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The achievement in counseling of client outcome goals has typically been referred to as *outcome effectiveness* (Miller & Duncan, 2004; Lambert & Hill, 1994). Two theoretical frameworks have been highly supported as viable explanations for the way in which counselors achieve outcome effectiveness (i.e., Empirically-Validated Treatment and Common Factors Theory), but neither framework has gained full support as a comprehensive explanation of outcome effectiveness. One component of outcome effectiveness that is common between both frameworks is the therapeutic relationship; nonverbal immediacy behaviors are theoretically supported as potential contributors to the therapeutic relationship. In this study, it was found that therapeutic relationship increased from session one to session three, but nonverbal immediacy behaviors did not change across sessions. Nonverbal immediacy behaviors did not predict therapeutic relationship, but therapeutic relationship was found to be a significant predictor of outcome effectiveness. Implications of these results and areas for future research are discussed.

OUTCOME EFFECTIVENESS IN COUNSELING: THE ROLE OF  
NONVERBAL IMMEDIACY BEHAVIORS AND  
THE THERAPEUTIC RELATIONSHIP

by

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CHAPTER I  
INTRODUCTION

**Rationale for the Study**

Counseling is a helping profession that addresses a wide variety of client goals through the enactment of a relationship between counselor and client (American Counseling Association, [ACA], 2005, A.1.a., 2010; Duncan & Moynihan, 1994). According to the ACA (2005) *Code of Ethics*, counselors should work collaboratively with their clients to devise treatment plans that are likely to help clients achieve their individual outcome goals (A.1.c.). The achievement in counseling of these client outcome goals related to individual functioning, interpersonal relationships, and social performance has typically been referred to as *outcome effectiveness* (Miller & Duncan, 2004; Lambert & Hill, 1994).

Counseling is an empirically-supported method for achieving outcome effectiveness, regardless of the theory, technique, or method used (Ahn & Wampold, 2001; Chambless, 2002; Duncan, Miller, Wampold, & Hubble, 2010; Hauser & Hays, 2012; Lambert, 2013; Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1983; Smith & Glass, 1977; Wampold et al., 1997). Specifically, counseling has been shown to produce better outcomes than no treatment. In three separate meta-analyses (i.e., Luborsky et al., 1975; Shapiro & Shapiro, 1982; Smith & Glass, 1977) individuals who received some form of psychotherapy showed significantly greater improvement than

those who received no intervention. Lambert (2013) conducted a comprehensive review of meta-analyses from 1971 to 2010 and concluded that clients who enter counseling are more likely to experience goal attainment than those who do not receive mental health treatment.

Two theoretical frameworks have been highly supported as viable explanations for the way in which counselors achieve outcome effectiveness. Supporters of the Empirically-Validated Treatment (EVT) framework assert that the two main components of outcome effectiveness are the client's presenting problem and the use of an empirically-validated treatment (APA, 1995; Chambless et al., 1996, 1998). Advocates of the Common Factors Theory (CFT) assert that several universal components (e.g., client factors and therapeutic relationship) are present in all effective psychotherapeutic experiences (Grencavage & Norcross, 1990; Rosenzweig, 1936).

Although both theories have offered some structure for understanding outcome effectiveness, neither theoretical framework has gained full support in the counseling field as a comprehensive explanation of outcome effectiveness. CFT models include innumerable variables that have not been comprehensively tested for direct contributions to outcome effectiveness (Budd & Hughes, 2009; Duncan et al., 2010). The insurmountable problem of EVT is that every presenting problem and every possible treatment must be adequately studied to compile a complete list of EVTs, which would require hundreds of thousands of studies to validate in its entirety (Budd & Hughes, 2009; Hauser & Hays, 2010). Additionally, with the recent addition of therapist and client factors into the otherwise simplistic EVT framework (APA Task Force, 2006), the

factors of EVT are even more numerous and begin to reflect the framework of common factors (e.g., client factors, therapist factors, model/technique, therapeutic relationship; Duncan et al., 2010). EVT and CFT researchers work to identify all factors that potentially contribute to outcome effectiveness, but studying both frameworks in their entirety seems implausible. It is important to find a common component of both frameworks that is present in all counseling relationships that can be concretely studied and built upon through future research.

One component of outcome effectiveness that is common between CFT and EVT is the therapeutic relationship (Chambless & Hollon, 1998; Rosenzweig, 1936). The very definition of counseling describes the counselor and client joining together in a relationship (ACA, 2010). In CFT, the therapeutic relationship has been found to account for up to 35% of outcome effectiveness (Thomas, 2006) and was the single most frequently reported common factor amongst CFT researchers and theorizers (Grencavage & Norcross, 1990).

In EVT, the therapeutic relationship is the vehicle through which a counselor implements any empirically-validated treatment, and the therapeutic relationship is strengthened when counselors and clients agree with the particular treatment used (ACA Task Force, 2006; Bordin, 1979; Chambless & Hollon, 1998; Fireman, 2002; Miller & Duncan, 2004). The American Psychological Association (APA) Society of Clinical Psychology (2006) asserted that EVTs should be implemented in the context of the therapeutic relationship; this is currently known as evidence-based practice in psychology (EBPP; APA Presidential Task Force, 2006; Cukrowicz et al., 2011; Fireman, 2002;

Stewart & Chambless, 2007; Southam-Gerow & McLeod, 2013). In EBPP, the therapeutic relationship allows therapists to accommodate client needs and integrate clinical judgment while implementing EVT (APA Task Force, 2006). The therapeutic relationship plays an important role when translating efficacious treatments to real-life settings (APA Presidential Task Force, 2006; Chambless et al., 1998;). EBPP allows clinicians to utilize empirically-supported treatments while still accounting for the nuances that occur within a real therapeutic relationship (APA Task Force, 2006; Chambless & Hollon, 1998; Fireman, 2002). Overall, it appears that the therapeutic relationship is a critical component to counseling and outcome effectiveness that is common to all outcome effectiveness frameworks.

### **Therapeutic Relationship: The Common Component**

The therapeutic relationship encompasses the quality of the relational bond between therapist and client, as well as the degree of agreement on the goals, methods, and overall approach to therapy (Miller & Duncan, 2004). The therapeutic relationship has been linked to outcome effectiveness in over 1,000 studies (Orlinsky, Ronnestad, & Willutzki, 2004). Miller, Duncan, Brown, Sorrell, and Chalk (2006) studied 6,424 clients receiving services through an Employee Assistance Program in which the agency policy encouraged clients to see the therapist who was available soonest, not necessarily who they had seen previously. Miller et al. found that clients who switched therapists frequently experienced significantly less change in individual functioning, interpersonal relationships, and social performance than clients who stayed with the same therapist (i.e., a final effect size of .40 versus .93 when gain score was divided by standard

deviation of a non-treatment normative sample). Miller et al. found that therapeutic relationship at intake was not a predictor of outcome effectiveness; rather the predictor was the improvement in therapeutic relationship over time. Thus, it may be that staying with the same therapist led to better achievement of outcomes because the therapeutic relationship had time to develop. This supports the idea that therapeutic relationship is built over time, indicating a need for a stable, consistent relationship with one counselor. What is not known from Miller et al.'s study is the way in which a therapeutic relationship is actually built by a counselor (i.e., the specific behaviors or techniques) and how to continually maintain or improve the therapeutic relationship across time (Couture, 2006; Rogers, 1957). Further exploration of how to establish a therapeutic relationship is needed, along with continued examination of how and when the therapeutic relationship is most impactful in explaining outcome effectiveness.

Researchers have begun to explore some specific factors through which counselors build the therapeutic relationship, but the counselor behaviors, characteristics, or traits that contribute to a strong therapeutic relationship are still largely unknown and further research on this topic is needed (Baldwin, Wampold, & Imel, 2007; Couture, 2006; Okiishi et al., 2006). Baldwin et al. (2007) assessed data from 331 clients and 80 of their therapists (average caseload of 4.1) and found that some counselors do indeed form generally stronger therapeutic relationships with their clients than other counselors, which in turn produced greater outcome effectiveness than the counselors with generally poorer therapeutic relationships. However, it is not counselor demographics or level of training that contribute to outcome effectiveness (Okiishi et al., 2006).

Marcus, Kashy, and Baldwin (2009) confirmed Baldwin et al.'s (2007) findings and found that clients who reported a particularly strong therapeutic relationship with their therapist experienced greater outcome effectiveness than clients who did not experience an equally strong therapeutic relationship with the same therapist. An important thing to note, though, is that although some counselors are able to form greater therapeutic relationships in general, Marcus et al. (2009) found that therapists who formed strong therapeutic relationships with some clients did not form strong relationships with all their clients. If counselor demographics do not directly contribute to outcome effectiveness (Okiishi et al., 2006), it is possible that there are particular behaviors that a counselor engages in that match some clients and not others. It is important to identify the behaviors a counselor may engage in with a client, or the match between client and counselor specific behaviors, that contribute to a strong therapeutic relationship.

Although it has been established that the therapeutic relationship is a critical component of outcome effectiveness (Baldwin et al, 2007; Blow & Sprenkle, 2001; Lambert, 1992; Marcus et al., 2009; Okiishi et al., 2006; Thomas, 2006), the current knowledge of specific client and counselor characteristics or behaviors that cultivate the therapeutic relationship is limited (Blow, Sprenkle, & Davis, 2007; Couture, 2006; Sexton & Ridley, 2004; Simon, 2006). Rogers (1957, 1958, 1961/1995) proposed that counselor communication of congruence, empathy, and unconditional positive regard in a way that the client could clearly perceive and understand was key to creating outcome effectiveness; however, while this was stated over half a decade ago, it has yet to be fully

explored (Duncan et al., 2010; Norcross, 2011). One reason these variables may not have been studied is that congruence, empathy, and unconditional positive regard are difficult to measure concretely (Norcross, 2011). As such, it might be beneficial to explore other communication behaviors that are easily measured, yet theoretically convey constructs similar to congruence, empathy, and unconditional positive regard. It would be important to identify the way in which counselor and client communication behaviors contribute to the therapeutic relationship and outcome effectiveness.

### **Nonverbal Immediacy Behaviors, Therapeutic Relationship, and Outcome Effectiveness**

Nonverbal Immediacy Behaviors (NIB) are nonlinguistic communication behaviors that convey availability, warmth, and approachability (Andersen & Andersen, 1982). Although not identical, these constructs loosely align with Rogers' (1957) congruence, empathy, and unconditional positive regard. NIB have primarily been studied in the field of instructional communication, and researchers have found that the NIB of classroom teachers are highly related to student learning outcomes (McCrosky, 2003; McCrosky, Richmond, & Bennett, 2006). Student perceptions of teachers' NIB have been positively related to student-reported motivation and affect for teacher (McCrosky et al., 2006), and student-perceived credibility and attractiveness of their teacher (McCrosky, Valencic, & Richmond, 2004). If these findings translate to the field of counseling, counselor NIB behaviors can build the therapeutic relationship by increasing the quality of the bond (i.e., counselor attractiveness and affect for counselor) and increasing counselor and client degree of agreement on the goals, methods, and

overall approach to therapy (i.e., counselor credibility and client motivation), which are the two main components to Miller and Duncan's (2004) definition of therapeutic relationship. It is important to explore the way in which counselor NIB relate to the therapeutic relationship.

As mentioned earlier, some counselors form stronger relationships with their clients than other counselors, yet they still do not form strong relationships with all of their clients (Baldwin et al., 2007; Marcus et al., 2009). This might indicate that some counselors are generally stronger than others in using communication to build the therapeutic relationship, but that client communication behaviors also play a role. As Rogers (1957, 1958) postulated, counselors must adjust their communication in a way that the client can clearly receive and understand. As such, some sort of interaction between counselor and client nonverbal immediacy behaviors might occur in relation to the therapeutic relationship.

The social meaning model is based upon the principle that two individuals should mimic, or match, each others' nonverbal immediacy behaviors (Floyd & Erbert, 2003). Floyd and Erbert studied NIB similarity and found that communicators who intentionally matched their target's NIB conveyed greater receptivity, greater similarity, and less dominance. Although not identical, these constructs also loosely align with Rogers' (1957) congruence, empathy, and unconditional positive regard. Greater similarity aligns with Roger's (1957) notion that counselors should adjust their communication according to the client's needs and Miller and Duncan's (2004) assertion that the therapeutic relationship relies upon agreement of counselor and client. Overall, counselors who

match their clients' NIB can improve the way in which their clients perceive them and potentially increase the quality of the therapeutic relationship (Andersen, 2009; Berko, Aitken, & Wolvin, 2010; Flaskerud, 2013; Floyd & Erbert; Hall, 1983; Rogers, 1961/1995).

Some counselors might inherently be better at matching their clients' NIB in order to build a therapeutic relationship (Berko et al., 2010; Rogers, 1961/1995). However, counselors need to intentionally adjust their own NIB in accordance to the client's NIB preferences and characteristics in order to form a strong therapeutic relationship with a variety of clients (Andersen, 1982, 2009; Berko et al., 2010, Floyd & Erbert, 2003; Hall, 1983; Rogers, 1957), which supports the idea that some counselors build consistently stronger therapeutic relationships than other counselors (Baldwin et al., 2007), but are unable to do so with all of their client (Marcus et al., 2009). Therefore, exploring counselor and client NIB in terms of similarity (i.e., correspondence) may be one way to understand how the therapeutic relationship is built and thus how it contributes to outcome effectiveness.

### **Purpose of the Study**

The purpose of this study is to explore client and counselor NIB in relation to the therapeutic relationship and outcome effectiveness. Therapeutic relationship is the one variable that has consistently been identified as a key contributor to outcome effectiveness (Baldwin et al., 2007; Duncan et al., 2010; Marcus et al., 2009; Miller et al., 2006; Orlinsky et al., 2004) and is a common component across the CFT and modern

EVT frameworks (APA Presidential Task Force, 2006; Cukrowicz et al., 2011; Duncan et al., 2010; Wampold, 2001).

Although therapeutic relationship has been found to be a consistent and important contributor to outcome effectiveness across a minimum of a century (Rosenzweig, 1936; Rogers, 1961/1995), the specific way in which therapeutic relationship can be fostered intentionally by a therapist is still largely empirically unknown (Blow et al., 2007; Crits-Christoph et al., 2006). Previous researchers have found that speaker NIB affects audience perception of the speaker and that speaker and audience NIB should ideally match one another (Berko et al., 2010; Flaskerud, 2013; Floyd & Erbert, 2003; McCrosky et al., 2004, 2006). If this holds true in the counseling relationship, counselor NIB may affect the client's perception of the counselor and the therapeutic relationship (which affects outcome effectiveness; Baldwin et al., 2007; Blow & Sprenkle, 2001, Marcus et al., 2009). Better understanding the match between counselor and client NIB can assist counselors in a more purposeful development of the therapeutic relationship. Therefore, the purpose of this study is to explore how NIB contribute to the therapeutic relationship, and to examine how the correspondence or difference between client and counselor NIB impact the therapeutic relationship. The second purpose of this study is to better understand the point at which therapeutic relationship has the greatest affect on outcome effectiveness, as perceived by the client.

### **Need for the Study**

Outcome effectiveness in mental health has been the focus of research for almost a century (Freud, 1920/1966; Hauser & Hays, 2010; Rosenzweig, 1936). Although

several important theoretical frameworks (e.g., CFT and EVT) and research findings (e.g., Baldwin, et al., 2007; Chambless et al., 1996, 1998; Grenavage & Norcross, 1990) have contributed to a greater understanding of the relationship between therapeutic relationship and outcome effectiveness, it is important to continue exploring concrete, measurable ways that outcome effectiveness can be achieved. More specifically, if counselors have an understanding of how to enhance or more quickly develop the therapeutic relationship through communication (i.e., NIB), and at which point the therapeutic relationship most affects outcome effectiveness (e.g., at first session verses across all sessions), it would affect all stakeholders, counselor educators, and clients. An improved understanding of how therapeutic relationship can shape outcome effectiveness will be beneficial for counselor educators (CACREP, 2009; Duncan et al., 2010), counselors (Mellin et al., 2011; Pearlman & Saakvitne, 1995), and clients (ACA, 2005; APA Task Force, 2006).

Counselor education (CE) programs can benefit from teaching counselor trainees improved methods of achieving outcome effectiveness because the primary purpose of their job is to educate counselors about helping others (CACREP, 2009; Savickas, 2011). The research on outcome effectiveness is constantly evolving (Duncan et al., 2010), and it is important that students learn the history of outcome effectiveness research in addition to the most updated outcome effectiveness findings. If it is found that NIB directly contribute to the therapeutic relationship (which has been linked to outcome effectiveness), this information would be important for counselor educators to pass onto their students.

Counselors benefit from increased outcome effectiveness because they are better able to perform their jobs, which can increase job security (McLaughlin & Boettcher, 2009) and reduce the possibility of vicarious trauma and burnout (Pearlman & Saakvitne, 1995). ACA (2005, A.1.c.) ethical codes state that it is important for counselors to demonstrate that clients will be aided in reaching their goals, and an increased understanding of NIB and the therapeutic relationship could improve counselors' outcome effectiveness, strengthen the relatively young profession's identity (McLaughlin & Boettcher, 2009), and increase job satisfaction (Pearlman & Saakvitne, 1995).

Clients will benefit from counselors' intentional matching of NIB because they will more favorably perceive the therapeutic relationship (Floyd & Erbert, 2003; Rogers, 1961/1995) and potentially experience greater outcome effectiveness (Baldwin et al., 2007; Duncan et al., 2010; Marcus et al., 2009; Miller et al., 2006; Orlinsky et al., 2004). It is theoretically supported that counselors can use NIB to build the therapeutic relationship (Floyd & Erbert; McCrosjy et al., 2004, 2006), which is essential when helping clients reach their individualized goals (ACA (2005, A.1.c.; Duncan et al., 2010; Duncan & Moynihan, 1994; Lambert & Hill, 1994; Miller & Duncan, 2004; Wampold, 2001), but it is time to add empirical support. If counselors are able to increase outcome effectiveness through NIB, clients can achieve a greater level of wellness, which is a primary purpose of counseling (Myers & Sweeney, 2008).

An increased understanding of the way in which NIB can be used to create outcome effectiveness can also benefit counselors and clients because legislators have the ability to influence laws that directly affect counseling practice (Miller & Duncan, 2004;

Wittig, 2000), and legislators want to be assured that clients are likely to experience outcome effectiveness before offering their support (Myers et al., 2002). Legislation dictates which types of mental health professionals can become licensed, serve certain populations, and be reimbursed by certain insurance companies (Resiner, 2005); counselors rely upon this financial support in order to make a living and clients rely upon it in order to receive services (Miller & Duncan, 2004; Wittig, 2000). The introduction of managed care has increased legislators' and insurance companies' focus on outcome effectiveness (Fireman, 2002; Okiishi, Lambert, Neilson, & Ogles, 2003; Reisner, 2005), and all third-party payers want to be assured that clients are receiving interventions that help them reach their goals (ACA, 2005; Blow et al., 2007; Davis et al., 2012; Stewart, Chambless, & Baron, 2012). An increased understanding of NIB can lead to outcome effectiveness and could increase the support that the counseling profession receives from legislators and third-party payers, which ultimately benefits CE programs, counselors, and their clients.

### **Research Questions**

1. How do correspondence (i.e., similarity) of counselor and client nonverbal immediacy behaviors and therapeutic relationship change across sessions?
2. How do counselor and client nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness relate within each session?
3. At what point in counseling does therapeutic relationship have the greatest effect on outcome effectiveness?

## Definition of Terms

*Counselor and Client Pairs* include one master's-level counselor and one client who have worked together in a counseling relationship for a minimum of three sessions (no maximum is specified).

*Common Factors Theory* is a theoretical framework of outcome effectiveness in which several universal components are present in all effective psychotherapeutic relationships (Rosenzweig, 1936).

*Empirically-Validated Treatment* is a theoretical framework of outcome effectiveness in which the use of an empirically-validated treatment for the corresponding client problem creates outcome effectiveness (APA, 1995).

*Session* is a time period of at least 45 minutes in which a counselor and client join together in a counseling relationship.

*Across Sessions* refers to comparison of data from one session to another.

*First Session* refers to the initial session between counselor and client.

*Second Session* refers to a session that occurs directly after the first session and before the third session with the same counselor and client.

*Third Session* refers to the session directly after the second session, which may or may not be the termination session.

*Nonverbal Immediacy Behaviors (NIB)* are conceptually defined as nonlinguistic communication behaviors that convey availability, warmth, and approachability (Andersen & Andersen, 1982); NIB are operationally defined as counselor and client use

of haptics, kinesics, oculesics, proxemics, and vocalics in a counseling session. This operational definition is measured in its entirety by the Nonverbal Immediacy Scale.

*Nonverbal Immediacy Scale (NIS)* is a scale used to measure the NIB variable; the observer-reported NIS will be used for this study.

*Correspondence of Counselor and Client Nonverbal Immediacy Behaviors (CNIB)* is the correlation between each item on the NIS for counselor and client in any given session; higher correlation indicates greater correspondence. There will be one overall score of correspondence for each counselor and client dyad per session.

*Outcome Effectiveness (OE)* is the amount of change in individual functioning, interpersonal relationships, and social performance (Miller & Duncan, 2004) from the first session to the third session; this construct is measured in its entirety by the Outcome Rating Scale.

*Outcome Rating Scale (ORS)* is a scale used to measure general outcome effectiveness; the ORS is completed by the client at the beginning of each session.

*Therapeutic Relationship (TR)* is “the quality of the relational bond, as well as the degree of agreement between the client and therapist on the goals, methods, and overall approach of therapy” (Miller & Duncan, 2004, p. 13); this construct is measured in its entirety by the Session Rating Scale.

*Session Rating Scale (SRS)* is a scale used to measure the therapeutic relationship; the SRS is completed by the client at the end of each session.

## **Brief Overview**

This study will be presented in five chapters. The first chapter has served as an introduction to the importance of the therapeutic relationship, the role of nonverbal immediacy behaviors in building the therapeutic relationship, and the relationship between therapeutic relationship and outcome effectiveness in the counseling profession. The purpose of this study, statement of the problem, the need for the study, and research questions also were outlined in this introduction, and definitions of key terms were included. The second chapter includes a review of the literature as it is related to theoretical frameworks of outcome effectiveness, nonverbal immediacy behaviors, the therapeutic relationship, and the relevant research regarding outcome effectiveness that has been conducted to this point. The third chapter presents the methodology to be used in the study, including participants, sampling method, instruments, data analyses, and results of a pilot study. The fourth chapter presents the results of this research by addressing each research question. Finally, the fifth chapter summarizes the study and includes limitations and recommendations for future research on counselor outcome effectiveness.

## CHAPTER II

### REVIEW OF THE LITERATURE

In chapter one, the rationale for a study on nonverbal immediacy behaviors and the therapeutic relationship was presented; specifically, the use of nonverbal immediacy behaviors to improve the therapeutic relationship and potentially increase outcome effectiveness was discussed. In this chapter, literature relevant to this study is presented in the following order: (a) the history of outcome effectiveness, (b) measuring outcome effectiveness, (c) outcome effectiveness and the therapeutic relationship, (d) empirically validated treatments, (e) common factors theory, (f) nonverbal immediacy behaviors, and (g) importance of nonverbal immediacy behaviors in the therapeutic relationship. The chapter concludes with a summary of the literature that supports the need for an increased understanding of nonverbal immediacy behaviors in relation to the therapeutic relationship and outcome effectiveness.

#### **Outcome Effectiveness**

Outcome effectiveness is the achievement of client-desired change in individual functioning, interpersonal relationships, and social performance (Miller & Duncan, 2004; Lambert & Hill, 1994). Although outcome effectiveness is important (ACA, 2005,2010; CACREP, 2009), and researchers have conducted different assessments and controlled studies to determine that counselors or therapists are in fact effective (Ahn & Wampold, 2001; Lambert, 2013; Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1983;

Smith & Glass, 1977; Wampold et al., 1997), the specific variables and behaviors that generate outcome effectiveness, or achievement of client goals, are still to some degree unknown (Duncan, Miller, Wampold, & Hubble, 2010; Okiishi, Lambert, Neilson, & Ogles, 2003). It is important that counselors have a clear and consistent method for creating outcome effectiveness with clients in order to support the purpose of the profession.

Outcome effectiveness is of interest to counselors, counselor educators, clients, and stakeholders (ACA, 2005,2010; CACREP, 2009; Duncan & Moynihan, 1994; Miller & Duncan, 2004; Myers, Sweeney, & White, 2002; Okiishi, et al., 2003; Paul, 1967; Reisner, 2005) because outcome effectiveness is at the heart of counseling and ensures that clients receive what they need from the counseling process (ACA, 2005, A.1.c., 2010; Duncan & Moynihan, 1994, Paul, 1967). The definition of counseling (as determined by 31 counseling organizations) asserts that outcome effectiveness is the ultimate goal of counseling (ACA, 2010) and counselor educators are responsible for training counselors to achieve outcome effectiveness (CACREP, 2009, I.AA.4.). Additionally, third-party payers are increasingly interested in supporting mental health interventions that are effective (Okiishi, et al., 2003; Reisner, 2005), and legislators are more likely to support a profession that effectively serves their constituents (Miller & Duncan, 2004; Myers et al., 2002). It is important to determine the specific ways in which counselors produce outcome effectiveness.

