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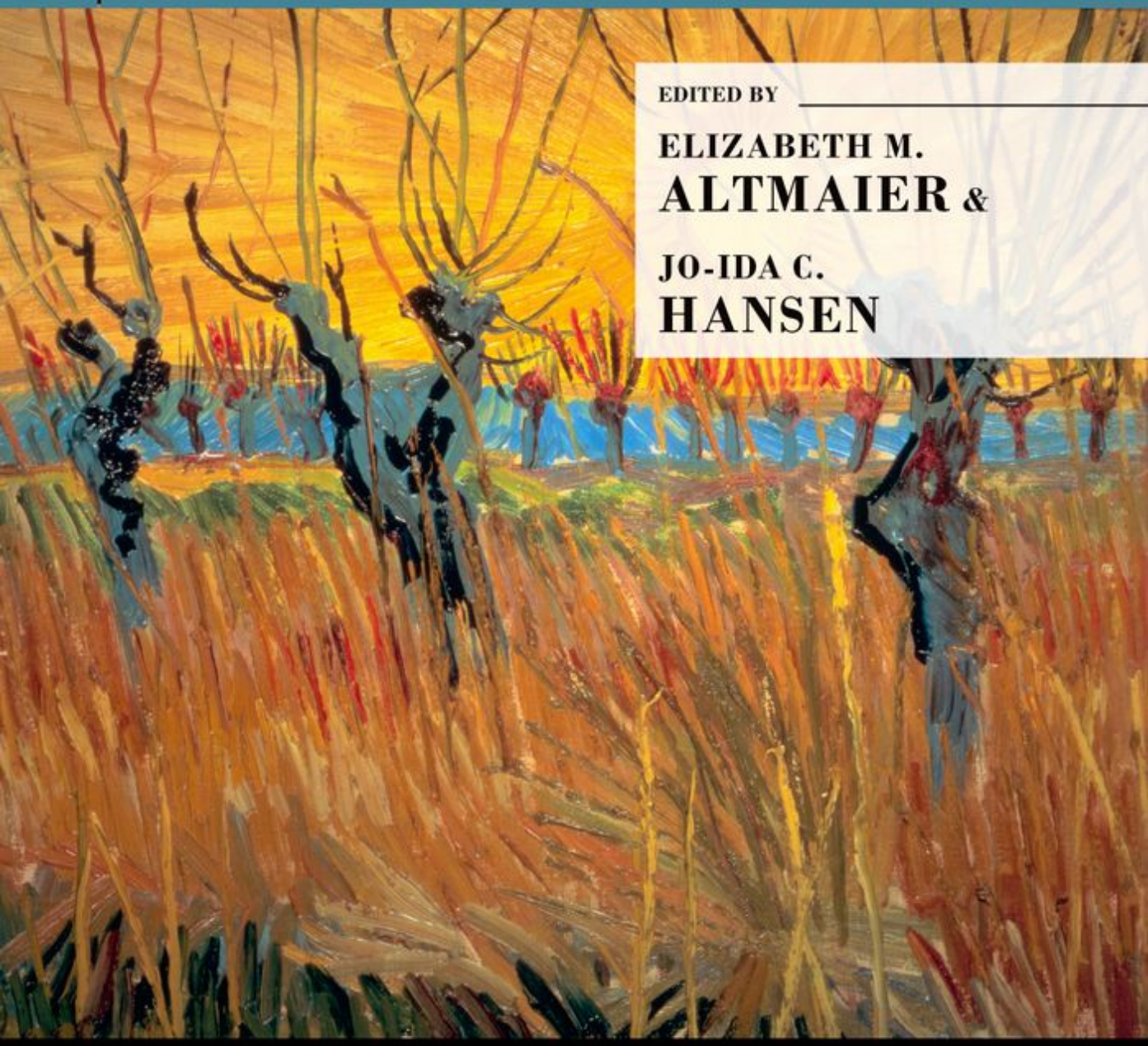

EDITED BY

ELIZABETH M. ALTMAIER &

JO-IDA C. HANSEN

The Oxford Handbook *of* COUNSELING PSYCHOLOGY

The Oxford Handbook of Counseling Psychology

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CONTENTS

PART 1

Introduction and Overview

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CHAPTER

1 A View Across the Life Span of Counseling Psychology

Elizabeth M. Altmaier *and* Saba Rasheed Ali

Abstract

It has been said of psychology, as a discipline, that it has a long past and a short history. This contrast refers to the roots of psychology in philosophy, medicine, and education that date back over several hundred years—and in the case of philosophy and medicine, several thousand. Counseling psychology has deep roots, as well, although its technical birth was in 1952. At that time, the Division of Personnel and Guidance of the American Psychological Association renamed itself the Division of Counseling Psychology. In this chapter, we consider three domains in which our specialty has begun with deep "roots" and has "leafed" out into new ways of thinking about our work with clients and our broader roles in the communities in which we live. These three domains are a focus on building strengths; a holistic, or systems, perspective; and a collaborative, patient-centered model. We trace the development of these domains, noting where, in other parts of this volume, more complete discussion can be found, and we highlight their current explications.

Keywords: values, history, development

Counseling psychology, as a specialty, officially dates to 1952, when the Division of Counseling and Guidance of the American Psychological Association changed its name to the Division of Counseling Psychology, thus formalizing a specialty in psychology that had increasingly differentiated itself from related psychological specialties to form a unique identity. As discussed in many chapters that follow, counseling psychology is one of three original specialties in psychology (the others being clinical psychology and school psychology). Although these specialties differed in their target client population and the activities engaged in by practitioners identified with the specialty, they shared a commitment to client welfare, to the application of scientific knowledge to assessment and intervention, and to training and education. Their differences, however, are significant and continue to this day.

Readers will find this *Handbook* divided into four parts. The first part pertains to foundational knowledge and methods. These chapters concern themselves with the basic interactions of counseling—the counseling relationship, a counselor's assessment of a client, the counselor's choice of interventions—and how theory, research, and professional context influence these interactions over time. Thus, this part covers those critical issues of methodology, ethics and professional issues, and training and supervision that are foundational to all chapters that follow.

From its inception, counseling psychology has emphasized three themes. The first theme is that psychologists work toward a goal larger than that of removing pathology. Rather, counseling psychologists promote positive health through the identification and enhancement of constructive aspects of human functioning, both personal

strengths and available resources. The second theme is that clients are best understood in a systems perspective: When conceptualizing persons, counseling psychologists focus on interacting variables, including developmental stage, the person–environment fit, and external systems acting on the person, including family and community. The third theme is that counseling psychologists are collaborative: They are client-centered, using shared relationships, sensitive to the multicultural components of the interaction, to enhance client welfare and outcomes.

In this chapter, each of these themes will be considered in more detail. The purpose is to define a context for the chapters that follow. By considering both the earliest and the most recent iterations of these themes, we hope that the reader will gain a wider view in which to locate the general and specific information contained in the *Handbook* chapters.

Promotion of Health

As a discipline, psychologists respond to clients—whether individuals, couples, groups, or organizations—who face difficulties with their emotional and physical well-being. Are clients best assisted when the difficulty is accurately diagnosed and an intervention is made to reduce or remove the difficulty? Or, are they best served when the assessment and intervention process assists clients in identifying their own personal strengths and resources, then reinforces these strengths and resources within the intervention, so that they can serve to prevent future distress? The response to this question is part of the historical differentiation between clinical and counseling psychology, in which clinical psychology has emphasized diagnosis and treatment of disorders, and counseling psychology has emphasized normal development. Louttit (1939) defined clinical psychology as concerned with diagnosing the nature and extent of psychopathology, with abnormalities present even in "normal" persons. In contrast, Gustad (1953) noted counseling psychology's concern with *hygiology*, with normalities and strengths present even in "abnormal" persons, and with the identification and promotion of adaptive personal tendencies.

However, the specialties are more recently in convergence on the notion of health promotion as well as remediation. Taken from the websites of clinical and counseling psychology are the following definitions (Division of Clinical Psychology, 2010; Division of Counseling Psychology, 2010):

The field of clinical psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development. Clinical psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioral aspects of human functioning across the lifespan, in varying cultures, and at all socioeconomic levels.

Counseling psychology as a psychological specialty facilitates personal and interpersonal functioning across the lifespan with a focus on emotional, social, vocational, educational, health-related, developmental, and organizational concerns. Through the integration of theory, research, and practice, and with a sensitivity to multicultural issues, this specialty encompasses a broad range of practices that help people improve their well-being, alleviate distress and maladjustment, resolve crises, and increase their ability to live more highly functioning lives. Counseling psychology is unique in its attention both to normal developmental issues and to problems associated with physical, emotional, and mental disorders.

A focus on the promotion of mental health was a vital characteristic of early counseling psychologists, most of whom were operating as guidance specialists during the time between World War I and World War II. These early guidance professionals were concerned with the problems of children and adolescents, particularly those from poor urban environments, who left school early and needed to work to support families but were unable to navigate the work world. Frank Parsons, in particular, focused his efforts on the Civic Service House of Boston, where he assisted students in planning their work future. This foundation for guidance was well received, and national interest in "vocational guidance" increased dramatically. Counseling psychologists of that time were also busy developing curriculum to educate and train the persons who would be guidance specialists in the future.

A second vital focus on health was present in the work of Carl Rogers. Rogers (1940), in contrast to the prevailing therapeutic model of his time, proposed that clients were capable of their own emotional growth and adjustment in the presence of the deeply supportive relationship environment provided by a counselor who was warm, genuine, and fully present to the client. This view contrasted with the notion of the counselor as a removed "expert," whose knowledge would result in a diagnosis of the client and/or the provision of the necessary information to the client for his or her adjustment. Rogers' work was seconded by an early

pioneer of counseling psychology, Leona Tyler, who wrote a seminal text in 1953 entitled *The Work of the Counselor*, in which she set forth the proposition that the person and presence of the counselor was more important than counseling content or techniques.

As is clearly detailed in many chapters that follow, counseling psychology has maintained this emphasis on health promotion and has transformed it into a promotion of positive psychology. Notably, this promotion of health by identifying and fostering strengths has expanded beyond the individual to the point at which counseling psychologists maintain an advocacy role for clients and a commitment to fostering social justice in systems, organizations, and communities. Within this contemporary commitment, counseling psychologists use research and theory to identify persons at risk of difficulties and to intervene before serious adversity is present. They also promote client welfare beyond the individuals whom they serve, acting as an advocate for community betterment. And, finally, they are focused on social justice as a necessary and appropriate goal for all clients.

Systems Perspective

As stated previously, counseling psychology emerged as a specialty from the vocational guidance movement. Yet, counseling psychology would eventually branch into many different areas, one of which was the area of career development/vocational psychology. This area of counseling psychology is mostly concerned with helping individuals plan for a career. More recently, vocational psychologists have been more concerned with how to help individuals find and maintain gainful employment in the midst of economic crises and downsizing.

Some of the earliest theories in career development were driven by historical and contextual influences. During the Industrial Revolution, there was a need to assist individuals to find the correct "match" in terms of their skills and a specific job. This could be seen most prominently in factory work, where efficiency was considered paramount. As mentioned previously, Frank Parsons, considered to be the founder of modern vocational psychology, was particularly interested in immigrant youth. Parsons believed that the best way to help immigrant youth find work was to help them find a job that was "a function of the fit between a person's capacities and characteristics on one hand and the requirements of routines of the occupation on the other" (Parsons, 1909). Parsons was a frequent lecturer at a Boston settlement home established to assist neighborhood immigrant residents to develop English fluency and complete high school. His favorite topic was the importance of matching one's abilities to a vocation. Largely, Parson's work was built upon the premise of creating a more efficient society by assisting youth in becoming and *staying* employed in occupations that would provide them with life's necessities and ultimately assist them in transcending poverty.

From Parson's work emerged the trait factor approaches to career planning and development. For example, Holland's (1959) *theory of vocational choice* is centered on the premise that an individual's personality and occupational environments can be matched, and the greater the match, the more successful the person will be in his or her chosen career. Holland developed a series of personality instruments and theoretical positions that outline this model in great detail. Another theory that was developed around the same time was the *theory of work adjustment* (TWA; Dawis, Lofquist, & Weiss, 1968), which is the only major theory that took into account both the needs and interests of the worker, as well as the needs and interests of the work environment. Very briefly, TWA outlines important relationships between the needs of the individuals and the requirements of the particular workplace and the constant adjustment between the two.

More recently, vocational psychologists have been interested in the application of developmental psychology perspectives to career development and to vocational psychology to explain the career development process for disenfranchised groups. For example, Bronfenbrenner's *ecological systems theory* (Bronfenbrenner, 1977) has been used to explain the career development of women in poverty and women of color. Ecological systems theory is a developmental theory that takes into account the multiple systemic influences and interactions that occur for a given individual. Bronfenbrenner asserts that each individual operates within a series of nested systems in which development occurs (e.g., family, culture, government), and that the individual is an active participant in many of these systems and therefore, is not simply acted upon by the system but also influences and changes the environment. This perspective has been used within vocational psychology/counseling psychology to understand the complexity of career development from a multicultural standpoint, and it takes into account that human behavior and development

varies depending on the context in which it is occurring. Although Bronfenbrenner's theory has been developed for over 40 years, the application of the model to vocational psychology, career development, and counseling psychology is relatively new.

Collaborative, Client-centered Model

Perhaps the strongest characteristic of counseling psychology, particularly in comparison to the two closely related specialties of clinical and school psychology, is its emphasis on the collaborative nature of the relationship between counselors and clients. A view of the client as working in a collaborative relationship with the counselor carries with it several important components. First, since the client and counselor are working together, the client's view of the nature of his or her distress and its origins carries as much weight as the counselor's view. Thus, the counselor is not the source of information as the expert on the client's condition so much as the counselor facilitates the client's self-exploration, whereby both client and counselor gain valuable insights into the client. Second, the counselor respects the client in the counseling relationship as a partner in both assessment and intervention processes. Clients are not "cured" by counselors; rather, clients work in relationships with counselors to achieve important outcomes, including, as noted above, the identification and promotion of personal and contextual strengths.

Perhaps the earliest explication of these views was in Tyler's 1953 book, referred to earlier. In her writing, she emphasized the individuality of each client and each counselor, and the unique nature of their interaction. Therefore, although technique and knowledge are critical, they are not enough. As Tyler noted in a later edition of her book (1969), "at the heart of the counseling process is a meeting of counselor and client. Whether they meet for 15 or 50 minutes, whether they talk about symptoms, explore feelings, or discuss facts and schedules . . . whatever influence counseling has is related most closely to the nature of the relationship that grows out of this encounter" (p. 33).

A related view of the importance of a collaborative model of counselor and client is the collaborative model of training and education adopted in counseling psychology programs, namely the scientist–practitioner model. This model, established originally at the Boulder Conference, articulated the essential importance of the relationship of science and practice. During graduate education and after, a dual emphasis on the scientist–practitioner model (Altmaier & Claiborn, 1987) allows the integration of both scientific activities and modes of thinking with the art of therapy. Thus, scholarship and practice share reciprocal and essential functions in the advancement of science and clinical work.

This emphasis on collaboration between counselor and client resulted in significant thinking about essential tasks of the counselor, who must be "present" for clients. In particular, how cultural differences between counselor and client influence successful or unsuccessful outcomes were considered. Recently, counseling psychology has been characterized by and differentiated from clinical and school psychology in its emphasis on critical aspects of the multicultural interaction between counselor and client. The second part of this *Handbook* identifies essential elements of multicultural knowledge, attitudes, and skills. As noted in the definition of counseling psychology presented earlier, counseling psychologists carry a sensitivity to multiculturalism into all their activities, ranging from counseling and therapy to testing to research to supervision and training. Much of the current work in the field of psychology in these areas has been accomplished by counseling psychologists. Although *multiculturalism* in its earliest meaning was defined primarily as racial differences between counselor and client, counseling psychology now promotes the view of each encounter between two people as a multicultural encounter. As chapters in this part consider, gender, social class, and sexual minority concerns are examples of cultural encounters in which counseling psychologists have contributed to current knowledge.

Conclusion

Counseling psychology is engaged in exhilarating new directions, as well as continuing time-honored domains of contributions. The fourth and fifth parts of the *Handbook* cover both of these applications. The fourth part considers how counseling psychologists have traditionally assisted clients who are individuals, groups, couples, or families, and who have a variety of identified difficulties. The fifth part identifies "intersections," new areas of practice that have recently developed as counseling psychologists have embraced previously underserved client populations—clients with medical concerns, school-aged children, persons who have experienced trauma—and used both the specialty's roots and its leaves to explicate theories and applications that build on the traditional strengths

of counseling psychology in new ways. Increasingly, counseling psychologists operate outside of the borders of the United States, and our last chapter opens the boundaries of our specialty even wider, by identifying the increasing internationalism of counseling psychology.

All of the chapter authors share a deep commitment to our specialty, as well as recognized expertise in the areas they encompass in their chapters. We acknowledge with gratitude their work in bringing historical strengths, current directions, and the exciting future agenda of our specialty.

References

Altmaier, E. M., & Claiborn, C. D. (1987). Some observations on research and science. *Journal of Counseling and Development*, *66*, 51.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*, 513–531.

Dawis, R.V., Lofquist. L. H., & Weiss, D. L. (1968). A theory of work adjustment: A revision. *Minnesota Studies in Vocational Rehabilitation*, *Vol. 23*.

Division of Clinical Psychology, American Psychological Association. (2010). About clinical psychology. Retrieved from http://www.div12.org/about-clinical-psychology.

Division of Counseling Psychology, American Psychological Association. (2010). About counseling psychologists. Retrieved from http://www.div17.org/students_defining.html.

Gustad, J. W. (1953). The definition of counseling. In R. F. Berdie (Ed.), Roles and relationships in counseling. *Minnesota Studies in Student Personnel Work*, *No. 3*.

Holland, J. L. (1959). A theory of vocational choice. *Journal of Counseling Psychology*, *6*, 35–45.

Louttit, C. M. (1939). The nature of clinical psychology. *Psychological Bulletin*, *36*, 361–389.

Parsons, F. (1909). *Choosing a vocation*. Boston: Houghton Mifflin.

Rogers, C. R. (1940). The processes of therapy. *Journal of Consulting Psychology*, *4*, 161–164.

Tyler, L. E. (1953). *The work of the counselor*. New York: Appleton-Century-Crofts.

Tyler, L. E. (1969). *The work of the counselor* (3rd ed). Englewood Cliffs, NJ: Prentice-Hall.

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PART 2

Foundations

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CHAPTER

2 Professional Issues

Judy E. Hall

Abstract

After addressing the attributes of a profession, this chapter discusses the requirements for accountability due to the profession's contract with society. The mechanisms of accountability for the profession of psychology—education, training, licensure, and credentialing—are reviewed in the context of counseling psychology. Information on the transition from an input model of education and training to an outcome-driven model is presented. Current challenges in quality assurance are outlined, including distance education, the movement toward competency assessment, and international mobility.

Keywords: accreditation, designation, licensure, credentialing, competency, mobility, distance education, internship, practicum, postdoctoral

In this chapter, the attributes of a profession, its requirements for accountability, and its contract with society are addressed. We focus on the accountability mechanisms and their relationship to professional practice, and as applicable, to counseling psychology. Of great consequence to prospective psychologists are the decisions they make with regard to education, training, licensing, and credentialing; and those are described. Organizations' roles in the development of the profession and today's pressing issues related to distance education, competence, and international mobility are also reviewed.

Professional attributes involve complex activities supported by the efforts of individuals, organizations, and legislative bodies, all of which are committed to ensuring quality assurance for the public. Space does not allow a comprehensive treatment of all the forces, and the reader is encouraged to examine these developments separately.

Definition of a Profession

Psychology is a *profession*. There are many definitions of a profession, but most share four components (Pellegrino, 1991).

> First, a profession is based on a systematic body of knowledge, mastered through a broadly defined educational and training process. Second, a profession regulates its own practitioners through a code of ethics and a means of enforcing that code. Third, a profession is characterized by an expectation of all of its members to serve the profession itself, through teaching and mentoring junior members and through other activities that have as their goal the advancement of the profession and the improvement of its contributions to human welfare. Fourth, a profession is held accountable by its implicit contract with the public. The profession agrees to use its special skills and knowledge to promote human and societal welfare. In return for

> this promise, the public gives the profession some degree of control over the education and certification of its members.
> (Altmaier & Hall, 2008, p. 3)

Thus, as a profession, psychology has certain obligations predicated on its implicit social contract with the public. These obligations often lead to professional issues, and thus are described in the following section.

> Professions have what has been called a "special relationship" with society, the essence of which is that professions are given greater autonomy than other social groups. [They] set their own standards, regulate entry into their own ranks, discipline their members, and operate with fewer restraints than the arts, trades, or business. In return, the professions are expected to serve the public good and enforce high standards of conduct and discipline.
> (Skrtic, 1991, p. 87)

Thus, a profession is accountable to society in maintaining its status. By carrying out the responsibilities noted, psychology provides assurance to the public that it has purposely considered, developed, and disseminated the methods by which the quality of services is assured. Note that the words *society, public*, and *consumer* are used almost interchangeably, so as to be as inclusive as possible. In this chapter, the word *consumer* includes the direct recipient of services by psychologists as well as the prospective student who is a consumer of the education, training, and credentialing processes.

Another example of the importance of terminology is addressed by Ritchie (2008), when he considers the evolution of the *patient* to *client* to *consumer* and the implications of these title changes. He reminds us that the consumer of services has his or her own responsibility to pursue quality by demanding that standards be met through the provision of feedback.

Specialization

Psychology as a profession was initiated with licensure laws, program accreditation, and training conferences. The Boulder Model, named for the location of the conference (Boulder, Colorado, 1949), shaped professional training by establishing the doctorate as the minimum educational requirement for entry into professional practice and the scientist–practitioner model as the desired training model (Raimy, 1950). With the knowledge that was being generated, specialization (focusing on a smaller subset than that encompassed by all of psychology) was inevitable. At this time, a large number of practitioners were needed to serve the mental health needs of returning World War II veterans. With expansion of psychology's scientific foundation, practitioners began to specialize and to define their areas of specialization (e.g., vocational guidance) and their specialty (typically based on the title of their doctoral program or training site, such as counseling). Even today, after being prepared with broad and general knowledge, skills, and abilities, students often begin to specialize while in their education and training sequence by focusing on populations, theoretical techniques, interventions or locations of practice (e.g., clinics, counseling centers, schools). After licensure, professionals specialize further in the services they provide in order to compete in the marketplace.

Given the historical confusion and lack of agreement on what constitutes specialization, organized psychology asked itself the question, "What is a specialty?" Even though earlier attempts had been made to wrestle with this problem, none was successful. Thus, the American Psychological Association (APA) decided, in 1979, that a consistent set of policies and procedures needed to be developed to identify specialties. This was initiated by the Task Force on Specialty Criteria (TFSC; APA, 1979), with the Subcommittee on Specialization (SOS; Sales, Bricklin, & Hall, 1983, 1984a, b) completing the extensive development of criteria and sample procedures. This effort involved articulating what psychology needed to do that was also developmentally consistent with the history of specialty recognition in medicine, dentistry, and nursing. The basic similarity of psychology and the other three professions is the assumption of a common core of generalist skills and knowledge. Building upon this perspective, the SOS principles and procedures directly impacted on organized psychology's subsequent efforts to define a specialty; this included identifying the parameters of practice, delineating the criteria for recognition/continuation of a specialty and proficiency, and separating the initial recognition principles from the continued recognition principles.

The APA committees/task forces (APA Task Force on Scope and Criteria for Accreditation, Joint Council on Professional Education in Psychology) incorporated these criteria and concepts into their policy documents. Outside of APA, the American Board of Professional Psychology (ABPP) developed its own recognition procedures for new specialties using the SOS principles and procedures

(Bent, Packard, & Goldberg, 1999). In Canada, a task force appointed by the Canadian Psychological Association (CPA) and the Council of Provincial Associations of Psychology (CPAP) built on the work of SOS in its specialty deliberations (Service et al., 1989). In 1993, the APA established the Joint Interim Committee on Recognition of Specialties and Proficiencies in Psychology, which drew representation from outside APA. Its successor, the Commission on Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), proposed a set of specialty principles and procedures that were approved by APA as policy (American Psychological Association [APA], 1995). That body continues to review and recommend for approval specialty and proficiency areas in professional psychology. (For current information, see http://www.apa.org/crsppp/rsp.html.)

The APA established the first accreditation process for clinical psychology programs in 1948 (Goodstein & Ross, 1966). To justify its position as a specialty, clinical psychology had both program accreditation standards and the recognition of clinical psychology practitioners by the American Board of Examiners in Professional Psychology (ABEPP). Counseling psychology was only shortly behind in its development as a specialty. The ABEPP awarded its first diploma in Counseling and Guidance in 1947. The first training conference, held at Northwestern University, produced counselor education and training standards (APA Committee on Counselor Training, 1952). The APA accredited its first counseling program in 1950 (Goodstein & Ross, 1966). Much of this programmatic development was stimulated by veterans returning from World War II who needed vocational guidance. Since the numbers returning would strain the usual resources of college counseling centers, federal subsidies for training were made available to these counseling centers, thus providing impetus for the development of counselor training programs. (The distinction between the labels *counseling* and *counseling psychology* was not an issue at that time.) The Department of Medicine and Surgery of the Veterans Administration (VA) instituted a vocational counseling program in its hospitals, so that, by 1958, the VA employed 130 doctoral-level counseling psychologists (Hall & Sales, 2002).

During this period of growth and definition, a committee report from APA Division 17 encouraged members to think of counseling psychology, although still evolving, as a specialty within applied psychology that could be differentiated from clinical psychology (APA Committee on Definition, 1956). In 1961, the Greystone Conference, the second training conference on the preparation of counseling psychologists, was held (Thompson & Super, 1964). Two possible directions for counseling psychology were proposed: one as a subspecialty of the clinical area, and the other as distinct from clinical and other areas of psychology. The two recommendations were prescient in that counseling psychology, more so than any other area of psychology, is still consummately introspective, comparing itself to its origins in counselor education and vocational guidance (Thompson & Super, 1964) and its practice to clinical psychology (Watkins, 1984).

Indeed, the debate about counseling psychology differing from clinical psychology remains an issue today for some individuals, especially as crossover in practice occurs after graduation and distinction across programs is eroded. But, despite this continued dialogue about counseling psychology's definition within professional psychology, APA's accreditation of counseling programs and board certification by American Board of Professional Psychology (ABPP, formerly ABEPP) justifies its position as a recognized specialty. Counseling psychology, because of its having met many of the characteristics of a recognized specialty, was initially recognized by the APA as a doctoral-level specialty, first through a de facto process and later through a formal de jure process. (See http://www.apa.org/crsppp/counseling.html for its current definition.) For more detail on the history of counseling psychology, see Gelso and Fretz (2001).

Quality Assurance and Accountability of Programs and Individuals

Belonging to a profession includes assuming the responsibility to regulate that profession, both individually and as a group. The various groups in self-regulation of education, training, and credentialing include professional associations that accredit programs (APA/CPA); licensing and credentialing bodies that designate doctoral programs (Association of State and Provincial Psychology Boards [ASPPB] and the National Register of Health Service Providers in Psychology [National Register]); and organizations that designate or approve for listing/membership internship and postdoctoral training programs, such as the Association of Psychology Postdoctoral and Internship Centers (APPIC), Canadian Council of Professional Psychology

Table 2.1. Credentialing Organizations and Their Roles

Competence Level & Scope	Program Evaluation (Designation/Accreditation)	Individual Evaluation (Credentialing)
Basic & Minimal	Criteria-based designation of doctoral programs that produce professional psychologists: *ASPPB/National Register*	Certification of individual's degree/ training in professional psychology: *Universities/Professional Schools*
Basic & Extensive	Criteria-based accreditation of doctoral programs and internships that produce professional psychologists: *Commission on Accreditation (CoA); Canadian Psychological Association Committee on Accreditation* Criteria-based review of internships: *Association of Psychology Post-Doctoral & Internship Centers (APPIC); Canadian Council of Professional Psychology Programs; School Psychology APA Div 16, Council of Directors of Programs in School Psychology and National Association of School Psychologists; National Register of Health Service Providers in Psychology*	License to practice as a professional psychologist: *Regulatory bodies in States, Provinces & Territories in United States & Canada* Credentialing as a health service provider in psychology: *National and Canadian Register of Health Service Providers in Psychology; State Recognition of Health Service Provider*
Traditional Substantive & Specialized	Criteria-based accreditation of postdoctoral programs in professional psychology in traditional substantive & specialized areas: *CoA; Criteria-based Membership of Post Doctoral Training Programs: APPIC*	Board certification through examination of advanced skill in specialty areas: *American Board of Professional Psychology, American Board of Professional Neuropsychology, etc.* Certification bodies for proficiencies: *APA Practice Organization, College of Professional Psychology*

Training Programs (CCPPP), and a joint working group of organizations that review school psychology internships (APA Division 16, National Association of School Psychologists and Council of Directors of School Psychology Programs [CDSPP]) (Go to http://www.ed.psu.edu/educ/espse/school-psychology/internship-directory for a current list.) These organizations and their roles are included in Table 2.1, which is updated from Drum and Hall (1993). Not mentioned are the state or provincial mechanisms that approve doctoral programs for their own jurisdictional purposes, such as in New York State (New York State Doctoral Evaluation Project, 1990).

