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The Effects of Training in Evidence-Based Relationships on Counselor Self-Efficacy and Client Outcomes in Practicum

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by

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Abstract Content:

This study evaluated the effects of an evidence-based relationship factors training (EBRFs) on the self-efficacy of counselors-in-training (CITs), the therapeutic relationship, and the mental health outcomes of clients. Participants included masters level CITs and their assigned undergraduate student clients (USCs). The USCs were a non-clinical sample enrolled in a course on intimate relationships. A quasi-experimental, nonequivalent pretest-posttest design was employed to measure the effects of the EBRFs training with the following assessments: Counselor Activity Self-Efficacy Scale (Lent et al., 2003), Barrett-Lennard Relationship Inventory OS-40, MO-40 (Barrett-Lennard, 2015), Outcome Rating Scale (Miller, Duncan, Sparks, & Claud, 2003), Session Rating Scale (Duncan et al., 2003), Outcome Questionnaire (Lambert et al., 1996). The data analysis showed the training had no effect between the treatment and control groups. However, post hoc analysis showed significant differences within the treatment group on some measures at early intervals. Implications include increasing the length of the training, a larger sample of participants, and a clinical client sample.

Dedication

To my husband, Jody. Among your plethora of talents, I believe your greatest gift to the world is your ability to see and foster the potential in others. Over the course of your life you have helped many people excel because of your unwavering attention, support, and guidance. I am a proud member of this circle and I thank you for your belief in a version of me I am only now coming to believe in and recognize.

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Chapter One

Introduction to the Study

In 2005, the American Counseling Association (ACA) and the Association of State Counseling Boards (ASCB) assembled the Vision 20/20 task force to deliberately plan the future of the counseling profession (Kaplan, Tarvydas, & Gladding, 2014). The planning began with the generation of a list of issues that would be addressed by the 20/20 task force: (a) strengthen the counseling identity, (b) present as a united profession, (c) improve the public perception and increase advocacy for professional issues, (d) create licensure portability, (e) expand the research base of counseling, (f) increase the focus on current and prospective students, and (g) promote client welfare and advocacy (Kaplan et al., 2014).

Along with pinpointing key areas for growth, the Vision 20/20 task force arrived at a consensus definition of counseling (Kaplan et al., 2014). Arguably, the consensus definition was the most important accomplishment. The definition identifies the heart of counseling by beginning with the words, "Counseling is a professional relationship..." and continues "…that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education and career goals" (Kaplan et al., 2014, p. 366). The acknowledgement of relationships as the nexus for accomplishing counseling goals is consistent with the history of the counseling discipline, but also can be viewed as a culmination of decades of research by scholars from multiple disciplines involved in psychotherapy and counseling including psychology (e.g. Barrett-Lennard, 2015; Norcross, 2012; Wampold, 2010), social work (e.g. Barber, 1988; Gockel & Burton, 2014), and counseling (e.g. Bell, Hagedorn, & Robinson, 2016; Kottler & Balkin, 2017; Capuzzi & Gross, 2017). This vein of research explores the interwoven presence of the therapeutic relationship, within the provision of counseling and psychotherapy, regardless of

professional discipline or theoretical stance. Following is a summary of historical progression of research in counseling and psychotherapy that forms the foundation of the proposed study.

A Historical Summary of the Evidence-Based Debate in Counseling and Psychotherapy

The commitment to psychotherapy treatment based on empirical research has existed since the late 19th century (Lister & Moody, 2017; Wampold, 2010). During that time psychologists like James and Hall from the Boston School of Psychopathology, and Freud, the father of Psychoanalysis, were providing scientific explanations for mental disorders and their successful treatments (Wampold, 2010). This research had a medical model underpinning that ascribed to the cannon that a treatment must be specific to the disorder being treated (Miller, Hubble, Chow & Seidel, 2013; Wampold, 2010). More recently, scholars who adhere to the medical model believe evidence-based treatment is only achieved by vetting empirically supported treatments (ESTs) through the use of randomized clinical trials (RCT; Miller et al., 2013). For example, Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Therapy (CBT) have cleared the RCT hurdle and are generally accepted as ESTs for the treatment of depression (Laska, Gurman, Wampold, 2014).

Alongside the medical model, researchers grounded in humanistic schools of thought (e.g., Rosenzweig, 1936; the founder of common factors, and Marmor, known for removing homosexuality from the Diagnostic and Statistical Manual of Mental Disorders; Drescher, 2006) rejected the medical model and claimed the factors common to all therapies were responsible for successful outcomes (Messer, 2004; Rosenzweig, 1936; Wampold, 2010). Within this realm, emphasis was placed on the relationship between the client and therapist as a source for improvement, along with EST protocols (Wampold, 2010). Empirical research supports the

proposition that common factors indeed play a significant role in successful psychotherapy outcomes (Lambert & Barley, 2002).

Thus, at the root of the evidence-based practice (EBP) controversy lies a tension between scientific-oriented scholars who propose psychotherapy is better seated within the medical model in the form of ESTs, and those who hold that the humanistic relationship-oriented common factors are also evidence-based (Lister & Moody, 2017; Miller et al., 2013; Parrow, Sommers-Flanagan, Cova, Lungou, 2019; Sommers-Flanagan 2015; Wampold, 2010). Messer (2004) described the division between ESTs and common factors in psychotherapy outcomes research as a culture war; he viewed it as a humanistic versus scientific dichotomy, with each side holding that their research and treatment is evidence-based. Wampold (2010), described the two sides as intertwining strands in the development of evidence-based psychotherapy.

Evidence-Based Practice in Counseling

In conjunction with the decades old debate among psychotherapy scholars, a reemphasis on EBP has occurred (Lister & Moody, 2017; Sommers-Flanagan, 2015; Yates, 2013). Currently, the generally accepted definition of EBP, notably written for the medical profession, has been adapted by the disciplines of counseling, psychology, social work, and nursing (Yates, 2013). It reads, “Evidence-based practice is the integration of the best research evidence with clinical expertise and patient values” (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 147).

The adapted definition of EBP put forth by the American Psychological Association (APA) for EBP in psychotherapy, and seemingly accepted in the counseling profession, is “The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (2006, p. 273). Later, Yates (2013) clarified the

definition of EBP for counselor educators, practitioners, and students. Thus, EBP in counseling is a combination of the following three components: (a) the best available research evidence, (b) clinical expertise, and (c) the client's culture, values, and preferences (Yates, 2013, p. 43-46).

The ACA code of ethics and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards reflect a commitment to EBP by including the following: (a) C.7.a. "When providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation" (ACA, 2014, p.10) and (b) F.5.j. Counseling curriculum must include "evidence-based counseling strategies and techniques for prevention and intervention" (CACREP, 2016, p. 10-13).

Although the ACA ethics code (2014) and CACREP (2016) standards are clear about teaching and conducting EBP, exactly what constitutes EBP remains unclear (Lister & Moody, 2017; Sexton, 2000; Sommers-Flanagan, 2015; Yates, 2013). This is, in part, due to the aforementioned differing opinions in psychotherapy that divided scholars between the EST camp and those who hailed the power of therapeutic relationship for improving client outcomes (Norcross & Lambert, 2011). Lister and Moody (2017) described the tensions surrounding EBP as the counseling profession's *Gordian Knot*:

> The challenge faced by counseling professionals is determining what EBP means in the context of counseling, how it can be used in counseling practice, and how counseling professionals can conduct EBP research that remains true to the values and identity of the profession (p. 137).

Although the therapeutic relationship was not specifically identified or defined in any of the EBP definitions, several scholars have advocated for its inclusion (Yates, 2013). Some scholars continue to point out this oversight and assert relationship factors are evidence-based

and should be explicitly considered a part of EBP (Norcross, 2012; Norcross & Lambert, 2018; Parrow et al., 2019; Sommers-Flanagan, 2015). Specifically, Norcross and Lambert (2018) wrote, "Efforts to promulgate best practices and evidence-based treatments without including the relationship and responsiveness are seriously incomplete and potentially misleading" (p. 308). Incidentally, relational factors that are research-based and contribute to positive treatment outcomes are not integrated into the ACA (2014) ethics code or the CACREP (2016) standards.

A Historical Summary of Common Factors in Psychotherapy

When referring to factors common to all therapies the historical psychotherapy nomenclature includes the terms "implicit factors" (Rosenzweig, 1936), "nonspecific factors" (Ziskind, 1949), and more recently, "common factors" (Feinstein, Heiman, & Yager, 2015; Hubble, Duncan, Miller, & Wampold, 2010; Grencavage, Norcross & Delworth, 1990; Lambert & Ogles, 2014; Rosenzweig, 1936). Rosenzweig (1936) spoke to the power of common factors when he hypothesized, "With such potent implicit factors in common, externally different methods of therapy may well have approximately equal success" (p. 413).

Following Rosenzweig's, now famous, hypothesis more than 89 common factors have been proposed and evaluated in the literature (Grencavage et al., 1990). This inquiry includes several conceptual models and clusters of common factors created in efforts to define, operationalize, and measure implicit agents of change (Feinstein et al., 2015; Ivey, Ivey, & Zalaquett, 2018; Lambert, 1992; Lambert & Barley, 2002; Sommers-Flanagan, 2015; Wampold, 2010). Examples of common factors include *support factors* (e.g. positive relationship, empathy, reassurance), *learning factors* (e.g. feedback, affective experiencing, insight) and *action factors* (e.g. behavioral integration, modeling, practice) (Lambert, 1992).

Rosenzweig's (1936) foreshadowing that common factors were responsible for equivalency based on treatment has come to pass. The preponderance of evidence shows that various therapeutic approaches are equally effective (Grencavage et al., 1990; Wampold, 2010). Thus, common factors are considered pantheoretical and are now believed to account for why a broad variety of approaches to counseling and psychotherapy produce positive outcomes (Lambert, 1991; Luborsky, Singer, & Luborsky, 1975).

In a seminal article on psychotherapy outcomes research, Lambert and Barley (2002) distilled decades of research and put forth estimates of key variables that influence change in psychotherapy. The authors proposed that the common factors including relationship factors (30%), extratherapeutic factors (40%), and expectancy factors (15%), combine with specific technical factors (15%), to determine treatment outcomes. Later, Norcross and Lambert (2011) provided more refined descriptions and estimates of the variables, within the purview of the therapist, related to change and outcomes. In this light, the common factors are ever present across therapeutic factors; whereas the relationship is recognized for contributing approximately 12% of the variance along with the treatment method (8%), the individual therapist (7%), and other factors (3%) (Norcross & Lambert, 2011).

The Common Factors and Evidence-Based Relationship Factors in Counseling

Before and after Lambert and Barley's (2002), and Norcross and Lambert's (2011) demarcation of therapeutic factors, numerous researchers reported that the most efficacious common factors, over which counselors can exert direct influence, involve the therapeutic relationship (Grencavage et al., 1990; Hatchett, 2017, Norcross & Lambert, 2018; Lambert & Ogles, 2014; Wampold & Imel, 2015; Whiston & Coker, 2000). Thus, within the larger pool of

common factors lies a subgroup of evidence-based relationship factors (EBRFs; Parrow et al. 2019; Sommers-Flanagan, 2015).

Specifically, EBRFs are distinctly different than other common factors in three ways: (a) they are operational and measured in the research literature, (b) they are not necessarily common to all counseling approaches, and (c) they are distinctly relational (Parrow et al., 2019). These features make relationship factors categorically different than non-relational common factors such as the positive expectations and extra-therapeutic factors as described by Lambert (1991).

Sommers-Flanagan (2015) proposed an EBP model for counselors that identified the following evidence-based relationship factors (EBRFs), all of which have empirical links to positive outcomes in counseling: (a) congruence and genuineness, (b) the working alliance (including a positive emotional bond, mutual goals, and collaborative tasks), (c) unconditional positive regard, (d) empathic understanding, (e) rupture and repair, (f) managing countertransference, (g) in-and-out of session procedures, and (h) progress monitoring.

The Psychotherapy Debate Today

The relationship-oriented common factors versus ESTs as EBP debate is becoming resolved as the intersection between ESTs and therapeutic relationship factors become clearer. As was stated previously, both are linked to improved outcomes. There is, however, a notable distinction found in comparison study summaries. According to most research reviews and meta-analyses, common relationship factors are more highly correlated with improved client outcomes than specific ESTs (Lambert & Barley, 2002; Wampold, 2010; Wampold & Imel, 2015).

Recently, Norcross and Lambert (2018) explained that the therapeutic relationship and treatment method are inseparable and influence one another. Thus, treatment methods may have a relational impact because of the reciprocal nature of the two (Norcross & Lambert, 2018).

There is little evidence that treatment methods are valid without active relational components (Norcross & Lambert, 2018). Managed care guidelines, which sometimes require ESTs, are remiss and incomplete when they leave out time and attention necessary to cultivate an evidence-based therapeutic relationship (Norcross & Lambert, 2018). Together, the therapeutic relationship and specific treatment procedures create the *how* (relating and interpersonal behavior) and the *what* (techniques or interventions) of counseling (Norcross & Lambert, 2018).

Basic Skills Training in Counselor Education

Basic skills training for counseling students begins prior to entering practicum, when students counsel their first clients. Counselor educators have a number of training approaches, models, and texts that define specific counseling skills for novice counselors to learn and practice (Baker, Daniels, & Greeley, 1990; Ridley Kelly, & Mollen, 2011; Sommers-Flanagan & Heck, 2012). Incidentally, some basic counseling skills are operationalized common factors; listening skills that are closely related to the therapeutic relationship (Ivey et al., 2018).

Although each training approach has course content that reflects the model's uniqueness, most basic skills training programs have three common objectives: (a) introduce and practice interpersonal counseling skills (e.g. attending, paraphrases, feeling reflection, immediacy), (b) develop counselor-in-training (CIT) intrapersonal skills by expanding cognitive complexity (e.g. client conceptualization, cultural considerations, flexibility in interventions, intentionality) and increasing self-awareness (e.g. self-awareness (self-knowledge or self-insight), self-consciousness (attunement to internal states), and self-focused attention (momentary shifts toward oneself), and (c) support and increase CIT self-efficacy (Baker et al., 1990; Buser, 2008; Ridley et al., 2011; Schaefle, Smaby, Maddux, & Cates, 2005; Sommers-Flanagan & Heck, 2012; Tolleson, Grad, Zabek, & Zeligman, 2017).

This combination of CIT cognitions and behaviors is a basic representation of the *what* and *how* of counseling (Norcross & Lambert, 2018). It is important to note, most basic skills training models, like common factors, are pantheoretical. Pantheoretical models allow CITs to bridge the gap between practical application and their budding theoretical understanding (Baker, et al., 1990; Ivey et al., 2018; Ridley et al., 2011; Truax & Carkhuff, 1967).

Self-Efficacy in Counseling and Psychotherapy

Counseling self-efficacy is defined as the beliefs or judgments that counselors hold about their ability to effectively counsel clients in the near future (Larson & Daniels, 1998). Research has indicated that counselor self-efficacy is considered a major determinant of positive treatment outcomes along with the therapeutic relationship and treatment methods (Lambert & Barley, 2002; Larson & Daniels, 1998; Lent et al., 2009; Meyer, 2015).

Researchers have reported positive correlations between higher self-efficacy and counselor performance and developmental level; conversely, self-efficacy is negatively correlated with counselor anxiety (Larson & Daniels, 1998, Lent et al., 2009). Self-efficacy relates to several aspects of providers' experience, including how much effort they expend and the quality of their performance (Larson & Daniels, 1998). Further, self-efficacy influences the likelihood a counselor or psychotherapist will continue in the field (Larson & Daniels, 1998; Lent, Hill, & Hoffman, 2003; Meyer, 2015).

Statement of the Problem

It is estimated that more than 500 theories inform the different ESTs used in counseling and psychotherapy (Cheston, 2000; Lambert, 1991; MacCluskie, 2010; Young, 2017). Early on, CITs may be unable to distinguish the strengths and weaknesses among various theories (Brabeck & Welfel, 1985; Ridley & Mollen, 2011; Whiston & Coker, 2000) and can become

confused and overwhelmed by the vast array of concepts and ESTs attached to each theory (Cheston, 2000; Feinstein et al., 2015; MacCluskie, 2010; Young, 2017).

Due to the streamlined focus and pantheoretical nature of the topic, basic skills training texts often under-focus or exclude a theories section (MacCluskie, 2010; Ridley et al., 2011; Young, 2017). Thus, counselor educators often teach CITs basic interpersonal and intrapersonal skills first or simultaneous with other courses on theories of psychotherapy and their related ESTs (Adams, Vasquez, & Prengler, 2015; MacCluskie, 2010; Ridley & Mollen 2011; Tovar-Murray & Gaetjens, 2018). Because of this, CITs may feel theoretically rudderless and their self-efficacy may suffer as they counsel their first clients in practicum (Ridley & Mollen, 2011).

According to Bandura (1977) self-efficacy can be increased through mastery, modeling, social persuasion, and affective arousal. Given the influential nature of counselor self-efficacy as potentially a key aspect in counselor skill development and performance (Larson & Daniels, 1998; Meyer, 2015), CITs need a solid foundation to bolster their self-efficacy and increase positive client outcomes (Meyer, 2015). Further, early training may be the most potent time for increasing CIT self-efficacy (Larson & Daniels, 1998). Counseling self-efficacy researchers have provided some evidence for the positive influence of modeling, role-plays, visual imagery, and affirmative feedback (Alberts & Edelstein, 1990; Buser, 2008; Duys & Hedstrom, 2000; Larson & Daniels, 1998; Sommers-Flanagan & Heck, 2012; Whiston & Coker, 2000). Still, studies in this area often have methodological flaws including a lack of control groups and of research being conducted in analog rather than naturalistic settings (Buser, 2008; Larson & Daniels, 1998).

A meta-analytic review of the counselor training literature confirms there are several training approaches to develop CIT interpersonal competence, expand their cognitive complexity

and self-awareness, and thus, improve self-efficacy (Buser, 2008; Ridley, et al., 2011). However, due to a lack of manualized training programs and program variation, the quality of these inquiries may not meet the standards for process and outcome research (Hill & Lent, 2006). Further, there is little research literature connecting training program content to client outcomes (Buser, 2008, Hill & Lent, 2006; Ridley et al., 2011).

Some counselor education scholars have called for clinical training of CITs to go beyond basic interpersonal skills and to include therapeutic relationship-building skills which are evidence-based and known to facilitate positive client outcomes (Sexton 2000, Whiston & Coker, 2000). Others have recommended specific training models or treatment manuals that will provide CITs with specific instructions for how to implement techniques (Buser 2008; Sexton, 2000, Whiston & Coker, 2000).

Even with a variety of basic skills texts to teach a gamut of skills to CITs, there are no training models or texts specifically dedicated to teaching CITs how to intentionally develop and maintain a therapeutic relationship. Closing this gap for CITs is crucial, given that the identity of counseling is based on the premise that counseling is a "professional relationship" Kaplan et al., 2014, p. 366). Consequently, there is a need for an evidence-based therapeutic relationship skills model that CITs can understand easily apply as they begin counseling in practicum.

Purpose of the Study

This dissertation study examined the effects of a semi-manualized EBRFs training designed to address several needs identified in the literature. Specifically, the study addresses: (a) the provision of practical skills training beyond basic skills training (Ridley et al., 2011), (b) learning and assessment of therapeutic relationship skills as EBP (Lister & Moody, 2017; Sommers-Flanagan, 2015; Norcross & Lambert, 2018; Norcross & Wampold, 2011; Yates,

2013), (c) validation of training programs with studies that measure counseling outcomes (Buser, 2008, Hill & Lent, 2006; Ridley et al., 2011), and (d) which training elements can improve CIT self-efficacy as CITs counsel their first clients (Buser, 2008; Larson & Daniels, 1998; Lent et al., 2009). Finally, the research meets the CACREP (2016) standards and ACA (2014) ethics codes related to the teaching and the provision of EBP in counselor education, and did so through teaching relationship skills, rather than technical procedures and strategies associated with the concepts and ESTs attached to various psychotherapy theories.

Research Questions and Hypotheses

Research Question One and Hypothesis

Will undergraduate student-clients (USCs) rate their sessions with CITs higher if their CIT has completed a training on the deliberate practice of using EBRFs in counseling?

H1: Undergraduate student clients (USCs) whose CIT attends a semi-manualized EBRF training will rate their sessions statistically significant higher on the Session Rating Scale (SRS; Duncan et al., 2003) as compared with USCs whose CITs do not attend the manualized EBRF training.

$H1_0$: USCs whose CIT attends a semi-manualized EBRF training will not have statistically significant higher scores on the SRS (Duncan et al., 2003) as compared with USCs whose CITs do not attend the semi-manualized EBRFs training.

Research Question Two and Hypothesis

Will USCs rate their well-being and progress in counseling higher if their CIT has attended a training on the deliberate practice of EBRFs in counseling?

H2: USCs whose CIT attends a semi-manualized EBRF training will have statistically significant higher scores on the Outcome Rating Scale (ORS; Miller, Duncan, Sparks, & Claud, 2003) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

$H2_0$: USCs whose CIT attends a semi-manualized EBRF training will not have statistically significant higher scores on the ORS (Miller et al., 2003) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

Research Question Three and Hypothesis

Will USCs report an improved mental health after eight counseling sessions if their CIT has attended a training on the deliberate practice of EBRFs in counseling?

H3: USCs whose CIT attends a semi-manualized EBRF training will have statistically significant lower scores on the Outcome Questionnaire (OQ-45.2, Lambert et al., 1996) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

$H3_0$: USCs whose CIT attends a semi-manualized EBRF training will not have statistically significant lower scores on the OQ-45.2 (Lambert et al., 1996) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

Research Question Four and Hypothesis

Will USC/CIT pairs rate their therapeutic relationship higher if the CIT has attended a training on the deliberate practice of EBRFs in counseling?

H4: USC/CIT pairs whose CIT attends a semi-manualized EBRF training will have statistically significant higher combined scores on the Barrett-Lennard Relationship Inventory me-to-other (MO) and other-to-self (OS) (BLRI-MO & BLRI-OS, Barrett-Lennard, 2015) as compared to USC/CIT pairs whose CIT did not attend the semi-manualized EBRF training.

$H4_0$: USC/CIT pairs whose CIT attends a semi-manualized EBRF training will not have statistically significant higher combined scores on the BLRI-MO and BLRI-OS (Barrett-Lennard, 2015) as compared to USC/CIT pairs whose CIT did not attend the semi-manualized EBRF training.

Research Question Five and Hypothesis

Will CITs rate their self-efficacy to conduct counseling tasks higher after attending an EBRFs training and engaging in the deliberate practice of EBRFs in counseling clients?

H5: CITs who attend a semi-manualized EBRF training will have statistically significant higher scores on the Counselor Activity Self-Efficacy Scales (CASES, Lent et al., 2009) as compared to CITs who did not attend the semi-manualized EBRF training.

$H5_0$: CITs who attend a semi-manualized EBRF training will not have statistically significant higher scores on the CASES (Lent et al., 2009) as compared to CITs who did not attend the semi-manualized EBRF training.

Definition of Terms

For the purpose of the study the following terms are defined:

Cognitive complexity. "One's ability to use varied constructs and draw useful distinctions in understanding interpersonal situations" (Buser, 2008, p. 90).

Counselor education. The specific professional discipline related to the governing body of the American Counselor Association (ACA; 2014).

Counseling training. Academic education for a number of helping professions including counseling psychology, social work, and counseling.

Counselor(s)-in-training (CIT). Counselors-in-training are students enrolled in counseling training programs.

Congruence. Congruence is about the relationship between the counselor's inner and outer experiences and the transparent expression of these experiences; this requires self-awareness and open expression (e.g. self-disclosure). Notably, Rogers (1957) and others (Kolden, Klein, Wang, Austin, & Hilsenroth, 2011) have also used the terms "genuineness" or "authenticity" to describe congruence.

Counselor self-efficacy. The counselor's or CIT's belief or judgment about their capability to effectively counsel a client (Larson & Daniels, 1998).

Countertransference. Therapist reactions that are based on unresolved conflicts, conscious or unconscious, and are triggered by client transference or other phenomena (Tishby & Wiseman, 2014).

Cultural humility. Cultural humility includes three interpersonal dimensions: (a) An other-orientation instead of a self-orientation, (b) respect for others and their values, and (c) an attitude of non-superiority (Hook, Davis, Owen, Worthington, Utsey, & Tracey, 2013).

Empathic understanding. The ability 'to sense the client's private world as if it were your own, but without ever losing the "as if" quality (Rogers, 1957, p. 99).

Empirically supported treatments. Specific psychological treatments that have been shown to be efficacious in controlled clinical trials (APA, 2006).

Evidence-based relationship factors. Relationship factors that are empirically linked to positive counseling outcomes (Sommers-Flanagan, 2015).

Microskills. Microskills are "discrete, free-standing behaviors that vary in the degree of directiveness imposed by the counselor" (MacCluskie, 2010, p. 44).

Mircroskills Training. Method of teaching CITs basic counseling skills to reduce therapeutic complexity "by focusing on single skills and allowing students to practice and master them individually" (Ridley et al., 2011, p. 803).

Practicum. The practicum course in counselor training programs is designed to help students transfer concepts, skills, and abilities obtained through classroom activities to actual practice in professional settings (The University of Montana Department of Counselor Education Practicum and Internship Guide, August 2019).

Progress monitoring. Progress monitoring is a systematic method for assessing client change and providing client feedback to counselors (Miller, Duncan, Sorrell, & Brown, 2005).

Repair. Repair behaviors are those that signal to clients that the counselor is open to hearing about the client's disappointment or frustration with counseling (Safran & Muran, 1996).

Rupture. Ruptures are client behaviors or communications that indicate a relationship strain in counseling or psychotherapy (Safran & Muran, 1996).

Unconditional positive regard. "The extent that the therapist finds himself [sic] experiencing a warm acceptance of each aspect of the client's experience... it means there are no conditions of acceptance...It means a 'prizing' of the person [and]...a caring for the client as a separate person" (Rogers, 1961, p. 98).

Working alliance. Bordin's (1979) three distinct alliance factors include: (a) positive emotional bond, (b) goal consensus, and (c) task collaboration.

Delimitations

The study was delimited by CITs who were enrolled in a master's degree program and who had completed basic skills training in Clinical Mental Health Counseling or School Counseling.

The study was also delimited by USCs who were enrolled in an undergraduate course on intimate relationships and selected counseling as their laboratory component. The current study focused on the USCs who were engaged in eight sessions of counseling along with the aforementioned CITs.

Limitations

The research study was a quasi-experimental, nonequivalent pretest-posttest design, and thus limited by the lack of random assignment between the CIT participant groups (Privitera, 2015). Further, the researcher was expected to control for limitations such as threats to internal validity which are present in all research designs (Creswell, 2014; Sheperis et al., 2017). Specifically, the level of control in a research design relates to internal validity while generalizability relates to external validity (Privitera, 2015). The study attempted to address and control for the following limitations.

History. The history threat is possible should an unanticipated event co-occur during the research manipulation period (Privitera, 2015). The study took place during a 15-week semester. Given the long period of time, an event outside of the control of the researcher might have occurred but was not evident. In accordance with Creswell's (2014) recommendation to control for this threat to internal validity, the study utilized both a control and treatment group who likely experienced the same external events during the study period.

Mortality. The threat of mortality or attrition is based on the possibility that not all participants who have agreed to participate will complete the study (Creswell, 2014; Privitera, 2015). Controlling for the internal threat of mortality involves recruiting a large enough sample to accommodate the number of potential dropouts (Creswell, 2014). When attrition occurs, typically, the attrition will be homogenous, or the same for each group (Privitera, 2015).

Diffusion of treatment. Creswell (2014) refers to this threat as the likelihood members from the control and treatment group will communicate with one another and influence the outcome. It is recommended that the researcher keep the groups as separated as possible (Creswell, 2014). The study was set up to control for the internal threat of diffusion by keeping the treatment and control groups separate based on their assigned practicum classrooms.

Compensatory or resentful demoralization. An experiment may introduce inequality when the treatment group receives an intervention and the control group does not (Creswell, 2014). The internal compensatory threat can be controlled by offering the control group the same treatment at the end of the experiment (Creswell, 2014). In order to compensate for this threat, the researcher prescheduled and provided the EBRFs training to the control group during the last week of the semester in which the research study occurred.