Historically, two theoretical frameworks that identify the components of outcome effectiveness have been empirically supported and widely used: Empirically-Validated

Treatment (EVT) and Common Factors Theory (CFT; Duncan et al., 2010; Budd & Hughes, 2009). In EVT, the two main components of outcome effectiveness are the client's presenting problem and the use of an empirically-validated treatment (APA, 1995; Chambless et al., 1996, 1998). Alternatively, CFT theorists assert that several universal components (e.g., client factors, therapeutic relationship) are present in all psychotherapeutic relationships and lead to outcome effectiveness (Rosenzweig, 1936; Grencavage & Norcross, 1990). The debate between EVT and CFT has been festering for decades, with little consensus regarding the way in which outcome effectiveness is actually produced (Budd & Hughes, 2009; Hauser & Hays, 2010). However, proponents of both theories (e.g., APA Task Force, 2006; Wampold, 2001) have begun to simplify the associated outcome variables, and therapeutic relationship is common to both EVT and CFT. It is now important to build upon this commonality in order to help counselors efficiently develop the therapeutic relationship and work to achieve outcome effectiveness with clients.

### **The History of Outcome Effectiveness**

The history of mental health interventions has been traced back to the 1700s (Myers et al., 2002); however, the mental health profession became more widely recognized in the 20<sup>th</sup> century (Freud, 1920/1966; Savickas, 2011). Outcome effectiveness has been an important consideration of psychotherapy since the early 1900s, and various disciplines have studied how to best help clients with mental health issues (Budd & Hughes, 2009; Hauser & Hays, 2010). It is important to understand the history of outcome effectiveness in mental health in order to determine areas for future research.

Sigmund Freud (1920/1966), the father of psychoanalysis, published his introduction to psychoanalysis in 1920, which explained his views and methods of outcome effectiveness. Freud was a neurologist and believed that outcome effectiveness could be achieved by helping clients identify their repressed feelings and ways in which their psychosocial development was stunted or otherwise compromised at an early age. Freud is regarded as one of the original psychotherapy scientists and he was attuned to the need for outcome effectiveness in his practice of psychotherapy (Hauser & Hays, 2010; Wampold, 2007). Freud regarded the unique therapeutic relationship as a critical component of outcome effectiveness, and therapeutic relationship is still one of the most frequently studied components of outcome effectiveness (Duncan et al., 2010; Hauser & Hays, 2010). Given Freud's perspective of therapeutic relationship as a critical outcome component, along with the commonality of therapeutic relationship between EVT and CFT, it seems as if therapeutic relationship should remain at the forefront of outcome effectiveness research. Additionally, it seems imperative to have a more empirical understanding of the way in which therapeutic relationship is developed between counselor and client.

Around the time that Freud was researching and implementing psychoanalysis, another psychotherapist named Saul Rosenzweig (1936) became attuned to the need for measurable outcomes in the mental health field. Rosenzweig was the first mental health researcher to write about outcome effectiveness as a unique and important factor of psychotherapy (Grencavage & Norcross, 1990; Sprenkle & Blow, 2004). In his seminal 1936 article, Rosenzweig defined outcome effectiveness as "notable successes" (p. 412)

in psychotherapy. Rosenzweig hypothesized that all effective psychotherapies shared common ingredients, which included (a) the personality of a good therapist and unverbilized factors within the therapeutic relationship, (b) consistency of the therapist's therapeutic ideology as a base for reintegration, and (c) integration of an alternative interpretation of psychological events into the client's personality. Rosenzweig identified these common factors through his personal experience with psychotherapy and noted that they required further research. His thought-provoking work inspired others to begin exploring the meaning of outcome effectiveness and the factors that contribute to it.

The definition of outcome effectiveness has been disparate across the many years of outcome effectiveness research (e.g., ACA, 2010; Parsons, 1909; Rogers, 1958; Rosenzweig, 1936). Similar to Rosenzweig's (1936) definition of outcome effectiveness, Luborsky et al. (1975) defined outcome effectiveness as the "amount of improvement" (p. 995) experienced by clients. As noted by Duncan and Moynihan (1994), Fireman (2002), and Miller and Duncan (2004), it is helpful to measure success and improvement as it is defined by clients, as they can qualitatively identify internal changes and they are the ones personally invested in receiving mental health services. As such, it is important to determine a comprehensive definition of outcome effectiveness that reflects the client's perspective as the most important gauge of outcome effectiveness.

In order to create a definition of outcome effectiveness that reflects the client's perception of change, Miller and Duncan (2004) utilized Lambert and Hill's (1994) report that client-defined goals often address individual functioning, interpersonal relationships, and social performance. As such, Miller and Duncan (2004) created the

following comprehensive definition of outcome effectiveness: the achievement of client-desired change in individual functioning, interpersonal relationships, and social performance (Miller & Duncan, 2004; Lambert & Hill, 1994). This definition will be used in this study in order to assess outcome effectiveness as it is experienced by the client.

### **Measuring Outcome Effectiveness**

Outcome effectiveness can be measured using specific or general measures, which should be guided by the researcher's definition of outcome effectiveness. Specific outcome effectiveness measures reflect a definition of outcome effectiveness that is based upon a reduction of the diagnostic symptoms related to a specific presenting problem (Chambless & Hollon; Fireman, 2002). An example of a specific measure of outcome effectiveness would be the use of the Beck Depression Inventory (BDI) to measure alleviation of depressive symptoms (Luborsky et al., 1999). A general outcome measure reflects a definition of outcome effectiveness in which the individual experience and the quality of client change is of interest (Duncan & Moynihan, 1994; Fireman; Miller & Duncan, 2004). An example of a general outcome measure would be the Outcome Rating Scale (ORS), which focuses on overall client wellbeing rather than specific diagnostic symptoms.

There are benefits and limitations to using specific and general outcome measures. A benefit of using specific measures of outcome effectiveness is that very specific client change for a particular presenting problem can be measured. However, a limitation of specific measures is that a variety of measures regarding the same

presenting problems might be used across studies, which limits generalization of findings. For example, if two studies on depression use two different specific outcome measures (e.g., the BDI and the Zung Self-Rating Depression Scale), the results of these two studies do not show the same type of client change and cannot easily be compared with one another. Researchers have many statistical methods for adjusting study data in order to place the results on comparable scales, but the construct being measured will always be different (Chambless et al., 1998; Lambert, 2013).

A limitation of using a general measure of outcome effectiveness is that it can be difficult to isolate the particular symptoms that have changed within a particular client. For example, if a client notes that their interpersonal relationships have improved, the counselor cannot know for sure if these include relationships with coworkers, friends, or family members. However, a benefit of using a general measure of outcome effectiveness is that such a measure can be used in a variety of studies and the results will measure the same construct of outcome effectiveness with the same scale (Miller & Duncan, 2004). In current literature trends, researchers are moving away from specific outcome measures and utilizing general measures of outcome effectiveness (Davis, Lebow, & Sprankle, 2012; Miller & Duncan, 2004; O'Donovan, Halford, & Walters, 2011) to assess the effectiveness of certain interventions across a wide variety of client populations and presenting problems. This allows researchers to identify the quality of the change instead of the quantity of symptom reduction (e.g., Clavelle, Dickerson, & Murphy, 2012; Leibert, Smith, & Agaskar, 2011; Okiishi et al., 2006).

There are two general outcome effectiveness measures that are currently widely used by researchers: the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996) and the ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003). The OQ-45, was developed in 1996 based upon outcome effectiveness benchmarks originally proposed by Lambert and Hill (1994). These criteria include improvement in clients' individual functioning, interpersonal relationships, and social performance (Miller & Duncan, 2004). The OQ-45 has statistically high levels of validity and reliability, which indicates that it effectively measures outcome effectiveness as it is defined by Lambert and Hill (1994; Kim, Beretvas, & Sherry, 2010; Lambert et al., 1996; Lambert, 2012).

The OQ-45 has been translated into more than 30 languages and used in dozens of studies since it was developed in 1996 (Lambert, 2012). The OQ-45 has been used to assess the relationship between outcome effectiveness and therapeutic relationship (Marcus, Kashy, & Baldwin, 2009; Leibert et al., 2011), counselor characteristics (Baldwin, Wampold, & Imel, 2007; O'Donovan et al., 2011; Okiishi et al., 2003, 2006), and client characteristics (Baldwin, et al., 2007). This measure has also been used with a variety of populations; Leibert et al. (2011) administered the OQ-45 to 135 Caucasian, African-American, multiracial, and Asian clients between the ages of 18 and 81 and found high internal validity (.89). Okiishi et al. (2003) calculated concurrent validity by administering the OQ-45 to 1841 Caucasian, Hispanic, Asian-American and Native-American clients at a university counseling center and found significant moderate to strong correlations ranging from .5 and .85 with the Beck Depression Inventory, Symptom Checklist-90, State-Trait Anxiety Inventory, and the Zung Depression

Inventory. Lambert (2012) reported internal consistency of .90, .84 test-retest reliability over three weeks, and concurrent validity in the mid .80s for the OQ-45.

Although the OQ-45 is valid, reliable, and measures general, client-defined outcome effectiveness, clinicians complained that it was not feasible to administer the 45-question assessment to clients (Bringhurst, Watson, Miller, & Duncan, 2006), especially if asking clients to repeatedly fill out the assessment. As a result, Miller et al. (2003) created the Outcome Rating Scale (ORS), which also has acceptable psychometric properties (Miller & Duncan, 2004) and measures similar outcome constructs as the OQ-45. This simple and quick four-item instrument can be completed by clients on a weekly basis and measures achievement of client-desired change in individual functioning, interpersonal relationships, and social performance (Lambert et al., 1996; Miller & Duncan, 2004). Using the ORS, clients can individually define outcome effectiveness in a standardized, time-efficient way (Miller & Duncan, 2004).

The ORS has been widely used by researchers (e.g., Anker, Duncan, & Sparks, 2009; Bringhurst et al., 2006; Campbell & Hemsley, 2009; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Miller, Duncan, Sorrell, & Brown, 2004; Miller et al., 2003) and is supported by the U. S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's (SAMHSA, 2013) National Registry of Evidence-based Programs and Practices when used in conjunction with the Session Rating Scale (SRS; Miller and Duncan, 2004), which is a measure of therapeutic relationship. Researchers have used the ORS to improve couples therapy in accordance to client feedback (Anker et al., 2009) and to improve outcomes of clients with addictions

(Miller, Duncan, Sorrell, et al, 2004). Overall, the ORS is a valuable general measure of outcome effectiveness.

### **Outcome Effectiveness and the Therapeutic Relationship**

In the same era as Rosenzweig (1939), Carl Rogers (1958) identified six necessary and sufficient conditions of psychotherapy, which were common to all effective therapeutic relationships (Rogers, 1957, 1958). The first condition included the counselor and client entering into a therapeutic relationship to create psychological contact. Although the client enters in a state of incongruence (condition two), the therapist is responsible for experiencing (condition three) and effectively communicating congruence, empathy, and unconditional positive regard (conditions four through six; Rogers, 1957). Both Rogers (1957, 1961/1995) and Rosenzweig (1936) purported that the therapeutic relationship was at the heart of outcome effectiveness; however, neither empirically explored this theory.

Since Rosenzweig's (1936) and Rogers' (1957, 1961/1995) work, researchers and clinicians have empirically explored the theory relating therapeutic relationship to outcome effectiveness and have found a positive relationship (e.g., Leibert et al., 2011; Miller et al., 2006; Orlinsky, Ronnestad, & Willutzki, 2004). Miller et al. (2006) studied 6,424 clients receiving services through an Employee Assistance Program who were 33.3% male, average age of 36, American, European, African, Latin, and Caribbean descent, with top five presenting problems of marital issues, depression, anxiety, grief/loss, and drug/alcohol problems. The clients received primarily telephonic-based counseling at an agency and clients who attended more than one session attended 3.5

sessions on average (Miller et al.). Clients completed the ORS at the beginning of each session and Miller et al. found a significant ( $p < .001$ ) correlation between improvements in the therapeutic relationship over time and increased outcome effectiveness. However, the authors noted that correlation does not imply causation and that further research should be conducted to explore the relationship between therapeutic relationship and outcome effectiveness.

Baldwin et al. (2007) worked to further explore the role that therapeutic relationship plays in outcome effectiveness. Baldwin et al. analyzed data obtained from the Research Consortium of Counseling and Psychological Services in Higher Education; all participants completed the OQ-45 as a general measure of outcome effectiveness and the WAI in order to assess the therapeutic relationship. Baldwin et al. identified a sample of 331 clients who attended at least four sessions and 80 therapists (average caseload of 4.1) and used multilevel models to assess the relationship between therapeutic relationship and outcome efficacy. Participants' OQ-45 scores from intake and final session, and Working Alliance Inventory (WAI) from session four were analyzed. Baldwin et al. found that counselors who had stronger therapeutic relationships with more clients than other counselors produced greater outcome effectiveness. While some therapists are able to create stronger therapeutic relationships with their clients, it is unclear how this develops (Baldwin et al.; Okiishi et al., 2006). It is important to gain an increased understanding of the way in which therapeutic relationship is fostered so that more counselors can potentially create greater therapeutic relationships and outcome effectiveness.

In another study, Marcus et al. (2009) obtained a sample of 227 clients from the Research Consortium of Counseling and Psychological Services in Higher Education. Each participant completed the OQ-45 at their first and final session; additionally, each client and counselor completed the WAI regarding their own specific therapeutic relationship. Marcus et al. used dyadic analysis in order to analyze the data in pairs (rather than separately from each counselor and client). Marcus et al. found that therapists who formed strong therapeutic relationships with some clients did not form strong relationships with all their clients. Marcus et al. also found that clients who reported a particularly strong therapeutic relationship with their therapist (as compared to other clients of the same therapist) experienced greater outcome effectiveness than other clients of the same therapist. It would be helpful to know the measurable ways in which counselors intentionally convey the necessary and sufficient conditions in order to form strong relationships. With this information, counselors could intentionally work to form strong therapeutic relationships with more (or even all) clients.

Although researchers have found Rosenzweig's (1936) and Rogers' (1957, 1961/1995) posited connection between therapeutic relationship and client outcomes to be true (Baldwin et al., 2007; Leibert et al., 2011; Marcus et al., 2009; Miller et al., 2006), what is unknown are the specific counselor and client characteristics or behaviors that lead up to the development of a strong therapeutic relationship (Blow, Sprenkle, & Davis, 2007; Couture, 2006; Duncan et al.; Sexton & Ridley, 2004; Simon, 2006). For example, if it is found that counselors can engage in specific communicative behaviors to develop therapeutic relationship, it would potentially be possible for counselors to gain

increased control over consistently developing a strong relationship with their clients, and thus produce outcome effectiveness. Additionally, while being able to determine counselor and client behaviors that lead to therapeutic relationship, it is especially important to determine at which time point in counseling the therapeutic relationship best predicts outcome effectiveness, or if it is overall therapeutic relationship across time. As such, counselors can intentionally foster the therapeutic relationship and have a better understanding of the time point by which therapeutic relationship needs to exist in order to produce outcome effectiveness.

### **Theoretical Frameworks of Outcome Effectiveness**

Although Rosenzweig (1936) and Rogers (1957, 1958) brought up some factors and/or conditions that might contribute to outcome effectiveness, their work did not explain specific behaviors or interventions that would produce outcome effectiveness (Couture, 2006; Duncan et al., 2010). While some moved forward to build upon Rosenzweig's and Rogers' work (e.g., Blow et al., 2007; Reisner, 2005; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003; Wampold et al., 1997), others specifically attempted to identify specific, measurable interventions that produce outcome effectiveness (e.g., Chambless et al., 1996, 1998). As such, Empirically-Validated Treatments reflect research regarding specific, measurable interventions, and Common Factors Theories includes research about the various components of outcome effectiveness. It is important to blend the strongest merits of both theoretical frameworks in order to identify a comprehensive and measurable method for creating outcome effectiveness.

## **Empirically-Validated Treatments**

Although many researchers agreed with Rosenzweig's (1936) and Rogers' (1961/1995) assumptions that every effective counseling relationship shares certain factors and conditions, many researchers believed that certain interventions were clearly more effective than others, and that common factors/conditions were an oversimplification of a very scientific process (APA, 1995; Chambless et al., 1996, 1998; Chambless & Hollon, 1998; Stewart & Chambless, 2007, 2010). Accordingly, the American Psychological Association (APA) division 12 created a task force in 1993 for the promotion and dissemination of psychological procedures (APA, 1995). This task force was charged with the responsibility of determining which psychotherapy interventions were effective for particular DSM diagnoses. These supported interventions are called *empirically-validated treatments* (EVT; APA, 1995).

In the original APA (1995) division 12 task force report, the task force members acknowledged that no intervention could ever completely be validated, and that the criteria for determining an EVT were somewhat subjective. Additionally, the APA (1995) task force report and subsequent updates (see Chambless et al., 1996, 1998) focused on efficacy, rather than effectiveness. Efficacy refers to empirical support of a particular intervention in a laboratory study that potentially can be translated into real-life clinical practice (Chambless & Hollon, 1998). Effectiveness refers to the degree to which EVTs are actually effective in real-life clinical application (Chambless & Hollon). Despite these caveats, the APA (1995) and the division 12 task force was hopeful that EVTs would allow educators and clinicians to have a basic understanding of

interventions that could be used with empirical confidence, rather than other interventions that would be considered experimental (APA, 1995).

The APA (1995) division 12 task force identified two categories of EVT: *well established treatments* and *probably efficacious treatments*. The criteria outlined by APA for a well established treatment included (a) at least two good group design studies conducted by different investigators demonstrating efficacy by being superior (no standard effect size required) to a pill, placebo, or alternative treatment or equivalent to an already established treatment, or (b) a large series of single case studies with good experimental designs that compare the intervention to a pill, placebo, or an established treatment demonstrates efficacy of the treatment. For both methods of establishing a well established treatment, the studies must use a treatment manual for the psychotherapeutic intervention and the characteristics of the sample must be clearly identified.

The criteria outlined by APA (1995) for probably efficacious treatments included (a) two studies showing the treatment is more effective than a waiting list control group, (b) two studies by the same investigator, or only one study, meet all other standards for a well established treatment, (c) two studies meet the criteria for a well established treatment except their sample is too heterogeneous, or (d) the criteria for a well established treatment are met except there is a small series of single case studies, rather than a large sample. As noted, these criteria are somewhat arbitrary (e.g., large versus small amount of studies, and use of the subjective term *good*), but these criteria were established by consensus of the task force in order to serve as a guideline for establishing EVTs.

If a psychotherapeutic intervention did not fall into one of the two EVT categories, it was considered experimental. The decisions made by the APA (1995) task force regarding EVTs were meant to inform clinical recommendations and policies. Their intention was to identify specific psychotherapeutic interventions that could be used to treat specific mental health difficulties (APA, 1995; Chambless et al., 1996, 1998). Although many studies used DSM criteria to denote the client difficulties, other specific descriptions that did not necessarily align with the DSM would also be considered for review.

In their original report, the APA (1995) task force outlined the criteria and implications of EVTs. In 1995, the authors also presented a table of 18 well established treatments and seven probably efficacious treatments. These interventions included primarily cognitive-behavioral and behavioral EVTS, and APA noted that the majority of randomized control trials published at that time were cognitive and/or behavioral. The authors noted that this initial list was just the first of many and urged members of APA to continue researching a variety of therapeutic interventions. APA requested that other members of APA continue to explore specific psychotherapeutic interventions that could be added to the list and considered ways to continue integrating these EVTs into training programs across the United States (APA).

Since the 1995 report, Chambless et al. (1996, 1998) issued two more APA task force updates with adjusted EVT criteria. For well established treatments, APA (1995) required two good group design studies and Chambless et al. (1998) required two good *between* group design studies. Chambless et al. (1998) also removed the

recommendation for approximately 30 participants per group (which allowed for even more flexibility in judging the criteria), but added that a large series of single case experiments referred to at least nine cases. Finally, Chambless et al. (1998) also added that the studies used to meet the criteria must have been conducted by at least two separate researchers or research teams. Additionally for probably efficacious treatments, Chambless et al. (1998) added that the studies must show statistically significant superiority to a control group. Chambless et al. (1998) also removed the possibility of a treatment being considered an EVT if the sample was too heterogeneous. Finally, Chambless et al. (1998) added the requirement that even if the EVT did not meet the large size of 9 single case studies, it must have at least three. These changes to the EVT criteria were not substantial, but worked to make the system slightly more stringent (Chambless et al., 1998). However, while some criteria were stricter, qualifications for “large” and “good” were still lacking.

The EVT updates published by Chambless et al. (1996, 1998) also extended the lists of well established and probably efficacious treatments. In their 1998 publication, Chambless et al. identified 16 well established treatments and 55 probably efficacious treatments. Examples of well established treatments included cognitive behavior therapy for panic disorder and behavior therapy for depression (Chambless et al., 1998). Probably efficacious treatments included applied relaxation for panic disorder, cognitive therapy for obsessive compulsive disorder, and exposure treatment for post-traumatic stress disorder (Chambless et al., 1998).

An updated list of 79 EVT's can be found on the APA Society of Clinical Psychology (2006) division 12 website, but the website clearly states that EVT's should be used in conjunction with clinical judgment regarding client characteristics and needs. As such, the APA no longer fully promotes EVT's in their purest form (i.e., a presenting problem and according treatment; APA Task Force, 2006; Cukrowicz et al., 2011). Instead, the APA now promotes a concept called evidence-based practice in Psychology (EBPP), in which clinicians assess clients' characteristics in addition to their presenting problems in order to provide interventions that will best meet the clients' needs (APA Task Force, 2006). This might include the use of an EVT, or it might include other interventions that are deemed appropriate through a clinician's expertise (APA Task Force, 2006).

EBPP is a more holistic method of psychotherapy than EVT, in which clinicians account for the unique characteristics of every therapeutic relationship. Many psychologists were concerned about the way in which EVT's disregarded the importance of other outcome effectiveness factors, such as client culture and therapeutic relationship (APA Task Force, 2006). As such, EBPP still regards EVT's as an important part of mental health practice, but emphasizes implementation of EVT's in the context of the therapeutic relationship (APA Task Force, 2006). The APA's movement from EVT to EBPP further supports that the therapeutic relationship is an important part of outcome effectiveness, and it is necessary to have a therapeutic relationship before any interventions can be used effectively.

**Strengths of EVT.** Although there was a shift to EBPP, due to the emphasis on using clinician expertise along with empirically based findings, there are strengths to EVTs. Specifically, it is assumed that when using EVTs, clinicians can treat their clients with confidence and demonstrate competency to third-party payers and other stakeholders since their methods and interventions in counseling are based on previous outcome efficacy findings (APA Presidential Task Force, 2006). Due to the requirement that an EVT be manualized, it is assumed that any counselor, even neophyte counselors, can properly implement the treatments (APA, 1995; Chambless et al., 1996, 1998). Additionally, the efficacy of each EVT has been empirically demonstrated in a laboratory, which can potentially show stakeholders scientific support that mental health professionals have the potential ability to create outcome effectiveness in actual clinical settings (APA Presidential Task Force; Hauser & Hays, 2010; Stewart & Chambless, 2007). Thus, a benefit of using EVTs is that it may provide a simplistic way to study and implement mental health interventions.

**Limitations of EVT.** As noted by the original APA division 12 task force (1995), the EVT system is not without flaws. The criteria set forth by the task force was arbitrarily chosen by the members, thus not grounded in any form of empiricism; and it was acknowledged that different criteria could have supported alternative psychotherapeutic interventions as recognized EVTs (APA; Chambless & Hollon, 1998). Additionally, APA authors noted that the lists of EVTs were determined from research that was available at the time, and thus relied upon researchers to expand their methods and studies in order to continue building the EVT literature. Therefore, the EVT lists

were incomplete and creating a complete list would be a daunting task involving many researchers and authors (APA, 1995). In addition to the difficulties identified at the beginning of the task force's work (APA), there are several additional difficulties with the EVT system.

Although the premise behind studying efficacy in a laboratory setting is to practically apply it in a clinical setting, efficacy in a controlled environment may not transfer into actual effectiveness of a counseling method (Chambless et al., 1998). This possible lack of transferability from efficacious findings to effective practical outcome adds an additional layer of complexity to the otherwise simple EVT formula (Chambless et al., 1996, 1998; Chambless & Hollon, 1998). Although there is plentiful research on EVT efficacy, there is limited information of EVT effectiveness in practical clinical settings (Chambless & Hollon).

Most EVT researchers acknowledge the importance of clinical judgment, counselor characteristics, and client diversity as they relate to and affect the use of EVTs in the clinical setting (APA Presidential Task Force, 2006; Chambless et al., 1998; Stewart & Chambless, 2007). EVTs demonstrate efficacy in a controlled setting, but effectiveness in a real clinical setting is still debatable and consists of many nuances that cannot be controlled for in real life (Fireman, 2002; Southam-Gerow & McLeod, 2013). Although EVTs have been supported as well established or probably efficacious in laboratory settings, the use of EVTs on real client populations is not as easily studied and validated (Chambless et al; Southam-Gerow & McLeod, 2013; Stewart, Chambless, & Baron, 2012).

An additional limitation to the EVT model is that it is nearly impossible to empirically explore the validity of every potential EVT for every presenting problem or diagnosis (Budd & Hughes, 2009; Hauser & Hays, 2012). The Diagnostic and Statistical Manual IV-TR (DSM IV-TR; American Psychiatric Association, 2000) had over 300 diagnoses, and at the time that this version of the DSM was in use, it was estimated that there might be up to 75,000 combinations of EVTS and presenting problems (Hauser & Hays, 2012), and it would be an infinite undertaking to run controlled studies on each combination (Budd & Hughes, 2009; Hauser & Hays, 2012). Now that the DSM has shifted to the DSM-5 (currently 244 diagnoses; American Psychiatric Association, 2013), where some of the DSM-IV-TR have been removed or altered, and new diagnoses have been added, this may equate all previous EVTs to be null and void in application. As such, clinical practice might never be informed solely by the EVT framework.