The accreditation/designation of educational programs, accreditation or approval of internships and postdoctoral residencies, and review of individual psychologists for licensing and credentialing involve multiple national bodies. The first element of regulation relates to the establishment of education and training standards for programs that voluntarily apply for professional recognition. Sometimes, there is a choice for the student. For instance, the developing professional psychologist chooses whether to apply for admission to an accredited or a designated program and to an accredited or designated internship (and if so, approved by whom). At present, 900 doctoral programs, internships, and postdoctoral programs are accredited by the APA Committee on Accreditation (CoA, now Commission on Accreditation) and 36 programs are designated by the ASPPB/National Register as doctoral programs in psychology, but are not APA accredited. The APPIC's membership includes 700 internship program and 126 postdoctoral training programs, including those that are accredited by CoA. The CCPPP has 38 Canadian internship programs as members. These decision points are illustrated in Figure 2.1 and discussed in greater detail in the following sections.

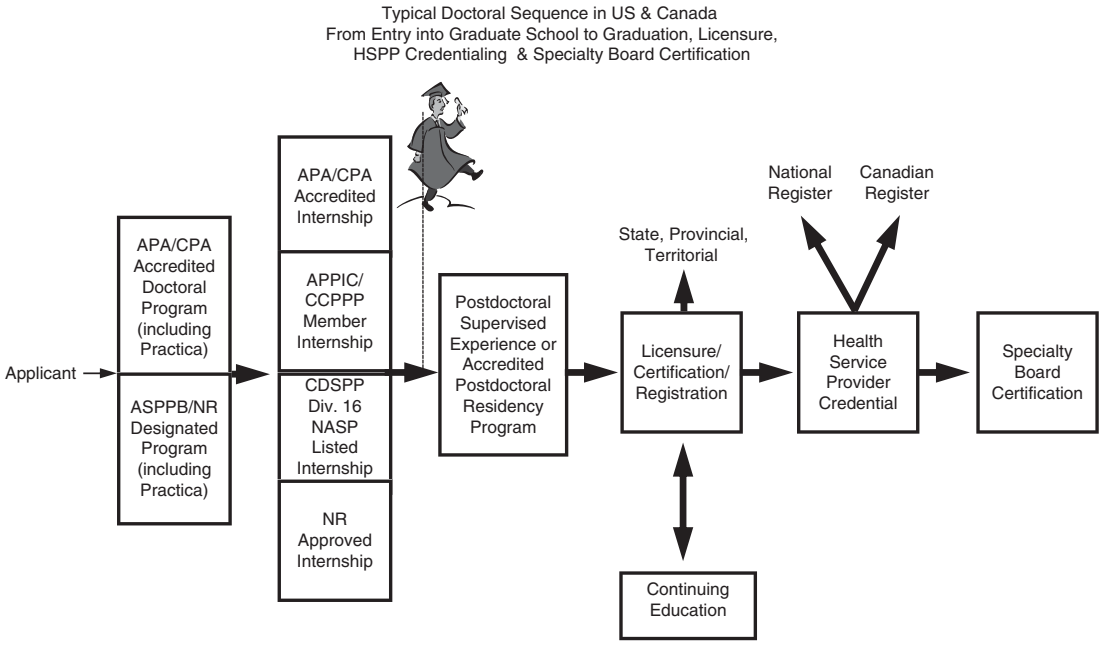

Fig. 2.1 Typical doctoral sequence in the United States and Canada from entry into graduate school to graduation, licensure, Health Service Provider in Psychology (HSPP) credentialing, and specialty board certification.

Education, Training, Licensure, and Credentialing

The first step in the education and training sequence involves choosing a doctoral program. The potential student asks several questions: What are the approved programs? How can I tell that the program is approved? Will completing that program ensure that I meet the educational requirements for licensure as a psychologist? To answer these questions, the concepts of accreditation (institution and program) and designation (program) are presented.

Accreditation in the United States can be characterized as nongovernmental, voluntary, and self-regulatory. Doctoral education programs in psychology are housed in academic institutions and professional schools. Accreditation assesses these institutions and programs to determine their quality and to provide for continuous improvement. Typically, the term applied to this process is *accreditation*. We also use the term *designation* to apply to the approval of programs. Thus, in the United States, there are accredited institutions, accredited programs, and designated programs. Similarly, there are institutions and programs that are not approved.

Resources for identifying accredited institutions and programs are provided online by the United States Department of Education (USDOE). Even though the USDOE does not accredit educational institutions and/or programs, it does publish a list of nationally recognized accrediting agencies that are considered reliable authorities as to the quality of education or training provided by the institutions of higher education and the higher education programs they accredit. (The list can be found online at http://www.ed.gov/admins/finaid/accred/accreditation.html#Overview.)

APPROVAL OF INSTITUTIONS AND PROGRAMS

There are two types of accrediting agencies: specialized and institutional. *Institutional accreditation* refers to accreditation of the entire academic institution by one of the regional accrediting authorities recognized by USDOE. These regional accrediting bodies are identified by licensing boards and credentialing organizations as necessary but not sufficient assurers of quality. Laws and regulations for licensing typically refer to the program having to be housed in an institution that is approved by one of the regional accrediting bodies.

Thus, in choosing a program, the student should first verify that the institution is regionally accredited by one of the following bodies. Such institutions are listed online under the regional association that is responsible for that geographic region of the United States.

• Middle States Association of Colleges and Schools, http://www.msache.org
• New England Association of Schools and Colleges, http://www.neasc.org
• North Central Association of Colleges and Schools, http://www.ncahigherlearningcommission.org
• Northwest Commission on Colleges and Universities, http://www.nwccu.org
• Western Association of Schools and Colleges, http://www.wascweb.org
• Southern Association of Colleges and Schools, http://www.sacscoc.org.

After verifying that the institution is regionally accredited, the potential applicant should then determine if the desired program (e.g., clinical, counseling) is approved. Four categories describe doctoral programs in psychology.

Accredited Programs
The first category includes regionally accredited institutions with programs that are *accredited* by the CoA. The CoA accredits doctoral training programs in the specialty areas of clinical, counseling, and school psychology; in other developed practice areas; and a combination of two or three of those specialty areas. (A program may not apply for accreditation in a developed practice area until that area has been added to the scope of accreditation. For more information about CoA accreditation and its purpose and process, see http://www.apa.org/ed/accreditation/accrfaq.html.)

Although regional accreditation is not the term used in Canada, all universities offering doctoral training must be similarly reviewed and approved. The CPA accredits doctoral training programs in the specialty areas of clinical, clinical neuropsychology, school, and counseling psychology. For more information about CPA accreditation and its purposes and process, see http://www.cpa.ca/education/accreditation. Graduates from APA and CPA accredited programs typically meet the educational requirements for licensure and for credentialing in psychology in the United States and Canada.

Designated Programs
The second category includes regionally accredited institutions with programs that are *designated* as psychology programs by the ASPPB/National Register. The ASPPB/National Register Designation Committee reviews doctoral programs in psychology from any specialty area to determine if they meet the "Guidelines for Defining a Doctoral Program in Psychology," typically known as the *designation criteria* (http://www.nationalregister.org/designate.htm). Note that Criterion 1 specifies that programs that are APA/CPA accredited by definition automatically meet the designation criteria. Programs that are not accredited must meet the remaining nine criteria. Graduates from ASPPB/National Register designated programs typically meet the educational requirements for licensing and credentialing in psychology.

Unapproved Programs
The third category addresses regionally accredited institutions with programs that are neither accredited nor designated. Graduates of these programs may not qualify for licensure. In a few states, the applicants may be admitted to the licensing examination on the basis of the institution's regional accreditation. However, these graduates will not qualify for credentialing by the National Register or ABPP. This category may include programs that are so new that they have yet to apply for recognition or ones that have applied and not met the criteria.

Unaccredited Schools
The fourth category is institutions that are not regionally accredited, with a program that is neither APA/CPA accredited nor ASPPB/National Register designated. Graduates from these programs will not qualify for licensure or credentialing (except that graduates of California programs established prior to a change in California statute may be eligible for admission to the California licensure examination, http://www.psychboard.ca.gov/exams/unaccredited.shtml).

The desired outcome for graduates of doctoral education and training programs is preparation for and admission to professional practice. The current APA *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (G&PAPA, 2009) emphasize quality by measuring program goals and outcomes, focusing on competencies rather than curriculum, and stressing self-study rather than external reviews. This shift in emphasis to outcomes was reflected first in the 1996 G&P (APA, 1996).

> That is, while it continued to be appropriate to assess the quality of an institution or program in terms of the appropriateness of its education resources (e.g., faculty, students, facilities, financial support) and processes (e.g., curriculum, methods

> of pedagogy, faculty–student relationships) in the context of its mission or goals, it is the final outcomes of an institution or program (e.g., attrition or graduation, demonstrated student learning, faculty productivity) that many argue are ultimately the most accurate measures in assessing quality.
> (Nelson, Belar, Grus, & Zlotlow, 2008, p. 19)

However, lack of consistency among the many programs' outcomes and the methods by which they are assessed raises concern for licensing and credentialing bodies and others within the profession of psychology. To counter this concern, advocates of the revised standards point out that—in keeping with the principle that such programs be broad and general—there should be professional competence domains in which all students are prepared. These domains represent the knowledge, skill, and professional function bases of professional practice (e.g., scientific foundations, ethics, and assessment, intervention, and consultation).

A requirement to report student achievement in terms of time to completion, tuition and fees, internship acceptance, attrition, licensure outcomes, and job placement rates became effective January 1, 2007. (See Implementing Regulation C-20 at http://www.apa.org/ed/accreditation/implementregs200524.pdf.) Programs post outcomes on their websites and include this information in other material made available to prospective students. For instance, of great interest is the performance by graduates of doctoral programs on the Examination for Professional Practice in Psychology (known as the EPPP) which is required for licensure in the US and Canada. That information is now posted on the ASPPB web site (go to http://www.ASPPB.org). Mayne, Norcross, and Sayette (2006) also provide program-reported measures to help prospective students evaluate programs in advance of application.

DESIGNATION PROJECT

Licensure laws typically incorporate two paths to meeting educational requirements: accreditation or designation of programs. Designation was created in the late 1970s because of a concern about consistency in the educational curricula in accredited programs and the fact that not all students applying for licensure came from accredited programs. Recognizing that psychology was behind other professions in defining the core curriculum needed to meet the educational requirements for licensure, two national conferences on education and training in psychology convened by the APA and the National Register brought together representatives of organized psychology to establish guidelines for the identification of doctoral programs in psychology for credentialing purposes (Wellner, 1978). This effort intended to present a unified front to state legislatures and to courts as to the educational requirements of a psychologist.

The Guidelines for Defining a Doctoral Program in Psychology were adopted as the educational standard for the National Register and the ASPPB in 1978, were used by the National Register in its development of the Designation Project in 1980 (ASPPB became a partner in that project in 1986), and as a result, had a major impact on licensing and credentialing standards for doctoral programs. They were eventually included in the APA's 1979 accreditation standards (Nelson & Messenger, 2003). For instance, one criterion relates directly to counseling psychology programs: "The program, wherever it may be administratively housed, must be clearly identified as a psychology program. Such a program must specify in pertinent institutional catalogs and brochures its intent to educate and train professional psychologists" (Wellner, 1978). Gelso and Fretz (2001) note that, "the more than 100% increase in the number of APA-accredited programs in counseling psychology from the early 1970s to the late 1980s was directly related to this change. The majority of the newly approved programs were formerly counselor education or counseling and guidance programs in colleges of education" (p. 119).

Although program designation is different from accreditation, both refer to a certification process for programs and training facilities. Designation is the process of reviewing programs, using publically available documentation, to determine if they meet established and public criteria. There is no site visit by peers, such as employed by the CoA. Another distinction is that doctoral programs in any area of psychology may apply for designation (e.g., industrial-organizational psychology), as the focus is on whether the degree program meets the general criteria. Once approved, the program is added to the online list of designated programs and re-reviewed by the ASPPB/National Register Designation Committee at least every 3 years. Although this imprimatur provides assurance to the program applicant, students who are considering enrollment in a doctoral program and intending to practice psychology should still contact the licensing board in the jurisdiction in which they intend

to seek licensure to determine any unique education and training requirements. However, typically, the licensing board rules require that the doctoral program be APA/CPA accredited or ASPPB/National Register designated. (All these programs are listed at http://www.nationalregister.org/designate_stsearch.html.)

Practicum

The Association of Psychology Training Clinics (APTC) is the APA-affiliated organization of directors of psychology training clinics. These 115 training clinics offer pre-internship training to clinical, counseling, and school psychology doctoral students. Typically, these clinics are department- or university-based facilities that provide behavioral/mental health services to the community. Other types of training provided in doctoral programs are the practicum that accompany specific courses (e.g., assessment, intervention) Usually, 2 or 3 years of practicum experiences are made available to students by the program. Coming early in graduate school, these are essential training experiences that provide a foundation for professional practice.

The doctoral student needs to have sufficient experiential training to be competitive when applying for internship; this need has led to an increase in the number of practicum hours over the years, with current applicants for internship documenting 1,800–2,000 hours (Association of Psychology Postdoctoral and Internship Centers [APPIC], 2008). The current APA G&P state the following: the applicant must "have completed adequate and appropriate supervised practicum training, which must include face-to-face delivery of professional psychological services." As this criterion no longer specifies a minimum number of hours needed for admission to the internship, students often ask how much is enough. The numbers vary, depending upon the source: academic director versus training director. The percent of time spent in direct service adds another variable when interpreting practicum hours and may place students in a quandary as to what makes them more competitive for internship placement. However, adding on hours is not the solution. In fact, experience is only one of the three factors that help a student secure an acceptable internship (letters of recommendation and the internship application are the other two). Nonetheless, practicum remains a basic requirement that can be fulfilled in a number of ways. With the potential changes at the state level in education and training requirements leading to licensure, it is hoped that the practicum can be "defined, delineated, and formalized" (Rodolfa, Owen, & Clark, 2007).

Internship

The first internship program in professional psychology was accredited in 1956. Even then, the number of students seeking formal internships was higher than the number of positions available. As a result, students often developed their own training experience "on the job," leading to considerable variability in training. To address this lack of standardization, in 1980, the National Register Appeal Board developed specific internship criteria, which were adapted by the APPIC, APA, and the Council of Doctoral School Psychology Programs (CDSPP) to meet their own needs. (See www.nationalregister.org_internship.pdf for the current National Register criteria.) The major difference between the criterion sets relates to the placement of the internship in the education and training sequence.

Today's internships are intended to provide broad and general education and training and are not classified with a specialty title, such as clinical or counseling psychology. The APPIC, an organization composed of internship and postdoctoral training sites that apply for membership, offers a searchable database containing internships in the United States and Canada. The database indicates if the internship is accredited by APA or CPA, and offers other information, such as the specialization training areas offered (populations, treatment modalities, and specialty areas, such as neuropsychological assessment and intervention, primary care, substance abuse, and geropsychology). APPIC members can indicate the preference given applicants by specialty area of degree. For instance, of the 700 internships listed online as of April 14, 2011, 634 would consider counseling psychologists for internship placement. The current standard for the length of training (e.g., APA, APPIC, National Register) is that the internship must consist of 1 year of full-time training completed in no less than 12 months (for school psychology internships, 10 months) and in no more than 24 months.

The APPIC developed the uniform application for internships (this application went online in 2009) and then, in 1999, initiated the matching process for internship placement, followed in 2011 by a second match for those positions not filled in the initial match. Yearly match statistics are provided to the relevant constituencies, with the most recent results showing 79% of students matched in 2011

(without reference to degree, specialty area of degree, or location of doctoral program) out of a total of 3,899 students. There were 3166 available positions in 2011. Even though new internship positions are created each year, insufficient internship training positions are available to meet the need. Thus, students are experiencing difficulty in obtaining an internship. For several years now, a portion of students have not matched to an internship on the first attempt, now they either move to the second APPIC match or to the Association of Counseling Center Training Agencies (ACCTA) clearinghouse for placement (internship sites that have available positions after the match date). The ACCTA is an organization composed of 150 internships located in college and university counseling centers, the largest single category for internships. (See https://www.accta.net/default.asp for more information.)

For counseling psychology students, a comparable decline in matching rates from 90% (1995–2005) to 78% (2007) was reported on a survey of the members of the Council of Counseling Psychology Programs (CCPTP). Using predictions from training directors on which students would not have matched, Miville, Adams, and Juntunen (2007) believe that a 90% placement rate is achievable for APA-accredited counseling psychology programs. Counseling psychology programs typically admit seven or eight students a year and account for only 10% of the internship applications submitted yearly.

Although many argue that the best resolution to the supply-and-demand problem is admitting fewer students, a program failing to place a reasonable number of students in internships on a consistent basis might constitute "an operational definition of taking too many students" (Stricker, 2008, p. 207). With increasing attention paid to outcomes, doctoral programs are taking more responsibility in helping students locate an internship or are creating captive internships designed for their students. Nonetheless, students must be careful about developing their own experiences, as internships developed outside the scrutiny of an objective, criterion-based organization may not be acceptable for licensing or credentialing. (For a more detailed consideration of the many questions in applying for the internship, interested readers should consult the handbook developed by Williams-Nickelson, Prinstein, and Keilin, 2008).

Postdoctoral Year

The second year of supervised experience typically required for licensure and credentialing is a year of postdoctoral experience. Licensing boards and credentialing organizations have developed their own approval criteria with little commonality other than length. Of concern is whether the experience is supervised by qualified licensed psychologists (for instance, those not qualified would be psychologists in a dual relationship, master's degree psychologists, and psychologists with degrees from unaccredited/unapproved program). With increasing difficulty in achieving an experience that is acceptable from one jurisdiction to another, standardization of the postdoctoral experience requirement was needed.

Concern about postdoctoral experience led to the second conference on postdoctoral training, in 1992, the National Conference on Postdoctoral Fellowship Training in Applied Psychology. This APPIC-sponsored conference, supported by multiple organizations, resulted in draft standards that became the instigating force for organized psychology to work together in solving the quality assurance aspects of the postdoctoral year (Belar, Bieliauskas, Klepac, Stigall, & Zimet, 1993). The first step was the formation of the Inter-Organizational Council for Accreditation of Postdoctoral Programs in Psychology (IOC), consisting of representatives from United States and Canadian organizations concerned with accreditation, credentialing, and licensing, along with the training council representative from each specialty. The purpose was to develop consensual standards and procedures for a postdoctoral accreditation process. Five years later, the APA adopted as policy the postdoctoral accreditation standards (APA, 1996), and it accredited the first two postdoctoral residency training programs in 1997.

Today, postdoctoral residencies may be accredited as programs preparing individuals for practice at an advanced level in the *traditional* practice areas of clinical, counseling, or school psychology (there are currently 30). Other types of postdoctoral residencies may be accredited in *specialty* practice areas (currently 30). Specialty areas that have met the guidelines to be included within the scope of accreditation are clinical child psychology, clinical health psychology, clinical neuropsychology, family psychology, forensic psychology, and rehabilitation psychology.

Finding postdoctoral sites for employment or residency training is also a challenge for graduates. Although electronic mailing lists disseminate information on available positions, there is no matching service such as is provided for internships (APPIC, 2008). The APPIC lists in their online directory 126 postdoctoral programs, 60 of those are APA-accredited residency programs. However,

the number of psychologists potentially trained in a year is even smaller than that in internship training, as the number of training positions at each site is usually two. A year (or more) of postdoctoral experience is required by the majority of state licensing bodies, so graduates face a difficult time locating an acceptable, adequately funded postdoctoral experience.

Licensure requirements for the postdoctoral year of experience also vary, so the graduate is advised to determine the specific geographic regulations in advance of signing an employment contract. Then, the specific responsibilities of the site can be included in the negotiations so as to qualify the experience for licensure purposes. Many settings will accommodate a professional's need to acquire experience for licensure purposes, in the hopes of retaining the psychologist after licensure, as this more likely will ensure continuity in service provision to the client population. This is especially true of geographic, demographic, or institutional locations that are classified as underserved (health professional shortage area [HPSA]; see http://hpsafind.hrsa.gov). In general, however, both formal postdoctoral residency training programs and less organized experience, such as supervised employment, meet licensure standards and credentialing requirements for a health service provider in psychology.

Building upon the IOC's success in bringing together a postdoctoral accreditation system for professional psychology, the training councils in professional psychology adopted a similar model when they formed the Council of Chairs of Training Councils (CCTC), consisting of training councils as members and liaisons from licensing and credentialing bodies. The credentialing organizations in professional psychology did the same when they created the Council of Credentialing Organizations in Professional Psychology (CCOPP). The CCOPP's membership consists of the credentialing organizations (including licensure) in the United States, Canada, and now Mexico, with liaisons from the education and training community and graduate students. These organizations were initiated in the 1990s. Like the CoA, which is also interorganizational, the member organizations select the representatives for these important and sometimes policy-recommending bodies. With the many organizations in professional psychology concerned with quality assurance and accountability, and in an era of diminishing resources, interorganizational working groups make the most sense in terms of ensuring essential and relevant representation.

Global universities represent a growth industry, so major universities based in the United States are quickly establishing undergraduate and graduate programs abroad. As a matter of policy, neither the APA nor the CPA accredits programs located outside their own country. However, the ASPPB/National Register Designation Project modified the designation criteria several years ago to permit foreign program review. These programs will be held to the same criteria as programs in the United States and Canada; however, the institution where the program is located must be "accredited by a body that is deemed by ASPPB/National Register Designation Committee to be performing a function equivalent to U.S. regional accrediting bodies." It is likely that approved psychology programs in the United States may decide to offer doctoral education in psychology in foreign countries and will want those programs approved in the United States. If those programs apply for and meet the designation criteria, the key issue will be whether the state and provincial regulatory bodies will find the graduates acceptable on educational grounds.

Licensing and Credentialing

Licensing authorities determine that a psychologist meets state, provincial, or territorial requirements for entry-level, generic practice. Professional licensing has very little to do with the assurance of quality. Although most people assume it does, or wish it did, knowing that a provider is licensed assures one only that the state, province, or territory has determined him or her to possess a *minimum* level of competence. This level of competence is defined as having completed a sequence of education, training, and experience, followed by successful performance on an independent examination of knowledge and skills.

Credentialing and *certification* are terms that are often used interchangeably and usually refer to individual achievement. For instance, the university or professional school certifies to the public that the graduate has met the requirements for the degree by awarding the diploma. Certification typically indicates quality, "especially in the absence of knowledge to the contrary" (Drum & Hall, 1993, p. 151). Credentials for health care professionals are important because "in no other field does a consumer care so much about the quality of services and yet have so little ability to judge quality themselves. . . . Credentials serve as necessary proxies for direct measurement of quality" (Stromberg,1991, p. 1). Even though credentials signal distinction for

a professional, both in terms of services offered as well as in education, training, licensure, and advanced competency, compared to physicians, only a small percentage of psychologists pursue credentials beyond licensure. Credentialing organizations then assess varying levels of specialized education and training, as well as specific competencies or areas of expertise, to determine if the licensee has met national standards, which are often more stringent than licensure requirements.

Credentialing organizations have no requirement to protect the public, yet they play a significant role in this special relationship with consumers. Typically, credentialing organizations conduct primary source verification of credentials (education, training, and licensure). Thus, they provide an independent check on the accuracy and currency of these qualifications. Licensing authorities investigate and adjudicate professional misconduct complaints, and then report the information to professional organizations and credentialing bodies and the federal disciplinary health care databanks. Credentialing bodies may review and take action on disciplinary information and disseminate their actions to the public. Credentialing organizations require psychologists to report disciplinary actions as part of an annual attestation. This process holds the psychologists accountable for professional misconduct. Noting this symbiotic relationship between licensure and credentialing in terms of protecting consumers, Hall (2000) stated that "neither licensing nor certification alone is sufficient . . . [Rather,] both are needed" (pp. 317–318).

Licensure Laws

Licensing laws, established to define the practice of the profession, set educational, training, and examination standards for the profession and assist the consumer in identifying who is qualified to practice the profession. Although this is different from saying that the license assesses quality, the jurisdiction does offer a recourse for complaints against practitioners regarding professional conduct. Presently, 64 jurisdictions in the United States and Canada regulate the practice of psychology or the title of psychologist. Both types of laws attempt to protect the public by clearly identifying who is qualified to practice as a psychologist (practice including title act) or identify him- or herself as a psychologist (title only act).

Stromberg et al. (1988) explained the difference:

> Licensure is a process by which individuals are granted permission to perform a defined set of functions. If a professional performs those functions (such as diagnosing or treating behavioral, emotional, or mental disorders) regardless under what name (such as therapist, psychologist, or counselor), he is required to be licensed. In contrast, certification focuses not on the function performed but on the use of a particular professional title (such as psychologist), and it limits its use to individuals who have met specified standards for education, experience and examination performance. (pp. 1–2)

Not all jurisdictions have licensure laws. Many have certification laws, including those labeled as *permissive acts*, requiring the person to be licensed if he or she practices psychology and uses the title. In this volume, the term *license* refers to either type of regulation.

General Licensing Criteria

At present, the various admission requirements for licensure as a psychologist in the United States are similar: a doctoral degree in psychology from an approved program housed in a regionally accreditation institution of higher learning, and 2 years of properly supervised experience, 1 of which may be an internship and the other a year of postdoctoral experience. These requirements are evaluated by each jurisdiction somewhat differently in terms of implementing criteria (e.g., supervisor's qualifications, number of hours on internship), so it is advisable to complete an APA/CPA-accredited or ASPPB/National Register-designated doctoral program; to complete an APA/CPA-accredited internship, if possible; and if not, to seek an internship with an organization that is a member of the APPIC or is developed so that it meets the APPIC, CDSPP, or National Register criteria for internship. In general, it is advisable for any student to acquire the maximum number of hours on internship and in the postdoctoral year (2,000 hours) and to ascertain in advance what is required by the state of intended residency (Hall, Wexelbaum, & Boucher, 2007).

Generic Licensing

Following the tradition of other health care professions, such as medicine, generic licensing has been the model adopted by legislative bodies in seeking to regulate the practice of psychology (Stigall, 1983). This approach assumes that a common body of knowledge, skills, and ability should be mastered prior to entry into the profession, regardless of any specialty area. Using the word *generic* in reference to the license to practice also stems from the fact

that any psychologist is eligible to apply for licensure. It does not mean that a licensed psychologist is qualified to practice in any area, as ethics and professional conduct rules restrict practice to within specific areas of expertise. Continuing professional education (CPE) is required by most jurisdictions as a way of ensuring that psychologists remain current with scientific knowledge and applied skills. Criticized by many professionals as unrelated to continuing competence, CPE has face validity from the public perspective and can be a valuable tool for the expansion of practice areas after graduation.

Most graduates of professional psychology programs become licensed as psychologists. The current number of licensed psychologists at the doctoral level is approximately 92,000 (Andrew Boucher, personal communication, July 11, 2008); the exact number is unknown because some psychologists hold more than one license, and some states do not list a degree or differentiate between a master's-level and a doctoral-level psychologist. Licensing criteria are set by each jurisdiction, but have been influenced over time by a series of APA guidelines for state legislation (1955, 1967, 1987 and 2010) and by the ASPPB model for state legislation (1992, 2001 and 2010).

