1984, p. 45).

*Research review.* There is much less empirical literature on unconditional positive regard than there is on empathy. Perhaps this is because empathy has components that are easier to measure, even if only superficially; as Lietaer (1984) suggested, unconditional positive regard and genuineness are "basic attitudes that are not readily visible in the therapist's interventions" (p. 44). Nevertheless, the available evidence paints a convincing picture of the effectiveness of unconditional positive regard in facilitating client change.

Early research examining the relationship between unconditional positive regard and outcome frequently included measures of the other Rogerian factors. Although many of these studies did not report separate findings for the three conditions, several reports did. For example, in the Wisconsin Schizophrenia Project, Rogers and colleagues used trained judges to rate therapists using the Unconditional Positive Regard scale of the Truax Relationship

Inventory (Truax & Carkhuff, 1967). They reported that the correlation between these ratings and scores on a combined outcome measure was .73 ( $p < .01$ ). As previously noted, Barrett-Lennard (1962) achieved similar results using the Level of Regard and Unconditionality of Regard subscales of the Barrett-Lennard Relationship Inventory. He reported that clients who rated their therapists more highly on these subscales were significantly more likely to improve over the course of therapy ( $p < .01$ ). Likewise, Lorr (1965) constructed and factor-analyzed a measure of interpersonal behaviour patterns and found that clients' ratings of therapist acceptance were significantly related to client and therapist ratings of improvement.

In 1971, Truax and Mitchell reviewed twelve studies investigating the relationship between the therapeutic conditions and therapy outcome and found that, on the whole, nonpossessive warmth was a significant predictor of therapy outcome. They noted that not one finding showed a negative relationship between therapists' warmth and outcome.

As mentioned earlier, a number of review articles published toward the end of the 1970s seriously questioned the effectiveness of Roger's (1957/1992) core conditions (e.g., Lambert et al., 1978; Mitchell et al., 1977; Parloff, Waskow, & Wolfe, 1978). However, other reviews were more positive. For instance, Orlinsky and Howard's (1986) review examined 94 findings on the relationship between outcome and "therapist affirmation," which included constructs such as warmth, acceptance, and positive regard. They found that, overall, more than half of these results indicated a significant positive relationship between these variables. Of the 30 findings using clients' ratings of therapist affirmation, two thirds of the results represented significant positive associations with outcome. When Orlinsky and colleagues (1994) updated the 1986 review by adding 64 new process-outcome findings, they found that 90 of 154 findings (56%) showed that therapist affirmation is significantly

positively related to outcome, but that “the considerable variation in effect size (ES) suggests that the contribution of this factor to outcome differs according to specific conditions.” (p. 326) They did not speculate as to which conditions these might be.

The Division 29 Task Force report (Norcross, 2001a) section on therapist positive regard presents comparable results (Farber & Lane, 2002), although, as mentioned earlier, this literature review includes both positive regard and therapist support. The authors found that approximately half of the 55 findings reviewed indicated that positive regard or support were significantly related to outcome, whereas the other half of the results were nonsignificant. Client ratings yielded slightly more significant findings, with 17 out of 31 results (55%) showing a significant positive relationship to therapy outcome. Effect sizes for the relationship between positive regard or support and outcome were modest, and the larger effect sizes occurred more often when outcome was measured in terms of length of stay in therapy. Based on these aggregated results, the authors concluded that

The therapist’s ability to provide positive regard seems to be significantly associated with therapeutic success – at least when we take the client’s perspective on therapeutic outcome...we conclude that therapists’ provision of positive regard is strongly indicated in clinical practice. We assume that, at a minimum, it ‘sets the stage’ for other mutative interventions and that, at least in some cases, it may be sufficient by itself to effect positive change (Farber & Lane, 2002, p. 191).

The most frequently mentioned methodological flaws in the literature on unconditional positive regard and outcome are similar to those noted in other sections of this paper, and include inappropriate measurement of constructs (Gurman, 1977), correlational

designs, and publication bias. These and other limitations will be discussed in the conclusion of this section.

### *Congruence*

Therapist *congruence* or *genuineness* is thought to be comprised of two basic elements (Klien et al., 2002; Lietaer, 1993). The first element is an intrapersonal ability and requires that the therapist be self-aware; the second element requires the interpersonal communication of this internal state. The intrapersonal aspect of congruence is effectively represented in Rogers' (1957/1992) definition:

The third condition is that the therapist should be, within the confines of this relationship, a congruent, genuine, integrated person. It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly (p. 828).

According to Rogers, the therapist does not need to be fully integrated in every aspect of his or her life. As long as the therapist is "accurately himself in this hour of this relationship" (p. 828/97) and does not deny thoughts and feelings that may arise during session, this condition is satisfied. The interpersonal component of congruence, the outward expression of the therapist's internal clarity, can be more confusing to implement. Rogers offers little advice except to say that the therapist "should not be deceiving the client as to himself" (p. 829) and that occasionally the therapist may need to "talk out his own feelings...if they are standing in the way of [the other two conditions]" (p. 829).

Klein and colleagues (2002) and Lietaer (1993) agreed that there is a distinction between the internal and external components of congruence; however, they emphasized

different aspects of how congruence is best communicated to the client. Klein and colleagues (2002) implied that congruence is conveyed more in the therapists' attitude than in his words. Although they recommended that the therapist not deceive the client about his or her emotions, they specifically cautioned against "indiscriminant self-disclosure or ventilation of feelings" (p. 195). Similarly, Lietaer (1993) suggested that the therapist should rarely reveal personal history or information; however, he encouraged the practice of *transparency*, which he defined as "the explicit communication by the therapist of his conscious perceptions, attitudes and feelings" (p. 18). According to Lietaer, the therapist should not only be continuously aware of his or her thoughts and emotions, but he or she should explicitly communicate these to the client.

Congruence or genuineness is also conceptualized as being part of the *therapist real relationship*, which Eugster and Wampold (1996) described as "the relationship between patient and therapist that is based on accurate perceptions of each other, neither prescribed by technique or role fulfilment, nor dictated by the operations of transference or countertransference" (p. 1020). Gelso and Carter (1994) conceptualized the therapist real relationship as having two facets: (a) genuineness, and (b) realistic perceptions. Little research has been conducted on this construct, although a measure has recently been developed (Gelso et al., 2005).

Because being congruent allows the relationship to be grounded in reality, Rogers (1961) believed that congruence is the fundamental relationship condition. He wrote that it is essential to be real, "even when the attitudes I feel are not attitudes with which I am pleased, or attitudes which seem conducive to a good relationship" (p. 33). Klein and colleagues (2002) remarked that one reason why this attitude is so important is that the healing process



involves the client becoming more congruent, and “therapist congruence can serve as a model for the client” (p. 196). As Rogers (1961) stated, “It is only by providing the genuine reality which is in me, that the other person can successfully seek for the reality in him” (p. 33). Furthermore, Lietaer (1993) pointed out the importance of congruence as a precursor to acceptance and empathy:

Congruence is a correlative of acceptance: there can be no openness to the client’s experience if there is no openness to one’s own experience. And without openness there can be no empathy either. In this sense, congruence is the ‘upper limit’ of the capacity for empathy (Barrett-Lennard, 1962, p. 4). To put it differently: the therapist can never bring the client further than where he is himself as a person (p. 23).

On the other hand, too much genuineness may be destructive (Morstyn, 2002).

Lietaer (1993) noted that a transparent therapist may be either congruent or incongruent, and that the latter makes him or her a “‘dangerous’ therapist” (p. 18). Morstyn (2002) wrote that the destructive effects of such therapists may be responsible for the current situation where the distinction between sexual abuse and genuine caring has become blurred. As Eugster and Wampold (1996) stated,

The actual human relationship with the patient is often treated with suspicion through admonitions against over-involvement, breach of boundaries, inappropriate gratification, and other such departures from good technique. Nowhere is the trainee taught to embrace the real relationship with the patient without jeopardizing the imperative defining frame of the therapy interaction, nor are trainees ever rewarded for their personhood or humanness (p. 1025).

*Research review.* Like the research on unconditional positive regard, the literature on congruence is relatively sparse compared to the literature on empathy. However, the research that has been done generally supports the hypothesis that congruence improves therapy outcome.

In the Wisconsin Schizophrenia Project, congruence was measured using the Truax's Therapist Self-Congruence scale and was shown to be significantly correlated with a composite measure of therapy outcome at .66 ( $p < .01$ ; Truax & Carkhuff, 1967). Reporting on a separate study conducted in the context of the Wisconsin project, van der Veen (1967) stated that although length of therapy was significantly related to all therapist relationship conditions, "congruence at all therapy points was particularly strongly related to length, adding to the evidence that more effective therapist behaviour is associated with an interaction of longer duration (van der Veen, 1965b)" (p. 301). Furthermore, client-rated therapist congruence throughout the course of treatment was significantly related to several types of client processing, particularly problem expression and deep intrapersonal exploration. In addition, van der Veen reported that client-rated therapist congruence was strongly related to therapist congruence three months later. Finally, Barrett-Lennard's (1962) study showed that both client and therapist ratings of therapist congruence were significant predictors of outcome, although therapist rated congruence was not significantly associated with changes in adjustment among the more disturbed clients in his sample.

In their review article, Truax and Mitchell (1971) reported consistently positive results for congruence (81% of findings were positively correlated with outcome measures); however, Klein and colleagues (2002) cautioned readers to be careful in generalizing from their results, because all of the studies in the review were conducted by Truax and his

colleagues. Lambert and colleagues (1978) reviewed literature from the same period and reported that 62% of findings showed a positive relationship between congruence and outcome, although positive findings were mostly found in studies conducted by Truax. Meanwhile, a review article by Mitchell and colleagues (1977) reported that congruence was only associated with outcome 50% of the time.

Orlinsky and Howard's (1978b) report included 26 studies on congruence. They reported that 58% of the 20 studies that used observer ratings of therapist congruence showed a positive relationship with outcome. On the other hand, among the 6 studies that used client ratings, 83% found such an association. Orlinsky and Howard concluded that "these studies seem to warrant the conclusion that therapist genuineness is at least innocuous, is generally predictive of good outcome, and at most may indeed be a causal element in promoting client improvement" (p. 307). However, they also concluded that congruence is likely neither necessary nor sufficient to produce gains in psychotherapy.

In Orlinsky & Howard's (1986) updated report, which included two additional studies, 38% of tabled results showed a positive relation between congruence and outcome, 60% were not significant, and 1% (one finding) showed a negative relationship. Client ratings improved the picture somewhat: 45% of studies found that client ratings of therapist congruence were positively associated with outcome, and no negative findings were reported. The authors stated that congruence was "most important when measured from the patient's perspective" (p. 340), but that overall, "genuineness had an occasional but not consistent significantly positive association with outcome" (p. 339). When Orlinsky and colleagues (1994) added another five studies to this list, the results were nearly identical.

In the review conducted by the Division 29 Task Force (Norcross, 2001a), Klein and colleagues (2002) summarized 77 findings from 20 studies. They reported that 34% of results showed a positive relationship between therapist congruence and outcome. Client ratings of congruence were associated with outcome in 33% of findings, although 50% of client ratings using the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962) or Truax Therapy Relationship Questionnaire (TRQ; Truax & Carkhuff, 1967) were significant. The authors reported that 65% of positive findings were from Rogers' Chicago or Wisconsin research groups, from client-centred treatment clinics, or from student counselling centres. Klein and colleagues summarize their findings as follows:

While the empirical evidence for congruence as an independent condition for therapy outcome is mixed, there remains both empirical and theoretical support for it to continue to be considered as an important component of a more complex conception of the psychotherapy relationship (p. 207).

Most of the limitations of congruence research are common to research on all of the Rogerian factors and were reviewed earlier. However, one issue that is somewhat unique to congruence research (although as Lietaer, 1984, noted, it can be an issue for investigations on unconditional positive regard as well) is that it is often difficult to “differentiate between the appearance of genuineness and real sincerity” (Morstyn, 2002, p. 327). In other words, are the therapists included in these studies genuinely genuine? Some therapists may not see any practical difference between real or feigned congruence, as long as the client believes that the therapist is being genuine (Schottler, 2004). In this case, it would seem that this limitation would not be as much of an issue for research using clients' ratings of therapist congruence. However, as noted earlier, congruence has as much to do with being personally integrated

and self-aware as it does with communicating one's inner experiences to the client (Rogers, 1961). Even if the client can be fooled into believing that the therapist is being real, outcome is likely to be adversely affected if the therapist does not have the personal awareness necessary for empathy and unconditional positive regard.

### *The Alliance*

Although the therapeutic alliance has become a prominent research topic in recent years, some authors have been writing about this construct for close to a century. One of the first authors to write about the alliance in psychotherapy was Freud (1913/1958), who distinguished between two essential relationship factors in psychotherapy: the transference and the working alliance. Whereas he described transference as being rooted in the client's neurosis, he saw the working alliance as an interpersonal connection between analyst and analysand necessary for successful treatment:

It remains the first aim of the treatment to attach [the patient] to...the person of the doctor. To ensure this, nothing need be done but to give him time....It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding (pp. 139-140).

Zetzel (1956) later described the alliance as a healthy transference between therapist and patient. Like Freud, she conceptualized the transference neurosis and the therapeutic alliance as distinct constructs and she believed that both are essential to the therapist-patient relationship: whereas she highlighted the importance of the transference neurosis as a form of resistance that should be interpreted, she also believed that "effective analysis depends on a sound therapeutic alliance, a prerequisite for which is the existence, before analysis, of a degree of mature ego functions" (p. 370). Greenson (1967) also distinguished between the

transference neurosis and the therapeutic alliance. Because he emphasized the patient's role in the development of the alliance, he preferred Freud's (1910) term *working alliance* over similar terms (e.g., *therapeutic alliance*, *rational transference*, or *mature transference*) because it "has the advantage of strengthening the vital elements: the patient's capacity to work purposefully in the treatment situation" (Greenson, 1967, p. 157). Bordin (1979) used these previous psychoanalytic conceptualizations to come up with his commonly cited definition of the working alliance, which is "an agreement on goals, an assignment of tasks or a series of tasks, and the development of bonds" (p. 253). Bordin's definition of alliance is most frequently mentioned in the literature; not surprisingly, the two fundamental factors measured by most alliance scales are (a) the bond between therapist and client, and (b) agreement and collaboration regarding the tasks and goals of therapy (Horvath & Luborsky, 1993).