As researchers have begun to explore the ways in which efficacious EVTs translate into effective clinical practices, it has been found that the specific intervention used might not be as important as researcher allegiance (Duncan, et al., 2010; Messer & Wampold, 2002). Researcher allegiance is the extent to which the researcher believes a specific treatment is valuable and effective (Luborsky et al., 1999, 2002). The importance of researcher allegiance over a particular EVT has been demonstrated in numerous studies (Luborsky et al., 1999, 2002; Messer & Wampold, 2002; Miller, Wampold, & Varhely, 2008). Luborsky et al. (2002) compared 17 meta-analyses in which one active treatment was compared with another active treatment and found that each specific type of treatment accounted for a mean effect size of .20 (Cohen's *d*) or .10

(Pearson  $r$ ). This small, non-significant effect size represented the outcome effectiveness that could be directly attributed to the specific type of treatment used by a therapist.

Then, when Luborsky et al. (2002) adjusted for the researcher's allegiance to the specific intervention, the effect size of the treatment itself was even smaller (Cohen's  $d$  of .12).

Luborsky et al.'s (2002) findings support Rosenzweig's hypothesis that certain common factors of outcome effectiveness are present across all therapies, and the specific treatment or intervention does not account for a significant portion of outcome effectiveness (Luborsky et al., 2002).

Consistent with Luborsky et al.'s (2002) findings, Miller et al. (2008) reviewed 23 studies published between 1980 and 2005 that compared at least two manualized psychotherapeutic interventions administered to clients under the age of 18 with depression, anxiety, conduct, or attention deficit disorder. The researchers found a small (but significant) effect size of .22 for the relationship between the specific therapy used and outcome effectiveness. However, after controlling for researcher allegiance, the variability of all treatment effects was eliminated; all outcome effectiveness variance was attributed to researcher allegiance to the therapy rather than to the therapy itself (Miller et al.). Both Luborsky et al. (2002) and Miller et al. (2008) based their analyses on primarily controlled clinical trials, so the researchers were assessing efficacy rather than effectiveness. Based on these findings, it is arguable that researcher's allegiance may be more important to outcome efficacy than the EVT itself.

The exact mechanism that connects researcher allegiance to outcome effectiveness is still unknown; researchers still need to explore how and why researcher

allegiance translates into actual outcome efficacy in clinical trials (Luborsky et al., 2002). Luborsky et al. (1999) posited that researcher allegiance might actually increase therapist allegiance to a particular intervention. This could be due to subtle ways that the researcher expresses allegiance toward a particular treatment, subtle differences in which the researcher assigns certain therapists to certain treatment conditions, or therapist morale boost due to the researcher's interest in their particular type of therapy (Luborsky et al., 1999). An improved therapist allegiance to the EVT might increase client and counselor agreement on the approach (Messer & Wampold). This counselor and client agreement could potentially improve the therapeutic relationship, because counselor and client agreement on goals and overall approach is understood as a contributor to a strong therapeutic relationship (Bordin, 1979; Miller, Duncan, & Johnson, 2000; Miller & Duncan, 2004). It is possible that researcher allegiance indirectly contributes to the therapeutic relationship, which has been identified as a key contributor to outcome effectiveness (Orlinsky et al., 2004; Thomas, 2006; Tracey et al., 2003). Therefore, an improved therapeutic relationship due to counselor and client agreement might actually account for some of the effect size that was previously attributed to any specific EVT.

Although EVTs have been scientifically proven in a laboratory setting, counselor and client characteristics must be considered when EVTs are used in clinical settings (APA, 2006; Chambless et al., 1998; Fireman, 2002; Southam-Gerow & McLeod, 2013; Stewart & Chambless, 2007; Stewart et al., 2012; Wampold). Particularly, it is important to determine the way in which therapeutic relationship is related to outcome effectiveness (Hauser & Hays, 2012; Messer & Wampold, 2002).

Luborsky et al. (2002) and Miller et al. (2008) found that researcher allegiance to a treatment contributes to outcome efficacy more than the actual treatment itself. In a discussion of these findings, Messer & Wampold (2002) reported that therapist-client alliance (i.e., therapeutic relationship) should be a main variable studied in relationship to outcome effectiveness. Before more EVTs are explored and created, it seems like future research needs to focus more on the factors that have the strongest influence on outcome efficacy, and more importantly, outcome effectiveness in applied clinical settings. More specifically, what aspects, such as therapeutic relationship, truly influence the outcome effectiveness of counseling for a client? And additionally, what counselor and client behaviors contribute to the development of factors such as the therapeutic relationship? It is important to explore the way in which therapeutic relationship is formed and the manner in which it fosters outcome effectiveness.

### **Common Factors Theory**

Despite some support for EVT in the mental health profession (e.g., APA, 1995; Chambless, 2002), recent researchers have supported CFT as a more accurate framework for understanding the components of outcome effectiveness (Ahn & Wampold, 2001; Duncan et al., 2010; Hauser & Hays, 2012; Luborsky et al., 2002; Messer & Wampold, 2002; Shapiro & Shapiro, 1982; Smith & Glass, 1977). Approximately two decades ago, Shapiro and Shapiro (1982) conducted a meta-analysis of 143 studies that compared two different treatments against each other and against a control group. They found that clients who received some form of psychotherapy experienced greater outcome effectiveness than 82% of clients who received no treatment or a placebo; however, when

comparing the types of treatments that were used (e.g., behavioral, cognitive), no significant differences in outcome effectiveness were found. Additionally, Shapiro and Shapiro found that type of therapy accounted for no more than 10% of the change in outcome effectiveness. Instead, variables such as presenting problem, methods of measuring outcome effectiveness, and experimental design were more influential to outcome effectiveness. Generally, their findings indicate that all forms of psychotherapy are equally effective.

Almost two decades later, Ahn and Wampold (2001) conducted a similar meta-analysis on 27 studies that compared an established treatment (i.e., one that contained critical components [active ingredients] as defined by a treatment manual or clear description of the treatment), and an unestablished treatment that did not contain these critical components. Through a chi square analysis, Ahn and Wampold found that the outcome effectiveness created by each type of therapy (established and unestablished) were statistically the same; effectiveness did not differ significantly between therapies that did and did not contain the critical components. Similar to Shapiro and Shapiro (1982), Ahn and Wampold (2001) found that all psychotherapies contributed equally to outcome effectiveness, and emphasized the importance of interviewing skills, the therapeutic relationship, and the core conditions as outlined by Rogers (1961/1995). Ahn and Wampold (2001) found that common factors (e.g., therapeutic relationship) were greater contributors to outcome effectiveness than the specific treatment used, which further supports the use of the CFT framework over the EVT framework. It is important

to identify the most crucial components of CFT and ways in which they can be practically implemented in counseling sessions.

Although Rosenzweig reported that his 1936 publication was “a statement of the obvious” (Duncan et al., 2010, p. vii), his work sparked generations of CFT research (Budd & Hughes, 2009; Grencavage & Norcross, 1990; Sprenkle & Blow, 2004). Rosenzweig’s (1936) work was purely conceptual and he took care to note that his proposed factors were “intricate” and some were even “yet undefined” (p. 415). Building upon Rosenzweig’s original work, successive researchers worked to clearly define each common factor and its specific relationship to outcome effectiveness (e.g., Grencavage & Norcross, 1990; Lambert 1992; Miller, Duncan, & Hubble, 1997; Thomas, 2006; Tracey et al., 2003; Wampold, 2001).

Researchers have been able to identify many common factors over the past century (Grencavage & Norcross, 1990). In fact, at least 89 common factors were developed from 1936 to 1989, and the identified amount of common factors increased as the years progressed (Grencavage & Norcross). In order to begin consolidating the numerous common factors, researchers reviewed existing literature to find areas of overlap. Grencavage and Norcross reviewed more than 50 years of common factors publications to identify five main categories of overlap: (a) client characteristics, (b) therapist qualities, (c) change processes, (d) treatment structure, and (e) relationship elements. However, Grencavage and Norcross simply collapsed the existing common factors into categories, or overarching themes; they did not identify the extent to which each common factor, or these categories, explained outcome effectiveness.

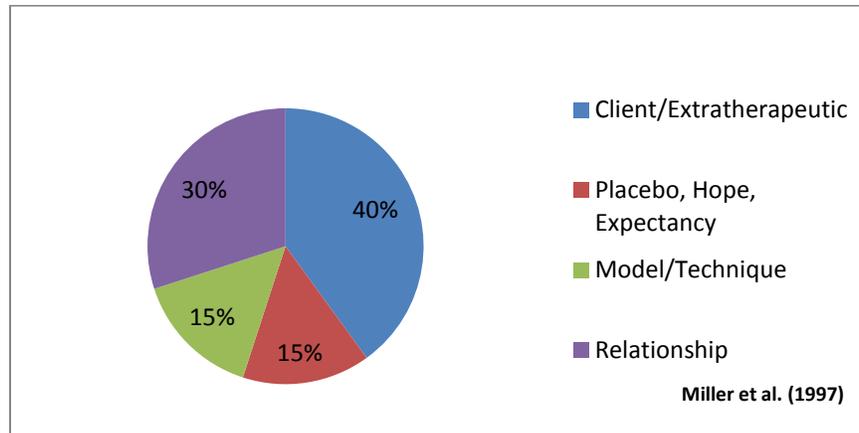
Similar to Grencavage and Norcross's (1990) attempt to collapse the multitude of common factors, Lambert (1992) reviewed empirical outcome research that spanned more than six decades, identified four specific components (i.e., extratherapeutic change, expectancy, techniques, and common factors) that contributed to outcome effectiveness, and then assigned percentages of variance to each of the factors he identified from the empirical literature. Although the percentages were not obtained through statistical analysis, Lambert assigned percentages based on what he perceived as the trends through various empirical studies, including naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues.

Lambert's (1992) component of extratherapeutic change included the client factors (e.g., personality) and environmental factors that aid in recovery. He determined that extratherapeutic change accounted for 40% of the variance explaining outcome effectiveness. Expectancy included client hope that results from participating in psychotherapy and the credibility of the process, and explained 15% of outcome effectiveness. Techniques, also explaining 15% of outcome effectiveness, included the factors that are specific to the type of therapy used (e.g., behavioral charting or biofeedback). Finally, the component of common factors incorporated the characteristics present throughout all therapies, such as counselor empathy and client risk taking (Lambert, 1992). Lambert included common factors as just one factor that contributed to outcome effectiveness, and cited Grencavage and Norcross (1990) as the leading researchers on common factors. Lambert believed that this common factors component contributed 30% to outcome effectiveness in clients.

Lambert (1992) identified his four components as therapeutic factors (not common factors), and these therapeutic factors were subsequently used by future researchers and authors to inform CFT models (e.g., Blow & Sprenkle, 2001; Duncan & Moynihan, 1994; Hubble, Duncan, & Miller, 1999; Miller et al., 1997; Sprenkle & Blow, 2004). Lambert's work seemed to provide researchers with a starting point for determining the major factors that contribute to outcome effectiveness, which is the main premise of common factors (Rosenzweig, 1936). In fact, Miller et al. (1997) asserted that Lambert's model was actually a model of common factors (i.e., factors that are present in all psychotherapeutic encounters and lead to outcome effectiveness).

Miller et al. (1997) declared that new names for each of Lambert's (1992) therapeutic factors would more accurately explain the common factors of therapy. Miller et al. (1997) explained that the way in which Lambert described his component of *common factors* could more accurately be called *relationship factors* (e.g., empathy and warmth) and that other factors deserved a more thorough title for easier understanding. Therefore, Miller et al., proposed the following four common factors: (a) client/extratherapeutic factors, (b) placebo, hope, and expectancy factors (c) model/technique factors, and (d) relationship factors (see Figure 1). Each factor proposed or titled by Miller et al. (1997) directly aligned with Lambert's (1992) original model and each factor was assigned the same percentage of outcome effectiveness based upon Lambert's original review of the existent empirical literature (Miller et al.; Blow & Sprankle, 2001).

**Figure 1. Common Factors of Outcome Effectiveness**



The common factors model proposed by Lambert (1992) and edited by Miller et al. (1997) was the most relevant and well-supported common factors framework for several years (Hubble et al., 1999). Thomas (2006) conducted a study in which clients and therapists were asked to report their perceptions regarding the importance of each common factor as outlined by Miller et al. (1997). Thomas found that counselors attributed 35% of outcome effectiveness to the therapeutic relationship and just 16% of outcome effectiveness to models/techniques. However, clients reported that therapeutic relationship contributed to 29% of outcome effectiveness and models/techniques contributed to 28% of outcome effectiveness. Additionally, in Thomas' study, clients attributed 13% of outcome effectiveness to client/extratherapeutic factors, and counselors attributed 22% to this factor. Finally, counselors and clients found client hope and expectancy to make a similar contribution to outcome effectiveness with clients rating it at 30% and therapists rating it at 27%. It seems as though therapists and clients view the

importance of the common factors differently and it is important to explore the ways in which these factors actually do relate to outcome effectiveness.

Recent findings have led researchers away from the summative nature of Miller et al.'s (1997) common factors model (i.e., a certain percent of outcome effectiveness is created by each factor) and toward a more synergistic view of common factors (i.e., common factors interact uniquely to create outcome effectiveness; Duncan et al., 2010; Wampold, 2001). Duncan et al. (2010) and Wampold (2001) asserted that common factors do not contribute a certain, linear percentage of outcome effectiveness. Rather, common factors “cause and are caused by each other” (Duncan et al., 2010, p. 35). That is, the common factors cannot be perceived as specific ingredients that can be added or removed in order to create outcome effectiveness; each common factor must be understood in the context of the specific counselor-client relationship and adjusted accordingly (Duncan et al., 2010; Wampold, 2001).

Wampold (2001) consolidated years of empirical research on common factors and reported that the strongest contributing factors to outcome effectiveness were client factors, therapist factors, and relationship factors. In relation to Miller et al.'s (1997) model of common factors, this negated the importance of model/technique factors and placebo, hope, and expectancy factors and asserted a need to more thoroughly attend to therapist factors as important contributors to outcome effectiveness (Duncan et al., 2010; Wampold). As such, Wampold identified these three, more simplistic, common factors and asserted that they work together in synergy to create outcome effectiveness.

At one time, up to 15% of variance was attributed to model/technique factors (Hubble et al., 1999; Lambert, 1992; Miller et al., 1997), but more recent studies and meta-analyses attribute only zero to one percent of variance to specific techniques or models (Duncan et al., 2010; Messer & Wampold, 2006; Miller et al., 2008; Wampold, 2007, 2001). Although the particular model or technique used by a therapist does not significantly contribute to outcome effectiveness, Rosenzweig (1936) proposed that consistency of the therapist's model or technique is an important contributor to outcome effectiveness, and this is currently empirically supported (Duncan et al., 2010; Frank & Frank, 1991; Miller, et al., 2008; Wampold, 2007). Consistency refers to the extent to which the therapist continually uses one particular model or technique and the extent to which it is congruent with the counselor's and client's view of change (Blow et al., 2007; Rosenzweig, 1936; Simon, 2006). A counselors' belief in a specific model or technique and presentation of the model in a way that fosters client hope has been found to account for nearly all of the variance that was once attributed to the model or technique itself (Duncan et al., 2010; Miller et al., 2008; Wampold, 2007). These findings negate the importance of model/technique factors as proposed by Miller et al. (1997), but encourage the importance of allegiance to a particular model by a therapist.

Similar to research allegiance discussed earlier in EVT, the portion of model and technique factors that actually contributes to outcome effectiveness is counselor and client belief in the model or technique (Frank & Frank, 1991; Miller et al., 2008; Wampold, 2007). When counselor and client belief in the model or technique is strong, the therapeutic relationship is strengthened (Bordin, 1979; Davis, et al., 2012; Duncan &

Miller, 2000; Lambert, 1992; Miller & Duncan, 2004). As such, the variance that was once attributed to placebo, hope, and expectancy can potentially be attributed to the therapeutic relationship. Duncan et al. (2010) reported that model and technique factors simply “induce positive expectations” (p. 36), and this negates the importance of placebo, hope, and expectancy factors as proposed by Miller et al. (1997).

**Client and Extratherapeutic Factors.** Client and extratherapeutic factors include everything that happens to the client outside of therapy and the characteristics that clients bring into the therapeutic setting (Duncan et al., 2010; Hubble et al., 1999; Sprenkle & Blow, 2004). Extratherapeutic factors include internal resources (e.g., religious beliefs, motivation to change), external resources (social/family support, employment, community involvement), and life events (Duncan et al.; Lambert, 1992; Leibert et al., 2011; Thomas, 2006). Client factors include client demographics (e.g., race, ethnicity, age, sex), presenting problem (Duncan et al.; Okiishi et al., 2003), and communication methods (Ackerman & Hilsenroth, 2003; Andersen, 2009).

Although extratherapeutic events are outside of the therapist’s control and client demographics cannot be manipulated to achieve outcome effectiveness (Duncan et al., 2010), it is of utmost importance for therapists to tailor treatment according to client and extratherapeutic factors (Beutler et al., 2004; Duncan & Moynihan, 1994; Duncan et al.; Miller & Duncan, 2004; Wampold, 2001). Counselors should adjust their services according to client needs and perceptions (Duncan & Moynihan; Duncan et al.); counselors cannot assume that they know how the client perceives the counselor, the interventions, or the therapeutic relationship. In order to learn about their clients’ needs

and perceptions, counselors should regularly communicate with clients and ask them what can be changed to improve the counseling relationship and meet client needs (Miller & Duncan; Duncan et al.; Wampold, 2001). An increased understanding of the way in which counselor and client factors interact in relation to therapeutic relationship could contribute to a greater understanding of ways in which counselors can foster outcome effectiveness.

**Therapist Factors.** Wampold (2001) reported “the essence of therapy is embodied in the therapist.” (p. 202); however, that embodiment appears to be more than simple demographics. Therapist factors are an important part of CFT (Duncan et al., 2010; Miller, Hubble, & Duncan, 2007) and Rosenzweig’s (1936) original CFT model included the personality of a good therapist. CFT studies have included a wide range of therapist factors, such as therapist demographics and level of training (Beutler et al., 2004; Duncan et al., 2010). Through two separate studies, Okiishi et al. (2003; 2006) negated the contribution of therapist sex, training, or theoretical orientation to client outcome effectiveness. In fact, therapist age, gender, training, supervision, experience, or use of EVT have not been found to directly affect outcome effectiveness (Beutler et al., 2004; Duncan et al.; Miller et al., 2007).

The specific therapist variables that affect outcome effectiveness are much more complex than simple demographics (Duncan et al., 2010; Okiishi, et al., 2003, 2006; Zane, et al., 2005; Okiishi, 2003, 2006; Miller et al., 2007; Rosenzweig, 1936). Some therapists are able to use the common factors to achieve outcome effectiveness (Duncan et al., 2010; Wampold, 2001). For example, Duncan and Moynihan (1994) suggested

that therapists should use clients' frames of reference to inform their practice and Simon (2006) suggested that therapists should use interventions that are consistent with their own worldview. Both of these practices are likely to increase counselor allegiance to the technique (Luborsky et al., 1999, 2002), which can potentially increase client-counselor agreement and improve the therapeutic relationship (Bordin, 1979; Duncan, et al., 2010; Messer & Wampold, 2002). Although the therapist factors that contribute to outcome effectiveness have been theoretically purported, it is now important to study the way in which specific therapist factors affect the therapeutic relationship and outcome effectiveness.

Therapist communication techniques have also been supported as an important therapist factor that contributes to the therapeutic alliance (Ackerman & Hilsenroth, 2003; Crits-Christoph et al., 2006; Omylinska-Thurston & James, 2011; Rogers, 1957, 1958; Tepper & Haase, 1978). Rogers (1957) proposed that a therapist's ability to experience and clearly communicate empathy, congruence, and unconditional positive regard was necessary and sufficient to produce outcome effectiveness. Ackerman and Hilsenroth (2003) reviewed articles and book chapter from 1988 to 2000 that regarded the therapeutic relationship and concluded that therapist communication of warmth, friendliness, and openness contributed to stronger therapeutic relationship, which supports Rogers' (1957) assertion. It is important to further explore the specific communication behaviors that counselors can use to communicate effectively.

Buetler et al. (2004) and Sprenkle and Blow (2007) proposed that counselors should tailor their interventions based upon client needs and characteristics. This can be

done through observation of client behaviors, interpretation of client stories, or simply by asking the client about the therapeutic process and relationship (Miller and Duncan, 2004). After counselors obtain this information from clients, it is still widely unknown exactly how counselors alter the interventions and behaviors to accommodate client needs and characteristics (Beutler et al., 2004; Duncan et al.; Sprenkle & Blow). Future research should focus on identifying ways in which therapists use client feedback to adjust their interventions and improve the therapeutic relationship.

**Therapeutic Relationship Factors.** Bordin (1979) surveyed psychoanalytic literature regarding the relationship between therapist and client and determined that the therapeutic relationship includes the three common features of (a) client and therapist agreement on goals, (b) identification of task(s) to be addressed in therapy, and (b) the development of a bond between client and therapist. Miller and Duncan (2004) integrated Bordin's (1979) work with an additional construct of *client's theory of change*, or the way in which a client believes change occurs within individuals. Miller and Duncan (2004) used this expanded conceptualization in order to create the following comprehensive definition of therapeutic relationship: "the quality of the relational bond, as well as the degree of agreement between the client and therapist on the goals, methods, and overall approach of therapy" (Miller & Duncan, p. 13).

It is well documented that the therapeutic relationship is a key contributor to outcome effectiveness (Duncan et al., 2010; Rosenzweig, 1936; Rogers, 1957, 1958; Thomas, 2006; Tracey et al., 2003). Rosenzweig noted therapeutic relationship as one of his original common factors and Rogers (1957) noted the relationship as one of six

“necessary and sufficient” (p. 100) conditions of outcome effectiveness. Grencavage and Norcross (1990) found that therapeutic relationship was the single most commonly reported factor amongst 50 CFT publications, and more than 1,000 studies have supported the therapeutic relationship as an important contributor to outcome effectiveness (Orlinsky et al., 2004).

Client-reported therapeutic relationship is closely linked with outcome effectiveness (Duncan et al, 2003; Miller et al., 2006). Duncan et al. (2003) randomly selected 100 clients from an outpatient counseling agency and found a significant, positive relationship between early client ratings of the therapeutic relationship and client ratings of outcome effectiveness at their last session. Relatedly, Miller et al. (2006) sampled 6,424 people who contacted an employee assistance program and found that improvements in the therapeutic relationship over the course of treatment were positively and significantly correlated with client-reported improvements in outcome effectiveness.

The therapeutic relationship is intimately connected to therapist and client factors (Duncan et al., 2010; Wampold, 2001); client and therapist factors interact to form every therapeutic relationship (Beutler et al., 2004; Duncan et al., 2010; Duncan & Moynihan, 1994; Miller & Duncan, 2004; Wampold, 2001). CFT researchers have found that client factors and therapist factors are important contributors to outcome effectiveness (Duncan & Moynihan, 1994; Lambert, 1992; Leibert et al., 2011; Thomas, 2006; Okiishi et al., 2003; Wampold, 2001), but therapeutic relationship has consistently been found as the key contributor to outcome effectiveness (Beutler et al., 2004; Grencavage & Norcross, 1990; Miller et al., 2006; Orlinsky et al., 2004; Wampold, 2001). As posited by Rogers

(1957), counselor and client factors seem to contribute to the therapeutic relationship, which is highly linked to outcome effectiveness (Leibert, et al., 2011; Miller et al., 2006; Orlinsky et al., 2004).

Duncan et al. (2010) and Wampold (2001) suggested that the common factors are not simply additive, but play a synergistic role in creating outcome effectiveness. It is therefore plausible that therapist and client communication factors (as supported by Rogers, 1957) interact within the formation of the therapeutic relationship, which then contributes to outcome effectiveness. An example may be a counselor utilizing communication skills (i.e., therapist factors) to work with a client, or even match a client's communication behaviors (i.e., client factors), in order to enhance therapeutic relationship, which in turn leads to greater outcome effectiveness. Some therapists more effectively create outcome effectiveness than others (Beutler et al., 2004; Bordin, 1979; Duncan et al.; Duncan & Moynihan; Simon, 2006; Sprinkle & Blow, 2007), but the specific way in which client and therapist factors interact to form the therapeutic relationship and contribute to outcome effectiveness is still unknown (Blow et al., 2007; Couture, 2006; Duncan et al.; Sexton & Ridley, 2004; Simon, 2006). It is important to identify the counselor and client factors that are most influential in forming the therapeutic relationship.

**Strengths of CFT.** CFT is empirically supported as a more accurate outcome effectiveness theory than EVT (Luborsky et al., 2002; Messer & Wampold, 2002; Wampold, 2001). The broad reach of CFT encompasses all of the components that might potentially contribute to outcome effectiveness (Blow & Sprengle, 2001; Budd, &

Hughes, 2009; Thomas, 2006). Grencavage and Norcross (1990) identified over 89 common factors and CFT research has continued for two more decades (e.g., Blow, et al., 2007; Reisner, 2005; Sexton & Ridley, 2004; Sprenkle & Blow, 2004). Whether the model is very general (e.g., Rosenzweig, 1936) or very specific (e.g., Tracey et al., 2003), CFT identifies general factors that are present in all effective therapeutic relationships (Duncan et al., 2010).