Health Service Provider in Psychology

The National Register was established in 1974 to meet the need for a system by which various insurers, governmental agencies, health services, and other organizations, as well as individual consumers, could identify licensed psychologists who have specific education, training, and supervised experience in health services. Given that licensure was generic, a mechanism was needed that went beyond licensure to identify qualified providers of psychological services, especially given the wide variation in states' requirements. Although licensing was *necessary*, it alone was not sufficient to identify a qualified health care provider.

Both the ABPP and the APA played a role in the establishment of a credential that did provide the *sufficient* information. The APA Board of Professional Affairs formally voted on October 1, 1973, to recommend that the APA request the ABPP to establish a National Register of Health Service Providers in Psychology; on March 1, 1974, the ABPP Board of Trustees voted to implement the project. On June 1, 1974, the initial meeting of the 12-member Council for the National Register of Health Service Providers in Psychology was held, the *Health Service Provider in Psychology* was defined, and the criteria for credentialing were established.

A *Health Service Provider in Psychology* is defined as:

> [A] psychologist currently and actively licensed/certified/registered at the independent level in a jurisdiction, who is trained and experienced in the delivery of direct, preventive, assessment and therapeutic intervention services to individuals whose growth, adjustment, or functioning is impaired or to individuals who otherwise seek services.
> (National Register of Health Service Providers in Psychology, 2011)

On September 1, 1974, a joint letter from APA President Bandura and National Register Chairman Zimet was sent to 40,000 psychologists soliciting applications for credentialing by the National Register. More than 11,000 licensed psychologists applied and met the criteria during the grandparent period, which ended January 1, 1978.

Note that this more inclusive definition of psychological practice did not refer to a specialty title. However, credentialing by the National Register provided more protection to the consumer seeking psychological services than did a generic license. After the National Register's success, several state licensure boards decided to adopt the criteria for their own provider certification, first in 1978 in Texas, and soon after in eight more states (Indiana, Iowa, Kentucky, Oklahoma, Missouri, Massachusetts, North Carolina, and Tennessee). The National Register also formed the basis for the later development of the Canadian Register in 1985. Today, approximately 11,000 psychologists are credentialed by the National Register as health service providers in psychology, with 1800 credentialed by the Canadian Register (see Wise, Hall, Ritchie & Turner, 2006, for a discussion of both registers).

Clinical Versus Professional Psychologist

The necessity to be inclusive within the area of health care is highlighted by the original federal legislation for Medicare reimbursement. Rather than choosing the term *professional psychologist*, which would have avoided many of the definitional problems that ensued, *clinical psychologist* was selected and predictably defined as someone who graduated from a clinical psychology program. (The intended reference was to psychologists providing health care.) Although this narrower legal definition would have applied to the majority of graduates of professional psychology programs, it would have eliminated many qualified health service psychologists from providing needed services to Medicare patients, such as counseling psychologists. The word *clinical*

in other fields is an adjective that distinguishes provision of services from other roles in education and research, such as clinical medicine and clinical social work. This "small c clinical" problem became a major problem in terms of reimbursement for those other qualified psychologists. Many years later, and in response to public comments, the Center for Medicare and Medicaid Services defined clinical psychologists as persons who hold doctoral degrees in psychology and are state licensed at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services (Health Care Financing Administration, 2000).

From the perspective of serving the public's health care needs, psychologists are essential team members in integrated health care. Psychologists serve as behavioral experts, reducing overall medical costs, enabling consumers to adhere to medical regimens, helping physicians make medical decisions on the appropriate medication, and choosing the best behavioral practices for treatment of mental health and addictions. Excellent tools are available to guide the psychologist's choice of the best evidence-based practices (Norcross, Hogan, & Koocher, 2008). In addition, psychologists are essential to the education, training, and practice of physicians and other health care professionals. Although many organized practice settings, such as the United States Department of Veterans Affairs, incorporate an integrated health care model, it is not restricted to institutional practice; it is however, central to the practice of primary care physicians and other group practices seeking to serve patients with a comprehensive approach to health care.

The concept of a health care/health service provider exists throughout health care and is not specific to psychology. However, when the National Register was initiated in 1974, it was a new concept for psychology, partly because of its prior focus on serving the mental health needs of the public. Since then, this definition has been adopted by other professional organizations and state licensing boards. The APA has included health in its mission statement. The broad definition of a health service provider in psychology was developed especially to address psychology's uniqueness as both a profession and a science; this definition does not describe a specialty area, but offers a definition of desired services tied to a doctoral degree in psychology and training (internship and postdoctoral year) in health service. It helped define psychology as essential to the health care system, and in understanding and evaluating the body–mind interrelationship as crucial to improvement in functioning. Psychologists who complete approved counseling psychology doctoral programs, as well as an internships and postdoctoral experience in health service, are eligible for credentialing as health service providers immediately upon licensure.

Credentialing

In deciding whether to pursue credentialing, it is important to separate credible credentials from those that are not, determine eligibility for credentialing, and evaluate the benefits offered by the credentialing organization. For a full discussion of these issues, see Hall and Boucher (2008). The large number of credentials available to professional psychologists necessitates careful evaluation by the consumer. For example, this author includes a list of 52 different acronyms for specialty and proficiency credentialing organizations in her presentations to doctoral psychology students.

From the public perspective, as Stromberg (1991) noted, "credentialing performs a valuable role by reducing *search costs* for consumers or payers who seek information about the qualifications of a large universe of providers." Credentialing organizations provide a public service by "efficiently disseminating information to the marketplace with respect to the training and expertise of health care providers" (*MacHovec v. Council*, 1985). According to Stromberg (1990), "certification is a process by which government or a private association assesses a person, facility, or program and states publicly that it meets specific standards" (p. 1). These standards are considered to be significant measures. Accreditation and designation are approval mechanisms that refer to the certification of programs, whereas credentialing applies to certification of individuals.

The CCOPP, the organization for credentialing organizations, recently completed a comprehensive sequential analysis of the roles played by the various credentialing organizations in specialization. The conceptual document provides another frame of reference for understanding specialization. (See http://www.nationalregister.org/CCOPP.pdf for more information.)

Once licensed, a psychologist is typically eligible for credentialing as a health service provider in psychology in the United States and Canada, followed by specialty board certification in the United States (few Canadian psychologists seek specialty board certification). Although there are many such certification bodies, only one specifically for counseling

psychologists is offered by the ABPP. As of February 17, 2011, there were 166 psychologists with ABPP specialty certification in counseling psychology. Also, of the existent board certification bodies in psychology, only the ABPP is included in a number of state regulations to offer some degree of mobility to its 2948 psychologists (Nancy McDonald, personal communication, February 17, 2011).

The ASPPB offers the certificate of professional qualification (CPQ) to psychologists with five years of licensure experience. As of 3/11/11 the CPQ is held by 2608 licensed psychologists. It was created in 1998 to enhance mobility for licensed psychologists. During its grandparenting period (until 2001), licensed psychologists credentialed by the National Register or ABPP qualified for an expedited review.

Ethical and Professional Conduct

As a doctoral student moves through the sequence, there are repeated opportunities in which issues of being responsible for adhering to scientific and professional ethics arise (e.g., research, practica, internship). Then, as that individual becomes licensed and subsequently credentialed, additional ethical guidelines and professional conduct codes pertain (for instance, annual attestation of any ethical complaints/adjudications). At the time of licensure, the applicant is typically required to be examined about the laws and regulations that apply to practice in that jurisdiction. Licensed professionals are expected to adhere to these ethical and professional conduct codes by virtue of membership in those associations and for renewal of state and national credentials.

The APA (2002) and the CPA (2000) each has its own code of ethics and an ethics committee that educates members and adjudicates complaints. If a professional is licensed in two professions (psychology and counseling), the provisions of both ethics code apply (and may conflict). Ethics and professional conduct is a cornerstone in accountability, and the active monitoring of these responsibilities is itself a responsibility of the profession. Ritchie (2008) addresses this accountability in an excellent chapter while referencing international developments in ethics codes. A comprehensive discussion on this topic is also available in this volume (Vasquez & Bingham, 2011, Chapter 10, this volume).

Challenges to Accountability

Professional educators and practitioners frequently debate the merits of programs housed in distance education or online universities, the current status of the definition and assessment of competencies, and barriers to international mobility. These issues are central to issues of accountability and quality assurance today.

Distance Learning and Online Education

Distance education is a thriving industry, with many companies publicly traded. Investors have seen their stocks increase in value and pay dividends. Historically, higher education was not for profit. That has changed. Other changes relate to the significant and pervasive use of technology in education. According to a survey conducted in 2000–2001, college-level, credit-granting distance education courses are offered at the graduate level by 22% of all institutions. Furthermore, college-level, credit-granting distance education courses are offered at the graduate/first-professional level by 52% of institutions that have graduate/first-professional programs (USDOE National Center for Education Statistics, 2003).

The defining characteristic of distance programs is that students and faculty are geographically dispersed. Because online courses are the most common form of distance education, there is a tendency to assume that distance programs are exclusively provided over the Internet. However, the modalities inherent in distance education are many, including methods involved in campus-based education. Distance learning appeals to those with undergraduate or master's degrees without easy access to traditional residency-based professional schools or university programs and who are unable to move or wish to remain in their geographic location. The typical consumer is the adult learner. However, this group may include students who are either not admitted to or cannot afford tuition in doctoral residency-based programs. Murphy, Levant, Hall, and Glueckauf (2007) report the results of an APA Task Force that examined these issues in 2001, described educators' opinions on best practices, and reviewed the implications of the 1996 CoA accreditation standards for distance education programs.

For those seeking to become professional psychologists, these programs carry considerable risk, as few are approved by licensing bodies for admission to the profession. Such a program faces challenges in ensuring that the scientific foundation in psychology is acquired in an organized sequence that is developmentally complex, that the faculty and students interact effectively with each other, and that outcomes are measured adequately—all at a doctoral level. Integration of the training aspects

of education, such as practicum or the laboratory, presents an even greater task within this type of model.

These programs attempt to match (or some would argue exceed) the quality assurance and accountability dimensions inherent in more traditional doctoral programs. A cornerstone of campus-based programs is a mandated residency period. Historically, residency was the mechanism that provided for immersion in the discipline, socialization into the profession, and oversight by a faculty of the developing competencies essential for entry to independent practice (Nelson et al., 2008). Implementing residency in a professional program that is totally online constitutes an even greater challenge. (Jones International University, a totally online university, is now regionally accredited by the North Central Association.)

In 2011, two CoA-accredited programs employ distance education techniques as a major facet of doctoral education. The Philadelphia College of Osteopathic Medicine uses both traditional methods of education and training at a central site and at an extension campus where students meet in traditional classroom formats and interact through teleconferencing. The Fielding Graduate University exemplifies a distributed educational model organized into clusters of students at various sites that also uses electronically mediated instruction. No primarily distance education programs have met the requirements for the ASPPB/National Register designation, although several programs have been evaluated.

The role of distance education programs for psychology is unique among health care professions in which the doctorate is the entry level for professional practice. Medicine and dentistry use distance education programs primarily for upgrading degrees and certifications beyond the entry level. This separates out the important issue of qualification for independent practice from continuing professional education.

Competency Assessment

At the same time that the USDOE underscored a need to improve the quality assurance process involved in higher education, the CoA began to require programs to specify expected, essential competencies and to report information on student learning outcomes. As outcomes vary as a function of the model adopted by the program, what was needed was agreement on the core competencies for psychologists entering independent practice. Previously, the psychologist was considered ready for independent practice upon completion of a sequence of education and training that included doctoral program, practicum, internship, and post-doctoral year of experience. That sequence was articulated through various model acts from the APA and ASPPB but questioned by various training conferences and in other organized meetings. For instance, could the internship take place after the doctoral degree? Or, was the psychologist ready for independent practice once the doctoral degree was granted?

With the movement toward competency assessment and foundations on which competencies were essential, it was decided to examine carefully the steps in the sequence to determine if one did lead to the other in terms of the acquisition of essential competencies. Multiple factors impacted on these various developments.

Since the original model licensure act (APA, 1955), many changes in doctoral education and training occurred, related to the location of doctoral education, the number of students admitted per year, the extent of the practicum, the diversity of internship experiences, and the increasing adoption of the postdoctoral year as a standard for licensing laws and the variability in licensure rules. The latter led to difficulty in mobility.

Following the creation of the American Psychological Association Graduate Students (APAGS) in 1988, students actively represented their perspective throughout organized psychology. Psychology's status in the health care marketplace, length of training in comparison to other health care professions, problems finding effective and supported internship and postdoctoral training, and the tremendous debt load assumed by some students were identified as critical issues for the profession and a burden for those entering the profession. Thus, in 2000, the APA invited 30 commissioners selected from a wide range of constituencies to a meeting which recommended changes to the sequence of education and training leading to licensure (APA, 2001).

This potential policy change meant that it was very important to define the competencies of licensed psychologists and to determine when in the sequence those were attained. It also shifted the proof of competence from the postdoctoral year to internship completion. Several organizations urged caution in implementing this recommendation without collecting more information. Thus, an agreement was reached to obtain the needed information

and to consider the policy change for official approval 5 years later.

Multiple efforts followed. The APPIC sponsored the Competencies Conference in 2002 (Kaslow, 2004; Kaslow et al., 2004). At about the same time, Hatcher and Lassiter's practicum competencies document was drafted as a follow-up to the 2001 APA Education Leadership Conference and approved in 2005 by the relevant constituencies (go to http://www.APTC.org). The APPIC urged the APA to carefully examine the impact of not requiring a year of postdoctoral experience for licensure by convening another conference to develop the benchmarks for competencies at all levels of education and training. If the levels could be integrated and coordinated, and changes to the practicum and the internship made, it was more likely that the proposed change of not requiring the postdoctoral year for a license would succeed.

Thus, in 2006, the APA Council of Representatives approved a change in APA policy, namely that licensure applicants be allowed to complete a sequential, organized, supervised professional experience equivalent to 2 years of full-time training *prior or subsequent* to the granting of the doctoral degree. The policy clarified that, for applicants intending to practice in the health services domain of psychology, one of those 2 years of supervised professional experience was the doctoral internship (APA, 2006). This decision implied that state regulatory bodies should be encouraged to offer applicants a choice of completing required supervised hours either before or after the internship, or some combination of both. This policy did not dismiss the year of postdoctoral experience and reminded us that "postdoctoral education and training remains an important part of the continuing professional development and credentialing process for professional psychologists. Postdoctoral education and training is a foundation for practice improvement, advanced competence, and inter-jurisdictional mobility" (APA, 2006).

Instead of holding a conference, as the APPIC recommended in 2007, the APA Board of Educational Affairs decided to fund a benchmarks workgroup to build upon what had already been completed by the APTC for practicum. A group of 32 psychologists participated in the Assessment of Competencies Benchmarks Work Group and developed a model for defining and measuring competence in professional psychology (APA, 2007).

> Because the group was so inclusive, because the rough draft was of high quality, and because the process for further revisions was so open, APPIC did not see a need to establish a separate process devoted exclusively to internship or postdoctoral benchmarks.
>
> (Stephen R. McCutcheon, personal communication, June 30, 2008)

The document is still evolving based upon public comment and continued refinement by various task forces. Interested parties can follow further developments by visiting the CCTC website periodically to look for updates (http://www.psychtrainingcouncils.org/documents.html).

Thus, psychology appears to be in transition, from an input to an output model of quality assurance. Although unlikely to ever relinquish the former completely (degrees remain necessary), considerable time and expertise have been applied toward the latter, with more to come.

PRACTICUM COMPETENCE

The Practicum Competency Outline approved in 2005 describes the baseline competencies needed to enter practicum training and the 11 competency domains that are the focus of that training. Using that outline, psychology training clinics can develop their own competency-based student evaluations (rated as novice, intermediate, or advanced) of the essential practicum competencies. In addition, this methodology can be used to collect objective data about specific training sites, thereby providing a frame of reference for prospective students, and a method for relating the practicum and doctoral program's goals. Updates to the outline will be posted online (http://www.aptc.org).

INTERNSHIP COMPETENCE

Currently, licensing bodies and credentialing organizations view the internship, and in most states, the postdoctoral year of supervised experience, as necessary supplements to the doctoral education in determining readiness for practice. The internship's purpose is to provide developing psychologists with the opportunity to master more skills. Some skills are introduced in practicum; others may be reserved for the internship. The identification and assessment of specific competencies is handled by each internship site, using multiple methods, such as observation of clinical work, apprenticeship to individual mentors, presentations to clinical seminars, and various evaluation tools including self assessment. The internship provides a much more extensive period (1 year full-time or 2 years half-time)

for the refinement of competencies than does practicum. At the conclusion of the internship, the director certifies to the licensing/credentialing body the completion of a satisfactory internship experience.

Although programs (doctoral degree and internship) engage in formative evaluations (process) and summative evaluations (outcomes) throughout the education and training sequence, there is no independent performance examination as part of the psychologist licensing process that directly assesses competence in practice. Also, if no postdoctoral year is required for a license, the graduate is deemed qualified for licensure at the successful completion of the internship. The policy change regarding the sequence of education and training leading to licensure has heightened the awareness of internship directors that they are more directly responsible for ascertaining readiness for independent practice. It remains unclear whether this realization means that the training directors will become more vigilant about signing off on the internship as satisfactory only when they have determined that the person is indeed competent.

POSTDOCTORAL COMPETENCE

The third component in the sequence is the year of postdoctoral supervised experience or postdoctoral residency training. The CoA guidelines for accreditation of postdoctoral education and training programs are parallel to those adopted for programs and internships. A judgment is made on the degree to which the program achieves the goals and objectives specified in its training model. It should be "of sufficient breadth to ensure advanced competence as a professional psychologist and of sufficient depth and focus to ensure technical expertise and proficiency in the substantive traditional or specialty practice areas" (APA, 2009, p. 22). The length of the program may vary from 1 year up to 3 for some specialty areas.

The traditional substantive areas include counseling psychology. The specialty practice areas include clinical neuropsychology, clinical child, and rehabilitation psychology. To accomplish the accreditation of specialty postdoctoral residencies, the organizations that represent the specialty each developed their specialty-specific education and training guidelines. These organizations serve on the Council on Specialties (CoS). The CoS was formed upon the recommendation of the IOC, when it ceased operation, as essential to ensuring quality and self-governance in postdoctoral training. (See http://www.cospp.org for more information.) Thus, although no document parallel to the practicum competencies outline exists for internships or for traditional substantive postdoctoral training, given the continuing dialogue by organized psychology in determining how to assess competencies across the development of the professional, it should emerge.

Prior to this change in policy, Alabama was the only state that allowed independent practice at the doctoral level without requiring a year of postdoctoral experience. Today 11 states offer licensure at the culmination of the doctoral degree, based upon documentation of sufficient supervised experience, including an internship, while in doctoral training. These include Alabama, Arizona, Connecticut, Indiana, Maryland, Ohio, Kentucky, North Dakota, Utah, Washington and Wyoming. For instance, Washington was the first to implement regulations allowing the 2 years to be completed before graduation, with 1 of the years being practicum (or postdoctoral year) and the other an internship. The supervision topics required for the practicum are extensive and may be more complex and difficult to implement than typical for practicum. A careful reading of those criteria is essential if planning to use those practicum hours toward licensure. It is entirely possible that the applicant will find the postdoctoral year of supervised experience more easily satisfied. Completing the postdoctoral year has the added benefit of meeting the requirements for mobility. Regardless of whether it remains linked to the licensure requirements, the postdoctoral experience (before or after licensure) is important for advanced specialization/competency, licensure mobility, and continuing professional development. For instance, credentialing mechanisms such as the CPQ and the National Register require a year of postdoctoral experience (Hall & Boucher, 2003).

International Mobility

We have focused on the United States, and to some degree, Canada, in discussing the professional issues involved in education, training, licensing, and credentialing. However, psychologists increasingly seek employment or training opportunities abroad. For that to happen, at least for licensed psychologists, it is important to understand other countries' perspectives on the preparation of psychologists. There are positive signs that indicate that psychology may be ready to meet the needs of a global population. First, the numbers of psychologists and psychology students are increasing worldwide, and the definition

of a psychologist is becoming articulated internationally. At the same time, psychologists are forming organizations within and across borders to promote globalization of practice. Advances in technology make it more likely that expertise can be widely disseminated and services provided across borders.

Countries and geographical regions have developed their own systems of accountability. As psychology operates within a societal context, its manifestation varies considerably from country to country. Some examples of different systems of accountability noted by Altmaier and Hall (2008) follow.

Regulatory

In the United States and Canada, systems of credentialing are regulated by 64 licensing bodies. Mobility mechanisms developed by credentialing organizations (ABPP, ASPPB, Canadian Register and the National Register) assist mobility within and between these two countries, and the Mutual Recognition Agreement promotes mobility for psychologists within Canada. (See http://www.cpa.ca/psychologyincanada/psychologyintheprovincesandterritories for more information.)

Independent

European countries do not adhere to a specific template for regulation of the practice of psychology. Governmental licensing does not exist in all 43 countries. However, compliance with the Bologna Declaration may raise the standard of education offered in universities, which, in turn, may lead to a more universal criterion for the education required for a license (Lunt, 2008).

Collaborative

Australia's system is managed by cooperation between the professional association and the regulatory boards and has a mutual recognition agreement with New Zealand. More importantly, the five states and two territories now implement national licensure (Waring, 2008).

Evolving

Mexico ties federal licensing to a specific degree and a social service requirement. Now under way is a newly established accreditation system and a postlicensure examination with opportunities for specialized certification. Its national licensing is similar to other countries in Central and South America and Spain (Hernández Guzmán & Sanchez-Sosa, 2008).

Psychologists in training today in the United States increasingly seek the opportunity to obtain part of their education and training outside the United States and Canada. These individuals want to be able to qualify for licensure in the United States when they return. Because of the variability in models of education, training, and recognition/licensure outside the United States and Canada, this can be risky to achieve. Currently, there is no guarantee that state licensure boards will accept supervision by an individual who meets the recognition requirements or licensure in another country if not also licensed in the United States. For a thorough review of some of the mechanisms and the challenges to international mobility, see Bullock and Hall (2008).

North American Mobility

Anticipating more global activity due to the North American Free Trade Agreement (NAFTA) signed in 1993, psychologists from the three signatory countries participated for 11 years in the Trilateral Forum on Professional Psychology, primarily to compare structure and process for education and training in the U.S., Canada, and Mexico. Whether or not directly related to those efforts, substantial changes did occur over that time period in Mexico's accreditation and certification process. At the same time, mobility was facilitated for psychologists at the doctoral level between the United States and Canada and within Canada. Mobility has not been achieved between Mexico and the United States and Canada primarily due to an inability to compare outcomes from education and training. Thus, determining comparability of education and training could be solved with competency-based assessments (outcomes).

Beginning in the late 1990s, emphasis was placed on enhancing the mobility of psychologists within the United States. Multiple mechanisms now exist, each with different criteria and purposes, with the foundation being a license to practice psychology in at least one jurisdiction, and the goal to facilitate virtual or geographic mobility (Hall & Boucher, 2003). Such mobility serves a public purpose as well, in that delays in obtaining a license are decreased and faster access to services is provided the public. Often, newly licensed psychologists are most interested in and seeking mobility. (See http://www.nationalregister.org/mobility.htm for up-to-date information.)

A majority of the jurisdictions in the United States and Canada have incorporated one or more

mechanisms in laws or regulations permitting psychologists with specialty board certification (ABPP), mobility certificate (CPQ), or health service provider certification (National Register) to expedite their license acquisition in the United States and Canada without waiting or without being examined again, except for a jurisprudence examination. Thus, having mobility or expedited licensure is a major benefit of credentialing, and is reported by early career psychologists as the major reason for applying for credentialing (Hall & Boucher, 2008).

Conclusion

Psychology meets its accountability requirement as a profession in many ways. It reviews and approves education and training programs based upon national criteria using both formative and summative evaluations. It requires professional psychologists to be individually evaluated for licensure and credentialing. These evaluations take place at the state and national level. The move to assess competencies in practicum and internship will assist students in directing their focus on which experiences will make them a more effective psychologist, qualified for independent practice and competitive in the health care marketplace. A similar evolution will eventually occur for postdoctoral training, as it is necessary for advanced competence, mobility, and specialization. Accountability also includes monitoring psychologists' practice to protect the public. Monitoring ethical conduct is supported by the efforts of licensing boards and national credentialing bodies. Ultimately, the profession is accountable to the consumer; self-regulation is the key to meeting this responsibility.

Consumers have opinions about who is best suited to address their issues. Their participation is fostered by the direct representation on policy-establishing and implementing organizations and by direct feedback on the quality of services provided. As pointed out by Stricker, "the rise in consumer voice increases the pressure on psychological groups to self-regulate" (p. 212).

References

Altmaier, E. M., & Hall, J. E. (2008). Introduction to international quality assurance for psychology. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 3–15). New York: Oxford University Press.

American Psychological Association. (1987). Model act for state licensure of psychologists. *American Psychologist*, *42*, 696 –703.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1060–1073.

American Psychological Association. (2007). *Competency Benchmarks Work Group*. Retrieved June 28, 2008, from http://www.apa.org/ed/graduate/competency.html.

American Psychological Association. (2010). *Model Act for State Licensure of Psychologists*. http://www.apa.org/about/governance/council/policy/model-act-2010.pdf Accessed March 12, 2011.

American Psychological Association, Committee on Accreditation. (1996). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: Author.

American Psychological Association, Committee on Accreditation. (2009). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: Author.

American Psychological Association, Committee on Counselor Training, Division of Counseling and Guidance. (1952). Recommended standards for training counseling psychologists at the doctoral level. *American Psychologist*, *7*, 175–181.

American Psychological Association, Committee on Definition, Division of Counseling Psychology. (1956). Counseling psychology as a specialty. *American Psychologist*, *11*, 282–285.

American Psychological Association, Committee on Legislation. (1955). Joint report of the APA and CSPA (Conference of State Psychological Associations). *American Psychologist*, *10*, 727–756.

American Psychological Association, Committee on Legislation. (1967). A model for state legislation affecting the practice of psychology 1967: Report of the APA Committee on Legislation. *American Psychologist*, *22*, 1095–1103.

American Psychological Association, Council of Representatives. (2006, February). *Minutes*. Washington, DC: Author.

American Psychological Association, Council of Representatives. (1995, February). *Minutes*. Washington, DC: Author.

Association of Psychology Postdoctoral and Internship Centers. (2011). *Match statistics*. Retrieved April 13, 2011, from http://www.appic.org/match/5_2_2_1_10_match_about_statistics_general_2011Comb.html.

Association of Psychology Postdoctoral and Internship Centers. (2008, May). *APPIC e-newsletter*. Retrieved June 24, 2008, from http://appic.org/news/Newsletter/May2008.pdf.

Association of State and Provincial Psychology Boards. (1992). *Model act for licensure of psychologists*. Montgomery, AL: Author.

Association of State and Provincial Psychology Boards. (2001). *Model act of licensure for psychologists*. Montgomery, AL: Author.

Association of State and Provincial Psychology Boards. (2010). *Model act of licensure for psychologists*. Montgomery, AL: Author.

Belar, C. D., Bieliauskas, L. A., Klepac, R. K., Larsen, K. G., Stigall, T. T., & Zimet, C. N. (1993). National Conference on Postdoctoral Training in Professional Psychology. *American Psychologist*, *48*, 1284–1289.

Bent, R. J., Packard, R. E., & Goldberg, R. W. (1999). The American Board of Professional Psychology, 1947 to 1997: A historical perspective. *Professional Psychology: Research and Practice*, *29*, 65–73.

Bullock, M., & Hall, J. E. (2008). The promotion of international mobility. In J. E. Hall, & E. M. Altmaier (Eds.), *Global*

promise: Quality assurance and accountability in professional psychology (pp. 216–231). New York: Oxford University Press.

Canadian Psychological Association. (2002). *Accreditation standards and procedures for doctoral programmes and internships in professional psychology*. Ottawa, CA: Author. Retrieved June 24, 2008, from http://www.cpa.ca/accreditation.

Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa, CA: Author. Retrieved July 10, 2008, from http://www.cpa.ca/publications.

Drum, D. J., & Hall, J. E. (1993). Psychology's self-regulation and the setting of professional standards. *Applied and Preventive Psychology*, *2*, 151–161.

Gelso, C., & Fretz, B. (2001). *Counseling psychology*. Orlando, FL: Harcourt Brace.

Goodstein, L. D., & Ross, S. (1966). Accreditation of graduate programs in psychology. *American Psychologist*, *21*, 218–223.

Hall, J. E. (2000). Licensing and credentialing as quality management tools in behavioral health care. In G. Stricker, W. G. Troy, & S. A. Shueman (Eds.), *Handbook of quality management in behavioral health* (pp. 317–332). New York: Kluwer Academic/Plenum.

Hall, J. E., & Boucher, A. P. (2003). Professional mobility for psychologists: Multiple choices, multiple opportunities. *Professional Psychologist: Research and Practice*, *34*, 463–467.

Hall, J. E., & Boucher, A. P. (2008). Early career psychologists' knowledge of credentialing in professional psychology. *Professional Psychology: Research and Practice*, *39*, 480–487.

Hall, J. E., & Sales, B. D. (2002). *Evolution of specialty credentialing in professional psychology*. Unpublished manuscript.

Hall, J. E., Wexelbaum, S., & Boucher, A. P. (2007). Doctoral student awareness of licensure, credentialing, and professional organizations in psychology: The 2005 National Register international survey. *Training and Education in Professional Psychology*, *1*, 38–48.

Health Care Financing Administration. (2000). *Medicare claims manual*, Part 3: *Claims processes*. Section 2150 clinical psychologists services. Retrieved July 2, 2008, from www.cms.hhs.gov/transmittals/downloads/R1660B3.pdf.

Hernández Guzmán, L., & Sanchez-Sosa, J. J. (2008). Practice and professional regulation of professional psychology in Latin-America. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 109–127). New York: Oxford University Press.

Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist*, *59*, 774–781.

Kaslow, N. J., Borden, K. A., Collins, F. L., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., et al. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology*, *80*, 699–712.

Lunt, I. (2008). Professional mobility and quality assurance within the European Union. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 128–139). New York: Oxford University Press.

MacHovec v. *Council for the National Register of Health Service Providers in Psychology*, 616 F. Supp. 258, 271 (E.D. Va. 1985).

Mayne, T. J., Norcross, J. C., & Sayette, M. A. (2006). *Insider's guide to graduate programs in clinical and counseling psychology*. New York: Guilford Press.

Miville, M. L., Adams, E. M., & Juntunen, C. L. (2007). Counseling psychology perspectives on the predoctoral internship supply-demand imbalance: Strategies for problem definition and resolution. *Training and Education in Professional Psychology*, *1*, 258–266.

Murphy, M. J., Levant, R. F., Hall, J. E., & Glueckauf, R. L. (2007). Distance education in professional training in psychology. *Professional Psychology: Research and Practice*, *38*, 97–103.

National Register of Health Service Providers in Psychology. (2011). *Health service provider in psychology*. Retrieved April 14, 2011from http://www.nationalregister.org/about_NR.html.

Nelson, P. D., Belar, C. D., Grus, C. L., & Zlotlow, S. (2008). Quality assessment in higher education through accreditation. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 16–37). New York: Oxford University Press.

Nelson, P. D., & Messenger, L. C. (2003). Accreditation in psychology and public accountability. In E. M. Altmaier (Ed.), *Setting standards in graduate education: Psychology's commitment to excellence in accreditation* (pp. 7–38). Washington, DC: American Psychological Association.

New York State Doctoral Evaluation Project. (1990). *Doctoral education in psychology*. Doctoral Evaluation Project, New York State Education Department, Albany NY 12230.

Norcross, J. C., Hogan, T. P., & Koocher, G. P. (2008). *Clinician's guide to evidence-based practices: Mental health and the addictions*. New York: Oxford University Press.

Pellegrino, E. D. (1991). Trust and distrust in professional ethics. In E. D. Pellegrino, R. Veatch, & J. Langan (Eds.), *Ethics, trust and the professions* (pp. 69–89). Washington, DC: Georgetown University Press.

Raimy, V. C. (Ed.). (1950). *Training in clinical psychology*. New York: Prentice Hall.

Ritchie, P. L.-J. (2008). Codes of ethics, conduct, and standards as vehicles of accountability. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 73–97). New York: Oxford University Press.

Rodolfo, E. R., Owen, J. J., & Clark, S. (2007). Practicum training hours: Fact and fantasy. *Training and Education in Professional Psychology*, *1*, 64–73.

Sales, B. D., Bricklin, P., & Hall, J. E. (1983). *Manual for the identification and continued recognition of proficiencies and new specialties in psychology* [Draft report of the subcommittee on specialization]. Washington, DC: American Psychological Association.

Sales, B. D., Bricklin, P., & Hall, J. (1984a). *Specialization in psychology: Principles* [Draft report of the subcommittee on specialization]. Washington, DC: American Psychological Association.

Sales, B. D., Bricklin, P., & Hall, J. E. (1984b). *Specialization in psychology: Procedures* [Draft report of the subcommittee on specialization]. Washington, DC: American Psychological Association.

Service, J., Sabourin, M., Catano, V. M., Day, V., Hayes, C., & MacDonald, G. W. (1989). *Report of the CPA/CPAP Specialty Designation Task Force*. Ottawa, CA: Canadian Psychological Association.

Skrtic, T. M. (1991). *Behind special education: A critical analysis of professional culture and school organization*. Denver: Love.

Stigall, T. T. (1983). Licensing and certification. In B. D. Sales (Ed.), *The professional psychologist's handbook* (pp. 285–337). New York: Plenum.

Stricker, G. (2008). Quality assurance in professional psychology education. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 199–215). New York: Oxford University Press.

Stromberg, C. D. (1990, May). *Associations' certification programs: Legal and operational issues*. Paper presented at the meeting of the American Speech and Hearing Association, Rockville, MD. Unpublished manuscript.

Stromberg, C. D. (1991, April). *Healthcare credentialing: Implications for academic health centers*. Paper presented at the meeting of the Academic Health Centers, Washington, DC. Unpublished manuscript.

Stromberg, C. D., Haggarty, D. J., Liebenluft, R. F., McMillian, M. H., Mishkin, B., Rubin, B. L., et al. (1988). *The psychologist's legal handbook*. Washington, DC: National Register of Health Service Providers in Psychology.

Thompson, A. S., & Super, D. E. (Eds.). (1964). *The professional preparation of counseling psychologists: Report of the 1964 Greystone Conference*. New York: Teachers College.

U.S. Department of Education, National Center for Education Statistics. (2003). *Distance education at degree-granting postsecondary institutions: 2000-2001* (NCES 2003-017). Washington, DC: Author.

Vasquez, M. J. T., & Phillips Bingham, R. (2011). Ethics in counseling psychology. In E. M. Altmaier, & J. C. Hansen (Eds.), *The Oxford handbook of counseling psychology*. New York: Oxford University Press.

Waring, T. (2008). The regulation of psychology in Australia. In J. E. Hall, & E. M. Altmaier (Eds.), *Global promise: Quality assurance and accountability in professional psychology* (pp. 164–185). New York: Oxford University Press.

Watkins, C. E. (1984). Counseling psychology versus clinical psychology: Further explorations on a theme or once more around the "identity" maypole with gusto. *The Counseling Psychologist*, *11*, 76–92.

Wellner, A. M. (Ed.). (1978). *Education and credentialing in psychology: Proposal for a national commission in education and credentialing in psychology*. Washington, DC: National Register of Health Service Providers in Psychology.

Williams-Nickelson, C., Prinstein, M. J., & Keilin, W. G. (2008). *Internships in psychology: The APAGS workbook for writing successful applications and finding the right fit*. Washington, DC: American Psychological Association.

Wise, E. H., Hall, J. E., Ritchie, P. L.-J., & Turner, L. C. (2006). The National Register of Health Service Providers in Psychology and the Canadian Register of Health Service Providers in Psychology. In T. J. Vaughn (Ed.), *Psychology licensure and certification: What students need to know*. Washington, DC: American Psychological Association.

CHAPTER

3 The Counseling Relationship

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Abstract

Counseling psychology offers a distinctive perspective on the therapeutic relationship, one that is grounded in the discipline's history, values, and professional identity. In the current work, selections from one of the field's pioneers, Leona Tyler, introduce key areas of contemporary research and theory on the counseling relationship. The chapter begins with an examination of early formulations of the therapeutic relationship, the historical context in which they emerged, and early efforts to investigate its role in psychotherapy. Next, enduring themes within relationship research, as well as key contemporary concerns, are surveyed, with an emphasis on the distinctive contributions of counseling psychologists. Closing sections of the chapter identify emerging areas of research, particularly as they relate to traditional counseling psychology concerns, and propose potentially useful avenues for further investigation of the dynamic and interdependent character of counseling relationships.

Keywords: counseling psychology, counseling relationship, therapeutic relationship, therapeutic alliance, history of psychology

> [I]t is the relationship with the counselor that makes the difference. . . . It is because of this principle that recent writers on the counseling process are stressing relationships rather than techniques, the general structure of the situation rather than specific rules about what to do and say.
>
> —Leona Tyler, *The Work of the Counselor* (1953, p. 17)

The field of counseling psychology encompasses extraordinary diversity in research and practice, yet the phenomenon known as "the counseling relationship" has been a source of perennial interest and investigation. Repeated references to the counseling relationship in counseling psychology's self-descriptions (Howard, 1992; Packard, 2009) suggest that the relationship lies at the heart of our field's identity as a specialization within applied psychology and that counseling psychology's perspective on the relationship is a core element differentiating the field from other areas of applied psychology. Notably, concern with the relationship was visible at the outset of the field's emergence. Leona Tyler, one of the field's pioneers, assigned a central role to the counseling relationship in the three editions of her influential text, *The Work of the Counselor* (1953, 1961, 1969), and her assertion that "it is the relationship with the counselor that makes the difference. . . ." (1953, p. 17), was echoed in Packard's 2008 Leona Tyler Award Address, in which he identified nine core values for counseling psychology; the second of which is, "Positive relationships are a necessary condition for stimulating change in those we seek to help" (2009, p. 622).

Research on the counseling relationship has begun to accelerate and assume new prominence within applied psychology, along with convincing documentation of its role in therapeutic outcomes

(see Norcross, 2002a). But, before examining contemporary research on the counseling relationship, it is informative to consider the historical context of counseling psychology's contribution. In this chapter, rather than attempt to address the full spectrum of relationships research (see Norcross, 2002a, for a synthesis), my goal is to present an explicit counseling psychology perspective on the counseling or therapeutic relationship. I propose to do so in three areas: First, for those new to this literature (or for those who may have forgotten), I will examine early formulations of the therapeutic relationship, the historical context in which they emerged, and early efforts to investigate its role in psychotherapy. Second, in discussing key contemporary areas of research on the counseling relationship, there will be an emphasis on the distinctive contributions of counseling psychologists, as well as attention to enduring themes within relationship research. Closing sections of the chapter will identify emerging areas of research on the counseling relationship, particularly as they relate to traditional counseling psychology concerns, and will propose potentially useful avenues for further investigation.

The selections of research and commentary presented in the following sections reflect my view that a unique counseling psychology perspective on the relationship is discernible and that this perspective has influenced the development of counseling psychology as a specialization and continues to be reflected in relationship research being conducted by counseling psychologists. Early writing that emphasized respect for client autonomy, agency, and a focus on client strengths is still visible in newer areas of research, such as social justice (Vera & Speight, 2003) and positive psychology (Lopez et al., 2006; Smith, 2006).

Readers of the current chapter will have an opportunity to consider, for themselves, the roots of counseling psychology's unique perspective on the relationship: Selected quotations from the first edition of Tyler's (1953) *The Work of the Counselor*, are used to introduce key sections. Although the idea of selecting a few key Tyler quotations was appealing from the start, I think readers will share my surprise at the extent to which Leona Tyler's 1953 work remains relevant to contemporary concerns. This chapter summarizes what we have learned, over the past 50 years, about the importance of the counseling relationship in many domains; Tyler's comments remind us that many contemporary conclusions echo assertions advanced at the time when counseling psychology first emerged as a specialization within psychology.

Historical Emergence of a Counseling Psychology Perspective on the Relationship

> Down through the years men have always found that when they have difficult and important decisions to make they can clarify their thinking by talking the problems over with friends whom they trust and respect. . . . that sympathy and understanding make it easier to face these troubles courageously. (Tyler, 1953, p.1)

Counseling psychology's formulation of the relationship is often traced to the 1940s and 1950s, coinciding with Carl Rogers' introduction of the influential idea that an accepting relationship with a counselor, characterized by empathy, warmth, and genuineness, is necessary and sufficient for change. Few would disagree that Rogers' (1942, 1957, 1963) contributions constitute the single most important influence on contemporary understandings of the counseling relationship, but it is important to note two earlier influences, both of which emerged in the early years of the 20th century and which continue to be reflected in contemporary perspectives and research on the counseling relationship.

Freudian psychoanalysis contributed the view that change occurs in the context of interaction between analyst and analysand, as well as the observation that, in transference and countertransference, the process is influenced by forces and feelings outside the awareness of client and therapist. Both the processes of therapeutic interaction and the phenomemon of transference/countertransference continue to be a focus of counseling psychology research (e.g., Gelso & Carter, 1994; Gelso & Samstag, 2008).

The vocational guidance movement of the early 1900s, a core forerunner of contemporary counseling psychology, was a second key influence through its focus on the identification of client skills and strengths, not pathology. Parson's early attention to identifying client strengths and capacities as a basis for selecting occupations (Parsons, 1908, cited in Gelso & Fretz, 2001; Lopez et al., 2006) was later reflected in Super's characterization of counseling psychology as emphasizing "a value system aiming at optimum functioning of the individual" (Super, 1955, cited in Samler, 1980, p. 155). Super used the term *hygiology* in arguing that counselors were concerned with client strengths and health, rather than pathology.

With this base—Rogers' attention to an empathic relationship, the Freudian insight that relationship

is a dynamic process, and the vocational guidance focus on skills and strengths—counseling psychology formally defined itself as a field (see Whitely, 1980), differentiating itself from clinical psychology, industrial organizational psychology, and school guidance. These distinctions were drawn initially on the basis of work setting and client populations but, before long, could also be characterized by different values and distinctive views of the counselor–client relationship. Super (1955) credited Rogers with making people aware that "one counsels *people* rather than *problems*" (Whitely, 1980, p. 18, italics in original) and went on to note that, "Some clinical psychologists are beginning to say, now that counseling psychology has made clear this surprisingly novel philosophy [attention to strengths/hygiology] and these nonetheless time-honored methods, that clinical psychology made a serious error in defining itself as it did, that it should have been more independent of psychiatric traditions and interests and concerned itself with hygiology as well as pathology" (Whitely, 1980, p. 19).

At this nascent moment in the field's development, Leona Tyler's (1953) *The Work of the Counselor* offered a comprehensive portrait of the new discipline and, by extension, its characterization of the counseling relationship. As noted by Zilber and Osipow (1990), "Tyler integrated many theories in developing her own view . . . her work reflects her own unique blending of the concepts of Carl Rogers, individual differences and psychometrics, psychoanalytic theory, behaviorism, developmental stage theory and existentialism. . . ." (p. 337). Tyler's defining contribution was to effect this integration through the lens of the emerging values and concerns of the new discipline of counseling psychology.

Tyler's core themes can be summarized briefly and, upon first reading, are likely to strike readers as self-evident or not remarkable to any practicing therapist, but they provided one of the first systematic sets of instruction for how a counseling relationship should be conducted. Tyler regarded the relationship itself as central to the whole therapeutic endeavor and was specific about its essential characteristics: The counselor and client must establish a relationship of *safety and trust*; the relational focus includes the *whole person* of the client; the counselor adopts a core focus on *client strengths*, rather than pathology; and counseling activities such as psychological testing or occupational information are employed *within* the counseling relationship and pursued in ways that do not diminish rapport. Tyler also calls attention to additional aspects of the relationship that continue to be influential in contemporary counseling psychology: Each counseling relationship must focus on the *individual's uniqueness*, a mandate now reflected in the field's emphasis on issues of diversity. In describing how counselors establish relationships, she often reminded readers that "counseling is basically a perceptual skill . . . learning to listen and watch and understand" (p. 35), which foreshadows the cognitive aspects of relationship formation and the subsequent influence of social psychology (e.g., Heppner & Frazier, 1992, Strong, 1978).

Tyler's core themes continue to be visible in comprehensive reviews of relationship research, particularly those contributed by counseling psychologists, and they helped create a template for a counseling psychology perspective on the therapeutic relationship. Those readers who may question the uniqueness of Tyler's counseling psychology perspective—that a warm, safe, respectful counseling relationship is essential to the therapeutic endeavor—are invited to consider an alternate view, also published in 1953. John Dollard who, with Neil Miller, advanced a highly influential synthesis of psychodynamic and behavioral approaches to therapy, produced a text comparable to Tyler's, titled *Steps in Psychotherapy* (Dollard, Auld, & White, 1953). The section, "The role of the therapist," opens as follows:

> We were tempted to refer to the therapist as circling around the embattled patient as an army might circle a citadel awaiting the moment of attack. . . . It is true that there are resistant forces operating within the patient which make it difficult for him to cooperate as he would like to do; but it is equally true that there are strong cooperative forces within the patient which keep him trying and proceeding with therapy. (p. 16)

Although this language will sound harsh to contemporary practitioners, I believe it is important for counseling psychologists to know that our field has been focused on "cooperative forces" all along.

Empiricism: Early Counseling Psychology Research on the Relationship

> It seems to me very important that we do shift over as rapidly as we can to the use of dependable evidence rather than custom and intuition as a basis for judgments as to how counseling should be done. (Tyler, 1953, p. ix)

From the outset of counseling psychology's emergence as a discipline, there was widespread interest in conducting research on the process of counseling and the client–counselor relationship. This stance reflects counseling psychology's enduring tradition of empiricism and, to complete our understanding of counseling psychology's historical perspective on the relationship, this tradition of and some of its early contributions are considered.

Tyler's work reflects a consistent commitment to what we now call *evidence-based practice*. The recommendations offered in her 1953 text were based on the earliest available relationship research; each chapter of *The Work of the Counselor* was followed by a research summary containing examples of early research on the counseling relationship. For example, Seeman (1949, cited in Tyler, 1953), in investigating client response to different counselors, found that, "There were significant differences in the favorableness of the response to different counselors, but they were not related to techniques used. Counselor *responsiveness* seemed to be the quality that produced the favorable reactions" (p. 55). His research illustrates a perennial question, one that previews a contemporary conclusion regarding the distinctive contributions of the counselor (Kim, Wampold, & Bolt, 2006; Wampold, 2007).

Evidence-based practice tends to be associated with outcome research, pursuing questions of "Is the treatment effective?" But a good deal of relationship research is concerned with the counseling process, and counseling psychologists took an early interest in this type of inquiry. A group of eminent counseling psychology researchers (Gelso, Betz, Friedlander, Helms, Hill, Patton, Super, & Wampold, 1988), while noting that process research was not unique to counseling psychology, described process research as "particularly notable" in counseling psychology and as having a "deep and substantial history in our specialty" (p. 388). This group's work alerted me to the pioneering contributions of Francis P. Robinson, of the Ohio State University, and a former president of the American Psychology Association (APA) Division 17, who inaugurated a program of process research in the 1940s. Asserting that "a counselee's willingness to talk is usually symptomatic of a good working relationship between client and counselor" (Carnes & Robinson, 1948, p. 635), Robinson's lab used "typescripts" of counseling sessions to investigate the relationship between the proportion of client talk time and counseling effectiveness.

Evidence of early research interest in the counseling relationship is also found in the inaugural issue of the *Journal of Counseling Psychology* (*JCP)* in 1954. As reported by Wrenn (1966), the first issue of *JCP* included ten research articles, three of which reflect the field's interest in therapist contributions to the counseling relationship: Dipboye's "Analysis of Counselor Style by Discussion Units," Cottle and Lewis' "Personality Characteristics of Counselors: II. Male Counselor Responses to the MMPI and GZTS," and Shaw's "Counseling from the Standpoint of an 'Interactive Conceptualist.'"

Rogers' (1957) description of the "necessary and sufficient" conditions for change had a significant impact on psychology's views of the therapeutic relationship and generated substantive early research on the core conditions of empathy, unconditional positive regard, and genuineness, as well as development of new research tools. Counseling psychologists made noteworthy contributions to investigations of Rogers' hypotheses: A counseling psychologist's dissertation research operationalized the core conditions (Barrett-Leonard, 1959), resulting in the Relationship Inventory, a measure still used in counseling process research (e.g., Heppner, Rosenberg, & Hedgespeth, 1992; Watson & Geller, 2005). Truax and Carhkuff's (1967) five-level observational rating system, the Accurate Empathy Scale, is still used to measure empathic understanding in client–counselor interactions (e.g., Barone et al., 2005).

Research on the counseling process and the role of the counseling relationship also reflects the specialization's openness to theory and research from other areas of psychology, being one of the first areas of counseling psychology research to incorporate ideas drawn from social psychology research. Stanley Strong (1968) drew on Jerome Frank's (1961) characterization of counseling as a social influence process and reformulated Frank's ideas as explicit counselor factors within the counseling relationship. Strong's model identified counselor expertness, perceived attractiveness, and trustworthiness as sources of persuasion. Once a counseling relationship was established in which the client viewed the counselor as influential, the counselor selected an "influence base" which, in his or her judgment, best suited the client's needs (Dixon & Claiborn, 1987). Strong's characterization of the counseling relationship as a social influence process led to a flood of analogue investigations in which variables such as "trustworthiness" and "credibility" were investigated for their relationship to both outcome (e.g., client attitude change; Bergin, 1962) and process factors (e.g., openness to influence; Dell & Schmidt, 1976; Strong & Schmidt, 1970).

Specific counselor factors that are influential in creating effective therapy relationships are surveyed in subsequent sections; this brief historical sketch illustrates the roots of an empirical tradition that continues to infuse counseling psychology's relationship research. Contemporary manifestations of this orientation are reflected in contributions from counseling psychologists to current definitions of "empirically supported relationships," a research-based complement to research on "empirically supported treatments" (see Norcross, 2002b).

Key Formulations of the Counseling Relationship

> The three aspects, understanding, acceptance, and communication, are so inextricably bound up together in the counseling process that it is only for purposes of talking about them that we can single out one at a time. They cannot be separately practiced or learned, and it is inconceivable that a competent counselor could ever be rated high on one and low on the others.
> (Tyler, 1953, p. 23)

A consensus has emerged that the quality of the counseling relationship, across a range of therapeutic approaches and client populations, is a consistent predictor of positive client outcomes (Beutler et al., 2004; Gelso et al., 2005; Horvath, 2001; Lambert & Barley, 2001). In the current edition of the classic resource, *Handbook of Psychotherapy and Behavior Change* (Lambert, 2004), Beutler et al. (2004) note that the 1994 edition had already identified the therapeutic relationship as "among the stronger predictors of treatment outcome" (p. 282). Lambert and Barley (2001) have gone so far as to argue that we now have decades of research demonstrating that the therapeutic relationship is a foundational "curative" component.

These conclusions are supported by a series of meta-analyses (Horvath & Symonds, 1991; Stevens, Hynan, & Allen, 2000) that have produced moderate effect sizes for the association between the therapeutic relationship and outcome. One relatively new conclusion, however, is that the magnitude of the relationship between the quality of the counseling relationship and outcome is less substantial than had been identified previously. Where prior estimates had suggested that 30% of the variance in outcome was attributable to the relationship (Lambert, 1992), more recent reviews (Beutler et al., 2004) have produced mean effect sizes ranging from $r = .22$ ($p < .05$) for a general outcome in symptom improvement and $r = .17$ ($p < .05$) for targeted symptoms. Reviewers have pointed out that the larger effect sizes were obtained with clients who sought help for more subjective distress (e.g., depression, self-esteem, generalized anxiety), as opposed to diagnosable illness. The implication of this finding for counseling psychologists, whose training tends to be more focused on adjustment concerns, may be that the relationship plays an even greater role in their work than would be true in more clinical or psychiatric settings.

Given the well-established consensus on the importance of the counseling relationship in facilitating client change, the next questions concern the unexplained variance in outcome and can be framed as, "what type of relationship?" and, as "what elements of the relationship?" The first question can be explored by reviewing the findings associated with varying definitions or components of the counseling relationship. The second question, concerning factors that influence relationship development, is addressed in a subsequent section. However, before we can examine the evidence associated with various models of the counseling relationship, it is important to examine some of the definitional challenges associated with this area of research.

Definitional and Conceptual Challenges

> [T]he relationship between two people is something different than the sum of the contributions they make to it.
> (Tyler, 1953, p. 17)

Many researchers would argue that meaningful description rests on precise definition; if we hold to that truism with regard to the counseling relationship, we are in trouble. Gelso and Hayes (1998) have pointed out that, despite agreement on the centrality of the relationship in psychotherapy, there has been a lack of definitional work and few explicit definitions offered. This is not to suggest that there have not been efforts to define the phenomenon but, in each case, the definitions offered have been criticized for either being incomplete, or not being "it." In the 1960s, Carl Rogers expressed his frustration that, "we were all talking about the same experiences, but attaching different words, labels, and descriptions to these experiences. . . . the field of psychotherapy is in a mess" (1963; cited in Patterson, 1966, p. 506). In this section, several influential conceptualizations of the relationship are described briefly to illustrate some

of the key definitional issues in this area of theory and research. In a subsequent section, several key formulations, as well as associated research, are considered in greater detail.

One of the most widely cited contemporary definitions of the relationship was developed by Gelso and Carter (1985, 1994), and asserts that "The relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed" (1985, p. 159). This definition was adopted by the APA Division of Psychotherapy Task Force on Empirically Supported Therapy Relationships (see Norcross, 2002) for its comprehensive empirical review of relationship research; as such, it is assuming an influential place in psychology's understanding of the counseling relationship.

The Gelso and Carter definition (1985, 1994) is only one of several formulations that have been influential at some point in the history of relationship research and, in each case, the definitions offered have been criticized. As an initial example, we can consider the model most familiar to counselors, that of Carl Rogers' *person-centered therapy*. Rogers' approach is defined by his view of the relationship, which is considered to be the central mechanism of change and as healing in itself (Gelso & Hayes, 1998). However, Gelso and Hayes (1998) have argued that Rogers equated the relationship with the core conditions of empathy, unconditional regard, and congruence. In their view, the facilitative conditions are more appropriately viewed as factors that help create a relationship, rather than constituting the relationship itself. They also offered the critique that the therapist-offered conditions fail to acknowledge the client's role or contribution to the relationship.

A similar argument could be made regarding Stanley Strong's (1968) social influence model, which presented a view of the counseling relationship derived from social psychological theory. Strong characterized the counseling relationship as a venue for persuasion on the part of the counselor; counselor expertness, attractiveness, and trustworthiness were bases for influence, and the counselor's role was to select the stance best suited to the client's receptivity to influence and, by extension, to adaptive change. Strong's ideas generated extensive research in the 1970s and his contributions expanded the field's understanding of how different therapist characteristics (e.g., trustworthiness) are related to client response. As a model of the relationship, however, his work illustrates the difficulty in separating therapist characteristics and actions from what we would label as the relationship. Similar to Gelso and Hayes' (1998) critique of Rogers, Strong's conditions for influence cannot be equated with the relationship itself.