As is true for other relationship variables, researchers have yet to agree on a definition of the alliance (Duan & Hill, 1996; Horvath & Luborsky, 1993; Saketopoulou, 1999). In addition, The terms alliance, therapeutic alliance, working alliance, and helping alliance have been used to refer to various related concepts. Following Horvath and Bedi (2002), for the purposes of this paper I will use the terms alliance or therapeutic alliance interchangeably to refer to all of these constructs.

### *Research Review*

Over two thousand articles have been written on the alliance since the late 1970s (Horvath & Bedi, 2002). Much of this literature has focused on the relationship between the alliance and therapy outcome in psychotherapy. According to Orlinsky and colleagues (1994), the alliance is the strongest predictor of outcome, as demonstrated by 1,000 process-

outcome findings. It has been shown to be an important predictor of outcome in experiential psychotherapy (Eckert & Biermann-Ratjen, 1990; Sachs, 1983), cognitive behaviour therapy (Keijsers et al., 2000; Raue, Castonguay, & Goldfried, 1993; Safran & Wallner, 1991), and psychodynamic therapy (Luborsky, 1976; Raue, Castonguay, & Goldfried, 1993). Alliance ratings taken between the third and fifth therapy sessions seem to be particularly related to outcome (Barber et al., 1999; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Hersoug et al., 2000; Horvath & Symonds, 1991). Nevertheless, it should be noted that some studies have reported negligible or non-existent relationships between alliance and therapy outcome (see Lambert, 1992).

In a frequently cited study, Horvath and Symonds (1991) meta-analyzed 24 studies investigating the association between alliance and outcome and reported an overall effect size of .26. They found that the strength of this relationship did not vary as a function of length of treatment or type of therapy practiced. Similarly, Martin and colleagues (2000) meta-analyzed 79 studies relating the alliance to outcome and found an overall effect size of .22. They concluded that the relation of alliance to outcome is moderate but consistent. Furthermore, both research teams reported that the effect of publication status on this relationship was negligible. Finally, Horvath and Bedi (2002) reviewed the literature linking alliance and outcome and found an average relation of .21 across all studies and a median effect size of .25. The authors concluded that “the quality of the alliance is an important element in successful, effective therapy” (p. 61).

Other researchers have looked specifically at the goal consensus and collaboration element of the alliance. For the Division 29 Task Force (Norcross, 2001a) report section on these elements, Tryon and Winograd (2002) reviewed the literature linking goal consensus

and collaboration to therapy outcome. They concluded that both are positively associated with treatment outcome. However, the authors stated that collaboration is a stronger predictor of outcome than goal consensus. They speculated that this may be because goal consensus is difficult to assess, as the client and the therapist may have different conceptualizations of the same goal. They concluded that the studies in their review “tend to support the importance of goal consensus and collaborative involvement in facilitating initial patient-therapist therapeutic engagement” (p. 120).

A number of therapist techniques and characteristics have been found to impact the quality of the therapeutic alliance in psychotherapy. Ackerman and Hilsenroth (2003) reviewed research examining therapist variables as predictors of alliance. They reported that attributes such as flexibility, honesty, respect, trustworthiness, confidence, warmth, interest, and openness are correlated with alliance ratings. They also reported an association between alliance ratings and techniques such as noting past therapy success and making accurate interpretations. This suggests that while therapist personal qualities and attitudes contribute to effective therapeutic alliances, so do certain therapeutic techniques. This idea is consistent with Mallinckrodt and Nelson’s (1991) speculation that effective use of techniques may mediate the relationship between experience and alliance ratings. These authors noted that experienced therapists are likely to have a broader knowledge base and more efficient cognitive strategies, which may allow them to conceptualize clients’ cases and formulate clearly defined treatment goals more effectively than novice therapists.

Although the evidence linking the alliance with client improvement is relatively strong, there are several limitations that should be considered. One important limitation concerns the confounding of alliance measures with treatment outcome. For instance, some



authors have acknowledged that certain scale items of the Helping Alliance Questionnaire Method (HAQ; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985), which is a common alliance measure, may tap outcome as well as alliance (e.g., Gaston, 1991). Moreover, the results of a factor analysis conducted by Hatcher & Barends (1996) suggest that this confound is not unique to the Pennsylvania scales. These authors factor-analyzed 3 alliance measures (the California Psychotherapy Alliance Scale (CALPAS, Gaston & Marmar, 1994), the HAQ (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985), and the WAI (Working Alliance Inventory; Horvath, 1981) completed by 231 clients. They called their first factor Confident Collaboration, and they gave several examples of the types of items that loaded highly on this factor, such as "I feel that the things I do in therapy will help me to accomplish the changes that I want" (p. 1330). Furthermore, they indicated that this first factor is typified by the following item: "How confident do you feel that through your own efforts and those of your therapist you will gain relief from your problems" (p. 1330). Their results suggest that one of the primary constructs being measured by alliance scales is clients' predictions of their own therapy outcomes. If this is the case, it should not come as a surprise that clients' ratings of the alliance are highly correlated with outcome. This argument is further supported by the finding that the task and goal components of alliance measures correlate more highly with outcome than the affective bond element. This point is seldom raised in discussions of the therapeutic alliance; however, the literature should be considered with this confound in mind.

#### *Limitations of the Research*

The research reviewed here suggests that the interpersonal contributions of the therapist play a large role in determining therapy outcome; however, it also indicates that

research in this area has faced many methodological challenges. Many of the difficulties inherent to research on the psychotherapy relationship were discussed earlier in a historical context. However, the limitations discussed were those that may account for nonsignificant results. There are also some limitations that may have contributed to spurious significant results.

For instance, a large proportion of the process-outcome research reviewed above used correlational designs. As Horvath and Bedi (2002) suggested, this method is appropriate for examining associations among a broad range of variables, but it does not allow testing of specific causal theories. Although a few recent studies have begun to examine the association between the therapy relationship and outcome (e.g., Kivlighan & Shaugnessy, 1995; Kolden, 1996), the body of literature is still too small to form any firm conclusions.

Another noteworthy concern relates to publication bias. As in any field, positive results on relationship skills may be more publicized than negative ones. Although some studies have found a negative relationship between relationship factors and therapy outcome (e.g., Jacobs & Warner, 1981; Mintz et al., 1971) or early treatment dropout (Emmelkamp & van der Hout, 1983; Ford, 1978; Hansen, Hoogduin, Schaap, & de Haan, 1992), these studies are seldom mentioned in reviews of relationship skills literature. Such studies may be suppressed either at the publication stage or else in later review articles as a result of researchers' allegiance biases. Furthermore, as Bohart and colleagues (2002) pointed out, many associations reported as "nonsignificant" may actually show a negative trend. If the direction (i.e., positive or negative) of nonsignificant trends are reported less often for

negative trends than for positive ones, then meta-analyses that set “nonsignificant” associations at zero may overestimate the strength of some relationships.<sup>3</sup>

A further consideration relates to the perspective from which the therapist’s skills are measured. Although the problems with using therapists’ or observers’ ratings of these variables have already been reviewed, the problem with clients’ ratings remains unaddressed. Measuring therapists’ relational contributions from the client’s perspective is consistent with Rogers’ (1957/1992) hypothesis that relationship conditions must be felt by the client, and it would make sense to generalize this hypothesis to measures of the alliance as well. However, as Gurman (1977) noted, clients’ perspectives may be distorted, as clients’ ratings inevitably reflect client’s conceptions about human relationships in general. Although some authors have claimed that this view has its origins in a positivist research paradigm and is contrary to the basic tenets of client-centred therapy, Rogers (1965) himself acknowledged this confound:

Schizophrenic patients perceive a much lower level of these attitudes in their therapists than do neurotic clients, though there is good reason to believe that the therapists are experiencing much the same attitudes with each group. This confirms Barrett-Lennard’s finding that the more disturbed person can less easily perceive and trust the positive attitudes of the therapist (p. 104).

Of course, the therapists’ attitude may vary in response to the interpersonal perceptions of the client. Nevertheless, of all the available methods for measuring therapeutic relationship

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<sup>3</sup> On the other hand, this confound can bias results in the opposite direction (i.e., toward nonsignificance) as well, if most of the associations reported as “nonsignificant” actually approach significance in the positive direction.

variables, using clients' ratings may still be the best option. However, it is important to note that these ratings may be biased.

In summary, there appear to be many methodological limitations to the research on relationship variables in psychotherapy. Overall, however, nonsignificant findings are more easily attributable to methodological flaws than are significant findings (Orlinsky & Howard, 1978b). Despite the research limitations, we can conclude that relationship variables are among the most significant predictors of therapy outcome and the most effective means we have for helping our clients.

### Training in Relationship Skills

Based on the large amount of research pointing to the importance of relationship factors, it seems that training in relationship skills should be a major priority for the education of psychotherapists. Surprisingly, a thorough review of the literature failed to find even one research study investigating relationship skills training in graduate programs. Nevertheless, we can reasonably assume that if such programs were consistently effective at increasing students' interpersonal skills, training level would be a robust predictor of therapy outcome. However, the literature presents a remarkably bleak picture of the effectiveness of graduate psychotherapy training (Stein & Lambert, 1995; Strupp & Hadley, 1979).

Stein & Lambert's (1995) meta-analysis of the literature on graduate psychotherapy training shows a modest relationship between training level and therapy outcome. Nevertheless, the authors conclude that the correlation is much weaker than would be expected: "Given the enormous, national investment of physical and human resources in graduate programs, it is quite remarkable that more compelling evidence is not available that demonstrates that graduate training directly relates to enhanced therapy outcomes" (p. 194).

In a similar vein, Atkins & Christensen (2001) reviewed comparable literature, including research comparing the efficacy of professional psychotherapists to paraprofessionals. They, too, concluded that the evidence for a relationship between psychotherapy training and client improvement is underwhelming. They did report that, in general, professional practitioners have reduced drop-out rates, produce longer-lasting effects, and facilitate better overall functioning in their clients. However, they also reported that paraprofessionals have repeatedly demonstrated successful outcomes with their clients, even when they have not been trained in the particular therapy methods used in the outcome study. Moreover, in many cases, paraprofessionals seem to be just as effective as professionals. The authors concluded that “the data up to this point have not shown an impact of experience and training in general, as evidenced by a therapist’s degree or years of experience” (p. 128). This observation is astonishing. For most mental health practitioners, the assumption that training improves the effectiveness of psychotherapy goes unquestioned. And reasonably so; after all, why would institutions spend enormous amounts of time and money on psychotherapy training if it has no impact on therapy outcome? Based on the available evidence, it seems that professional programs have considerable room for improvement.

Many papers have been written in recent years that stress the need to improve clinical psychology training (e.g., Calhoun et al., 1998; Crits-Christoph et al., 1995; Morin, 1999). Interestingly, despite three decades of research pointing to the power of the therapeutic relationship, most of this literature addresses the need for more training in empirically supported treatments. However, if improving the effectiveness of graduate programs is a

priority for the psychological profession, then the focus needs to shift toward training in relationship skills and away from training in techniques.

Are graduate training programs effective at increasing students' relationship skills? Again, due to correlational designs and other methodological limitations inherent to research in this area, it is difficult to answer this question definitively (Atkins & Christensen, 2001; O'Donovan, Bain, & Dyck, 2005). Research has demonstrated the effectiveness of several early training models designed to teach relationship skills (Baker, Daniels, & Greeley, 1990), which will be discussed in a later section. However, findings from research on psychotherapy training programs as a whole have been less conclusive. For instance, in an early review assessing the effectiveness of counselling psychology programs, Bath and Calhoun (1977) concluded that trainees' empathy skills generally do not increase as a result of graduate training. Similarly, Thompson et al. (1983) compared professional counsellors and paraprofessionals as leaders of treatment groups for elderly clients, and found that professionals did not differ from paraprofessionals in terms of non-specific (i.e., relationship) factors. In fact, the authors reported a nonsignificant trend for the paraprofessionals to be rated as more empathic than the professionals.

O'Donovan, Bain, and Dyck (2005) also failed to find a significant relationship between graduate training and relationship skills. They assessed the therapy skills of clinical psychology graduate students at the beginning of their first year of graduate school and then again one year later. They found that although one year of clinical training did improve students' knowledge of psychological assessment, treatment, and evaluation, it did not improve students' overall ability to establish working alliances with their clients or to communicate empathically. Similarly, a recent study looking at professional counsellors and

counselling students at various stages of training found the difference between these groups on measures of therapist-client alliance and therapist genuineness to be negligible (Gelso et al., 2005).

Some authors have reported more positive results, however. For instance, Mallinckrodt and Nelson (1991) investigated the association between training level and working alliance among professional counsellors. They found that the bond component of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was not related to training level; however, the task and goal components of the WAI were. In addition, Lyons & Hazler (2002) investigated the difference between first and second year counselling students on measures of cognitive development and empathy and found that students in their second year of training demonstrated higher levels of affective and cognitive empathy than first year students. These two studies suggest that, at least in some cases, training does improve students' relationship skills.

Nevertheless, it seems that the overall evidence for the effectiveness of graduate psychotherapy training at improving trainees' relationship skills is tentative at best. This evidence is consistent with findings from psychotherapy training effectiveness studies; if graduate training has no significant effect on students' relationship skills, it would make sense that psychotherapy training does not significantly increase students' effectiveness as psychotherapists. The question, then, is why might training fail to improve students' relationship skills? There are several possible explanations. First, if these skills are being trained, the effects of the training may not be evident in the literature because either (a) the research is methodologically flawed, or (b) the training methods being used are not effective at increasing students' relationship skills. Alternatively, it could be that most graduate

psychotherapy courses include little or no training in relationship skills. There are several factors that could account for this, including (c) psychotherapy instructors' beliefs about the importance of relationship skills in psychotherapy, (d) psychotherapy instructors' beliefs about how trainable these skills are; and (e) departmental research emphasis, which may crowd out relationship skills training in clinical psychology Ph.D. programs through a decreased emphasis on clinical work and an increased emphasis on ESTs. I will discuss each possibility in turn.