Selection bias. The threat of selection bias can occur when one group is predisposed to receive the treatment or intervention and not representative of the population (Sheperis et al., 2017; Tuckman & Harper, 2012). Controlling for selection bias as it relates to external validity can be done through defining the parameters of the target population (Tuckman & Harper, 2012). In this study, the CIT participants were enrolled in a CACREP accredited program. Because of this, it is expected that they were receiving an education similar to other CITs who were also enrolled in CACREP programs within the United States. This meets the assumption of a representative sample with regard to training (Tuckman & Harper, 2012). Thus, one target population to generalize to would be CITs who are enrolled in CACREP accredited programs.

The other target population is USCs who are receiving counseling from master's level CITs. There is likely differences between areas of the country, particularly in terms of racial diversity. The majority of the population attending this university are Caucasian which is

reflected in the demographics of the current study participants. Thus, the USC and CIT participant sample may not be representative of racial, cultural, social, or economic diversity in the United States.

Reactive effects of the experimental arrangement. The potential for participant bias to affect the results by knowing they are a part of an experiment (Sheperis et al., 2017; Tuckman & Harper, 2012). The CIT students were aware that they were participating in a research study and likely knew whether they were in the treatment group or control group. Minimization of this threat was linked to controlling for the compensatory internal validity threat, which was to provide the same training to the control group after the research data collection was completed. Additionally, the researcher attended the CIT participant practicum orientation and taught both control and treatment groups the processes of the research study including informed consent for themselves and assigned USCs, administered the CASES, and discussed the other surveys used in the research study. It is likely the USC participants did not recognize their status of control group or treatment group.

Multiple treatment effects. Participants may be exposed to a number of treatments, some of which are not a part of the experiment (Tuckman & Harper, 2012). This external threat might have come from attending courses that some, but not all, CITs were exposed to during the semester. The threat of multiple treatments might have also come from instructor similarities in the classrooms for the CITs and USCs. According to Tuckman and Harper (2012) randomization controls for this and other potential variables. The external threat of multiple treatments in the current study was minimized for the USC participants because the UCSs followed their respective CITs into either the treatment or control groups.

Significance of the Study

This dissertation study has the potential to serve the counseling profession, counselor education, CITs, and clients. Many authors recommend further research on interpersonal and intrapersonal skills as they relate to client outcomes (Buser, 2008; Ridley et al., 2011). Researchers have also noted that current research is laden with design flaws including lack of control groups**,** poor measurements, and insufficient research settings (Buser, 2008; Larson & Daniels, 1998). One major concern is the absence of a specific training model, leaving what CITs are taught in each research setting inconsistent (Hill & Lent, 2006).

Through the use of a semi-manualized EBRF training program, this results of this study may further the understanding of learning and skill development for CITs in counselor education. The results could also help counselor educators determine which training components are responsible for improved skills and increased CIT self-efficacy by the client outcomes as recommended by many counseling scholars (Buser, 2008; Larson & Daniels, 1998; Lent et al., 2003). Finally, the provision of this semi-manualized EBRFs training program for CITs as they entered practicum might have ensured their engagement in EBP during a crucial stage in the development of a relational-oriented counselor identity (Lister & Moody, 2017) and implementation of the technical strategies associated with the concepts and ESTs attached to various psychotherapy theories.

Summary

The dissertation research study addressed issues identified by the Vision 20/20 task force and other scholars in the field of counselor education. The study was in line with the ACA ethics code and CACREP standards regarding teaching and conducting EBP in counselor education and practice. Finally, the research results provide some insight into how the EBRFs semi-manualized

training program could affect the development of a relational-oriented counselor identity, improve CIT self-efficacy, and improve counseling outcomes.

Chapter Two

Review of the Literature

The interwoven presence of common factors and relationship building skills is evident throughout the basic skills training literature and thus, is described in the following literature review. Basic skills training is the first wave of counseling preparation and seems to illustrate the common factors and relationship factors in action; both those that are implicit and those that are evidence-based. Many scholars agree that successful counseling training programs prepare CITs to engage in EBP as they support clients' efforts toward behavioral change and relief of distress; the foundation of which is the therapeutic relationship (Gockel & Burton, 2014; Lister & Moody, 2017; Kottler & Balkin, 2017; Nutt, 2011; Sexton, 2000; Yates, 2013).

This literature review begins with a historical summary of basic skills training pedagogy from a variety of disciplines that train psychotherapists, social workers, and counselors. The review provides an in-depth examination of the most prevalent models and methods employed by counselor educators. In particular, three crucial basic skills training objectives and their interrelated influence on professional counseling training are identified and explored.

The review continues with a summary of research related to basic skills training efficacy in general, and the identified training objectives, in particular. Strengths and weaknesses of the research are identified. Further, empirically based methods of instruction are highlighted along with validated assessments of counseling skills performance and CIT self-efficacy.

The review then progresses to selected evidence-based relationship factors (EBRFs) that form an EBP training and practice model, specific to the discipline of counseling. The review includes generally accepted definitions, operationalized behaviors, and validated measures of EBRFs skills. This literature review concludes with a summary of the current research study which examined the usefulness of an EBRFs training model on the development of specific

relationship building skills and CITs' self-efficacy as they conducted EBP with their first clients in practicum.

Basic Skills Training in Counseling

Counselors and psychotherapists from psychiatry, clinical social work, clinical psychology, counseling psychology, and counseling often receive the same or similar initial training on basic clinical skills (Ford, 1979; Ladany, 2007). At the same time, each discipline's more specific academic requirements are provided to students (e.g. community and organizational systems for social work students; research methodology and psychometrics for clinical psychologists-in-training; interpersonal adjustment problems for counseling psychology and counseling students; Ford, 1979).

Counseling educators can select from a number of training approaches, models, and texts for teaching new counselors basic skills (Baker et al., 1990; Hill & Lent, 2006; Ridley et al., 2011; Sommers-Flanagan & Heck, 2012). Typically, successful training delivery and practice includes a combination of didactic instruction, role-plays, videotape instruction, video recording and review of skills, self-reflection, and supervisor and peer feedback (Baker et al, 1990; Bennett-Levy, 2006; Duys & Hedstrom, 2000; Ford, 1979; Loganbill, Hardy, & Delworth,1982; Ridley et al., 2011).

While each basic skills training approach, model, and text is distinct, three main objectives are commonly found in the curricula. Objectives include: (a) introduce and practice basic interpersonal counseling skills (e.g. attending, paraphrases, feeling reflection, immediacy), (b) develop CIT intrapersonal skills by expanding cognitive complexity (e.g. client conceptualization, cultural considerations, flexibility in interventions, intentionality) and increase self-awareness (e.g. self-knowledge or self-insight, self-consciousness (attunement to internal

states), and self-focused attention (momentary shifts toward oneself), and (c) support and increase CIT self-efficacy (Baker et al.,1990; Barnes, 2004; Buser, 2008; Goreczny, Hamilton, Lubinski, & Pasquinelli, 2015; Ladany, 2007; Ridley et al., 2011; Schaefle et al., 2005; Sommers-Flanagan & Heck, 2012; Tolleson et al., 2017).

Each basic training program model is unique, based on the developer's view of the counseling training process and the interrelated influences of interpersonal and intrapersonal skills, and CIT experiences of self-efficacy (Baker et al, 1990). The focus on each of the three main objectives varies, although most programs put the greatest emphasis on introducing and practicing basic interpersonal counseling skills (Hill, 2020; Ivey et al., 2018; Smaby, Maddux, Torres-Rivera, & Zimmick, 1999; Truax and Carkhuff, 1967; Young, 2017). Notably, most basic counseling skills are common factors, intended for building the therapeutic relationship (Ivey et al., 2018; Nutt, 2011). Thus, programs are often considered pantheoretical allowing for later integration of specific theoretical techniques and ESTs (Baker et al., 1990; Ridley et al., 2011; Ivey et al., 2018; Young, 2017).

The following discussion begins with a brief progression of pedagogy for basic skills acquisition, the most common training approaches are then summarized, and relevant outcomes research is provided. The discussion concludes with a deeper exploration of intrapersonal counseling skills development and CIT self-efficacy, and their apparent in-tandem influence on counselor performance and client outcomes.

The Progression of Basic Skills Pedagogy in Psychotherapy and Counseling

Prior to the late 1950's training of psychotherapists was limited to a supervision model that leaned heavily on the trainee's recapitulation of session content as a means to hone interpersonal and interviewing skills (Baker et al., 1990). In 1957, Carl Rogers developed the

first systematic approach to teaching counselors basic skills by including didactic instruction of skills, one-way mirror observation of sessions, and audiotape review. Rogers believed that the core conditions for change (genuineness, unconditional positive regard, and empathic understanding) would support learning psychotherapy skills in the same way the core conditions work with clients in psychotherapy (Rogers, 1961). In the time since Rogers' redirection of training, several structured and comprehensive models for teaching basic skills have emerged.

A few of the most recognized basic skills programs are the Human Resource Training/Human Resource Development (Truax and Carkhuff, 1967), Microcounseling (Ivey, Normington, Miller, Morrill, & Haase, 1968), the Skilled Counselor Training Model (Smaby et al., 1999), Learning the Art of Helping (Young, 2017), and Helping Skills (Hill, 2020). Following is a summary of each aforementioned model and relevant efficacy research, when available.

Human Resource Training/Human Resources Development (HRT/HRD). Truax and Carkhuff (1967) followed Rogers's lead, incorporated his methods, and used the core conditions to teach concrete behaviors and facilitate client change with the HRT/HRD program. The HRT/HRD training model employs methods like role-play, video review, and quasi-group therapy to teach therapists how to recognize and demonstrate empathy, warmth, and genuineness (Truax & Carkhuff, 1967).

The unique aspect of the HRT/HRD model is an emphasis on leveraging the core conditions to facilitate change in the counselor, while in training, and the client, while in psychotherapy (Truax & Carkhuff, 1967). CITs are taught three stages of counseling: (a) exploring (identification of client distress), (b) understanding (development of goals), and (c) acting (implementation of plans for reaching goals; Truax & Carkhuff, 1967). The model reflects

a combination of development in theoretical understanding and counselor intrapersonal growth though didactic instruction and the facilitation of Rogers' core conditions in experiential, therapeutic group processes (Truax & Carkhuff, 1967).

Studies of the HRT/HRD, with a focus on objective and measurable behaviors, showed promise for trainees' skills in promoting client change while improving trainee's autonomy, movement toward self-actualization, and decreasing their defensiveness (Ridley et al., 2011). Further, a meta-analysis of nine research studies that evaluated the training effects of the HRT/HRD model on counselor behaviors showed a large effect size (Baker et al, 1990). Still, the authors cautioned that the large effect size might have been reflective of flawed research designs that are often common in early research (Baker et al, 1990).

Microcounseling. Ivey et al. (1968) introduced a more specific basic skills training method called "Microcounseling." Microcounseling is a unique teaching and learning framework, adapted from a model called "micro-teaching" in education (Allen, 1966; Ivey et al., 1968; Ivey et al., 2018). The approach reduces each counseling skill into a microskill by defining and practicing each as a discrete and observable task (Ivey et al, 1968). Many scholars endorse presenting skills in this way as it seems to stave off overwhelm and confusion while supporting CIT self-efficacy and confidence (Ivey et al., 2018; MacCluskie, 2010; Ridley, et al., 2011).

The microcounseling program is conceptualized as a pyramid with learning more basic skills (e.g. attending, paraphrasing) at the bottom and working toward more complex skills (e.g. reflection of meaning, empathic challenging) toward the top (Ivey et al., 2018). The tip of the pyramid depicts expanding cognitive complexity (an integration of skills, the CITs developing theoretical understanding, client conceptualization, and personal style) (Ivey et al., 2018).

The microcounseling program employs written positive and negative examples of each skill, video-recorded practice with supervisor feedback, self-confrontation, all with added practice until mastery (Ivey et al, 2018). Once mastered, CITs become able to use individual microskills with intention; intentional use allows for responsiveness to whatever the client brings into session (Baker et al., 1990; Ivey et al., 2018). Further, as the skills become integrated, CITs are prepared to conduct Ivey's five-stage counseling session: (a) empathic relationship (develop rapport) , (b) story and strength (gather data), (c) goals (set goals mutually), (d) restory (explore alternative thoughts, behaviors, and feelings), and (e) action (planning for generalizing session content into life) (Ivey et al., 2018).

Since its introduction, microcounseling has continued as the most prevalent and researched basic skills training program with, as reported by Ivey, more than 500 data-based research studies, and is available in 20 translations worldwide (Ivey et al., 2018). One meta-analysis of 23 research studies evaluating microskill demonstration showed a large effect size (Baker et al., 1990). Hill and Lent's (2006) meta-analysis also endorsed microcounseling as useful for teaching CITs helping skills.

Of note, the meta-analyses of research conducted by Baker et al. (1990) and Hill and Lent (2006) also showed that the HRT/HRD model was more effective with lower level skills (e.g. attending, empathy, actively listening) and the Microcounseling model was shown as more effective for higher level interpersonal skills (e.g. self-disclosure, confrontation, influencing skills).

Microskills as the Preferred Interpersonal Skills Training Method

A number of counseling training scholars (only a few are represented here) have adapted Ivey's (1968) microskills approach to their specific models for teaching basic counseling skills

as discrete observable behaviors (Hill, 2020; MacCluskie, 2010; Ridley et al., 2011; Smaby et al.,1999; Young, 2017). The term microskills has proliferated the counseling literature and is now used interchangeably with basic skills, fundamental skills, interpersonal skills, and helping skills (Buser, 2008; MacCluskie, 2010; Tovar-Murray, & Gaetjens, 2018; Yates, 2013). Many agree that the microskills training method is favored because it allows students to master specific skills individually and supports self-efficacy as they begin to bridge the gap between theory and practice (Baker et al., 1990; Nutt, 2011; Ridley et al., 2011).

The Skilled Counselor Training Model (SCTM). Smaby et al. (1999) merged Microcounseling and HRT/HRD to form the SCTM, also presented as the Skilled Group Counselor Training Model (SGCTM) in group contexts (Crews et al., 2005; Buser, 2008; Smaby et al., 1999). CITs are taught specific skills linked to each stage of the exploring, understanding, and acting stages found in the HRT/HRD model (Smaby et al., 1999). During the exploring stage, CITs engage with a simulated client to determine a specific problem to focus on. The understanding stage is denoted by a deliberate focus on the counselor/client relationship and conceptualization of the problem. The acting stage involves action planning and the encouragement of client change (Crews et al., 2005).

The 12-week SCTM program promotes learning lower and higher-level interpersonal skills and client conceptualization through experiential modeling, support of CIT self-efficacy, furthering cognitive skills, and regular self-appraisal (Buser, 2008; Little, Packman, Smaby, & Maddux, 2005). SCTM leverages earlier achievement in basic skills acquisition to bolster confidence for learning more complex influencing and conceptual skills (Little et al., 2005). At its core, SCTM trainers teach basic skills while also encouraging and expecting the development of accurate self-assessment of said skills in self and others (Little et al., 2005).

Research on the SCTM supports the program's efficacy in teaching interpersonal skills (Crews et al., 2005). CITs who were trained on the method scored significantly higher on pretest posttest measures of demonstrated lower and higher-level skills in both analog and naturalistic settings (Crews et al., 2005). Further, those trained in SCTM demonstrated higher scores in cognitive complexity (Little et al., 2005) and self-efficacy (Urbani et al., 2002).

Learning the Art of Helping. In 1998, Young introduced the Learning the Art of Helping approach, an integration of the HRT/HRD, Microcounseling, and common factors identified by Frank and Frank (1991; Young, 2017). Young (2017) incorporated the latest research on ESTs while also directing students to check-in with clients on what is working best for them as a way to engage "practice-based" evidence (p. v).

Young's (2017) approach uses the acronym REPLAN to outline the techniques related to each evidence-based therapeutic factor: R- maintaining a strong relationship, E- enhancing efficacy and self-esteem, P- practicing new behaviors, L- lowering and raising emotional arousal, A- activating client expectations, hope, and motivation, and N- providing new learning experiences. The basic skills are divided into five subgroups: (a) invitation skills, (b) reflecting skills, (c) advanced reflecting skills, (d) challenging skills, and (e) goal-setting skills (Young, 2017).

Helping Skills. The Helping Skills model is a comprehensive approach that leverages client affect to foster an understanding of their problems in addition to a psychology-oriented, problem-solving approach (Hill, 2020; Hill & O'Brien, 1999). The model focuses on the client's exploration of feelings and thoughts as a way to gain new insight and move toward behavior change (Hill, 2020; Hill & O'Brien, 1999). The three-stage model includes: (a) exploration (e.g. attending skills, reflection of feelings), (b) insight (e.g. challenges, immediacy), and (c) action

(e.g. information, direct guidance) (Hill & Lent, 2006). The Helping Skills model views the counseling process as a series of in-the-moment interaction sequences between the helper's behaviors and intentions (cognitive processes), and the client's reactions (Hill, 2020; Hill & O'Brien, 1999).

Research on the Helping Skills Model indicated an increase in CIT helping skills, the ability to create a therapeutic relationship, and skills for conducting a thorough session as measured by the Helping Skills Measure (Hill & Kellems, 2002). Clients reported a positive response to helping skills as factors that made a difference in the helping process (Hill & Kellems, 2002).

The most prevalent training models and texts presented here are representative of how most counseling psychologists and counseling trainers teach basic interpersonal clinical skills. Each has varying degrees of emphasis on the three main objectives discussed at the introduction of this chapter. Namely, (a) introduce and practice interpersonal counseling skills, (b) develop CIT intrapersonal skills, and (c) support CIT self-efficacy (Buser, 2008; Ridley et al., 2011; Schaefle et al., 2005; Sommers-Flanagan & Heck, 2012). The literature review continues with a deeper exploration of intrapersonal counseling skills development and CIT self-efficacy and their influence on counseling performance and outcomes.

The Development of Intrapersonal Counseling Skills

During the 1990's a number of counseling psychology and counselor education scholars called for an increased focus on the development of CIT cognitive skills (Buser, 2008; Fong Borders, Ethington, & Pitts, 1997; Granello, 2010; Ridley et al., 2011). Buser (2008) recognized the dynamic nature of cognitive skills and the need to measure cognitive complexity through multiple indicators and assessments. This essential apperception is also evident in the counseling

literature from that time, as some scholars were focused on the developmental intrapersonal processes of *cognitive complexity* (e.g. client conceptualization, cultural considerations, empathic communication, intentionality, flexibility in interventions) (Granello, 2010; Duys & Hedstrom, 2000; Fong et al., 1997; Kindsvatter & Desmond, 2013; Wilkinson, 2011) and others examined the influence of CIT *self-awareness* on their skill development and counseling effectiveness (e.g. self-knowledge, affect regulation, empathy, congruence) (Loganbill et al. 1982; Tolleson et al., 2017; Williams, Judge, Hill, & Hoffman, 1997; Williams, 2008). Although the intrapersonal constructs of cognitive complexity and self-awareness have some overlap, they often appear in the literature as distinct areas of inquiry.

Cognitive Complexity. Cognitive complexity is defined as "one's ability to use varied constructs and draw useful distinctions in understanding interpersonal situations" (Buser, 2008, p. 90). Cognitive complexity is understood as having two interrelated domains, differentiation and integration (Welfare & Borders, 2010). Differentiation refers to the counselor's ability to identify a variety of discrete client characteristics. Integration refers to the understanding of how the client's characteristics fit together (Welfare & Borders, 2010). In the context of counseling, increased cognitive complexity in CITs manifests as more holistic client conceptualizations, greater flexibility in selecting interventions, recognition of and appreciation for cultural influences, and improvements in self-confidence (Borders, 1989; Granello, 2010; Wilkinson & Dewell, 2019).

Instructional methods to increase cognitive complexity include metacognitive practices such as participation in Socratic supervision and intentional self-reflection (Bennett-Levy, 2006; Granello, 2010; Wilkinson & Dewell, 2019) and experiential classroom activities that include participation and observation of counseling, along with supervisor and peer feedback (Duys &

Hedstrom, 2000; Kindsvatter & Desmond, 2013). CITs often master basic interpersonal skills (e.g. attending, paraphrasing, reflection of feelings) before developing higher levels of cognitive complexity (Fong et al., 1997; Granello, 2010). However, basic skills acquisition and cognitive complexity may occur simultaneously (Duys & Hedstrom, 2000; Kindsvatter & Desmond, 2013). Therefore, some counseling scholars have pressed for the deliberate inclusion of methods known to increase cognitive complexity in basic training programs (Bennett-Levy, 2006; Buser, 2008; Granello, 2010; Ridley et al., 2011; Wilkinson, 2011).

The dynamic nature of cognitive complexity is reflected in how cognitive complexity has been conceptualized and the broad array of variables researchers have used to measure how and when cognitive complexity develops. Cognitive complexity has been framed using developmental models (e.g. Perry's Model in Granello, 2000; Bloom's Taxonomy in Kindsvatter & Desmond, 2013; Loevinger's Ego Development Model in Fong et al., 1997; The Integrative Developmental Supervision Model, Stoltenberg, McNeil, & Delworth, 1998) and systems models (Declarative, Procedural, and Reflective Model, Bennett-Levy, 2006). Further, cognitive complexity has been measured using both general (e.g. Washington University Sentence Completion test in Fong et al., 1997; Learning Environment Preferences in Granello, 2000) and counselor domain-specific assessments (e.g. Role Category Questionnaire in Duys & Hedstrom, 2000; Case Conceptualization Integrative Complexity in Ladany, Marotta, & Muse-Burke, 2001).

Although research in cognitive complexity has not been particularly specific, scholars have been able to infer the influences of cognitive complexity in both CIT training and counseling outcomes. Researchers have found that as cognitive complexity increases the CITs' ability to recognize the dynamic nature of clients also increases (Granello, 2010; Loganbill et al.,

1982; Welfare & Borders, 2010). For example, novice CITs typically see their clients in a simplistic light and hold client conceptualizations that are more dualistic; while CITs with greater cognitive complexity often view their clients as dynamic, hold relativistic judgments grounded in metacognitive self-reflection practices, and are more tentative in their conceptualizations (Granello, 2010; Loganbill et al., 1982; Welfare & Borders, 2010).

Cognitive complexity is correlated with increased tolerance for ambiguity, higher levels of empathy, less prejudice, and increased autonomy (Kindsvatter & Desmond, 2013; Wilkinson & Dewell, 2019). Notably, more complex levels of client conceptualizations are also correlated with positive counseling outcomes and higher client ratings of counseling experiences (Fong et al., 1997; Jennings & Skovholt, 1999). It seems increased cognitive complexity allows CITs to hold flexible client conceptualizations and thus, reflect acceptance and understanding.

CITs appear to experience the most changes in cognitive complexity after basic skills training and when students are engaging in practicum and internship (Bennett-Levy, 2006; Fong et al, 1997; Granello, 2010; Ladany et al., 2001). This marked increase in cognitive complexity may be a reflection of the integration of interpersonal skills and technical knowledge (Bennett-Levy, 2006). Still, research indicates that bulk of growth in cognitive complexity occurs after entering the field (Granello, 2010, Welfare & Borders, 2010).

Self-Awareness. The self-awareness of CITs and counseling professionals is considered a crucial factor in effective client conceptualization, counseling processes, and client outcomes (Friedman & Gelso, 2000; Jennings & Skovholt, 1999; Pieterse, Lee, Ritmeester & Collins 2013; Williams, 2008). Williams (2008) provided a summary of her decades-long research in self-awareness and postulated that self-awareness in counseling is best understood as three interrelated constructs: (a) self-awareness (self-knowledge or self-insight), (b) self-consciousness

(attunement to internal states), and (c) self-focused attention (momentary shifts toward oneself). Further, Williams asserted that this definitional clarity is essential for making connections across future research studies. The counseling literature reflects the varying constructs of self-awareness and are presented here accordingly.

Self-awareness. Self-awareness refers to self-knowledge or self-insight and is broadly defined as a global understanding of one's own dynamics, biases, motivations, and goals (Williams, Hurley, O'Brien & DeGregorio, 2003). This type of awareness also includes the counselor's self-awareness of how their body language and verbal cues influence the session (Hill, 2020; Whiston & Cooker, 2000; Young, 2017). Self-awareness answers the question, "Who am I?" (Hill, 2020, p. 52) and establishes the foundation for emulating the core conditions of empathy and congruence (Capuzzi & Gross, 2017).

While in session, self-awareness plays a crucial role in how well CITs can manage intrapersonal influences like countertransference (Capuzzi & Stauffer, 2016; Friedman & Gelso, 2000; Hill, 2020; Williams et al., 1997), personal values and beliefs (Hill, 2020; Ridley et al., 2011), and tolerance for cultural differences (Capuzzi, & Gross, 2017; Hill, 2020; Ladany, 2007; Wilkinson & Dewell, 2019). When not in session, self-awareness and insight can be fostered through self-reflection practices, psychotherapy, small group discussions, supervision, and self-care (Hill, 2020; Pieterse et al., 2013).

As CITs become more skilled in engaging in self-awareness, their ability to select appropriate counseling interventions increases (Adams et al., 2015; Gockel & Burton, 2014; Wilkinson, 2011). Thus, self-awareness fosters increased cognitive complexity (Bennett-Levy, 2006; Pieterse et al., 2013), skill development (Gockel & Burton, 2014; Ivey et al., 2018), and cultural competence (Capuzzi & Stauffer, 2016; Friedman & Gelso, 2000; Ladany, 2007) and

seems to act as a bridge between theory and the application of appropriate interventions in practice (Adams et al., 2015; Nutt, 2011).

Self-consciousness. Williams (2008) refers to CIT and counselor self-consciousness as "the trait of being continuously attuned to internal states" (both positive and negative) (p. 143). In this light, CITs may experience a full range of emotions while engaging in counseling including anxiety, distraction, empathy, comfort, frustration, and inadequacy (Loganbill at al., 1982; Williams, 2008; Williams et al., 1997).

The development of CIT self-consciousness normally progresses from an unawareness of emotional reactions, to attuning to them, and then utilizing both positive and negative reactions in session (Hill et al., 2007; Loganbill et al., 1982). The CIT's positive and negative experiencing of a client can be a valuable source of information for the selection of appropriate interventions to promote change in the client's maladaptive behaviors (Hill et al., 2007; Loganbill et al., 1982; Wilkinson, 2011).

Thus, the goal of developing self-consciousness in CITs is so that they may be able recognize when their personal reactions occur and understand how to use them in counseling (Nutt, 2011; Pieterse et al., 2013). Most often, the negative responses evoked in a counselor or CIT lead to formulating appropriate diagnoses and treatment interventions (Loganbill et al., 1982). Thus, the negative affect experienced by the counselor can become a positive influence on client care, as long as the affect is not extreme (Loganbill et al., 1982).

When self-consciousness becomes too extreme it may hinder the counseling process by causing debilitating anxiety within CITs (Gockel & Burton, 2014; Williams et al., 2003; Wilkinson et al., 2003). Beginning CITs are prone to experience anxiety as hindering, because they are often unsure of their role, may feel powerless to help, and can become overly critical of

their enactment of interpersonal skills (Gockel & Burton, 2014; Williams et al., 1997) This experience as well as boredom or distraction can usher excessive self-focused attention (Williams et al., 2003).

Self-focused attention. Self-focused attention is described as the CIT or counselor's in-the-moment awareness of their thoughts, feelings and behaviors (Pieterse et al., 2013; Williams et al., 2003). This heightened state of self-focus answers the question "What am I feeling in this moment?" (Hill, 2020, p. 52). At times, CITs may experience self-focused attention as a result of being distracted by personal issues like needing to pay a bill or return a phone call (Williams, 2008). At other times, CITs may feel anxious and become self-focused and preoccupied about their performance, experience critical self-talk (Hill, 2020; Hill et al., 2007; Williams et al., 2003) and lose their ability to provide effective counseling (Tolleson et al., 2017).

When self-focused attention interferes with being present with clients, it may also impact the client's perception of the CITs ability to help and lower counseling effectiveness (Tolleson et al, 2017; Williams et al., 1997). This cycle can perpetuate increased anxiety and negative self-evaluation (Tolleson et al, 2017; William et al., 1997). As a result, CITs may act incongruent and display negative interpersonal behaviors (Williams, 2008).