**Limitations of CFT.** As research about common factors has continued, the specific components have become more numerous and complex (Hubble et al., 1999; Duncan et al., 2010). There is still not one standard set of common factors, and the specific relationship between each common factor and outcome effectiveness is still debated (Budd & Hughes, 2009; Duncan et al., 2010; Hauser & Hays, 2010). Lambert's (1992) model has served as the basis for various four-factor models (Duncan et al., 2010; Hubble et al., 1997; Miller et al., 1997; Wampold, 2001), but Lambert's original model was never empirically tested. Additionally, each of these models encompasses numerous variables under each factor (e.g., all client demographics, characteristics, and life experiences are included under client and extratherapeutic factors), many of which cannot be measured and studied.

The three common factors that are most relevant to outcome effectiveness are client, therapist, and therapeutic relationship factors (Wampold, 2001). However, the specific ways these factors are created is unknown. It is important to explore the way in which client and therapist factors interact in order to build the therapeutic relationship, which is a known contributor to outcome effectiveness.

## **Nonverbal Immediacy Behaviors and the Therapeutic Relationship**

Carl Rogers (1957) was aware of the importance of communication within the counseling relationship. Rogers created person-centered therapy in which the counselor's ability to effectively communicate congruence, empathy, and unconditional positive regard was sufficient enough to build a therapeutic relationship and produce outcome effectiveness. Research has supported that person-centered therapy is an effective counseling intervention (Gibbard & Hanley, 2008; Stiles, Barkham, Mellor-Clark, & Connell, 2008). Gibbard and Hanley (2008) studied 697 clients over five years and identified a Cohen's *d* effect size of 1.2 for person-centered therapy as opposed to an effect size of .24 for clients who received no treatment. Stiles et al. (2008) studied 5613 clients over three years and found that the outcome effectiveness of person-centered therapy is equivalent to psychodynamic or cognitive-behavioral therapy.

Although it has been proven that person-centered therapy is effective, the specific components that actually create the therapeutic relationship are still largely unknown (Elliott, Greenberg, Watson, Timulak, & Friere, 2013). In an extensive review of literature exploring therapeutic relationship and outcome effectiveness, Elliott et al. concluded that there is a relationship ("moderately strong", p. 515) between Rogers' (1957) necessary and sufficient conditions and outcome effectiveness. However, Elliott et al. (2013) also concluded that the relationship is complex because it is difficult to concretely measure Rogers' necessary and sufficient conditions. Norcross (2011) concluded that empathy, positive regard, and congruence are most likely linked to therapeutic relationship, but the research at this time is insufficient to support an absolute

confirmation of this hypothesis. As such, it is important to identify a concrete way to measure counselors' use of the necessary and sufficient conditions and further explore their relationship to outcome effectiveness.

No single therapy is superior to another (Luborsky et al., 2002; Messer & Wampold, 2002), but person-centered therapy is effective and focuses on communication within the therapeutic relationship (Elliott et al., 2013; Rogers, 1957). Effective counselors utilize the therapeutic relationship in order convey the core conditions of congruence, empathy, and unconditional positive regard and create outcome effectiveness (Duncan et al., 2010; Wampold, 2001). Some therapists are innately better than others at fostering the therapeutic relationship and creating outcome effectiveness (Baldwin et al., 2007). Baldwin et al. assessed data from 80 therapists who worked with 331 clients (average caseload of 4.1) and found that some counselors form generally stronger therapeutic relationships with their clients than other counselors. Okiishi et al. (2006) found that such differences in counselors' outcome effectiveness could not be attributed to demographic factors such as counselor gender, training, or experience. Therefore, there must be an alternative, more complex way to explain and understand the differences in counselors' outcome effectiveness.

Although we know that some counselors form generally stronger therapeutic relationships with their clients, which in turn produces greater general outcome effectiveness with these clients (Baldwin et al., 2007), we still do not know exactly how the therapeutic relationship is built (Blow et al., 2007). To begin exploring the process of therapy in a new and unique way, Couture and Sutherland (2006) explored the practice of

advice-giving through conversational analysis in actual family therapy sessions. Couture and Sutherland found that even the slightest change in a counselor's or client's communication (e.g., delivery or content of the message) changed the overall structure of an entire session. Couture (2006) completed another innovative study regarding communication and the therapeutic process in which the author use conversational analysis and critical discourse analysis on passages that were identified by clients as particularly helpful. Couture found that therapists who conveyed acceptance of difference, varied their tone according to the situation, and invited client contribution were able to co-develop helpful therapeutic processes in which clients were able to work through conversational impasses. As such, it has been found that communication is an important part of outcome effectiveness, which might begin to explain the specific ways in which the therapeutic relationship is built.

As noted by Couture (2006) and Blow et al. (2007) it is important to continue exploring two-way (i.e., counselor and client) communication that fosters the therapeutic relationship and other helpful therapeutic processes. The innovative findings of Couture (2006) and Couture and Sutherland (2006) support the use of a communication framework to more thoroughly explore the therapeutic relationship and its relationship with outcome effectiveness. Incorporating a communication theory within the existing counseling frameworks of outcome effectiveness might improve the field's current understanding of how therapeutic relationship might develop across counseling sessions.

Clients and counselors can build the therapeutic relationship through communication (Andersen, 2009; Elliott et al., 2013; Rogers, 1957, 1958).

Communication is an informational exchange process that is present in personal and professional relationships (Andersen, 2009; Cahn, 1994, Merrill & Afifi, 2012).

Communication is essential to the formation of any relationship, especially the therapeutic relationship (Andersen, 2009; Rogers, 1957).

### **Nonverbal Immediacy Behaviors**

One particular set of communication skills that might play a role in the formation of the therapeutic relationship are Nonverbal Immediacy Behaviors (NIB). NIB are “nonlinguistic actions which send four simultaneous and complementary messages” (Andersen & Andersen, 1982, p. 100); these messages include sensory stimulation, availability, warmth, and approachability (Andersen, 2009; Andersen & Andersen, 1982; Rogers, 1957). There are seven categories of NIB which will be explained in regard to communication and counseling: proxemics, haptics, vocalics, kinesics, oculosics, chronemics, and environment (Andersen & Andersen, 1982).

Proxemics includes the distance between one communicator and another and the angle at which the communicator is positioned. Counselors are taught to align their shoulders with the client’s and to lean toward the client in order to convey a sense of connection (Egan, 2007). Different amounts of space should be left between two people in different settings. For example, two people who are 1.5 to 4 feet from each other are sharing personal space, whereas two people who are 12 feet or more away from each other are sharing public space. Counselors should judge the client’s needs and remain 1.5 to 12 feet away from the client (Hill, 2010). Two people within these boundaries are

sharing personal or social space. This, however, is a large range of space and the space needed by every client must be judged by the counselor.

Haptics involves the use of physical contact and touch. Although in NIB, increased physical contact signals interest and availability towards another person (Andersen & Andersen, 1982), it is suggested that counselors use touch in a very limited, minimal way (Hill, 2010). As opposed to other communication settings, many clients in counseling have experienced traumatic forms of touch, and it is possible that a counselor touching a client could be viewed as an invasion of space or otherwise inappropriate (Hill). Stenzel and Rupert (2004) surveyed 470 practicing psychologists and found that almost 90% very rarely or never used touch. The only form of touch used with some frequency was a handshake (Stenzel & Rupert). Although the use of touch is supported as a form of NIB, it was found when norming the NIB constructs that touch was not often used in communication between adults (Richmond, McCrosky, & Johnson, 2003). As such, there are very clear reasons that touch might not be useful in counseling, and counselor judgment is the best way to gauge the client's needs regarding the use of haptics.

Vocalics describes communication qualities such as pitch, tone, and use of minimal encouragers (e.g., “uh-huh” and “mmmmm”). Counselors are taught to strategically use vocalics with clients. Sometimes counselors will use a slow, calm tone and pace in order to help the client slow down and think. Other times, counselors will match a client's fast and loud tone in order to demonstrate how that affects interpersonal communication and intrapersonal processing (Hill, 2010). Counselors are also

encouraged to use enough minimal encouragers to demonstrate that the client is being heard, but not too many so that it becomes distracting (Hill).

Kinesics includes the communicator's use of physical movements (e.g., smiling, nodding, and body posture) and oculusics refers to the communicator's use of eye contact. Counselors are taught to use head nodding and eye contact in similar ways to minimal encouragers: enough to let the client feel heard and understood, but not so much that it becomes distracting (Hill, 2010). Counselors must employ their own interpersonal judgment in order to know how and when to use kinesics.

Chronemics refers to the use of time in communication, including the length of time spent with someone, the tense of communication (i.e., past, present, or ongoing), and punctuality. The length of counseling sessions is determined by the setting in which the counselor is practicing and based upon client needs (Leon, 2001). Counselors are also encouraged to help clients pivot between the past (e.g., telling the story) and the present (e.g., identifying how the story is currently affecting the client; Hill, 2010). Again, counselors must use their clinical intuition and judgment to identify the best way to use time with clients.

Finally, the environment in which the communication takes place is a component of NIB and includes the appearance of a room, physical barriers between communicators, and other environmental factors that influence the other six NIB. Frank and Frank (1991) reported that it is important for counseling to take place in "a healing setting" (p. 41). This helps clients feel safe, recognize that the counseling relationship is separate and different from other interpersonal relationships in their lives, and provides a certain

amount of esteem and credibility to the counselor. Additionally, counselors are encouraged to avoid any physical barriers between them and the client (e.g., a desk), and remain open physically to the client (Egan, 2007). As such, the environment is important in NIB and the therapeutic relationship.

### **Quantity and Correspondence of Nonverbal Immediacy Behaviors**

In communication literature, an increased use of NIB leads to increased sensory stimulation, availability, warmth, and approachability (Andersen, 2009; Andersen & Andersen, 1982; Jones & Wirtz, 2007; Richmond et al., 2003). However, other researchers contend that NIB should be used in accordance to client needs (Egan, 2007; Hill, 2010; Stenzel & Rupert, 2004). It is important to evaluate this discrepancy and identify the role that NIB play within the therapeutic relationship.

Jones and Wirtz (2007) asked 217 students in a communication class to identify three distressing emotional events and disclose them to one of four confederates trained in the use of NIB. Jones and Wirtz found that participants liked the confederates who used higher levels on NIB. The researchers also found that participants tended to match the confederate's NIB levels (i.e, high, moderate, and low), regardless of the NIB level displayed by the confederate. This indicates that counselors who use higher levels of NIB could improve the therapeutic relationship, and potentially increase their clients' use of NIB.

Higher levels of NIB also increase teachers' affect for their students. Baringer and McCrosky (2000) found that teachers expressed higher levels of affection toward students who used higher levels of NIB when communicating with them. As such, it

could potentially be important for both counselors and clients to use higher levels of NIB for the maximum benefit of the therapeutic relationship. One way in which counselors might support the increased use of client NIB is to increase their own use of NIB; Jones & Wirtz (2007) found that individuals expressing their difficulties tended to match their helper's level of NIB, regardless if it was low, moderate, or high. However, it is important the counselors are thoughtful about the ways in which they attempt to increase their own NIB and clients reciprocation of such.

In the midst of communication, individuals strive to properly identify and accommodate one another's NIB cues (Andersen & Andersen, 1982; Bertko, Aikem, & Wolvin, 2010; Hall, 1963). For example, many Americans are very sensitive to touch, and prefer to use it minimally (Andersen & Andersen, 1982; Stenzel & Rupert, 2004). In a counseling setting, counselors are trained to use touch minimally, if at all (Hill, 2010). However, if a client prefers to use high level of touch in their NIB, the counselor should adjust accordingly, in a professional, ethical manner (ACA, 2005, A.2.c., Andersen & Andersen, 1982; Hill, 2010). In fact, Jones and Wirtz (2007) found that participants expressed higher levels of affection for a helper who uses higher levels of NIB. Richmond & McCrosky (2000) also found that higher levels of supervisor NIB led to higher levels of subordinate satisfaction and job motivation. Although this generally indicates that higher levels of NIB are more helpful in interpersonal relationships, Jones & Wirtz (2007) also found that participants tended to match their helper's level of NIB, regardless if the helper displayed high or low levels of NIB. This indicates that matching is another important aspect of NIB.

During the process of communication, counselors and clients should adjust their NIB in order to approach a comfortable level of similarity and agreement (Bertko et al., 2010). Floyd and Erbert (2003) studied 32 participant-participant-observer triads in which the two participants were unacquainted and discussed a prompt for 10 minutes as the observer watched. Floyd and Erbert found that communicators who intentionally matched their target's NIB conveyed greater receptivity, greater similarity, and less dominance ( $p < .001$ ). The constructs in this study loosely align with Rogers' (1957) congruence (similarity), empathy (receptivity), and unconditional positive regard (less dominance). Additionally, greater similarity aligns with Roger's (1957) notion that counselors should adjust their communication according to the client's needs, and Miller and Duncan's (2004) assertion that the therapeutic relationship relies upon agreement of counselor and client. Overall, counselors who match their clients' NIB can improve the way in which their clients perceive them and potentially increase the quality of the therapeutic relationship (Berko, Aitken, & Wolvin, 2010; Floyd & Erbert; Flaskerud, 2013; Andersen, 2009; Hall, 1963; Rogers, 1961/1995).

NIB are a reflection of an individuals' internal state (Andersen & Andersen, 1982; Hall, 1963), and individuals can become consciously aware of this internal state in order to adjust their NIB accordingly (Andersen, 2009; Rogers (1961/1995). Rogers (1961/1995) stated "...if I can be sensitively aware of and acceptant toward my own feelings—then the likelihood is great that I can form a helping relationship toward another." (p. 51). With an awareness of their own internal state, counselors can adjust their NIB to reflect congruence, empathy, and unconditional positive regard and build the

therapeutic relationship (Rogers, 1957, 1961/1995; Staemmler, 2011). Rogers (1957) stated that the ultimate goal of therapy is to help clients reach a state of congruence. Clients can potentially learn congruence from the counselor, and convey congruence through their own NIB (Andersen & Andersen, 1982; Rogers (1957, 1961/1995; Staemmler, 2011). As such, as counselor and client NIB become more similar (i.e., correspond), the therapeutic relationship is built, and outcome effectiveness is achieved.

### **Importance of Nonverbal Immediacy Behaviors in the Therapeutic Relationship**

NIB have been studied in the field of instructional communication regarding the relationship between teacher and student and in interpersonal communication regarding the use of NIB in romantic relationships (Richmond et al., 2003). The use of NIB in a counseling relationship falls somewhere in between that of a teacher-student relationship and a romantic relationship; counselors hold a degree of power in a counseling relationship, similar to that of a teacher (Baringer & McCrosky, 2000; Hill, 2010), but the counseling relationship is deeply personal, similar to that of a romantic relationship (Floyd & Erbert, 2003; Richmond et al., 2003). As such, it is important to explore past NIB research in context of the relationship under review and carefully apply the findings to that of the counseling relationship. Additionally, it is important to gain a firm understanding of the current knowledge of the use of NIB in a helping profession.

Research regarding the use of NIB in helping relationships supports the importance of NIB in the counseling relationship. Miller (2007) interviewed 23 individuals in helping professions (e.g., counselor, nurse, pastor, and psychologist) and developed an interview protocol that explored the helpers' use of compassion in their

daily work. Miller analyzed the interviews for basic concepts and found that compassionate communication in the helping profession includes three processes in which a helper identifies a need for compassion (i.e., the process of noticing), gains insight into the problem (i.e., the process of connecting), and then provides a helpful intervention (i.e., the process of responding). During the process of connecting, helpers utilize empathy, which is one of Rogers' (1957) core conditions. During the process of responding, helpers use NIB in conjunction with verbal messages in order to provide helpful assistance. This supports the notion that empathy and NIB are important components of outcome effectiveness in helping relationships.

Although Miller (2007) found that NIB and actual verbal messages were important aspects of helping professionals' interventions, Tepper and Hause (1978) found that clients and counselors consistently rated NIB as more important than verbal messages. Tepper & Hause asked 15 clients and 15 counselors to rate the importance of NIB as compared to an actual verbal message and found the ratio of variance attributed to NIB over verbal messages was 2:1 for empathy, 5:1 for respect, and 23:1 for congruence; NIB explained twice as much variance in observer perception of empathy than did verbal messages. NIB explained five times more variance in observer perception of respect than did verbal messages, and NIB explained 23 times more variance in observer perceived congruence than did verbal messages. Empathy, congruence, and unconditional positive regard form the therapeutic relationship (Rogers, 1957, 1958), and it is important to further explore the way in which counselor and client NIB contribute to the therapeutic relationship.

Additional research regarding NIB in the instructional communication context can be carefully applied to the counseling field. NIB are supported as important components of effective teaching and are highly related to student learning outcomes (McCrosky, 2003; McCrosky, Richmond, & Bennett, 2006; Richmond & McCrosky, 2000). McCrosky et al. (2006) found that teachers' student-perceived use of NIB was positively correlated ( $p < .001$ ) with student-reported motivation (.45) and affect for teacher (.48). McCrosky, Valencic, and Richmond (2004) found significant, positive correlations between teachers' student-perceived use of NIB and teachers' student-perceived credibility (.77) and attractiveness (.25). If these findings translate to the field of counseling, counselor NIB behaviors can build the therapeutic relationship by increasing the quality of the bond (i.e., counselor attractiveness and affect for counselor) and increasing counselor and client degree of agreement on the goals, methods, and overall approach to therapy (i.e., counselor credibility and client motivation), which are the two main components to Miller and Duncan's (2004) definition of therapeutic relationship.

NIB contribute to the therapeutic relationship, and the therapeutic relationship is directly linked to outcome effectiveness (Andersen, 2009; Andersen & Andersen, 1982; Duncan et al., 2003; Miller, et al., 2006; Richmond et al., 2003; Rogers, 1957, 1961/1995, Staemmler, 2011). Despite the fact that counselors can intentionally use concrete and measurable NIB to create the necessary and sufficient conditions of psychotherapy (Andersen, 2009; Richmond et al., 2003; Rogers, 1961/1995), NIB have been only minimally researched and emphasized in counselor training literature (Egan, 2007; Couture, 2006; Hill, 2010; Staemmler, 2011). It is important to further explore the

way in which counselor and client NIB interact in relation to the therapeutic relationship and outcome effectiveness.

### **Demographic Information about Nonverbal Immediacy Behaviors**

It is important to note that there may be significant NIB differences between men and women. Richmond et al. (2003) administered the Nonverbal Immediacy Scale (NIS; which measures NIB) to 1241 individuals and found that women rated a target (whether themselves, a past teacher, or a past supervisor) with higher NIB than men rated the same targets. However, women and men rated past romantic partners similarly (Richmond et al.), which might indicate that gender differences are more apparent in instructional communication rather than interpersonal communication. Houser, Horan, and Furler (2008) administered the NIS to 157 speed daters, and found no significant gender differences, which further supports that NIB gender differences are less common in interpersonal communication than instructional communication. Counseling lies somewhere between these two communication concentrations, and Jones and Wirtz (2007) observed the NIB of 216 individuals in an emotional support situation (i.e., disclosing personal difficulties to a helper) and found that females tended to match their helpers' NIB more than males. As such, it seems as though the gender differences found in instructional communication would tend to persist in a counseling relationship, and it will be interesting to explore how this relates to client NIB, counselor NIB, congruence of counselor and client NIB, and the therapeutic relationship.

Some counselors build consistently stronger therapeutic relationships with clients than other counselors (Baldwin et al., 2007), but counselors who are consistently stronger

in fostering the therapeutic relationship are not able to do so with all of their clients (Marcus et al., 2009). It has been found that therapist gender (among many other demographic factors) does not directly affect outcome effectiveness (Beutler et al., 2004; Duncan et al.; Miller et al., 2007). As such, the counselors who are generally better at fostering the therapeutic relationship might be inherently better at matching their clients' NIB (Berko et al., 2010; Rogers, 1961/1995). However, this matching process between counselor and client must be an intentional act by the counselor (Andersen and Andersen, 1982, Andersen, 2009; Berko et al., 2010, Floyd & Erbert, 2003; Hall, 1983; Rogers, 1957). Therefore, exploring counselor and client NIB in terms of correspondence (as opposed to simply studying the level of counselor NIB) may be one way to understand how therapeutic relationship is built and the way in which this contributes to outcome effectiveness. Additionally, exploration of NIB correspondence supports the notion that counselor and client NIB are dependent upon one another and allows for more complex examination of NIB in a dyadic relationship.

### **Summary**

Nonverbal immediacy behaviors are one form of communication that might contribute to the formation of the therapeutic relationship (Andersen & Andersen, 1982; Madlock, 2008; Richmond et al., 2003; Rogers, 1957). More specifically, if counselor and client NIB become more similar across sessions (as the counselor accounts for client NIB preferences), a stronger therapeutic relationship might be formed (Andersen, 2009; Baldwin et al., 2007; Berko et al., 2010; Floyd & Erbert, 2003; Hall, 1983; Rogers). Some counselors might inherently match client NIB better than other counselors (Berko

et al., 2010; Rogers, 1961/1995, Rosenzweig, 1936; Marcus et al., 2009), but research regarding the relationship between correspondence of counselor and client NIB could potentially allow this process to become more intentional. It is important to identify ways in which counselors can foster strong therapeutic relationships with their clients because the therapeutic relationship is strongly linked to outcome effectiveness (Duncan et al., 2010; Orlinsky et al., 2004). As such, an increased understanding of the way in which counselor and client NIB affect the therapeutic relationship could potentially lead to a new understanding of the way in which counselors can learn to create outcome effectiveness.

## CHAPTER III

### METHODOLOGY

In Chapters I and II, the rationale and literature foundations for this study of outcome effectiveness were presented. The purpose of this chapter is to provide a detailed description of the methodology for the current study, including hypotheses, participants, procedures, instrumentation, and data analyses.

As indicated in Chapter II, the current outcome effectiveness theories (i.e., CFT and EVT) have limited empirical support, and the most recent research indicates that counselor and client factors interact to form the therapeutic relationship; the therapeutic relationship is known to be a strong contributor to outcome effectiveness. Researchers and practitioners have been searching for a way to identify the specific factors that create outcome effectiveness, and this study was designed to identify how counselor and client nonverbal immediacy behaviors relate to the therapeutic relationship and outcome effectiveness.

#### **Research Questions and Hypotheses**

The researcher sought to explore the relationship between counselor and client nonverbal immediacy behaviors (NIB) and the therapeutic relationship. Within and between session changes of NIB and therapeutic relationship for counselor and client were explored. Additionally, the current study further explored the relationship between

therapeutic relationship and outcome effectiveness. The research questions and hypotheses were as follows.

### **Research Question 1**

How do correspondence (i.e., similarity) of counselor and client nonverbal immediacy behaviors and therapeutic relationship change across sessions?

**Hypothesis 1a.** Correspondence of counselor and client nonverbal immediacy behaviors will increase across sessions, from first to third session.

**Hypothesis 1b.** Therapeutic relationship will increase across sessions, from first to third session.

### **Research Question 2**

How do counselor and client nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness relate within each session?

**Hypothesis 2a.** Individual scores of counselor and client nonverbal immediacy behaviors will be positively related to therapeutic relationship within each session.

**Hypothesis 2b.** The correspondence of counselor and client nonverbal immediacy behaviors will be a stronger predictor of therapeutic relationship than the individual scores of client and counselor nonverbal immediacy behaviors within each session.

**Hypothesis 2c.** Therapeutic relationship within each session will be positively related to outcome effectiveness.

### **Research Question 3**

At what point in counseling does therapeutic relationship have the greatest effect on outcome effectiveness?

**Hypothesis 3.** Therapeutic relationship at third session will be a stronger predictor of outcome effectiveness than therapeutic relationship at first or second session.

### **Participants**

Participants were obtained through an existing database in a counselor training clinic at a state university in the southeastern United States. This database consisted of videotaped sessions and corresponding files that contained counselor, client, and session information (including SRS and ORS scores for each session) and client and counselor demographics. The database included sessions from fall 2011, spring 2012, summer 2012, fall 2012, spring 2013, and summer 2013. After reviewing the entire database, only data from spring 2012 and spring 2013 were used because one requirement of the final sample was that the counselor must be a first-year master-level student (see procedures below), and this counselor demographic only saw clients in the spring.

Master's-level counselors in their first year (second semester) of training served as the counselors; undergraduate students served as the clients. Of the 77 participants in the database, 33 clients (43%) attended counseling in order to fulfill university-mandated requirements due to insufficient academic achievement, 41 clients (53%) attended counseling in order to receive extra credit for a counseling or social work class, and 3 clients (4%) did not report a reason for attending counseling sessions. Therefore, this resulted in a mixture of volunteer and mandated clients.

All counselors had completed a minimum of one course on basic counseling skills (including nonverbal behaviors). Additionally, each counselor received regular, weekly individual and/or group supervision by a doctoral student or doctoral-level faculty

member throughout their work with the clients. Some clients might have been directly discussed in supervision, and all counselors received feedback on their counseling skills and personal/professional development. Counselor and client pairs were assigned by each counselor's supervisor or the clinic director based upon scheduling availability or counselor/client needs. Each client and counselor was given the opportunity to read and voluntarily sign an informed consent to contribute to the research database.

Power analyses were conducted using G\*power, and it was found that a total sample of 77 counselor and client pairs across three sessions (i.e., first, second and third) were needed in order to run a linear multiple regression with three predictor variables, which were used to answer research questions two and three. All other analyses required a smaller sample size to avoid type II error (see Table 1). This resulted in a total sample of 231 sessions (i.e., three sessions per counselor and client pairs). For all analyses, this was expected to result in power of .80, alpha of .05, and a medium effect size (.15  $f^2$  and .25  $f$ ). A medium effect size has been consistently reported in the therapeutic relationship literature (e.g., Crits-Christoph et al., 2006) and outcome effectiveness literature (e.g., Horvath & Symonds, 1991; Luborsky et al., 2002) as a substantial indicator of effect.