### *Limitations of the Research*

The evidence for the effectiveness of graduate psychotherapy training at increasing relationship skills is discouraging. However, there have not been enough methodologically sound studies conducted to form a firm conclusion that students' relationship skills are not impacted by graduate education (O'Donovan, Bain, & Dyck, 2005). It could be that programs are actually quite effective at improving relationship skills and that, as a result, the psychologists who graduate from these programs are in fact very effective psychotherapists. The small number of research studies on graduate program effectiveness may not reflect a representative sample. Furthermore, flaws in the research may obscure the true positive effects of graduate training. Methodological issues include inadequate or inconsistent operational definitions for the variables being studied (Reynolds, Scott, & Jessiman, 1999) and difficulties generalizing findings to clinical settings (Stein & Lambert, 1995). Ethical considerations often preclude randomized experimental research (O'Donovan, Bain, & Dyck, 2005), and it is impractical to randomize training levels to any significant degree (Atkins & Christensen, 2001). Given these limitations, it is impossible to make definitive conclusions as to the effectiveness of graduate psychotherapy training. Nevertheless, based on the available



literature, it seems doubtful that programs have a substantial impact on the relationship skills of their students.

### *Ineffectiveness of Training Methods*

Another possible reason for these discouraging results is that the methods used to teach relationship skills to students are ineffective. However, research has identified several training methods that facilitate the development of relationship skills among trainees (e.g., Baker, Daniels, & Greeley, 1990). Most of the evidence for the effectiveness of these programs comes from research on training models designed to enhance students' empathic abilities. Three of these models were studied extensively. One of these is a microcounseling (MC) program developed by Ivey, Normington, Miller, Morrill, and Haase (1968), which breaks down therapist and client interactions into discrete units that can then be integrated into the therapy process. Another is Carkhuff's human resource training (HRT; Truax & Carkhuff, 1967), which was originally used to train therapists in the Rogerian approach (Truax & Carkhuff, 1967; Truax, Carkhuff, & Douds, 1964). In this method, trainees participate in a client-centred group therapy experience, and they learn to discriminate and communicate seven conditions: empathy, respect, genuineness, concreteness, self-disclosure, immediacy, and confrontation (Baker et al., 1990). The third model is Kagan's interpersonal process recall (IPR; 1984), which is unique in that it requires trainees to review their recorded sessions with clients while recalling thoughts and feelings that they may not have been aware of during their sessions. Baker and colleagues (1990) conducted narrative and meta-analytical reviews of each of these programs and found that all three models are effective to varying degrees. They classified the effects of Kagan's interpersonal process

recall as small, the effects of Ivey's microcounseling as medium, and the effects of Carkhuff's human resource training model as large.

Although it is tempting to conclude, based on Baker and colleagues' (1990) findings, that empathy training can indeed be effective, several authors have cautioned against making this assumption. The primary criticism of their review seems to be that the studies they examined only addressed training in low-level relationship skills. Cormier (1990) pointed out that many studies demonstrating significant effects for training used inappropriate measures of relationship skills. She noted that some of the investigations examined preliminary measures of counsellor verbal responses, whereas she wrote that "there is very limited evidence of increased outcomes for other measures, such as empathy and affective sensitivity" (p. 448). In addition, Cormier remarked that many of the microcounseling studies measured the frequency rather than the appropriateness with which these skills were used, suggesting that microcounseling may only train a superficial pattern of responding that has little to do with true empathic understanding.

Gormally (1990) agreed with Cormier's critique, and added that Baker and colleagues' (1990) review focused on pre-practicum level students but did not address "how the acquisition of interviewing skills relates to the literature on counsellor development" (Gormally, 1990, p. 442). He observed that by using novice therapists to gauge training effectiveness, researchers may have missed many of the more complex elements of learning to practice psychotherapy, seeing as "we are not likely to see an experienced counsellor behave the way a newly trained pre-practicum student behaves in session" (p. 442). Furthermore, Gormally argued that the short-term training modules used in many program evaluation studies are likely to be ineffective at developing mature integration of skills into a

student's overall counselling style. In a similar vein, Cormier (1990) noted that "the lack of evidence for maintenance of skills for any of the three models suggests that trainees acquire these skills in a rote fashion, only to later drop back to what is most familiar in their repertoire" (p. 450).

The comments of these authors suggest that the training programs reviewed by Baker and colleagues (1990) may have only trained a limited conception of relationship skills. For instance, Gormally's (1990) and Cormier's (1990) responses indicate that the studies in Baker and colleagues' (1990) review article may not have measured the effect of training on the complex skills that are required to deeply understand another person's experience. As Greenberg and Goldman (1988) wrote, the ability to be truly empathic requires "the perceptual skill to hear the subtle feelings and complex meanings expressed by the client, which is a skill that takes time and personal development to acquire" (p. 698). Furthermore, they noted that empathic understanding likely involves higher-order cognitive processes and probably operates through multiple channels of communication. For this reason, many authors have discussed the importance of personal growth as an important element of relationship skills training (e.g., Carlozzi & Hurlburt, 1982; Peterson, 1985; Sundararajan, 2002). Mearns and Thorne (2000) stated that it is important for the therapist to fully accept and value all aspects of him or herself. This is in line with Peabody and Gelso's (1982) finding that openness to countertransference feelings predicts counsellor empathy, and it echoes Rogers' (1961) view that personal congruence helps the therapist to understand and accept all aspects of the client's psyche. Rogers wrote that in order to facilitate change in another person, the therapist must develop as well: "if I am to facilitate the personal growth

of others in relation to me, then I must grow, and while this is often painful it is also enriching" (p. 51).

Similarly, Lietaer (1993) remarked that "there can be no openness to the client's experience if there is no openness to one's own experience" (p. 23). He argued that fostering an attitude such as congruence does not involve direct training, but rather the more gradual process of personal development, in which "the person of the therapist is as much focused on as the client's process" (p. 29). Lietaer recommended experiential training such as participation in long-term group therapy because it provides trainees with the opportunity to observe their own interpersonal patterns, which he believes is essential for therapeutic work. Findings from a study by Puleo and Schwartz (1999) support this view. These authors examined the relationship between a number of training variables and empathic understanding among novice trainee therapists, and found that the only factor that was significantly correlated with empathy was the completion of a graduate group counselling course with a personal growth component.

Other authors have noted the importance of the development of the therapist as a person who is emotionally mature and open to forming a therapeutic connection (Lambert & Bergin, 1983; Wheeler & Manhart-Barrett, 1994). The question, then, is how to foster these traits the context of a psychotherapy training program. Greenberg and Goldman (1988) briefly review the literature on psychotherapy training effectiveness and conclude that skills such as attending and summarization of feeling can be learned didactically through brief microcounseling training. The ability to create and maintain an empathic relationship, however, is learned in a more experiential fashion (p. 698).

There has been much speculation as to the particular components of experiential training that enable students to establish and maintain therapeutic relationships. Some writers have observed that the supervisory environment plays an important role. Lietaer (1993) wrote that “a sufficiently safe atmosphere is...a must, in order to allow the taking of personal risks and the acceptance of a vulnerable position” (p. 29), suggesting that the supervisor’s attitude plays a significant role in this process. This is consistent with the finding that non-critical and empathic supervisory relationships are associated with more successful empathy training (Nerdrum & Ronnestad, 2002). In addition, supervisors who are high in facilitative conditions tend to have a positive impact on trainees’ relationship skills, whereas supervisors who are low in these conditions are more likely to have the opposite effect (Carkhuff, 1969). Similarly, education research indicates that teachers who are high in facilitative conditions are more effective at increasing students’ self-esteem, thereby increasing motivation to learn (Makri-Botsari, 2001). Motivation is a significant factor in psychotherapy training and has been associated with an increase in intellectual and emotional empathy (Duan, 2000).

This literature suggests that effective training in relationship skills would necessarily involve a much longer and more in-depth process than simply learning to respond empathically through a series of training sessions. In addition, it seems that the measures used in the studies reviewed by Baker and colleagues (1990) may not actually reflect the important elements of empathy training. It is true that the literature they review does not address the development of more complex dimensions of relationship skills among trainees. However, let us not forget that the type of superficial relationship skills measures that were used in these studies are similar to the instruments used in the process-outcome research reviewed earlier. Therefore, it seems that the skills that trainees were able to develop as a

result of the IPR, HRT, and MC programs may well be similar to the facilitative conditions consistently correlated with measures of therapeutic outcome. This would suggest that these training programs should increase outcome for the clients of trainees. Of course, it is very possible that complex empathic abilities have positive effects on both (a) therapy outcome, and (b) superficial measures of empathic responding (i.e., the more observable aspect of empathy that is often measured in empathy training studies). If this is true, then training students to respond empathically without resonating with clients' experiences may have no effect on therapy outcome. However, the available evidence is consistent with the hypothesis that empathy training programs are effective, and therefore we cannot rule out this possibility.

A separate issue is whether graduate psychotherapy programs are actually using these empathy training models to teach their students. These methods may well be effective; however, if programs are not using these techniques, training cannot be expected to improve students' relationship skills. Therefore, a possible explanation for the lack of correlation between psychotherapy training and relationship skills is that graduate programs do not to use *any* training model that emphasizes these skills. There are several factors that may account for this.

#### *Instructors' Beliefs About the Importance of Relationship Skills*

Relationship skills may be underemphasized in training because instructors believe that they have little influence on client improvement. This may seem like an implausible hypothesis, given the large body of research linking the therapeutic relationship to client change. However, in a study investigating researchers' opinions about various factors involved in delivering empirically supported treatments, only 54% of participants believed

that the therapeutic relationship is an important predictor of therapy outcome (O'Donohue, Buchanan, & Fisher, 2000). This finding is consistent with Norcross's (2001) contention that lists of ESTs give little credit to the importance of the relationship in psychotherapy:

All of this is to say that extant lists of empirically supported treatments and practice guidelines give short shrift—some would say lip service—to the person of the therapist, the individual patient's characteristics, and their emergent relationship. Current attempts are thus seriously incomplete and potentially misleading, both on clinical and empirical grounds (Norcross, 2001, p. 347).

Similarly, Eugster and Wampold (1996) found that while clients associate valuable sessions with therapist interpersonal style, therapists tend to associate valuable sessions with therapist expertness. While it may be surprising that the research evidence indicating the importance of the therapeutic relationship has not impacted the views of many professionals, it has been suggested that the beliefs of clinical psychologists are related to personality characteristics and are formed early in their careers (Conway, 1988). It could be that in some cases, personal values play a greater role than research evidence in determining instructors' beliefs.

#### *Instructors' Beliefs About the Trainability of Relationship Skills*

Alternatively, psychotherapy instructors may believe in the importance of relationship skills, but they may be sceptical about the extent to which these skills can be trained. One argument that authors may give for increasing EST training is that it is effective. Indeed, studies have shown that training in manualized interventions reliably enhances one's ability to competently deliver a particular type of therapy (e.g., Crits-Christoph et al., 1998; Henry et al., 1993). However, literature on the effectiveness of graduate training in relationship skills is less conclusive. As noted earlier, although there is some (perhaps flawed) research

indicating that low-level relationship skills are trainable (Baker, Daniels, & Greeley, 1990), training higher-level skills may be more difficult (Greenberg & Goldman, 1988). Findings from a recent study investigating the opinions of students and professionals about the trainability of relationship skills indicate that many psychologists may be aware of this difficulty (Schottler, 2004).

### *Research Emphasis of Training Programs*

Unlike counselling psychology programs and clinical psychology Psy.D. programs, clinical psychology Ph.D. programs include a major research component in addition to clinical requirements. The goal of the scientist-practitioner model espoused by these programs is to integrate both science and practice in training their students (Cherry, Messenger, & Jacoby, 2000).<sup>4</sup> However, when Himelein and Putnam (2001) surveyed clinical psychologists in academia, they found that faculty members' reported activities were very biased toward the research end. While 92% of their sample reported spending at least some time working on their own research in an average week, only 56% reported the same for clinical practice. The authors suggested that the emphasis on research in psychology Ph.D. programs may contribute to "ineffective instruction in clinical course work, less informed clinical research, and the devaluing of clinical practice in traditional academic settings" (p. 537).

Moreover, Frank (1984) noted that researchers and clinicians differ in terms of interests, cognitive abilities, and personality traits and that clinical and research skills may be

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<sup>4</sup> Interestingly, Belar (1998) points out that there is actually no scientific evidence to indicate that the scientist-practitioner model is superior to the scholar-practitioner model in promoting public welfare. If this is the case, it seems ironic that the research minded professionals who tout the benefits of the scientist-practitioner model are actually basing these views on personal opinion.



incompatible for this reason. Gross (2001) contended that clinical and scientific language are based on different cultures:

Clinically and scientifically oriented psychologists have difficulty communicating with one another because of underlying paradigmatic differences in their languages. Unfortunately, both cultures use the same sensory-system-based vocabulary, which leads to the unwitting and confusing assumption that they are speaking the same language (p. 221).

If clinical and research skills are, as Frank (1984) suggested, fundamentally incompatible, then programs that emphasize research may sacrifice clinical skills training, and vice versa. Furthermore, if an emphasis on research activities compromises clinical training, it would probably have a similar impact on relationship skills training. The literature on clinical psychology programs suggests that a research emphasis may affect students' relationship skills via several routes.