CITs often overestimate their ability to use microskills prior to training (Barnes, 2004; Goreczny et al., 2015; Hill & Lent, 2006; Little et al., 2005; Urbani et al, 2002). In this case, when skill acquisition and demonstration become unexpectedly challenging, CITs may experience hindering anxiety and struggle with attending to their client (Barnes, 2004) and/or lose their motivation to continue (Little et al., 2005). Regardless of the source, given the impact of self-focused hindering anxiety, affect regulation is paramount to skill development and counseling effectiveness (Loganbill et al. 1982; Tolleson et al., 2017; Williams et al., 1997).

Ideally, when CITs notice a feeling of self-focused anxiety, they will use it as a signal to focus on the interpersonal skills and lessen discouraging critical self-talk (Little et al., 2005).

Several strategies for managing hindering anxiety and the resulting distraction of self-focused attention are found in the literature. Tolleson et al. (2017) proposed using experiential mindfulness, practice, and feedback activities during basic skills training to attune to and lower anxiety and enhance CIT self-efficacy. Granello (2000) suggested reducing hindering anxiety by providing CITs with a cognitive map to help them understand their expected progress and recognize that their experiences are developmentally appropriate. CITs can then focus on learning the basic skills; knowing they will receive additional instruction and support until mastery (Little et al., 2005).

The pursuit of increasing CITs' intrapersonal skills namely, cognitive complexity and self-awareness, in all forms seems necessary. Many scholars agree that the presence of basic counseling skills does not establish competent counselors if cognitive and affective processes and management are absent (Buser, 2008; Fong et al., 1997; Granello, 2010; Ridley et al., 2011) Further, "it seems that deliberately assisting counseling students to develop these skills to increase self-awareness will inadvertently add years of "experience" to their counseling abilities" (Wilkinson, 2011, p. 27).

Counselor-in-Training Self-Efficacy

Counselor self-efficacy is defined as beliefs or judgments one holds about their ability to effectively counsel a client now or in the near future (Larson & Daniels, 1998). Research has shown that counselor self-efficacy is a primary factor affecting both interpersonal and intrapersonal skills as it mediates a multiplicity of interrelated processes (e.g. affective arousal,

cognitive complexity, skills performance, motivation, outcome expectations) (Barnes, 2004; Goreczny et al., 2015; Larson & Daniels, 1998, Lent et al., 2009; Meyer, 2015).

According to Bandura (1986) self-efficacy pertains more to beliefs about skill performance than actual skill performance. For example, CITs who have high self-efficacy report feeling calmer (Lent et al., 2006). They also demonstrate more fluid interpersonal skills and exhibit more in-session flexibility [cognitive complexity] than CITs with lower self-efficacy (Lent et al., 2006). Fong et al., (1997) reported that CITs who have greater self-efficacy and cognitive complexity have increased potential for providing effective counseling interventions. In other words, "…people who believe in their ability to make changes happen are more likely to make those changes than are people who do not hold such beliefs" (Goreczny et al., 2015, p. 79).

Counselor self-efficacy relates to several aspects of CITs' experiences, including how much effort they expend and the quality of their performance (Larson & Daniels, 1998). Counselor self-efficacy has also been shown to have a positive correlation with performance and developmental level, and a negative correlation with anxiety in the counseling role (Larson & Daniels, 1998, Lent et al., 2009). Further, self-efficacy is related to the likelihood a CIT or counselor will continue in the field (Larson & Daniels, 1998; Lent et al., 2009; Meyer, 2015).

Early on, CITs are often preoccupied with issues related to competence and performance (Borders, 1989; Levitt, 2002). Like self-awareness, in general, CITs' self-efficacy increases over time as they gain experience and move through practicum and internship (Goreczny et al., 2015; Lent et al., 2009). However, research has indicated the growth is typically not linear (Larson & Daniels, 1998). CITs appear to experience a significant drop in self-efficacy at the end of basic skills training, followed by gains associated with added experience (Fong et al., 1997; Larson & Daniels, 1998; Lent et al., 2009). This drop in self-efficacy is related to confusion, uncertainty,

and eroding confidence (Larson & Daniels, 1998). Thus, the lowered self-efficacy CITs experience as they enter practicum can influence their skill performance and the anxiety they experience as they counsel their first clients (Larson & Daniels, 1998; Meyer, 2015).

Counselor self-efficacy and hindering anxiety are negatively correlated; increased anxiety is associated with lower self-efficacy (Larson & Daniels, 1998; Tolleson et al., 2017). Because self-efficacy and anxiety are closely related, as in the case of hindering anxiety, lowered self-efficacy in CITs may predict CITs' willingness to expend effort while learning challenging counseling tasks, as well as their willingness to continue in the field (Fong et al., 1997; Larson & Daniels, 1998; Lent et al., 2009; Meyer, 2015). Alternatively, higher self-efficacy is directly related to CITs attributing their successes to their skillfulness, feelings of increased satisfaction (Larson & Daniels, 1998), positive views of the client/counselor relationship, lowered anxiety, and ease with skill delivery and performance (Lent et al., 2009).

There are known methods for increasing CIT self-efficacy. Bandura (1977) postulated that generally, self-efficacy can be increased through mastery, modeling, social persuasion, and affective arousal. Counselor education researchers have also provided evidence for the positive influence of modeling, didactic instruction, role-plays, visual imagery, and affirmative feedback (Hill & Lent, 2006; Larson & Daniels, 1998; Lent et al., 2009; Tolleson et al., 2017). In particular, modeling is found to have greater impact than instruction or feedback and the use of multiple methods is the most effective approach for increasing CIT self-efficacy (Hill & Lent, 2006; Tolleson et al., 2017).

Summary

The interrelated constructs of intrapersonal skills (cognitive complexity and self-awareness) and self-efficacy, in combination with basic interpersonal skills, form the foundation

for most models of basic skills training in counseling training (Baker et al.,1990; Barnes, 2004; Buser, 2008; Goreczny et al., 2015; Ladany, 2007; Ridley et al., 2011; Schaefle et al., 2005; Sommers-Flanagan & Heck, 2012; Tolleson et al., 2017). Further, the processes involved in the development and enactment of interpersonal and intrapersonal skills have been established to support CITs as they grapple with questions of "Who am I?" and "What am I feeling in this moment?" (Hill, 2010, p. 52). Based on the preceding review of the counseling training literature, the ideal basic skills program curriculum is a structured model that includes a cognitive map of expected skills development, skills demonstrations (modeling), experiential practice, positive supervisor and peer feedback, and time for self and group reflection and integration of concepts related to other counseling course work.

Basic Training Programs and Skills Acquisition Research

Although the discussion of basic skills training programs in the corresponding section included some skills outcome research relevant to each training model, a more explicit exploration of how educators measure the effectiveness of basic clinical skills training on CIT behaviors and counseling outcomes is warranted. This section reviews basic skills training programs research in general, and intrapersonal skills and CIT self-efficacy research in particular.

Basic skills training program efficacy research. Throughout the past several decades, numerous outcomes studies of basic skill training programs, and thus interpersonal skills, are found in the literature. However, there is little consensus on dependent and independent variable selection (Alberts & Edelstein, 1990; Baker & Daniels, 1989; Buser, 2008; Ford, 1979; Hill & Lent, 2006). For example, interpersonal skill development and training outcomes have been assessed using a plethora of instructional variables including teaching intervention (e.g. didactic

instruction, modeling, feedback), role perspectives (e.g. peer, supervisor, self, client), basic skills training model (e.g. Microcounseling, SCTM, Helping Skills), timing of supervision (e.g. immediate, weekly), duration of instruction (e.g. 40 hours, one to two semesters), and helper characteristics (e.g. gender, undergraduate, graduate; Baker & Daniels, 1989; Ford, 1979; Hill & Lent, 2006). Further, a single meta-analysis of training program studies identified and evaluated 81 inquiries, with 82 different assessments of counselor behaviors used at least once (Baker & Daniels, 1989).

This broad scope of research notwithstanding, the aggregated results of basic training program efficacy studies have established an empirical foundation for the effectiveness of basic skills training programs (Alberts & Edelstein, 1990; Baker & Daniels, 1989; Ford, 1979; Hill & Lent, 2006). Indeed, meta-analytic research of basic skills training indicates that training programs can improve CIT skills and client outcomes when compared to control groups who do not receive training (Alberts & Edelstein, 1990; Baker & Daniels, 1989; Buser, 2008; Ford, 1979; Hill & Lent, 2006).

Despite evidence for the positive effects of basic counseling skills training, several reviewers have cautioned that a number of studies included in reviews and meta-analyses did not meet the standards for process and outcome research (Alberts & Edelstein, 1990; Buser, 2008; Ford, 1979; Baker & Daniels, 1989; Hill & Lent, 2006). Many identified methodological and design flaws such as a lack of manualized training (Buser, 2008; Hill & Lent, 2006), the use of invalid or non-validated measures (Baker & Daniels, 1989; Ford, 1979), lack of control groups, (Buser, 2008), inequivalent training times (Alberts & Edelstein, 1990; Hill & Lent, 2006), inadequate operationalization of skills, (Alberts & Edelstein, 1990; Buser, 2008), and a lack of performance criteria (Baker & Daniels, 1989).

Although the quality of general training skills program research has been at times subpar, recent intrapersonal skills and counselor self-efficacy studies are more empirically grounded. Following is a review of specific intrapersonal skills development and counselor self-efficacy research that provides a clearer picture of how these variables are interrelated and impact CIT basic skills development and counseling service delivery.

Cognitive complexity skills development research. Cognitive complexity has been measured using both general (e.g. Washington University Sentence Completion Test in Fong et al., 1997; Learning Environment Preferences in Granello, 2000) and counselor domain-specific assessments (e.g. Role Category Questionnaire, RCQ, in Duys & Hedstrom, 2000; Case Conceptualization Integrative Complexity in Ladany et al., 2001). Of these two approaches, counselor domain-specific assessment is preferred over general measures because they offer greater insight into how cognitive complexity can be leveraged and developed in counseling training.

The domain-specific assessment RCQ (Burleson & Waltman, 1988) meets both reliability and validity standards. Coders measure levels of cognitive complexity on the basis of participant responses to two open ended questions with higher scores associated with increased social cognition skills. Duys and Hedstrom (2000) reported that CITs who attended a basic counseling skills training course had significantly higher cognitive complexity scores than the CIT control group who attended other introductory courses ($p < .001$).

Duys and Hedstrom (2000) speculated that increases in cognitive complexity were related to the experiential nature of counseling practice and the opportunity to synthesize academic content from other courses. The study also supported the hypothesis that cognitive complexity increases as CITs make meaning of the counseling process through supervised practice (Duys &

Hedstrom, 2000). This finding also supports a rationale for introducing basic skills early-on, as increased cognitive complexity allows for better comprehension and skill implementation in other courses (Duys & Hedstrom, 2000).

Another highlight from the domain-specific research is found in Ladany et al. (2001). In this study, researchers measured *Conceptualization Integrative Complexity* using a valid and reliable coding system, developed by Suedfeld, Tetlock, and Streufert (1992). CITs responded to open-ended etiology-treatment prompts and coders assigned complexity scores based on the number of factors the CITs presented related to the client's problem.

The researchers reported that experience increased CIT competence for differentiated and integrated conceptualizations. Interestingly, the number of hours of experience was more positively correlated with cognitive complexity than the number of clients (Ladany et al., 2001). This finding illustrated that cognitive complexity may increase more rapidly when CITs have time to make meaning and reflect on their work and the counseling process, rather than investing that time in seeing more clients (Ladany et al., 2001).

Self-awareness skills development research. The most prevalent measure of self-conscious self-awareness and management is the Self-Awareness and Management Strategies scale (SAMS; Williams et al., 2003). The SAMS measures incidents of disruptive self-awareness that occur while in session. Clinicians self-report either hindering anxiety or management of disruptive self-awareness. The SAMS has acceptable psychometrics, meeting the standards for both validity and reliability. When validating the measure the authors found the most popular techniques favored by CITs and counselors included: (a) self-care/self-reflection, (b) cognitive/relaxation, (c) actively returning focus on the client, (d) attempts at ignoring or

suppressing self-awareness and, (e) returning to basic therapeutic techniques (Williams et al, 2003).

Pascual-Leone and Andreescu (2013) proposed a training program specific to the development of self-awareness or "perceptual-acuity" (p. 3) as measured by the SAMS. The researchers also utilized other assessments to evaluate the efficacy of their experiential 13-week program on CIT self-awareness. The curriculum included reflective assignments (e.g. emotional diary, narrative relationship processing with peers), formal practice with clients, client level feedback, and supervised practice with peers.

The significance of this study is mostly related to the consistent finding that multiple teaching methods (e.g. lecture, reading and class discussion, modeling, supervised practice) increase CITs' self-efficacy and confidence (Hill & Lent, 2006; Pascual-Leone & Andreescu, 2013; Tolleson et al., 2017) Further, the results indicated that the curriculum increased CITs' ability to manage their hindering anxiety through relaxation techniques, re-focusing on the client, and suppressing intrusive thoughts (Pascual-Leone & Andreescu, 2013). The implications of this study for teaching are significant, as the researchers showed that using multiple processes, along with corresponding valid and reliable measures, accelerates learning and increases intrapersonal skills and CIT self-efficacy and competence (Pascual-Leone & Andreescu, 2013).

Counselor-in-Training Self-efficacy research. The most common measures of counselor self-efficacy are the Counseling Self-Estimate Inventory (COSE, Larson et al., 1992) and the Counselor Activity Self-Efficacy Scales (CASES, Lent et al., 2003) (Goreczny et al., 2015). Both measures assess the counselor's perception of their attitude and aptitude toward counseling skills (e.g. basic skills, interpersonal skills, intrapersonal skills).

The CASES evaluates CIT self-efficacy for three types of skills: (a) insight, (b) exploration, and (c) action skills as measured by six skills-based self-report subscales: (a) exploration, (b) insight, (c) action, (d) session management, (e) client distress, and (f) relationship conflict (Lent et al., 2003).

Recently, the CASES (Lent et al., 2003) was used to assess an IRB approved, unpublished pilot study similar to the proposed dissertation study presented here (Parrow & Sommers-Flanagan, 2018). In particular, CIT pre- and post-CASES scores were compared after master's students attended a six-hour EBRFs experiential workshop and semester-long advanced theories course that included didactic instruction, modeling, experiential in class role-plays, reflective assignments, and client sessions. Paired sample *t*-tests showed significant changes in pre and post CASES mean scores on each subscale ($p < .001$; n = 15). The results supported other research that has shown multiple instructional methods (e.g. modeling, didactic instruction, role-plays) increases CIT self-efficacy (Hill & Lent, 2006; Larson & Daniels, 1998; Lent et al., 2009; Tolleson et al., 2017). Although this pilot study lacked a control group, it shows promise for the potential effectiveness for the influence of EBRFs training on CIT self-efficacy while in practicum.

Goreczny et at. (2015) compared scores on both the CASES (Lent et al., 2003) and COSE (Larson et al., 1992), along with CIT anxiety and level of training. The results were consistent with other research and further highlighted the importance of developing CIT self-efficacy and confidence early in training. It seems that successful basic skills acquisition builds self-efficacy and increased capacity for more complex counseling processes (Goreczny et al., 2015). As was stated previously, self-efficacy appears to influence nearly every aspect of CIT development (Barnes, 2004; Goreczny et al., 2015; Larson & Daniels, 1998, Lent et al., 2009; Meyer, 2015).

Summary

The now decades-long research in counseling training, although broad and at times mediocre, has confirmed the efficacy of a using structured approaches to teach basic counseling skills. Further, a number of scholars recognized the need to shift toward more empirically validated approaches to show effectiveness of methods for teaching basic skills and higher order intrapersonal skills (Baker et al., 1989; Fong et al., 1997; Hill & Lent, 2006). This progression in the research has demonstrated the necessity of deliberate instruction, development of intrapersonal skills (cognitive complexity and self-awareness), support for CIT self-efficacy, and the use of psychometrically sound measures for deepening the understanding and effectiveness of counselor skills training.

Beyond Basic Counseling Skills Training

Microskills training, in general, is a good introductory method for acclimating neophyte counselors and psychotherapists from a number of disciplines to the counseling process and the development of specific interpersonal behaviors (Ford, 1979; Ladany, 2007; Ridley et al., 2011; Whiston & Coker, 2000). However, some scholars assert that microskills training continues to miss on other integral, more sophisticated counseling competencies like teaching cultural adaptations, the process and efficacy of developing the therapeutic relationship, the various sources of change, and the increased cognitive complexity needed to meet the challenge of creating change with clients (Buser 2008; Ridley et al., 2011; Norcross & Wampold, 2011; Norcross & Lambert, 2018; Whiston & Coker, 2000; Sexton, 2000). Further, many agree that beginning students will benefit from learning efficacious treatment models and specific techniques beyond basic interviewing skills (Nutt, 2011; Ridley et al., 2011; Whiston & Coker, 2000).

The need for expansion in counselor and psychotherapist training curricula is well-understood. The Second and Third Interdivisional APA Task forces recommended that training programs include elements of the therapeutic relationship that are empirically efficacious, teach students how to assess and make appropriate cultural adaptations, and develop a criterion for assessing training in evidence-based relationships (Norcross & Wampold, 2011; Norcross & Lambert, 2018). In addition to evaluating relationship skills training, many authors suggested further research to identify which training elements are responsible for increased CIT self-efficacy (Buser, 2008; Larson & Daniels, 1998; Lent et al., 2009) and increasing the emphasis on cognitive complexity (Buser 2008; Duys & Hedstrom, 2000; Fong et al., 1997; Whiston & Cooker, 2000).

A Professional Counseling Research and Training Agenda

Given the definition of counseling begins with, "counseling is a professional relationship…", counselor educators and practicing professional counselors are positioned well to leverage therapeutic relationship inquiry in service of expanding the counseling research base and strengthening the identity of counseling as petitioned by the Vision 20/20 task force (Kaplan et al, 2014, p. 366). Further, this line of research and training will support the development of a professional counselor identity along with teaching EBPs to CITs as outlined in several of the CACREP (2016) standards and ACA (2014) ethics codes (Parrow et al., 2019).

Many counselor education scholars agree with the need to advance relationship-oriented research to inform counseling-specific clinical training and professional practice (Patel, Hagedorn, Bai, 2013; Whiston & Coker, 2000; Sexton, 2000). Further, some have suggested that the question of what constitutes EBP in counseling can be answered with empirical evidence derived from therapeutic relationship research (Lister & Moody, 2017; Patel et al., 2013; Parrow

et al., 2019; Sexton, 2000; Sommers-Flanagan, 2015; Yates, 2013) and thus, is well-suited for dissemination throughout the counseling profession (Patel et al., 2013). Indeed, the need for an academic agenda that integrates empirical research findings into counselor education curricula for the development of an "evidence-based counseling model" has been well established (Sexton, 2000, p. 220).

An Evidence-Based Relationship Factors Training

Currently, the American Psychological Association (APA) conducts most of the research on the therapeutic relationship. In 2018, results of the Third Interdivisional APA Task Force on Evidence-Based Relationships reconfirmed and elevated a number of known elements of the therapeutic relationship to evidence-based status. Scholarly reviews of each factor were required to meet rigorous meta-analytic standards (e.g. evaluate actual psychotherapy studies (analog settings were excluded), report an aggregated effect size, perform and report on tests for homogeneity, provide a table or funnel plot for analyses of fewer than 50 studies) and included all available empirical studies (Norcross & Lambert, 2018). The results showed that of the 16 scrutinized relationship factors, 15 were considered as either demonstrably or probably effective (Cohen's *d* ranged from .14 to .85). Notably, meta-analytic reviews solicited by the Third Interdivisional APA Task Force on Evidence-Based Relationships included work conducted by researchers from the counselor education discipline (Peluso & Freund, 2018).

The purpose of the current research study was to examine the efficacy of a training model comprised of 10 of the 16 EBRFs identified by the Third Interdivisional APA Task Force. The selected EBRFs included: (a) congruence, (b), unconditional positive regard (UPR), (c) empathic understanding, (d) culture and cultural humility, (e) working alliance: emotional bond, (f)

working alliance: goal consensus, (g) working alliance: task collaboration, (h) rupture and repair, (i) managing countertransference, and (j) progress monitoring (Norcross & Lambert, 2018).

In an effort to affirm the inclusion of the selected EBRFs, the balance of this literature review includes the following for each: (a) a generally accepted definition, (b) a summary of the literature, including relevant findings from the corresponding APA Third Task Force Meta-analysis (APA, 2018), (c) line items from a common corresponding psychometrically accepted measure (see Appendix A, Table A1), and (c) examples of prototypical counselor behaviors, when applicable.

The Core Conditions: EBRFs 1-3

In 1957, Rogers proposed that the presence of congruence, unconditional positive regard, and empathic understanding were all that was necessary and sufficient for creating client change in psychotherapy. Meaning, in order to facilitate change and engage a client's actualizing tendency, the counselor and client must be engaged in a "real relationship" where each of the core conditions are present (Gelso, 2011, p. 14). These core conditions form the basis, of what is now known as person-centered theory, therapy (Rogers, 1957), and supervision (Rogers, 1961). Although derived from person-centered theory, the core conditions are likely present in all therapeutic relationships regardless of the therapist's theoretical orientation (Gelso, 2011; Farber, Suzuki, & Lynch, 2018; Suzuki & Farber, 2016).

In the seven decades since Rogers proposed person-centered theory, counselors and researchers have come to recognize the significance of the core conditions in facilitating client change and promoting positive client outcomes (Gelso, 2011; Farber & Doolin, 2011; Kirschenbaum, & Jourdan, 2005; Kolden et al., 2011; Suzuki & Farber, 2016; Tishby & Wiseman, 2014). The three constructs are interrelated and interdependent, and at times difficult

to separate due to their overlapping influences (Suzuki & Farber, 2016). Still, efforts to identify and measure specific counselor attitudes and behaviors responsible for congruence, UPR, and empathic understanding have yielded some success.

When considered together, congruence often acts as a moderator on client perceptions of a counselor's unconditional positive regard and empathic understanding (Gelso, 2011; Klein Kolden, Michaels, & Chisolm-Stockard, 2002). For example, if the client experiences the counselor as inauthentic or fake, empathy "may fall on deaf ears," trust will be eroded, and the relationship will suffer (Gelso, 2011, p. 36). Further, in qualitative studies of client and therapist interactions, UPR is often inherent in client reports of empathic understanding and authentic exchanges (Suzuki & Farber, 2016).

Rogers' assertion that together, the core conditions facilitate change has been established in research studies across the helping professions (Kirschenbaum, & Jourdan, 2005). However, there is no consensus that the core conditions are necessary and sufficient for all clients (Kirshenbaum & Jourdan, 2005). Although interrelated, and helpful for most clients, each of Rogers' core conditions can be operationalized and are often researched and measured individually in the literature. Thus, they are separated in this review and make up the first three EBRFs in the training model.

Measuring the core conditions. The most common assessment of the core conditions is the BLRI (Cramer, 1986; Farber & Lane, 2002; Farber et al., 2018; Gelso, 2011; Kolden et al., 2011). The BLRI is administered as either a 64-item or 40-item measure; both have acceptable reliability and validity psychometric properties (Barrett-Lennard, 2015). The two versions of the BLRI have been adapted for varying perspectives (e.g. counselor, client, observer) where the reporter assesses the constructs of empathy, positive regard, and congruence (Barrett-Lennard,

2015; see Appendix A, Table A1). Notably, the BLRI is a selected measure for the current study; a more specific review can be found in the "Instrumentation" section of Chapter Three.

Congruence: EBRF 1. According to Rogers (1961) congruence facilitates personal change "…when the psychotherapist [counselor] is what he [she] *is*, when in the relationship with his client he is genuine and without "front" or façade, openly being the feelings and attitudes which at the moment are flowing *in* him" (Rogers, 1961, p. 61). Congruence is two-fold, the counselor as their authentic self in the relationship is coupled with a capacity to accurately express their natural selves to the client (Klein, et al., 2002). In this context, the term congruence illustrates the connection between the inner and outer experience of the therapist and the transparent expression of this experience to the client. Further, congruence ushers in the expression of empathy and positive regard (Kolden, Wang, Austin, Chang, & Klein, 2018).

Congruence can move beyond the honest expression of the counselor's intrapersonal experience to include an interpersonal aspect of feelings of mutuality between the counselor and client (Gelso, 2011; Klein et al., 2002; Kolden et al., 2011). In other words, congruence is both interpersonal (the experiential aspect of the therapeutic relationship) and intrapersonal (the experience of self-awareness and authenticity; Kolden et al., 2018). It seems interpersonal congruence and intrapersonal congruence work together to support client change (Gelso, 2011; Klein et al., 2002; Kolden et al., 2011). Meaning, the counselor and client are interactive in forming and sustaining the therapeutic relationship (Kolden et al., 2011). In this light, the client's congruence or genuineness also acts as a variable in the relationship.

Congruence may not remain valid in contexts outside of Western culture; members of different cultures may view counseling quite differently (Klein et al., 2018). Kolden et al. (2011) warned that culture might affect the client's comfort with congruence. Minority or diverse clients

may prefer the therapist take on a more directive, less congruent, formal role (Kolden et al., 2011; Sue & Sue, 2016). Research has also suggested that people from collectivist-oriented cultures may prefer a more authoritative counselor (Sue & Sue, 2016). In most cases, treatment is likely more beneficial if counselors align with their clients' cultural background (Smith, Rodriquez, & Bernal, 2011; Sue & Sue, 2016).

The meta-analytic review of congruence research conducted on behalf of the Third Interdivisional APA Task Force by Kolden et al. (2018) included 21 studies and represented 1,192 clients. The review compared the perception of counselor congruency and client outcomes based on reports by clients, therapists, and third-party observers. The results showed a weighted aggregate effect size I of .23 or an estimated Cohen's d = .46 between congruence and positive client outcomes. The authors noted similar results across a variety of measures of congruence and research studies. Essentially, among four styles of outcome measures the aggregated ESs ranged from .16 to .33 or small to medium (Kolden et al., 2018).

Two BLRI line items that measure congruence are: (a) "[My counselor] is openly himself/herself in our relationship" and (b) "[My counselor] doesn't avoid or go around anything that is important for our relationship" (Barrett-Lennard, 2015, p. 102). Researchers consider congruence as present when clients subjectively perceive their counselors as open and genuine and counselors directly address relational issues in counseling. Given the preceding definition of congruence and BLRI item content, concrete counselor manifestations of congruence are likely to include: (a) self-disclosure, (b) spontaneity, (c) speaking openly and with immediacy about here-and-now interactions, and (d) statements that facilitate reciprocal client openness (Barrett-Lenard, 2015).

Unconditional Positive Regard: EBRF 2. Unconditional positive regard is the counselor's ability to create an environment of warmth and unconditional acceptance for the client (Rogers, 1957). Rogers further described UPR as "the extent that the therapist finds himself [sic] experiencing a warm acceptance of each aspect of the client's experience. . . it means there are no conditions of acceptance," (Rogers, 1961, p. 98). The operational definition of UPR for research purposes has taken on a variety of descriptions including non-possessive warmth, positive regard, acceptance, and many others (Farber & Doolin, 2011). Regardless of specific wording, the essence of UPR, as captured in Rogers' description, points to importance of the counselor having no conditions of acceptance. In this light, the client is a prized, separate person with permission to have independent feelings and experiences (Rogers, 1957).

Counselors and researchers from a variety of theoretical stances have come to recognize the power of UPR in facilitating client change (Farber & Doolin, 2011; Suzuki & Farber, 2016; Thishby & Wiseman, 2014). The essence of UPR is affirming the client's worth; in that the counselor can create a corrective emotional experience for the client by making direct statements of acceptance (Farber et al., 2018). Further, clients can begin to safely explore their insecurities and weaknesses when they feel accepted (Sommers-Flanagan & Sommers-Flanagan, 2018). Alternatively, when a counselor fails to demonstrate UPR a rupture in the therapeutic alliance is likely to occur (Farber et al., 2018).