An influential cluster of definitions for the relationship is associated with the general term *therapeutic alliance*. In contrast to models of the relationship that emphasized therapist contributions, the alliance construct captures an interactive process and recognizes both therapist and client roles. At the same time, it presents some distinctive definitional challenges, particularly with regard to the theoretical roots of the varying formulations. As Horvath and Bedi (2002) point out, variations on the term (e.g., working alliance, helping alliance) represent related but distinct constructs with varying historical antecedents, some with clear roots in psychodynamic thought (e.g., Greenson, 1965, 1967) and others that have become more pantheoretical (e.g., Bordin, 1976). Two influential formulations are those developed by Luborsky and Bordin. Luborsky's (1976) formulation of a type I and type II alliance makes distinctions based on the stage of engagement, with type I referring to initial establishment of the relationship and type II emerging as the work of therapy begins. Bordin, who is most closely associated with the term "working alliance," defined the alliance as a collaboration consisting of three components: a bond between therapist and client, and an agreement on both the goals of therapy and on the tasks pursued. Horvath and Bedi (2002) argue that the common elements in alliance definitions of the relationship have been collaboration and agreement between client and counselor, in contrast to earlier work that was focused on either therapist contributions (e.g., Rogers) or on unconscious distortion (Gelso & Carter, 1985, 1994).

Although definitions based on the therapeutic alliance have shifted attention from therapist factors to an interactive characterization of the relationship, most writers consider the alliance as only one component of the relationship, rather than constituting the whole (Horvath & Bedi, 2002). For Gelso and Carter (1985, 1994), the working alliance is one of three components of the therapeutic relationship, the other two being a transferential component (including therapist countertransference) and a real relationship (Greenson, 1967), with features of genuineness and realistic perception. This tripartite model (see Gelso & Hayes, 1998, Gelso & Samstag, 2008, for extended discussion) offers

a more comprehensive characterization of the relationship than the scope of either Rogers' proposal or the alliance literature and has been employed in several influential surveys of relationship research (e.g., Norcross, 2002; Sexton & Whiston, 1994). However, Gelso and Carter's extension in scope has also become the focus of criticism. Hill (1994) has charged that, by going beyond feelings and attitudes to inclusion of their manner of expression, the model becomes overinclusive and could be applied to almost everything that happens in psychotherapy. A related challenge to the model concerns the difficulty in differentiating between the three components, particularly in defining and differentiating the real relationship (Greenberg, 1994; Patton, 1994).

What each of these definitions—and attendant criticisms—reflects is the extreme difficulty of differentiating the counseling relationship from relationship-relevant techniques that a therapist employs (e.g., unconditional regard) and in making clear distinctions between therapist factors, client factors, and the relationship itself. The APA Division of Psychotherapy Task Force on Empirically Supported Therapy Relationships (see Norcross, 2002), in its investigation of relationship factors related to therapy outcome, wrestled with these dilemmas and made a choice to include therapist contributions as distinguishable from the relationship itself. But, with regard to the issue of what a therapist may *do*, they acknowledged the impossibility of fully separating these, noting, "The relationship does not exist apart from what the therapist does in terms of technique, and we cannot imagine any techniques that would not have some relational impact" (Norcross, 2002b, p. 8). And, of course, others would argue that therapist contributions go well beyond "technique" (e.g., Gelso, 2004).

For relationship research to advance, investigators will need to grapple with the fact that, not only are these factors intertwined and reciprocal, they are teleological in character. In other words, they exist within the dimension of *time* and are enacted with *purpose.* Several authors have offered suggestions for a renewed examination of relationship variables; for example, Carter (1994) draws a useful distinction between form and process elements of the relationship. She describes form as those components that exist at a point in time or across people, typically assessed with quantitative methods, and process as "more individualized experiences of interaction and changes in and through the interaction across time" (p. 79).

My own view is that Carter has captured a critical limitation in our definitions of the relationship, and likely one that has been shaped by the quantitative methods that are familiar to us. Counseling psychology researchers, who have demonstrated openness to qualitative methods and a social constructionist paradigm (see Haverkamp, Morrow, & Ponterotto, 2005), may be uniquely prepared to explore how the dimensions of time and purpose can inform our definitions of the therapeutic relationship.

In the sections that follow, three influential formulations of the relationship are considered, along with illustrative research that has explored their association with client outcomes: Rogers' core conditions of empathy, unconditional positive regard, and congruence; investigations of the relationship as a common factor; and research on the working alliance. Two more recent formulations, those of the real relationship and consideration of the "empirically supported relationship," are also considered. The following discussion cannot offer an exhaustive review but reports current consensual conclusions and draws attention to counseling psychology contributions.

Carl Rogers' Core Therapeutic Conditions

> The value of the basic nondirective technique, reflection of feeling, in stimulating self-exploration has been demonstrated.
> (Tyler, 1953, p. 227)

Graduate students tend to forget that, when Carl Rogers' (1957) proposed that empathy, unconditional positive regard, and congruence were "necessary and sufficient" conditions for therapeutic change, he wanted to advance a testable *hypothesis*, not a "truth claim" or description of fact. Gelso and Hayes (1998) observed that our familiarity with this triad puts us at risk for assuming that there is little more to learn or to say—and, given that Tyler was drawing a similar conclusion in 1953, it is not surprising that many would consider this to be an area where the answers are established. However, although several decades of research have produced a strong consensus as to the positive contribution made by the core conditions, debate and uncertainty continue regarding their relative importance and the mechanisms through which they support change. For example, in 1985, Gelso and Carter

evaluated the empirical evidence and concluded that the core conditions cannot be considered either necessary or sufficient, yet a recent review (Bohart, Elliott, Greenberg, & Watson, 2002) advances the idea, with empirical support, that empathy may play a causal role in positive client outcomes, particularly when viewed from the client's perspective. Contemporary researchers continue to explore the role of the facilitative conditions within different therapeutic models (e.g., Watson & Geller, 2005) and client populations (e.g., Chang & Berk, 2009). What cannot be disputed, however, is that Rogers was a remarkably keen observer, as his core therapeutic conditions have continued to be identified as central to an effective counseling relationship (Norcross, 2002a).

Some of the earliest investigations of Rogers' core conditions were conducted by Truax and Carkhuff (1967), who provided some of the first summary evidence for Rogers' formulation of the relationship. These early investigations indicated that, although the association between the individual facilitative conditions and outcome were mixed, more positive results were obtained when the three conditions were treated as an aggregate (Farber & Lane, 2002). This finding, that an aggregate of the core conditions has the greatest predictive power, has continued to gain support. Contemporary investigations have reaffirmed that the association with outcome for the individual core conditions is more variable than for the relationship as a single entity (Farber & Lane, 2002).

Client perception appears to play an important role in the operation of Rogers' core relationship conditions. Work by Batchelor (1988) revealed that clients differ in what they perceive as an empathic response, a point that highlights the necessity of attending to individual differences in clients' experience of the relationship. Lambert and Barley (2002), in a discussion of the facilitative conditions, point to consistent evidence that the more positive associations with outcome are obtained for client-perceived relationship factors, rather than those reported by therapists or observers.

The most compelling contemporary support for the association between Rogers' core conditions and client outcome is presented in the work of the Division 29 Task Force on Empirically Supported Therapy Relationships (Norcross, 2002a). Following their comprehensive review of extant research, the Task Force concluded that the factor of empathy was "demonstrably effective" in promoting positive outcomes and that the factors of congruence/genuineness and positive regard were "promising and probably effective" in facilitating positive change.

The Counseling Relationship as a Common Factor

> There is some evidence that Rogerian, Freudian, and Adlerian therapy situations are more similar, at least in the important matter of the counseling relationship established with the client, than they had been assumed to be.
> (Tyler, 1953, p. 227)

Dare we ask whether psychotherapy researchers are "slow learners?' Tyler's observations in 1953 were empirically based, and Truax and Carkhuff's (1967) review indicated that aggregate measures of the relationship were a stronger predictor than theoretically derived components. Smith and Glass' (1977) classic meta-analysis, which demonstrated both the effectiveness of psychotherapy and the lack of significant differences among treatments, was published over 40 years ago. But, as a field, we have been slow to abandon our faith in the uniqueness of theoretically driven interventions. As Lambert, Garfield, and Bergin (2004) note, "Yet, there is tremendous resistance to accepting this finding as a legitimate one. Numerous interpretations of the data have been given in order to preserve the idea that technical factors have substantial, unique and specific effects" (p. 809). Perhaps in this new century, given the consistent evidence that specific approaches and treatments do not differ in effecting positive client outcomes for most presenting concerns (Lambert, Garfield, & Bergin, 2004), we are ready to "give it up" and learn more about what makes the counseling relationship a critical element of therapeutic success.

The common factors approach can be described as the search for those "active ingredients" that cut across psychotherapeutic approaches, are important in all forms of psychotherapy, and are not linked to the change mechanisms specified by specific theoretical orientations. First advanced by Rosenzweig (1936), the idea of common factors has attracted increased attention as contemporary research continues to document the lack of specificity attached to particular theoretical approaches (Ahn & Wampold, 2001). Various authors have advanced lists of potential common factors (e.g., Greencavage & Norcross, 1990; Stiles, Shapiro, & Elliott, 1986;

Weinberger, 1995). Lambert and Ogles (2004), for example, categorize common factors as support, learning, and action factors. Regardless of the form of categorization for common active ingredients, the counseling relationship is named consistently as an influential factor that crosses theoretical boundaries; Lambert and Ogles (2004) assert that, based on a series of extensive empirical reviews, "Reviewers are virtually unanimous in their opinion that the therapist–patient relationship is critical to positive outcome" (p. 174).

As a common factor, the counseling relationship is frequently operationalized as a constellation of Rogers' core conditions, in contrast to assessing the individual contributions of empathy, unconditional regard, and genuineness. As noted above, there is empirical support for treating them as an aggregate, and Lambert and Ogles (2004) assert that, "Virtually all schools of therapy accept the notion that these [client-centered necessary and sufficient conditions] or related therapist relationship variables are important for significant progress in psychotherapy and, in fact, fundamental in the formation of a working cooperative effort between patient and therapist" (p. 173).

A number of counseling psychology researchers have made important contributions to our understanding of the therapeutic relationship as a common factor. Louis Castonguay, who has emerged as an influential psychotherapy process researcher, conducted comparative research showing that the relationship is associated with outcome more strongly than are specific treatments (e.g., Castonguay, Goldfried, Wiser, & Raue, 1996). Bruce Wampold (2007; Ahn & Wampold, 2001) has been at the forefront of the argument that common factors account for more variance in outcome than do specific techniques. Wampold's work on common factors and the counseling relationship represents several of the themes that have long been central to a counseling psychology perspective; in his program of research, he has used the tools of empiricism to explore the "particularity" of individual counseling relationships, concluding that factors unique to a given relationship are central to the change process. Wampold is not concerned with the relationship as a curative factor in its own right; instead, he has advanced the argument that the relationship with the therapist is critical to the client's engagement in other aspects of the change process, with a particular emphasis on client perceptions of the therapist as a trustworthy guide in exploration of his or her concerns (Baldwin, Wampold, & Imel, 2007, Wampold, 2007). Readers interested in learning more about this counseling psychologist's perspective are invited to review Wampold (2007).

The broad consensus on the importance of the therapeutic relationship as a common factor has prompted further investigation of the mechanisms through which it may influence positive change. Some of the factors that have been identified as moderators and mediators are discussed in subsequent sections of this chapter.

The Working Alliance

> In this first hour, some kind of relationship must be established. Out of this meeting the client must get something that will make him willing to come back and to put forth the further effort that is required. When this first hour begins, counselor and counselee are strangers; when it ends they must have formed some sort of partnership.
> (Tyler, 1953, p. 24)

Tyler may have underestimated the length of time required to establish a working alliance, as current research indicates that the alliance established by the third session can predict outcome (e.g., Horvath & Symonds, 1991), but it is clear that she appreciated the essential focus on collaboration and partnership that defines the therapeutic alliance.

Horvath and Bedi's (2002) definition of the alliance "refers to the equality and strength of the collaborative relationship between client and therapist in therapy" (p. 41) and includes positive affective and cognitive elements, and an active, conscious, purposeful engagement. They also note that some writers use the terms "alliance" and "counseling/therapeutic relationship" interchangeably, but point out that there are subtle, yet important differences between these terms. Although the contemporary understanding of the alliance is more pantheoretical, the construct has roots in psychodynamic theory and has produced a range of definitions, with varying emphasis on individual components.

Given the diverse perspectives on this construct, any discussion of findings needs to reference the measures developed to operationalize the alliance. The three measures used most widely are the Penn Helping Alliance (HA) scales (Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983), the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), and the Working Alliance Inventory (WAI, Horvath, 1981, Horvath & Greenberg, 1986). Horvath and Bedi (2002) report

high correlations among the scales cited but emphasize that differences do exist in both the inclusion and weighting of different alliance dimensions. This discussion considers research using the WAI, given its associations with counseling psychology in both its development and ongoing research (Horvath, 1981; Mallinckrodt, 1993, 1996).

The relationship between strength of the working alliance and therapy outcome is now firmly established, across both assessment perspectives (client, therapist, or observer) and across various forms of therapy (Horvath, 2001). Horvath (2005) provides a succinct summary of research to date, noting that, "At the risk of ignoring complexity, a reasonable summary is that the relationships reported across reviews have been quite consistent: the alliance–outcome correlation is moderate but significant (ranges from .22 to .29), clients' assessments tend to be more predictive of outcome than are other sources, early alliance is as good or better predictor of outcome than assessments taken later, and the alliance as measured appears to be related to but not identical to parallel therapeutic gains" (p. 4). Lambert and Barley (2002), following their review of empirical research on the alliance–outcome relationship, noted that therapist contributions to the alliance go beyond provision of the facilitative conditions to include reaching agreement with clients on goals and tasks and to the ability to manage ruptures in the alliance (Hatcher & Barends, 1996; Safran, Muran, & Samstag, 1994).

Contemporary research continues to extend the application of the alliance formulation of the therapeutic relationship to new areas of counseling practice and research, and counseling psychologists are key contributors. As examples, Patton and Kivlighan (1997) used hierarchical linear modeling to explore the relationship between a supervisory working alliance and the working alliance experienced by a trainee's clients and found parallels between a trainee's perceptions of the supervisory alliance and his or her client's perceptions of the working alliance. Bedi (2006) used multivariate concept mapping to understand what factors clients experienced as contributing to the development of the alliance and learned that clients attached importance to both the counselor's personal characteristics and to the physical setting. Friedlander and colleagues (2006, 2008) have investigated alliance formation and its relationship to outcome in family therapy, in which the client perspective on the alliance is represented by multiple family members. To pursue this work, Friedlander et al. (2006) developed an observational rating tool, the System for Observing Family Therapy Alliances. In recent work (2008), they learned that, in contrast to individual counseling, a strong alliance within the family is more important to treatment success than is an alliance with the counselor.

Another research focus pursued by counseling psychologists has considered whether counselors working in online modalities can establish effective therapeutic alliances. A review published in *The Counseling Psychologist* by Mallen et al. (2005) reported that, at that time, only three studies had investigated this question and had produced mixed results. The authors note that variables related to age and familiarity with online technologies have not been isolated in previous research, making any conclusions highly tentative, and that the absence of nonverbal cues in online environments can increase counselor susceptibility to common stereotypes. In contrast, other research indicates that clients can establish an effective alliance in online counseling (e.g., Cook & Doyle, 2002). Knaevelsrud and Maercker (2006) found that clients seeking online assistance for post-traumatic stress reactions reported positive alliance scores, although there was a variable association between the therapeutic relationship and treatment outcome ($r = .13 – .33$). What may be most noteworthy is the finding that, in a population at risk for premature termination, the alliance was associated with retention in online therapy. The 48 participants in their study had a drop-out rate of 17%, which the authors note contrasts with reported rates of up to 28%.

Although much of the extant research has examined the therapeutic alliance as a predictor of therapy outcome, there has been an increased call to move beyond a direct association. More recently, alliance research has examined the alliance as a mediating variable between provision of Rogers' core conditions and client outcome. As one example, Watson and Geller (2005) used the Relationship Inventory (Barrett-Lennard, 1962), one of the field's earliest measures of Rogers' conditions, and the WAI (Horvath & Greenberg, 1986) to explore mediation in both cognitive-behavioral and process-experiential therapy. Although the two forms of therapy did not differ on measured therapist empathy, acceptance and congruence, the core conditions were related to outcome measures of depression, interpersonal distress, self-esteem and negative attitudes. Importantly, the alliance mediated the relationship between the core conditions and three of

the four outcome measures. The authors argued that Rogers' core conditions make their contribution to outcome by fostering a strong working alliance. This point echoes arguments made by other counseling psychology researchers, as noted in a subsequent section on therapist factors in the relationship.

The Real Relationship

> To put on a mask of friendliness to cover hostility, contempt, or plain lack of interest, is to confuse the client, not to help him. Signs of the real feelings will inevitably appear during the interview. . . . (Tyler, 1953, p. 27)

A more recent arrival on the theoretical landscape has been Gelso and colleagues' elaboration of the real relationship component of his tripartite model (see Gelso & Samstag, 2008), in which the other components consist of the working alliance and the transferential dimensions of relationship. Gelso (2004) has defined the real relationship as, "the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (p. 6), and argues that it both emerges in the first moments of client–counselor interaction and is the base from which a working alliance develops (Gelso et al., 2005).

The importance of the real relationship construct to research on the counseling relationship resides in Gelso et al's. (2005) claim that it plays a unique and significant role in both the counseling process and outcome, across types of therapy, beyond that contributed by variables previously under investigation. Research on the real relationship has been catalyzed by the development of measures to operationalize therapist and client perspectives on the construct (Fuertes et al., 2007; Gelso et al., 2005). To date, the authors report that the real relationship is empirically distinct from the working alliance (r = .47, p < .01) and demonstrates an independent relationship with session outcome, measured as depth and smoothness of sessions (Gelso et al., 2005).

New ideas often generate controversy, and the claims advanced for the real relationship by Gelso and colleagues are no exception (e.g., Greenberg, 1994; Horvath, 2009). It appears that the primary criticisms are definitional and concerned with the most informative and defensible means of partitioning elements of the relationship, as well as whether conceptual clarity can be achieved in describing the separate components. Greenberg (1994), for example, questioned whether the real relationship, consisting of genuineness and realistic perception, can be differentiated from Rogers' core condition of genuineness. It remains to be seen whether the recent development of measures for the real relationship will generate research that answers the critics.

The Empirically Supported Relationship: Report of the APA Division 29 (Psychotherapy) Task Force

> I still hope that the research summaries . . . will be a help to practicing counselors trying to distinguish between things we do simply because they seem to work well and things we do because of some definite research evidence. (Tyler, 1953, p. x)

One of the most significant advances in our understanding of the therapeutic relationship has emerged from the work of a task force established by Division 29 Psychotherapy of the APA (see Norcross, 2002). The task force was commissioned in response to widespread concerns over the emphasis on empirically validated treatments (EVTs, Norcross, 2002b), as advanced by APA Division 12 (clinical psychology; e.g., Chambless & Hollon, 1998) and counseling psychology (Wampold, Lichtenberg, & Waehler, 2002). Now termed *empirically supported treatments*, these lists of therapeutic approaches, with effectiveness demonstrated through randomized clinical trials and manualized treatment, were viewed as emphasizing technique over process factors that have demonstrable impact (Norcross, 2002b). Specifically, the Division 29 Task Force identified three areas that had not received attention: the therapy relationship, the person of the therapist, and the client's characteristics.

The Task Force's goal was to identify therapeutic relationship elements that had sufficient empirical support to qualify as components of an "empirically supported relationship," comparable to the claims of empirically supported treatments (Norcross, 2002a). After 3 years of careful analysis, using clear operational definitions and rigorous selection criteria, the group advanced conclusions and recommendations regarding the empirical evidence for the contribution of various components of therapeutic relationships to positive client outcome. Relationship elements and therapist factors that had accumulated broad and consistent research support were categorized as either "demonstrably effective" or, in cases in which the substantive evidence was positive

but still mixed, elements were described as "promising and probably effective."

The conclusions of the Task Force, with regard to "general elements of the therapeutic relationship" (Norcross, 2002a, p. 441), were as follows: Factors with sufficient empirical evidence to be regarded as demonstrably effective included the therapeutic alliance, cohesion in group therapy, empathy, and goal consensus and collaboration. Evidence to support a conclusion of promising and probably effective was found for the factors of positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of interpersonal interpretations.

The alert reader will note that many of the factors identified by the Task Force have been cited in the current work as influential components of the various models of the therapeutic relationship. Much of the work reviewed here was considered by the Task Force, and the relevance of its conclusions to counseling psychology is supported by the fact that approximately one-third of the Task Force members are counseling psychologists. The therapeutic relationship, congruent with its now established status as a common factor in change, is an arena in which applied psychologists from diverse specializations are collaborating to understand this most basic element of the psychotherapy process. A summary list cannot begin to capture the depth of investigation that underlies the Task Force conclusions, or to convey the subtle variations or individuating factors that would inform application of these findings. Interested readers are strongly encouraged to consult the full report of the Task Force, which appears in book form (Norcross, 2002a).

Variables That Influence the Counseling Relationship

> Counselors have much to say about "the counseling relationship" and psychoanalysts have had still more to say about "the transference." What has not been stressed enough in all these discussions of "the counseling relationship" or "the transference" is the fact that each relationship has its own individual characteristics; each is unique. It is on these unique characteristics of this particular relationship that the counselor should focus his attention at the beginning.
> (Tyler, 1953, p. 35)

To this point, much of our discussion has treated the counseling relationship as an entity, itself, with little attention to the factors that make each relationship unique, as Tyler so pointedly reminds us. The following section surveys some of the individuating characteristics that have been investigated as influential in the formation or operation of the counseling relationship. Although researchers have considered factors associated with the therapist, the client, and their reciprocal interaction, the current discussion (for purposes of managing the scope) emphasizes therapist factors. Once again, Leona Tyler's words provide evidence that counseling psychologists have been aware of these factors for a long time, and that contemporary efforts to understand their influence rest on a substantial base of scholarship.

Attachment Style

> It is almost inevitable that attitudes carried over from parent–child relationships should weave themselves into the complex fabric of the counseling relationship.
> (Tyler, p. 41)

A number of psychotherapy researchers have explored the relevance of Bowlby's (1969) and Ainsworth's (1964) work on the attachment of infants to their caregivers, and extensions of this work to adult relationships (Bartholomew, 1994; Bartholomew & Thompson,1995) to characteristics of the counseling relationship (e.g., Mallinckrodt, Gantt, & Coble, 1995). A steady stream of investigation has explored whether client and therapist attachment styles (characterized as anxious, avoidant, or secure) influence either the type or the strength of the counseling relationship, which can also present conditions of emotional vulnerability and stress. In general, investigators have demonstrated that both client and therapist attachment style are important factors in the development and maintenance of the counseling relationship. At the same time, the modest correlations between the range of methods used to operationalize attachment style (e.g., narrative, interview, self-report) mandates caution in assuming that one study's definition of "secure" attachment is comparable to another's (Meyer & Pilkonis, 2002).

There appears to be a consensus that client attachment style plays an important role in the therapeutic relationship, both in ability to form an alliance (Eames & Roth, 2000) and in eliciting different response styles from a therapist (Hardy et al., 1999). Clarkin and Levy (2004), in their summary of the research, suggest a paradox that, although attachment anxiety or avoidance could interfere with establishing a counseling relationship,

a preoccupation with intimacy could lead to successful engagement over time, and that the interaction between therapist and client attachment style is important.

Mallinckrodt, a counseling psychologist whose work has been influential in examining the association between attachment style and the alliance, worked with colleagues to develop the Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995). The CATS assesses client attachment to therapists as secure, avoidant, or preoccupied by assessing client perceptions of their therapist as emotionally responsive, disapproving, or rejecting, and the client's wish to feel closer to the therapist. Support for the construct validity of the CATS comes from evidence that clients with difficult family histories experience avoidant-fearful attachment to their therapists (Mallinckrodt, King, & Coble, 1998), whereas those with secure therapeutic attachments experience a stronger working alliance (Mallinckrodt et al., 1995).

In considering the impact of a therapist's attachment style, evidence is emerging that attachment plays an independent role in the form the alliance takes. Some intriguing research indicates that having an attachment style that differs from that of the client is beneficial, in that clients have an opportunity to disconfirm their expectations of relationships with others (e.g., Tyrrell, Dozier, Teague, & Fallot, 1999). Other research indicates that therapists with less secure attachment styles may be prone to respond less empathically (Rubino, Barker, Roth, & Fearson, 2000).

Meyer and Pilkonis (2002) have recommended that researchers investigate attachment as a mediator in the counseling relationship. They offer a compelling rationale, based on Mischel and Shoda's (1995) social cognitive work, that attachment styles be viewed as stable individual factors that are expressed in a context-dependent manner. In other words, a client or therapist with less secure attachment may not act in an "insecure" manner until they perceive a sense of threat or insecurity in the environment. This formulation supports an interactional view of the role of attachment in the therapeutic relationship, one that adds a situational dimension to the current exploration of therapist and client factors.

Countertransference

> The counselor's own feelings are bound up in [the relationship]. . . . Inevitably, since he is a sensitive human being, he will react on an immediate unconscious level to subtle indications of hostility in a person he is interviewing. These things will be true no matter how well-integrated a person he is and even if he has set his own personality in order through some thorough-going psychotherapy before beginning his work. (Tyler, p. 42)

Countertransference occurs when a therapist's reactions to a client are based in the therapist's earlier conflicts or relationships, rather than in the present interaction, and are assumed to be a distortion (Gelso & Carter, 1994). Although the construct of countertransference has roots in psychodynamic thought, other definitions have included all therapist reactions or highlighted its interactive dimension (Gelso & Samstag, 2008). One contemporary, integrative formulation describes it as a component of all therapy relationships (Gelso & Hayes, 1998). Given that countertransference emerges in the context of therapist–client interaction, it needs to be considered as another potentially influential factor in the formation and maintenance of the therapeutic relationship.

There is a longstanding consensus that unrecognized countertransference has negative effects on psychotherapy outcome (Gelso & Hayes, 1998), in part by limiting the therapist's accurate understanding of the client (Lambert & Ogles, 2004; Singer & Luborsky, 1977). As Hayes et al. (1997) noted, "relationships predicated and sustained on illusory perceptions are not likely to succeed in helping clients attain their goals" (p. 151).

Much of the early research on countertransference attempted to identify factors or client types that evoked negative therapist reactions (see Gelso & Hayes, 1998), rather than investigate its role in the therapeutic relationship, and the first links between countertransference and the therapeutic relationship were indirect. In a qualitative investigation, Hill et al. (1996) reported an association between countertransference and client–counselor disagreement and premature termination. Counselors in the study identified their own difficult family histories as contributing to their impasses with clients. As a second example, Hayes and Gelso (1993) and Gelso et al. (1995) found that therapists assessed as high in homophobia exhibited avoidance of important client material presented by analogue gay and lesbian clients. Given that many definitions of the relationship cite therapist–client engagement as a central component, it seems probable that

therapist avoidance would have a negative effect on the relationship.

Counseling psychologist Charles Gelso, and a research team with links to the University of Maryland, have been vigorous contributors to research on countertransference, both in explicating definitional issues and in exploring its role in the counseling relationship (see Gelso & Hayes, 2002, for a review). This group has contributed to growing evidence that countertransference influences psychotherapy outcome through its influence on the therapy relationship. In a large-scale field study of therapist trainees (Ligiero & Gelso, 2002), both therapist and supervisor ratings documented a relationship between therapists' negative countertransference behaviors and a less effective working alliance with clients. Interestingly, ratings of therapists' positive countertransference (e.g., being overly friendly or supportive) were associated with lower ratings of the bond component of the alliance.

Another aspect of countertransference research related to the counseling relationship suggests that the therapist's ability to manage countertransference reactions may mediate the countertransference–alliance link. For example, there are demonstrations of a relationship between countertransference and empathic ability (Hayes, Riker, & Ingram, 1997; Peabody & Gelso, 1982), in which greater empathic ability has been associated with both the therapist's recognition and management of countertransference reactions. In a case study of a 13 sessions of psychotherapy, Rosenberger and Hayes (2002) found that the therapist's effectiveness in managing countertransference had positive associations with the client's assessment of their working alliance.

One of the most explicit discussions of the role of countertransference in the relationship comes from Gelso and Hayes' (1998) reflections on their survey of countertransference research. They argued that the negative impact of countertransference may result from its effect in dividing the therapist's attention between his or her internal concerns and the client's concerns. Furthermore, they asserted that countertransference may have an impact on psychotherapy by first influencing the therapist and then, by extension, the relationship. Gelso and Hayes refer to this as "limiting the therapist's instrumentality of self" (p. 100) and argued that its effects will be most noticeable in therapeutic approaches that employ the relationship as a key mechanism of change.