#### *Graduate Admissions Criteria*

Because the scientist-practitioner model requires that students conduct their own research, clinical psychology students are often selected based on their research skills. Brown (2004) analyzed students' personal statements written for admission to clinical psychology programs, and found that successful applicants emphasized their research goals and commitment to scientific epistemology more than unsuccessful applicants. Furthermore, Piotrowski and Keller (1996) surveyed clinical training directors of clinical psychology Ph.D. programs and found that 75% of directors placed greater weight on research than on clinical experience when making admissions decisions. However, admitting students based primarily on their research skills disregards the necessary interpersonal component of clinical

practice. Because characteristics such as latent empathy may increase trainees' ability to benefit from training in relationship skills (Nerdrum & Hoglend, 2002; Steibe, Boulet, & Lee, 1979), it may be necessary for graduate programs to screen for relational as well as research skills when selecting applicants. Although this is a potential area for future research, addressing this hypothesis is beyond the scope of the present study.

### *Crowding Out*

Clinical psychology education involves training in many areas, including therapy, assessment, ethics, statistics, cognitive processes, research methods, individual differences, and biological bases of behaviour. Due to the broad span of topics covered in these programs, there is a limited amount of training that students can receive in any one area before graduating. By definition, programs with more research emphasis give higher priority to research related activities than to clinical training. Furthermore, research oriented clinical psychology programs may place a higher value on training in technical skills. Plante, Boccaccini, and Anderson (1998) found that professionals who participate in research activities are more supportive of ESTs than professionals whose work is primarily clinical. This may suggest that research oriented programs invest more time in teaching technical skills and, therefore, less time teaching relationship skills.

### *Instructors' Beliefs About the Trainability of Relationship Skills*

Research orientation may have an indirect impact on relationship skills training through trainers' beliefs about the trainability of these skills. Research oriented programs may also attract and select students whose research skills are more developed than their interpersonal skills. After spending several years training these individuals in psychotherapy, instructors may come to believe that relationship skills are difficult to train, because these

students entered the program with relatively low levels of these skills (see Nerdrum & Hoglend, 2002). Of course, the opposite could be true: trainers may compensate for trainees' poor relationship skills by increasing the time they spend teaching these skills.

#### *Instructors' Beliefs About the Importance of Relationship Skills*

Research emphasis may also impact relationship skills training indirectly through trainers' beliefs about the importance of these skills. For instance, programs that place greater weight on research may also hire instructors who view adherence to EST models as particularly important. EST manuals underemphasize the role of the relationship, and instructors at more research focused programs may have adopted a similar perspective. Even if some instructors are initially hired for their clinical relationship skills, over time, the social pressures in the department and the beliefs of the other faculty members may have an impact on trainers' beliefs about the importance of relationship skills.

#### *Instructor Orientation*

Finally, research emphasis may influence relationship skills training through its impact on the professional self-perceptions of instructors. For instance, if instructors are hired for their research skills, they may be less likely to possess the relationship skills necessary to foster these skills in their students (see Carkhuff, 1969), and they may recognize this. Realizing that their efforts to train relationship skills would yield few results, they may elect to focus on technical skills instead.

### Summary and Hypotheses

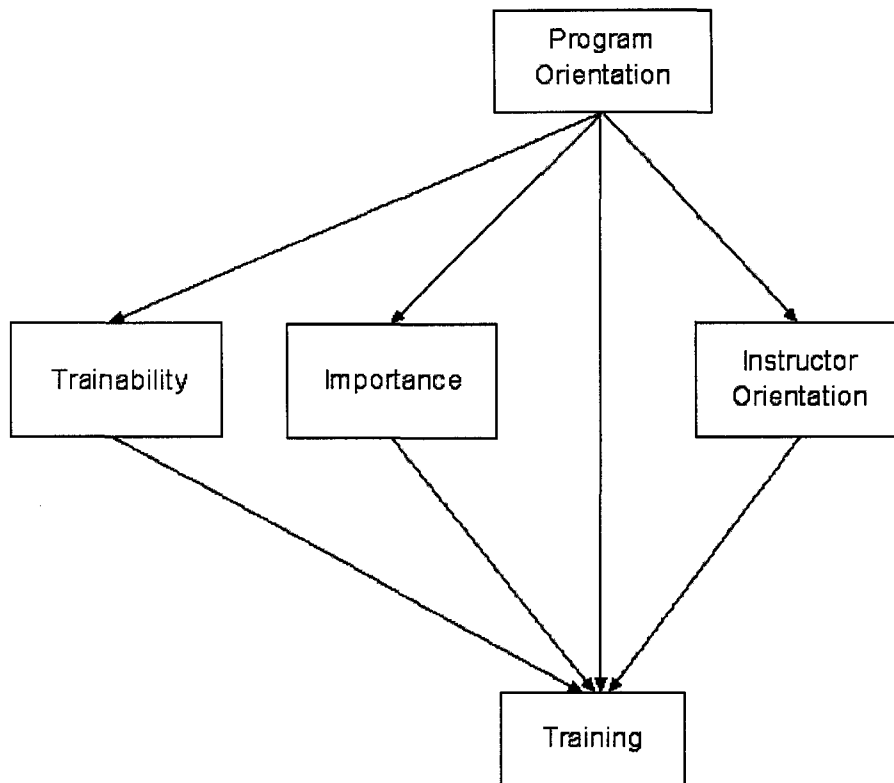
Over the past few decades, interest in the field of psychotherapy research has moved away from the therapeutic relationship and toward ESTs. Clinical psychology psychotherapy programs have evidenced a similar shift over this time period as well; more recently, these

changes have been more noticeable, as recent APA accreditation guidelines have begun to explicitly emphasize the importance of EST training.

Meanwhile, research studies conducted over the past few decades have found limited support for the effectiveness of psychotherapy training. Admittedly, there are many methodological challenges involved in studying this area; however, it is striking that the association between graduate training and therapy outcome is not more robust. One of the most plausible explanations for this result is that training programs provide limited training in relationship skills. Therefore, identifying the predictors of relationship skills training in graduate psychotherapy programs is an important step toward improving the quality of psychotherapy training. The current study aimed to identify these predictors in the context of clinical psychology Ph.D. programs.

As there have been no studies investigating the correlates of relationship skills training in graduate psychology programs, there is no direct evidence on which to base specific hypotheses. Therefore, due to the exploratory nature of this study, the current hypotheses were largely speculative. First, it was hypothesized that programs' clinical/research orientations would predict the degree to which instructors at those programs emphasize relationship skills in their courses. Second, it was hypothesized that program orientation would predict three instructor variables: (a) psychotherapy instructors' beliefs about the importance of relationship skills; (b) psychotherapy instructors' beliefs about the trainability of relationship skills; and (c) psychotherapy instructors' clinical/research orientations. Third, it was hypothesized that these three instructor variables would predict training frequency. Finally, it was hypothesized that each of the three instructor variables

would mediate the relationship between program orientation and training frequency (a path model of the hypotheses is shown in Figure 1).



*Figure 1.* Hypothesized model: Direct and indirect influence of instructors' ratings of program orientation on relative training frequency.

## CHAPTER II

### METHOD

#### Participants

The email addresses of approximately 2,700 tenure-track psychology department faculty members from 177 APA and CPA accredited clinical psychology programs were obtained from departmental websites, and two waves of recruitment letters were sent to each faculty member via email (see Appendix A).<sup>5</sup> The present sample was self-selected from this broader population: the recruitment letter described the participation criterion for the study, which was to have taught at least one course with a significant psychotherapy skills component during the 2005-2006 school year.

Based on response rates reported in previous research with similar populations (e.g., Norcross & Prochaska, 1982; Plante, Boccaccini, & Andersen, 1998; Stevens, Dinoff, & Donnenworth, 1998), a response rate of approximately 50% was expected for this investigation. Because a larger number of individuals were contacted than were eligible to participate (as discussed in the next section), it is difficult to determine the exact response rate. However, instructors from 73 of the 177 programs contacted responded to the survey. There was therefore a 41% response rate by program.<sup>6</sup>

Ninety psychotherapy instructors from APA and CPA accredited clinical psychology Ph.D. programs were included in the analyses for this study. Although 98 instructors participated in the online survey, eight cases were removed because they did not meet the

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<sup>5</sup> The University of Windsor was excluded, as these therapy instructors had provided input into the development of the questionnaire.

<sup>6</sup> Removal of participants based on participation criteria reduced the number of programs to 71, which works out to a 40% response rate by program.

participation requirements. Of the 90 participants in the final sample who indicated their sex, 41 were women and 47 were men. Their reported ages ranged from 29 to 80.

### Measure

A 47-item survey was constructed for this study and administered to five psychotherapy instructors for feedback. Their comments were incorporated into the final version of the instrument (see Appendix C).

The first two pages of the survey collect demographic information, such as age, gender, and number of years of experience as a psychotherapist. In this preliminary section, participants are also asked to indicate how they perceive themselves professionally on a 7-point Likert-type scale with end points ranging from (1) *clinician* to (7) *researcher/academic*. A second 7-point Likert-type scale asked participants to rate the research emphasis of their respective programs from (1) *clinically oriented* to (7) *research oriented*.

The body of the survey is divided into three sections. These sections assess (a) perceived importance, (b) perceived trainability, and (c) the frequency with which the instructor has taught various therapy skills the last time they taught a psychotherapy course. A list of 12 skills is presented in each of these sections. Four categories of relationship skills are included in this list: (a) empathy, (b) unconditional positive regard, (c) congruence, and (d) the alliance. Two items tapping technical skills were included in this list as well. The wording for several of these items was based on definitions provided by Bordin (1979) and Schottler (2004).

Items assessing Rogerian conditions and the alliance were selected based on theoretical conceptualizations discussed in an earlier section. In particular, items relating to

therapist empathy were designed to tap experienced empathy and communicated empathy. These two factors are based on Rogers' (1961) two-fold definition of empathy, and they also correspond to the first two stages of Barrett-Lennard's (1981) three-stage model (experienced empathy and communicated empathy). Because empathy can be cognitive or emotional (Duan & Hill, 1996), two items were constructed to assess experienced empathy. These are "understanding the client's experiences from the client's perspective" and "resonating emotionally with the client's experience." A third item, "communicating empathy to the client," was included to assess communicated empathy.

Two items were selected to represent Barrett-Lennard's (1962) conceptualization of unconditional positive regard, which includes (a) the therapist's caring feelings toward the client, and (b) the constancy of the therapist's feelings toward the client. These items are "prizing/valuing the client" and "accepting the client unconditionally."

Items assessing congruence were based on Klein and colleagues' (2002) and Lietaer's (1993) definitions of congruence. These definitions have two similar components: (a) the inward experience of congruence, and (b) the outward expression of congruence. Therefore, two congruence items were included on the list of therapist skills: "self-awareness" and "being genuine with the client."

Finally, items relating to the therapeutic alliance were loosely based on Bordin's (1979) conceptualization of the alliance, which includes (a) agreement on goals, (b) collaboration on tasks, and c) therapist-client bonds. When conceptualized as a therapist skill, the latter aspect of the alliance, therapist-client bonds, is very similar to the Rogerian conditions (Mallinckrodt & Nelson, 1991); therefore, the survey does not assess this component of the alliance per se. Only the first two aspects of Bordin's (1979)



conceptualization were assessed. The items reflecting these aspects are “collaborating in determining goals and methods of therapy” and “communicating to the client how the tasks and goals of treatment relate to the client’s current concerns.”

As noted earlier, two additional items were constructed to assess skills specific to a particular theoretical orientation (i.e., technical skills). These items were included to control for biases in participant response styles. For instance, some instructors may rate relationship skills on the high end of the Likert-type scale simply because they would rate all therapy skills as indispensable. If the measurement error produced by this bias in responding is correlated with another variable in the hypothesized model (for example, if a personality trait is correlated with both response style and ratings of instructor orientation), this could result in spurious relationships between beliefs about importance and other variables. However, by measuring instructors’ beliefs about the trainability and importance of technical skills and the frequency with which they train technical skills in their courses, we can control for this type of bias (see Results).

The two technical skills items that were included in the scale are “using a theoretical/conceptual framework to guide interactions” and “developing an appropriate treatment plan.” These particular skills were selected because they are present across orientations but manifest differently between treatment models. Therefore, it was expected that they would apply to all of the courses taught by the instructors participating in the study.

As indicated earlier, the list of therapist skills was included in each of the three sections of the questionnaire. In the first section, instructors were asked to rate the importance of these skills for a therapist to be highly competent on a 7-point Likert-type scale, ranging from (1) *not at all* to (7) *extremely*. The second section was identical to the

first except that instructors were asked to rate how trainable they felt each therapist skill to be. The third section of the survey gathered information about how often the instructors trained these skills in the past. To obtain realistic rather than idealized estimates of training practices, this section of the survey requested that instructors recall the last time they taught a psychotherapy course. Participants were asked to check the box next to the option that best represents how often they trained each therapist skill, with options ranging from “never” to “most or every meeting.”

The clinical/research orientation of the instructors' programs was gauged based on (a) the instructors' ratings of their programs' research emphasis on a 7-point Likert-type scale ranging from (1) *clinically oriented* to (7) *research oriented*, and (b) data reported in the 2004-2005 edition of *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Sayette, Mayne, & Norcross, 2004). This publication is geared toward informing prospective students of current statistics for all APA accredited programs across the U.S. and Canada. The measure taken from this publication was clinical training directors' ratings of their own clinical psychology programs' research emphasis, again using a 7-point Likert-type scale ranging from (1) *clinically oriented* to (7) *research oriented*.

### Procedure

A recruitment letter was sent to all of the clinical faculty members at each institution via e-mail (see Appendix A). This letter included the participation criterion, which was to have taught at least one course with a significant psychotherapy skills component during the 2005-2006 school year. The letter also briefly explained the purpose of the study and invited instructors to participate by clicking on a URL at the bottom of the email. This link opened a new window containing the letter of information (see Appendix B), which contained more

detailed information regarding the purpose and procedures of the study and indicated that consent was implied by completing the online survey. All procedures of this study complied fully with ethical regulations, and this study was approved by the University of Windsor Research Ethics Board.

## CHAPTER III

### RESULTS

SPSS 14.0 for Windows was used to screen the data before performing the analyses. After replacing the missing values with the means for each variable, the following average scores were calculated for each participant: average trainability rating of relationship skills; average trainability rating of technical skills; average importance rating of relationship skills (RSs); and average importance rating of technical skills (TSs). Descriptive statistics for these four variables are presented in Table 1.