UPR is especially pertinent when working with individuals who hold minority status or are from a different culture (Farber et al., 2018). For example, counselors who are members of the majority and are serving diverse clients may need to consider the influence of the power differential and how to best express UPR to individual clients (Farber et al., 2018). Consistent expression of UPR on behalf of the counselor will likely support the development of trust in the

therapeutic relationship (Farber et al., 2018; Sue & Sue, 2016). Like most EBRFs, UPR initiated by the therapist, confirmed in the experience of the client, often leads to psychological growth.

The meta-analytic review of UPR research conducted on behalf of the Third Interdivisional APA Task Force by Farber et al. (2018) included 64 studies that represented 3,527 participants. The meta-analysis examined the relationship between counselor UPR, and treatment outcomes based on reports by the client, therapist, third party observer or in some combination. The random effects model showed an aggregated effect size for Hedges' *g* was .28, indicating a small association with client outcomes. The analysis included 369 effect sizes from 136 measures of positive regard. The most common measure of UPR was the BLRI followed by the Truax rating scales (Farber et al., 2018).

Examples of counselor UPR according to the BLRI (Barrett-Lennard, 2015) are: (a) [My counselor] respects me as a person and, (b) [My counselor] feels a true liking for me. Counselor behaviors that demonstrate the condition of UPR might include: (a) allowing clients to talk about themselves and what is important to them, (b) responding to a client's emotional pain with empathy and absence of judgment, and (c) providing accurate summaries of what the client has stated previously (Sommers-Flanagan & Sommers-Flanagan, 2017).

Empathic understanding: EBRF 3. Empathic understanding is the counselor's ability to sense the client's private world as if it were their own, but without ever losing the "as if" quality (Rogers, 1957, p. 99). Rogers explained that empathy occurs when the counselor understands the client's world, has the ability to communicate understanding of what is known to the client, and can also "voice meanings in the client's experience of which the client is scarcely aware" (Rogers, 1957, p. 99). Although, a consensus definition of empathy has been difficult (Elliot, Bohart, Watson, & Murphy, 2018), the definition suggested by Clark (2007), "attunement with

the feelings and meanings of an individual's experience from an immediate or extended perspective" (p. 162) seems to capture what Rogers described.

In 1964, Rogers discussed the nature of experiencing empathy from three contexts: (a) subjective, (b) interpersonal, and (c) objective. Later, Clark (2010) expanded on the idea and proposed an integral model of empathic understanding by way of subjective empathy (awareness of self), interpersonal empathy (understanding of client's perspective), and objective empathy (theoretically informed conceptualization of the client). The model provides counselors with multiple modes for conceptualizing and selecting appropriate interventions both in-the-moment during session, and during treatment planning (Clark, 2010).

The subjective mode relates to the counselor's self-awareness of their reactions to clients' experiences as they imagine what a certain experience is like for the client (Clark, 2010; Elliot Bohart, Watson, & Greenberg, 2011). The counselor's visceral reactions act as a tool for gaining insight into the client's world (Clark, 2010). The counselor is then, better able to empathize with the client and use the objective mode to gain an extended perspective and select appropriate interventions (Clark, 2010).

The counselor's felt reactions allow for an exchange of interpersonal empathy as they use the interpersonal mode to respond to the client with "felt meaning" or reflection of feeling (Elliot et al., 2018, p. 400). Interpersonal empathy helps form the therapeutic relationship as the counselor affirms and validates the client's perspectives (Elliot et al., 2011). Objective empathy embodies never losing the "as if" quality in Rogers description (1957, p. 99). Meaning, the counselor maintains their own sense of what is occurring so that they are able to integrate their subjective experiences with objectively appropriate interventions (Clark, 2010). In summary, the

counselor focuses on understanding the client's perspective of their experience, attunes to the emotional quality, and responds with a sense of understanding (Clark, 2010; Elliot et al, 2018).

In 2011, Elliot et al. provided evidence for a biological perspective of empathy based on neurological research. Each process, when activated, can be detected in the limbic system and certain areas of the prefrontal cortex. Counselor empathy can be found in this array of three neurological processes: (a) emotional stimulation which mirrors the other's experience, (b) perspective taking which allows for conceptualization, and (c) emotional regulation which allows the counselor to self-sooth and express compassion (Elliot et al., 2011). The confirmatory evidence of empathy depicted in the biological model proposed by Elliot et al. (2011) provides a more concrete understanding of the dynamic nature of empathy captured in Rogers' (1957, 1964) descriptions and Clark's model (2010).

The meta-analytic review of therapist empathy research conducted on behalf of the Third Interdivisional APA Task Force by Elliot et al. (2018) included 80 studies and represented 6,138 clients. The review examined the association between therapist empathy and client outcomes. The study-level random effects results showed a weighted aggregate effect size (*r)* of .28 or an estimated Cohen's *d* = .58 or medium to large. Although the authors noted a "confusing welter of measures has been developed," client measures predicted outcome better than both observer and therapist rated measures (Elliot et al., 2018, p. 401). As with congruence and UPR the BLRI was more widely used than any other measure (Elliot et al., 2018).

Examples of counselor empathic understanding according to the BLRI (Barrett-Lennard, 2015) are: (a) [My counselor] usually senses or realizes what I am feeling and (b) [My counselor] realizes what I mean even when I have difficulty saying it. Counselor behaviors that depict empathy include: (a) expressions of understanding of the client's experience, (b) allowing

the client time for silence and reflection, (c) responding with accurate reflection of feeling and, (d) helping the client make meaning out of their emotional response to an experience (Clark, 2010; Elliot et al., 2011).

Culture and Cultural Humility: EBRF 4

The first multicultural competencies developed for counselors, psychotherapists, and social workers in training, practice, and research formed a tripartite model that included: (a) an understanding the influence one's own culture has on their attitudes, values and beliefs, (b) a developing knowledge of diverse cultural worldviews, and (c) the development and use of culturally appropriate counseling interventions (Hook et al., 2013). More recently, multicultural scholars have shifted toward a focus on cultural humility or openness to the other. Ideally, counselors will exemplify both intrapersonal humility (having an accurate view of self) and interpersonal humility by having an other-orientation instead of a self-orientation, respect for others and their values, and an attitude of non-superiority (Hook et al., 2013).

Counselors are compelled by ACA code of ethics to "recognize that culture affects the manner in which clients' problems are defined and experienced (ACA, 2014, Standard E.5.b). Further, the CACREP (2016) standards require that counselor educators and CITs develop a counselor identity that reflects an understanding of social and cultural diversity in providing mental health care. To accomplish this task, it is necessary for counselors to explore and understand the sociopolitical barriers many clients face as a result of having a diverse background (Day-Vines et al., 2007; Drinane, Owen, Adelson, & Rodolfa, 2016) and modify their ESTs to accommodate the cultural beliefs, attitudes, and behaviors of the client (Whaley, Davis, & Anderson, 2007).

Many scholars have asserted that the key competence for providing multiculturally competent care is the ability to make appropriate adaptations to interventions and treatments that reflect the individual client's cultural experiences and values (Soto, Smith, Griner, Rodríguez, & Bernal, 2018; Smith & Trimble, 2016; Whaley et al., 2007). Cultural treatment adaptations are specific adjustments that consider the language, context, and/or culture of the client so that care is aligned with their worldview (Soto et al., 2018; Whaley et al., 2007). For example, when working with a Latinx person, it would be important to consider the potential importance of maintaining strong familial connections, when developing treatment goals (Soto et al., 2018).

One effective way to ensure cultural adaptation is through broaching or introducing the subject of cultural diversity into the counseling process (Choi, Mallinckrodt, & Richardson, 2015; Day-Vines et al., 2007). Broaching ensures that sociopolitical issues are addressed rather than unacknowledged or left in isolating secrecy (Day-Vines et al., 2007). A counselor can engage in broaching issues of race by simply asking the client how race may be a factor in their experience of distress or within the counseling relationship (Day-Vines et al., 2007). Research has shown that clients favor counselors who actively broach the subject of race, especially when the counselor has a different ethnicity (Choi et al., 2015).

Culture and cultural humility were not addressed as a specific relationship factor in the APA Third Task Force Meta-analysis. Instead, "Diversity Considerations" were a required section in each of the meta-analyses (Norcross & Lambert, 2018, p. 305). In order to maintain consistency in this review the results of a meta-analyses conducted by Soto et al. (2018) are provided.

This meta-analytic review of multicultural competence included 15 studies and represented 2,640 clients (Soto et al., 2018). Most participants identified as either

Hispanic/Latinx American (32%) or African American (41%) with limited information from a variety of other ethnic groups. The results evaluated client participation with overall counselor cultural competence and showed an aggregated Pearson's correlation of $r = .26$ and Cohen's d of .50 or a medium effect size. The authors noted a high variability across studies was accounted for in delineating between client perceptions of counselor competence and therapist-reported cultural competence. In other words, clients saw their therapists as competent to a much greater degree than the therapists themselves (Soto et al., 2018). Further, research has indicted a positive correlation between client's perceptions of their counselor's cultural competence and their counseling outcome (Davis et al., 2016; Hook et al, 2013).

Examples of how counselors exhibit cultural humility according to the Cultural Humility Scale (CHS, Hook et al., 2013; Table A1) are: (a) [My counselor] is genuinely interested in learning more and (b) [My counselor] acts superior (reverse scored). Counselor behaviors that demonstrate cultural humility and adaptations include: (a) regularly assessing clients' racial and ethnic backgrounds and racially salient experiences (Day-Vines, 2007; Soto et al., 2018), (b) broaching issues of diversity by inviting the client to explore any sociopolitical factors that may be influencing their care (Day-Vines, 2007), and (c) addressing cultural issues with sensitivity and humility (Soto et al., 2018).

The Working alliance: EBRFs 5-7

Originally a psychoanalytic construct, the working alliance (WA) was later redefined by Bordin (1979) as a tripartite, pantheoretical therapeutic factor having three distinct parts: (a) a positive emotional bond, (b) goal consensus, and (c) task collaboration. Further, in the context of counseling, the working alliance is based on a collaboration between the counselor and the client (Horvath & Bedi, 2002; Horvath & Greenberg, 1989; Flückiger, Del Re, Wampold, & Horvath,

2018). Thus, the counselor and the client are interdependent, and the quality of their mutual reliance has a direct influence on the effectiveness of the therapy (Horvath & Greenberg, 1989).

Bordin (1979) did not see the WA as a theory or intervention, rather he believed the WA was pantheoretical and could support a variety of psychotherapeutic interventions. The emphasis on the tasks, bonds, and goals of the WA varies based on the type of psychotherapy employed (Bordin, 1979).

Measuring the working alliance. The most common measure of the working alliance is the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989; Table A1). The assessment has three versions that correspond with the perspective of the reporter (e.g. client, counselor, or a third-party observer or supervisor. The questionnaire includes 36 Likert-type questions: (a) 12 items pertain to counselor-client emotional bond, (b) 12 items pertain to goal consensus, and (c) 12 items pertain to task collaboration. The WAI meets the psychometric standards of reliability and validity (Horvath & Greenberg, 1989).

The meta-analytic review of the working alliance research conducted on behalf of the Third Interdivisional APA Task Force Third by Flückiger et al., (2018) included 295 studies and represented more than 30,000 participants. The results showed an overall association between alliance and outcome that had a $r = .28$ and an estimated ES of $d = .58$ or medium effect. The authors noted that the relationship was consistent across perspectives, measures, treatment approaches, patient contributions, and country (Flückiger et al., 2018).

Positive emotional bond: EBRF 5. Despite the elusive and recursive quality of the emotional bond, there have been multiple attempts to operationalize it qualitatively and quantitatively. The idea of the emotional bond includes the interrelated concepts of attachment, mutual trust, and confidence (Horvath & Greenberg, 1989). Bordin (1979) defined the emotional

bond between the counselor and client as a need for trust and attachment in order to accomplish therapeutic goals. The emotional bond may vary depending on the nature of the psychotherapy and/or therapeutic goals (e.g. client homework, counselor disclosure); as in the directive role or non-directive role of the counselor in behavioral therapy vs. psychoanalysis (Bordin, 1979).

Prototypical examples of the counselor/client emotional bond according to Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) are: (a) My relationship with [my counselor] was very important to me and (b) I felt that if I said or did the wrong things, [my counselor] would stop working with me (reverse scored). Counselor behaviors that demonstrate an emotional bond include both positive non-verbal cues (e.g. smiling, warm handshake) and verbal expressions (e.g. warm welcomes, affirming comments). Other ways to promote positive emotional bonds include in-session relaxation and mindfulness activities (Parrow et al., 2019).

Goal consensus: EBRF 6. Goal consensus is the product of an explicit discussion between the counselor and the client. It is a collaborative agreement with, and commitment to, treatment goals and the means of reaching them. Goal consensus ensures that the counselor and client both understand the reason for treatment (Bordin, 1979). An initial focus on goal consensus will support the development of a collaborative working alliance. Further, goal consensus should be addressed beginning with the informed consent and then regularly during treatment through termination (Parrow et al., 2019). In summary, this component of the alliance is collective willingness of client and counselor to engage in the work (Horvath, Del Re, Flückiger, & Symonds, 2011).

Examples of goal consensus between the counselor and client, according to the WAI (Horvath & Greenberg, 1989) are: (a) We were in agreement on what was important for me to work on and (b) [My counselor] and I collaborated on setting goals for my therapy. Counselor

behaviors that demonstrate the initiation of goal consensus include: (a) soliciting client concerns directly, and (b) checking in on the client's perception of how the counseling process is progressing (Parrow et al., 2019).

Task collaboration: EBRF 7. Task collaboration is defined as the agreed upon contract between client and counselor which identifies the tasks assigned to each (Bordin, 1979; Doran, 2014, Horvath et al., 2011). Specifically, task collaboration refers to engaging in a process that both the counselor and client believe are important and useful in helping the client meet their counseling goals (Parrow et al., 2019). If clients are disinterested in counseling tasks, then the tasks are less likely to prove effective for the client.

Examples of task collaboration according to the WAI (Horvath & Greenberg, 1989) are: (a) What I was doing in therapy gave me new ways of looking at my problem and (b) We were in agreement of what was important for me to work on. The counselor can ensure task collaboration by presenting the client with a variety of potential tasks then encouraging the client to choose which fits best and then debriefing with the client on their experience of the task (Parrow et al., 2019.

Rupture and Repair: EBRF 8

Safran and Muran (1996) defined ruptures as "deteriorations in the relationship between the therapist and patient" (p. 447). Ruptures can result from a disagreement between the client and counselor regarding treatment goals, little collaboration on tasks, and/or tension in the emotional bond (Eubanks, Muran & Safran, 2018). Some identified deteriorations initiated by counselor behaviors included counter-hostility toward the client, distancing (Safran & Muran, 1996), breaking confidentiality, acting disinterested, and misunderstanding client values (Bartholomew, Gundel, & Scheel, 2017). Thus, ruptures can be viewed in two contextual

subtypes: (a) withdrawal (where the client moves away from the counselor and the work of therapy) and (b) confrontation (where the client expresses dissatisfaction or anger toward the counselor or therapy) (Eubanks et al., 2018).

Repair strategies can be either direct (acknowledging the misstep) or indirect (where resolution occurs without an explicit acknowledgment) (Eubanks et al. 2018; Sommers-Flanagan & Sommers-Flanagan, 2017). The counselor has several effective options for initiating a repair in the alliance including: (a) repeating the reason for the interventions, (b) changing the goal or making a new goal, (c) exploring how the rupture might relate to the therapeutic relationship (Parrow et al., 2019; Sommers-Flanagan & Sommers-Flanagan, 2017).

Using repair strategies post relationship ruptures are key to reducing client dropout and increasing positive outcomes in counseling (Feinstein et al., 2015; Gülüm, Soygüt, & Safran, 2016; Safran, Muran, Eubanks-Carter, & Hilsenroth, 2011) as there is a positive correlation between the presence of rupture-repair processes and good outcomes (Safran et al., 2011). Should the counselor ignore ruptures in the therapeutic relationship the likelihood of the client dropping out of care increases (Gülüm et al., 2016; Safran et al., 2011).

The meta-analytic review of the alliance rupture and repair research conducted on behalf of the Third Interdivisional APA Task Force Third by Eubanks et al. (2018) included 11 studies with a collective total of 1,314 clients. Three classifications of rupture-repair were analyzed: (a) rupture-repair incidents (as indicated by self-report and third party observers) and client completion of therapy, (b) outcomes for clients with rupture-repair incidents vs. outcomes for clients without rupture-repair, and (c) outcomes of clients with repaired ruptures and those with unrepaired ruptures. The results showed a significant ($p = .003$) correlation between rupture-repair incidents and positive client outcomes ($r = .29$, $d = .62$) or a medium effect size. The

authors noted that the relationship was consistent across perspectives, measures, treatment approaches, patient contributions, and country (Flückiger et al., 2018).

Examples of rupture and repair strategies in the counseling relationship according to The Alliance Negotiation Scale (ANS, Doran, Safran, Waizmann, Bolger, & Muran, 2012; Table A1) are: (a) My therapist encourages me to express any anger I feel toward him/her and (b) My therapist and I are not good at finding a solution if we disagree (reverse scored).

Countertransference and countertransference management: EBRF 9

Countertransference occurs when counselors have reactions to clients based on unresolved conflicts, conscious or unconscious, and that are triggered before, during, or after counseling sessions. Over a century ago, Freud described countertransference as unresolved, unconscious feelings within the therapist that can diminish their objectivity which poses a threat to treatment and should be avoided (Friedman & Gelso, 2000; Hayes, Gelso, Hummel, & Hilsenroth, 2011; Tanzilli, Colli, Del Corno, & Lingiardi, 2016). Since Freud's time, the study of countertransference has come to include any conscious or unconscious reactions to clients (Friedman & Gelso, 2000, Tishby & Wiseman, 2014).

Currently, countertransference is conceptualized in three ways: classical, totalistic, or complementary (Hayes, Gelso, Goldberg, & Kivlighan, 2018). The classical definition reflects Freud's view that countertransference is the result of an unconscious reaction to the client's transference that interferes with treatment (Freidman & Gelso, 2000; Hayes et al., 2018). The totalistic view of countertransference considers all of the counselor's reactions to the client as important and worthy of consideration. In this light, countertransference is considered beneficial to treatment (Freidman & Gelso, 2000; Hayes et al., 2018). Finally, the complementary view of countertransference refers to the counselor's tendency to complement the client's style of

relating. In other words, the counselor will exhibit similar behaviors and feelings as the client (Hayes et al., 2018). Countertransference is seen as an inevitable, natural and does not automatically mean harm to the relationship as long as the counselor acknowledges the occurrence (Capuzzi, & Gross, 2017; Freidman & Gelso, 2000).

Most often countertransference is indicated by the counselor's withdrawal or avoidance of client's presentation of experience or information (e.g. diverting content, ignoring affect, changing topics; Hayes et al., 2018). Alternatively, approach-oriented countertransference can manifest as overinvolvement with a client's experience or meeting their own needs through the therapeutic relationship (Hayes et al. 2018). If the counselor has developed self-awareness, the experience of countertransference can provide insight into how the client may be inducing the same reactions in others (Capuzzi, & Gross, 2017).

Counselors can manage countertransference by recognizing that the experience of countertransference is normal and inevitable (Sommers-Flanagan & Sommers-Flanagan, 2017). However, when countertransference becomes difficult to manage the counselor may need to seek consultation, supervision (Capuzzi, & Gross, 2017; Parrow et al., 2019; Sommers-Flanagan & Sommers-Flanagan, 2017), their own counseling, or learning more about the client experience that is provoking a countertransference response (Sommers-Flanagan & Sommers-Flanagan, 2017).

The meta-analytic review of the countertransference management research conducted on behalf of the Third Interdivisional APA Task Force Third by Hayes et al. (2018) included 9 studies and represented more than 392 participants. This particular meta-analysis evaluated the correlation between counselor countertransference management and client outcome based on assessments completed by supervisors, third party observers, or the helper. Results showed an

overall association between countertransference and client outcomes that had a $r = .39$ and a large estimated effect size of $d = .84$. After making an adjustment for a notable publication bias by imputing three additional studies, the results remained significant.

Examples of the presence of countertransference according to the Therapist Response Questionnaire (TRQ, Tanzilli, et al., 2016; Table A1) are: (a) I feel pushed to set very firm limits with him/her and (b) I feel less successful helping him/her than other patients.

Progress Monitoring: EBRF 10

Progress monitoring (PM) or client feedback helps counselors become aware of problems in the relationship, the need to adjust treatment, or troubles with the goals of treatment (Lambert, Shimokawa, & Hilsenroth, 2011). Collecting client feedback can reduce poor outcomes as it allows for opportunities to make needed adjustments (Feinstein et al., 2015). By actively monitoring client progress, both client reports of wellness and measurable outcome factors tend to improve (Feinstein et al., 2015). It has been suggested that informal methods of progress monitoring are effective and that the spirit of the process is more important than adherence to the established assessment administration protocol (Miller et al., 2013). Notably, evidence also suggests clinicians perform better when receiving progress monitoring evaluations (Lambert et al., 2011; Miller et al., 2013).

The meta-analytic review of progress monitoring research conducted on behalf of the Third Interdivisional APA Task Force Third by Lambert, Whipple and Kleinstäuber (2018) included 24 studies and showed that routine outcome monitoring (ROM) was associated with better outcomes when compared to control groups receiving treatment from the same counselor. Effect sizes ranged from small to moderate (Lambert et al., 2018). Progress monitoring showed

to reduce dropout rate and nearly double client change rates when clients were predicted to have a poor counseling outcome (Lambert et al., 2018).

Examples of counselor progress monitoring included both verbal check-ins and formal assessments. The Session Rating Scale (SRS; Duncan et al., 2003; Table A1) assesses the quality of the bond and the degree of agreement between the counselor and client on: (a) goals, (b) methods, and (c) overall approach to therapy. Exemplars of verbal check-ins include "Are we focusing on what you want to focus on in our sessions?" or "Let's check back in on our goals today." (Parrow et al., 2019, p. 337).

Summary

Counselors, psychotherapists, and social workers from across the helping professions typically receive the same basic counseling skills training. Three common objectives of basic training courses are: (a) introduce and practice basic interpersonal counseling skills (b) develop CIT intrapersonal skills, and (c) support and increase CIT self-efficacy (Baker et al.,1990; Barnes, 2004; Buser, 2008; Goreczny et al., 2015; Ladany, 2007; Ridley et al, 2011; Schaefle et al., 2005; Sommers-Flanagan & Heck, 2012; Tolleson et al., 2017).

The current research study looked to extend counselor education curricula by providing a semi-manualized EBRFs training that included elements that are known to expand interpersonal and intrapersonal skills. It is not suggested that the EBRFs training preempt basic skills training. Rather, EBRFs training may further CIT development of a counselor identity in practicum. Specifically, the study included training beyond basic microskills training as suggested by Ridley et al. (2011), taught CIT participants therapeutic relationship skills as EBP (Lister & Moody, 2017; Sommers-Flanagan, 2015; Norcross & Lambert, 2018; Norcross & Wampold, 2011; Yates, 2013), measured the training program's efficacy using counseling outcomes data

(Buser, 2008, Hill & Lent, 2006; Ridley et al., 2011), and (d) attempted to identify which training elements improve CIT self-efficacy as CITs counsel their first clients as suggested by counseling scholars (Buser, 2008; Larson & Daniels, 1998; Lent et al., 2009). Further, the study met the CACREP (2016) standards and ACA (2014) ethics codes related to the teaching and the provision of EBP in counselor education and did so through teaching relationship skills, rather than technical procedures and strategies associated with the concepts and ESTs attached to various psychotherapy theories.

Research Hypotheses

The EBRFs training and research study was informed by the following hypotheses:

Hypothesis 1. Undergraduate student clients (USCs) whose CIT attends a semi-manualized EBRF training will rate their sessions statistically significant higher on the Session Rating Scale (SRS; Duncan et al., 2003) as compared with USCs whose CITs do not attend the manualized EBRF training.

$H1_0$: USCs whose CIT attends a semi-manualized EBRF training will not have statistically significant higher scores on the SRS (Duncan et al., 2003) as compared with USCs whose CITs do not attend the semi-manualized EBRFs training.

Hypothesis 2. USCs whose CIT attends a semi-manualized EBRF training will have statistically significant higher scores on the Outcome Rating Scale (ORS; Miller et al., 2002) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

$H2_0$: USCs whose CIT attends a semi-manualized EBRF training will not have statistically significant higher scores on the ORS (Miller et al., 2002) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

Hypothesis 3. USCs whose CIT attends a semi-manualized EBRF training will have statistically significant lower scores on the Outcome Questionnaire (OQ-45.2, Lambert et al., 1996) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

$H3_0$: USCs whose CIT attends a semi-manualized EBRF training will not have statistically significant lower scores on the OQ-45.2 (Lambert et al., 1996) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

Hypothesis 4. USC/CIT pairs whose CIT attends a semi-manualized EBRF training will have statistically significant higher combined scores on the BLRI-MO and BLRI-OS (Barrett-Lennard, 2015) as compared to USC/CIT pairs whose CIT did not attend the semi-manualized EBRF training.

$H4_0$: USC/CIT pairs whose CIT attends a semi-manualized EBRF training will not have statistically significant higher combined scores on the BLRI-MO and BLRI-OS (Barrett-Lennard, 2015) as compared to USC/CIT pairs whose CIT did not attend the semi-manualized EBRF training.

Hypothesis 5. H5: CITs who attend a semi-manualized EBRF training will have statistically significant higher scores on the Counselor Activity Self-Efficacy Scales (CASES, Lent et al., 2009) as compared to CITs who did not attend the semi-manualized EBRF training.

$H5_0$: CITs who attend a semi-manualized EBRF training will not have statistically significant higher scores on the CASES (Lent et al., 2009) as compared to CITs who did not attend the semi-manualized EBRF training.

Chapter Three

Research Methodology

The dissertation research study was a quasi-experimental, nonequivalent pretest-posttest design (Privitera, 2015). Further, the study used two non-probability samples: (a) CIT participants enrolled in a master's degree program and (b) their assigned USCs engaged in eight sessions of counseling. According to Privitera (2015), a quasi-experimental design may include a quasi-independent variable or a variable that prevents random assignment. The current study divided participants into two groups (treatment and control) based on the CITs pre-assigned practicum section, thus meeting the criteria for a quasi-independent variable and a quasi-experiment (Privitera, 2015).

Participants

The study included two non-probability convenience samples of participants enrolled at a university in the northwest United States. The first sample of participants were graduate student CITs enrolled in their first semester of practicum. The second sample of participants were USCs who selected eight individual counseling sessions as their experiential lab component in a course on intimate relationships.

The CIT participants were pursuing a master's degree in Clinical Mental Health Counseling or a master's degree in School Counseling from a CACREP accredited Counselor Education program. All CITs were enrolled in one of three sections of practicum classes led by a faculty member or doctoral candidate. The three CIT practicum sections were combined into two groups (treatment and control). The treatment group was comprised of one section of mental health CITs and one section of school CITs. The control group was comprised one section of mental health CITs.

As a part of the requirements of the master's degree and the practicum course the CITs attended a weekly 2-hour supervision and educational class, attend a weekly triadic supervision meeting, and completed 100 hours of clinical work. At least 40 hours of clinical work was in direct client contact. In order to meet the direct hours requirement, clinical mental health CITs provided eight counseling sessions to five USCs and school CITs provided eight counseling sessions to three USCs. It should be noted that school CITs received the balance of their direct client hours in a school-based practicum placement, within the community.

The USC participants were matched with their respective CIT based on scheduling availability. The USC sample participants automatically followed their assigned CIT sample participant into either a treatment or control group. Thus, creating two layers of sample participants, (CITs and USCs) and four groups: (a) CIT treatment, (b) CIT control, (c) USC treatment and, (d) USC control.

The number of participants in the CIT sample was 18 and number of participants in the USC sample was 49. All participants were 18 years of age or older and were given an informed consent form that provided information about the study. Participants who agreed to participate confirmed their consent by their signature of agreement and were reminded of their right to withdraw from the study without penalty.

Independent Variable

The independent variable was a 4-hour, semi-manualized EBRFs training derived from seminal literature (Norcross & Wampold, 2011; Norcross & Lambert, 2018); textbooks (Ivey et al., 2018; Sommers-Flanagan & Sommers-Flanagan, 2018), digital media (Sommers-Flanagan, 2016), and open access on-line media content.