Although the conceptual link between countertransference and the strength of the relationship strikes many as intuitively obvious, there is still scant research to support this claim. Further complicating the picture, several authors have argued that, under certain circumstances, countertransference can be employed to facilitate a counselor's understanding of a client. Finally, it is important to note that countertransference does not operate in isolation; Mohr, Gelso, and Hill (2005) found that, for counselor trainees, countertransference behavior reflected an interaction of both client and counselor attachment style. These initial findings strongly suggest that countertransference, by producing therapist behaviors that interfere with effective engagement, plays a role in the formation and maintenance of therapeutic relationships. However, given the paucity of research, conclusions must remain tentative.

Expectancies and Preferences

> [T]he first question he asks himself is, "What are this person's expectations from counseling? What does he think is going to happen? What does he hope to get out of it?"
> (Tyler, 1953, p. 36)

Both client and therapist bring their individual expectations to the therapeutic encounter. But, it is within the relationship that expectations have their effect on process and outcome, as that is the arena in which they are either met or not met. Each of us can recall the impact of unmet expectations. For example, the experience of receiving critical supervisory feedback on a counseling session that one considered a success can leave the recipient feeling vulnerable and exposed, perhaps angry, and can raise questions about either oneself or the relationship. Psychologists were quick to note the relevance of expectations to the counseling process and relationship—one of Carl Rogers' students investigated the association between client outcome expectations and observed change (Lipkin, 1954; cited by Arnkoff, Glass, & Shapiro, 2002)—and there has been a lengthy history of research on the role of client expectancies in psychotherapy process and outcome (Clarkin & Levy, 2004).

Early research appeared to support the relevance of client expectations to the development of a strong therapeutic relationship. Clarkin and Levy (2004) report that, in the 1960s, a series of investigations characterized client role expectations as having features such as reciprocity and interdependence,

nurturance, and collaboration, as well as characteristics associated with authority and guidance. In 1980, counseling psychologist E. A. Tinsley and colleagues (1980) developed the Expectations About Counseling measure (EAC), based on four empirically derived factors that assessed client anticipation of client personal commitment, counselor provision of Rogers' facilitative conditions, counselor expertise, and counselor nurturance.

Many researchers have pointed out that the congruence, or match, between client and counselor expectations is likely to be most influential. In an early study that surveyed both clients and counselors, Netzky et al. (1982) found that, although both clients and counselors viewed a strong relationship as a central expectation, clients differed from counselors in raising questions that centered on whether the counselor would be trustworthy and respectful. Specifically, clients expected to evaluate counseling based on whether counselors treated them as equals, confronted them when appropriate, and would end counseling if the client was not benefiting.

Several decades of research support a conclusion that client expectancies do have a relationship to therapeutic outcome, although the association appears to be modest and is most likely to be indirect or mediated by third variables (Clarkin & Levy, 2004). Although the therapeutic relationship has been identified as a potential mediator of the correlation between expectations and outcome, very little research has explored the role of client expectations as a direct predictor of the strength of the therapeutic relationship. Several initial studies of actual psychotherapy suggest that expectations may play a significant role. Joyce and Piper (1998) reported a strong association between client expectations and the alliance, whereas two investigations by counseling psychologists Al-Darmaki and Kivlighan (1993) and Tokar et al. (1996) produced mixed findings. More recently, Rizvi et al. (2000, cited in Clarkin & Levy, 2004) found that client expectations, in comparison to therapist variables and problem severity, were the strongest predictor of the therapeutic alliance for clients diagnosed with borderline personality disorder.

Before further discussion, it is useful to consider important distinctions between the various types of expectancies that may operate in a counseling relationship. Garfield (1978) differentiated between the expectations that clients bring into counseling and those that develop out of experience with a specific counselor; both can be influential. A client's initial, positive expectancies for change can be considered a common factor in treatment, and Lambert and Barley (2002) include such expectancies in their category of "placebo effects," assigning as much as 15% of outcome variance to these factors. Alternately, derived expectations, those that emerge in a specific counseling experience, were illustrated in the earlier discussion of how attachment influences relationship formation, in which clients benefited from having a counselor disconfirm their expectations for relational patterns (e.g., Tyrrell et al., 1999).

The area of expectations that has generated the most research is associated with expectations that clients bring to the therapeutic encounter. Highlen and Hill (1984) have pointed out that these initial expectations are probably most influential in the early stages of counseling, before client and therapist have an opportunity to correct or disconfirm erroneous assumptions about what the process may involve. Consistent with this point, client expectations have been consistent predictors for the complementary variables of premature termination and continuation in therapy (Clarkin & Levy, 2004). Specifically, when client expectations for what will happen in psychotherapy are not met, there is a significant increase in premature termination (Hardin, Subich, & Holvey. 1988; Reis & Brown, 1999). Swift and Callahan (2008) note that a large body of literature supports these conclusions; they also describe the magnitude of this issue. According to their review, between 40% and 60% of clients drop out of therapy before any beneficial change is achieved. Furthermore, several authors have pointed directly to unmet client expectations as a key factor in premature termination (e.g., see Wierzbicki & Pekarik, 1993, for a meta-analysis).

One area within the body of research on client expectations that has been catalyzed by work on premature termination is that of expectations held by clients outside the dominant culture. Comas-Diaz (2006) reports earlier research, conducted with colleagues, in which she studied both pretherapy expectations and expectations for therapists that were held by clients of color. Although she found that "people of color have a complex set of expectations related to the cultural variation in the clinician's role" (p. 93), she links this finding to recommendations for managing a multicultural relationship from a position of cultural empathy. In my view, one of the major contributions of Comas-Diaz's work, as well as that of the larger body of work on unmet expectations and premature

termination, is that it invites us to reconsider what we are measuring when we investigate client expectations. A brief discussion follows.

As noted above, little research explores a direct link between unmet client expectations and the therapeutic relationship. However, it appears likely that these effects may be partially mediated by relationship factors. Two areas of expectancy research that are directly relevant to the counseling relationship are those focused on role expectations (in contrast to client expectations for therapy effectiveness or outcome) and those focused on client preferences, which refer to therapist characteristics one would choose if given the option. Role expectations refer to the behaviors one expects or considers appropriate in a given encounter and, for clients, can apply to their own behavior or that of the therapist. Therapists undoubtedly hold role expectations, as well; however, the overwhelming emphasis in expectancy research has been on client expectations.

An issue that has not been addressed in the relationship literature, but which may be critical to our understanding, is an examination of the cognitive structure and dynamic influence of expectations. Expectations consist of what we think will, or should, happen and, as an independent construct, appear to have limited predictive power. However, they may represent the tip of a cognitive iceberg, particularly as highly cultural "signs" of the belief structures that give rise to expectations. Similar to other cognitive frames that we use to interpret the world, expectations can arise from preexisting beliefs or prior experience. This formulation has received recent attention from cognitive-behavioral therapists; Leahy (2008), for example, describes the therapeutic relationship as reflecting therapist and client interpersonal schemas. When we measure expectations, we are probably obtaining a window on existing cognitive schemas for how the world "should" work, according to either therapist or client. A similar argument may apply to another construct employed in relationship research, that of "matching" client and therapist on various demographic characteristics; those issues are addressed in a subsequent section that explores research on diversity and the relationship.

For individual clients, an expectation may reflect a belief about themselves ("I don't believe anyone would care about me") or a group to which they belong ("In my experience, people of my sexual orientation may not be accepted"). The real relevance of expectancies to the strength of the counseling relationship may consist in what they tell us about underlying beliefs and attitudes—not only on the part of clients, but also on the part of counselors.

To illustrate this point, it is informative to consider research on client and counselor expectations associated with class and socioeconomic status (SES), as the association between client expectations and premature termination is particularly descriptive of clients in disadvantaged economic circumstances. A body of research on expectations emerged in the 1960s and, although cited sporadically, is largely ignored. Smith (2005), responding to a 2000 APA Resolution on Poverty and Socioeconomic Status, notes that, "Researchers of the 1960s had already established that poor clients terminate treatment prematurely—why, four decades later, does that still constitute the sum of psychology's knowledge about them?" (p. 690). Research conducted in the 1960s and the 1970s is relevant to a discussion of expectations but, to the surprise of some, challenges our assumptions about *therapist* expectations, an area that may be amenable to therapist modification and one likely to have indirect influences on the therapeutic relationship.

In 1971, Graff, Kenig, and Radoff reported that therapists believed that poor people were unlikely to benefit from therapy (expectation) and, in any event, would drop out prematurely (expectation). Lorion's (1973, 1974) significant work on psychotherapy with the poor refuted the notion that the lack of psychotherapeutic effectiveness was attributable to clients' unrealistic expectations about psychotherapy; instead, he made a convincing argument that therapist attitudes and biases (a source of expectations) contributed to treatment failures. In support of this argument, consider research conducted by Jacobs et al. (1972), in which a brief, pre-therapy orientation was provided for poor clients and, for their therapists, a session to enhance awareness of class and cultural factors. Findings indicated that the orientation was associated with significant increases in client continuation in therapy, when both clients and therapists received the orientation, and *if only the therapist received the orientation*. This research did not assess the status of the therapeutic relationship directly, so any connection must be speculative; on the other hand, the fact that a brief intervention for therapists produced positive effects suggests that it had an impact on the connection that therapists established with clients.

Our dominant models of the therapy relationship—the empathy, positive regard, and congruence of Rogers' facilitative conditions and the task, bond, and goal components of the working alliance

(Horvath, 1981)—will surely be undermined if therapist attitudes and biases produce expectations that clients are not engaging in the way they "should" or are expected to. Future research on the role of attitudes and stereotypes, and more research on therapist expectations, may offer promise in advancing this dimension of relationship research. As further context for that effort, we can consider what has been learned about other therapist factors in the formation and maintenance of the therapeutic relationship.

Therapist Factors

> Different personalities inevitably produce differences in the way in which any specified counseling procedure will be used. Two counselors who are attempting to use the same technique may not be producing at all the same psychological effect.
> (Tyler, 1953, p. 291)

An interesting paradox exists in the history of psychotherapy research: From some of the earliest research on counseling outcomes, investigators have hypothesized that outcome would be related to differences in the strength of the counseling relationship and to differences in various therapist characteristics (e.g., level of experience, training, ethnicity), but the two domains were not considered together. Until very recently, little research has examined therapist differences in forming or maintaining the counseling relationship (Baldwin et al., 2007).

The majority of research on therapist characteristics has treated these factors either as independent predictors or as "matching" variables, paired with client demographic characteristics. The most noteworthy conclusion that can be drawn from many decades of research is that therapist characteristics such as age, sex, race/ethnicity, training, skill, experience, and style are poor predictors of outcome (Beutler et al., 2004). When similar variables have been examined as predictors of relationship quality, they have also produced equivocal results but also demonstrate the limitations of treating therapist characteristics as isolated variables. For example, whereas Dunkle and Friedlander (1996) found that therapist experience did not predict strength of the working alliance, Kivlighan et al. (1998) uncovered a more complex association: Overall, therapist experience had no association with relationship strength but, for difficult clients, experienced therapists achieved stronger relationships than did less experienced therapists. Mallinckrodt and Nelson (1991) identified a series of complex interrelationships between training level and working alliance, and no differences on the bond component of the alliance.

Recognition of the complexity of therapist effects may contribute to what Beutler et al. (2004) have described as a "precipitous decline" (p. 289) in research on therapist variables. Although they express dismay over this shift, the authors also point out that researchers have reconceptualized many of the variables previously employed in investigating therapist characteristics, going beyond observable characteristics such as gender or age to an investigation of associated attitudes or values. For example, contemporary research is investigating "ageism" rather than age, or sex role attitudes rather than biological sex. Similarly, researchers are giving more attention to therapist factors or skill that emerge situationally, rather than generally, such as the earlier point that client attachment style may elicit differential responses from therapists (Hardy et al., 1999). The field does appear to be shifting to greater recognition of interactive and internal therapist factors; some of these domains of research are described below.

THERAPIST INTERPERSONAL STYLE: RECIPROCITY/COMPLEMENTARITY AND CIRCUMPLEX RESEARCH

> Counseling succeeds best when it steers clear of the autocratic attitude on the one hand and the laissez-faire on the other. . . .[and] views it always as a cooperative venture in which the two participants are making contributions of different sorts.
> (Tyler, 1953, p. 102)

One aspect of therapist behavior that has been a focus of relationship research in the past 30 years concerns whether the therapist's interpersonal style provides an effective complement to the client's style; in this domain, complementarity is defined as supporting or confirming a client's preferred style (Sexton & Whiston, 1994). Although there is not a great deal of research in this area, results have generally supported the contention that complementary interpersonal styles between therapist and client are associated with positive relationship development, particularly in the early stages of counseling (Beutler et al., 2004; Caspar, Grossman, Unmussig, & Schramm, 2005; Sexton & Whiston, 1994, Tracey, 1986).

Beutler et al. (2004) reviewed recent research and identified three subcategories of research in this area: investigations of complementarity in interpersonal style; assessments of reciprocal verbal patterns of interaction, focused on how a topic of conversation is negotiated through speaking turns; and investigations of nonverbal or multichannel communication, with an emphasis on the level of correspondence between verbal and nonverbal expression.

The first domain, that of complementarity in interpersonal style, emerged from Leary's (1957) interpersonal circle, which posits that persons on different points of the circle are continually negotiating the two relationship dimensions of control (to assert or submit) and affiliation (to be friendly or hostile). Benjamin (1982), Kiesler (1982), and Wiggins (1982) extended the circumplex model to client–therapist interactions in psychotherapy. Research in this area, including contributions by counseling psychologists (Kivlighan, McGovern, & Corazzini, 1984; Reandeau & Wampold, 1991), generally suggests that complementary styles (e.g., similarity on the friendly–unfriendly dimension and dissimilarity on the dominant–submissive dimensions) are associated with positive relationship development (Tracey, 1986).

In a 1994 review of research, Sexton and Whiston (1994) identified 14 counseling psychology investigations of complementarity, indicating that this has been an area of interest for the field. An illustrative example can be found in research conducted by Terence Tracey, who explored client–counselor reciprocity in negotiating the topic focus of counseling sessions. In a series of investigations between 1985 and 1989, Tracey and colleagues identified several associations between complementarity and the counseling relationship. To cite two examples, they found that high levels of client–counselor agreement on topic determination were associated with continuation in counseling, a finding that was subsequently cross-validated in a new sample (Tracey, 1986), and that more experienced counselors (in comparison to trainees) were more likely to use noncomplementary responses to challenge client's problematic interaction patterns (Tracey & Hayes, 1989). Beutler et al. (2004), summarizing research in this area, noted that, "such findings suggest that a subtle pattern of collaboration and tacit agreement exists between patient and therapist in successful treatment, which may be particularly important in the development of the therapeutic relationship" (p. 244).

Beutler et al. (2004) ended their discussion of complementarity with an expression of concern that this area of research is disappearing; however, their conclusion may have been premature. Recent frustration with static models of the counseling relationship (Angus, March 25, 2009, personal communication) has reactivated interest in more interactive models. A special issue of the journal *Psychotherapy Research* (2005; Vol. 15, 1–2) explored a range of topics identified as germane to complementarity and interaction within the relationship. Among others, these include perspective divergence in the working alliance (Fitzpatrick, Iwakabe, & Stalikas, 2005), nonverbal relationship regulation (Benecke, Peham, & Banniger-Huber, 2005), therapist–client connection in building the alliance (Sexton, Littauer, Sexton, & Tommeras, 2005), and a new model of complementarity in the therapeutic relationship (Caspar et al., 2005). This renewed interest is also reflected in the use of methods not often employed in relationship research; for example, Lepper and Mergenthaler (2007) employed conversation analysis, a qualitative method that applies a contextualized turn-by-turn analysis of talk, to examine the emergence of the therapeutic bond in a single dyad case study.

In anticipating the next 40 years of psychotherapy research, process researcher Lynne Angus predicts that influential therapist effects will reflect the qualities of "responsiveness" and "attunement" (Angus, 2009). Indirect—and somewhat amusing—support for Angus' prediction comes from research that has examined the use of manualized treatment protocols in controlled studies. In these research trials, it appears that the most effective therapists did not conform to the manualized instructions (Strupp & Anderson, 1997) and further, there was a negative correlation between measures of therapist interpersonal skill and ability to learn the manualized approach (Henry, Schacht, Strupp, Butler, & Binder, 1993a; Henry, Strupp, Butler, Schacht, & Binder, 1993b).

The first years of the 21st century produced a rapid escalation of interest in therapist effects, and a growing number of researchers contend that therapist contributions have their effect via their role in forming strong, effective therapeutic relationships (Wampold, 2007). As an example, Lutz and colleagues (2007) studied a naturalistic dataset of 1, 198 clients and 60 therapists and found that, whereas 8% of total outcome variance was attributable to therapist effects, 17% of the variance in

clients' rate of improvement was attributable to therapist factors. Although not discussed by the authors, one can speculate that the more we attend to moment-by-moment interaction between client and therapist, the larger the proportion of variance may be. Lutz et al.'s results produced proportions that are very similar to results obtained by other investigators who have begun dismantling therapist contributions to the alliance and to outcome.

Bruce Wampold is a counseling psychologist whose research has brought greater attention to therapist effects. In an APA award address in 2007, he argued that "there is increasing evidence that it is the therapist and not the treatment per se that is responsible for therapeutic change . . . and, it appears that much of the variability among therapists is due to therapists' ability to form a working alliance with a variety of patients" (p. 868). As we move ahead with our efforts to understand the counseling relationship, it is becoming increasingly clear that we must also increase our efforts to understand what is contributed by the individual therapist. As we do so, there is a perennial area of research that receives little attention and is cited rarely in surveys of the therapeutic relationship: that of the therapist's personal adjustment and well-being.

Therapist Well-being, Mental Health, Adjustment

> One can say, for instance, that a counselor should be a very stable, well-adjusted individual himself so that the help he attempts to give others with their problems will not constitute a case of the blind leading the blind. It can just as well be said, however, that a counselor should have experienced anxiety, conflict, and indecision in his own life so that he can understand it in others.
> (Tyler, 1953, p. 267)

Although many practitioners would accept the idea that a therapist's level of adjustment or distress could have an impact on the therapeutic encounter, there has been surprisingly little research on this topic, and even less on the relationship between therapist adjustment and the counseling relationship. Beutler et al. (2004) report a very modest positive relationship between therapist well-being and therapeutic outcome, with an average effect size across nine studies of $r = .12$ ($p < .05$). Horvath and Bedi (2002), in their review of research on the working alliance, cite several negative therapist characteristics that have been associated with poor alliance formation: a "take charge" approach (Lichtenberg et al., 1988), and being perceived as "cold" (Hersoug, Monsen, Havik & Hoglend, 2002) and as irritable (Sexton, 1996).

Although there is little empirical evidence in this area, it is fair to say that our profession holds an assumption that therapist distress or maladjustment can have a negative impact on the counseling relationship. Implicit evidence for this claim comes from our professional ethics codes, which require psychologists to "refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner" (American Psychological Association [APA], 2002, Standard 2.06a) and, "When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties" (APA, 2002, Standard 2.06b).

A substantial and possibly overlooked body of research may be relevant to the question of how therapist well-being effects the counseling relationship. Given the ubiquity of computerized literature searches driven by author-selected key words, it appears likely that relevant research on this topic has been categorized in other domains and not integrated with relationship research. For example, Nutt-Williams, Hayes, and Fauth (2008) report that, for therapists, there is a consistent positive association between anxiety, negative self-talk, and lower self-assessments of effectiveness. Nutt-Williams and Hill (1996) found that, as trainees increased their level of negative self-talk, clients rated them as less helpful. In a review of counselor supervision literature, Ladany et al. (1999) found that a weaker supervisory working alliance was related to supervisors' lack of adherence to ethical guidelines. Ethical violations can reflect interpersonal difficulties, a hypothesis that gains some support from Nigro's (2004) work: Her qualitative survey of problematic dual relationships ($N = 206$) documented negative consequences in therapists' relationships with clients.

Another area that suggests a connection between therapist factors and relationship quality is the limited research on trainee impairment. In their major contribution and review, Forrest et al. (1999) noted that much of the research has focused on trainees whose impairment is in the area of clinical and

interpersonal skills. They further report that "we can assume that most training programs in any 3-year period are probably dealing with four to five impaired or possibly impaired trainees (and) will dismiss one of those trainees" (p. 652).

A student or researcher conducting a search on the key words "therapeutic relationship" would be unlikely to uncover any of the research cited above. This may reflect a tendency to define relationship-relevant research too narrowly. As we learn more about the specificity of therapist contributions to relationship formation and maintenance, factors such as interpersonal skill and ethical adherence are likely to assume a greater role, and merit future research.

Capacity for Relationship: Training and Selection of Counselors and Psychotherapists

> The difficulty is that people with the necessary mental ability and a strong desire to do counseling do not all show the personal characteristics that make for success and satisfaction. It is just these personal characteristics which at present we are not able to analyze or predict.
> (L. Tyler, 1953, p. 267)

The field of relationship research is entering a new era: Psychotherapy researchers have identified the therapeutic relationship as our most consistent predictor of outcome (Horvath & Bedi, 2002; Imel & Wampold, 2008), and further evidence is accumulating that it is the therapist who carries the greatest weight in determining whether an effective relationship will be established. This presents the whole edifice of psychotherapy training with a profound challenge: If the most influential factor *is* the therapist, what is it about the therapist that matters? And, once those characteristics or skills are identified, are they something that can be taught? These may be uncomfortable questions for counseling psychologists. Although Tyler's comments indicate that such questions are not new, we have just begun to address them in a systematic fashion. Our historical values have emphasized the potential for growth in each individual—each trainee—and we may resist the idea that there are trait-like qualities that determine who will, or will not, be effective in developing therapeutic relationships.

At the same time, our legacy of empiricism propels us into an examination of these questions. What little research has been conducted to date presents findings that are challenging, although admittedly tentative and preliminary. Lambert and Ogles (2004), in their review of research investigating the role of training, reported that therapist training had no relationship to outcome or to strength of the therapeutic alliance. However, a therapist or trainee's level of interpersonal skill had a significant and positive relationship with both outcome and the alliance. Despite consistency in results, there are too few studies to draw firm conclusions; one has to wonder why this area has received so little attention.

Several investigators have evaluated the effects of specific training programs, and the results have not been encouraging. Henry et al. (1993a) provided systematic training on development of the alliance but failed to produce gains in therapists' ability to create stronger alliances. Horvath (2005) reported on his own survey of projects designed to train therapists in alliance skills, in which he found that the majority of such efforts failed to demonstrate an association between training and a resulting positive alliance, whether assessed by clients or independent raters. Intriguingly, he also noted that, although few identifiable skills were associated with alliance strength, researchers were successful in identifying personal attributes associated with alliance strength (e.g., flexibility and warmth).

Crits-Cristoph and colleagues (2006) investigated whether training in "alliance-fostering psychotherapy" (p. 268) would enable practicing therapists to enhance their alliance with clients diagnosed with major depressive disorder. Noteworthy as a field study with actual therapists and clients, the increases in alliance ratings for therapists failed to reach significance; further, decreases in alliance scores were observed for two of the five therapists . The authors also noted that therapists varied in their general tendency to form positive alliances and that differences were unrelated to training.

On a more positive note, a series of qualitative investigations conducted with therapist trainees in Norway (e.g., Nerdrum & Ronnestad, 2002, 2004) documented positive outcomes in empathic understanding following an empathy training program. At the same time, qualitative results exploring the trainees' perceptions indicated that many found it stressful and difficult to change their preferred style.

One significant project that has the potential to inform future research on the potential for training in therapist relationship skills is the Collaborative Research Network established by the Society for Psychotherapy Research. A summary report for this large-scale, international project (Orlinsky & Ronnestad; 2005) notes that, among the more than

5,000 therapists who participated, there were four identifiable patterns of engagement with clients: effective, challenging, disengaged, and distressing. Of concern, 17% of respondents reported disengaged relationships and 10% reported distressing engagement. The evidence that 27% of this sample described a stance toward therapeutic engagement that runs counter to descriptions of effective counseling relationships calls to mind some of the research cited earlier: Wampold's findings on the variability in therapist effectiveness and Forrest et al.'s report of the percentage of trainees identified as impaired while still pursuing their education. As Beutler et al. (2004) note, "high levels of therapist well-being cannot be assumed to be present among therapists in research studies. It may be a hidden moderator of many contradictory or inconsistent therapy findings" (p. 276–277). The Orlinsky and Ronnestad (2005) report concludes with some pointed recommendations. In particular, they argue that the available evidence points to the importance of relational skills that students bring to their training experience, as opposed to those that may be developed through supervision, and they recommend that possession of good interpersonal skills become a criterion in selection for psychotherapy training.

Career Psychology and the Counseling Relationship

> How would such a job suit Barney?. . . . It is to be noted that [the counselor] has not picked out a job for the client and is not preparing to sell him a new idea. That would be out of keeping with the counseling relationship he has worked hard to create. He is simply insuring that the task the two of them are working on together, the consideration of occupational alternatives and the choice of one, will be carried out as thoroughly and efficiently as possible.
> (Tyler, 1953, p. 175)

A longstanding debate has existed within counseling psychology as to whether career and personal counseling constitute independent domains of practice or share much in common. The question is relevant to any discussion of the role of the counseling relationship in career counseling, as one needs to consider whether the compelling findings obtained for its role in psychotherapy and personal counseling can be extended to the career arena. In general, those who have addressed the issue have pointed to commonalities: Crites (1981) described career counseling as an interpersonal process, and Corbishley and Yost (1989) noted that several aspects of career counseling (e.g., the relationship and client resistance) require a psychological approach. Swanson (1995) argued that the process of career and personal counseling should be regarded as similar, in that both require many of the same skills, including a negotiation of client and counselor roles and a relationship that supports the client's sharing of personal information. A useful resolution to the debate was offered by C. H. Patterson who, in a postretirement interview, remarked that, "Basically, the counselor as an understanding person is the commonality between therapy and career counseling" (Freeman, 1990, p. 297) and, "You still need to think in terms of the core conditions of counseling, whether it is career counseling or not. The core conditions are the principles of any good relationship" (p. 292).

Patterson's reference to the familiar core conditions suggests that the counseling relationship should be considered as central to client change in career counseling. However, few empirical conclusions can be drawn, given that there continues to be a paucity of research in this area. This is a curious state of affairs—not only is career counseling one of the defining domains of counseling psychology, it also reflects some of the strongest applications of our empiricist tradition, in which theory, assessment, and intervention have been subjected to rigorous scrutiny (Fouad, 2007).

The absence of research cannot be attributed to the discipline's failure to call attention to this gap. Swanson, in 1995, issued an urgent call for research on process aspects of career counseling, including the role of the counseling relationship. Her encouragement for additional research continues to be cited (e.g., Whiston & Rahardja, 2008), typically in either the introductory or summary paragraph of an article on career counseling research, by authors who lament the fact that there continues to be little new to report in the process arena. This may be overstating the case to some degree; it is clear that Swanson's call did catalyze new research on the role of the counseling relationship in career counseling, which is reviewed below. However, there continues to be much more to learn.

Overall, the conclusions that can be drawn from the limited research available are that effective career counseling includes operation of a strong counseling relationship or working alliance, and that clients, counselors, and independent observers comment on its importance. However, the association between the relationship and client outcomes

is less understood or investigated than is the case in psychotherapy and personal counseling.

Several early investigations used a case study method to investigate relational issues. Kirschner, Hoffman, and Hill (1994) examined seven sessions of successful career counseling with a midlife woman; their critical incident analysis identified an important role for the counseling relationship. Specifically, client and counselor discussions of the counseling relationship were rated as positive critical incidents, whereas avoidance of discussion of the relationship was rated as a negative critical incident. Heppner and Hendricks (1995) conducted a case study of two career clients, one classified as undecided and a second as indecisive and, in the context of assessing the utility of career interventions, determined that the counselor–client relationship was important for both clients. This finding echoes the results of an investigation of career clients who were either moderate or high in distress (Rochlen, Milburn, & Hill, 2004); although the more distressed client desired more active skill training, the two types did not differ in their perceptions of the therapeutic relationship.