To assess participants' perceptions of the *relative* trainability of relationship skills compared to technical skills in order to control for biases due to response styles (as discussed in Methods), difference scores were calculated by subtracting technical skills trainability scores from relationship skills trainability scores for each participant. Similarly, to assess participants' perceptions of the relative importance of relationship skills compared to technical skills, difference scores were calculated by subtracting technical skills importance scores from relationship skills importance scores for each participant. I will subsequently refer to these difference scores as relative trainability and relative importance. Therefore, high levels of relative trainability reflect beliefs that relationship skills are relatively more trainable, and high levels of relative importance reflect beliefs that relationship skills are relatively more important.

For the items assessing training frequency, difference scores were used as well; however, before calculating difference scores, the five response choices for training frequency were coded on a rank scale. The decision to use a rank scale rather than a ratio

Table 1

*Descriptive statistics for variables in hypothesized model*

Variable	<i>N</i>	<i>M</i>	<i>SD</i>	Range	Possible Range
Relationship Skills Trainability	90	4.80	.96	2.22 – 7.00	1.00 – 7.00
Technical Skills Trainability	90	6.37	.71	4.00 – 7.00	1.00 – 7.00
Relationship Skills Importance	90	5.92	.67	4.00 – 7.00	1.00 – 7.00
Technical Skills Importance	90	5.97	1.00	2.50 – 7.00	1.00 – 7.00
Program Orientation (INST)	90	4.60	1.24	2.00 – 7.00	1.00 – 7.00
Program Orientation (CTD)	71	4.68	.89	3.00 – 7.00	1.00 – 7.00
Relative Trainability <sup>a</sup>	90	-1.57	.95	-4.22 – 1.50	-6.00 – 6.00
Relative Importance <sup>a</sup>	90	-.04	1.00	-2.33 – 3.67	-6.00 – 6.00
Instructor Orientation	90	4.83	1.47	1.00 – 7.00	1.00 – 7.00
Relative Training Frequency <sup>a</sup>	90	-.64	1.12	-3.38 – 2.25	-4.00 – 4.00

Note. INST = instructors' ratings; CTD = clinical training directors' ratings. Missing data were replaced with mean values. <sup>a</sup> Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

scale to measure frequency of training was made because some of the response options for the training frequency items were ambiguous. For example, the option “Most or every meeting” provides only a very rough estimate of the actual frequency with which a particular skill was trained. Therefore, the response “Never” was coded as 1; “Once or twice during the term” was coded as 2; “About once each month” was coded as 3; “About every second week” was coded as 4; and “Most or every meeting” was coded as 5. (It may seem more intuitive to code these responses so that “Most or every meeting” was coded as 1 and

“Never” was coded as 5; however, the coding system used here makes the regression coefficients easier to understand, as higher levels indicate more frequent training.) For each participant, two average rank scores were calculated, one for relationship skills and one for technical skills. A difference score was calculated by subtracting averaged technical skills training rank scores from averaged relationship skills training rank scores. I will subsequently refer to this difference score as relative training frequency. High levels of relative training frequency reflect relatively more frequent training in relationship skills.

Instructors’ ratings of their programs’ clinical/research orientations were used as the primary measure of program orientation because the clinical training directors’ ratings (Sayette, Mayne, & Norcross, 2004) were only reported for 71 of the institutions in the current study, whereas instructors’ ratings were obtained for 90. Clinical training directors’ ratings were primarily included to verify the robustness of the results; therefore, the term *program orientation* will refer specifically to instructors’ ratings of program orientation, unless otherwise indicated.

The final six variables used in the data screening process and subsequent analyses were as follows: instructors’ ratings of program orientation; clinical training directors’ ratings of program orientation as reported in the student guidebook (Sayette, Mayne, & Norcross, 2004); instructor orientation; relative trainability; relative importance; and relative training frequency.

Boxplots of the six variables were examined for univariate outliers. Although one univariate outlier was identified in the boxplot for relative importance ratings, this case was retained for the analyses. This observation had a moderate impact on the mean and standard deviation of the variable when removed; however, this score was not a significant or

influential multivariate outlier, as assessed by Mahalanobis distance and Cook's distance, indicating that this outlier would probably have no effect on the results of statistical analyses. The latter statistics were within limits for all other participants, indicating that no multivariate outliers were detected. Scatterplots of the variables were examined to assess for normality, linearity, and homoskedasticity; no significant violations of these assumptions were apparent. Tabachnick and Fidell (2001) recommend using either a .01 or a .001 alpha level to evaluate the significance of these problems. Although both the skewness and kurtosis statistics for relative importance were significant when an alpha level of .01 was used, they were not significant at the .001 level. Because the probability plot indicated normally distributed error terms, the decision was made not to transform the data for this variable. Therefore, although relationship skills importance scores were not normally distributed, the deviations from normality were deemed to be too minor to affect the results of statistical tests. Finally, the correlations among the explanatory variables were weak to moderate; therefore, there was no evidence of multicollinearity or singularity. This indicates that each variable measured a substantial amount of unique variance, and so the effects of each variable would probably be relatively easy to disentangle from the effects of the other variables in the analyses (Tabachnick & Fidell, 2001). Descriptive statistics for each of the six variables are presented in Table 1, and Pearson correlation coefficients for the relationships among these variables are presented in Table 2.

Amos 6.0 was used to construct a path analysis to assess the degree to which the hypothesized model fit the data. The calculated standardized parameter estimates for the path coefficients of the original hypothesized model (i.e., the regression coefficients for the

Table 2

*Pearson correlation coefficients for variables in hypothesized model*

Variable	1	2	3	4	5	6
1. Program Orientation (INST)	---	.59**	.11	-.03	.09	.10
2. Program Orientation (CTD)		---	.14	-.13	.19	-.08
3. Relative Trainability <sup>a</sup>			---	.09	.08	.34**
4. Relative Importance <sup>a</sup>				---	-.27*	.56**
5. Instructor Orientation					---	-.27**
6. Relative Training Frequency <sup>a</sup>						---

Note. INST = instructors' ratings; CTD = clinical training directors' ratings. <sup>a</sup> Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

\* $p < .05$ . \*\* $p < .01$ .

hypothesized paths between the variables) are presented in Figure 2<sup>7</sup> and Table 3. The chi-square statistic was examined to assess how well the model fit the data. The chi-square value reflects the discrepancy between the covariance matrix estimated using the original sample and the reconstructed covariance matrix based on the specified model. In other words, the chi-square statistic reflects the amount of variance in the data that can be accounted for by the model. Large chi-square values indicate that the model only accounts for a small amount of variance in the data (indicating poor model fit), whereas small chi-square values indicate that the model accounts for a substantial amount of the variance in the data (indicating good

<sup>7</sup> Paths with nonsignificant coefficients are included in all model diagrams to reflect hypothesized relationships.



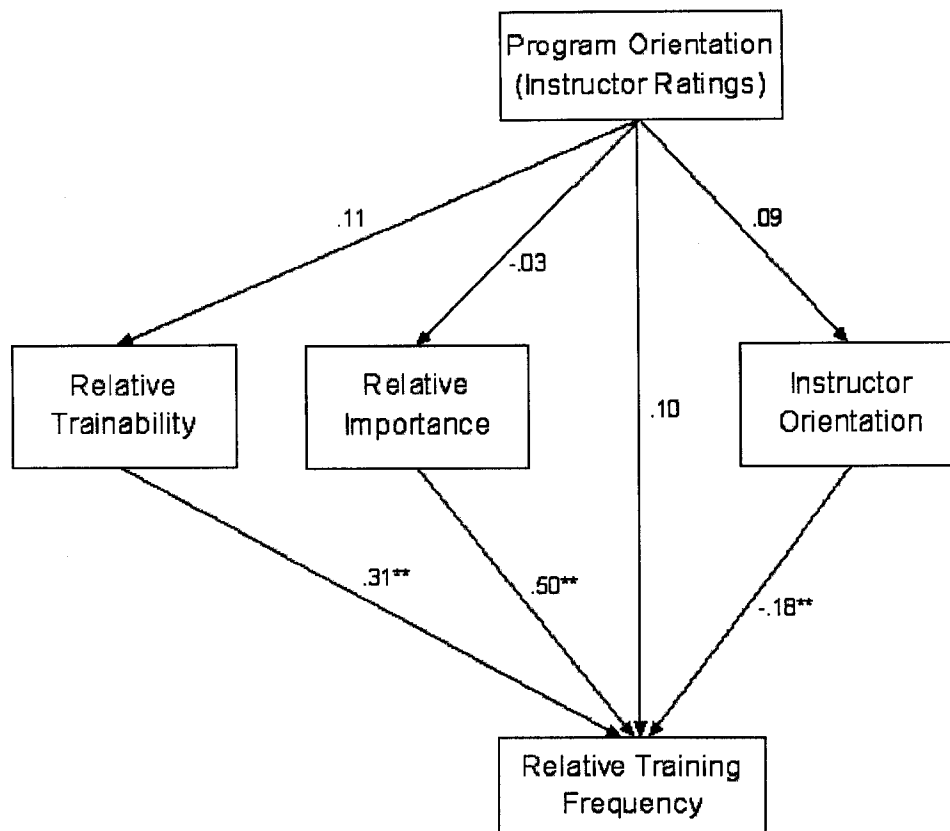


Figure 2. Hypothesized model: Direct and indirect influence of instructors' ratings of program orientation on relative training frequency. \* $p < .05$ . \*\* $p < .01$ .

model fit; Fan & Wang, 1998).<sup>8</sup> The chi-square statistic for this model was large enough to be statistically significant,  $\chi^2(3, N = 90) = 8.26, p < .05$ , indicating that the hypothesized model was a poor fit for the data. Therefore, the paths between the variables needed to be altered. A modification index provided by Amos suggested that adding an additional path between instructor orientation and relative importance would significantly improve the model fit. An arrow from instructor orientation to relative importance was added (rather than from

<sup>8</sup> It should be noted that good model fit does not necessarily reflect significant path coefficients for each of the paths in the model (MacCallum & Austin, 2000).

Table 3 (Standardized Estimates of Path Coefficients for Original Hypothesized Model)

*Standardized path coefficients for the hypothesized model*

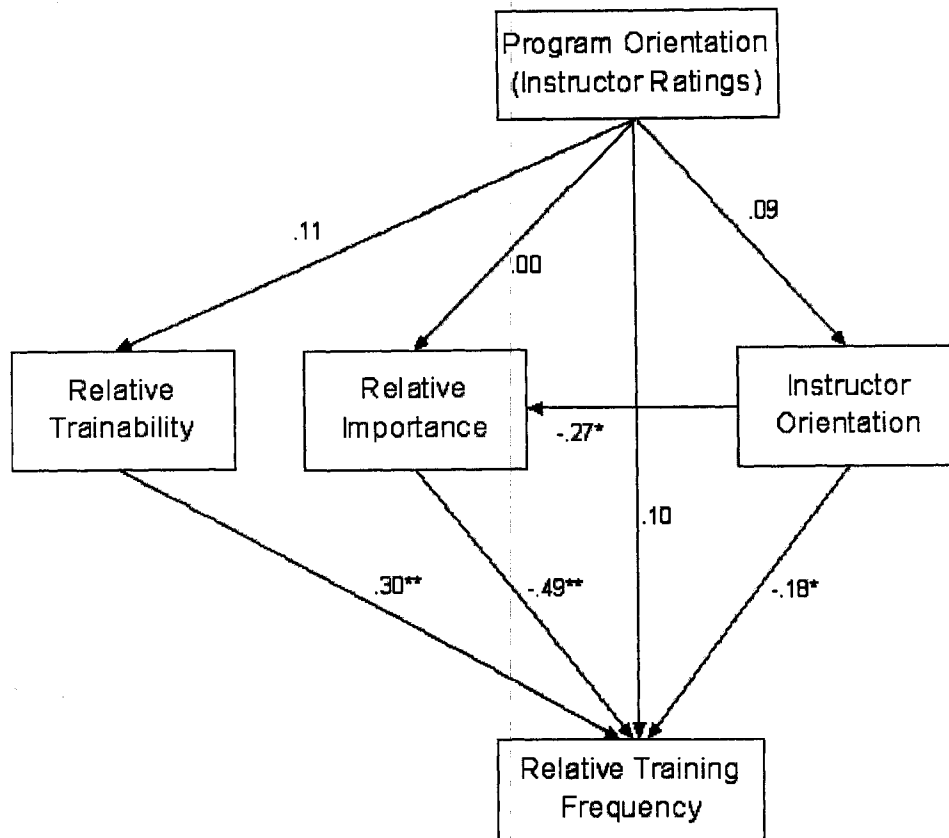
Path (from → to)	Path Coefficient	SE
Program Orientation <sup>a</sup> → Relative Training Frequency <sup>b</sup>	.10	.08
Program Orientation → Relative Trainability <sup>b</sup>	.11	.11
Program Orientation → Relative Importance <sup>b</sup>	-.03	.10
Program Orientation → Instructor orientation	.09	.11
Relative Trainability → Relative Training Frequency	.31**	.08
Relative Importance → Relative Training Frequency	.50**	.08
Instructor Orientation → Relative Training Frequency	-.18*	.08

<sup>a</sup> Program orientation was measured using instructor ratings. <sup>b</sup> Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

\* $p < .05$ . \*\* $p < .01$ .

relative importance to instructor orientation) because it is more likely that instructor orientation would impact relative importance than the reverse (however, the opposite could be true as well; see Discussion). Standardized parameter estimates for the path coefficients of this revised model are presented in Figure 3 and in Table 4.

A large number of statistics have been developed to estimate model fit, each of which offers both benefits and drawbacks (Weston & Gore, 2006). Based on recommendations of Fang and Wang (1998), three statistics were selected to use to assess the present model (see Table 5). First, the chi-square statistic was again examined to assess the degree of



*Figure 3.* Revised model: Direct and indirect influence of instructors' ratings of program orientation on relative training frequency. \* $p < .05$ . \*\* $p < .01$ .

discrepancy between covariance matrixes. For the revised model, this discrepancy was not significant,  $\chi^2(2, N = 90) = 1.75, p < .05$ , indicating a reasonable fit for the new model.