The program began with a brief historical summary of common factors, the therapeutic relationship, and evidence-based practice. Then, ten of the relationship factors identified in Norcross and Lambert (2018) were explored: (a) congruence, (b), unconditional positive regard, (c) empathic understanding, (d) culture and cultural humility, (e) working alliance: emotional bond, (f) working alliance: goal consensus, (g) working alliance: task collaboration, (h) rupture and repair, (i) countertransference, and (j) progress monitoring.

The educational format for the semi-manualized training followed the suggestions and evidence for using a distinct skills method for teaching CITs adapted in *"Microcounseling"* (Ivey et al., 2018). Thus, the exploration of each EBRF included: (a) a generally accepted definition, (b) prototypical examples of the EBRF as measured by psychometrically accepted research instruments, (c) one or more in vivo experiences of the EBRF (see Appendix A; Table A2), and (d) a psychometric assessment used to measure the EBRF (Table A1). The PowerPoint Presentation of the semi-manualized training can be found in Appendix B.

Instrumentation

Counselor Activity Self-Efficacy Scale (CASES). The CASES is a self-report survey that assesses a counselor's self-efficacy to conduct a variety of counseling tasks with most clients, over the next week (Lent et al., 2003). The questionnaire is divided into three sections with six subscales. The sections and associated subscales are: (a) Part I- Exploration Skills (Exploration Skills, Insight Skills, Action Skills), (b) Pa–t II - Session Management Skills (Session Management), and (c) Par– III - Negotiating Client Distress (Client Distress, Relationship Conflict).

The survey has 41 Likert-type questions utilizing a 10-point scale where 0 is (no confidence at all) and 9 is (complete confidence). Thus, the subscales, the associated number of

questions, and score rages are: (a) Exploration Skills (five, 0 to 45) (b) Insight Skills (six, 0 to 54) (c) Action skills (four, 0 to 36) (d) Session Management (ten, 0 to 90) (e) Client Distress (five, 0 to 54), and (f) Relationship Conflict (eleven, 0 to 99). The total CASES score can range from 0 to 369 with higher scores reflecting greater confidence. The CASES survey is in Appendix D.

The estimated internal reliability for each section of CASES ranged from *a* =.79 (Exploration Skills) to *a* = .94 (Session Management and Client Distress) (Lent et al., 2003). The total score reached a reliability alpha coefficient of *a* = .97 for measuring overall counseling self-efficacy (Lent et al., 2003). The CASES questionnaire meets convergent, discriminant, and criterion-related validity when compared to similar self-efficacy questionnaires (Lent et al., 2003). Permission to use the CASES in this research was given by the author (R.W. Lent, personal communication, August 26, 2018).

Barrett-Lennard Relationship Inventory OS-40, MO-40 (BLRI). The BLRI is a 64-item assessment created to evaluate the therapeutic relationship according to Rogers' (1957) core conditions of empathy, positive regard, congruence, and unconditionality of regard (Barrett-Lennard, 2015). Later, Barrett-Lennard (2015) produced the BLRI OS-40 (other toward self) and MO-40 (myself toward other), shorter forms of the original 64-item BLRI. The OS-40 and MO-40 are worded differently to reflect different perspectives (Barrett-Lennard, 2015). For example, question number one, "_____ respects me" in the OS-40 is worded as "I respect _____ as a person" in the BLRI MO-40 (Barrett-Lennard, 2015). In this study, the CITs completed the BLRI MO-40 and the USCs completed the BLRI SO-40. The BLRI MO-40 and OS- 40 surveys are in Appendix D.

Both versions of the 40-item BLRI are constructed of 10 questions for each of the subscales: (a) Level of Regard, (b) Empathy, (c) Unconditionality, and (c) Congruence. Respondents are asked to rate statements based on a 6-point Likert-type scale with answers ranging from -3 to +3 with the choices, -3 (No, I strongly feel that it is not true), -2 (No, I feel it is not true), -1 (No, I feel that it is probably untrue, or more untrue than true), +1 (Yes, I feel that it is probably true, or more true than untrue), +2 (Yes, I feel it is true), and +3 (Yes, I strongly feel that it is true). Twenty of the 40 questions are reverse scored and the possible range of scores for each subscale is -30 to +30. Higher scores indicate more positive perceptions of the subscale within the therapeutic relationship (Barrett-Lennard, 2015).

The shorter forms of BLRI have consistent reliability and validity with the longer 64-item version (Barrett-Lennard, 2015). A review of the original 64-item BLRI indicated a test retest reliability of a = .90 for all scores, alpha coefficients for the subscale scores were a = .84 for empathetic understanding, a = .91 for level of regard, a = .74 for unconditionality, and a = .85 for congruence. (Gurman, 1977). For comparison, the reliability and validity coefficients for the subscales of the 40-item BLRI were reported as a = .91 for empathetic understanding, a = .87 for level of regard, a = .82 for unconditionality, and a = .88 for congruence (Barrett-Lennard, 2015). In addition to Gurman (1977) other research has established internal consistency and the predictive validity of the BLRI (Barrett-Lennard, 2015).

The Outcome Rating Scale (ORS). The ORS is a brief outcome measure developed as an alternative to more complex outcome assessments (Miller et al., 2003). Some items were adapted from the OQ-45.2 including individual, relational, and social assessments of client functioning (Miller et al., 2003). The ORS is a 4-item measure of client well-being and progress in therapy, and when aggregated can show evidence for counselor effectiveness (Miller et al.,

2003). At the beginning of each session the client is asked to place a mark along a 10 cm analog scale indicating how well they have been doing in the following areas over the last week: (a) Overall (general sense of well-being) (b) Individually (personal well-being), (c) Interpersonally (family and close relationships), and (d) Socially, (work, school, friendships) (Miller et al., 2003).

The ORS is scored by summing the distances of the marks from zero (Seidel, Andrews, Owen, Miller, & Buccino, 2017). Thus, the range of scores is from 0.0 – 40.0 cm (higher scores indicating better global functioning) with a clinical level of poor functioning cutoff score of 25 or lower (Seidel et al., 2017). It takes less than a minute to administer and score the ORS, which has resulted in higher use among therapists than other assessments (Miller et al., 2013).

The ORS has shown a coefficient of $a = .93$ for internal consistency reliability after four administrations and a $r = .66$ for test retest reliability (Miller et al., 2003). The concurrent validity of $r = .59$ was determined by comparing to The Outcome Questionnaire (OQ-45.2) (Miller et al., 2003). The ORS is in Appendix D.

The Session Rating Scale (SRS). The SRS is a brief 4-item assessment given to clients to track their experience of the therapeutic alliance (Duncan et al., 2003). As in the ORS, the client is asked to place a mark along a 10 cm analog scale and is scored by measuring and summing the distance of the marks from zero. The items on the SRS indicate the client's rating of "today's" session in the following areas: (a) Relationship, (b) Goals and topics, (c) Approach or method, and (d) Overall Experience (Duncan et al., 2003).

The range of scores for the SRS is 0.0 to 40.0 with higher scores meaning a greater endorsement of the presence of a working alliance (Duncan et al., 2003). Scores which fall below

36 overall or lower than 9 on any scale should warrant further inquiry and discussion with the client (Duncan, et al. 2003).

The SRS demonstrated an a = .88 for internal consistency and a test re-test reliability of r = .64. The SRS showed a r =.48 concurrent validity when compared to the to the Helping Alliance Questionnaire II (HAQ-II) and a r = .63 when compared to the Working Alliance Inventory- Short Forms (WAI-S) $r = .63$ (Duncan et al., 2003). The SRS is in Appendix D.

The Outcome Questionnaire (OQ-45.2). The OQ-45.2 is a 45-item self-report questionnaire that assesses three areas of a client's life over the past week (Lambert et al., 1996). The three subscales are meant to assess different areas of functioning and include symptom distress, interpersonal relationships, and social role functioning (Lambert et al., 1996). Over time, the OQ-45.2 will detect changes in mental health over the course of treatment (Vermeersch et al., 2004).

The survey has 45 items that are rated on a 5-point Likert-type scale ranging from 0 (never) to 4 (almost always) with lower scores indicating less distress. The subscale *Symptom Distress* score has a range from 0 to 100, the subscale *Interpersonal Relations* score has a range from 0 to 44; the subscale *Social Role* score has a range from 0 to 36 leading to a total score range from 0 to 180. Nine of the items are reverse scored and higher final scores indicate greater distress (Lambert et al., 1996).

The OQ-45.2 can be used to measure therapeutic outcomes in clinical contexts based on four-levels (Kadera, Lambert, & Andrews, 1996). The four levels are: (a) recovered, (b) improved, (c) deteriorated, and (d) no change. Clients are considered "recovered" when their OQ-45.2 scores have moved from the clinical (a cutoff score of 63) to non-clinical status and decreased by 14 points or more. Clients who are identified as "improved" have a decrease in

their OQ-45.2 scores by 14 points or more although their scores remain in the clinical range. Those who are considered to have a "deteriorated" outcome have an increase in their OQ-45.2 scores by 14 points or more. Lastly, clients who are considered has experiencing "no change" have an either an increase or decrease in their OQ-45.2 scores of less than 14 points (Kadera et al., 1996; Lambert et al., 1996).

The reported test retest reliability of the OQ-45.2 is $r = .84$ and internal consistency reliability of $a = .93$ (Vermeersch et al., 2004). The OQ-45.2 shows strong concurrent validity with other self-report scales like the Beck Depression Inventory and the State-Trait Anxiety Inventory (Vermeersch et al., 2004). Further, a moderate to high validity estimate was found between criterion and OQ-45.2 total score (Lambert et al, 1996). The OQ-45.2 is in Appedix D.

Demographics questionnaire. The USC participants were asked to complete a demographics questionnaire at the beginning of their first session. The questionnaire included both options to circle and blank spaces for optional descriptors. Specific items included: (a) age, (b) year in college, (c) major, (d) relationship status, and (e) race/cultural background.

Procedures

The researcher attended the CIT practicum orientation meeting for the following purposes: (a) distributed and collected signed informed consent from CIT participants (see Appendix C), (b) administered the pretest CASES survey, (c) explained and distributed the USC informed consent forms (see Appendix C) and code number process, (d) explained and distributed the USC research surveys, (e) provided timelines for survey completion and processes for submitting completed surveys. In order to preserve anonymity all CITs were given a code number based on the pre-numbered informed consent forms (e.g. C1, C2, C3, etc.). Their corresponding USCs were given a matched code number (e.g. IR1, IR2, IR3, etc.).

Three CIT class sections were combined into two groups (treatment and control). The treatment group was selected based on their practicum instructors' willingness to participate. The treatment group received a 4-hour EBRFs training from the researcher during the first two, 2-hour class periods of the semester. The control group received treatment as usual. Meaning, their coursework began as was typical for their practicum course instructor. Additionally, beyond the EBRFs training, the practicum course content, instruction, and supervision remained as was typical for the individual practicum instructors for both CIT groups.

The CIT and USCs were matched based on scheduling availability. This a normal process conducted each semester in the Counselor Education Counseling Laboratory. Undergraduate student clients followed their respective CITs into either the treatment or control group. Thus, there were four participant groups: (a) CIT treatment, (b) CIT control, (c) USC treatment, and (d) USC control.

The CITs provided each USC with an informed consent form for the study at the beginning of their counseling sessions. This informed consent was in addition to the informed consent that is given to USCs every semester. The CITs were directed to affirm with the USCs that there were no anticipated risks or benefits associated with completing the surveys, participants could skip questions, and participants could leave the study at any time or not participate in the study, without penalty. Once consent was given, the CITs were directed to administer the OQ-45.2 and the ORS. At the end of session 1 the CIT asked the USCs complete the SRS. Data collection for the study continued at several intervals during the 15-week study. Following is the survey schedule for all participants which was posted in the counseling lab:

Counselors-in-training:

Will complete CASES prior to training and after session 8

Will complete BLRI MO-40 after sessions 4 and 8

Undergraduate student clients:

Will complete the SRS/ORS at sessions 1,3,5, and 7

Will complete BLRI OS-40 after sessions 4 and 8

Will complete the OQ-45.2 prior to session 1 and after session 8

At the completion of all sessions the researcher provided the 4-hour EBRFs training to the CIT control group. This training occurred during the last meeting of the semester.

Summary

The selected measures (CASES, Lent et al., 2003; BLRI OS-40, BLRI MO-40, Barrett-Lennard, 2015; ORS, Miller et al., 2003; SRS, Duncan et al., 2003; OQ-45.2, Lambert et al., 1996) were chosen to test each hypothesis. The use of multiple perspective surveys (BLRI & CASES) and outcome surveys (ORS; OQ-45.2) were expected to provide a more holistic evaluation of the efficacy of the EBRFs training. The descriptive data was collected to further inform the influence of differences, if any between the treatment and control group.

Chapter Four

Results

This chapter presents information about the USC research participants, findings for the five research hypotheses, and post hoc data analysis. Data for hypotheses one and two were analyzed using a repeated measures ANOVA. The data for hypothesis three, four, and five were analyzed using independent samples *t*-tests. Post hoc analysis included estimated marginal means and paired sample *t*-tests to illustrate CIT and USC changes over time. All data analyses were computed using either SPSS or Microsoft Excel software. Lastly, an alpha level of .05 was used to determine the significance for all statistical tests.

Demographical Information of the Study Participants

There were 18 CIT and 42 USC participants in the study. USC participant ages ranged from 18 to 40 years old. The largest number of USC participants (30) were between 18 and 22 years old; six were ages 23 to 27; zero participants were between 28 and 32 years old; two USC participants were older the 33 years old; four participants did not report their age.

The majority of USC participants identified as Caucasian (25), two identified as Hispanic, two participants identified as African American, two participants identified as Caucasian/Native American, two participants identified as African American/Caucasian, one participant identified as Japanese, one participant identified as European, one participant identified as Inuit, six participants did not report a racial identity.

The majority of the USCs reported their relationship status as single (21), 16 reported they were in a significant relationship, one reported they were married, and four participants did not report their relationship status. Notably, the USC participants entered the study as a part of a course in intimate relationships, and thus are considered a non-clinical sample. Demographic information was not collected from CIT participants.

Hypothesis One

H1: Undergraduate student clients (USCs) whose CIT attends a semi-manualized EBRF training will rate their sessions statistically significant higher on the Session Rating Scale (SRS; Duncan et al., 2003) as compared with USCs whose CITs do not attend the manualized EBRF training.

A repeated measures ANOVA was conducted to compare the total SRS mean scores of the USC treatment and control groups at four intervals. No significant differences were found among the mean scores at each interval based on group, Wilks' Lambda = .83, F (3, 37) = 2.57, p = .07 (one-tailed), multivariate partial eta squared = .172. Table 3 displays the mean, standard deviation, and sample sizes of the treatment, control group, and combined total scores at each interval.

Table 3

Descriptive Statistics for USC Session Rating Scale Scores at each Interval

Interval	Group	Mean	SD	n
Session 1	Treatment	37.01	2.59	28
	Control	33.37	4.49	13
	Total	35.86	3.68	41
Session 3	Treatment	37.22	2.76	28
	Control	36.15	5.13	13
	Total	36.87	3.64	41
Session 5	Treatment	37.65	2.66	28
	Control	36.15	4.15	13
	Total	36.88	3.19	41
Session 7	Treatment	38.01	2.44	28
	Control	37.41	3.62	13
	Total	37.81	2.83	41

Hypothesis Two

H2: USCs whose CIT attends a semi-manualized EBRF training will have statistically significant higher scores on the Outcome Rating Scale (ORS; Miller et al., 2002) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

A repeated measures ANOVA was conducted to compare the total ORS mean scores of the USC treatment and control groups at four intervals. No significant differences were found among the mean scores at each interval based on group, Wilks' Lambda = .85, F (3, 37) = 2.67, p = 1.0 (one-tailed), multivariate partial eta squared = .155. Table 4 displays the mean, standard

deviation, and sample sizes of the treatment, control group, and combined total scores at each interval.

Table 4

Descriptive Statistics for USC Outcome Rating Scale Scores at each Interval

Interval	Group	Mean	SD	n
Session 1	Treatment	28.50	5.83	28
	Control	29.11	4.64	13
	Total	28.70	5.43	41
Session 3	Treatment	31.36	5.34	28
	Control	28.22	5.74	13
	Total	30.37	5.60	41
Session 5	Treatment	32.06	7.44	28
	Control	31.72	4.96	13
	Total	31.95	6.69	41
Session 7	Treatment	33.65	5.63	28
	Control	31.86	6.41	13
	Total	33.09	5.87	41

Hypothesis Three

H3: USCs whose CIT attends a semi-manualized EBRF training will have statistically significant lower scores on the Outcome Questionnaire (OQ-45.2, Lambert et al., 1996) as compared with USCs whose CITs do not attend the semi-manualized EBRF training.

Independent samples *t*-tests, based on treatment or control group, were conducted on the USCs change scores between the preliminary data collected prior to the first session and after the eighth session for each sub-scale and total scores on the OQ-45.2. No significant differences were found in the change scores between groups. Specifically, for the subscale *Symptom Distress* there was not a significant difference in the scores between the treatment (M = -4.66, SD = 10.31) and control (M = -3.2, SD = 8.77) groups; t (33) = -0.49, p = .31 (one-tailed). For the subscale *Interpersonal Relationships*, there was not a significant difference in the scores between the treatment (M = -0.89, SD = 5.21) and control (M = 0.07, SD = 4.57) groups; t (32) = -0.63, p = .27 (one-tailed). For the subscale *Social Role*, there was not a significant difference in the scores between the treatment (M = -0.10, SD = 3.80) and control (M = -0.27, SD = 4.52) groups; t (24) = 0.12, p = .45 (one-tailed). Lastly, there was not a significant difference in the total OQ.45.2 change scores between the treatment (M = -5.66, SD = 16.41) and control (M = -3.4, SD = 15.60) groups; t (30) = -0.45, p = .33 (one-tailed).

Hypothesis Four

H4: USC/CIT pairs whose CIT attends a semi-manualized EBRF training will have statistically significant higher combined scores on the BLRI-MO and BLRI-OS (Barrett-Lennard, 2015) as compared to USC/CIT pairs whose CIT did not attend the semi-manualized EBRF training.

Independent samples *t*-tests were conducted on the combined BLRI-MO and BLRI-OS scores of treatment and control group pairs, for each *subscale* and *total*, after sessions four and eight. The results after session four, for the subscale *Level of Regard*, showed no significant differences between the treatment (M = 42.46, SD = 9.97) and control group (M = 43.92, SD = 9.28) pairs; t (26) = -0.45, p = .33 (one-tailed). The results after session four, for the subscale

Empathy, showed no significant differences between the treatment (M = 39.83, SD = 9.87) and control group (M = 34.53, SD = 14.28) pairs; t (18) = 1.20, p = .12 (one-tailed). The results after session four, for the subscale *Unconditionality,* showed a significant difference between the treatment group (M = 31.08, SD = 11.17) and control group (M = 39.85, SD = 8.71) pairs; t (30) = -2.64, p = .0007 (one-tailed); inverse of the hypothesis. The results after session four for the subscale *Congruence* showed a significant difference between the treatment (M = 35.21, SD = 11.27) and control group (M = 27.07, SD = 13.88) pairs; t (21) = 1.81, p = .04 (one-tailed). The results for the *Total* BLRI combined scores after session four showed no significant differences on the total BLRI combined scores between the treatment (M = 148.58, SD = 35.58) and control group (M = 145.39, SD = 36.07) pairs; t (24) = 0.26, p = .40 (one-tailed).

The results after session eight, for the subscale *Level of Regard*, showed no significant differences between the treatment (M = 44.33, SD = 7.70) and control group (M = 45.70, SD = 10.51) pairs; t (26) = -0.41, p = .34 (one-tailed). The results after session eight, for the subscale *Empathy*, showed a significant difference between the treatment (M = 45.67, SD = 8.79) and control group (M = 39.31, SD = 11.65) pairs; t (20) = 1.72, p = .05 (one-tailed). The results after session eight, for the subscale *Unconditionality*, showed no significant differences between the treatment (M = 36.42, SD = 10.70) and control group (M = 42.62, SD = 11.77) pairs; t (23) = -1.58, p = .06 (one-tailed). The results after session eight, for the subscale *Congruence*, showed no significant differences between the treatment (M = 37.54, SD = 12.60) and control group (M = 33.70, SD = 12.15) pairs; t (25) = 0.91, p = .19 (one-tailed). Finally, the results for the *Total* BLRI combined scores after session eight, showed no significant differences between the treatment (M = 163.96, SD = 32.73) and control group (M = 161.31, SD = 38.75) pairs; t (21) = 0.21, p = .42 (one-tailed).

Hypothesis Five

H5: CITs who attend a semi-manualized EBRF training will have statistically significant higher scores on the Counselor Activity Self-Efficacy Scales (CASES, Lent et al., 2003) as compared to CITs who did not attend the semi-manualized EBRF training.

Hypothesis five was tested using results from CASES data collected prior to the EBRFs treatment group training and data collected approximately fifteen weeks after the eighth counseling session. Independent samples *t*-tests were conducted on the change scores for each CASES *subscale* and *total* score based on treatment or control group, between the two data collection periods. No significant differences were found in the change scores for the subscale *Exploration* between the treatment (M = 4.81, SD = 5.98) and control group (M = 4.16, SD = 6.55); t (9) = 0.20, p = .42 (one-tailed). For the subscale *Insight*, no significant differences were found in the change scores between the treatment (M = 8.19, SD = 8.09) and control group (M = 4.33, SD = 11.5); t (7) = 0.74, p = .24 (one-tailed). No significant differences were found in the change scores for the subscale *Session Management* between the treatment (M = 14.85, SD = 13.32) and control group (M = 6.67, SD = 14.43); t (9) = 1.18, p = .13 (one-tailed). For the subscale *Client Distress* no significant differences were found in the change scores between the treatment (M = 14.23, SD = 13.72) and control group (M = 10, SD = 9.51); t (14) = 0.78, p = .22 (one-tailed). No significant differences were found in the change scores for the subscale *Relationship Conflict* between the treatment (M = 16.23, SD = 16.35) and control group (M = 13.92, SD = 18.25); t (9) = 0.27, p = .40 (one-tailed). The *Total* CASES change scores showed no significant difference between the treatment (M = 68.62, SD = 56.88) and control group (M = 44.08, SD = 57.12); t (10) = .87, p = .20 (one-tailed). Notably, the only significant difference for

hypothesis five was found in the subscale *Action*, for change scores between the treatment (M = 10.30, SD = 9.08) and control group (M = 5.0, SD = 2.76); t (16) = 1.92, p = .04 (one-tailed).

Post Hoc Data Analysis

Post hoc analyses were conducted on data from the following measures: (a) SRS (Duncan et al., 2003) (b) ORS (Miller et al., 2003), (c) CASES (Lent et al., 2003), and d) OQ-45.2 (Lambert et al., 1996).

SRS (Duncan et al., 2003). In order to further explore the USCs' perception of the therapeutic alliance, estimated marginal means analyses of the treatment and control group scores were conducted on each subscale and total SRS scores at each interval. Figures 1, 2, 3, 4, and 5 provide illustrations of the directional patterns for each of the USC treatment and USC control group subscale and total scores on the SRS at sessions one, three, five, and seven. The subscale scores range from 0 to 10 with higher scores indicating a greater endorsement of the presence of a working alliance. Subsequently, the total score range is from 0 to 40.