Table 1

Summary of Research Questions and Analyses

Research Question	Hypothesis	Variables	Analysis
<p><b><u>Research Question 1:</u></b> How do correspondence (i.e., similarity) of counselor and client nonverbal immediacy behaviors and therapeutic relationship change across sessions?</p>	<p><b><u>Hypothesis 1a:</u></b> Correspondence of counselor and client nonverbal immediacy behaviors will increase across sessions, from first session to third session.</p>	<p>CNIB at first, second, and third sessions</p>	<p>Repeated Measures ANOVA</p>
<p><b><u>Research Question 1:</u></b> How do correspondence of counselor and client nonverbal immediacy behaviors and therapeutic relationship change across sessions?</p>	<p><b><u>Hypothesis 1b:</u></b> Therapeutic relationship will increase across sessions, from first session to third session.</p>	<p>TR at first, second, and third sessions</p>	<p>Repeated Measures ANOVA</p>
<p><b><u>Research Question 2:</u></b> How do counselor and client nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness relate within each session?</p>	<p><b><u>Hypothesis 2a:</u></b> Individual scores of counselor and client nonverbal immediacy behaviors will be positively related to therapeutic relationship within each session.</p> <p><b><u>Hypothesis 2b:</u></b> The</p>	<p>Counselor NIB at first, second, and third sessions</p> <p>Client NIB at first, second, and third sessions</p> <p>CNIB at first, second, and third sessions</p>	<p>Hierarchical Regression: step 1 to answer 2a and step 2 (whole model) to answer 2b</p>

	<p>correspondence of counselor and client nonverbal immediacy behaviors will be a stronger predictor of therapeutic relationship than the individual scores of counselor and client nonverbal immediacy behaviors within each session.</p>	<p>TR at first, second, and third sessions</p>	
<p><b><u>Research Question 2:</u></b> How do counselor and client nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness relate within each session?</p>	<p><b><u>Hypothesis 2c:</u></b> Therapeutic relationship within each session will be positively related to outcome effectiveness.</p>	<p>TR at first, second, and third sessions  OE</p>	<p>Linear Multiple Regression</p>
<p><b><u>Research Question 3:</u></b> At what point in counseling does therapeutic relationship have the greatest effect on outcome effectiveness?</p>	<p><b><u>Hypothesis 3:</u></b> Therapeutic relationship at third session will be a stronger predictor of outcome effectiveness than therapeutic relationship at first or second session.</p>	<p>TR at first, second, and third sessions  OE</p>	<p>Multiple Regression with Multicollinearity Analysis</p>

## Instrumentation

The following section outlines the measures that were used and the variables that were created from the measures. The way in which these variables were calculated and interpreted is included in the summary table (see Table 2).

Table 2

### Summary of Variables

Variable Name	Acronym	Measure	Calculation Method	Interpretation
Nonverbal Immediacy Behaviors	NIB	NIS	NIS Total Score calculated separately for counselor and client	Score of 26 to 130; higher scores represent more frequent use of NIB
Correspondence of Counselor and Client NIB	CNIB	NIS	Correlation of each item on the NIS for counselor and client in a given session	Correlation close to 1 indicates counselor NIB and client NIB are very similar; correlation close to -1 indicates counselor NIB and client NIB are very different or almost opposite; correlation of 0 indicates no relationship, or lack of connection between counselor and client NIB
Outcome Effectiveness	OE	ORS	Subtract ORS at first session from ORS at third session.	Score of -40 to 40; larger positive numbers indicate high OE and larger negative numbers indicate unhelpful client change
Therapeutic Relationship	TR	SRS	SRS Total Score	Score of 0-40; higher scores indicate stronger TR

### **Nonverbal Immediacy Scale (NIS)**

**Nonverbal Immediacy Behaviors (NIB).** The NIS is a 26-item self- or observer-reported instrument used to measure NIB in a variety of settings (Richmond, et al., 2003). The NIS is the most recent and comprehensive measure of NIB (Aydin et al., 2013; Richmond et al., 2003) and measures the majority of NIB constructs identified by Andersen and Andersen (1982). It was found in the initial evaluation of the NIS that the scale measured eight areas of NIB (McCrosky et al., 2003), which aligned with five of seven NIB identified by Andersen and Andersen (1982); these included a lively voice tone/variety of vocal expressions (vocalic), relaxed body posture (kinesics), maintaining eye contact (oculesics), using gestures/being energetic (kinesics), standing or sitting close (proxemics), leaning toward/moving closer to students (proxemics/kinesics), and touching students while talking (haptics; Aydin et al., 2013). The NIB measured by each NIS item is listed in Table 3.

The NIS is regarded as a reliable, valid, and comprehensive measure of NIB in the school, work, and social environment (Aydin et al., 2013; McCrosky et al., 2006). As such, the researcher made the assumption that the NIS would be an effective tool for measuring NIB in the counseling setting, which lies somewhere between the work and social environment. The operational definition of NIB closely aligns with the conceptual definition of NIB (see chapter I), and it was assumed that the NIS would accurately capture the nuances of NIB in the counseling relationship.

Table 3

NIB Measured by the NIS

Item Number	NIB Measured	Item Number	NIB Measured
1	kinesics	14	kinesics
2	haptics	15	kinesics
3	vocalics	16	proxemics/kinesics
4	proxemics/kinesics	17	oculesics
5	proxemics/kinesics	18	kinesics
6	kinesics	19	vocalics
7	kinesics	20	kinesics
8	oculesics	21	proxemics/kinesics
9	kinesics	22	oculesics
10	proxemics	23	proxemics
11	vocalics	24	proxemics/kinesics
12	vocalics	25	kinesics
13	kinesics	26	haptics

The observer-reported NIS was used in this study by a third party to measure counselor and client NIB for each session (i.e., first, second, and third). The NIS observer report was created for one person to rate another person with whom they have communicated in the past (McCrosky et al., 2003); in the current study, a rater who has never communicated with the target observed the counselor and client interaction and rated either the counselor or client NIB. Jones and Wirtz (2007) also used a trained third-party observer to rate the NIB of a participant and a confederate, but this is a relatively new way to use this instrument. In doing a third-party observer rating, the researcher assumed the rater would be able to gain an understanding of the target's NIB by observing an interaction rather than engaging in communicative behaviors with that target. In order to ensure some consistency when using the NIS as a third-party

observation tool, formal bracketing procedures and inter-rater reliability were assessed between the principal researcher and rater (see procedures below).

The observer-reported NIS consists of 26 items, with raters responding on a 5-point Likert-type scale for each item; 1 represents never, 2 represents rarely, 3 represents occasionally, 4 represents often, 5 represents very often. This scale was used to rate the overall NIB of the target in each counseling session; therefore, the principle researcher and rater completed one NIS at the end of each videorecorded session for the counselor and the client. This provided one NIS score for the counselor and one NIS score for the client per session.

Three steps are used to score the NIS. In step one, add together all items that represent a speaker's use of NIB (as listed in the instrument scoring procedures; Richmond et al., 2003). In step two, add together all items that represent a speaker's lack of using NIB (as listed in the instrument scoring procedures; Richmond et al.). In step three, to find the total score, start with 78 (as determined by Richmond et al.), add the number derived from step one and subtract the number derived from step two. This provided a total score ranging from 26 to 130, with higher scores representing more frequent use of NIB and lower scores representing less frequent use of NIB (Richmond et al.).

**Correspondence of Counselor and Client NIB (CNIB).** The correspondence (i.e., similarity) of counselor and client NIB within each session was calculated for each counselor and client pair for each session. This resulted in three CNIB scores per client (i.e., one score for first, one for second, and one for third session). In order to calculate

this value, the score for all 26 individual items on the observer-reported NIS (ranging from 1 to 5) for counselor and client within a given session were correlated using a Pearson correlation. This correspondence calculation accounted for nonindependence of the dyadic data and explored the way in which counselor and client aligned on each of the five measured NIB.

The correlation coefficient obtained by correlating all 26 NIS items for counselor and client was the CNIB value for that given session. This correlation could range from 1 to -1; a correlation coefficient of 1 represented a perfect relationship in which as counselor NIB increased, so did client NIB, and vice versa; as counselor NIB decreased, so did client NIB. A score of +1 or close to +1 indicated that the counselor and the client were matched in the types of NIB they exhibited in a session, thus their behaviors were very similar. A correlation coefficient of -1 represented a perfect relationship in which as counselor NIB increased, client NIB decreased, and vice versa. Thus, a score of -1 or close to -1 indicated that the counselor and client NIB were not similar, but in fact may have been fairly opposite (e.g., as a counselor exhibited a high level of NIB, a client exhibited low levels of NIB). A correlation coefficient of 0 represented no relationship between counselor and client NIB. That is, a correlation of 0 or close to 0 indicated that counselor NIB did not affect, and was not affected by client NIB.

**Reliability.** Researchers have consistently found high internal consistency with Cronbach alphas of .90 and above (Madlock, 2008; McCrosky et al., 2006; Richmond et al., 2003). The majority of these studies have been conducted with large samples of college students; however, Madlock (2008) collected data from full-time working adults.

Specifically focusing on an observer-reported NIS, McCrosky et al. (2006) administered the NIS observer report to 189 undergraduate students (101 males; 90% Caucasian) and used their most recent teacher as the target, finding a Cronbach alpha of .92. Houser, Horan, and Furler (2008) administered the observer-reported NIS (shortened from 26 to 14 questions) to 157 adults (ages 25-60; 53% male) using their supervisor as the target and obtained an alpha coefficient of .81. Therefore, regardless of self-report or observer-report, the NIS has been found to be internally consistent across reporters and different types of communication and interaction.

**Validity.** Richmond et al. (2003) administered the NIS 1,241 times (53% male; 95% Caucasian) as a self- (n=930) and observer-reported (n=311) measure along with a four-item warmth/approachability scale. They found that NIS was strongly and positively correlated with warmth and approachability (.74 to .95 disattenuated), revealing strong predictive validity.

### **Outcome Rating Scale (ORS)**

**Outcome Effectiveness (OE).** This study used a general outcome measure, the Outcome Rating Scale (ORS) in accordance to the comprehensive definition of OE (Miller & Duncan, 2004; Lambert & Hill, 1994) and the recommendations for measuring OE as made by Fireman (2002) and Duncan and Moynihan (1994). Miller and Duncan (2004) created the ORS to measure client wellbeing in individual functioning, interpersonal relationships, and social performance. This instrument consists of four items that serve as general scores of functioning and should be completed by clients at the beginning of every counseling session. These general scores of functioning can

provide information regarding the client's goals in counseling, or needs in counseling, without being as specific as creating goals such as "lowering depression" or "enhancing relationship with my partner". This more general way of assessing allows comparison across clients regardless of specific goals, presenting concerns, or diagnoses.

On the ORS, each of the four items has a 10-centimeter visual analog scale with hash marks on either end (shaped like a sideways capital "I"). Clients are instructed to place a mark along the 10-centimeter line at a place that describes their feelings about the item; a hash mark toward the left denotes a negative feeling and a hash mark toward the right denotes a positive feeling. The counselor is then responsible for using a ruler to measure how many centimeters along the visual scale the client makes their mark (0 is at the left; 10 at the right); it is important for the ORS to be printed accurately in order to ensure proper measuring. The total client ORS score for each session is calculated by adding together each of the four item scores to create a score that ranges from 0 to 40. The ORS measurement scores for the current sample were already created and coded by previous counselors and entered into the larger client/counselor database.

The ORS indicates a client's level of satisfaction with individual functioning, interpersonal relationships, and social performance at the start of a given session. These scores can range from 0-40, and higher scores indicate greater satisfaction with these facets of outcome effectiveness (Miller & Duncan, 2011). A clinical cutoff score of 25 is used to indicate clients who are experiencing distress that is similar to a clinical population. A score below 25 on the ORS at intake is associated with greater outcome effectiveness because clients with more significant presenting concerns have greater

room for improvement across sessions (Miller & Duncan). It was important to consider client ORS scores at intake (i.e., first session) when interpreting OE results.

To determine client OE, the clients' ORS scores at first session were subtracted from the ORS scores at third session to indicate the amount of change—or movement—toward the goals or needs in counseling that occurred during their time in counseling, therefore determining the effectiveness of counseling (i.e., OE). This resulted in a number between 40 and -40. Larger positive numbers indicated high total OE or greater movement toward achieving one's goals regarding overall functioning, while a value of zero indicated no change in outcome effectiveness, and negative numbers indicated movement away from goals or unhelpful client change.

**Reliability.** Although it has fewer than 10% of the items on the OQ-45 (4 questions instead of 45), the ORS has demonstrated substantial reliability and validity (Miller & Duncan, 2004). Miller, Duncan, Brown, Sparks, and Claud (2003) administered the ORS to a non-clinical sample (86 master's students, therapists, and clinic staff with mixed gender, socioeconomic status, and ethnicities) and found an internal consistency Cronbach's coefficient alpha of .93. Test-retest reliability with the same population ranged from .49 to .66. Bringhurst, Watson, Miller, and Duncan (2006) administered the ORS to 98 university students and found a .97 overall internal consistency and test-retest reliability of .80 to .81.

Internal consistency of the ORS found by Duncan et al. (2003) and Bringhurst et al. (2006) is comparable (i.e., .93 and .97), but test-retest reliability was much higher for Bringhurst et al.'s sample than Duncan et al.'s (i.e., .49 to .66 versus .81). Although both

studies used a non-clinical sample, Duncan et al. administered the ORS at intervals of up to two weeks and Bringhurst et al., administered the ORS at intervals of no more than 1.5 weeks. Bringhurst et al. reported that the disparity in test-retest reliability might have been due to the increased time lapse in Duncan et al.'s study; the ORS was designed to be used in weekly sessions (Miller & Duncan, 2004). Additionally, although test-retest reliability for the ORS was somewhat low in Duncan et al.'s study, this could potentially indicate the instrument's high sensitivity to client change from week to week (Duncan et al.). Therefore, it could be assumed that if clients are actually moving toward their goals (i.e., OE), then the ORS should not stay stable, which would be indicated by higher test-retest reliability.

**Validity.** Miller et al. (2003) administered the ORS and the OQ-45 to a clinical sample (435 clients in an outpatient agency setting) and found a correlation of .59 between the two measures. Bringhurst et al. (2006) sought to replicate Miller et al.'s (2003) study by administering the ORS and OQ-45 to 98 students at the University of Utah (ages 20-59; 67 females and 30 males). The researchers found correlation coefficients of .57 to .69 between the ORS and the OQ-45. This indicated that the ORS and the OQ-45 measure a similar but not identical construct.

Construct validity for the ORS was demonstrated by Miller et al. (2003). Miller et al. administered the ORS at least 4 times to 77 non-clinical participants (who were receiving no psychotherapeutic interventions) and 435 clinical participants (who received psychotherapeutic interventions). T-tests were used to compare change in the ORS from first to last session for the clinical and non-clinical populations; the t-tests showed

significant change for the clinical sample and insignificant change for the non-clinical sample (Miller et al.). As such, it was demonstrated that the ORS measures outcomes that are the result of psychotherapeutic interventions (Miller & Duncan, 2004; Miller et al., 2003).

### **Session Rating Scale (SRS)**

**Therapeutic Relationship (TR).** Similar to the ORS, the Session Rating Scale 3.0 (SRS) is a succinct, four-item, client-completed measure of TR developed by Miller, Duncan, and Johnson (2000). The original version of the SRS was developed by Johnson (1995) and was directly informed by Bordin (1979) and Gaston (1990). Although the original SRS had sufficient reliability with 10 items, clinicians and clients who used the instrument complained that it was too time-consuming (Duncan et al., 2003). In order to decrease completion time, Miller et al. created (2000) the current version of the SRS, which includes only four items. Although the most recent version of the SRS was developed to measure a similar construct as the original SRS, Duncan et al. incorporated additional theories of outcome effectiveness (e.g., change theory). As such, the original SRS and the SRS 3.0 measure slightly different constructs.

The current 4-item SRS allows the client to report the level of respect and understanding within the relationship, agreement with the therapist on goals and topics, agreement with the therapist on approach and method, and an overall rating of the session (Miller et al., 2000). This measure should be administered at the end of each session to gauge the therapeutic relationship during the session that just occurred. Duncan et al.

(2003) found a Cronbach's coefficient alpha of .88 and determined that all four items work together to form a global assessment of therapeutic relationship.

Each of the four items on the SRS has a 10-centimeter visual analog scale with hash marks on either end (shaped like a sideways capital "I"). Clients are instructed to place a mark along the 10-centimeter line at a place that describes their feelings about the item; a hash mark toward the left denotes a negative feeling and a hash mark toward the right denotes a positive feeling. The counselor is then responsible for using a ruler to measure how many centimeters along the visual scale the client makes their mark (0 is at the left, 10 at the right); it is important for the SRS to be printed accurately in order to ensure proper measuring. The total client SRS score is created by adding each of the four items together to create a range from 0 to 40, with higher scores representing a stronger therapeutic relationship. All SRS measurements for the current study were previously created and entered into the larger database for the clinic.

**Reliability.** Duncan et al. (2003) administered the SRS to 70 self-referred clients at an outpatient counseling agency. Each client took the SRS on six different occasions, which resulted in 420 total SRS scores. A Cronbach's coefficient of .88 was found (Duncan et al., 2003). An independent study conducted by the Center for Clinical Informatics on 15,000 SRS administrations found a coefficient alpha of .96 (Miller & Duncan, 2004), both of which indicate strong internal consistency. Campbell and Hemsley (2009) also found strong internal consistency of the SRS; the researchers administered the SRS to 65 clients receiving psychological services and found a

Cronbach's alpha of .93. Campbell and Hemsley also found inter-item correlations ranging from .74 to .86 ( $p < .01$ ) for each of the four SRS items.

**Validity.** Duncan et al. (2003) correlated 420 SRS total scores from 70 self-referred outpatient counseling clients with the Helping Alliance Questionnaire II (HAQ-II) and found a Pearson product-moment correlation of .48 ( $p < .01$ ), which is a positive relationship. Duncan et al. also found a correlation of at least .39 between each of the four SRS items and the HAQ-II total score. Although the correlation is moderate, it indicates that SRS and HAQ-II are positively related, yet not completely measuring the same construct (Duncan et al.; Miller & Duncan, 2004).

Predictive validity has been demonstrated through positive correlations between the SRS and client outcome effectiveness (Duncan et al., 2003; Miller & Duncan, 2004; Miller, Duncan, Brown, Sorrell, & Chalk, 2006). Duncan et al. randomly pulled 100 cases from 1368 adults at a community family service agency and found a .29 ( $p < .01$ ) correlation between an early administration of the SRS and a final ORS score. Miller et al. (2006) found that significant increases in SRS over time correlated .13 ( $p < .0001$ ) with significant increases in outcome effectiveness scores over time.

### **Client Demographics**

Client demographics were collected using the training clinic's standard intake form. The demographics that were used for this study include client age, gender, race/ethnicity, presenting issue, and number of sessions attended. This information was self-reported by the client.

## **Counselor Demographics**

Counselor demographics were collected using the training clinic's existing database. The demographics that were used for this study include counselor age, gender, and race/ethnicity. This information was self-reported by the counselor.

## **Procedures**

The database for this study consisted of a combination of existing data along with newly-collected data. The existing database included recordings of all sessions, client demographics, counselor demographics, and client-rated SRS and ORS scales for each session. The existing data were collected by each counselor at the time in which the counseling session occurred. Intake paperwork was administered before the first session and included client demographic information. The ORS was administered before the start of each session, and the SRS was administered at the conclusion of each session. A staff member at the training clinic entered all of the data into an Excel sheet, where it currently resides.

Data for 77 counselor-client pairs across three sessions was collected. The principal researcher reviewed the entire database (which consisted of 414 potential participant pairs) to identify all counselor-client pairs that met the data requirements, which included: the counselor must be a first-year master-level student; each counselor-client pair must have a minimum of three sessions; the first, second, and third session must have an accompanying ORS and SRS score; all three sessions must have at least 45 minutes of counselor-client interaction; and the counselor and client must be fully visible in the recording. Counselors were not included or excluded from the study based on the

number of their clients who met these requirements, or on how many sessions the counselor and client had together (however, the total number of counseling sessions was controlled for through statistical analyses). Of the 414 possible counselor-client pairs in the database, only 95 pairs met the criteria and were eligible for inclusion in the database.

Data on the first, second, and third session was needed to complete the analysis. Although counselor and client pairs who only met with one another for a total of three sessions (i.e., the third session was also the termination session) might provide the most stringent results, this did not provide adequate sample size to provide enough statistical power for data analysis. Therefore, counselor and client pairs that met for 3 to 13 sessions (mean=5.6,  $sd=2.2$ ) were included, although data for just the first three sessions were used for this study.

To determine which 77 of the potential 94 counselor-client pairs were included, the principal researcher isolated the 95 eligible pairs in the order they were entered into the database. A random number sequence from 1 through 95 was then identified, and the first 77 pairs were included in the final dataset. This number (1 through 77) then became the identification for the counselor-client pair.

It was important to keep ORS and SRS scores for each session completely separate from the video until all NIS rating was complete (to eliminate the possibility of rater bias based upon session order and SRS score). In order to do so, each of the three sessions for each pair (231 total sessions) was listed in successive order (i.e., session 1 for all 77 pairs, then all second sessions, then all third sessions for pairs 1 through 77). Then, a random number sequence from 1-231 was created and this indicated the order in which

each video would be watched for NIS observation. This randomization decreased potential researcher bias in coding the NIS by removing the ability to watch counselor-client sessions in sequential order, which assisted in eliminating researcher hypothesis guessing regarding the ORS or SRS scores. The viewing order was kept in one single excel worksheet that was solely used for all NIS data collection, which made the order in which the videos were watched completely random, and any associated data was unknown to the principal researcher and rater while the NIS was completed.

It has been found that four five-minute segments of a counseling session provide a representative sample of the entire video (Kepecs, 1979; Riley-Tillman, Christ, Chafouleas, Boice-Mallach, & Briesch, 2010). This was tested in the pilot study (see Appendix D), and it was confirmed that watching minutes 0-5, 15-20, 30-35, and 40-45 of a video (which spans the entire duration of the counseling session with 5-10 minutes in between each time point) allowed an observer to produce a representative NIS score; a *t*-test of the differences between NIS scores produced by watching the whole video and NIS scores produced by watching the four five-minute segments was nonsignificant ( $t=.480$ ;  $p=.635$ ) indicating that the segments, in fact, can be used to measure the same behaviors as the entire video. As such, the principal researcher and rater watched every video in the sample at these four time points in order to code counselor and client NIS. The sessions were randomly ordered, and the principal researcher provided counselor NIS score for the odd-numbered videos and client NIS scores for the even-numbered videos. The rater provided opposite scores, which resulted in one counselor NIS and one client NIS score for each session.

### **Inter-rater Reliability for NIS Scores**

Two procedures were used in order to control for any potential bias in NIS score collection: bracketing and formally calculating inter-rater reliability. The rater was chosen because she is from a different geographic location than the principal researcher (i.e., Georgia as opposed to Ohio) and earned a Bachelor's degree in Communication Studies. The rater also participated in the pilot study and became familiar with the NIS through that process.

#### **Training**

The NIS was created for use by graduate students and researchers, so the principal researcher and rater meet the requirements for administration of the instrument (Richmond et al., 2003). As such, in order to begin training, the principal researcher and rater reviewed the NIS directions and then read every question on the scale. During this process, the specific NIB measured by each item was discussed. Additionally, the likert scale (i.e., 1-5) was discussed in relation to the specific behaviors that would merit a rating of 1, 2, 3, 4, or 5 for each item.

Next, the researcher and principal investigator discussed the liberties that were being taken by using the NIS in order to evaluate a counseling relationship. The way in which the NIS is used in instructional and interpersonal communication was discussed, and the way in which counseling relates to each of these communication disciplines was identified. As such, the principal researcher and rater discussed how communication is used in counseling and the similarities and differences between counseling and communication studies. Additionally, the use of the NIS to rate NIB as a third party,

rather than a member of the communication dyad, were discussed. This process took approximately 1.5 hours. At this point, the principal researcher and rater completed bracketing procedures (see below) and then returned to the training.

After completing bracketing procedures, the principal researcher and rater watched three videos of counseling demonstrations from a public database (called Alexander Street) on the university library website. Each video was watched in the designated four, five-minute segments (i.e., 0-5, 15-20, 30-35, 40-45). The first video was entitled “Cognitive-Behavioral Therapy with John Krumboltz,” and the counselor was a middle-aged, white man and the client was a young, white female. The second video was entitled “Adlerian Therapy,” and the counselor was a middle-aged white male and the client was a young black female. The third video was entitled “The Abused Woman: A Survivor Therapy Approach.” The counselor and client were both middle-aged white women. The three videos offered a variety of therapeutic approaches and gender/ethnic diversity of counselor and client.

For the first video, the principal researcher and rater paused after each five-minute segment to discuss their thoughts and completed one NIS for either counselor or client together. The counselor was rated after segments one and three, and the client was rated during segments two and four. This resulted in 4 NIS practice-runs for video 1 (two for counselor and two for client).

For video 2, the principal researcher and rater completed one NIS together (i.e., discussed thoughts and discrepancies while completing the scale) for the counselor after the first five-minute segment, and then completed one NIS together for the client after the

second segment. Then, the principal researcher and rater separately completed (i.e., withheld any discussion and independently completed the scale) the NIS on the counselor after segment three and separately completed an NIS for the client after the final segment. The inter-rater reliability Pearson correlation for video two was .723 ( $p=.000$ ) for the client and .751 ( $p=.000$ ) for the counselor. This met the minimum satisfactory Pearson correlation for inter-rater reliability of .70 (Multon, 2010).