Second, the root mean square error of approximation (RMSEA) value indicates degree of model fit. Steiger (as cited in Fan & Wang, 1998) suggests that small positive values around .01 indicate an almost perfect fit. The RMSEA value for the revised model was .00, indicating that the model fit the data very well.

Finally, the goodness of fit index (GFI) reflects the proportion of the total variance

Table 4

*Standardized path coefficients for the revised model*

Path (from → to)	Path Coefficient	SE
Program Orientation <sup>a</sup> → Relative Training Frequency <sub>b</sub>	.10	.08
Program Orientation → Relative Trainability <sup>b</sup>	.11	.11
Program Orientation → Relative Importance <sup>b</sup>	.00	.12
Program Orientation → Instructor orientation	.09	.11
Relative Trainability → Relative Training Frequency	.30**	.08
Relative Importance → Relative Training Frequency	.49**	.08
Instructor Orientation → Relative Training Frequency	-.18*	.08
Instructor Orientation → Relative Importance	-.27*	.10

Note. Orient. = orientation. <sup>a</sup>Program orientation was measured using instructor ratings. <sup>b</sup>Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

\* $p < .05$ . \*\* $p < .01$ .

Table 5

*Goodness of fit indexes*

Index	Revised Model	Post-hoc Model
$\chi^2$	1.75	3.09
RMSEA	.00	.08
GFI	.99	.99

that is explained by the model. Values above .90 are considered to indicate good model fit (Schumacker & Lomax, as cited in Gibbs, Giever, & Higgins, 2003). The GFI for the present model was .99, indicating a very good fit.

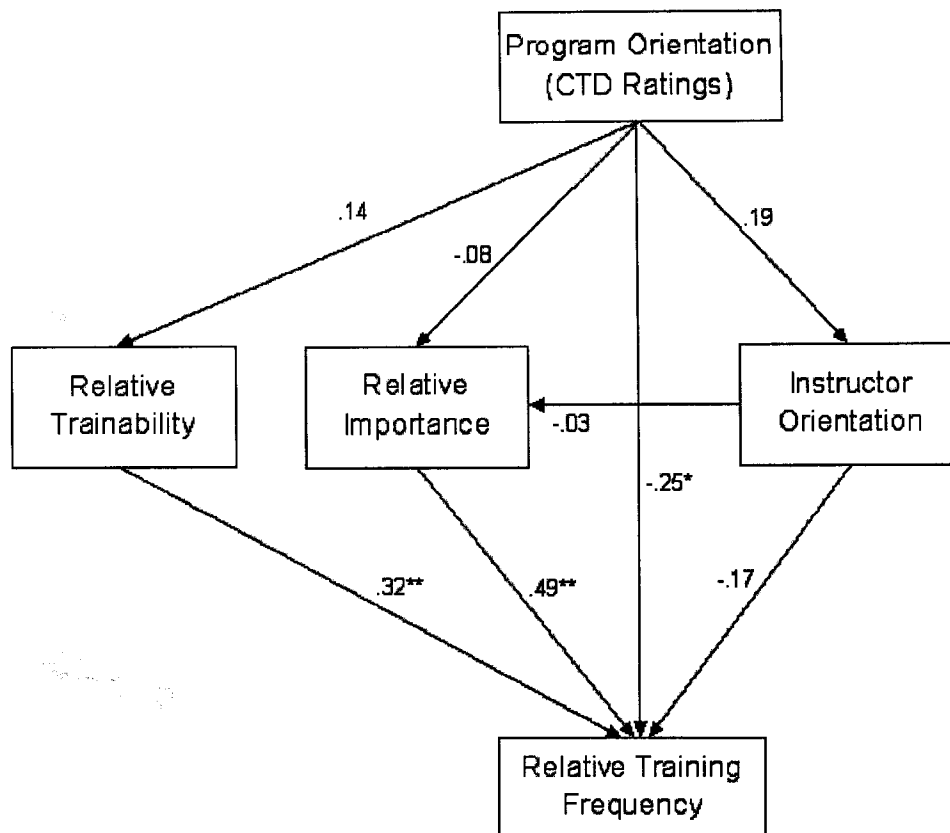
In summary, although the hypothesized model was a relatively poor fit for the data, the revised model fit the data very well. All three of the fit indices recommended by Fan and Wang (1998) indicated that the hypothesized model with an added path from instructor orientation to relative importance was a very good fit for the data.

As shown in Table 4, the hypothesis that program orientation would predict relative training frequency was not supported, as the coefficient for the path between program orientation and training frequency was not significant,  $r = .10, p > .05$ . The hypothesis that program orientation would predict the three instructor variables was not supported either, as the coefficients for the paths between program orientation and (a) relative trainability,  $r = .11, p > .05$ , (b) relative importance,  $r = .00, p > .05$ , and (c) instructor orientation,  $r = .09, p > .05$ , were not significant. On the other hand, the hypothesis that relative trainability, relative importance, and instructor orientation would each predict relative training frequency was supported: the coefficients for the paths between relative training frequency and (a) relative trainability,  $r = .30, p < .01$ ; (b) relative importance,  $r = .49, p < .01$ ; and (c) instructor orientation,  $r = -.18, p < .05$ , were each significant. This indicates that instructors who rated relationship skills as relatively more trainable and relatively more important and who rated themselves as being more clinically-focused than research-focused tended to train relationship skills relatively more frequently. The hypothesis that these three instructor variables would mediate the relationship between program orientation and relative training frequency could not be supported, however, because program orientation was not

significantly related to any of these three variables. Finally, an unanticipated relationship between instructor orientation and relative importance was found,  $r = -.27, p < .05$ , indicating that instructors who rated themselves as more clinically-focused than research-focused were more likely to rate relationship skills as relatively more important.

The finding that program orientation was unrelated to all other variables in the model is surprising. However, it should be noted that the relatively large standard error values of each of these paths precludes any confident interpretations. The finding that program orientation was unrelated to instructor orientation was especially surprising; however, this result is likely related to the particularly large standard error value of this path coefficient (see Table 4).

To investigate whether the null results would hold for a different measure of program orientation, the revised path model was recalculated using clinical training directors' ratings of program orientation (Sayette et al., 2004). The standardized parameter estimates for this model are presented in Figure 4 and Table 6. Clinical training directors' program ratings were no more related to the other variables in the model than were the instructors' program ratings, indicating that neither measure of program orientation was related to any of the other variables in the model.



*Figure 4.* Revised model: Direct and indirect influence of clinical training directors' ratings of program orientation on relative training frequency. \* $p < .05$ . \*\* $p < .01$ .

Table 6

*Standardized path coefficients for revised model using clinical training director ratings of program orientation*

Path (from → to)	Path Coefficient	SE
Program Orientation → Relative Training Frequency <sup>a</sup>	-.03	.08
Program Orientation → Relative Trainability <sup>a</sup>	.14	.11
Program Orientation → Relative Importance <sup>a</sup>	-.08	.10
Program Orientation → Instructor orientation	.19	.10
Relative Trainability → Relative Training Frequency	.32**	.08
Relative Importance → Relative Training Frequency	.49**	.09
Instructor Orientation → Relative Training Frequency	-.17	.09
Instructor Orientation → Relative Importance	-.25*	.10

<sup>a</sup> Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

\* $p < .05$ . \*\* $p < .01$ .

#### Post-Hoc Analyses

It is possible that the historical context in which participating instructors received their graduate training may have impacted their beliefs, their clinical/research orientations, and their training practices. Therefore, the possibility that instructor age may play a role in the present model was investigated.

Correlations between instructor age and the other variables are shown in Table 7. Instructor age was significantly correlated with relative trainability,  $r = .33$ ,  $p < .01$ , relative



Table 7

*Pearson correlations coefficients for instructor age with variables in hypothesized/ revised models*

Variable	Instructor Age
Program Orientation (INST)	-.06
Program Orientation (CTD)	-.04
Relative Trainability <sup>a</sup>	.33**
Relative Importance <sup>a</sup>	.47**
Instructor Orientation	-.25*
Relative Training Frequency <sup>a</sup>	.38**

Note. INST = instructor ratings; CTD = clinical training director ratings.

<sup>a</sup> Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

\* $p < .05$ . \*\* $p < .01$ .

importance,  $r = .47$ ,  $p < .01$ , instructor orientation,  $r = -.25$ ,  $p < .05$ , and relative training frequency,  $r = .38$ ,  $p < .01$ . This indicates that older instructors tended to rate relationship skills as relatively more trainable and relatively more important, tended to rate themselves as more clinically-focused than research-focused, and tended to train relationship skills relatively more frequently compared to younger instructors.

To test whether relative trainability, relative importance, and instructor orientation mediated the association between instructor age and relative training frequency, the path model was revised a second time using Amos. The post-hoc model is presented in Figure 5, and the standardized parameter estimates for the path coefficients are presented in Table 8. The chi-square value for this model was not significant,  $\chi^2(2, N = 90) = 3.09$ ,  $p > .05$ ,

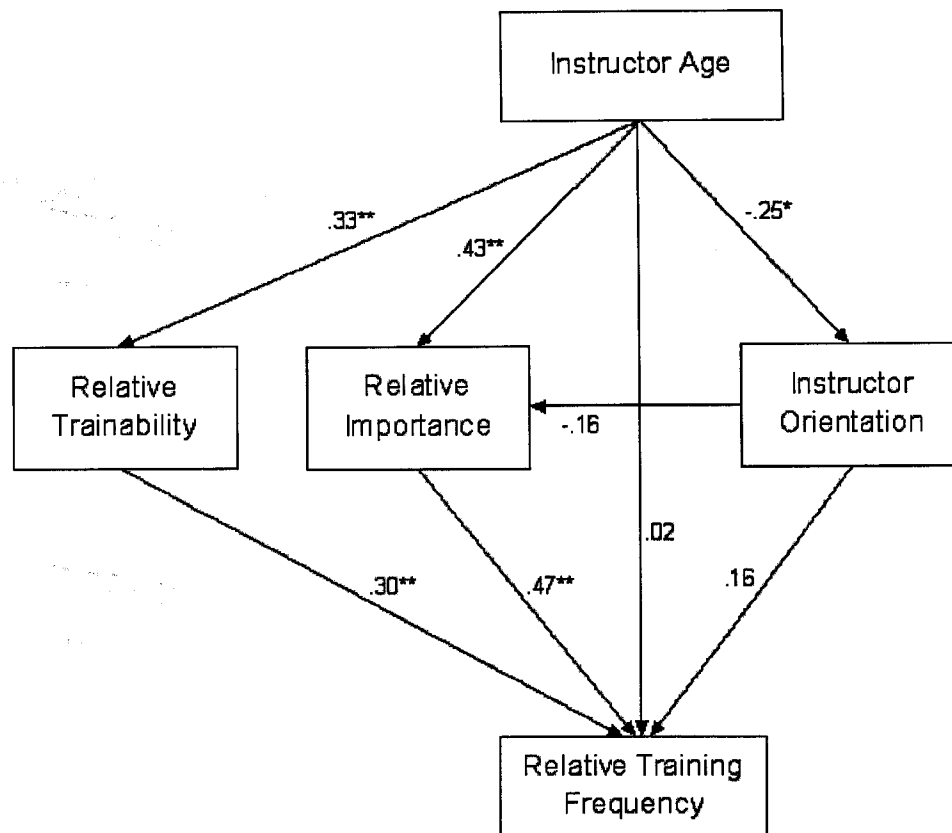


Figure 5. Post-hoc model: Direct and indirect influence of instructor age on relative training frequency.  $*p < .05$ .  $**p < .01$ .

indicating a good fit for the post-hoc model. Values calculated for RMSEA and GFI also indicated adequate model fit (see Table 5).

The significant bivariate correlation between instructor age and training frequency (see Table 7) was rendered nonsignificant after conducting a path analysis (see Figure 5) to account for relative trainability, relative importance, and relative training frequency,  $r = .02$ ,  $p > .05$ . However, coefficients between instructor age and (a) relative trainability,  $r = .33$ ,  $p < .01$ ; (b) relative importance,  $r = .43$ ,  $p < .01$ ; and (c) instructor orientation,  $r = -.25$ ,  $p < .05$ ,

Table 8

*Standardized path coefficients for post-hoc model*

Path (from → to)	Path Coefficient	SE
Instructor age → Relative Training Frequency <sup>a</sup>	.02	.09
Instructor age → Relative Trainability <sup>a</sup>	.33**	.09
Instructor age → Relative Importance <sup>a</sup>	.43**	.09
Instructor age → Instructor Orientation	-.25*	.10
Relative Trainability → Relative Training Frequency	.30**	.08
Relative Importance → Relative Training Frequency	.47**	.09
Instructor Orientation → Relative Training Frequency	-.16	.08
Instructor Orientation → Relative Importance	-.16	.09

<sup>a</sup> Relative trainability, relative importance, and relative training frequency indicate RS – TS difference scores.

\* $p < .05$ . \*\* $p < .01$ .

were each significant. Again, relative training frequency was predicted by relative trainability,  $r = .30$ ,  $p < .01$  and relative importance,  $r = .47$ ,  $p < .01$ . Although relative training frequency was not significantly associated with instructor orientation,  $r = -.16$ ,  $p > .05$ , this path coefficient was almost significant ( $p = .051$ ).

Interestingly, although the bivariate correlation between instructor age and relative training frequency (see Table 7) was significant,  $r = .38$ ,  $p < .01$ , the path coefficient for this relationship in the post-hoc path analysis model was not significant,  $r = .02$ ,  $p > .05$ .

Assuming causality, this finding suggests that instructor age did not impact relative training frequency directly; rather, instructor age only impacted relative training frequency indirectly

through its impact on the three instructor variables (relative trainability, relative importance, and instructor orientation).