Figure 1

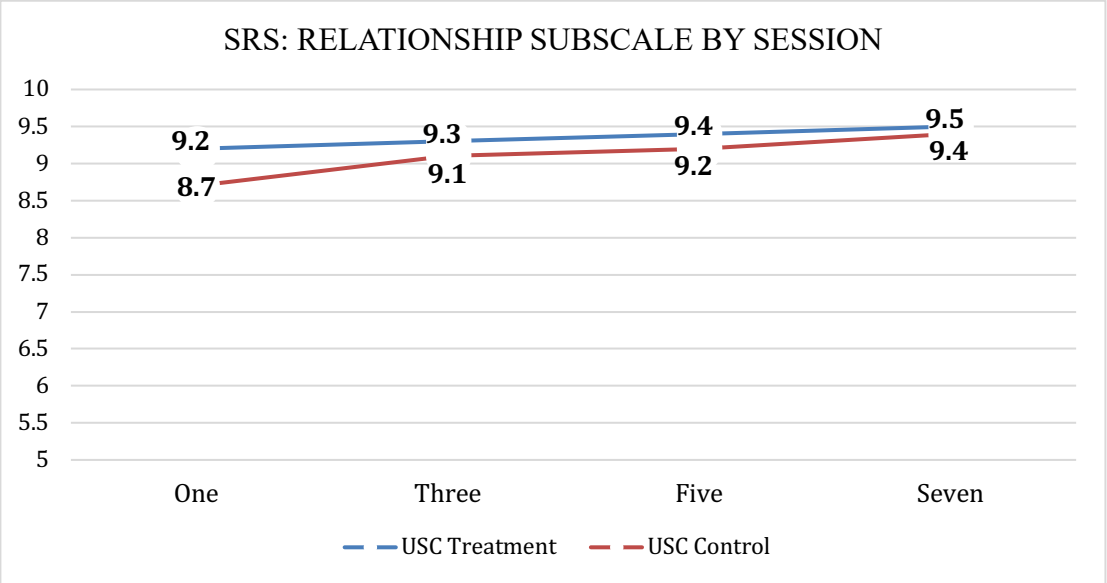


Figure 2

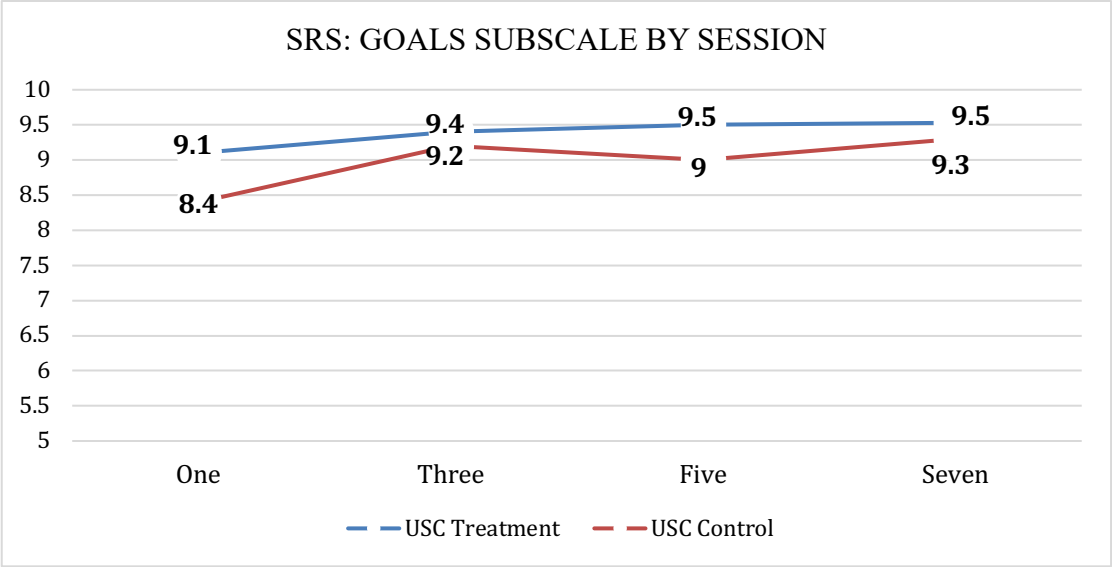


Figure 3

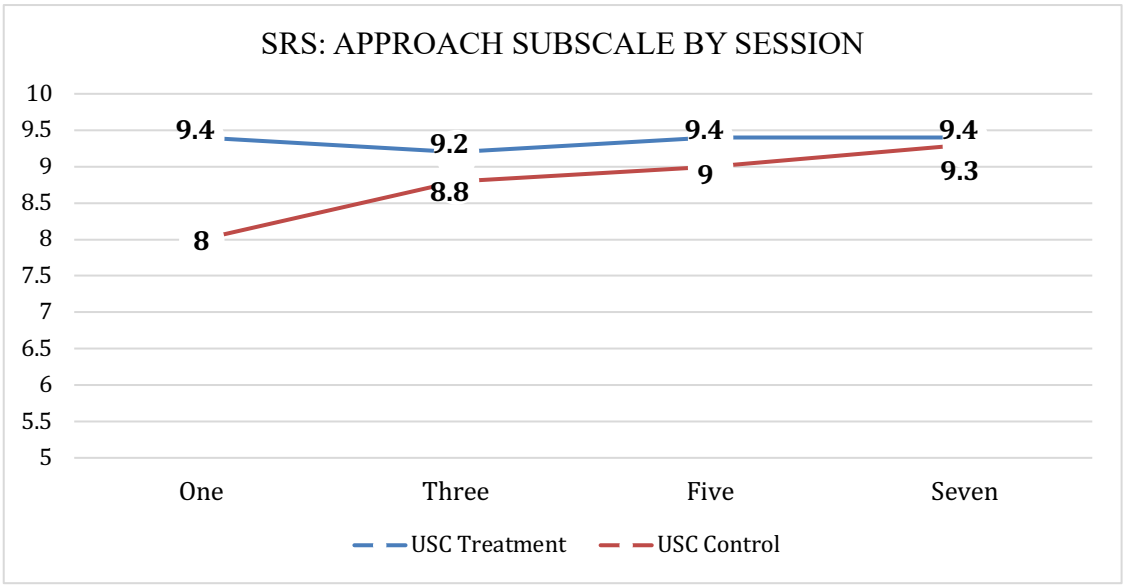


Figure 4

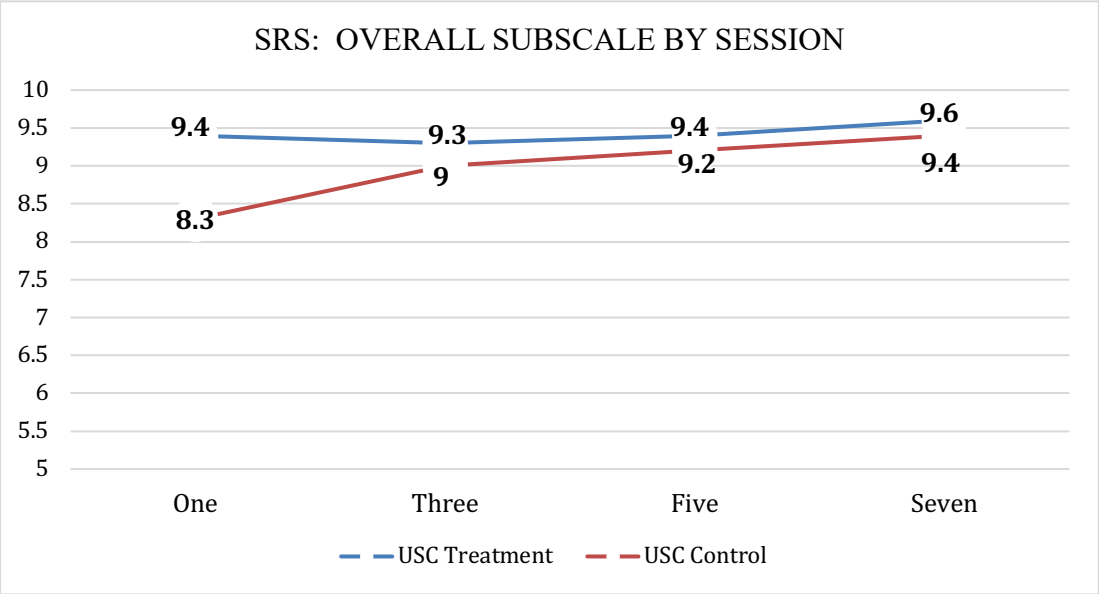
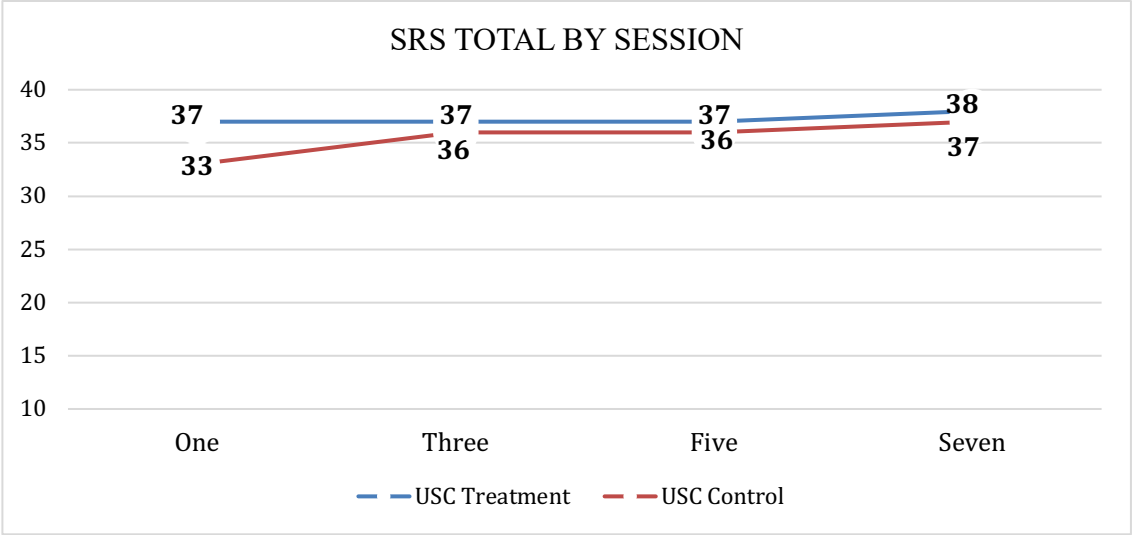


Figure 5



ORS (Miller et al., 2002). In order to further explore the USCs' perception of their well-being and progress in counseling, estimated marginal means analyses of the treatment and control group scores were conducted on each subscale and total ORS scores at each interval. Figures 6, 7, 8, 9, and 10 provide an illustration of the directional patterns of the USC treatment

and USC control group subscale and total scores on the ORS at sessions one, three, five, and seven. The subscale scores range from 0 to 10 with higher scores indicating a greater endorsement of the presence of a working alliance. Subsequently, the total score range is from 0 to 40.

Figure 6

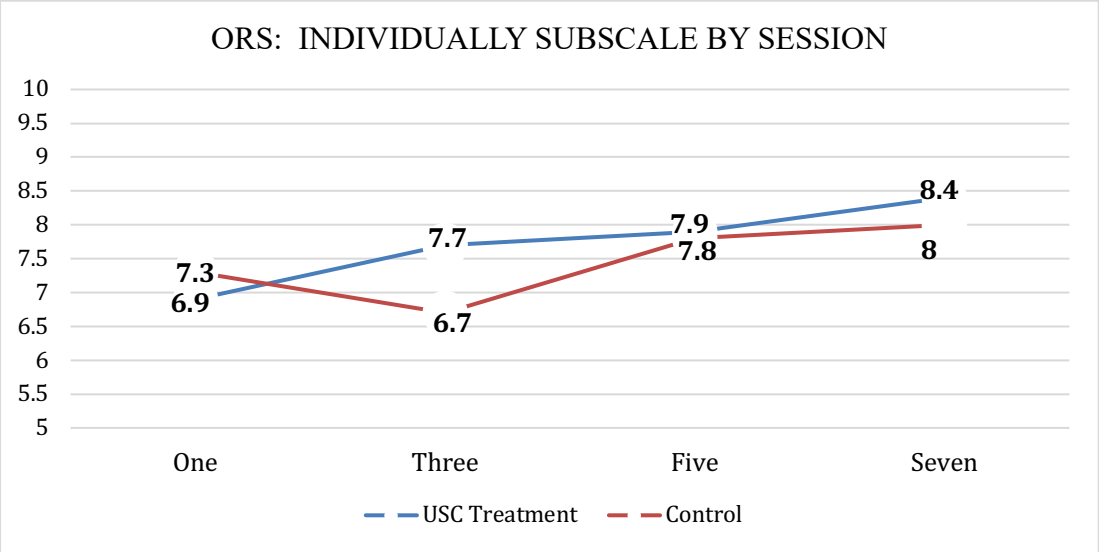


Figure 7

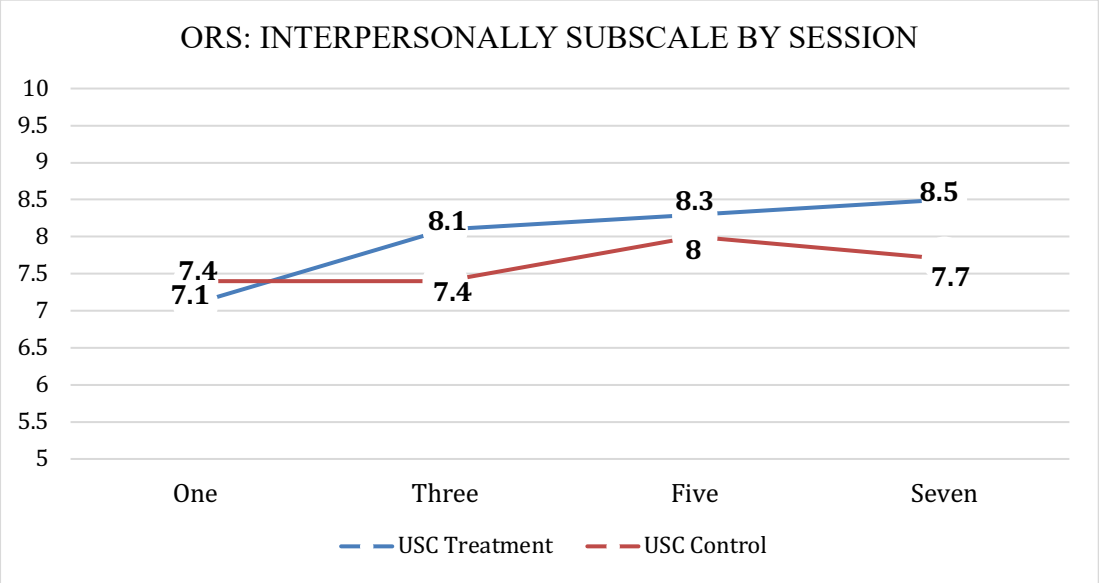


Figure 8

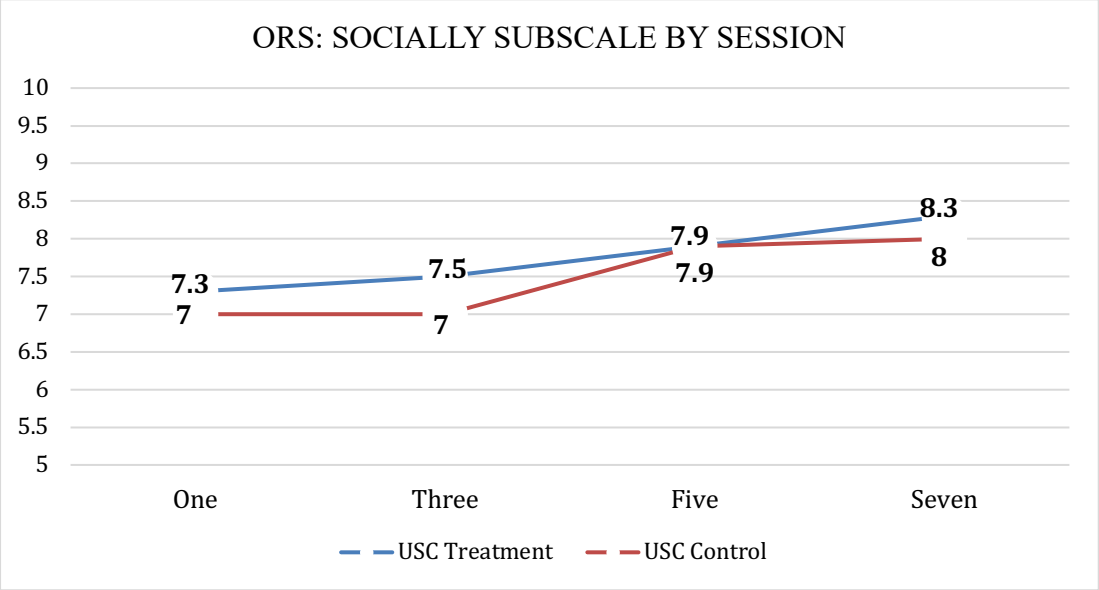


Figure 9

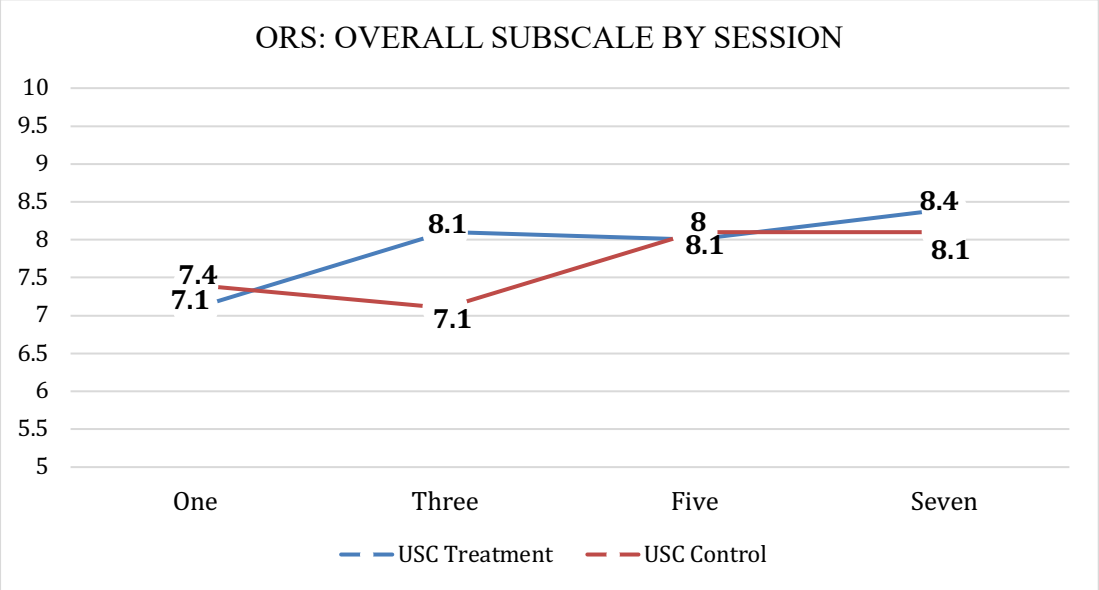
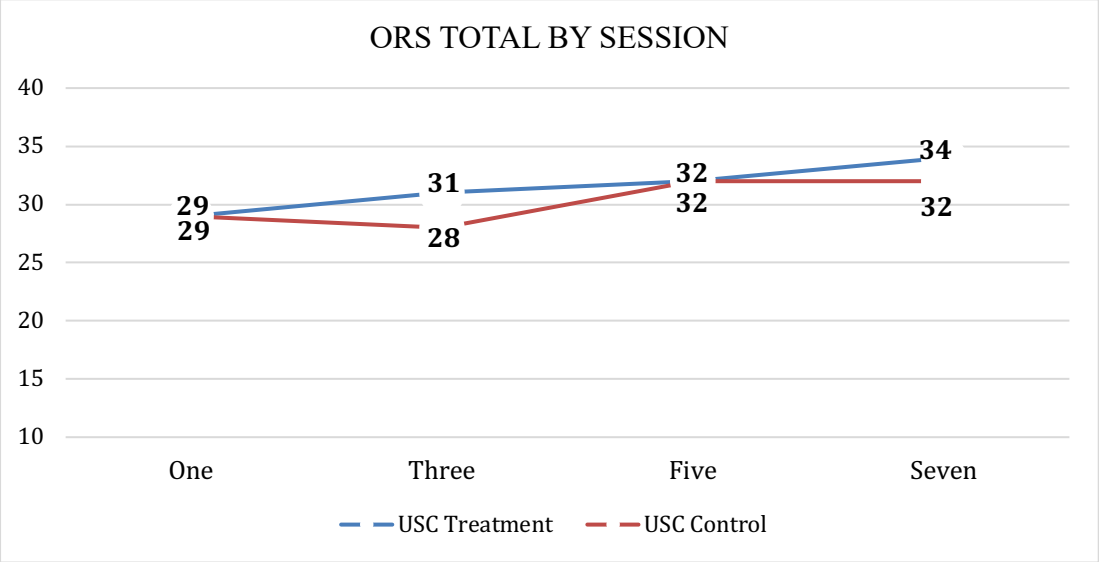


Figure 10



CASES (Lent et al., 2003). In order to further explore the CITs' experience of self-efficacy paired samples *t*-tests were conducted on the pre-post CASES data for each subscale and total scores collected from both the CIT treatment and CIT control groups. This separate analysis of within group scores revealed a notable pattern among the CIT treatment group and CIT control group. That is, the CIT treatment group pre-post paired sample (within group) *t*-test results were consistently statistically significant ($p \geq .001$, one-tailed) for each sub-section and total CASES score (Table 5). In comparison, the paired sample (within group) *t*-test results for each sub-section and total CIT control group CASES scores were only significant for Part III: Negotiating Client Distress (*Client Distress, Relationship Conflict*; $p = .04$, one-tailed; Table 6). The paired samples *t*-test results of the total CASES score for the control group were not significant. Figure 11 illustrates the noteworthy change in the pretest-posttest scores for the CIT treatment group in comparison to the CIT control group.

Table 5

CASES Paired Samples t-test Results for CIT Treatment Group

	Treatment $n = 13$					
	Pretest		Posttest			
CASES	Mean	*SD*	Mean	*SD*	*t*-value	*p*-value (one-tailed)
Part I	82.46	19.81	105.77	9.57	-4.53	0.0003
Part II	56.92	13.85	71.77	6.66	-4.02	0.0009
Part III	76.92	21.42	107.38	15.49	-3.82	0.0012
Total Score	216.31	50.84	284.92	28.47	-4.35	0.0005

Note. M = Mean. SD = Standard Deviation. Part I score ranges from 0 (no confidence at all) to 135 (complete confidence). Part II score ranges from 0 to 90. Part III ranges from 0 to 144. The CASES total score ranges from 0 to 369.

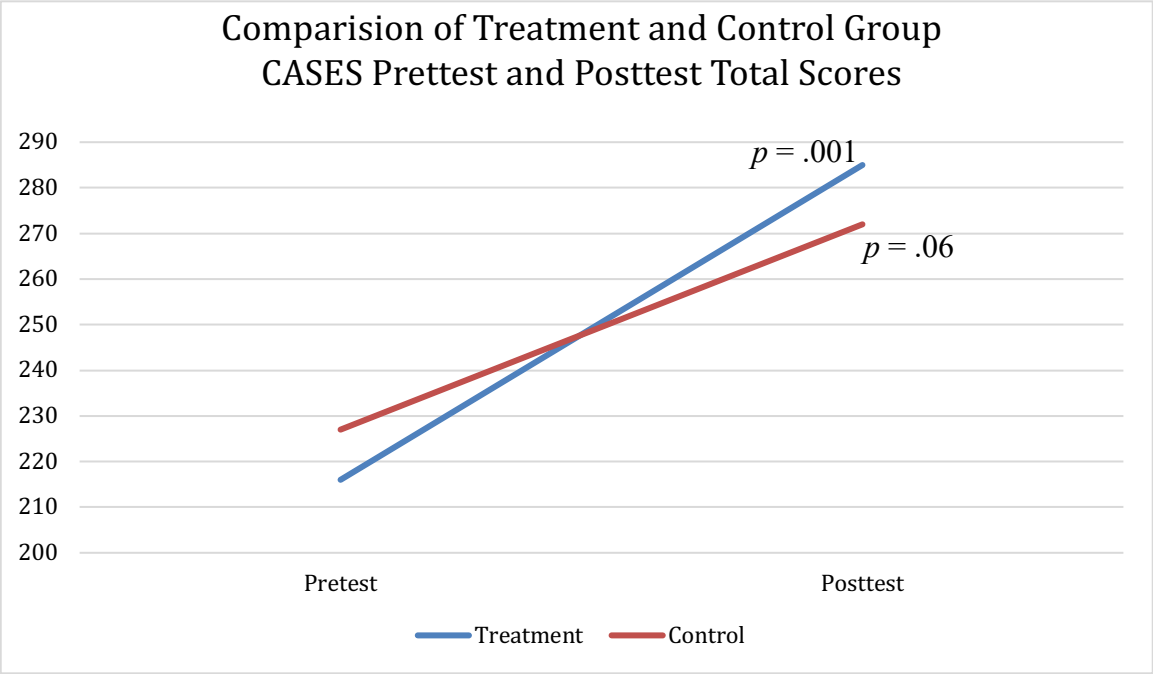
Table 6

CASES Paired Samples t-test Results for CIT Control Group

	Control $n = 6$					
	Pretest		Posttest			
CASES	Mean	*SD*	Mean	*SD*	*t*-value	*p*-value (one-tailed)
Part I	86.33	9.29	99.83	7.68	-1.73	0.072
Part II	60.33	12.83	67	8.56	-1.13	0.155
Part III	81.16	9.01	105.08	9.75	-2.21	0.039
Total Score	227.83	54.18	271.91	17.01	-1.89	0.059

Note. M = Mean. SD = Standard Deviation. Part I score ranges from 0 (no confidence at all) to 135 (complete confidence). Part II score ranges from 0 to 90. Part III ranges from 0 to 144. The CASES total score ranges from 0 to 369.

Figure 11



OQ-45.2 (Lambert et al., 1996). In order to further explore the USCs' perception of their mental health, paired samples *t*-tests were conducted on the USC pretest and posttest OQ-45.2 data for each subscale and total scores of the treatment and the control group. The USC treatment group results showed statistically significant differences between the pretest and posttest scores for the subscale *Symptom Distress* and the OQ-45.2 total scores (Table 7). No significant differences were found in the *Interpersonal Relationships* or *Social Role* subscale scores for the treatment group. The control group data showed no significant results between each of the pretest and posttest OQ-45.2 subscale scores or the OQ45.2 total score (Table 8).

Table 7

OQ-45.2 Paired Samples t-test Results for USC Treatment Group

	Treatment $n = 29$					
	Pretest		Posttest			
OQ-45.2	Mean	*SD*	Mean	*SD*	*t*-value	*p*-value (one-tailed)
Sympt. Distress	33.55	16.47	28.90	16.8	2.43	0.01
Interp. Rel.	11.66	5.86	10.76	6.06	0.92	0.18
Social Role	10.76	4.22	10.65	4.51	0.15	0.44
Total Score	55.97	23.89	50.31	25.62	1.86	0.03

Note. M = Mean. SD = Standard Deviation. Symptom Distress score ranges from 0 to 100. Interpersonal Relations score ranges from 0 to 44. Social Role score ranges from 0 to 36. The OQ-45.2 total score ranges from 0 to 180.

Table 8

OQ-45.2 Paired Samples t-test Results for USC Control Group

	Control $n = 15$					
	Pretest		Posttest			
OQ-45.2	Mean	*SD*	Mean	*SD*	*t*-value	*p*-value (one-tailed)
Sympt. Distress	35.8	14.93	32.6	12.51	1.41	0.09

Chapter Five

Discussion

Interp. Rel.	13.46	6.93	13.53	7.84	-0.06	0.48
Social Role	9.67	2.72	9.4	3.52	0.23	0.41
Total Score	58.93	21.89	55.53	21.39	0.84	0.21

Note. M = Mean. SD = Standard Deviation. Symptom Distress score ranges from 0 to 100. Interpersonal Relations score ranges from 0 to 44. Social Role score ranges from 0 to 36. The OQ-45.2 total score ranges from 0 to 180.

The purpose of this dissertation study was to expand counselor education research by responding to several needs identified in the literature including teaching relationship skills as EBP (Lister & Moody, 2017; Sommers-Flanagan, 2015; Norcross & Lambert, 2018; Norcross & Wampold, 2011; Yates, 2013), measuring counseling outcomes in research (Buser, 2008, Hill & Lent, 2006; Ridley et al., 2011), and increasing CIT self-efficacy (Buser, 2008; Larson & Daniels, 1998; Lent et al., 2009). In particular, I examined the effects of an EBRFs training on

the development of therapeutic relationship skills (hypotheses one and four), client outcomes (hypotheses two and three), and CIT self-efficacy (hypothesis five).

This chapter begins with a discussion of the results for each hypothesis, followed by a discussion of post hoc data analyses. Then, the limitations of the study and research implications are discussed. The chapter concludes with suggested future directions in EBRFs training and research.

Therapeutic Alliance and Relationship Skills – Hypotheses One and Four

Hypotheses one and four predicted that as a result of CITs attending the EBRFs training, the treatment group USCs and the USC/CIT pairs would rate the therapeutic alliance and relationship higher than the control group at statistically significant levels as measured by the SRS (Duncan et al., 2003) and the BLRI combined scores (MO-40 and OS-40; Barrett-Lennard, 2015).

Hypothesis one. The hypothesis was not supported; there were no statistically significant differences found in the SRS scores between the USC treatment and control groups. Thus, the result is a failure to reject the null hypotheses. Post hoc data analysis showed increasing endorsement of the presence of a therapeutic alliance for both USC treatment and control groups as the number of counseling sessions increased and the therapeutic relationships developed over time.

The same post hoc analysis revealed notable differences in the SRS scores between the two USC groups at session one. Specifically, on average, the USC treatment group members rated their therapeutic alliance higher at session one on all subscales (*Relationship*, *Goals and topics*, *Approach or Method*, and *Overall Experience*) and the resulting total SRS score (figures 1-5; Duncan et al., 2003). This trend could indicate that the EBRFs training increased the USC

treatment group's experience of the therapeutic alliance because session one occurred within days of the CITs attendance to the EBRFs training.

The literature offers some support and further explanation for the phenomena of early differences followed by the converging scores that occurred in the current study. A review of skills training program outcomes for psychotherapists showed increases in skill and knowledge are often detected immediately following training but then fade without continued exposure (Herschell, Kolko, Baumann, & Davis, 2010). In the case of this study, the CITs received training over the first two practicum class periods in the semester but did not receive any formal supplemental exposure to the EBRFs program.

The pattern was that the control group's ratings of the therapeutic relationship caught up to the treatment group by session three and remained at similar levels. This pattern could be explained by a ceiling effect, because, for example, at session one, the overall SRS score was at 9.4 on a 0 to 10 scale. These initial scores left no room for improvement.

Another explanation is that, over time, the EBRF training content was "leaked" from the treatment to the control group. Given the smallness of this counselor training program, such leakage was possible. Alternatively, there may have been a natural learning process that allowed control CITs to gain knowledge and expertise over time.

Hypothesis four. The hypothesis was not supported as there were no statistically significant differences between the treatment and control group USC/CIT pairs combined scores on the BLRI MO-40 and BLRI OS-40 (Barrett-Lennard, 2015). Thus, the result is a failure to reject the null hypotheses. The analytical results of the two data collection points (sessions four and eight) were curiously sporadic. For example, at session four, the subscale *Unconditionality* was statistically significant but inverse of the hypothesis; while the subscale *Congruence* was

statistically significant in support of the hypothesis. At the end of session eight only one subscale, *Empathy*, was statistically significant in support of the hypothesis. One explanation for the results is that the EBRFs treatment effect faded by session four as explained by Herschell et al. (2010). Another potential explanation was provided by author of the BLRI, Dr. Barrett-Lennard:

> I'm doubting that you will get statistically significant results in the data from client respondents on the RI, in favour [*sic*] of the clients as a group who are working with counselors exposed to the EBRF training. I'm presuming there will be resourceful trainee counsellors [*sic*] in both groups keen on what they are doing (personal communication, January 29, 2020).

Undergraduate Student Client Outcomes – Hypotheses Two and Three

Hypotheses two and three predicted better therapeutic outcomes for USCs in the treatment group as a product of their respective CITs attending the EBRFs training. Specifically, it was predicted that the USC treatment group on average, would report that their overall well-being and mental health improved more than the control group, at statistically significant levels, as measured by the ORS (Miller et al., 2002) and OQ-45.2 (Lambert et al., 1996).