For the third video, the principal researcher and rater watched the designated four, five-minute segments and then independently completed one NIS score for counselor and one for client at the end of videotape viewing. A Pearson correlation of .940 ( $p=.000$ ) for counselor and .868 ( $p=.000$ ) for client was obtained for this video.

Next, the principle researcher and rater watched four videos from the actual database that were not included in the final sample ( $n=77$ ). For each video, the designated four, five-minute segments were watched and the principle researcher and rater independently completed one NIS for the counselor and one NIS for the client. For video one, a Pearson correlation of .853 ( $p=.000$ ) for counselor and .850 ( $p=.000$ ) for client was obtained. For video two, a Pearson correlation of .861 ( $p=.000$ ) for counselor and .862 ( $p=.000$ ) for client was obtained. For video three, a Pearson correlation of .796 ( $p=.000$ ) for counselor and .822 ( $p=.000$ ) for client was obtained. For video four, a Pearson correlation of .840 ( $p=.000$ ) for counselor and .853( $p=.000$ ) for client was obtained.

Overall inter-rater reliability for this final stage of training was calculated by compiling all NIS scores completed by the principle researcher and correlating them with

all NIS scores completed by the rater; this was completed for counselor and client separately. For the counselor, overall inter-rater reliability was ( $r=.835, p=.000$ ). Overall inter-rater reliability for the client was ( $r=.845, p=.000$ ). The range of the inter-rater reliability for counselor was .796 to .861 (mean=.838,  $sd=.032$ ). The range of the inter-rater reliability for counselor was .822 to .862 (mean=.847,  $sd=.015$ ).

Overall, inter-rater reliability during training was never below the required .70 (Multon, 2010) and generally improved as training continued. As such, sufficient inter-rater reliability was consistently established on database videos and formal data collection was begun. This process took approximately 3.5 hours, which resulted in total training time of approximately 5 hours (in addition to the pilot study).

### **Bracketing**

After learning about the NIS, but before watching practice videos, formal bracketing procedures were completed. The principal researcher and rater identified key words and phrases that explain the way in which the researchers might be generally biased toward a counselor or client; this included words and phrases such as *gender*, *aggressive*, *want to help*, and *can't help it*. These words and phrases were used to create a definition of the potential bias and how it might affect the data collection (Fischer, 2009; Holstein & Gubrium, 1994). This definition is as follows: "As counselors, we tend to view NIB in context; when rating, we must process them as individual occurrences with consistency across the sample." The principal researcher and rater then determined that placing the definition of NIS bias on a note card would be helpful in preventing rater bias when completing the NIS. The principal researcher and rater kept the note card with

the definition in eyesight at all times throughout data collection and intentionally reviewed it before watching each video.

### **Inter-Rater Reliability**

The principal researcher completed an NIS for the counselor for all odd videos, and the rater completed an NIS for the client for all odd videos; this was reversed for the evenly-numbered videos. In order to formally calculate inter-rater reliability, the principal researcher and rater completed an NIS for both counselor and client every 12<sup>th</sup> video. The correlation for each video can be found in table 4.

Table 4

Inter-rater Reliability Correlations

Video	Counselor		Client	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
12	.806	.000	.812	.000
24	.953	.000	.955	.000
36	.872	.000	.878	.000
48	.941	.000	.886	.000
60	.935	.000	.919	.000
72	.899	.000	.916	.000
84	.927	.000	.934	.000
96	.955	.000	.943	.000
108	.972	.000	.945	.000
120	.874	.000	.980	.000
132	.943	.000	.967	.000
144	.951	.000	.933	.000
156	.906	.000	.952	.000
168	.978	.000	.920	.000
180	1.000	.000	.974	.000
192	.919	.000	.968	.000
204	.954	.000	.980	.000
216	.954	.000	.978	.000
228	.869	.000	.880	.000

Overall inter-rater reliability was calculated by correlating all principle researcher and rater NIS scores for videos 12, 24, 48, 60, 72, 84, 96, 108, 120, 132, 144, 156, 168, 180, 192, 204, 216, and 228; this was done for counselor and client separately. For the counselor, inter-rater reliability was ( $r=.919$ ,  $p=.000$ ), and the range was .806 to 1.00 (mean=.927,  $sd=.042$ ). Overall inter-rater reliability for the client was ( $r=.931$ ,  $p=.000$ ), and the range was .812 to .980 (mean=.933,  $sd=.043$ ).

Although the correlation never dropped below .70, procedures were in place if it had. If the correlation dropped below .70 at any point, the principle researcher would randomly pick two of the previous 12 videos to determine if IRR existed. To do so, the rater and principle researcher would watch these two videos and complete the NIS for the target for which they had not previously completed it (i.e., if the rater completed the NIS for the counselor originally, she would then complete the NIS for the client), and then the NIS scores from the rater and principle researcher would be correlated to obtain inter-rater reliability information. If either of the two randomly-chosen videos did not have inter-rater reliability of at least .70 (Multon, 2010) for counselor and client, the previous 12 sessions would be re-rated. Before rating resumed, the principal researcher and rater would use videos from the database that were not included in the full study to discuss biases and re-establish inter-rater reliability.

### **Data Analysis**

The data were collected using Microsoft Excel and directly imported into IBM Statistical Package for the Social Sciences 21 (SPSS) for data analyses. Descriptive statistics were completed prior to running the main analyses to identify the nature of the

data and to explore the demographic characteristics of the sample. There was limited information about counselor age, but there was no other missing data, as complete data sets were a criterion for inclusion in the study.

For hypothesis 1a, a repeated measures ANOVA was used to determine any significant differences between correspondence of counselor and client NIB at first, second, and third sessions. For hypothesis 1b, a repeated measures ANOVA for therapeutic relationship at first, second, and third session was used. Three hierarchical regressions (one for first, second, and third session) was used to answer hypothesis 2a and 2b; counselor and client NIB was loaded first, and then correspondence of counselor and client NIB were loaded second. Linear multiple regression with therapeutic relationship at first, second, and third sessions predicting outcome effectiveness was used to answer hypothesis 2c. To answer hypothesis 3, a multiple regression (with multicollinearity analysis) was used to predict outcome effectiveness from therapeutic relationship in each session. The multicollinearity analysis was necessary because it is expected that therapeutic relationship in each session would be related.

## CHAPTER IV

### RESULTS

In this chapter, the results of this study are presented using descriptive statistics, repeated measures analyses of variance (ANOVA), and several types of regressions (as detailed in chapter III). The characteristics of the sample will be described first. Then, the results of each research question and hypothesis will be presented.

#### **Resulting Sample Characteristics**

The final sample of 77 counselor and client pairs was selected from a database of 414 potential participants. Selection occurred first by meeting the a priori determined criteria requirements, and secondly by randomly selecting the counselor and client pairs from the remaining database. Requirements for inclusion in the sample were the following: the counselor must be a first-year master-level student; each counselor-client pair must have a minimum of three sessions; the first, second, and third session must have an accompanying Outcome Rating Scale (ORS) and Session Rating Scale (SRS) score; all three sessions must have at least 45 minutes of counselor-client interaction; and the counselor and client must be fully visible in the recording.

Ninety-five counselor and client pairs (22.9%) met the study requirements, and the final 77 pairs were randomly selected from this final database. Of the 77 counselor and client pairs included in the study, 8 counselors were in the database just once, 16 counselors were included twice, 9 counselors were included three times, 1 counselor was

included four times, and one counselor was included six times. Each time any counselor was included in the database, it was with a different client.

Of the 77 counselors, 66 (85.7%) were female, and 11 (14.3%) were male. Fifty-seven counselors (74%) identified as Caucasian, 19 counselors (24.7%) identified as African American, one counselor (1.3%) identified as Asian American. Information about counselor age was rarely reported; however, twenty-two counselors reported their ages ( $M=23.2$ ,  $SD=3.3$ , range 22 to 35). Every counselor was a first-year master's student in their second semester of a counseling program in the Southeastern United States, and the demographics of the sample were representative of the population of counselor trainees in this program.

Similar to counselors, of the 77 clients, the majority of clients were female ( $n=56$ , 72.7%); 21 clients (27.3%) were male. The clients identified as primarily as Caucasian ( $n=49$ , 63.6%), followed by 20 self-reporting as African American (26%), Hispanic ( $n=3$ , 3.9%), Asian American ( $n=2$ , 2.6%), Middle Eastern ( $n=1$ , 1.3%), Multiracial ( $n=1$ , 1.3%), and other ( $n=1$ , 1.3%). Age was reported by all 77 clients, and the average age was 21.8 years old ( $SD=4.8$ , range 18 to 54).

Most clients ( $n=41$ , 53.2%) reported attending counseling in order to receive extra credit for class, 33 clients (42.9%) attended counseling due to being mandated by the university due to poor academic standing, and three clients (3.9%) did not report their motivation for attending counseling. Of those who attended counseling for class credit, 31 (75.6%) clients were in a counseling class and 10 (24.4%) were in a social work class.

Although half of clients attended counseling for extra credit, all clients reported at least one, and up to three, presenting concerns. The most commonly noted were academic difficulties ( $n=37$ , 48.1%), mood ( $n=36$ , 46.8%), relationship difficulties ( $n=29$ , 37%), and family difficulties ( $n=27$ , 35.1%). Less frequently reported concerns included career ( $n=12$ , 15.6%), self-esteem ( $n=10$ , 13%), trauma ( $n=7$ , 9.1%), and addiction ( $n=2$ , 2.6%).

### **Preliminary Analyses**

Due to findings of previous studies indicating that various demographic variables could play a role in nonverbal behaviors, TR, and outcome effectiveness (OE), a series of t-tests were run to assess how client and counselor gender and race interacted with NIB and OE. It was found that female counselors ( $n=198$ ,  $M=78.47$ ,  $sd=5.36$ ) used significantly higher amounts of NIB ( $t=2.190$ ,  $p=.03$ ) than male counselors ( $n=33$ ,  $M=76.21$ ,  $sd=6.21$ ), but client NIB did not differ based upon gender ( $t=1.394$ ,  $p=.165$ ). Therapeutic relationship did not differ based upon counselor gender, but female clients ( $n=168$ ,  $M=37.72$ ,  $sd=37.71$ ) reported significantly higher TR ( $t=2.522$ ,  $p=.012$ ) than male clients ( $n=63$ ,  $M=36.29$ ,  $sd=36.29$ ).

At first session, 23 clients (29.9%) scored below the clinical cutoff level for the ORS. OE for those who scored below the cutoff at first session ( $n=23$ ,  $M=10.79$ ,  $SD=6.9$ ) was significantly higher ( $t=4.94$ ,  $p=.000$ ) than those who did not score below the cutoff at first session ( $n=54$ ,  $M=4.15$ ,  $SD=4.63$ ). Additionally, ORS scores at session three were significantly lower ( $t=-4.17$ ,  $p=.000$ ) for clients who scored below the clinical

cutoff on the ORS at session one ( $n=23$ ,  $M=30.69$ ,  $SD=5.16$ ) than for those who scored above the cutoff at session one ( $n=54$ ,  $M=35.30$ ,  $SD=4.10$ ).

At first session, 23 clients also scored below the clinical cutoff for the SRS (10 clients [13%] scored below the cutoff on both the ORS and the SRS at session one). OE for those who scored below the cutoff at first session ( $n=23$ ,  $M=5.55$ ,  $SD=4.25$ ) was not significantly different ( $t=.538$ ,  $p=.592$ ) than for those who did not score below the cutoff at first session ( $n=54$ ,  $M=6.38$ ,  $SD=6.85$ ). However, SRS was significantly correlated with ORS scores within each session for session one ( $r=.350$ ,  $p=.002$ ), session two ( $r=.408$ ,  $p=.000$ ), and session three ( $r=.596$ ,  $p=.000$ ).

### **Data Analyses and Results**

The purpose of this study was to explore client and counselor nonverbal immediacy behaviors (NIB) in relation to the therapeutic relationship (TR) and OE. Analyses were conducted on 77 counselor and client pairs across their first three sessions together. These analyses were used to answer the following research questions:

1. How do correspondence (i.e., similarity) of counselor and client nonverbal immediacy behaviors (CNIB) and TR change across sessions?
2. How do counselor and client NIB, TR, and OE relate within each session?
3. At what point in counseling does TR have the greatest effect on OE?

The numeric scores for each variable in the research questions was calculated according to a scaled, formal assessment. The ORS was used to measure client wellbeing at each session. ORS at session 1 was then subtracted from ORS at session 3 to determine OE. The SRS was used to measure TR and the Nonverbal Immediacy Scale (NIS) was used to

measure NIB and calculate CNIB by correlating counselor and client NIB for each session. The descriptive statistics for all instruments can be found in table 5.

### **Research Question 1**

The first research question was designed to explore the ways in which the TR and NIB changed across time. Two hypotheses were created: (H1a) correspondence of counselor and client NIB will increase across sessions, from first to third session; and (H1b) TR will increase across sessions, from first to third session. As such, two analyses were conducted.

**Hypothesis 1a.** To test H1a, the CNIB variable for 77 counselor-client pairs was analyzed for significant change across first, second, and third sessions using repeated measures ANOVA. Before completing the analysis, the data were checked for outliers, normal distribution, and sphericity. For all three sessions, CNIB was generally normally distributed with no extreme outliers, and the Mauchly's test for sphericity was not significant ( $W=.993, p=.770$ ), thus sphericity was not violated.

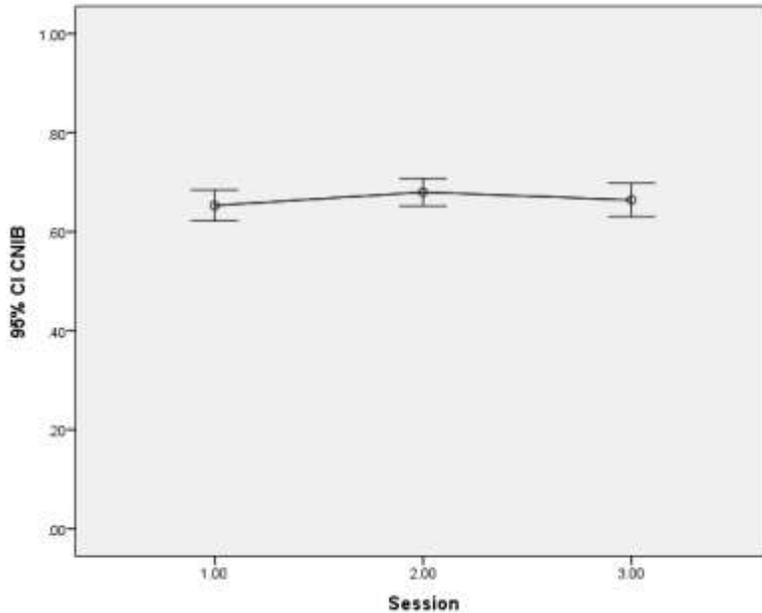
A repeated measures ANOVA with a Greenhouse-Geisser correction was then conducted and it was found that that CNIB did not differ significantly across first, second, and third sessions [ $F(1.986, 150.95) = .739, p=.479$ ]. These results suggest that the correspondence of nonverbal behavior between client and counselor does not increase, or become more similar, than what is present in the first intake session (see figure 2). Therefore, H1a is rejected; correspondence of counselor and client NIB does not increase across sessions, from intake to the third session.

Table 5

## Descriptive Statistics of Instruments

	<i>M</i>	<i>SD</i>	Range
<u>ORS</u>			
Session 1	27.79	6.40	13.60—40.00
Session 2	32.10	6.01	15.50—40.00
Session 3	33.92	4.86	18.40—40.00
<u>OE</u>			
	6.13	6.13	-12.00—26.00
<u>SRS</u>			
Session 1	36.54	4.29	19.30—40.00
Session 2	37.54	3.70	25.00—40.00
Session 3	37.89	3.41	26.10—40.00
<u>Counselor NIS</u>			
Session 1	77.77	5.20	67—91
Session 2	78.14	5.60	63—93
Session 3	78.53	5.72	66—91
<u>Client NIS</u>			
Session 1	74.64	6.91	59—88
Session 2	76.51	6.27	60—93
Session 3	76.48	7.30	60—92
<u>CNIB</u>			
Session 1	.65	.14	.26—.90
Session 2	.68	.10	.31—.89
Session 3	.66	.14	.19—.93

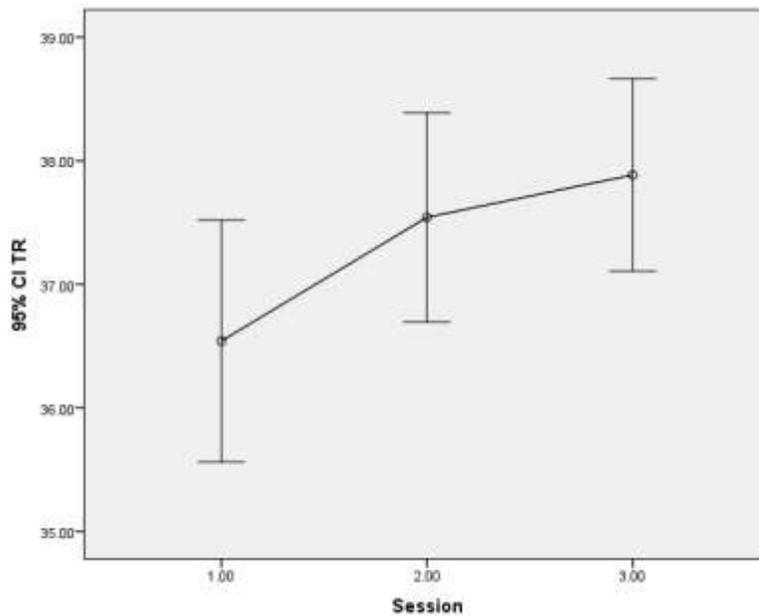
**Figure 2. Change of CNIB across Sessions**



**Hypothesis 1b.** To test H1b, the TR variable for the 77 counselor-client pairs was analyzed for significant change across first, second, and third sessions using repeated measures ANOVA. Before completing the analysis, the data were checked for outliers, normal distribution, and sphericity. TR was negatively skewed for first session (-1.972), second session (-1.896), and third session (-2.06). Although some scores were lower than average, there were no outliers that threatened the ANOVA results. Additionally, the Mauchly's test for sphericity was significant ( $W=.669, p=.000$ ), thus the degrees of freedom were adjusted for the test of within-subjects effects using the Greenhouse-Geisser correction. Although the data for variable TR violated the assumption of normality, it was still analyzed with a repeated measures ANOVA because this analysis is not greatly affected by non-normal distribution of data (Laerd, 2013).

A repeated measures ANOVA with a Greenhouse-Geisser correction was used to determine that TR did differ statistically significantly between first, second, and third sessions [ $F(1.503, 114.220) = 9.312, p = .001$ ]. A post hoc test using the Bonferroni adjustment revealed that TR changed significantly from first session ( $M=36.54, SD=4.31$ ) to second session ( $M=37.54, SD=3.73$ ) and from first session to third session ( $M=37.89, SD=3.43$ ). However, there was no significant difference in TR from second session to third session (see Figure 3). These results suggest that clients' perceive TR to be lower in the first session than in later sessions, even by the second session in counseling. Therefore, hypothesis 1b is accepted; TR does increase across sessions, from first session to third session.

**Figure 3. Change of TR across Sessions**



*Note.* The mean of TR could range from 0-40

## Research Question 2

The second research question was designed to explore how counselor and client NIB, TR, and OE are related in each session. Three hypotheses were created: (H2a) individual scores of counselor and client NIB will be positively related to TR within each session, (H2b) CNIB will be a stronger predictor of TR than the individual scores of counselor and client NIB within each session, and (H2c) TR within each session will be positively related to OE. Three hierarchical regressions (one for each session) were used to answer H2a and H2b (step 1: individual client and counselor NIB onto TR; step 2: CNIB onto TR); a linear multiple regression was used to evaluate H2c.

**Hypothesis 2a.** Before running three hierarchical regressions for H2a and H2b, the data were checked for the necessary assumptions. Independence of observations was confirmed for all three regressions ( $d_1 = 2.334$ ,  $d_2 = 2.371$ ,  $d_3 = 2.116$ ). Multicollinearity was not a concern for the first session (VIF= 1.034-1.064, tolerance=.940-.967), the second session (VIF=1.017-1.070, tolerance=.935-.983), or the third session (VIF=1.065-1.116, tolerance=.896-.939). Finally, linear relationships between all NIB and TR variables were also identified in individual scatter plots. As such, data analysis was completed for H2a and H2b.

To answer H2a, the first step of the three hierarchical linear regressions was analyzed. Counselor and client NIB in each session were loaded into a hierarchical regression with TR for that corresponding session. For the first session, counselor and client NIB accounted for 1.6% ( $r = .125$ ,  $r^2 = .016$ ) of the variability in TR, and counselor and client NIB did not significantly predict TR ( $F = .585$ ,  $p = .560$ ). For the second

session, counselor and client NIB accounted for 1.6% ( $r=.126$ ,  $r^2=.016$ ) of the variability in TR, and counselor and client NIB did not significantly predict TR ( $F=.597$ ,  $p=.553$ ). For the third session, counselor and client NIB accounted for 0% ( $r=.022$ ,  $r^2=.000$ ) of the variability in TR, and counselor and client NIB did not significantly predict TR ( $F=.018$ ,  $p=.982$ ). The results indicate that there is not a statistically significant relationship between counselor and client NIB and TR. As such, hypothesis 2a is rejected; individual scores of counselor and client NIB are not positively related to TR within each session.

**Hypothesis 2b.** To answer H2b, the second step of each hierarchical linear regression was analyzed. CNIB from each session was loaded into the hierarchical regression with TR for that corresponding session. For the first session, CNIB explained .1% more variability in TR than counselor and client NIB explained ( $r=.129$ ,  $r^2=.017$ ) and CNIB did not significantly predict TR ( $F=.411$ ,  $p=.746$ ). For the second session, CNIB explained .6% more variability in TR than counselor and client NIB explained ( $r=.147$ ,  $r^2=.022$ ) and CNIB did not significantly predict TR ( $F=.537$ ,  $p=.658$ ). For the third session, CNIB explained .3% more variability in TR than counselor and client NIB explained ( $r=.057$ ,  $r^2=.003$ ) and CNIB did not significantly predict TR ( $F=.079$ ,  $p=.982$ ). As such, H2b is rejected; correspondence of counselor and client NIB was not positively related to TR within each session. The results from H2a and H2b indicate that client and counselor non-verbal immediacy behavior, or the similarity between their behavior, did not significantly relate to client-reported therapeutic relationship.

These non-significant results, resulting in the rejection of the hypotheses, should be taken and interpreted with caution due to the low power found in post hoc analysis. Although an a priori power analysis for H2a and H2b indicated that a sample size of 77 would yield power of .80, a post hoc analysis with the actual effect sizes ( $r^2=.017$ , .022, and .003) indicated that the sample provided power of just .15. No significant relationship was found, and a small, non-significant effect size was found. However, there was not enough power to indicate if the effect size could potentially be significant. A sample size of 550 would be needed to obtain power of .80 to test this model with a small effect size. As such, the non-significant results for H2a and H2b should be taken with caution due to the lack of power given the small effect size found in this study.

**Hypothesis 2c.** In order to address H2c, a linear multiple regression was conducted with TR at first second and third sessions regressed onto OE. Before running the regression, the data were checked for the necessary assumptions. Independence of observations was confirmed ( $d = 2.360$ ). Multicollinearity was not a concern (VIF= 1.995-4.401, tolerance=.227-.501). Additionally, linear relationships between OE and TR1, TR2, and TR3 were identified; OE was normally distributed and the analysis was conducted.

The overall regression model was significant ( $F=8.090$ ,  $p=.000$ ). The model explained 25% of variance in OE ( $r=.500$ ,  $r^2=.250$ ). TR at first session significantly, negatively predicted OE ( $\beta = -.565$ ,  $t=-3.947$ ,  $p=.000$ ), and TR at third session significantly predicted OE in a positive direction ( $\beta = .512$ ,  $t=2.405$ ,  $p=.019$ ). However,

TR at second session did not significantly predict OE ( $\beta = .202, t = .963, p = .339$ ). These results indicate that as therapeutic relationship at first session increases, OE decreases by .565, and as therapeutic relationship at third session increases, OE increases by .512. As such, hypothesis 2c is partially accepted; TR within session one and three is related to OE, and TR at session three is positively related to OE.

**Post Hoc Analyses.** It was found through preliminary analyses that female counselors used significantly higher amounts of NIB than male counselors. However, the hierarchical linear regressions used to analyze the relationship between NIB and TR did not have enough power to accurately identify significant effects. As such, no further analyses were run for these preliminary findings.

It was also found in preliminary analyses that female clients reported significantly higher TR than male clients. As such, client gender was added as a control variable to the linear regression for H2c. The overall regression model was significant ( $F = 6.154, p = .000$ ) and explained 25.5% of variance in OE ( $r = .505, r^2 = .255$ ). However, client gender was not a significant predictor of OE ( $\beta = -.075, t = -.713, p = .478$ ). As such, client gender was not included in the overall model.

### **Research Question 3**

The third research question was designed to explore the point in counseling at which TR has the greatest effect on OE. It was hypothesized (H3) that TR at termination session would be the strongest predictor of OE. A multiple regression with collinearity analysis was used to answer research question 3. This analysis used the same variables as H2c, but did not employ a hierarchical process. Instead, TR at first, second, and third

sessions was loaded at the same time using a stepwise entry method. As such, only significant predictors were entered into the final model, providing a more accurate portrayal of the variable relationships (Allen, 1997).