Finally, in the post-hoc model, the coefficient for the path between instructor orientation and relative importance (see Table 8) was no longer significant,  $r = -.16, p > .05$ . This suggests that the relationship between instructor orientation and relative importance may not have been causal, but rather may have reflected the impact of instructor age on both instructor orientation and relative importance<sup>9</sup>.

In summary, the findings based on the post-hoc analyses indicate that older instructors tended to (a) view relationship skills as relatively more trainable, (b) view relationship skills as relatively more important, and (c) view themselves more as clinicians than as researchers. In addition, the results suggest that older instructors who taught relationship skills relatively more frequently also viewed these skills as being relatively more trainable and important, and they tended to perceive themselves as more clinically-focused than did younger instructors. Finally, the results of the post-hoc analyses suggest that instructors' clinical/research orientations actually had no influence on their beliefs about the relative importance of relationship skills (or vice versa).

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<sup>9</sup> Although the coefficient for the path between instructor orientation and relative training frequency was no longer statistically significant either, the significance level only decreased slightly after accounting for age.

## CHAPTER IV

## DISCUSSION

The purpose of the present study was to investigate the predictors of relationship skills training in clinical psychology graduate programs. It was hypothesized that programs' clinical/research orientations would predict the frequency with which instructors trained relationship skills relative to technical skills. It was also hypothesized that program orientation would predict (a) instructors' beliefs about how trainable relationship skills are relative to technical skills, (b) instructors' beliefs about how important relationship skills are relative to relationship skills, and (c) instructors' clinical/research orientations. In addition, it was hypothesized that the three instructor variables (relative trainability, relative importance, and instructor orientation) would each predict the frequency with which they trained relationship skills relative to technical skills in their courses. Finally, it was hypothesized that relative trainability, relative importance, and instructor orientation would each mediate the relationship between program orientation and relative training frequency. A path analysis was conducted to examine these hypotheses. The data supported the hypotheses that relative trainability, relative importance, and instructor orientation would predict relative training frequency, and an unanticipated relationship was found between relative importance and instructor orientation. However, neither measure of program orientation was related to any of the other variables.

## Descriptive Data

The implications of some of the mean values for the variables are worthy of note.

### *Program Orientation*

Seventy-one percent of participants rated the clinical/research orientation of their programs between 3 and 5 on the 7-point Likert-type scale. This result held for both instructors' and clinical training directors' ratings of program orientation, and it suggests that the programs included in this study emphasize clinical training and research training approximately equally.

### *Trainability*

The average rating for trainability of relationship skills on the Likert-type scale corresponded roughly to a rating of "moderately trainable," whereas the average rating for trainability of technical skills corresponded to a rating of "very trainable" (see Table 1). On average, relationship skills were viewed as less trainable than technical skills, which is consistent with Schottler's (2004) finding that psychologists often perceive relationship skills as being relatively difficult to train. It may also reflect the lack of clear research reports about relationship skills trainability in graduate psychotherapy programs (Cormier, 1990; Gormally, 1990). Moreover, instructors may be aware of the more conclusive evidence suggesting that technical skills are relatively easy to train (e.g., Crits-Christoph et al., 1998; Henry et al., 1993).

### *Importance*

The mean rating for importance of both relationship skills and technical skills corresponded to a rating of "very important." The finding that instructors viewed relationship skills as very important is not actually surprising, considering Norcross's (2001) observation that even EST (empirically supported treatment) manuals give "lip service" to the importance of relationship skills. On the other hand, this finding is optimistic compared to previous

research showing that only about half of psychotherapy researchers listed the relationship as an important ingredient of effective psychotherapy (O'Donohue, Buchanan, & Fisher, 2000). Because the participants in this study were EST researchers, the results of the present study might indicate that the opinions of EST researchers are not representative of the opinions of clinical psychologists in general.

### *Instructor Orientation*

As shown in Table 1, the mean rating of instructor orientation fell slightly above the midway point of the 7-point Likert-type scale. Seventy-six percent of participants rated themselves between 4 and 6 on the scale, indicating that, overall, instructors emphasized research more than clinical practice in their own professional work.

### *Analysis*

#### *Program Orientation Was Unrelated to All Other Variables*

The data did not support the hypothesis that program clinical/research orientation would be directly and indirectly associated with relative training frequency. Neither instructors' ratings nor clinical training directors' ratings of program orientation predicted relative training frequency, relative trainability, relative importance, or instructor orientation. Despite relatively large standard error values for each of these variables (see Table 4) it is possible to conclude with reasonable certainty that there is little or no relationship between program orientation and relative training frequency, relative trainability, or relative importance.<sup>10</sup>

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<sup>10</sup> The following discussion will not include any speculations regarding the relationship between program orientation and instructor orientation, as the extremely large standard error value of this relationship makes it impossible to make any claims about it. In addition, any reference to program orientation in this subsection refer to both measures of this variable.

There are several plausible explanations for this result. First, there was a lot of noise in the relationship between these variables. The fact that the two measures of program orientation were only moderately correlated with one another (see Table 2) suggests that program orientation may not be well-defined enough for faculty members within the same program to agree on that program's clinical/research emphasis. This ambiguity may have contributed to the nonsignificant findings for program orientation.

Second, program orientation may have been gauged by estimating the average clinical/research orientation of the individual professors in the department. In this case, ratings of program orientation may not reflect the fundamental values of the department, and therefore any given psychotherapy instructor's beliefs about relationship skills or any instructor's decision to train relationship skills may be minimally associated with program orientation. Given a large enough sample, a small correlation between estimates of the average department member's orientation and instructors' beliefs about relationship skills may be detected, but the sample size of the present study may be too small to detect this relationship.

A third possible explanation is that ratings of program orientation are based on the clinical/research leanings of the most prominent faculty members, which in many cases may bear little or no relationship to the beliefs and practices of the instructors who participated in this study. As an explanation of the lack of relationship between program orientation and relative training frequency, this is consistent with Strupp's (1974) early observation that the individual values of instructors may have more bearing on course material than departmental values.



*Relative Trainability Predicted Relative Training Frequency*

The data supported the hypothesis that relative trainability would be associated with relative training frequency. Instructors who rated relationship skills as relatively more trainable tended to spend comparatively more class time training these skills than instructors who rated relationship skills as relatively less trainable. Therefore, some instructors may train relationship skills less frequently because they believe they are difficult to train.

However, because these are correlational data, we cannot infer causality from this result. Perhaps Baker and colleagues' (1990) conclusion that relationship skills are trainable was correct, and therefore the more instructors attempt to train these skills, the more trainable they perceive them to be. Alternatively, instructors may feel obligated to teach certain skills regardless of how trainable they feel they are. After teaching these skills for awhile, it may be easier for instructors to convince themselves that they are trainable in order to feel that their efforts have been worthwhile. Finally, instructors who believe that relationship skills are relatively easy to train will likely be more willing to teach courses with significant relationship skills components. Due to the cross-sectional nature of the data, any combination of these alternative interpretations may be valid.

*Relative Importance Predicted Relative Training Frequency*

The results also supported the hypothesized relationship between relative importance and relative training frequency. Professors who viewed relationship skills as relatively more important tended to spend comparatively more class time training these skills than did those who viewed relationship skills as relatively less important. This indicates that one reason why instructors may provide less relationship skills training is because they see relationship skills as less important than other instructors.

Because the data are correlational, however, we cannot assume causality. Once again, it could be that instructors who view relationship skills as extremely important will tend to gravitate towards courses with more relationship skills content than other instructors.

*Instructor Orientation Predicted Relative Training Frequency*

The hypothesized relationship between instructor orientation and relative training frequency was affirmed by the analyses as well. There are several factors that could account for this association. First, as noted earlier, instructors who identify themselves more as researchers may have been hired for their research skills. These instructors may have relationship skills that are less developed than instructors who identify themselves as clinicians. If they are aware of their relatively limited relationship skills, they may decide to train more technical skills than relationship skills to use class time more productively. A second possibility is that a third variable may account for this association: once again, the relationship between instructor orientation and relative training frequency may be due to selection of certain types of instructors into certain types of courses. For example, instructors who self-identify as researchers more than clinicians may be assigned to teach courses that lend themselves more to technical skills training than relationship skills training.

*Instructor Orientation Predicted Relative Importance*

The revised path model included an unanticipated path between instructor orientation and relative importance, indicating that instructors closer to the researcher end of the clinician-researcher dimension tended to view technical skills as relatively more important than did those closer to the clinician end.. There are various possible explanations for this finding; however, post-hoc analyses indicated that the influence of instructor age on both instructor orientation and relative importance may account for this correlation.

### Post-Hoc Tests

The historical context in which instructors received their training may have influenced their beliefs about relationship skills, their clinical/research orientations, and possibly their training practices. Therefore, correlation coefficients were produced for the relationships between instructor age and each of the variables in the hypothesized and revised models. Interestingly, instructor age was directly associated with relative trainability, relative importance, instructor orientation, and relative training frequency. The revised path model was tested using instructor age as the exogenous variable. The results indicated that relative trainability, relative importance, and instructor orientation mediated the relationship between instructor age and relative training frequency.

#### *Instructor Age Predicted Relative Trainability*

The correlation between instructor age and relative trainability suggests that older instructors are inclined to view relationship skills as more trainable. One possible explanation for this finding is that older faculty members have had more experience as therapists and as supervisors. Their experience may have contributed to their proficiency at facilitating relationship skills development among student trainees; therefore, older instructors may have witnessed more relationship skills development among students than younger instructors. As a result, older instructors may be more likely to believe that these skills are trainable.

A second possible explanation for this correlation is that it reflects a cohort effect. Interest in relationship skills has declined in the last few decades (Norcross, 2001b), and the emphasis on these skills has likely declined in psychotherapy training programs as well. Although research evidence suggests that the graduate training during the 1960s and 1970s did not translate into increased relationship skills among students (Bath & Calhoun, 1977),

the emphasis on relationship skills during this period may have influenced students' attitudes about the trainability of these skills. For example, students may have concluded that relationship skills are trainable based on the fact that their programs emphasized these skills in their courses.

#### *Instructor Age Predicted Relative Importance*

The association between instructor age and relative importance may reflect the effect of experience on instructors' beliefs. For instance, older professors are likely more experienced psychotherapists and they may therefore possess more first-hand awareness of the importance of relationship skills. Alternatively, this correlation may again indicate a cohort effect. Older instructors are more likely to have been trained and socialized in a culture that emphasized relationship skills, whereas younger instructors are more likely to have been trained and socialized in a culture that emphasized ESTs. To the extent that one's graduate training has a long-term impact on students' beliefs, older instructors may be more inclined to view relationship skills as important.

#### *Instructor Age Predicted Instructor Orientation*

One plausible explanation for the correlation between instructor age and instructor orientation is that more junior faculty members see themselves as more research oriented than senior faculty because they are focusing on research in order to get tenure, whereas older faculty members likely have more freedom to pursue clinical activities. Once again, a second possibility is that this correlation is indicative of a cohort effect. In the 1960s and 1970s, professors were often hired by clinical psychology Ph.D. programs specifically to train students, and their careers have been much less research focused than the careers of faculty members hired more recently. In general, present psychology departments likely

emphasize research skills over clinical skills when hiring instructors, and clinical psychology faculty are likely to become increasingly research-focused as the older faculty members retire and are replaced with more research-focused professors.

Interestingly, the relationship between instructor orientation and relative importance was nonsignificant after adding instructor age to the model, indicating that this correlation was in fact not causal, but rather reflected the influence of instructor age on both instructor orientation and relative importance.

### *Summary and Implications*

In the final analysis, the results suggest that when instructors believe that relationship skills are relatively trainable and important, they tend to train these skills relatively more frequently. The results also suggest that when instructors perceive themselves more as clinicians than as researchers, they tend to train relationship skills relatively more frequently. Finally, the results of the post-hoc analyses suggest that older instructors are more likely to possess characteristics that are predictive of relationship skills training: they see relationship skills as relatively trainable and important and they perceive themselves more as clinicians than as researchers.

If the causal model outlined in this report is accurate, several tentative suggestions can be made to improve psychotherapy training practices. First, more methodologically sound research is needed to demonstrate the trainability of relationship skills. In particular, research examining the factors that contribute to higher-order relationship skills would address some of the criticisms directed at previous relationship skills training research (e.g., Cormier, 1990; Gormally, 1990). If researchers can demonstrate the effectiveness of

particular types of relationship skills training, instructors may be more likely to invest time and energy into teaching these skills.

Second, the results presented here indicate that some instructors may train relationship skills less frequently because they believe that they are relatively unimportant. The mean importance rating was the same for relationship skills and technical skills, despite research evidence that relationship skills are more predictive of therapy outcome than technical skills. Perhaps if instructors were reminded of this fact, they might alter their training practices to reflect the research literature. For example, the therapeutic relationship could be the focus of conferences and workshops attended by clinical psychology faculty.

Third, if clinical and supervisory experience is associated with increased relationship skills training, then clinical psychology programs might benefit from assigning psychotherapy courses to instructors who are most experienced in these areas. These courses could also be assigned to instructors who have more time to devote to teaching and supervising. In some cases, departments might consider assigning psychotherapy courses to experienced sessionals.

Fourth, the relationship between instructor orientation and relative training frequency suggests that perhaps a subset of faculty members should be hired for their clinical and supervisory skills rather than for their research skills. These professors could specialize in psychotherapy instruction, and they could have fewer research duties to allow them to focus on training students.

Finally, if the correlation between instructor age and instructors' beliefs and values regarding relationship skills is the result of a cohort effect, perhaps revitalizing training elements that were more prevalent several decades ago may increase relationship skills

training for future cohorts of students. Admittedly, changing the overall emphasis of clinical psychology psychotherapy training would be extremely difficult, if not impossible. However, if we knew which aspects of training were correlated with positive attitudes toward relationship skills, perhaps some programs would be interested in integrating these elements into their curricula.

#### Limitations of the present study

Several important methodological limitations should be considered when evaluating the results in this study.