Hypothesis two. The hypothesis was not supported as there were no statistically significant differences in the ORS (Miller et al., 2002) scores between the two USC groups across the intervals (sessions one, three, five, and seven). Thus, the result is a failure to reject the null hypotheses. A likely explanation for this result is that the mean scores of the USC treatment ($M = 37.01$, $SD = 2.59$) and control groups ($M = 33.37$, $SD = 4.49$) at pretest were well above the clinical level cutoff score of 25 (Seidel et al., 2017). The scores resulted in a ceiling effect that left little room for a substantial divergence in scores at posttest. Still, the non-clinical ORS

mean scores across the intervals are reflective of the sample participant pool. The USC participants in the study received counseling as the laboratory component of a class, rather than seeking counseling for a reduction of distressful symptoms. Thus, the USC participants are considered a non-clinical sample.

The post hoc analysis, however, revealed noticeable interactions between the USC treatment and control group average scores across sessions one and three. In particular, the scores on the subscales *Individually* (figure 6), *Interpersonally* (figure 7), and *Overall* (figure 9) showed on average, the treatment group reported that their well-being improved while the control group, on average, reported that their well-being had worsened. The two remaining data points showed that the control group's average scores on the subscale *Socially* (figure 8) remained the same and the resulting total ORS average score (figure 10) decreased by one from session one to session three.

It is important to reiterate that the differences between the USC treatment group and USC control group scores on the ORS were not significant. Rather, what is relevant is the timing (across sessions one and three) of the USC treatment group reports of improved well-being. The reported increase in well-being could be attributed to the timing of the data collection in relationship to the EBRFs training; both happened early in the study. It is possible that early on, the USCs were benefiting from the CITs' implementation of the EBRFs as a deliberate practice. This, albeit small, difference may be related to other research that has shown a correlation between the relationship alliance and improved client outcomes (Lambert & Barley, 2002; Wampold, 2001; Wampold & Imel, 2015).

Hypothesis three. The hypothesis was not supported as there were no statistically significant differences between the USC treatment and control group scores on the OQ45.2

(Lambert et al.,1996). Thus, the result is a failure to reject the null hypotheses. It should be noted that the mean scores of the treatment (M = 55.97, SD = 23.89) and control (M = 58.93, SD = 21.89) group scores at pretest and posttest (M = 50.32, SD = 25.62 and M = 55.53, SD = 21.39 respectively) did not meet the clinical level cutoff score of 63 set by Lambert et al. (1996). The pretest and posttest scores are again, reflective of the non-clinical sample of participants; and in this case demonstrated a floor effect. In light of this, meeting the expectation of finding a statistically significant difference in scores between the two groups on the OQ-45.2 may have been out of reach.

The post hoc analysis of paired samples *t*-tests showed a statistically significant difference for the USC treatment group from pretest (M = 55.97, SD = 23.89) to posttest (M = 50.32, SD = 25.62) t (29) = 1.86, p = 0.03 (one-tailed). In comparison, the post hoc paired samples *t*-test of the USC control group scores showed no statistically significant differences from pretest to posttest. In other words, the change in scores for the USC treatment group was significant from a within group perspective, but not large enough for the original hypothesis test to detect a difference between the USC treatment and control groups.

The statistically significant change in scores for the USC treatment group on the OQ45.2 may be an indicator that the EBRFs training influenced the USC treatment group outcomes. Still, this conjecture shall remain speculative as the mean improvement of the USC treatment group scores was around six points. Thus, the group is considered to have experienced “no change” in a clinical sense because the threshold for change is greater than 14 points (Kadera et al., 1996).

Counselor-In-Training Self-Efficacy – Hypothesis Five

Hypothesis five. The final hypothesis predicted that the CITs who attended the EBRFs training would rate their self-efficacy higher than the CITs who did not attend as measured by

the CASES (Lent et al., 2009). The hypothesis was not supported as there were no statistically significant differences between the CIT treatment and control group change scores on the CASES from pretest to posttest. Thus, the result is a failure to reject the null hypotheses. Perhaps the explanation for this is that the self-efficacy of both groups improved based on gaining experience and receiving regular and supportive supervision from their practicum instructors. CIT self-efficacy has been shown to increase as students gain experience in practicum (Goreczny et al., 2015; Lent et al., 2009) and receive didactic instruction and affirmative feedback regarding their skill acquisition (Hill & Lent, 2006).

Paired samples *t*-tests were conducted post hoc on the CASES pretest to post test scores of the CIT treatment and control groups. The control group showed only one statistically significant result. The CIT treatment group showed a statistically significant change in the CASES scores from pretest to posttest on each subscale and total; a significant and global shift in their experience of counseling self-efficacy. Notably, the results of the CIT treatment group data analysis are consistent with an unpublished pilot study conducted the prior year (Parrow & Sommers-Flanagan, 2018). Together, the results of both studies are an indication that CITs find the EBRFs training useful in improving their counseling self-efficacy. Whether CIT self-efficacy improves more as a function of EBRF training than other comparable trainings is an open question and could be the focus of future research.

The results of the hypothesis tests and post hoc data analyses when considered together provided a holistic evaluation of the efficacy of the EBRFs training, and the strengths and weaknesses of the research. The next section identifies and explores the limitations of the study and provides further insights regarding the research design and results.

Limitations of the Study

Several limitations of the research study were identified. First, the unexpected failure of every hypotheses to reject the null prompted questions about the EBRFs training program's dose and content. A further inquiry provided some explanation and also revealed specific training limitations that most likely influenced the results.

Researchers who have explored the effectiveness of continuing education for professional psychotherapists and counselors have found four key training elements that lead to long-term skill acquisition and adaptation of interventions, these are: (a) repeated exposure, (b) multi-media content, (c) training manuals, and (d) program lengths that exceed three hours (Herschell, 2010; Marinopoulous et al., 2007; Taylor et al., 2016). It should be noted that the studies cited here evaluated EBP trainings presented to licensed professional counselors and psychotherapists in communities rather than CITs in academia.

In light of this, it is easy to recognize that the 4-hour EBRFs training for CITs was probably not long enough and the inclusion of a treatment manual is warranted. The absence of a training manual and lack of formal, continued exposure to the specific skills likely thwarted long-term skill acquisition and adaptation. Still, it would have been difficult to avoid all of the EBRFs training program limitations. Time constraints within the academic semester prevented a longer training and formal follow-up. Further, the presence of a training manual could have introduced a diffusion of treatment threat between the CIT groups as they were providing treatment in the same location.

Another limitation is that the USC participants were a non-clinical sample. Although there were USC participants who scored within the clinical range on the ORS (Miller et al., 2003) and OQ-45.2 (Lambert et al., 1996) the sample on average, represented non-clinical levels of distress. Perhaps had the client participants been from a clinical sample the potential for

statistically significant findings would have been greater. Additionally, a clinical sample might have presented a greater challenge to the self-efficacy of the CIT participants and thus, affected the pretest and posttest scores on the CASES (Lent et al., 2003) questionnaire as well.

The study was also limited by the number of USC and CIT participants in the study. Fraenkel and Wallen (2006) recommended a minimum of 30 participants for experimental designs. The number of USC participants in the treatment group was N = 28 and the control group had N = 13. The CIT participants had N = 13 in the treatment group and N = 6 in the control group. Thus, the number of participants, especially in the CIT groups fell well-bellow the recommended sample size.

Implications of the Study

The results of the hypotheses tests and post hoc analysis, along with the identified limitations provide implications for counselor education and future EBRFs research. One implication is that the EBRFs training has the potential to affect the therapeutic alliance, client outcomes, and counselor self-efficacy for the better. This is evidenced by the changes that were detected in the first sessions that later diminished by the fourth session.

Further, nearly all of the results were in the direction of the hypotheses. Based on this trend, the study shows promise for a future EBRFs training that would include a longer training period, a training manual, and formal and informal psychoeducation and consultation. Perhaps the EBRFs training could be integrated into a semester long course providing opportunities for continued exposure. Additionally, as a part of regular coursework, CITs would have the opportunity to reflect and practice their EBRFs skills rather than interrupting valuable case conceptualization and presentation in practicum supervision.

In addition to a more comprehensive EBRFs training program, another important implication of this research is the confirmation of the need for client outcome measures. The USC outcome measures were integral to detecting the influence of the EBRFs training initially and when the effects faded. Further, the outcome measures revealed ceiling and floor affects indicating the necessity of a clinical population for this type of research, in the future.

The literature has firmly established that the ideal timing for affecting CIT self-efficacy is during practicum and internship (Larson & Daniels, 1998). The importance of CIT self-efficacy cannot be understated. This dissertation research in conjunction with the pilot study has affirmed the influence of the EBRFs on CIT self-efficacy. The implication of this research is that the provision of EBRFs improves CIT self-efficacy while supporting the development of interpersonal and intrapersonal skills and thus the counselor identity.

Future Directions in EBRFs Training and Research

This results of this dissertation corroborate a number of training and research design components called for by counselor and psychotherapy scholars. First, the need for concrete training manuals seems non-negotiable. CITs need specific instructions for how to implement the skills they are learning (Buser 2008; Sexton, 2000, Whiston & Coker, 2000) and the opportunity to formally revisit concepts (Herschell, 2010). Future inquiries of EBRFs training efficacy will come closer to meeting the standards for process and outcomes research as requested by Hill and Lent (2006) with the inclusion of a training manual.

Future EBRFs training and research will likely show better client outcomes and improved CIT self-efficacy with an increase in the training program time, including time set aside for CITs to reflect on and discuss their skill development and performance. Ladany et al. (2001) noted that cognitive complexity increases when CITs have time to reflect on, discuss, and receive feedback

about their counseling processes. It seems the ideal amount of time for the initial training would exceed four hours and include several opportunities for CITs to revisit the concepts through repeated exposure (Herschell, 2010; Marinopoulous et al., 2007; Taylor et al., 2016).

Lastly, counseling researchers have endorsed the positive influence of modeling, role-plays, visual imagery, and affirmative feedback (Alberts & Edelstein, 1990; Buser, 2008; Duys & Hedstrom, 2000; Larson & Daniels, 1998; Sommers-Flanagan & Heck, 2012; Whiston & Coker, 2000). It seems the current EBRFs training is on target with regard to content and presentation methods. The addition of a treatment manual and a longer training period are the logical next steps in EBRFs inquiry.

Conclusion

In summary, the literature review and results of this study have upheld the need for advanced practical counseling skills training that occur after initial training in basic counseling skills (Ridley et al., 2011). One component of this advanced training might include EBRFs as EBP (Lister & Moody, 2017; Sommers-Flanagan, 2015; Norcross & Lambert, 2018; Norcross & Wampold, 2011; Yates, 2013). Results from this study extended counselor education empirical research on counselor training by providing needed outcomes data that denote the timing of treatment effects for psychoeducation programing when presented to CITs in academic settings. Most importantly, the EBRFs program and dissertation research study serve as a contribution to the development of counseling-specific clinical training (Patel, Hagedorn, Bai, 2013; Whiston & Coker, 2000; Sexton, 2000) and efforts to strengthen the identity of counseling as petitioned by the Vision 20/20 task force (Kaplan et al, 2014, p. 366). Additional empirical research on how EBRFs can contribute to counselor training—research that includes larger sample sizes, longer and more sustained EBRF training dosages, and clinical samples—is strongly recommended.

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Appendix A

Relevant Psychometric Measures and In Vivo Experiences Tables

Table A1

Selected Psychometric Measures of Evidence Based Relationship Factors

Instrument, Acronym, and Citation	Evidence Based Relationship Factor	Report Type	No. of Items
Barrett-Lennard Relationship Inventory (BLRI, Barrett-Lennard, 2015)	Congruence Unconditional Positive Regard Empathic Understanding	Counselor Client	40
Cultural Humility Scale (CHS, Hook et al., 2013)	Cultural Humility	Client	12
Working Alliance Inventory (WAI, Horvath & Greenberg, 1989)	Emotional Bond Goal Consensus Task Collaboration	Counselor Client Observer	36
Alliance Negotiation Scale (ANS, Doran et al., 2012)	Rupture and Repair	Client	12
Therapist Response Questionnaire (TRQ, Tanzilli et al., 2014)	Countertransference Management	Counselor	79
Session Rating Scale (SRS, Miller et al., 2002)	Progress Monitoring	Client	4

Table A2

Evidence-Based Relationships Factors Training In Vivo Experiences and Relevant Measure

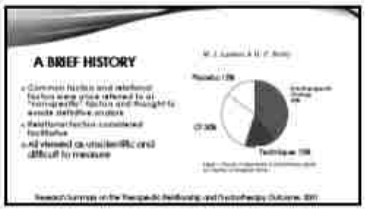
Evidence-Based Relationship Factor	*in Vivo* Experience	Measures
Congruence	(a)Write and state your authentic purpose statement (b)Practice answering difficult questions	Barrett-Lennard Relationship Inventory (BLRI, Barrett-Lennard, 2015)
Unconditional Positive Regard	(a) Role-play a response to client provocations (b) Role-play second session first question	
Empathic Understanding	(a) Watch vlog of client experiencing depressive symptoms, write potential feeling reflections and validations (b)Classroom discussion	
Culture and Cultural Humility	(a)Role-play broaching cultural differences	Cultural Humility Scale (CHS, Hook et al., 2013)
Working Alliance: Emotional Bond	(a)Role-play "I punched my last counselor"	Working Alliance Inventory (WAI, Horvath & Greenberg, 1989)
Working Alliance: Goal Consensus	(a)Watch Sommers-Flanagan dvd with Claire	
Working Alliance: Task Collaboration	(a) Watch Sommers-Flanagan dvd with Luis	
Rupture and Repair	(a)Write about a rupture experience (b)Role play the experience using new repair skills	Alliance Negotiation Scale (ANS, Doran et al., 2012)
Countertransference and countertransference management	(a) Classroom discussion of CT stories/management ideas	Therapist Response Questionnaire (TRQ, Tanzilli, Colli, Del Corno, & Lingiardi, 2016)
Progress monitoring	(a) Practice checking for verbal feedback	Session Rating Scale (SRS, Miller et al., 2002)

Appendix B

Presentation Slides

Building Therapeutic Relationships: The Essence of Evidence-Based Counseling

1



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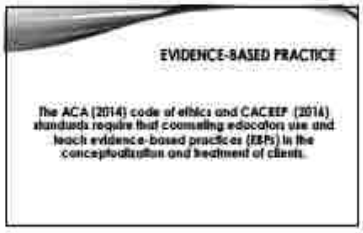

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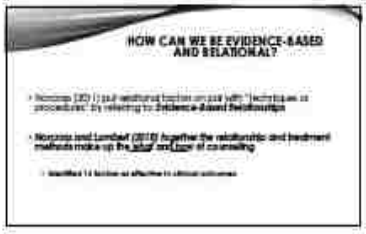

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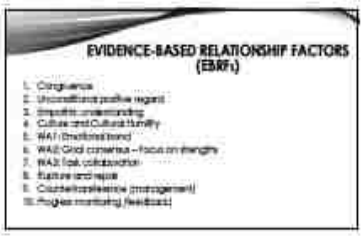

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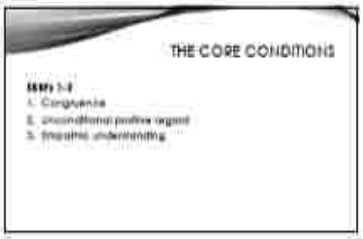

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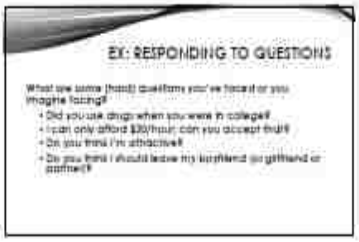

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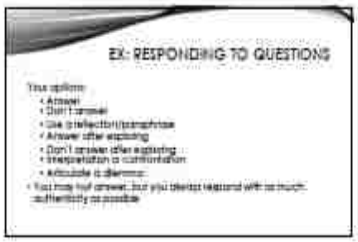

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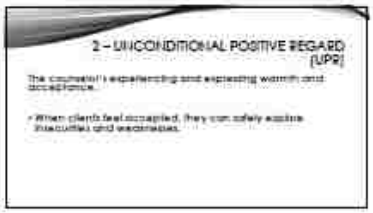

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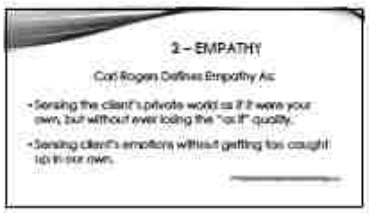

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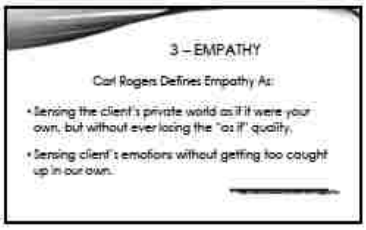

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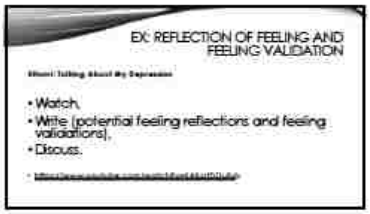

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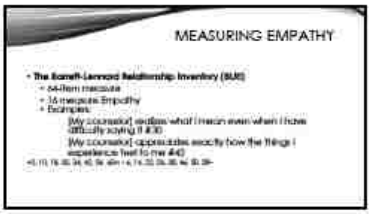

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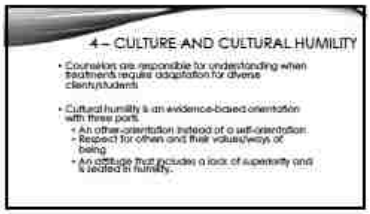

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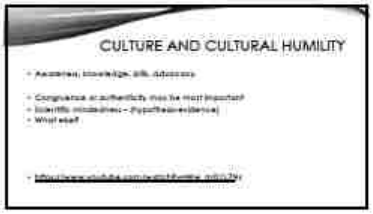

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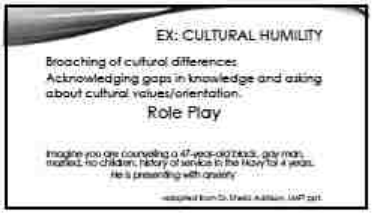

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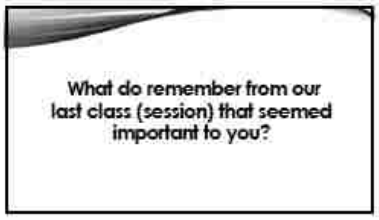

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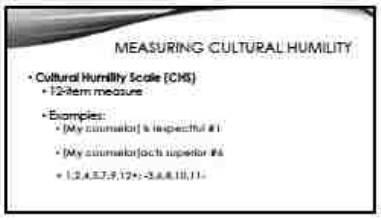

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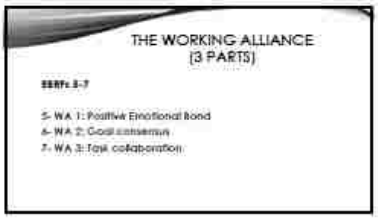

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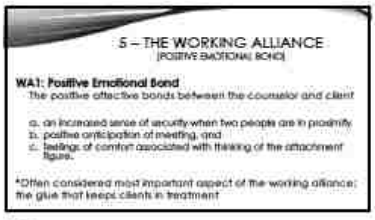

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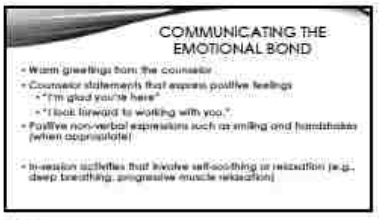

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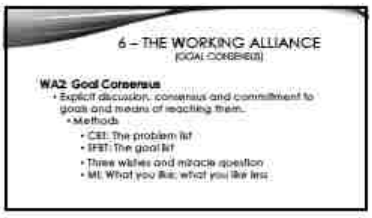

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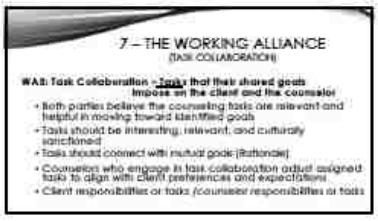

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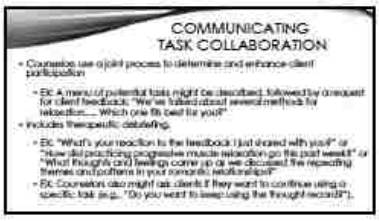

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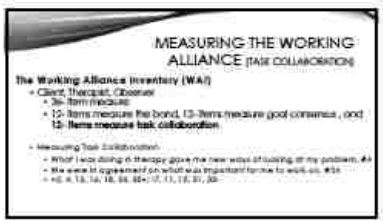

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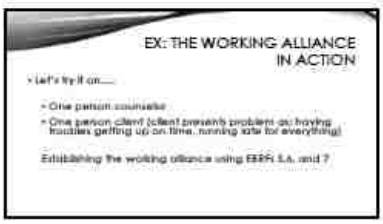

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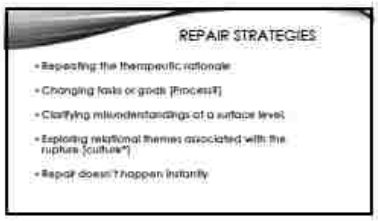

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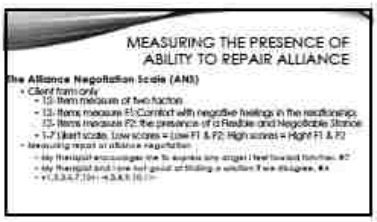

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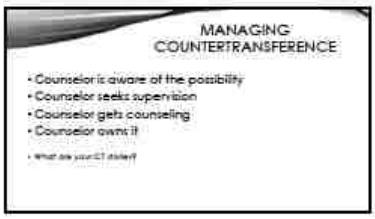

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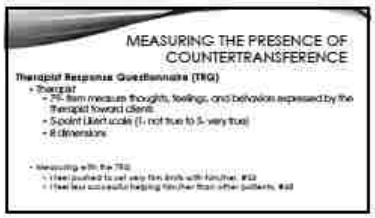

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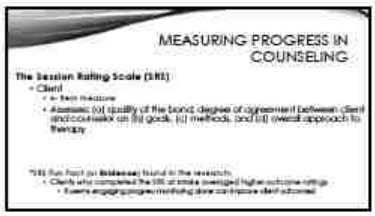

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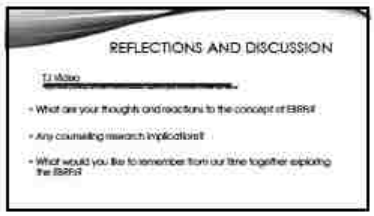

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Appendix C

Participant Consent Forms

Consent Form: Counselor-in-Training

Participant Code: _____

SUBJECT INFORMATION AND INFORMED CONSENT

Study Title: Evidence-Based Relationship Factors (EBRFs) for Counselors-in-Training

Investigator(s):
Kimberly Parrow
Doctoral Student, Counselor Education Department, University of Montana
406-546-2568
kimberly.parrow@umconnect.umt.edu
John Sommers-Flanagan
Faculty Supervisor
john.sf@mso.umt.edu
Inclusion [or Exclusion] Criteria: Counselor-in-Training participants:
Enrolled in COUN 530: Applied Counseling Skills (Practicum)
Completion of 4-hour EBRF training as required in the course syllabus
Be at least 18 years old

Purpose:
The purpose of this mixed methods study is to examine the influence of an Evidence Based Relationship Factors (EBRFs) training for counselors-in-training (CITs) on counseling process and outcomes in practicum/internship. Counselors-in-training are unlikely to identify with any particular theory or array of evidence-based treatments when entering practicum. Because of this, they may feel rudderless as they counsel their first clients. Norcross and Beutler (2000) recommended that CITs develop relationship and communication skills first, followed by an exploration of theoretical approaches.

In 2009, a task force formed by the American Psychological Association (APA), identified a number of relationship factors that are demonstratively effective in improving client outcomes (Norcross & Wampold, 2011). The report also included recommendations for implementing EBRFs into the practice of psychotherapy (Norcross & Wampold, 2011).

The therapeutic relationship in counseling has been heralded as the most influential component for producing positive client outcomes (Lambert and Barley, 2002; Wampold, 2001). If CITs are provided with the skills for developing a therapeutic relationship early in training, they are more likely to have better counseling process and client outcomes than without training. This has the potential to serve clients and CITs alike. As the client experiences increased mental well-being

the CIT may also experience greater self-efficacy and confidence in their ability to provide quality mental health care. Additively, outcomes from the study may inform curriculum development in counselor education.

The ACA Code of Ethics (2014) preamble states, "Counseling is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education, and career goals" (p.3). Given that counseling is defined as a professional relationship and research supports the value of a good therapeutic relationship, it makes sense to provide training aimed at the construction of a therapeutic relationship to CITs.

The primary objective of this study is to evaluate the effects of an EBRF-focused educational seminar on counseling process, CIT self-efficacy, and client outcomes. CIT subjects may benefit from learning more about how to apply EBRFs in counseling. CIT client-subjects may benefit from working with counselors with better relational skills.

Procedures:
If you agree to take part in this research study, in addition to the 4-hour EBRF training provided in the COUN 530 Applied Counseling skills and counseling undergraduate students enrolled in the COUN 242 Intimate Relationships course, who has selected counseling as their lab experiential lab component. You will also be asked to (a) complete a written qualitative questionnaire regarding you experiences of the EBRFs training and implementation of EBRFs within the counseling relationship, (b) complete the Counselor Activity Self-Efficacy Scales (CASES) at two intervals during the study (prior to the EBRFs training and at the completion of all counseling sessions), and (c) complete the Barrett-Lennard Relationships Inventory (BLRI) at two intervals during the study (after session 4 and at the end of session 8).

_____ By initialing this line, you agree to be audio video recorded and understand that these recordings will be destroyed at the end of the semester.

Payment for Participation:
There is no payment for participation in the study.

Risks/Discomforts:
Participant risk is minimal. You may experience some discomfort by some of the survey content or the time needed to complete the surveys. To minimize these risks, you have the option to not answer questions in the survey at any time. In the case you are experiencing discomfort please contact Kimberly Parrow or John Sommers-Flanagan via the contact information provided at the top of this form.

Benefits:
No benefits are guaranteed from participation in this study, however the potential benefit of the study is to add to the scientific knowledge of how the deliberate practice of teaching EBRFs to counselors-in-training might affect the well-being of their clients. Should the findings show a positive influence on client well-being the results could be used in curriculum development

within the field of counselor education, presented at professional conferences, and published in a professional journal.

Confidentiality:
Your records will be kept confidential and will not be released without your consent except as required by law. You will be assigned a pseudonym and all data gathered from you will be identified with that pseudonym. The consent forms, survey and focus group data will be stored in separate file folders and kept in a locked drawer accessible only to approved researchers. This data will be kept, in accordance with APA guidelines, for 5 years, after which it may be destroyed (shredded) and thrown away.

Voluntary Participation/Withdrawal:
Your decision to take part in this research study is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty or loss of benefits to which you are normally entitled.

Questions:
If you have any questions about the research now or during the study, please contact: Kimberly Parrow at (406) 546-2568.

If you have any questions regarding your rights as a research subject, you may contact the UM Institutional Review Board (IRB) at (406) 243-6672.

Statement of Your Consent:
I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.

_

Printed Name of Subject

_ _____

Subject's Signature Date

Consent Form: Undergraduate Student Client
Participant Code: _____

SUBJECT INFORMATION AND INFORMED CONSENT

Study Title: Evidence-Based Relationship Factors (EBRFs) for Counselors-in-Training

Investigator(s):
Kimberly Parrow
Doctoral Student, Counselor Education Department, University of Montana
406-546-2568
kimberly.parrow@umconnect.umt.edu
John Sommers-Flanagan
Faculty Supervisor
john.sf@mso.umt.edu
Inclusion Criteria:
Client being seen by a Counselor Education student enrolled in COUN 530 Applied Counseling Skills
Be at least 18 years old

Exclusion Criteria:
Prior participation in the experiential counseling lab in the Counselor Education Department

Purpose:
The purpose of this mixed methods study is to examine the influence of an Evidence Based Relationship Factors (EBRFs) training for counselors-in-training (CITs) on counseling process and outcomes in practicum/internship. Counselors-in-training are unlikely to identify with any particular theory or array of evidence-based treatments when entering practicum. Because of this, they may feel rudderless as they counsel their first clients. Norcross and Beutler (2000) recommended that CITs develop relationship and communication skills first, followed by an exploration of theoretical approaches.