Before running the regression, the data were checked for the necessary assumptions. Independence of observations was confirmed ( $d = 2.407$ ). Additionally, multicollinearity was not a concern (VIF = 1.895, tolerance = .528). Finally, a linear relationship between TR1, TR2, and TR3 was identified and the analysis was run with the data in its original form.

The overall model was significant ( $F = 11.683, p = .000$ ) and explained 24% of the variance in OE ( $r = .49, r^2 = .240$ ). TR2 was non-significant and did not load into the final model. TR at third session loaded highest and significantly predicted OE in a positive direction ( $\beta = .666, t = 4.774, p = .000$ ), and TR at first session loaded second-highest and significantly predicted OE in a negative direction ( $\beta = -.534, t = -3.831, p = .000$ ). As therapeutic relationship at third session increases, OE increases by .666; as therapeutic relationship at first session increases, OE decreases by .534. As such, H3 is accepted; TR at third session is a stronger predictor of outcome effectiveness than therapeutic relationship at first or second session.

## CHAPTER V

### DISCUSSION

The purpose of this study was to explore the relationship between nonverbal immediacy behaviors (NIB), therapeutic relationship (TR), and outcome effectiveness (OE) in a clinical setting. Descriptive and predictive statistics were used to explore the relationship between these variables. Findings from the preliminary analyses, specified research questions, and post hoc analyses will be summarized. Additionally, implications for counselors, counselor educators, and researchers will be explored in relation to the findings.

#### **Summary of Findings**

To fulfill the purpose of this study, three research questions and six hypotheses were created. Three hypotheses were accepted and three were rejected (see Table 6). Overall, the obtained information provides valuable insight into the relationship between nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness.

Table 6

Summary of Research Findings

Research Question	Hypothesis	Results
<p><b><u>Research Question 1:</u></b> How do correspondence (i.e., similarity) of counselor and client nonverbal immediacy behaviors and therapeutic relationship change across sessions?</p>	<p><b><u>Hypothesis 1a:</u></b> Correspondence of counselor and client nonverbal immediacy behaviors will increase across sessions, from first session to third session.</p>	<p>Rejected; correspondence of counselor and client nonverbal immediacy did not change significantly from first session to third.</p>
<p><b><u>Research Question 1:</u></b> How do correspondence of counselor and client nonverbal immediacy behaviors and therapeutic relationship change across sessions?</p>	<p><b><u>Hypothesis 1b:</u></b> Therapeutic relationship will increase across sessions, from first session to third session.</p>	<p>Accepted; therapeutic relationship did increase across sessions, from first session to third session.</p>
<p><b><u>Research Question 2:</u></b> How do counselor and client nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness relate within each session?</p>	<p><b><u>Hypothesis 2a:</u></b> Individual scores of counselor and client nonverbal immediacy behaviors will be positively related to therapeutic relationship within each session.</p> <p><b><u>Hypothesis 2b:</u></b> The correspondence of counselor and client nonverbal immediacy behaviors will be a stronger predictor of therapeutic relationship than the</p>	<p>Rejected; counselor and client nonverbal immediacy behaviors were not significantly related to therapeutic relationship.</p> <p>Rejected; correspondence of counselor and client nonverbal immediacy behaviors were not significantly related to therapeutic relationship.</p>

	individual scores of counselor and client nonverbal immediacy behaviors within each session.	
<b><u>Research Question 2:</u></b> How do counselor and client nonverbal immediacy behaviors, therapeutic relationship, and outcome effectiveness relate within each session?	<b><u>Hypothesis 2c:</u></b> Therapeutic relationship within each session will be positively related to outcome effectiveness.	Partially Accepted; therapeutic relationship at session one was negatively related to outcome effectiveness, and therapeutic relationship at session three was positively related to outcome effectiveness
<b><u>Research Question 3:</u></b> At what point in counseling does therapeutic relationship have the greatest effect on outcome effectiveness?	<b><u>Hypothesis 3:</u></b> Therapeutic relationship at third session will be a stronger predictor of outcome effectiveness than therapeutic relationship at first or second session.	Accepted; therapeutic relationship at third session was a stronger predictor of outcome effectiveness than therapeutic relationship at first or second session.

### **Research Question 1**

The first research question explored NIB and TR across sessions. It was generally hypothesized that both CNIB and TR would increase as counselors and clients spent more time with each other in session. It was found that only TR significantly changed across time, while CNIB did not statistically differ across the three sessions. The greatest increase in TR occurred from session one to session three, and a smaller, but significant

change also occurred from session one to session two. However, there was not a significant change in TR from session two to session three.

**CNIB across Sessions.** It is generally accepted that higher levels of NIB equate to higher levels of warmth and availability (Andersen & Andersen, 1982; Berko et al., 2010; Floyd & Erbert, 2003). It was hypothesized that CNIB would increase across sessions in accordance to Rogers' (1957, 1961/1995) work regarding congruence of counselor and client thought, feeling, and behavior. Rogers stated that it was important for counselors to be congruent within themselves in order to model this to the client. Rogers hypothesized that client change would come about when they were able to be fully congruent with their own thoughts, feelings, and behaviors. Although Rogers noted that it was important for counselors to model congruence within themselves, it was found through this study that might not necessarily be important for counselors to be congruent with their clients' NIB in order to build TR. Rather, it is possible that it is more important for counselors' NIB to be congruent with their own thoughts and feelings, something that was not assessed in this particular study.

The hypothesis that CNIB would increase across sessions was also supported by Berko, Aitken, and Wolvin's (2010) explanation of rhetorical sensitivity. This concept indicates that it is important for sensitive communicators to use NIB to communicate openness and acceptance of others' viewpoints, but it is also important for communicators to respect NIB as a personal choice. As such, it seems as though it is important for communicators (e.g., in this case, counselors) to be aware if their NIB are open and accepting, but it is not necessary for communicators to adopt the NIB choices of

others in order to build a working relationship. This seems to possibly be what occurred in this study, as some counselor and client pairs had more correspondence than others, yet CNIB did not change from intake to session three. However, TR did statistically increase across sessions. This supports what Berko et al. indicated; as long as counselors communicated nonverbal openness to the client, counselors might not necessarily need to match nonverbal behaviors of the client. Ultimately, it is equally important for communicators to use NIB that are true to their style as it is for communicators to convey warmth and acceptance. This work by Berko et al. seems to mimic what Rogers (1957, 1961/1995) has stated about counselors being congruent with their own personal preferences.

Although Floyd and Erbert found that communicators who intentionally matched their target's NIB conveyed greater receptivity and similarity, it is possible that correspondence of NIB in the counseling relationship is not necessary. The participants in Floyd and Erbert's (2010) study were engaged in informal helping relationships within a communication context rather than a counseling context. As such, communication and the use of NIB within a counseling context may be unique; it may not be necessary for counselors to match their clients' NIB in order to build TR.

While initially in this study it was proposed that the correspondence between client and counselor would be imperative to building and increasing TR, Ivey, Ivey, and Zalaquett (2013) proposed that a competent counselor might actually intentionally mismatch a client's nonverbal behaviors to bring about client insight and change. If counselors mismatch a client's fast pace or stern tone, they can model a slower, calmer

disposition. Similarly, counselors can intentionally match a client's closed posture to show them how this behavior might be received by others, and then transition to a more open posture in order to shift the dynamics of the relationship. It is possible that in the current study counselor CNIB did not change across sessions because counselors intentionally match or mismatch client behavior within each session, rather than a simple increase in matching over time.

Although it is possible that CNIB might not change across sessions because it is intentionally varied within each session, it is also possible that NIB were not intentionally used by this sample of neophyte counselors. Each counselor was in their first year, second semester of a master's-level training program, and counselors at this developmental level generally implement their skills in a concrete, universal manner (Borders & Brown, 2005). As such, it is possible that CNIB did not increase across time because the counselors were not developmentally prepared to attend to this level of detail.

It seems as though some counselors were inherently more skilled at achieving CNIB than others. CNIB ranged from .19 to .93 in the sample and generally remained consistent for counselor and client pairs across all three sessions (see Table 5). That is, some counselors' NIB were highly correlated with their clients', and some counselors in the sample had very low CNIB with their clients; this remained consistent across all three sessions. Although the factors that contributed to this phenomenon were not identified in the current study, past literature can provide some insight into possible explanations. Rosenzweig (1936, p.415) spoke of the "...undefined effect of the personality of the good therapist..." The wide range of CNIB achieved with different counselor and client pairs,

and the consistency of CNIB across sessions could potentially inform future research to explore the personality of a good therapist, which Rosenzweig hypothesized was just one component of TR and OE.

**TR across Sessions.** Although CNIB did not change across time, TR did increase across sessions. TR has been linked to OE in an abundance of research (e.g., Ahn & Wampold, 2001, Lambert (1992), Thomas, 2006; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003). More specifically, Miller, Duncan, Brown, Sorrell, and Chalk (2006) found that increases in TR across time were related to greater OE, and that early improvements in TR were associated with OE. Clients who experience deterioration in TR also experienced deterioration in OE (Miller et al.).

The findings of this study also supported the conclusion that TR increases across time. More specifically, the greatest improvement in TR was from session one to session two. The increase from session two to session three was small and non-significant (about one-third of the increase from session one to two). It seems as though counselors could take care to build TR between session two and three in order to achieve the highest possible TR, which has been linked to OE in this and other studies.

It is important to determine ways in which counselors can intentionally create TR with their clients. Cramer (1993) found that therapists can build the therapeutic relationship by session three if they display Rogers' core conditions in session one. Blow, Sprenkle, and Davis (2007) agreed that the therapist is responsible for building TR and facilitating OE in counseling. As such, it might be important to look at TR on an even smaller level by focusing specifically on therapist qualities.

Couture (2006) explored one therapist's conversational patterns and choices to determine how it affected his clients. Couture's method of exploring single sessions in great detail using discourse analysis allowed the researcher to identify within session patterns that were not grasped through the CNIB data collection method used in this study. Couture (2006) found that the therapists used a cyclical way of communication with the clients; he explained his viewpoint and affirmed the clients' views and then proposed a hybrid solution. The therapist then checked for the degree to which the client accepted the new viewpoint, and continued this pattern in a cyclical pattern until the client fully accepted the new viewpoints. Although these findings loosely align with the factors of NIB, TR, and OE, this type of study could be used as a model to explore variables that might be even more closely related to the variables of interest.

Currently, it has been found that TR does increase across time, but the exact mechanism for such change is yet unknown (Sprenkle et al., 2007). In this sample of neophyte counselors, however, TR did increase across time as a general trend. This suggests that the majority of counselors were conducting whatever basic behaviors led to increased TR. These behaviors could be explored in more depth similar to the Couture (2006) explored conversational patterns, or there might not actually be any behaviors that actually contribute to TR. It could be, as Rosenzweig (1936) postulated an undefinable characteristic found in those who become counselors. Or, the simple act of spending progressive amounts of time in a relationship with a client might lead to the increase in TR. In fact, counseling itself does not exist without a relationship (American Counseling Association, 20010; Rosenzweig, 1936). As such, there might not be actual factors that

counselors can harness in order to build TR, but the simple act of entering a counseling relationship with a client might build TR inherently.

Although it is possible that time and the act of two people engaging in a counseling relationship are the factors that contribute to TR, the data from the current study indicate that some counselor and client pairs form generally higher TR. This indicates that there is some factor, whether the undefinable quality of a good therapist (Rosenzweig, 1936) or the counselor's choices conversational patterns (Couture, 2006) that contributes to the formation of a strong TR. Future research on identifying these factors might be helpful in identifying how counselors can intentionally build TR, especially between session two and session three.

### **Research Question 2**

The second research question was developed to explore the relationship of NIB, TR, and OE within each session (as opposed to across sessions). The general assumption was that increased counselor and client NIB and CNIB would be related to increased TR, and TR would be positively related to OE. Generally, it was found that individual counselor and client NIB and CNIB were not related to TR in any session, but TR was significantly related to OE.

**NIB and TR within each session.** As mentioned above, CNIB did not change significantly across sessions, but this could have been the result of a neophyte sample of counselors who did not attend to this nuance of the counseling process. It also could indicate that counselors intentionally match and mismatch client NIB within each session. TR did increase across sessions, and the largest session-to-session increase was from

session one to session two. However, the exact way in which counselors can intentionally foster an increase in TR is yet undiscovered.

Although an a priori power analysis was completed in order to identify the necessary sample size to explore the relationship between NIB and TR, there was a small effect size and insufficient power on the analyses for H2a and H2b. As such, it is important to note that non-significant findings should be taken with caution as statistical non-significance may have been due to Type II error rather than nonexistence of a relationship. NIB were not found to be related to TR or OE with this data sample, but this does not necessarily mean that there is no relationship between these variables in the counseling field due to the lower statistical power. Further studies with greater power need to be conducted to continue to explore this potential relationship.

In addition to a small effect size, Session Rating Scale (SRS; a measure of TR) scores were not normally distributed; SRS for all three sessions were negatively skewed. Two transformations were run on the data (i.e., logarithmic and square root), but this did not improve the normality of the distribution. Campbell and Hemsley (2009) collected SRS scores from 65 mental health patients and the scores in this study were also negatively skewed. Campbell and Helmsley found also that transformations did not improve the data distribution and ran their analyses without a transformation. Miller and Duncan (2004) found satisfactory reliability and validity for the SRS, but did not report data regarding the range and distribution of scores. As such, a more normally distributed measure of TR might have produced different results in relation to NIB and OE.

It is also important to note the NIS was designed to be completed by the target of a communication (McCroskey et al., 2003). However, it was used as an observational tool in this study. As such, any bias in the use of the instrument would reflect that of the observer, rather than the target. Conversely, any bias in the use of the SRS to measure TR reflected that of the target (i.e., the client). As such, it is possible that the unique use of the NIS, combined with the disparity in rater bias, could have contributed to the lack of a relationship between NIB and TR.

Although NIB did not predict TR in this study, it is possible that NIB relate to another aspect of the counseling profession. NIB are taught briefly as basic helping skills for the counseling profession (Egan, 2007; Hill, 2010). Additionally, CNIB seemed to remain stable for each counselor and client pair (as CNIB did not change across sessions). NIB are present within every helping relationship (Andersen & Andersen, 1982) and it is important to determine the role of NIB in relation to OE.

**TR within each Session and OE.** The importance of TR in relation to OE has been consistently demonstrated in previous literature (e.g., Ahn & Wampold, 2001, Lambert (1992), Miller et al., 2006; Thomas, 2006; Tracey et al., 2003). TR has been linked to OE in more than 1,000 studies (Orlinsky Ronnestad, & Willutzki, 2004), and this study has again reproduced those results. However, it was found that high TR at the first session was negatively related to OE, TR at the second session was not significantly related to OE, and TR at third session was positively related to OE.

The relationship between TR at session one and OE seems complicated, but can be explained through previous research findings and the findings of the preliminary

analyses. First, OE was calculated by subtracting a client's Outcome Rating Scale (ORS, a measure of general wellbeing) score at session one from ORS at session three. As such, OE indicates the extent to which clients' wellbeing improved across three sessions. In the preliminary analyses, it was found that clients with ORS scores above the clinical cutoff at session one had significantly lower OE scores. Mathematically, this makes sense because higher ORS scores at session one left less room for growth and improvement at session three. It was also found in preliminary analyses that, for this sample, ORS scores at session one were significantly correlated with SRS scores at session one; as ORS increased SRS increased. Clients with high ORS scores at session one also had high SRS scores at session one, and high SRS scores at session one were negatively related to final OE. The negative relationship between TR at session one and OE can be explained by the possibility that clients with high TR at session one also had high ORS scores at session one and less overall room for improvement on OE.

Unlike sessions one and three, TR at session two was not a significant negative or positive predictor of OE. Arnou et al. (2013) found that therapeutic relationship at week two or four was a significant predictor of outcomes in subsequent sessions (analyzed at two-week intervals), but TR was more strongly associated with outcomes in clients who received a cognitive-behavioral based therapy rather than a brief supportive therapy. The authors explained that the more structured approach might have contributed to clients' belief that the treatment would be helpful and their alignment with the therapist (two aspects of TR; Miller & Duncan, 2004). This could potentially relate to previous findings in which improved allegiance to a particular treatment might increase client and

counselor agreement on the approach (Messer & Wampold). As such, the non-significant findings at session two in the current study could relate to counselors' individual counseling approaches and techniques (which were not measured), rather than a manualized or structured approach such as delivered in Arnow et al. (2013).

Although Arnow et al. (2013) found TR to be a significant predictor of OE, the researchers cited several studies that did not find a significant relationship between TR at session two and OE in clients with depression, which was the second most-common presenting concern for clients in this sample. For example, DeRubeis and Feeley (1990) found that TR at session two did not predict reduction of depressive symptoms in a sample of 25 clients. Feeley, Rubeis, and Gelfand (1999) also found that TR at session two did not predict outcomes in clients with depression. Because a substantial portion of the current sample reported mood difficulties, it is possible that TR at session two did not predict OE due to clients' presenting problems. Arnow et al. (2013) suggested that different psychotherapeutic approach might contribute to different parts of TR according to clients' presenting concerns. As such, the current findings might support the need for further exploration of the specific components of TR (e.g., agreement on task, bond of counselor and client; Miller & Duncan, 2004) in relation to specific counselor and client factors.

Finally, in the current study, session three was the strongest predictor of OE. At this point in counseling, TR had significantly improved from the first session for the general sample. In preliminary analyses, it was found that the final ORS scores at session three were significantly lower for those who initially scored below the clinical cutoff, but

the total difference between ORS at session one and ORS at session three (i.e., OE) was greater for those who scored below the clinical cutoff at intake. As such, it can be concluded that, by session three, those who scored below the clinical cutoff on ORS at session one had experienced larger OE, and those who did not score below the cutoff had experienced steady, yet smaller, increases in TR across sessions (as indicated by the results of H1b). Additionally, the greatest increase in TR was from session one to session three, and OE was calculated using the difference in ORS scores from session one to session three. As such, it is possible that TR at session three was the most significant predictor of OE because the majority of clients had experienced the majority of their changes in TR and OE by the third session.

Overall, Miller and Duncan (2004) explained that early increases in TR were strong predictors of increases in OE. However, the researchers also explained that as TR increases, so does OE, and vice versa. As such, it is also possible that TR at sessions four and beyond would have been stronger predictors of OE than session three. However, that information was not collected for the current study. Overall, the current study supports the notion that TR is significantly related to OE and counselors should take care to build it with their clients in each successive session, regardless if it is initially high or low.

### **Research Question 3**

The third and final research question was designed to identify the point in counseling at which TR is most predictive of OE. It was confirmed through this study that TR increases across time and TR at session three was the strongest positive predictor of OE. In this study, TR accounted for approximately 25% of OE. The current findings

align with the predictions of other common factors theorists in which TR was expected to account for anywhere from 10% (Tracey, 2003) to 30% (Lambert, 1992; Miller et al., 1997) of OE.

Although TR was the highest at the session that most significantly and positively predicted OE, it cannot be assumed that OE is simply a product of TR. A significant portion of OE was explained by TR in the current study (i.e., 25%), but this also confirms that other factors contribute to the remaining 75% of variance in OE. Messer & Wampold (2006) asserted that in addition to TR, other important factors that contribute to OE include therapist allegiance to a theory (rather than the actual theory itself) and other therapist effects. Client and extratherapeutic factors are also a common component to CFT models (e.g., Miller et al., 1997; Wampold, 2001). It is important to continue exploring the way in which common factors interact with one another to explain the full variance in OE.

Some CFT theorists indicated that common factors work summatively in nature (e.g., Lambert, 1992; Miller et al., 1997), and a more recent CFT perspective assumes that all factors likely works synergistically with one another (Duncan et al., 2010; Wampold, 2001). The current study explored the way in which NIB factors interacted with client NIB factors and TR. Although only TR significantly related to OE in the current study, it is important to continue exploring the therapist, client, and extratherapeutic factors that “cause and are caused by each other” (Duncan et al., 2010, p. 35) in order to build stronger TR across sessions and increase OE in the counseling field.

### **Implications for Counselors and Educators**

The purpose of this study was to bring more clarity to the debate between CFT and Empirically-Validated Treatments (EVT). Specifically, TR was found to be a common component to both theories and it was anticipated that NIB could be used to directly predict TR and OE. It was asserted that if counselors could intentionally enhance (or more quickly develop) the therapeutic relationship through NIB, the credibility and relevance of the counseling profession would improve.

Although NIB were not found to relate to TR or OE in this study, the results provide valuable insight regarding TR and OE. Additionally, it is important to remember that the non-significant NIB findings should be interpreted with caution due to a small effect size and low power in the analysis. Counselor Educators should be aware of the current findings so that they can educate new counselors in the most effective manner. Counselors should explore the findings of this study in order to ensure that their conceptualization and implementation of the counseling process is aligned with the most current research.

#### **Congruence and NIB**

Rogers (1957) indicated that congruence, empathy, and unconditional positive regard are the necessary and sufficient components of TR. It is important to note that, in this study, TR increased across time even though CNIB did not. As such, congruence (as explained by Rogers) might refer to congruence within the counselor not between counselor and client.

If this information about congruence is found true in additional research, counselors should be taught to model congruence within their own thoughts, feelings, and behaviors. They should work to align with clients' thoughts (unconditional positive regard) and feelings (empathy), but not necessarily intentionally align with clients' behaviors. NIB that are true to the counselor and congruent with the counselor's internal state likely increase the quality of the bond, which leads to increased TR (Miller & Duncan, 2004). Additionally, if counselors align with their clients' thoughts and feelings and display appropriate NIB, this might work to model more helpful congruence for the client. As such, clients can work to align their own thoughts, feelings, and behaviors to achieve greater congruence if counselors use empathy and unconditional positive regard, and model congruence of their own thoughts, feelings, and behaviors.

### **Therapeutic Relationship across Time**

The results of the current study once again confirmed the relationship between TR and OE. Although NIB were not supported in this study as a concrete way that counselors can produce TR, several inferences can be drawn from the results. Counselor Educators should explore the following implications with their students, and practicing counselors should work to incorporate this information into their practice.

Therapeutic relationship at the first session was a negative predictor of OE in this study. It was determined that this was due to a high initial sense of client wellbeing and limited opportunity for clients to experience a steady increase of TR across sessions. As such, counselors should know that their first encounter with a client is, indeed, important and high TR at the first session is not a bad thing. However, very high TR at the first

session might inform the counselor and client that a great deal of OE might not be expected for that client. In the current sample, 53.2% of clients were volunteer students who received course credit for attending counseling. Although every client reported at least one presenting concern, it is possible that these clients were already highly functioning with limited clinical need. Counselors could potentially explain to clients with less severe difficulties that they are not likely to experience as notable benefits as their peers with more severe difficulties. However, counseling is based in the philosophy of wellness, and all clients can benefit from the practice (Mellin, Hunt, & Nichols, 2011). In general, the results of this study confirmed that all clients can potentially experience greater TR and OE across sessions.

Although some clients enter counseling with high TR, counselors should know that building TR does not stop at the first session. Rather, it is important to establish a working relationship at first, and to continually reinforce and improve the TR with each successive meeting. As such, counselors are encouraged to mindfully establish TR at session one, but to remember to strive toward strengthening that bond at every session (especially from session two to three). TR can be monitored using the SRS, which has actually been shown to improve TR if the results are regularly discussed with clients (Miller et al., 2006). Additionally, clinicians and researchers are encouraged to explore other ways that counselors can intentionally strengthen the therapeutic relationship with their clients.

The results of this study and others (e.g., Miller et al., 2006) indicated that TR improved across time, and was positively related to OE in later sessions. As such,

counselors should make special efforts to meet with clients more than once. Counselors could explain to clients that they are likely to experience the greatest OE based if the counselor and client can build TR across time. Counselors should also advocate for themselves and their clients if they work at a site that encourages clients to see a particular counselor just once (based upon counselor availability, brief counseling requirements, or other factors). Administrators and supervisors should be informed that one-quarter of client OE can be improved by an increase in TR across time with one particular counselor.

### **Teaching and Practice Standards**

The most recent research regarding the debate between CFT and EVT has supported the notion that CFT provides the most relevant and complete framework for understanding OE in counseling (Messer & Wampold, 2006; O'Hara, 2012). The findings of the current study support this assumption. TR is one factor that works with other factors to create OE, and TR explains approximately 25% of the variability in OE).

Counselor Educators should integrate CFT and TR research throughout their curriculum. According to the Council for Accreditation of Counseling and Related Educational Programs (CACREP), all CACREP-accredited programs must ensure that counseling students can apply “relevant research findings to inform the practice of...counseling.” (CACREP, 2009, AC.J.1., CC.J.1., CMHC, J.1, MCFC.J.1., SC.J.1., SACC.J.1). As such, counselor educators should stay abreast of the most current CFT and TR literature in order to help new counselors understand the process and purpose of counseling.

Counselors should inform their work with clients through a CFT perspective. According to the American Counseling Association (ACA) *Code of Ethics*, it is important for counselors to join with their clients to devise treatment plans that are likely to help clients achieve their diverse goals (ACA, 2005, A.1.c.). In order to most effectively help clients achieve OE, counselors should keep in mind that it is important to model congruence with their own thoughts, feelings, and behaviors while using the skills of empathy and unconditional positive regard to explore their clients' needs. Counselors should also remember that a steady increase in TR across the first three sessions will lead to the greatest levels of OE. Because the current exploration of NIB did not provide insight into concrete behaviors that lead to the formation of TR, counselors should continue to explore current CFT and TR research in order to determine specific methods that can lead to a steady increase in TR across time.