#### *Sampling*

Selection bias is always a concern in survey investigations, and the relatively small number of eligible instructors who completed the survey makes this concern particularly salient to the present investigation. Although the response rate by program was comparable to previous studies surveying similar populations (e.g., Stevens, Dinoff, & Donnenworth, 1998), the response rate by instructor was much lower. To calculate the percentage of eligible professors who completed the survey, we would divide the 41% response rate by program by the average number of eligible instructors at each program. The final percentage would likely be quite modest.

If respondents represent a truly random sample from the population of interest, selection bias is not a concern (Goldberg, 2003). However, this is often not the case in survey research. Respondents may have differed from nonrespondents in several ways, and this could have influenced the results. For example, it could be that professors with strong opinions may have been most likely to respond to the survey, in which case the correlations for the general population of psychotherapy instructors may be weaker than the ones reported

here. Furthermore, previous research suggests that survey respondents tend to be older and to have more job satisfaction than nonrespondents (Goodman & Blum, 1996). The results of the post-hoc analyses suggest that older instructors may view relationship skills as more trainable and important relative to technical skills, to perceive themselves more as clinicians than as researchers, and to train relationship skills relatively more frequently than younger instructors. Therefore, a more representative sample may have yielded (a) lower ratings of relative trainability and relative importance, (b) lower estimates of relative training frequency, and (c) instructor orientation ratings that were closer to the research end of the scale.

#### *Causality*

Because there was no experimental manipulation, we cannot infer causal relationships between the variables. The path models presented above imply causality, but without random assignment we cannot know whether this inference is warranted.

#### *Measurement*

There are several ways in which measurement issues may have biased the results. First, using a frequency measure of training may provide only a topological assessment of skills training. Based on the present measure, an instructor's brief mention of a skill would appear the same as an entire lecture on the topic. Alternatively, participants could have been asked to estimate the percentage of class time they spent training each skill; however, this task would likely be difficult to complete and would probably have discouraged most participants from completing the survey. Of the possible alternatives, measuring training frequency seems like the best option.



Second, measuring training frequency using retrospective reports may have influenced the reliability of the results, as such reports can be inaccurate (Henry, Moffitt, Caspi, Langley, & Silva, as cited in Kazdin, 2003). One possibility is that responses could reflect idealized rather than realistic estimates of training frequency. This problem was anticipated, and asking instructors to respond based on the last time they taught a psychotherapy course probably eliminated some of this bias. Nevertheless, memory is often inaccurate, and therefore some of the results may be biased (e.g., the correlations between importance and training frequency may be inflated). Another measurement issue is that some instructors may train relationship skills without realizing that they are doing so. They may train relationship skills implicitly, for example, by modelling these skills when talking with students. Therefore, mean estimates of relationship skills training frequency may actually have been relatively conservative.

Finally, the use of rank data instead of absolute values to measure training frequency may have influenced the results somewhat, as different weightings of the values produce different results.

#### *Path Analysis*

An assumption of path analysis is that all statistically important variables are included in the model (Klem, 1995). The models presented here were developed based on available research; however, because the particular variables investigated in this study have not been researched in the past, the hypotheses were speculative. If one or more salient variables were overlooked, some of the results may be biased.

### *Post-hoc Inferences*

Although the associations between instructor age and other variables have interesting implications for psychotherapy training, these associations were not predicted. Therefore, further research is needed to assess the reliability of these results.

### Conclusions and Suggestions for Future Research

Because the therapeutic relationship is the most robust predictor of therapy outcome (Beutler, Machado, & Neufeldt, 1994; Lambert & Bergin, 1983; Orlinsky & Howard, 1986), awareness of the factors that contribute to relationship skills training is essential. The objective of this investigation was to identify variables that influence psychotherapy instructors' decisions to train or not to train relationship skills in their courses. The findings suggest that instructors' beliefs about the relative trainability and relative importance of relationship skills and their individual clinical/research orientations all have a significant bearing on how frequently instructors train these skills. The question that follows is, what factors affect instructors' beliefs about the trainability and importance of relationship skills?

Future research may investigate this question using questionnaires, interviews, or focus groups. If the results of the post-hoc analyses do reflect a cohort effect, it may be interesting to interview older faculty members to identify the elements that they believe contributed to their beliefs about relationship skills.

As stated earlier, improved studies on the effectiveness of relationship skills training might provide more conclusive evidence regarding the trainability of these skills. In particular, studies investigating training in higher-order relationship skills are needed. If these skills are shown to be trainable, the results of this research may positively influence psychotherapy instructors' beliefs about relationship skills trainability.

Because selection of particular types of instructors into particular types of courses may have accounted for some of the relationships in the models presented here, future research could be designed to rule out this possibility. For instance, perhaps some programs assign instructors to courses based on criteria that are likely unrelated to the variables of interest. This would allow researchers to conduct a quasi-experiment in which the relationships among instructor age, instructors' beliefs and values regarding relationship skills, and the extent to which instructors train these skills could be examined after removing the variance due to self-selection bias.

The findings concerning instructor age have unsettling implications for the future of clinical psychology training. To the extent that the correlations between instructor age and their beliefs and values regarding relationship skills is due to a cohort effect, there may be a general trend toward decreased emphasis on relationship skills in the training of clinical psychologists. This would be unfortunate, given the power of the client-therapist relationship in psychotherapy. The results of this study offer some suggestions as to how programs might take steps to re-establish a focus on the therapeutic relationship. Perhaps by implementing some of these suggestions, we as a profession might begin to remember the fundamental values at the core of psychotherapy and to reacquaint ourselves with the person of the therapist.

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## Appendix A

Dear Professor:

My name is Phoenix Gillis, and I am a clinical psychology graduate student at the University of Windsor in Windsor, Ontario. I am writing to request your participation in a study on current psychotherapy training practices in clinical psychology programs. This investigation is being conducted as part of my M.A. thesis and is being supervised by Dr. Jim Porter.

I am specifically interested in professionals who have taught at least one course with a significant psychotherapy skills component during the 2005-2006 school year. If this does not apply to you, you can disregard this email. Your willingness to consider participating is appreciated.

This study involves completing an online survey regarding your opinions about various psychotherapy skills and the extent to which you have trained these skills in the past. Completing the survey will take approximately 10-15 minutes. You may participate by clicking on the URL at the end of this message.

Thank you,

Phoenix Gillis

## Appendix B

### **LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH**

#### **Title of Study: Psychotherapy Training Study**

You are asked to participate in a research study conducted by Phoenix Gillis, from the University of Windsor Department of Psychology. This study will be completed in partial fulfillment of the requirements for a master's degree in psychology and is being supervised by Dr. Jim Porter, Associate Professor, Department of Psychology. If you have any questions or concerns about the research, please feel free to contact Dr. Porter at 519-253-3000, ext. 7012.

#### **Purpose of the Study**

The purpose of this study is to learn about the types of psychotherapy skills that are currently trained in clinical psychology programs and psychotherapy instructors' opinions about training in these skills.

#### **Procedures**

If you volunteer to participate in this study, you will be asked to complete an online survey about your beliefs about training in various psychotherapy skills and the types of skills you have recently taught. The survey will take approximately 10 - 15 minutes to complete.

#### **Potential Risks and Benefits**

The risk associated with this study is no greater than everyday life. Results from this survey will provide valuable information about the state of relationship skills training in clinical psychology programs and will help to inform future curriculum development and training practices.

#### **Payment for Participation**

There will be no compensation for participation in this study.

#### **Confidentiality**

Because we will ask that you indicate the name of your institution and the title of a course you taught, the responses you provide will not be anonymous. However, any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. It will not appear in any reports about this study, published or otherwise. Only the principal investigator (Phoenix Gillis, B.A.) and her supervisor (Dr. Jim Porter) will be able to connect your name to the information you provide. All identifying links will be destroyed 5 years after data collection.

**Subsequent Use of Data**

Data from this investigation may be used in subsequent studies.

**Participation and Withdrawal**

Your participation in this study is voluntary, and you may decline to answer any question or withdraw from the study at any time without consequences. Consent is implied by completing the survey.

**Feedback of the Results of this Study to the Participants**

A summary of the results of this study will be posted on the REB Study Results webpage, which you can access from the following web address: <http://athena.uwindsor.ca/reb#>. Results will be available in January, 2007.

**Rights of Research Participants**

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; telephone: 519-253-3000, ext. 3916; e-mail: lbunn@uwindsor.ca.

**Signature of Investigator**

These are the terms under which I will conduct research.

*Phoenix Gillis*

*August 26<sup>th</sup>, 2006*

**Signature of Investigator**

**Date**

## Appendix C

<b>Psychotherapy Training Survey</b>
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The following questions pertain to your opinions about training in psychotherapy skills and the specific psychotherapy skills you have taught in the past. Your participation is greatly appreciated.

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**BACKGROUND**

Gender:

<input type="checkbox"/>	Male
<input type="checkbox"/>	Female

Current Age:

<input type="checkbox"/>	20 - 29
<input type="checkbox"/>	30 - 39
<input type="checkbox"/>	40 - 49
<input type="checkbox"/>	50 - 59
<input type="checkbox"/>	60 +

How many years of experience do you have practicing psychotherapy?

<input type="checkbox"/>	0 - 5
<input type="checkbox"/>	6 - 10
<input type="checkbox"/>	11 - 15
<input type="checkbox"/>	16 +

How many psychotherapy clients are you currently seeing?

<input type="checkbox"/>	None
<input type="checkbox"/>	1 - 2
<input type="checkbox"/>	3 - 5
<input type="checkbox"/>	6 +

What is the name of the institution at which you last taught a psychotherapy course?

Are you on the faculty at this institution?

<input type="checkbox"/>	Yes
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<input type="checkbox"/>	No
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If yes, with which department are you affiliated?

In what context are students in your clinical psychology program most likely to develop therapeutic relationship skills?

<input type="checkbox"/>	A specific course designated primarily for training in these skills
<input type="checkbox"/>	Orientation specific psychotherapy courses
<input type="checkbox"/>	Practicum placements
<input type="checkbox"/>	Internship placements
<input type="checkbox"/>	Other:

In your clinical psychology program, is clinical supervision usually associated with particular courses?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Not sure

Do you perceive yourself primarily as a researcher/academic or as a clinician?

<i>Researcher/ Academic</i>							<i>Clinician</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	7

Please rank the clinical/research orientation of your clinical psychology program:

<i>Clinically Focused</i>							<i>Research Focused</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	7

**COMPETENCE**

Please rate how important you feel each skill is for a therapist to be highly competent:

1 = Not at all	5 = Fairly
2 = Slightly	6 = Very
3 = Somewhat	7 = Extremely
4 = Moderately	

	1	2	3	4	5	6	7
Self-awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prizing/Valuing the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding the client's experiences from the client's perspective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a theoretical/conceptual framework to guide interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individualizing therapy for each client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepting the client unconditionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resonating emotionally with the client's experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collaborating in determining goals and methods of therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being genuine with the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developing an appropriate treatment plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating empathy to the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Communicating to the client how the tasks and goals of treatment relate to the client's current concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## TRAINABILITY

Please rate how *trainable* you feel each of the following skills are (i.e., the degree to which students can learn these skills in a psychotherapy course):

1 = Not at all	5 = Fairly
2 = Slightly	6 = Very
3 = Somewhat	7 = Extremely
4 = Moderately	

	1	2	3	4	5	6	7
Self-awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prizing/Valuing the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding the client's experiences from the client's perspective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a theoretical/conceptual framework to guide interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individualizing therapy for each client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepting the client unconditionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resonating emotionally with the client's experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collaborating in determining goals and methods of therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being genuine with the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developing an appropriate treatment plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating empathy to the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating to the client how the tasks and goals of treatment relate to the client's current concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## TEACHING

What is the name of the last psychotherapy course you taught (if more than one course falls into this category, enter the name of the course that is required; if none were required, select any one of the last psychotherapy courses you taught)?

How *often* did the therapy class meet?

<input type="checkbox"/>	Less than once every two weeks
<input type="checkbox"/>	Once every two weeks
<input type="checkbox"/>	Once every week
<input type="checkbox"/>	Twice every week
<input type="checkbox"/>	More than twice every week
<input type="checkbox"/>	We never met as a class

Approximately how many hours long was a typical class meeting?

<input type="checkbox"/>	1 hr
<input type="checkbox"/>	2 hrs
<input type="checkbox"/>	3 hrs
<input type="checkbox"/>	4 + hrs

Approximately how many hours each week did you spend supervising students individually (in addition to class time)?

<input type="checkbox"/>	< 1 hr
<input type="checkbox"/>	1 hr
<input type="checkbox"/>	2 hrs
<input type="checkbox"/>	3 hrs
<input type="checkbox"/>	4 + hrs

Did the course have a seminar/lecture component?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

Did the course have a practicum component?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

If yes, did you supervise students in the practicum component?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

We recognize that many psychotherapy skills are not explicitly taught and that they do not always fall into discrete categories. Therefore, we ask you to think back to the last time you taught this course and to *give your best estimate* as to how often you trained the following skills:

Self-awareness

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Prizing/Valuing the client

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Understanding the client's experiences from the client's perspective

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Using a theoretical/conceptual framework to guide interactions

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Individualizing therapy for each client

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Accepting the client unconditionally

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Resonating emotionally with the client's experience

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Collaborating in determining goals and methods of therapy

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Being genuine with the client

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Developing an appropriate treatment plan

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Communicating empathy to the client

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

Communicating to the client how the tasks and goals of treatment relate to the client's current concerns

<input type="checkbox"/>	Never
<input type="checkbox"/>	Once or twice during the term
<input type="checkbox"/>	About once each month
<input type="checkbox"/>	About every second week
<input type="checkbox"/>	Most or every meeting

If you did teach this skill, training was most frequently...

Didactic       Experiential       Mixed didactic/experiential

**Thank you for taking the time to complete this survey.**

## VITA AUCTORIS

Phoenix Gillis was born in Winnipeg, Manitoba, and received her high school diploma from College Jeanne-Sauve in 1997. In 2002, she received a B.A. in Psychology from the University of Manitoba. She enrolled in the M.A. program in clinical psychology at the University of Windsor in 2004.