In a large-scale, longitudinal field study in Britain, Bimrose et al. (2004, 2005) conducted in-depth case studies of 50 career clients to identify effective career practice and its impact on clients' lives. In the analysis of counselor interventions, both clients and independent raters identified the development of a working alliance as one of four core categories that characterized the career sessions. The project's detailed analysis offers one of the most comprehensive descriptions of career practice available, and its attention to the importance of the counseling relationship in career guidance is noteworthy.

The most direct investigations of the role of the counseling relationship in career counseling have been conducted by Multon and colleagues (Heppner, Multon, Gysbers, Ellis, & Zook, 1998; Multon, Heppner, Gysbers, Zook, & Ellis-Kalton, 2001; Multon, Ellis-Kalton, Heppner, & Gysbers, 2003). In each investigation, the researchers documented the operation of a strong working alliance between career clients and their counselors and found that the strength of the alliance increased across sessions (Heppner et al., 1998; Multon et al., 2001). The strength of the measured alliance is noteworthy; for example, Multon et al. (2003) obtained a mean alliance rating of 71.54, out of a maximum score of 84, with a mean item response of 5.96 on a seven-point Likert scale. Multon and colleagues' findings regarding the relationship between the alliance and career client outcome have been mixed; the 1998 study failed to find an association, but the 2001 study found that the alliance accounted for 17% of the variance in outcome. Some reviewers (e.g., Whiston & Raharja, 2008) have characterized this as a weak association. However, recent summative reviews of psychotherapy alliance research report an average association between alliance and outcome of .21, with a median effect size of .25 (Horvath & Bedi, 2002), suggesting that the results obtained by Multon et al. are not widely discrepant.

An important program of research conducted by Kim and colleagues has included the counseling relationship among the variables explored in career counseling with Asian American clients. Kim and Atkinson (2002) identified an unexpected association, in that clients who endorsed high levels of Asian values rated an Asian American counselor as more empathic, but rated a European American counselor as more effective. In a further investigation (Li & Kim, 2004), in which a Euro-American counselor offered either directive or nondirective career assistance, the Asian American clients, regardless of their endorsement of Asian values, associated the directive counselor's approach with greater empathy, a stronger alliance, and cultural competence.

In a qualitative study designed to identify influential aspects of the counseling process, Whiston and colleagues (2005) interviewed 12 vocational counseling experts and learned that each considered the counseling relationship to be central to his or her work. Specifically, these counseling experts viewed the relationship as essential for supporting clients in the exploration stage, as well as in forming a trusting base from which they could implement more challenging interventions (e.g., challenging beliefs that interfered with exploration or decision).

As noted previously, there is a very limited body of research that has explored the counseling relationship as a specific factor in career counseling. However, there have been a series of investigations that provide indirect evidence for its role in the career counseling process. Perhaps the most important of these is the global conclusion that emerged from a meta-analysis conducted by Whiston et al. (2003). Based on a comprehensive review, they concluded that counselor-*free* career interventions are significantly less effective that those that include active engagement by a counseling professional. To further elaborate on the indirect evidence that has emerged, several investigations are noted briefly.

Gold et al. (1993) determined that affective components of the career counseling process

(e.g., the experience of counselor support and encouragement) were associated with the greatest change in clients' vocational identity. Anderson and Niles (2000), in a study that identified helpful events in career counseling, reported that both counselors and clients cited provision of emotional support as important to client gains. McIlveen (2007) conducted phenomenological research on implementation of a constructivist career assessment and guidance intervention and found that counselors emphasized the importance of embedding the intervention within an established counseling relationship.

Healy (2001) investigated factors that hindered counselor effectiveness in career counseling; the findings indicated that clients reacted negatively to counselors who were perceived as inadequate, as inattentive, and as delivering the results of standardized testing in a mechanistic fashion. Although the counseling relationship was not assessed directly in this study, few would argue that these identified characteristics are compatible with Rogers' core conditions; and, Healy's attention to the importance of attending to relational factors when using standardized assessment provides an introduction to the next topic of interest.

In a final example, Dorn (1988) employed Strong's social influence model in exploring the role of the relationship in career counseling and used the Counselor Rating Form (Barak & LaCrosse, 1975) in process research with a single career client. He found that client ratings of the counselor's Expertness and Trustworthiness were uniformly high across sessions, whereas ratings of the counselor's Attractiveness were high in session 1, dropped in session 3, then increased for session 5. This provides another speculative glimpse of relationship development as a dynamic process, in career as well as personal counseling.

The Counseling Relationship in Standardized Assessment

> It is not so many years ago that Bordin and Bixler, thoroughly imbued with the nondirective attitude, first proposed that tests should be chosen by the client rather than by the counselor. At first it seemed to many workers to be a fantastic idea, but as it was tried out it began to seem quite a natural sort of procedure. Its great advantage is that it keeps an essential feature of the situation clear for the counselee—namely, that he is to make the decisions by which the course of his life is to be governed. (Tyler, 1953, p. 143)

A domain of counseling practice that has relevance for our discussion of the counseling relationship, despite a marked absence of research investigation, is the use of standardized testing. The current discussion attempts to catalogue what little research has emerged in this area because, in contrast to many areas of psychotherapy, the counseling psychology approach to the use of standardized assessment represents a clear, historically embedded example of a distinctive counseling psychology approach to practice, one that is wholly grounded in the field's conceptualization of the core relationship between counselor and client. And yet, this is an area virtually ignored by researchers.

Students of the history of applied psychology may recall that expertise in standardized assessment was one of the first and most significant areas of practice that differentiated psychology from the medical domain of psychiatry. Furthermore, counseling psychology was rapidly differentiated from clinical psychology in its endorsement of testing practice that was focused on the needs of the client, and in advocating selection of tests that met client goals, rather than those of persons interested in categorization or diagnosis. As early as 1959, Barbara Kirk and one of her students (Rudikoff & Kirk, 1959) provided guidance to counselors for communicating test information in a manner that clients could comprehend and accept, anticipating a unique counseling psychology perspective on the use of standardized test information.

In 1986, Tinsely and Bradley asserted that the use of testing, and its interpretation, is best viewed as an integral component of the counseling process, rather than as something separate and distinct from other aspects of the work that counselors and clients do together. In 1990, Jane Duckworth advanced a classic formulation of a counseling psychology approach to testing, one that placed the client's concerns in a central role and described how the process of test use was integral to an overarching counseling relationship. If some readers are unfamiliar with this classic reference, I encourage each of you to read Duckworth in its entirety; your practice will be enhanced. As one example, consider Duckworth's advice to counselors on what elements of a test interpretation to address:

> Focusing on personal strengths as well as weaknesses leads to a more balanced picture of the individual who is coming in for testing. It also lets clients know that they can assist in their own treatment because they do have strengths . . . [this] approach to testing enlists the power of the client as well as the expertise

> of the therapist to effect the therapeutic change. The assumption is made that clients can be powerful and solve problems when they have accurate information about themselves. (p. 201)

Other authors have addressed this issue; Prediger and Garfield (1988), in offering a checklist of testing competencies and responsibilities, included the item, "Apply good counseling to test interpretation by attending to the counselee first and the test results second" (p. 53). Although indirect, these established and noteworthy counseling psychology authors and researchers have pointed to the importance of the counseling relationship in effective use of standardized testing.

The activity of communicating test results can be conceptualized as a form of client feedback and Claiborn et al. (2002), in a review of this aspect of the counseling relationship, report that feedback is most likely to be considered within a collaborative therapeutic relationship, and that positive feedback appears to be associated with establishment of strong therapeutic relationships. Furthermore, they note that the therapist's position, conceptualized according to Stan Strong's social influence model of expertness and attractiveness/similarity, plays an important role in client acceptance of test feedback.

In 1997, Finn and Tonsager published a report that described the positive impact of Minnesota Multiphasic Personality Inventory (MMPI) interpretations on clients' sense of self and encouraged the use of tests as an active means of engaging clients in both the therapeutic relationship and the work of psychotherapy. Their work on the potential benefits of test data as an intervention—akin to feedback–continues to be widely cited but, to date, does not appear to have had a significant impact on practice. Curry and Hanson (2010) conducted a national survey of counseling, clinical and school psychology practitioners with respect to both their graduate training and current practice in providing test feedback; one third indicated that their training experience had not prepared them to deliver feedback. Of equal concern from an ethical perspective, only one third reported providing verbal feedback each time tests were administered to clients.

A meta-analysis (Poston and Hanson, 2010) of the impact of psychological assessment as a therapeutic intervention provided robust evidence (Cohen's $d = 0.423$) that standardized testing can have a significant positive impact on the therapeutic process and outcome, "when combined with personalized, collaborative, and highly involving test feedback" (p. 203). Although readers familiar with the client-centered perspective advocated by Tyler (1959), Kirk (Rudikoff & Kirk, 1959), Tinsley and Bradley (1986) and Duckworth (1990) will not be surprised by the meta-analytic findings, these pioneering authors are virtually invisible in contemporary discussions of how to conduct a collaborative test interpretation to achieve measurable impact on therapy process and outcome. Further, a review conducted for the current discussion identified no research with an explicit focus on the role of the counseling relationship in clients' ability to make constructive use of test data.

One could argue that this is a missed opportunity to elucidate a distinctly counseling psychology perspective on a core therapeutic activity. The use of standardized measures continues to be an important aspect of applied psychology practice and I believe that counseling psychologists, with their distinctive perspective on both the counseling relationship and the use of assessment, could make a significant contribution in elucidating how relationship factors and assessment interact. Whiston et al. (2005) noted that a strong counseling relationship can provide a secure base for client exploration of potentially challenging material and, when used in the service of client goals, tests often provide this sort of information. I encourage researchers to explore the role of the counseling relationship in the domain of standardized assessment and, in particular, as a facilitating factor in counselee acceptance and use of data derived from standardized assessment.

Diversity and the Counseling Relationship

> The accepting attitude is the opposite of contempt . . . and, it is a feeling about an *individual*, not about mankind in the abstract. Lofty generalizations about the dignity of personality are irrelevant to it. . . . It is because acceptance is so closely tied to understanding the person as an individual that the two qualities we have stressed cannot be separated, in counseling or anywhere else. (Tyler, 1953, p. 26)

Counseling psychology's distinctive perspective on the therapeutic relationship, as argued previously, is an enactment of values that have long been central to the field's identity. One area where this is particularly germane is the formation of effective therapeutic relationships with clients from diverse backgrounds. This is particularly salient with clients from marginalized or disadvantaged backgrounds, whose cultural or ethnic heritage differs from that

of their counselor, or whose religion, sexual orientation, or gender differs from their counselor's life experience. Given that a significant majority of North American psychologists continue to be persons of European, Caucasian heritage, we are basically concerned with the question of whether majority culture practitioners succeed in forming strong relationships with people different from themselves, and whether those relationships promote positive outcomes for clients.

Many have argued that the task of forming strong alliances with clients unlike oneself is an area in which our practice has fallen short of our ideals (e.g., Comas-Dias, 2006; Smith, 2005) but, before examining some of the research conducted in this area, it is worthwhile to note some of the early expressions of our field's commitment to issues of diversity and social justice. Counseling psychology's values and commitment to diversity, if genuine, will be reflected in the types of relationships we construct with clients from diverse backgrounds. The stance that our profession has taken on these issues can provide some insight on the values we aspire to enact.

Despite the moments when we fall far short of our ideals, counseling psychology has played a leadership role in bringing these issues to the attention of the field at large. Roger Myers (2004) traces the field's concern with social justice back to Frank Parsons in the early 1900s, as well as to E.G. Williamson's effort to call attention to "the restrictions on freedom imposed by traditions and custom on racial, religious, or ethnic minority groups" (1965; cited by Myers, 2004, p. 129). In the second half of the 20th century, counseling psychologists understood that acceptance and understanding were not well served by what Tyler called "lofty generalizations" (based largely on the dominant male culture) and began to elucidate principles for practice that addressed the distinctive needs of specific groups. In 1978, the American Psychological Association's Division 17 (Counseling Psychology) approved the *Principles Concerning the Counseling and Psychotherapy of Women* as official policy (Fitzgerald & Nutt, 1986). This contribution was widely influential within the APA and was endorsed by several other divisions. In the 1980s, counseling psychologists began to call attention to cultural diversity and to advocate for guidelines on culturally competent practice (e.g., Sue et al., 1982). These efforts led to APA's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003), originating with the work of a joint task force of APA Division 17 (Counseling Psychology) and Division 45 (The Society for the Study of Ethnic Minority Issues). Vasquez (2007), among others, has called attention to the relevance of the *Guidelines* for development of therapeutic relationships with culturally different clients, particularly in calling for therapists to increase their awareness of unconscious beliefs and stereotypic attitudes.

A literature search on "therapeutic relationship" will not produce citations for these important guidelines; at the same time, they are essential for understanding how counseling psychologists regard establishment of an effective relationship with clients whose life history and experience differ from that of the dominant culture. The research review that follows illustrates some of the ways in which these questions have been explored.

Client–Counselor Matching on Demographic Variables

> Most high schools and many colleges arrange for men to take care of the boys and women the girls. There is no evidence, however, that this is the best practice or the one making for best rapport in all cases. . . . Furthermore, these questions are too complex to be thought through on the basis of rapport alone . . . we simply do not know enough about these things to decide wisely. Probably the best procedure . . . is to let the client decide, if counselors of both sexes are available.
> (Tyler, 1953, p. 39)

Some of the earliest investigations of counseling with clients whose ethnicity or culture differed from that of the counselor (who was typically a member of the majority culture) explored the hypothesis that matched dyads—on variables such as gender, race or culture—would produce better outcomes. Several decades of research have not supported this position and, at best, the results for some groups are described as "mixed" (e.g., Comas-Diaz, 2006; Norcross, 2002). In hindsight, the prediction that a match on group membership would be predictive is simplistic. There has been a longstanding awareness (although not always applied) that groups who share the same societal label also have significant within-group differences. More recently, several authors have drawn attention to the necessity of recognizing "multiple identities" and the intersectionality of varied group identifications within a single client (e.g., Cole, 2009; Vasquez et al., 2006).

The issue of multiple identities is particularly important to the question of whether "matching

research" can be a productive area for investigating the counseling relationship in diverse populations, as it is difficult to imagine how one could "match" a client on all dimensions that might be relevant to forming a strong counseling relationship. Some cases of multiple identity can present a mix of marginalization and privilege, as in the case of an architect whose progressive disability requires use of a wheelchair and help from a health attendant; this client might "match" a counselor on SES or disability status, but rarely both. Other clients may present multiple forms of marginalization, as in the case of a white lesbian refugee from Eastern Europe. Even beyond the simplistic question of whether a "white" counselor would be the best "match," we cannot assume that a lesbian counselor would be the best person to understand this client's refugee experience. And, neither of these pairings may match the aspect of identity most salient to the client or to the issues she brings to counseling. One of the potential contributions of the multiple identities literature is its capacity to remind us, not only of the more visible forms of diversity that clients may embody, but of the hidden diversities that may play an important role in the formation of the counseling relationship. The literature review conducted for this chapter did not identify any diversity research on the counseling relationship that has incorporated a multiple identities perspective; until we accept this challenge, it is likely that our understanding of the factors influencing relationship development with diverse clients will remain inconclusive. Nevertheless, every summative review on the counseling relationship appears to consider it necessary to discuss the literature on racial/ethnic/gender matching. Typically, this subject becomes the focus of a section or heading, and the reports of mixed and inconclusive results are highly consistent. One can choose to be either intrigued or discouraged by our continued absorption with the topic.

Beutler et al. (2004) note that, although the concept of matching is widely accepted and advocated, there is little empirical evidence to support the recommendation to match clients and counselors on demographic characteristics, particularly with regard to outcome, where results are either equivocal or weakly supportive. Simply stated, client–counselor match does not automatically produce a working alliance that predicts client outcome; Karlsson (2005) attributes the failure to identify consistent associations to both conceptual and methodological problems with matching research. Beutler et al.'s 2004 meta-analysis of 11 studies, published between 1990 and 2000, found a modest positive effect (mean weighted effect size of $r = .02$), particularly for Asian Americans and Mexican Americans, a finding that is consistent with conclusions reported by Sue and Lam (2002). For our present discussion, it is important to note that the authors found a great deal of heterogeneity in the data which, as they note, suggests that outcomes may be moderated by unidentified third variables. This idea is considered in more detail below.

There is a growing consensus that, although matching does not automatically produce a working alliance that predicts client outcome, it is likely to produce an indirect effect on outcome, particularly for less acculturated clients (e.g., Buetler et al., 2004; Karlsson, 2005; Sue & Lam, 2002). One salient example is the research on matching and therapy drop-out, or the number of sessions completed. A limited number of studies have found that, for African American, Asian American, American Indian, and Latino/Latina and Mexican American clients, matching on racial/ethnic similarity is associated with less likelihood of therapy drop-out. Comas-Diaz (2006) cites research indicating that, in racially similar physician–patient relationships, people of color participate more in their treatment than in racially dissimilar pairings.

As discussed in our examination of the role of expectations in therapy drop-out for low SES clients, the research on racial/ethnic matching and drop-out highlights the need to identify variables that may moderate or mediate these relationships. The following section presents examples of research on therapist, client, or relational characteristics that have been investigated for their role in matching. The studies cited also provide an illustration of Hill's (2005) point that client, therapist, and relationship variables are "inextricably intertwined" (p. 431) and that we lose meaning if we consider them in isolation. Several points are worth noting by way of introduction. First, many of the variables to be considered fall within the first stage of therapy, which Hill labels as one of initial impression formation, the stage at which critical elements of relationship development occur. As noted by Horvath and Bedi (2002), measurement of the therapist alliance is predictive at three sessions.

Second, the following discussion is organized around variables, rather than summarizing findings for groups or populations. This is deliberate; the paucity of research in this area precludes reliable group generalizations or distinctions, and the value of this overview is to suggest variables that are

potentially valuable targets for further investigation in many groups.

Third, the categorization of variables as client and therapist factors is necessarily somewhat arbitrary; it is much more likely that these variables exert their effects through an interaction between client and counselor perspectives on each factor described. Those listed as client factors are variables that counselors should take as "given" in a particular counseling relationship. Just as a client's attachment history may challenge or facilitate the counselor's efforts to form a relationship, various diversity factors are inextricable parts of the person with whom a counselor works to form a relationship. Those variables listed as therapist factors represent variables that are most likely to be amenable to some level of therapist control.

Matching Research: Client Factors

> [T]here is another whole set of factors affective the structure of the initial relationship—the client's general attitudes toward broad categories of people. These are extremely varied, as human beings classify their fellow-men in all sorts of ways.
> (Tyler, 1953, p. 38)

PREFERENCE AND SATISFACTION

The strongest evidence for the value of client–counselor match is found in measures of client satisfaction, as well as the previously noted indirect outcomes, such as continuation in treatment (Sue & Lam, 2002). This is not insignificant, as satisfaction may reflect a client's sense that she has been understood, or that her needs or goals have been met. Regrettably, there is little research to help us understand what constitutes client satisfaction, although a client's preference for the type of counselor she will see appears to be an important factor. For example, research has been consistent in documenting that black clients prefer to work with black therapists (Thompson, Bazile, & Akbar, 2004; Townes, Chavez-Korell, & Cunningham, 2009). However, even this finding is not without complexity; a client's degree of group identification, or racial identity, predicts black American client preferences for a black counselor (Ferguson, Leach, Levy, Nicholson, & Johnson, 2008) and earlier research (Parham & Helms, 1981) found that black clients with pre-encounter racial identity attitudes expressed preferences for white counselors.

In the area of career research. Kim and Atkinson (2002) found that Asian American vocational counseling clients rated their European American counselors more positively than they rated Asian American counselors. The authors found that client ratings of empathy and counselor credibility were associated with the counselors' attention to Asian values; in this sample, the attitudinal variable was more important than a demographic match on race or ethnicity. It appears likely that within-group differences on variables such as racial identity, attitudes and values–for both clients and counselors–are an influential component of client preference and likely moderate the link between group membership, strength of the alliance and outcome.

Research on gender matching has been inconclusive (Sue & Lam, 2002) and the findings of a small but significant outcome effect for female therapists applies to both male and female clients (Bowman, Scogin, Floyd, & McKendree-Smith, 2001). This result calls into question the conclusion that, for female clients, it is the gender match that is associated with greater satisfaction. Zlotnick and colleagues (1998), using National Institute of Mental Health (NIMH) data from the Depression Collaborative Research Program, found that gender match was not related to outcome, or to client perception of therapist empathy. Furthermore, when they examined clients' expectations about whether a male or female therapist would be more helpful, outcomes did not differ based on whether clients were matched or mismatched with the gender they expected to be most helpful.

It should be noted that this area of research has not fully explored whether client satisfaction is mediated by the presenting problem that the client brings to counseling (see the discussion of counselor credibility, below). In matching, the notion of client preference may tap some of the same characteristics that, in Strong's social influence model were classified as "attractiveness," or the sense that a counselor was sufficiently similar to serve as a base of influence or help. Again, the challenge to researchers is to identify what variables, beyond broad demographic categories, may produce this effect.

CULTURE AND LANGUAGE

As noted previously, recent research has documented some modest benefits for matching with Asian American and Mexican American clients (e.g., Beutler et al., 2004; Kim & Atkinson, 2002; Sue & Lam, 2002), and this research has also called attention to the potential roles of language and cultural assumptions and beliefs. Concerning language, Stanley Sue and colleagues (1991) divided

Latino clients based on primary language and found that, for those whose primary language was Spanish, ethnic match was related to drop-out and treatment outcome. Given the wealth of information that must be communicated verbally in "talk therapy," one can easily understand how an ability to differentiate between affect-laden words such as ashamed versus humiliated or disappointed versus devastated might have importance in a client's feeling understood. Sue et al.'s results are salient to the question of developing therapeutic relationships with recent immigrant and refugee clients; these groups are likely to have higher proportions of clients who speak English as a second language. Refugees and immigrants are also populations who are extraordinarily under-represented in psychotherapy research on how ethnicity and culture may influence development of counseling relationships.

In exploring other cultural factors, Nolan Zane, Stanley Sue, and colleagues (2005) have gone beyond purely demographic matching and have explored the "cognitive match" between Asian clients and their therapists. Their work measures counselor and client expectations and perceptions of psychotherapy (e.g., presenting problem, treatment goals) and appears to provide a cultural formulation of the task and goal components of the working alliance. The authors found that cognitive matches between clients and therapists were predictive of outcome and suggest that the cognitive match may account for the finding that ethnically matched therapy dyads complete more sessions. One of their key contributions has been to expand our conceptualization of what may be operating in a purely demographic match to include consideration of other cultural, cognitive, or attitudinal factors that are important in determining the strength of a therapeutic relationship.

In considering this area of research, it is important to note that most counseling psychology research relevant to "diversity" has been concerned with groups that are well established in the United States. In addition to domestic racial-ethnic groups, diversity research has focused on gender, gay/lesbian, and religious groups, but has given little attention to immigrants, refugees, or to clients whose disability status or age may present distinct "cultures" relevant to developing therapeutic relationships. There has also been little attention to an international understanding of diversity, or consideration of how North American conceptualizations of cultural factors may translate to psychotherapy relationships in cultures outside the United States. These groups, or questions about the diversity they represent, are under-represented or wholly absent in psychotherapy research on how ethnicity and culture may influence development of counseling relationships.

One exception to this charge can be found in a study that investigated the working alliance and counselor problem solving style in Taiwanese client–counselor dyads (Wei & Heppner, 2005). In addition to documenting similarities in alliance formation, this work provides a useful example of how culture-specific factors are important in developing a strong counselor–client relationship. For example, both the quantitative and qualitative component of this mixed-method study revealed that counselors' active problem-solving behaviors contributed to client perceptions of counselor helpfulness.

The Wei and Heppner (2005) investigation also provides a conceptual link to earlier counseling psychology research on the therapeutic relationship. As they note, the construct of counselor "credibility" can be conceptualized as client perceptions of counselor expertness, attractiveness, and trustworthiness, variables central to Strong's social influence model (see Hoyt, 1996, for a review). The social influence model has not been used widely to investigate factors that may account for the role of matching in reducing therapy drop-out or increasing client satisfaction; however, it offers a convenient and well-established umbrella for some of the variables associated with therapist factors, as discussed below.

Beyond Matching: Therapist Attitudes and Values

> The capacity for accepting others is a trait far broader than specific training in counseling skills. The counselor's basic attitudes toward human beings are involved, and such basic attitudes are not the product of a year's cultivation or of specific educational experiences. They grow from the responses a person makes to all the experiences of his life. . . .
> (Tyler, 1953, p. 25)

Historically, researchers have given little attention to therapist factors that may influence the process or outcome of psychotherapy with diverse clients (Karlsson, 2005; Leong & Gupta, 2008). This is particularly true for research on therapeutic relationships with cultural or ethnic minority clients. In contrast, literature on therapist attitudes, bias, and stereotypes has demonstrated that therapists

hold negative and stereotypic views of clients based on gender, sexual orientation, age, culture, or ethnicity (Beutler et al., 2004). These biases are presumed to have an impact on the process of therapy but little empirical research has investigated their influence on outcome or on the therapeutic relationship. This is another area where evidence related to the counseling relationship appears to be indirect, although two broad areas of therapist attributes that have received attention are therapist beliefs, attitudes, and values, and multicultural knowledge and skills.

Therapist attitudes and values related to a range of diverse populations, reflecting many of the "isms" that embody negative stereotypes of particular groups, have been cited as potential barriers to effective counseling. Similar to Smith's (2005) documentation of negative therapist attitudes toward the poor and low-SES clients, Danziger and Welfel (2000) found that therapists exhibited ageism in holding negative, stereotypic views of older clients. Barrett and McWhirter's (2002) analogue investigation of homophobia in counseling trainees found that those holding more homophobic attitudes viewed gay and lesbian clients more negatively than they did heterosexual clients; male trainees, in particular, were more likely to assign negative adjectives to gay and lesbian clients.

There is evidence that negative attitudes toward client group membership are associated with less empathic responding, a core component of effective relationships. Nelson and Baumgarte (2004) propose that this may be associated with difficulties in perspective taking on the part of the therapist, and report that individuals show less empathy when responding to another's distress when the distress arises from unfamiliar cultural contexts. Given the evidence that therapists are not immune to the negative attitudes that exist in the general population, therapists may experience less empathy for clients whose difficulties arise from unfamiliar life experiences.

The argument that a lack of cultural knowledge may be associated with negative therapist responses receives some support from research conducted by Hayes and Erkis (2000), who found that homophobic attitudes were associated with less empathy and reluctance to work with a gay client, as well as with a tendency to attribute blame and responsibility to HIV-positive clients. For support from the converse position, Constantine, Miville, and Kindaichi (2008), report a series of studies with ethnic minority clients in which therapist empathy was positively associated with client satisfaction with counseling and perceptions of therapist multicultural competence. One potential interpretation would be that, as therapists increased their multicultural knowledge and skill, their perspective taking and empathic abilities also increased. This could address what Comas-Diaz (2006) refers to as "missed empathic opportunities" (p. 84), or instances when a therapist with limited knowledge of the client's culture fails to recognize or address a client's indirect but culturally appropriate introduction of important issues.

A social psychological perspective on the relationship between negative attitudes and the counseling relationship is found in Vasquez' (2007) discussion of how negative behaviors can emerge outside the therapist's awareness. She cites a series of studies by Dovidio et al. (2002), which demonstrated that, when whites interact with persons of different racial background, they exhibit negative nonverbal behaviors. Although the whites report no awareness of their behavior, the ethnic minority participants experienced the interaction as reflecting a negative attitude toward them.

This research is relevant to what have been termed racial "microaggressions," subtle actions that signal power differences in ways that are demeaning and domineering (Fouad & Arrendondo, 2007). This area has begun to receive research attention and appears to offer promise for understanding the process of relationship formation and maintenance. For example, Constantine's (2007) research with black American clients found their perceptions of in-session microaggressions were associated with lower ratings of the working alliance, less satisfaction with counseling, and lower therapist competence.