In 2009, a task force formed by the American Psychological Association (APA), identified a number of relationship factors that are demonstratively effective in improving client outcomes (Norcross & Wampold, 2011). The report also included recommendations for implementing EBRFs into the practice of psychotherapy (Norcross & Wampold, 2011).

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quality mental health care. Additively, outcomes from the study may inform curriculum development in counselor education.

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The primary objective of this study is to evaluate the effects of an EBRF-focused educational seminar on counseling process, CIT self-efficacy, and client outcomes. CIT subjects may benefit from learning more about how to apply EBRFs in counseling. CIT client-subjects may benefit from working with counselors with better relational skills.

Procedures:
If you agree to take part in this research study, in addition to attending 8 counseling sessions, you will be asked to complete two short surveys at the beginning and end of sessions 1, 3, 5, and 7. One survey asks about your current mental health well-being the other asks about your experience with your counselor. You will also be asked to complete surveys about your overall mental well-being before session 1 and after session 8. Additionally, you will be asked to complete a survey about your relationship with your counselor after session 4 and after session 8.

_____ By initialing this line, you agree to be audio video recorded and understand that these recordings will be destroyed at the end of the semester.

Payment for Participation:
There is no payment for participation in the study.

Risks/Discomforts:
Participant risk is minimal. You may experience some discomfort by some of the survey content or the time needed to complete the surveys. To minimize these risks, you have the option to not answer questions in the survey at any time. In the case you are experiencing discomfort please contact Kimberly Parrow or John Sommers-Flanagan via the contact information provided at the top of this form.

Benefits:
No benefits are guaranteed from participation in this study, however the potential benefit of the study is to add to the scientific knowledge of how the deliberate practice of teaching EBRFs to counselors-in-training might affect the well-being of their clients. Should the findings show a positive influence on client well-being the results could be used in curriculum development within the field of counselor education, presented at professional conferences, and published in a professional journal.

Confidentiality:
Your records will be kept confidential and will not be released without your consent except as required by law. You will be assigned a pseudonym and all data gathered from you will be

identified with that pseudonym. The consent forms, survey and session content data will be stored in separate file folders and kept in a locked drawer accessible only to approved researchers. This data will be kept, in accordance with APA guidelines, for 5 years, after which it may be destroyed (shredded) and thrown away.

Voluntary Participation/Withdrawal:
Your decision to take part in this research study is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty or loss of benefits to which you are normally entitled.

Questions:
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If you have any questions regarding your rights as a research subject, you may contact the UM Institutional Review Board (IRB) at (406) 243-6672.

Statement of Your Consent:
I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.

_

Printed Name of Subject

_ _____

Subject's Signature Date

Appendix D

Assessments and Measures

Counselor Activity Self-Efficacy Scale (CASES; Lent et al., 2003)

WEB FORM K
COUNSELOR ACTIVITY SELF-EFFICACY SCALES

General Instructions: The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling. Please provide your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are right or wrong answers to the following questions. Using a dark pen or pencil, please circle the numbe that best reflects your response to each question.

Part I.

Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling most clients.

No Confidence Some Confidence Complete Confidence
0 1 2 3 4 5 6 7 8 9

How confident are you that you could use these general skills effectively with most clients over the next week?

1.	**Attending** (orient yourself physically toward the client)	0 1 2 3 4 5 6 7 8 9
2.	**Listening** (capture and understand the messages that clients communicate).	0 1 2 3 4 5 6 7 8 9
3.	**Restatements** (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear).	0 1 2 3 4 5 6 7 8 9
4.	**Open questions** (ask questions that help clients to clarify or explore their thoughts or feelings).	0 1 2 3 4 5 6 7 8 9
5.	**Reflection of feelings** (repeat or rephrase the client's statements with an emphasis on his or her feelings).	0 1 2 3 4 5 6 7 8 9
6.	**Self-disclosure for exploration** (reveal personal information about your history, credentials, or feelings).	0 1 2 3 4 5 6 7 8 9
7.	**Intentional silence** (use silence to allow clients to get in touch with their thoughts or feelings).	0 1 2 3 4 5 6 7 8 9
8.	**Challenges** (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change).	0 1 2 3 4 5 6 7 8 9
9.	**Interpretations** (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings).	0 1 2 3 4 5 6 7 8 9

10. Self-disclosures for insight (disclose *past* experiences in which you gained some personal insight).	0 1 2 3 4 5 6 7 8 9
11. Immediacy (disclose *immediate* feelings you have about the client, the therapeutic relationship, or yourself in relation to the client).	0 1 2 3 4 5 6 7 8 9
12. Information-giving (teach or provide the client with data, opinions, facts, resources, or answers to questions).	0 1 2 3 4 5 6 7 8 9
13. Direct guidance (give the client suggestions, directives, or advice that imply actions for the client to take).	0 1 2 3 4 5 6 7 8 9
14. Role-play and behavior rehearsal (assist the client to role-play or rehearse behaviors in-session).	0 1 2 3 4 5 6 7 8 9
15. Homework (develop and prescribe therapeutic assignments for clients to try out between sessions).	0 1 2 3 4 5 6 7 8 9

Part II.

Instructions: Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients.

No Confidence			Some Confidence				Complete Confidence		
0	1	2	3	4	5	6	7	8	9

How confident are you that you could do these specific tasks effectively with most clients over the next week?

1.	Keep sessions "on track" and focused.	0	1	2	3	4	5	6	7	8	9
2.	Respond with the best helping skill, depending on what your client needs at a given moment.	0	1	2	3	4	5	6	7	8	9
3.	Help your client to explore his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
4.	Help your client to talk about his or her concerns at a "deep" level.	0	1	2	3	4	5	6	7	8	9
5.	Know what to do or say next after your client talks.	0	1	2	3	4	5	6	7	8	9
6.	Help your client set realistic counseling goals.	0	1	2	3	4	5	6	7	8	9
7.	Help your client to understand his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
8.	Build a clear conceptualization of your client and his or her counseling issues.	0	1	2	3	4	5	6	7	8	9
9.	Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.	0	1	2	3	4	5	6	7	8	9
10.	Help your client to decide what actions to take regarding his or her problems.	0	1	2	3	4	5	6	7	8	9

Part III.

Instructions: Please indicate how confident you are in your ability to work effectively, over the next week with each of the following client types, issues, or scenarios (By "work effectively," I am referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions, and, ultimately, to help the client resolve his or her issues.)

No Confidence			Some Confidence				Complete Confidence		
0	1	2	3	4	5	6	7	8	9

How confident are you that you could work effectively over the next week with a client who…

1.	is clinically depressed.	0	1	2	3	4	5	6	7	8	9
2.	has been sexually abused.	0	1	2	3	4	5	6	7	8	9
3.	is suicidal.	0	1	2	3	4	5	6	7	8	9
4.	has experienced a recent traumatic life event (e.g., physical or psychological injury or abuse).	0	1	2	3	4	5	6	7	8	9
5.	is extremely anxious.	0	1	2	3	4	5	6	7	8	9
6.	shows signs of severely disturbed thinking.	0	1	2	3	4	5	6	7	8	9
7.	you find sexually attractive.	0	1	2	3	4	5	6	7	8	9
8.	is dealing with issues that you personally find difficult to handle.	0	1	2	3	4	5	6	7	8	9
9.	has core values or beliefs that conflict with your own (e.g., regarding religion, gender roles).	0	1	2	3	4	5	6	7	8	9
10.	differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social economic status).	0	1	2	3	4	5	6	7	8	9
11.	is not "psychologically-minded" or introspective.	0	1	2	3	4	5	6	7	8	9
12.	is sexually attracted to you.	0	1	2	3	4	5	6	7	8	9
13.	you have negative reactions toward (e.g., boredom, annoyance).	0	1	2	3	4	5	6	7	8	9
14.	is at an impasse in therapy.	0	1	2	3	4	5	6	7	8	9
15.	wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions).	0	1	2	3	4	5	6	7	8	9
16.	demonstrates manipulative behaviors in-session.	0	1	2	3	4	5	6	7	8	9

Barrett-Lennard Relationship Inventory (BLRI MO-40; Barrett-Lennard, 2015)

BASIC 40-ITEM FORMS

Name or code ..... Answer date .....

Barrett-Lennard Relationship Inventory: Form MO–40 (version 3)

Developed by Godfrey T. Barrett-Lennard, PhD

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with _____, mentally inserting his or her name in the space provided. For example, if the other person's name was John, you would read the first statement as "I respect John as a person" and the second as "I usually sense or realize what John is feeling."

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. *Write in a minus number (–3, –2, or –1) when your answer is on the 'no' side, and a plus number (+1, +2, or +3) when your answer is a 'yes.'* Here is the exact meaning of each answer number:–

+3:	YES, *I strongly feel that it is true*	*–1*:	(No) *I feel that it is probably untrue, or more untrue than true*
+2:	Yes, *I feel it is true*	*–2*:	No, *I feel it is not true*
+1:	(Yes) *I feel that it is probably true, or more true than untrue*	*–3*:	NO, *I strongly feel that it is not true*

_____ 1. I respect _____ as a person.
_____ 2. I usually sense or realize how _____ is feeling.
_____ 3. The interest I feel in _____ depends on his/her words and *actions*.
_____ 4. I tend to put on a role or front with _____.
_____ 5. I *like* _____.
_____ 6. I hear _____ 's words but don't know how s/he feels inside.
_____ 7. Whether _____ is feeling happy or unhappy with himself (herself) doesn't make me feel more or less positive toward him (her).
_____ 8. I don't avoid or put off dealing with anything that matters between us.
_____ 9. I feel indifferent to _____.
_____ 10. I nearly always see exactly what _____ means.
_____ 11. Depending on _____'s actions, I have a better opinion of him/her sometimes than I do at other times.
_____ 12. I feel that I am genuinely myself with _____.
_____ 13. I appreciate and value _____, as a person.
_____ 14. My own feelings or attitude tend to get in the way of understanding _____.
_____ 15. My liking or disliking of _____ isn't changed by anything s/he reveals or says about her/himself.
_____ 16. I don't show my inner impressions and feelings with _____.
_____ 17. I find _____ rather dull and uninteresting.

_____ 18. I can tell what _____ means, even when s/he has difficulty saying it.

_____ 19. I would like _____ to be a particular kind of person.

_____ 20. I'm willing to say whatever is in my mind with _____, including feelings that come up in me about either one of us, or how I see us getting along.

_____ 21. I care for _____.

_____ 22. I screen out and don't pick up on some of _____ 's feelings.

_____ 23. I like or respect certain things about him/her, and there are other things that really put me off.

_____ 24. I am able to be openly myself in our relationship.

_____ 25. I do feel disapproval of _____.

_____ 26. I usually can tune in and understand all of _____ 's meaning.

_____ 27. Whether _____ is expressing 'good' thoughts and feelings, or 'bad' ones, does not affect the way I feel toward him/her.

_____ 28. Sometimes I am not at all comfortable with _____ but we go on, outwardly ignoring it.

_____ 29. I feel friendly and warm toward _____.

_____ 30. I really don't understand _____.

_____ 31. I am quite pleased with _____ sometimes, and then s/he disappoints me at other times.

_____ 32. I know fully what I feel in relation to _____. I don't sense anything that's hard for me to admit to myself.

_____ 33. I put up with _____, as s/he is.

_____ 34. I appreciate just how _____ 's experiences *feel to him/her*.

_____ 35. Sometimes _____ seems to me a more worthwhile person than s/he does at other times.

_____ 36. There are times when my outward response to _____ is quite different from the way I feel underneath.

_____ 37. I feel affection for _____.

_____ 38. I respond to _____ rather automatically, not really taking in what *s/he is experiencing*.

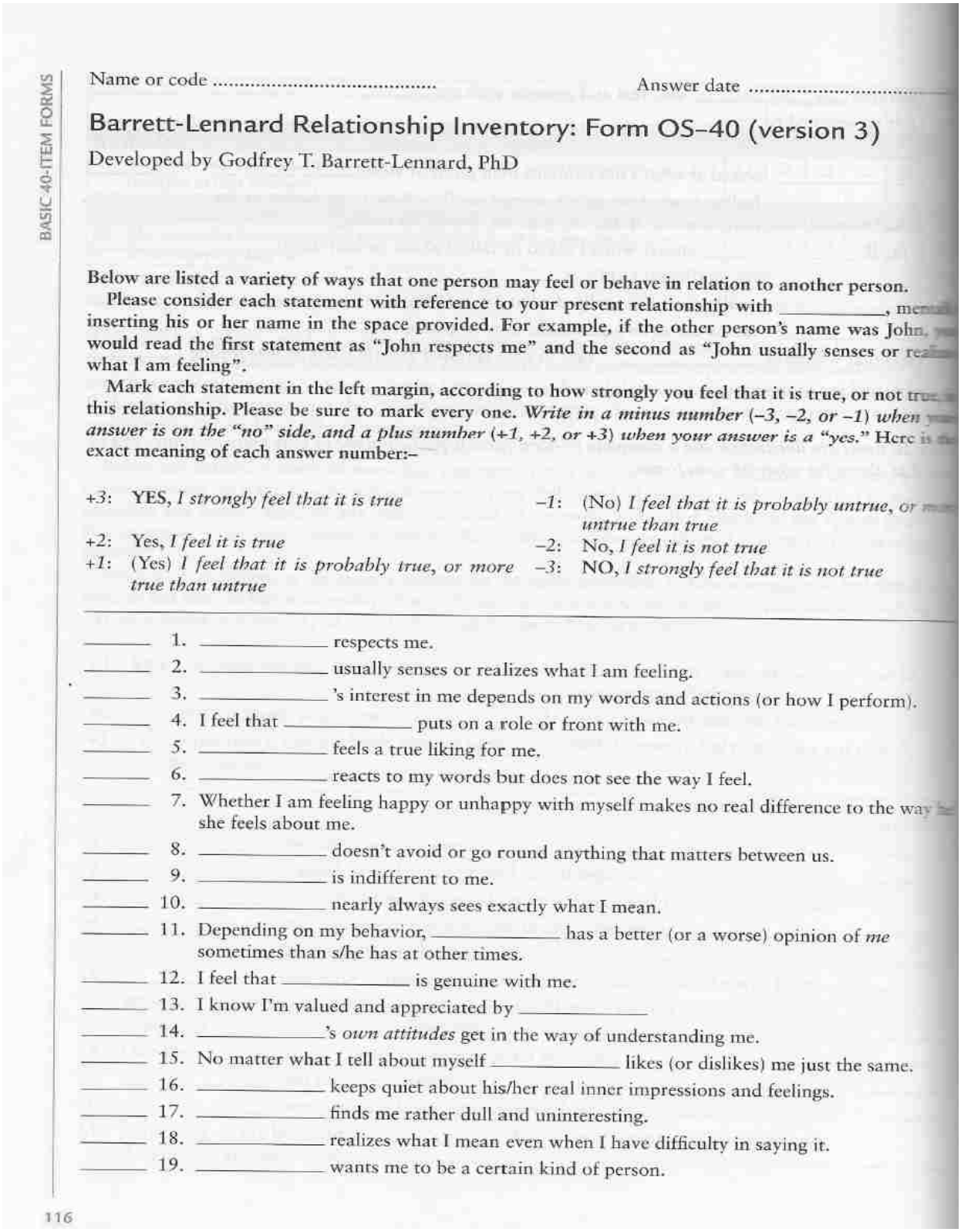
_____ 39. The different things _____ says or does don't alter my feeling toward him/her.

_____ 40. I feel there are things that we don't bring up and talk about that are causing difficulty in our relationship. .....

Please double-check and make sure that you have given an answer to every item. *Thank you.*

Please also note the other person's relation to you, e.g., personal friend, spouse/partner, mother, father or other family member, teacher or supervisor, client, counsellor. .....

Barrett-Lennard Relationship Inventory (BLRI OS-40; Barrett-Lennard, 2015)



BASIC-40-ITEM FORMS

Name or code ..... Answer date .....

Barrett-Lennard Relationship Inventory: Form OS–40 (version 3)

Developed by Godfrey T. Barrett-Lennard, PhD

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with _____, mentally inserting his or her name in the space provided. For example, if the other person's name was John, you would read the first statement as "John respects me" and the second as "John usually senses or realizes what I am feeling".

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. *Write in a minus number (–3, –2, or –1) when your answer is on the "no" side, and a plus number (+1, +2, or +3) when your answer is a "yes."* Here is the exact meaning of each answer number:–

+3: **YES,** *I strongly feel that it is true*

+2: Yes, *I feel it is true*

+1: (Yes) *I feel that it is probably true, or more true than untrue*

–1: (No) *I feel that it is probably untrue, or more untrue than true*

–2: No, *I feel it is not true*

–3: NO, *I strongly feel that it is not true*

_____ 1. _____ respects me.

_____ 2. _____ usually senses or realizes what I am feeling.

_____ 3. _____ 's interest in me depends on my words and actions (or how I perform).

_____ 4. I feel that _____ puts on a role or front with me.

_____ 5. _____ feels a true liking for me.

_____ 6. _____ reacts to my words but does not see the way I feel.

_____ 7. Whether I am feeling happy or unhappy with myself makes no real difference to the way he/she feels about me.

_____ 8. _____ doesn't avoid or go round anything that matters between us.

_____ 9. _____ is indifferent to me.

_____ 10. _____ nearly always sees exactly what I mean.

_____ 11. Depending on my behavior, _____ has a better (or a worse) opinion of *me* sometimes than s/he has at other times.

_____ 12. I feel that _____ is genuine with me.

_____ 13. I know I'm valued and appreciated by _____

_____ 14. _____ 's *own attitudes* get in the way of understanding me.

_____ 15. No matter what I tell about myself _____ likes (or dislikes) me just the same.

_____ 16. _____ keeps quiet about his/her real inner impressions and feelings.

_____ 17. _____ finds me rather dull and uninteresting.

_____ 18. _____ realizes what I mean even when I have difficulty in saying it.

_____ 19. _____ wants me to be a certain kind of person.

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_____ 20. _____ is willing to say whatever is on his/her mind with me, including feelings about either of us or how we are getting along.

_____ 21. _____ cares for me.

_____ 22. _____ doesn't listen and pick up on what I think and feel.

_____ 23. _____ likes certain things about me, and there are other things he/she does not like in me.

_____ 24. _____ is openly himself (herself) in our relationship.

_____ 25. I feel that _____ disapproves of me.

_____ 26. _____ usually understands the whole of what I mean.

_____ 27. Whether thoughts or feelings I express are 'good' or 'bad' makes no difference to _____'s feeling toward me.

_____ 28. Sometimes _____ is not at all comfortable but we go on, outwardly ignoring it.

_____ 29. _____ is friendly and warm toward me.

_____ 30. _____ does not understand me.

_____ 31. _____ approves of some things about me (or some of my ways), and plainly disapproves of other things (or ways I act and express myself).

_____ 32. I think _____ always knows exactly what s/he feels with me: s/he doesn't cover up inside.

_____ 33. _____ just tolerates or puts up with me.

_____ 34. _____ appreciates exactly how the things I experience feel to me.

_____ 35. Sometimes I am more worthwhile in _____'s eyes than I am at other times.

_____ 36. At moments I feel that _____'s outward response to me is quite different from the way s/he feels underneath.

_____ 37. _____ feels affection for me.

_____ 38. _____'s response to me is so fixed and automatic that I don't get through to him/her.

_____ 39. I don't think that anything I say or do really changes the way _____ feels toward me.

_____ 40. I believe that _____ has feelings s/he does not tell me about that affect our relationship.

Please double check and make sure that you have given an answer to every item. *Thank you for doing so.*

Please note the other person's relation to you, e.g., a personal friend, spouse or partner, mother, or other family member, teacher or supervisor, counselor/therapist .....

.....

Outcome Rating Scale (ORS; Miller et al., 2003)

Outcome Rating Scale (ORS)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Looking back over the last week, including today, help us understand how you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually:
(Personal well-being)

I----------I

Interpersonally:
(Family, close relationships)

I----------I

Socially:
(Work, School, Friendships)

I----------I

Overall:
(General sense of well-being)

I----------I

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www.talkingcure.com

Session Rating Scale (SRS, Duncan et al., 2003)

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

Relationship:

I did not feel heard, understood, and respected	I----------I	I felt heard, understood, and respected

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk about	I----------I	We worked on and talked about what I wanted to work on and talk about

Approach or Method:

The therapist's approach is not a good fit for me.	I----------I	The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today	I----------I	Overall, today's session was right for me

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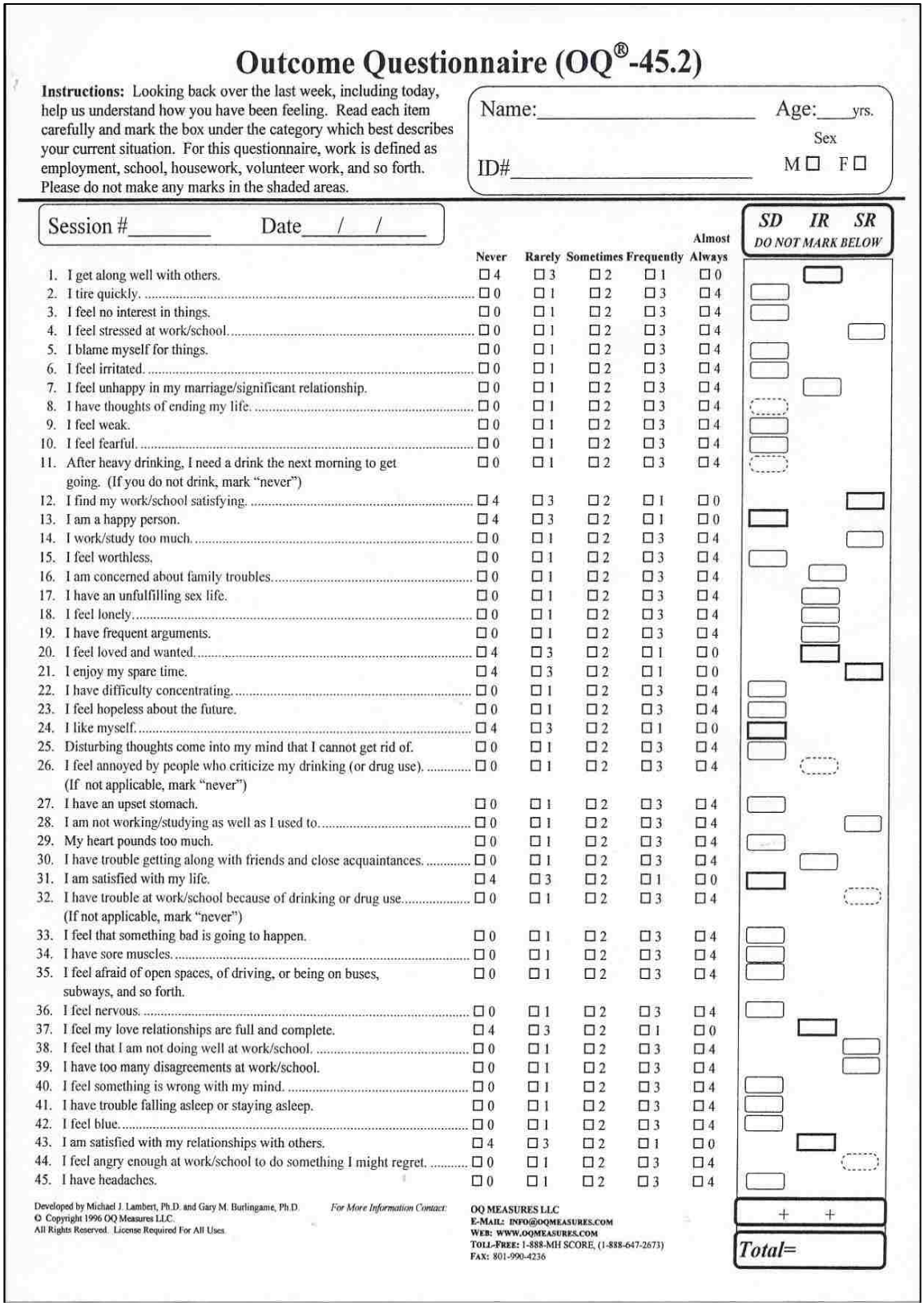
Outcome Questionnaire (OQ-45.2; Lambert et al., 1996)



Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name:_____ Age:___yrs.
Sex
ID#_____ M☐ F☐

Session #_____ Date___/___/_____

	Never	Rarely	Sometimes	Frequently	Almost Always	SD IR SR DO NOT MARK BELOW
1. I get along well with others.	☐4	☐3	☐2	☐1	☐0	
2. I tire quickly.	☐0	☐1	☐2	☐3	☐4	
3. I feel no interest in things.	☐0	☐1	☐2	☐3	☐4	
4. I feel stressed at work/school.	☐0	☐1	☐2	☐3	☐4	
5. I blame myself for things.	☐0	☐1	☐2	☐3	☐4	
6. I feel irritated.	☐0	☐1	☐2	☐3	☐4	
7. I feel unhappy in my marriage/significant relationship.	☐0	☐1	☐2	☐3	☐4	
8. I have thoughts of ending my life.	☐0	☐1	☐2	☐3	☐4	
9. I feel weak.	☐0	☐1	☐2	☐3	☐4	
10. I feel fearful.	☐0	☐1	☐2	☐3	☐4	
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐0	☐1	☐2	☐3	☐4	
12. I find my work/school satisfying.	☐4	☐3	☐2	☐1	☐0	
13. I am a happy person.	☐4	☐3	☐2	☐1	☐0	
14. I work/study too much.	☐0	☐1	☐2	☐3	☐4	
15. I feel worthless.	☐0	☐1	☐2	☐3	☐4	
16. I am concerned about family troubles.	☐0	☐1	☐2	☐3	☐4	
17. I have an unfulfilling sex life.	☐0	☐1	☐2	☐3	☐4	
18. I feel lonely.	☐0	☐1	☐2	☐3	☐4	
19. I have frequent arguments.	☐0	☐1	☐2	☐3	☐4	
20. I feel loved and wanted.	☐4	☐3	☐2	☐1	☐0	
21. I enjoy my spare time.	☐4	☐3	☐2	☐1	☐0	
22. I have difficulty concentrating.	☐0	☐1	☐2	☐3	☐4	
23. I feel hopeless about the future.	☐0	☐1	☐2	☐3	☐4	
24. I like myself.	☐4	☐3	☐2	☐1	☐0	
25. Disturbing thoughts come into my mind that I cannot get rid of.	☐0	☐1	☐2	☐3	☐4	
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4	
27. I have an upset stomach.	☐0	☐1	☐2	☐3	☐4	
28. I am not working/studying as well as I used to.	☐0	☐1	☐2	☐3	☐4	
29. My heart pounds too much.	☐0	☐1	☐2	☐3	☐4	
30. I have trouble getting along with friends and close acquaintances.	☐0	☐1	☐2	☐3	☐4	
31. I am satisfied with my life.	☐4	☐3	☐2	☐1	☐0	
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4	
33. I feel that something bad is going to happen.	☐0	☐1	☐2	☐3	☐4	
34. I have sore muscles.	☐0	☐1	☐2	☐3	☐4	
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐0	☐1	☐2	☐3	☐4	
36. I feel nervous.	☐0	☐1	☐2	☐3	☐4	
37. I feel my love relationships are full and complete.	☐4	☐3	☐2	☐1	☐0	
38. I feel that I am not doing well at work/school.	☐0	☐1	☐2	☐3	☐4	
39. I have too many disagreements at work/school.	☐0	☐1	☐2	☐3	☐4	
40. I feel something is wrong with my mind.	☐0	☐1	☐2	☐3	☐4	
41. I have trouble falling asleep or staying asleep.	☐0	☐1	☐2	☐3	☐4	
42. I feel blue.	☐0	☐1	☐2	☐3	☐4	
43. I am satisfied with my relationships with others.	☐4	☐3	☐2	☐1	☐0	
44. I feel angry enough at work/school to do something I might regret.	☐0	☐1	☐2	☐3	☐4	
45. I have headaches.	☐0	☐1	☐2	☐3	☐4	
						+ +
						Total=

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