### **Legislation**

It was found that 25% of the variability in OE was predicted by TR. This supports the previous findings that counseling is effective (Ahn & Wampold, 2001; Chambless, 2002; Duncan, Miller, Wampold, & Hubble, 2010; Hauser & Hays, 2012; Lambert, 2013; Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1983; Smith & Glass, 1977; Wampold et al., 1997). The opportunity for clients to build a relationship with a counselor produces actual changes in their wellbeing and it is an important service for the public.

Legislators influence laws that directly affect the counseling practice, and they want to know that they are supporting something that is relevant and helpful for their

constituents (Reisner, 2005; Wittig, 2000). As such, counselors and counselor educators should express the deeply important benefits that clients can obtain from attending counseling. Stakeholders and legislators should be informed of the important relationship between counselor and client and the way that it predicts actual improvements in their stakeholders' lives.

### **Limitations of the Study**

Many steps were taken to ensure the credibility of this study. For example, two independent raters separately collected data from 231 counseling videos in order to ensure rater bias was at a minimum. However, there are always limitations to any well-designed study (Heppner, Kivlighan, & Wampold, 2008).

The NIS was created by Richmond, McCrosky, and Johnson (2003) for an individual to rate the NIB of a person with whom they have communicated. For this study, the principal researcher and rater completed the NIB for a target with whom they had never communicated; observations of the target communicating with another person were used to determine the NIS scores. As such, the target's perception of the speaker's NIB might not have been accurately captured. Jones and Wirtz (2007) completed an experiment in a similar fashion; trained coders rated the NIB of 216 participants as they shared information with a confederate. Although this is not the way in which the NIS was intended to be used, acceptable levels of inter-rater reliability were achieved throughout the entire data collection process for the NIS. The measure was appropriate for the current study, but some adjustments might be made in further studies that explore NIB in a counseling context.

The NIS accounts for five of the seven NIB as outlined by Andersen & Andersen (1982). The scale accounts for vocalic, kinesics, oculusics, proxemics, and haptics. The scale does not account for environment and chronemics. Frank & Frank (1991) explained that the counseling environment is very important to a client's perception of the counselor's credibility. The lack of assessing for environmental factors might have directly related to the lack of a relationship in this study between NIB and TR (which is measured in part by the client's agreement with the counselor on tasks and goals; Miller & Duncan, 2004). Additionally, as TR increased across time, it was a significant, positive predictor of OE in this study; it would be helpful to explore the role that time plays in the formation of helpful TR. As such, it would be important for future researchers to explore specific NIB in relation to TR and possibly OE.

The NIS does not account for all major categories of NIB, and it also does not account for every possible NIB under each category. For example, kinesics includes smiling, nodding, and body posture (Andersen & Andersen, 1982), and the NIS accounts for body posture, but not smiling or nodding (Aydin et al., 2013), which are two important aspects of counseling (Hill, 2010). It has been noted that the NIS was developed in the field of Communication Studies and some important counseling concepts that were not measured include voice tone, voice volume, pace/rate of speech, head nods, and minimal encouragers (such as mm-hmm; Egan, 2007; Hill, 2010). This must also be taken into account when interpreting results of this study.

The SRS was used in this study to measure the TR between counselor and client in each session. Clients completed the SRS at the end of each session in the presence of

their counselor, and it is possible that some clients might have rated the TR higher due to the desire to please or be liked by their counselor. Additionally, the SRS was likely influenced by client's perceptions of the counselor's NIB, but NIB were measured by a third-party observer. As such, it would be helpful to know ways in which SRS scores were influenced by the client perceptions of the counselor.

Additionally, one of the four items on the SRS allows the client to rate the extent to which the material they wanted to discuss was addressed in session. However, during session one, counselors were instructed by the clinic director to complete specific intake paperwork, which limited counselors' abilities to address the topics most important to the client. As such, SRS scores for session one might have been lower than SRS scores for sessions two and three due to intake paperwork requirements. However, this would have been skewed uniformly across the sample because each counselor was instructed to complete the same paperwork during session one.

An additional limitation for this study could be the result of collecting data from a limited, pre-existing database. As a result of meeting the stringent inclusion criteria, some counselors were included in the database multiple times with several different clients. Although each counselor and client pair was analyzed separately and videos were coded in random order, it is possible that the inclusion of multiple counselors could have skewed the data.

In addition to the limited amount of counselors, the preexisting database only included 95 counselor and client pairs that met the stringent study criteria, and 77 pairs were chosen from those eligible pairs. This means that 337 counselor and client pairs

were not included in this study, and 319 were excluded due to missing data, lack of ability to see both the counselor and client in the video, or not meeting other criteria. Therefore, it is impossible to determine whether those who were excluded from the final sample differed from those included in any significant ways.

One criterion for selecting the final sample included that the counselor was a first-year master's student. Although this served to make the sample more uniform, the findings are also limited to this demographic. It is possible that counselors with greater experience would have had different SRS and NIB scores. Additionally, first-year master's students saw a variety of volunteer and mandated clients from primarily the university community. The results might have differed if the client population more accurately reflected a clinical sample from the community regarding education level, presenting concern, and other demographics. As such, implications for this study should be regarded in the context of these limitations.

### **Suggestions for Future Research**

The results of the current study have contributed to the wealth of knowledge regarding counseling theory and practice, and there is still much to be learned about TR, OE, and NIB. Scholars should integrate previous literature and findings from this study in order to conduct informed and innovative research in the future. With a decades-old debate between EVT and CFT, there are plenty of opportunities for continued discoveries (Budd & Hughes, 2009).

Although NIB did not prove to be a significant predictor of TR in this study, the theoretical grounding for such a relationship is strong. The current results could

potentially indicate an impasse between the Nonverbal Immediacy Scale (NIS), a communication studies instrument, and the counseling field. Many nonverbal behaviors that are valuable to the counselor profession (e.g., voice tone, voice volume, pace/rate of speech, head nods, and minimal encouragers) are not specifically measured by the NIS (Aydin et al., 2013; Hill, 2010). Additionally, the NIS includes two items that assess for the use of touch, which is not commonly used in the counseling profession (Hill, 2010). As such, future researchers could use the current findings and previous counseling and communication literature to create a nonverbal immediacy behavior measure that aligns with the values and mission of the counseling profession.

Again, the theoretical grounding for a relationship between NIB and TR was sound, but no relationship was found. A major difficulty in data analysis was the lack of a linear relationship between NIS and SRS scores; the SRS scores were not normally distributed. As such, this same study could be replicated with a more normally-distributed measure of TR.

In addition to using different measures to test the hypotheses between NIB and TR, it might be helpful to conduct a similar study on a sample of more advanced counselors. As previously mentions, the current sample included neophyte counselors who tend to implement skills in a concrete, universal manner. It might be helpful to explore the NIB of more seasoned counselors who might more intentionally vary these behaviors change within and across sessions.

Finally, it was found in this study that TR is one factor that interacts with other common factors to produce OE. Future researchers should continue to explore other

counselor, client, and extratherapeutic factors that work synergistically to produce OE. As researchers are able to further explore and identify the specific common factors that consistently work together within any given session to produce OE, the mission of this study will be realized; counselors will know specific, concrete ways to provide a better quality of life for clients, and the counseling profession will be strengthened.

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APPENDIX A  
IRB APPROVAL



**OFFICE OF RESEARCH INTEGRITY**  
2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
336.256.0253  
Web site: [www.uncg.edu/orc](http://www.uncg.edu/orc)  
Federalwide Assurance (FWA) #216

**To:** Nicole Adamson  
Counsel and Ed Development

**From:** UNCG IRB

Authorized signature on behalf of IRB

**Approval Date:** 11/25/2013  
**Expiration Date of Approval:** 11/24/2014

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)  
**Submission Type:** Initial  
**Expedited Category:** 5.Existing or non-research data  
**Study #:** 13-0468  
**Study Title:** Outcome Effectiveness in Counseling: The Role of Nonverbal Immediacy Behaviors and the Therapeutic Relationship

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

**Study Description:**

The principle investigator will watch archived videos of actual counseling sessions from the UNCG Voc Counseling and Consulting Clinic to assess counselor and client nonverbal immediacy behaviors using the Nonverbal Immediacy Scale. These behaviors will be analyzed in relation to archived data that was previously obtained under IRB approval 10-0364 so that these videos and associated data could be used for research purposes.

**Regulatory and other findings:**

- This research meets criteria for a waiver of consent entirely according to 45 CFR 46.116(d).

**Investigator's Responsibilities**

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification application available at <http://integrity.uncg.edu/institutional-review-board/>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website. Please be aware that valid human subjects training for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found at [http://policy.uncg.edu/research\\_data/](http://policy.uncg.edu/research_data/).

CC:  
Kelly Wester, Counsel and Ed Development

03/06/2012



THE UNIVERSITY of NORTH CAROLINA  
**GREENSBORO**

**OFFICE OF RESEARCH INTEGRITY**

2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
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Federalwide Assurance (FWA) #216

**To:** Allen Mobley  
Counsel And Ed Development  
220 James S. Ferguson Bldg

**From:** UNCG IRB

**Approval Date:** 10/31/2013  
**Expiration Date of Approval:** 10/30/2014

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

**Submission Type:** Renewal

**Expedited Category:** 7. Surveys/interviews/focus groups, 4. Noninvasive clinical data, 6. Voice/image research recordings

**Study #:** 10-0364

**Study Title:** Processes and Outcomes of Counseling and Clinical Supervision in the Vacc Counseling and Consulting Clinic

This submission has been approved by the IRB for the period indicated.

**Study Description:**

The purpose of this project is to study the process and outcomes of the counseling and supervision services provided in the Vacc Counseling and Consulting Clinic.

**Submission Description:**

We are removing the pilot study language from the modification from January 2013 - these two instruments and the modification in protocols for counselors/supervisors has been discontinued.

This means that we are no longer piloting these procedures and the incentive language from the original submission and subsequent changes has been removed altogether.

**Regulatory and other findings:**

- This research, which involves children, meets criteria at 45 CFR 46.404 (research involving no greater than minimal risk). Permission of one parent or guardian is sufficient.

**Investigator's Responsibilities**

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date.

You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification application available at <http://integrity.uneg.edu/institutional-review-board/>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website.

Please be aware that valid human subjects training for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found [http://policy.uneg.edu/research\\_data/](http://policy.uneg.edu/research_data/).

CC:

Christine Murray, Counsel And Ed Development  
James Benshoff, Counsel And Ed Development  
Leslie Borders, Counsel And Ed Development  
Craig Cashwell, Counsel And Ed Development  
Laura Gonzalez, Counsel And Ed Development  
Erik Hines, Counsel And Ed Development  
Todd Lewis, Counsel And Ed Development  
John Young, Counsel And Ed Development  
Kelly Wester, Counsel And Ed Development

## APPENDIX B

### INSTRUMENTATION

#### Nonverbal Immediacy Scale-Observer Report (NIS-O)

**This is the most up-to-date measure of nonverbal immediacy as an other- or observer-report. Earlier measures have had problematic alpha reliability estimates. This instrument may be used for any target person (most earlier measures were designed only for observations of teachers). Alpha reliability estimates around .90 should be expected. This measure also has more face validity than previous instruments because it has more and more diverse items. Its predictive validity is also excellent.**

**When using this instrument it is important to recognize that the difference in these observer-reports between females and males is not statistically different. Hence, it is unnecessary to employ biological sex of the person completing the instrument in data analyses involving this instrument. It is recommended that the COMBINED norms be employed in interpreting the results employing this instrument. However, sex differences of the target persons on whom the instrument is completed may be meaningful. This possibility has not been explored in the research to date (September, 2003).**

**DIRECTIONS:** The following statements describe the ways some people behave while talking with or to others. Please indicate in the space at the left of each item the degree to which you believe the statement applies to **(fill in the target person's name or description)**. Please use the following 5-point scale:

**1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Often; 5 = Very Often**

- \_\_\_\_\_ 1. He/she uses her/his hands and arms to gesture while talking to people.
- \_\_\_\_\_ 2. He/she touches others on the shoulder or arm while talking to them.
- \_\_\_\_\_ 3. He/she uses a monotone or dull voice while talking to people.
- \_\_\_\_\_ 4. He/she looks over or away from others while talking to them.

- \_\_\_\_\_ 5. He/she moves away from others when they touch her/him while they are talking.
- \_\_\_\_\_ 6. He/she has a relaxed body position when he/she talks to people.
- \_\_\_\_\_ 7. He/she frowns while talking to people.
- \_\_\_\_\_ 8. He/she avoids eye contact while talking to people.
- \_\_\_\_\_ 9. He/she has a tense body position while talking to people.
- \_\_\_\_\_ 10. He/she sits close or stands close to people while talking with them.
- \_\_\_\_\_ 11. Her/his voice is monotonous or dull when he/she talks to people.
- \_\_\_\_\_ 12. He/she uses a variety of vocal expressions when he/she talks to people.
- \_\_\_\_\_ 13. He/she gestures when he/she talks to people.
- \_\_\_\_\_ 14. He/she is animated when he/she talk to people.
- \_\_\_\_\_ 15. He/she has a bland facial expression when he/she talks to people.
- \_\_\_\_\_ 16. He/she moves closer to people when he/she talks to them.
- \_\_\_\_\_ 17. He/she looks directly at people while talking to them.
- \_\_\_\_\_ 18. He/she is stiff when he/she talks to people.
- \_\_\_\_\_ 19. He/she has a lot of vocal variety when he/she talks to people.
- \_\_\_\_\_ 20. He/she avoids gesturing while he/she is talking to people.
- \_\_\_\_\_ 21. He/she leans toward people when he/she talks to them.
- \_\_\_\_\_ 22. He/she maintains eye contact with people when he/she talks to them.
- \_\_\_\_\_ 23. He/she tries not to sit or stand close to people when he/she talks with them.
- \_\_\_\_\_ 24. He/she leans away from people when he/she talks to them.
- \_\_\_\_\_ 25. He/she smiles when he/she talks to people.

\_\_\_\_\_26. He/she avoids touching people when he/she talks to them.

**Scoring:**

Step 1. Add the scores from the following items: 1, 2, 6, 10, 12, 13, 14, 16, 17, 19, 21, 22, and 25.

Step 2. Add the scores from the following items: 3, 4, 5, 7, 8, 9, 11, 15, 18, 20, 23, 24, and 26.

Total Score = 78 plus Step 1 minus Step 2.

**Norms:**

Females      Mean = 96.7    S.D. = 16.1    High = >112    Low = <81

Males          Mean = 91.6    S.D. = 15.0    High = >106    Low = <77

Combined      Mean = 94.2    S.D. = 15.6    High = >109    Low = <79

**Source:**

Richmond, V. P., McCroskey, J. C., & Johnson, A. E. (2003). Development of the Nonverbal Immediacy Scale (NIS): Measures of self- and other-perceived nonverbal immediacy. *Communication Quarterly*, 51, 502-515.

## APPENDIX C

### PERMISSION TO USE INSTRUMENTATION

# COMMUNICATION RESEARCH MEASURES

**These are measures that have been developed by researchers who are, or at one time were, faculty members or graduate students at West Virginia University. They were developed for use by researchers and may be used for research or instructional purposes with no individualized permission. There is no cost for this use. Please cite the source(s) noted at the bottom of the measure when publishing articles based on research using these instruments.**

Affective Learning  
Attitude, Generalized  
Attraction, Interpersonal  
Belief, Generalized  
Classroom Anxiety  
Communication Competence (SPCC)  
Compulsive Communication, Talkaholic Scale  
Environment  
Ethnocentrism  
Evaluation Apprehension  
Fear of Physician (FOP)  
Homophily Scales  
Humor Assessment(RHA)  
Image Fixation  
Innovativeness, Individual (II)  
Innovativeness, Organizational (PORGI)  
Introversion  
**Nonverbal Immediacy Scale - Observer Report (NIS-O)**  
Nonverbal Immediacy Scale - Self Report (NIS-S)  
Nonverbal Immediacy-Short Form (SRNI)  
Organizational Orientations  
Perceived Quality of Medical Care (PQMC)  
Personal Report of Communication Apprehension (PRCA-24)  
Personal Report of Interethnic Communication Apprehension (PRECA)  
Personal Report of Intercultural Communication Apprehension (PRICA)  
Personal Report of Public Speaking Anxiety (PRPSA)  
PowerMeasures

Satisfaction with Physician (SWP)  
Shyness  
Singing Apprehension (TOSA)  
Situational CA Measure (SCAM)  
Sociocommunicative Orientation (SCO)  
Sociocommunicative Style (SCS)  
Source Credibility  
Teacher Apprehension  
Teacher Burnout  
Test Anxiety  
Time  
Tolerance for Disagreement (TFD)  
Touch Apprehension  
Willingness to Communicate (WTC)  
Willingness to Listen  
Writing Apprehension (WAT)

Retrieved from: <http://www.jamesmccroskey.com/measures/>

## APPENDIX D

### PILOT STUDY

The main objective of the pilot study was to explore and confirm the assertion that four five-minute segments can be representative of a one-hour videotaped session (Kepecs, 1979; Riley-Tillman et al., 2010). The secondary objective was to increase the principal researcher and rater's familiarity with the Nonverbal Immediacy Scale (NIS). In the full study, the observer-reported NIS will be used to assess counselor and client Nonverbal Immediacy Behaviors (NIB) in videotaped counseling sessions. It has been found that a video clip lasting 10 to 20 minutes sufficiently represents a full-length (e.g., 50-minute counseling session) interaction (Kepecs, 1979; Riley-Tillman et al., 2010). Riley-Tillman et al. found that four five-minute segments more accurately produced observer ratings than one 20-minute observation. The results of this pilot study will be used to determine if four five-minute segments are representative of a full-length counseling session.

#### **Sample**

The sample was obtained through an existing database from a counselor training clinic at a state university in the southeastern United States. The database contains videotaped sessions and corresponding client/session information. Master's and doctoral-level counselor trainees in a practicum course served as the counselors; undergraduate students served as the clients and attended three to seven counseling sessions. Each client and counselor signed informed consent to contribute to the research database.

According to G\*power, it was necessary to have a sample size of 27 (which was obtained by watching five counselor-client pairs across three sessions; see procedures) in order to determine if the four, five-minute segments were representative of the whole session. This provided a power of .80, medium effect size of .5 (Cohen's d), and alpha of .05. As such, the principal researcher was able to conduct a paired t-test and assure non-significance was not due to Type II error.

### **Procedures**

In order to assess if four five-minute segments were representative of an entire session, time intervals that capture the beginning, middle, and end of each session were identified. Riley-Tillman et al. (2010) chose four five-minute segments that spanned the duration of an observation period and found that this method produced representative and reliable ratings. As such, four five-minute segments that capture the beginning, middle, and end of each videotaped counseling session with 5-10 minutes lapsing between each observation were tested in this pilot study: 0-5 minutes, 15-20 minutes, 30-35 minutes, and 40-45 minutes.

Through G\*power, it was found that at least 27 NIS scores obtained by watching the full video and at least 27 NIS scores obtained by watching four five-minute segments of the same video needed to be compared. The five counselor and client pairs each had three sessions which resulted in 15 videos for analysis. Although the main study will assess the first, second, and third sessions, the pilot study assessed the intake (first sessions), middle (session halfway through the counseling relationship), and termination sessions (final session, which ranged from session 3 through 7). The rater watched half

of the videos in whole, and the principal researcher watched those videos in the segmented 20 minutes, and vice versa (see Table 7). Each time a video was watched, one counselor NIS score and one client NIS score was produced (see bracketing procedures below). As such, 15 videos were watched by the principal researcher and the same 15 videos were watched by the rater. This resulted in 30 NIS scores from the rater (one for counselor and one for client for 15 videos) and 30 NIS scores from the principal researcher. Of these, 30 were produced by watching the segmented 20 minutes and 30 were produced by watching the whole session. All intake sessions were watched first (videos 1-5), then middle sessions (videos 6-10), then all termination sessions (videos 11-15).

**Selecting Participants.** The principal researcher reviewed the database to identify counselor-client pairs that met the data requirements. Requirements included: each counselor-client pair must have a minimum of three sessions, and these sessions must include an intake, middle, and termination session; the intake, middle, and termination session must have an accompanying ORS and SRS score; and all three sessions must have lasted at least 45 minutes. The existing data is organized by semester, and the principal researcher began with the most recent semester (i.e., summer 2013) and randomly identified the first five eligible participants. Data within each semester is organized alphabetically; as such, the researcher randomly chose a number between 1 and 26 to identify the letter at which data collection will start (e.g., a=1) and three letters were skipped between each collection until five eligible counselor-client pairs were identified.

Table 7

Schedule of Videotape Viewing

Tape #	Whole	20min
1	PR	R
2	R	PR
3	PR	R
4	R	PR
5	PR	R
6	R	PR
7	PR	R
8	R	PR
9	PR	R
10	R	PR
11	PR	R
12	R	PR
13	PR	R
14	R	PR
15	PR	R

*Note.* PR stands for principal researcher and R stands for rater.

**Training and Bracketing.** The principal researcher and a rater completed the observer-rated NIS for both the counselor and client in each session, which could have potentially led to researcher bias. In order to control for this, bracketing was used. First, the principal researcher trained the rater on use of the NIS before tape viewing began. This training included an overview of NIB, ways in which the NIS is used to assess NIB, and a discussion of biases regarding NIB and how these biases might affect use of the NIS. When discussing these biases, formal bracketing procedures were used. The principal researcher and rater identified key words and phrases that explain the way in

which the researchers might be generally biased toward a counselor or client; this included words and phrases such as *gender*, *aggressive*, and *can't help it*. These words and phrases were used to create a definition of the potential bias and how it might affect the data collection (Fischer, 2009; Holstein & Gubrium, 1994). This definition is as follows: "As counselors, we tend to view NIB in context; when rating, we must process them as individual occurrences with consistency across the sample." The principal researcher and rater then identified ways in which this definition and biases can be avoided when rating counselor and client NIB and determined that a note card including the definition of NIS biases would be helpful. The principal researcher and rater then kept a written copy of the definition in eyesight at all times throughout data collection.

After training and initial bracketing procedures, the principal researcher and rater practiced using the NIB on a few counseling videos from a library archive. The principal researcher and rater continued discussing biases as they watched these videos. When the principal researcher and rater were able to reach an agreement on use of the NIS, tape viewing began. Throughout data collection, the principal researcher and rater reviewed the bracketing procedure before watching each video to ensure researcher bias was minimized throughout the data collection process.

### **Data Analysis**

The data was collected using Microsoft Excel. The principal researcher and rater each kept a separate database in Excel that had identical columns and numbering. Upon completion of data collection, the rater placed the completed database on the principal researcher's jumpdrive. The principal researcher then created a formula that aligned with

the NIS scoring procedures in order to identify one NIS score for the counselor and one NIS score for the client for each of the 15 tapes (resulting in two sets of 30 scores).

The principal researcher then organized the data in two ways. First, ratings 1 through 30 for the principal researcher were compiled in a column and the same was done for ratings 1 through 30 for the rater. Next, ratings 1 through 30 for all whole tapes were placed in a column and ratings 1 through 30 for the four five-minute segments were in an adjacent column in which each video aligned (e.g., counselor rating for whole video 1 was next to counselor rating for partial video 1). The data were then directly imported into IBM Statistical Package for the Social Sciences 20 (SPSS) for analysis.

The representative nature of the four five-minute segments in relation to the entire video was analyzed using a paired t-test for two dependent means. Counselor and client NIS scores for the entire video were compared to the corresponding NIS score for the specified four five-minute segments. Additionally, principal researcher ratings for each video were correlated with rater ratings for each video in order to obtain initial inter-rater reliability information.

## **Results**

For the 30 NIS scores obtained by watching the entire video, the mean was 85.5 ( $SD=10.63$ ). For the 30 NIS scores obtained by watching four five-minute clips, the mean was 84.5 ( $SD=9.58$ ). The paired t-test comparing the scores obtained by watching the whole video and the scores obtained by watching the four five-minute segments was non-significant ( $t=.480$ ;  $p=.635$ ). As such, it can be concluded that there is not a significant difference between NIS scores obtained by watching the whole video and NIS

scores obtained by watching the four, five-minute segments. Therefore, four five-minute segments will be utilized in the main study to represent the entire video.

In order to assess initial levels of inter-rater reliability, the 30 scores produced by the rater were correlated with the 30 scores produced by the principal researcher. A Pearson correlation of .645 was obtained ( $p < .001$ ).

### **Implications**

As a result of this pilot study, it has been shown that NIS scores produced by watching minutes 0-5, 15-20, 30-35, and 40-45 of a counseling video are not significantly different than NIS scores produced by watching an entire counseling video. As such, the principal researcher and rater will watch the designated four five-minute segments of each video rather than the entire video when collecting data for the full study. This reduces the amount of time that will be spent collecting data for this study. Future researchers and supervisors might wish to use the findings of this pilot study to justify watching clips of counseling sessions, rather than full sessions, for other data and information collection procedures.

Additionally, inter-rater reliability was significant, but will need to be improved for the full study. Intentionally working toward inter-rater reliability might have created unnecessary bias when determining the difference between watching the full video or the four five-minute segments in the pilot study. However, inter-rater reliability between the principal researcher and the rater will be intentionally fostered in the main study to reach the minimum  $r = .70$ . The principal researcher and rater will review bracketing procedures, synchronize rating methods, and practice achieving inter-rater reliability

before data collection begins. Additionally, the same four five-minute clips will be watched by the principal researcher and inter-rater (as opposed to one rater watching the whole video and the other rater watching four five-minute segments), which will also aid in achievement of the required .70 Pearson correlation for inter-rater reliability.