Therapist attitudes appear to be important contributors to the strength of therapeutic relationships, and the field has begun to explore their operation through the construct of multicultural competence, which includes an awareness of both one's own attitudes and beliefs as well as those of diverse clients (Sue et al., 1982). The area of multicultural competence has generated a significant amount of research but has been criticized for a reliance on survey and analogue research (e.g., Leong & Gupta, 2008). However, in a wide-ranging review, Beutler et al. (2004) concluded that the few studies that use actual clients for investigating culturally sensitive therapist attitudes show promising results, with positive effect sizes (ES) ranging from ES = .12 to .71.

One aspect of multicultural knowledge and skill is the ability to perceive and respond to client

expectations for the counseling relationship. As noted previously, there is consistent evidence that clients from many cultural and ethnic groups complete fewer sessions than do majority culture clients, providing indirect evidence that strong relationships had not been established. Many authors have noted that different groups can hold differing expectations and needs for what constitutes a preferred counseling relationship. Although client preferences were discussed in an earlier section, several types of expectations that therapists could act to address are worth noting. Comas-Diaz (2006) asserts that many Latino clients look to their therapists for *familismo*, a sense of being part of a close family or social network, and *platica*, taking time to open a session with small talk in order to establish trust.

Future Directions: New Paradigms, New Methods

> Perhaps we will be closer to the truth if we assume that any personality pattern that permits rich and deep relationships with other human beings to develop is satisfactory. Just as there is no one kind of personality essential to one's functioning as husband or wife, mother or father, lover, neighbor, or friend, so there is no one kind essential to the counselor. (Tyler, 1953, pp. 267–268)

In considering the body of relationship research, it is difficult to avoid the impression that our science has focused on a search for "the effective counseling relationship" and has often conceptualized the alliance between client and counselor in rather static terms. However, a good deal of current research has begun to conceptualize the relationship in a more complex form. In the previous discussion, this new attention to complexity was evident in recent work examining the alliance in multicultural counseling through the lens of intersectionality rather than matching on demographic factors (e.g., Vasquez, 2007), in explorations of how a particular attachment style may only be activated under conditions of vulnerability (Meyer & Pilkonis, 2002), or in the discussion of how therapist factors not often examined in alliance research, such as impairment or ethical behavior (e.g., Nigro 2004), may offer useful information.

Two trends have begun to influence relationship research, which I believe offer the potential to expand both our conceptualization and knowledge of this key area of the psychotherapeutic process: qualitative contributions from a social-constructionism paradigm and emerging methods that permit modeling of complex interactions over time. Building on those ideas, I want to issue an invitation to researchers to explore interdisciplinary research tapping the long tradition of social psychological research on close relationships.

One of the first calls for reconceptualizing the counseling relationship from a social-constructionist perspective was advanced by Sexton and Whiston in 1994. To implement this perspective, they note that, "the primary focus of attention shifts from the identification of components of the counseling relationship to the jointly determined meaning systems developed by the relationship participants" (p. 62). The authors cite a range of studies, available at that time, that were consistent with an interactional perspective. However, in the intervening decades, few researchers have pursued explorations of the more qualitative notions of "meaning" or "purpose." Exceptions can be found in process research conducted from a narrative paradigm and method (e.g., Angus & McLeod, 2004) and in explorations of career counseling as goal-directed action, investigated from an action theory perspective (e.g., Young & Valach, 2009; Young, Valach, & Domene, 2005).

A focus on purpose invites us to consider the function of various elements of the counseling relationship, beyond their identification or level of strength. In describing the operation of common factors in psychotherapy, Lambert and Ogles (2004) note that, "they provide for a cooperative working endeavor in which the patient's increased sense of trust, security, and safety, along with decreases in tension, threat, and anxiety, lead to changes in conceptualizing his or her problems and ultimately in acting differently by reframing fears, taking risks, and working through problems in interpersonal relationships" (p. 173). Or, as Young and Valach (2009) argue in their description of the career counseling process, we must consider the intent of actions that client and counselor undertake, noting that, "this intent is not realized solely by the counselor or the client, but jointly and reflects the goal-directed processes in which they are engaged" (p. 300).

Some methodological advances, pursued from within a post-positivist quantitative framework, reflect an appreciation of the joint, relational character of the counseling relationship. Two examples are offered as illustration. First, the title of a 2007 investigation by counseling psychologist Dennis Kivlighan asks, "Where is the relationship in research on the alliance?" In response, the author presents two statistical approaches for analyzing

interdependence in therapeutic dyads. The models are illustrated with alliance and session impact data from 53 client–counselor pairs, and the results identified a shared dyad-level component in the alliance, characterized by mutual influence. The findings, although quantitative, are consistent with the social-constructionist view that the counseling relationship emerges through client–counselor interaction.

A second example of an innovative and relational approach appears in work conducted by Lakey, Cohen, and Neely (2008), who drew upon recent social support research in exploring the unique relational characteristics that emerge in specific therapy dyads. Their analysis was based on prior research indicating that constructs like supportiveness are highly relational; in other words, they are not characteristics of an individual, but of a specific relationship between a provider and recipient. Lakey, Cohen, and Neely's work found strong, statistically significant relational effects for both the working alliance and appraisals of therapist competence, indicating that the most influential factor was the specific relationship, not a uniquely effective therapist or receptive client.

Both Kivlighan (2007) and Lakey, Cohen, and Neely (2008) were investigating relationship concepts that have long been of interest to social psychologists. And, to advance our understanding of counseling relationships further, I believe that our field would benefit from greater familiarity with that body of research. In doing so, we would be repeating a pattern that has characterized past advances in therapy process research, dating back to Strong's (1968) use of social psychological theory in conceptualizing the relationship as an interpersonal influence process. There are several current models that I believe warrant particular attention; although space does not permit detailed description, I encourage interested readers to investigate the work of these authors.

One of the dominant models in current social psychological research is *interdependence theory*, associated with the work of Caryl Rusbult and colleagues (see Rusbult & Van Lange, 2003). This comprehensive model of relationship interaction accords an explicit role for long-term goals and concern for a partner's welfare, as well for social cognitive processes such as attribution, affect, and disposition. Issues such as mutuality and perceived progress toward relationship goals have been examined as predictors of relationship quality (Avivi, Laurenceau, & Carver, 2009) and would appear to have relevance for understanding relationship dynamics in psychotherapy. Furthermore, interdependence models differentiate between relationship formation and relationship maintenance; research on the latter (e.g., Reis, 2007) has identified a key role for perceived security of the relationship, perhaps comparable to establishment of trust in the counseling dyad.

A second area of investigation with potential application to the dyadic nature of the counseling relationship is that of *relational-independent self construal* (Cross, Bacon, & Morris, 2000), which builds on attention to cultural differences between an interdependent self-in-relationship construal and the group-oriented interdependence more common in collectivist cultures. The authors explored the role of self-construal in relationship development and, specifically, investigated whether a participant's evaluation of a dyadic partner's openness and responsiveness were related to that person's self-construal. Results were positive and confirmed predictions for the role of self-construal in self-disclosure and responsiveness, both qualities that characterize effective counseling relationships.

Finally, social psychologists have been investigating issues of "risk regulation" and emotional self-protection in relationships (e.g., Murray, Holmes, & Collins, 2006). This approach draws on elements of both attachment theory and interdependence theory in exploring the importance of the expectations people hold about a partner's relationship goals. The relevance of this work for psychotherapy relationships is perhaps best illustrated by Baumeister et al.'s (1993) observation (offered with regard to intimate relationships) that the relationships with the greatest potential to satisfy adult needs for connection are precisely those that will evoke the greatest sense of vulnerability and anxiety about rejection. For many clients, progress toward their counseling goals requires a choice to become highly vulnerable, expose troublesome parts of the self, and risk rejection by a therapist.

One can predict that the next advances in relationship research will reflect an increased appreciation for both the complexity and the uniqueness of each dyadic encounter, a stance highly congruent with the earliest expressions of counseling psychology's values as a discipline. Attention to social psychological research on interdependence, methodological advances that help us untangle both shared and independent influences, and a social-constructionist perspective on the meaning clients attach to therapeutic relationships, all hold potential for illuminating what contributes to an effective counseling relationship.

We know that strong relationships are important in counseling; it is time to shift our focus from describing "the relationship" to understanding what facilitates or impedes the therapeutic connection between counselor and client. In doing so, we can be guided by Leona Tyler's observation that effective relationships, like counselor personalities, can take many forms.

Note

1. Leona E. Tyler (1906–1993), the 81st president of the American Psychological Association and long-time faculty member at the University of Oregon, is widely acknowledged as one of counseling psychology's most influential pioneers. The three editions of *The Work of the Counselor* have been described as a leading influence on the development of the counseling profession (Sundberg & Littman, 1994), and the APA Society of Counseling Psychology's most prestigious award is named in her honor. Interested readers are encouraged to consult Zilber and Osipow (1990) or Fassinger (2003) for a biography.

References

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology*, *48*, 251–257.

Ainsworth, M. (1964). Patterns of attachment behavior shown by the infant in interaction with his mother. *Merrill-Palmer Quarterly*, *10*, 51–58.

Al-Darmaki, F., & Kivlighan, D. M., Jr. (1993). Congruence in client-counselor expectations for relationship and working alliance. *Journal of Counseling Psychology*, *40*, 379–384.

American Psychological Association (APA). (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1060–1073.

American Psychological Association (APA). (2003). Guidelines on multicultural education, training, research, practice and organizational change for psychologists. *American Psychologist*, *58*, 377–402.

Anderson, W. P., Jr., & Niles, S. G. (2000). Important events in career counseling: Client and counselor perceptions. *Career Development Quarterly*, *48*, 251–264.

Angus, L. (2009, March). *Psychotherapy research*. Colloquia presented to the Faculty of Education, University of British Columbia, Vancouver, BC, Canada.

Angus, L., & McLeod, J. (2004). *Handbook of narrative and psychotherapy: Practice, theory and research*. Thousand Oaks, CA: Sage.

Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 335–356). New York: Oxford University Press.

Avivi, Y. E., Laurenceau, J.-P., & Carver, C. S. (2009). Linking relationship quality to perceived mutuality of relationship goals and perceived goal progress. *Journal of Social and Clinical Psychology*, *28*, 137–164.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, 842–852.

Barak, A., & LaCrosse, M. B. (1975). Multidimensional perception of counselor behavior. *Journal of Counseling Psychology*, *22*, 471–476.

Barone, D. F., Hutchings, P. S., Kimmel, H. J., Traub, H. L., Cooper, J. T., & Marshall, C. M. (2005). Increasing empathic accuracy through practice and feedback in a clinical interviewing course. *Journal of Social and Clinical Psychology*, *24*, 156–171.

Barrett, K. A., & McWhirter, B. T. (2002). Counselor trainees' perceptions of clients based on client sexual orientation. *Counselor Education and Supervision*, *41*, 219–232.

Barrett-Lennard, G. T. (1962). Dimensions of therapeutic response as causal factors in therapeutic change. *Psychological Monographs: General and Applied*, *76*(43, Whole No. 562).

Bartholomew, K. (1994). The assessment of individual differences in adult attachment. *Psychological Inquiry*, *5*, 23–27.

Bartholomew, K., & Thompson, J. (1995). The application of attachment theory to counseling psychology. *The Counseling Psychologist*, *23*, 484–490.

Batchelor, A. (1988). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy*, *25*, 227–240.

Baumeister, R. F., Wotman, S. R., & Stilwell, A. M. (1993). Unrequited love: On heartbreak, anger, guilt, scriptlessness and humiliation. *Journal of Personality and Social Psychology*, *64*, 377–394.

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology*, *53*, 26–35.

Benecke, C., Peham, D., & Banninger-Huber, E. (2005). Nonverbal relationship regulation in psychotherapy. *Psychotherapy Research*, *15*, 81–90.

Benjamin, L. S. (1982). Use of Structural Analysis of Social Behavior (SASB) to guide intervention in psychotherapy. In J. C. Anchin, & D. J. Kiesler (Eds.), *Handbook of interpersonal psychotherapy* (pp. 190–212). New York: Pergamon.

Bergin, A. E. (1962). The effect of dissonant persuasive communications upon changes in a self-referring attitude. *Journal of Personality*, *30*, 423–438.

Bergin, A. E., & Garfield, S. L. (1978). *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.). New York: Wiley.

Beutler, L. E., Malik, M., Alimohamed, S., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227–306). New York: Wiley.

Bimrose, J., Barnes, S.-A., & Hughes, D. (2005). *Effective guidance one year on: Evidence from longitudinal case studies in England*. Coventry: Warwick Institute for Employment Research. Retrieved June 29, 2009, from http://ww2.warwick.ac.uk/fac/soc/ier/publications/bydate/2005/egreportoct05.pdf

Bimrose, J., Barnes, S.-A., Hughes, D., & Orton, M. (2004). *What is effective guidance? Evidence from longitudinal case studies in England*. Coventry: Warwick Institute for Employment Research. Retrieved June 29, 2009, from

http://ww2.warwick.ac.uk/fac/soc/ier/publications/bydate/2005/egr2004.pdf

Bohart, A. C., Elliott, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 89–108). New York: Oxford University Press.

Bordin, E. S. (1976). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, *16*, 252–260.

Bowlby, J. (1969). *Attachment and loss*. New York: Basic.

Bowman, D. G., Scogin, F., Floyd, M., & McKendree-Smith, N. (2001). Effect of therapist sex on outcome of psychotherapy: A meta-analysis. *Psychotherapy*, *38*, 142–148.

Carnes, E. F., & Robinson, F. P. (1948). The role of client talk in the counseling interview. *Educational and Psychological Measurement*, *8*, 635–644.

Carter, J. A. (1994). Refining notions through converging paradigms. *The Counseling Psychologist*, *22*, 79–81.

Caspar, F., Grossmann, C., Unmussig, C., & Schramm, E. (2005). Complementary therapeutic relationship: Therapist behavior, interpersonal patterns, and therapeutic effects. *Psychotherapy Research*, *15*, 91–102.

Castonguay, L. G., Goldfried, M. R., Wiser, S., & Raue, P. J. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, *64*, 497–504.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *64*, 497–504.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*, 521–536.

Claiborn, C. D., Goodyear, R. K., & Horner, P. A. (2002). Feedback. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 217–233). New York: Oxford University Press.

Clarkin, J. F., & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 194–226). New York: Wiley.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*, 170–180.

Comas-Diaz, L. (2006). Cultural variation in the therapeutic relationship. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 81–105). Washington, DC: American Psychological Association.

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, *54*, 1–16.

Constantine, M. G., Miville, M. L., & Kindaichi, M. M. (2008). Multicultural competence in counseling psychology practice and training. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 141–158). Hoboken, NJ: Wiley.

Cook, J. E., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face: Preliminary results. *CyberPsychology & Behavior*, *5*(2), 95–105. doi:10.1089/109493102753770480.

Corbishley, M. A., & Yost, E. B. (1989). Psychological aspects of career counseling. *Journal of Career Development*, *16*, 43–51.

Crites, J. O. (1981). *Career counseling: Models, methods and materials*. New York: McGraw-Hill.

Crits-Cristoph, P., Gibbons, M. B. C., Crits-Cristoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-forming psychotherapy. *Psychotherapy Research*, *16*, 268–281.

Cross, S. E., Bacon, P. L., & Morris, M. L. (2000). The relational-interdependent self-construal and relationships. *Journal of Personality and Social Psychology*, *78*, 791–808.

Curry, K. T., & Hanson, W. E. (2010). National survey of psychologists' test feedback training, supervision and practice: A mixed methods study. *Journal of Personality Assessment*, *92*, 327–336.

Danzinger, P. R., & Welfel, E. R. (2000). Age, gender and health bias in counselors: An empirical analysis. *Journal of Mental Health Counseling*, *22*, 135–149.

Dell, D. M., & Schmidt, L. D. (1976). Behavioral cues to counselor expertness. *Journal of Counseling Psychology*, *23*, 197–201.

Dixon, D. N., & Claiborn, C. D. (1987). A social influence approach to counselor supervision. In J. E. Maddux, C. D. Stoltenberg, & R. Rosenwein (Eds.), *Social processes in clinical and counseling psychology* (pp. 83–93). New York: Springer.

Dollard, J., Auld, F., & White, A. M. (1953). *Steps in psychotherapy*. New York: Macmillan.

Dorn, F. J. (1988). Utilizing social influence in career counseling: A case study. *Career Development Quarterly*, *36*, 269–280.

Dovidio, J. F., Gaertner, S. L., Kawakami, K., & Hoson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity & Ethnic Minority Psychology*, *8*, 88–102.

Duckworth, J. (1990). The counseling approach to the use of testing. *The Counseling Psychologist*, *18*, 198–204.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology*, *43*, 456–460.

Eames, V., & Roth, A. (2000). Patient attachment orientation and early working alliance—A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research*, *10*, 421–434.

Farber, B. A., & Lane, J. S. (2002). Positive regard. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 175–194). New York: Oxford University Press.

Fassinger, R. E. (2003). Leona Tyler: Pioneer of possibilities. In G. A. Kimble, & M. Wertheimer (Eds.), *Portraits of pioneers in psychology, vol. 5* (pp. 231–247). Washington, DC: American Psychological Association.

Ferguson, T. M., Leach, M. M., Levy, J. J., Nicholson, B. C., & Johnson, J. D. (2008). Influences on counselor race preferences: Distinguishing Black racial attitudes from Black racial identity. *Journal of Multicultural Counseling and Development*, *36*, 66–76.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment*, *9*, 374–375.

Fitzgerald, L. F., & Nutt, R. (1986). The Division 17 principles concerning the counseling/psychotherapy of women: Rationale and implementation. *The Counseling Psychologist*, *14*, 180–216.

Fitzpatrick, M. R., Iwakabe, S., & Stalikas, A. (2005). Perspective divergence in the working alliance. *Psychotherapy Research*, *15*, 69–80.

Forrest, L., Elman, N., Gizara, S., & Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal, and legal issues. *The Counseling Psychologist*, *27*, 627–686.

Fouad, N. A. (2007). Work and vocational psychology: Theory, research and applications. *Annual Review of Psychology*, *58*, 543–564.

Fouad, N. A., & Arrendondo, P. (2007). *Becoming culturally oriented: Practical advice of psychologists and educators*. Washington, DC: American Psychological Association.

Frank, J. D. (1961). *Persuasion and healing*. Baltimore: Johns Hopkins University Press.

Freeman, S. C. (1990). C. H. Patterson on client-centered career counseling: An interview. *The Career Development Quarterly*, *38*, 291–301.

Friedlander, M. L., Escudero, V., Horvath, S., Heatherington, L., Cabero, A., & Martens, M. P. (2006). System for observing family therapy alliances: A tool for research and practice. *Journal of Counseling Psychology*, *53*, 214–225.

Friedlander, M. L., Lambert, J. E., & de la Pena, C. M. (2008). A step toward disentangling the alliance/improvement cycle in family therapy. *Journal of Counseling Psychology*, *55*, 118–124.

Fuertes, J., Mislowack, C., Brown, S., Shovel, G.-A., Wilkinson, S., & Gelso, C. (2007). Correlates of the real relationship in psychotherapy: A study of dyads. *Psychotherapy Research*, *17*, 423–430.

Garfield, S. L. (1978). Research on client variables in psychotherapy. In S. L. Garfield, & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 191–232). New York: Wiley.

Gelso, C. J. (2004, June). *A theory of the real relationship in psychotherapy*. Paper presented at the International Conference of the Society for Psychotherapy Research, Rome.

Gelso, C. J., Betz, N. E., Friedlander, M. L., Helms, J. E., Hill, C. E., Patton, M. J., Super, D. E., & Wampold, B. E. (1988). Research in counseling psychology: Prospects and recommendations. *The Counseling Psychologist*, *16*, 385–406.

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist*, *13*, 155–243.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology*, *41*, 296–306.

Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. C. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology*, *42*, 356–364.

Gelso, C. J., & Fretz, B. (2001). *Counseling psychology* (2nd ed.). Fort Worth, TX: Harcourt.

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research and practice*. New York: Wiley.

Gelso, C. J., & Hayes, J. A. (2002). The management of countertransference. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 267–283). New York: Oxford University Press.

Gelso, C. J., Kelly, F. A., Fuertes, J. N., Marmarosh, C., Holmes, S. E., Costa, C., & Hancock, G. R. (2005). Measuring the real relationship in psychotherapy: Initial validation of the therapist form. *Journal of Counseling Psychology*, *52*, 640–649.

Gelso, C. J., & Samstag, L. W. (2008). A tripartite model of the therapeutic relationship. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 267–283). New York: Wiley.

Gold, P. B., Kivlighan, D. M., Jr., Kerr, A. E., & Kramer, L. A. (1993). The structure of students' perceptions of impactful, helpful events in career exploration classes. *Journal of Career Assessment*, *1*, 145–161.

Graff, H., Kenig, L., & Radoff, G. (1971). Prejudice of upper class therapists against lower class patients. *Psychiatric Quarterly*, *45*, 475–489.

Greenberg, L. S. (1994). What is "real" in the relationship? A comment on Gelso and Carter (1994). *Journal of Counseling Psychology*, *41*, 307–309.

Greencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, *21*, 372–378.

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly*, *34*, 155–181.

Greenson, R. R. (1967). *Technique and practice of psychoanalysis*. New York: International University Press.

Hardin, S. I., Subich, L. M., & Holvey, J. M. (1988). Expectancies for counseling in relation to premature termination. *Journal of Counseling Psychology*, *35*, 37–40.

Hardy, G. E., Aldridge, J., Davidson, C., Rowe, C., Reilly, S., & Shapiro, D. A. (1999). Therapist responsiveness to patient attachment styles and issues observed in patient-identified significant events in psychodynamic-interpersonal psychotherapy. *Psychotherapy Research*, *9*, 36–53.

Hartley, D. E., & Strupp, H. H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), *Empirical studies in analytic theories* (Vol. 1, pp. 1–37). Hillsdale, NJ: Erlbaum.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, *64*, 1326–1336.

Haverkamp, B. E., Morrow, S. L., & Ponterotto, J. G. (Guest Eds.). (2005). Special Issue: Knowledge in context: Qualitative methods in counseling psychology research. *Journal of Counseling Psychology*, *52*, 121–260.

Hayes, J. A., & Erkis, A. J. (2000). Therapist homophobia, client sexual orientation, and source of client HIV infection as predictors of therapist reactions to clients with HIV. *Journal of Counseling Psychology*, *47*, 71–78.

Hayes, J. A., & Gelso, C. J. (1993). Counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology*, *40*, 86–93.

Hayes, J. A., Riker, J. R., & Ingram, K. M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research*, *7*, 145–153.

Healy, C. C. (2001). A follow-up of adult career counseling clients of a university extension center. *Career Development Quarterly*, *49*, 363–373.

Henry, W. P., Schacht, T. E., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993a). Effects of training in time-limited dynamic psychotherapy: Mediators of therapists' responses

to training. *Journal of Consulting and Clinical Psychology*, *61*, 441–447.

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993b). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology*, *61*, 434–430.

Heppner, M. J., & Hendricks, F. (1995). A process and outcome study examining career indecision and indecisiveness. *Journal of Counseling and Development*, *73*, 426–437.

Heppner, M. J., Multon, K. D., Gysbers, N. C., Ellis, C. A., & Zook, C. E. (1998). The relationship of trainee self-efficacy to the process and outcome of career counseling. *Journal of Counseling Psychology*, *45*, 393–402.

Heppner, P. P., & Frazier, P. A. (1992). Social psychological processes in psychotherapy: Extrapolating basic research to counseling psychology. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 141–176). New York: Wiley.

Heppner, P. P., Rosenberg, J. I., & Hedgespeth, J. (1992). Three methods in measuring the therapeutic process: Clients' and counselors' constructions of the therapeutic process versus actual therapeutic events. *Journal of Counseling Psychology*, *39*, 20–31.

Hersoug, A. G., Monsen, J. T., Havik, O. E., & Hoglend, P. (2002). Quality of early working alliance in psychotherapy: Diagnoses, relationship, and intrapsychic variables as predictors. *Psychotherapy and Psychosomatics*, *71*, 18–27.

Highlen, P. S., & Hill, C. E. (1984). Factors affecting client change in individual counseling: Current status and theoretical speculations. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 334–396). New York: Wiley.

Hill, C. E. (1994). What is the therapeutic relationship? A reaction to Sexton and Whiston. *The Counseling Psychologist*, *22*, 90–97.

Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic relationship: Inextricably intertwined in the therapy process. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 431–442.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology*, *43*, 207–217.

Horvath, A. O. (1981). *An exploratory study of the working alliance: Its measurement and relationship to outcome*. Unpublished doctoral dissertation, University of British Columbia, Vancouver, Canada.

Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*, 365–372.

Horvath, A. O. (2005). The therapeutic relationship: Research and theory. *Psychotherapy Research*, *15*, 3–7.

Horvath, A. O. (2009). How *real* is the "real relationship?" *Psychotherapy Research*, *19*, 273–277.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37–69). New York: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1986). Development of the working alliance inventory. In L. S. Greenberg, & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: Guilford.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139–149.

Howard, G. S. (1992). Behold our creation! What counseling psychology has become and might yet become. *Journal of Counseling Psychology*, *39*, 419–442.

Hoyt, W. T. (1996). Antecedents and effects of perceived therapist credibility: A meta-analysis. *Journal of Counseling Psychology*, *43*, 430–447.

Imel, Z. E., & Wampold, B. E. (2008). The importance of treatment and the science of common factors in psychotherapy. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 249–266). New York: Wiley.

Jacobs, D., Charles, E., Jacobs, T., Weinstein, H., & Mann, D. (1972). Preparation for treatment of the disadvantaged patient: Effects on disposition and outcome. *American Journal of Orthopsychiatry*, *42*, 666–674.

Joyce, A. S., & Piper, W. E. (1998). Expectancy, the therapeutic alliance, and treatment outcome in short-term individual psychotherapy. *Journal of Psychotherapy Practice and Research*, *7*, 236–248.

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology*, *11*, 113–129.

Kiesler, D. J. (1982). Interpersonal theory for personality and psychotherapy. In J. C. Anchin, & D. J. Kiesler (Eds.), *Handbook of interpersonal psychotherapy* (pp. 3–24). New York: Pergamon.

Kim, B. S. K., & Atkinson, D. R. (2002). Asian American client adherence to Asian cultural values, counselor expression of cultural values, counselor ethnicity and career counseling process. *Journal of Counseling Psychology*, *49*, 3–13.

Kim, D. M., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random effects modeling of the NIMH TDCRP data. *Psychotherapy Research*, *16*, 161–172.

Kirschner, T., Hoffman, M. A., & Hill, C. E. (1994). Case study of the process and outcome of career counseling. *Journal of Counseling Psychology*, *41*, 216–226.

Kivlighan, D. M., Jr. (2007). Where is the relationship in research on the alliance? Two methods for analyzing dyadic data. *Journal of Counseling Psychology*, *54*, 423–433.

Kivlighan, D. M., Jr., McGovern, T. V., & Corazzini, J. G. (1984). Effects of content and timing of structuring interventions on group therapy process and outcome. *Journal of Counseling Psychology*, *31*, 363–370.

Kivlighan, D. M., Jr., Patton, M. J., & Foote, D. (1998). Moderating effects of client attachment on the counselor experience-working alliance relationship. *Journal of Counseling Psychology*, *45*, 274–278.

Knaevelsrud, C., & Maercker, A. (2006). Does the quality of the working alliance predict treatment outcome in online psychotherapy for traumatized patients? *Journal of Medical Internet Research*, *8*(4), e31. Published online December 19, 2006. doi: 10.2196/jmir.8.4.e31.

Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist*, *27*, 443–475.

Lakey, B., Cohen, J. L., & Neely, L. C. (2008). Perceived support and relational effects in psychotherapy process constructs. *Journal of Counseling Psychology*, *55*, 209–220.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross, & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

Lambert, M. J. (Ed.). (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, *38*, 357–361.

Lambert, M. J., & Barley, D. E. (2002). Research summary. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 17–32). New York: Oxford University Press.

Lambert, M. J., Garfield, S. L., & Bergin, A. E. (2004). Overview, trends and future issues. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 805–821). New York: Wiley.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioral and cognitive psychotherapy*, *36*, 769–777.

Leary, T. (1957). *Interpersonal diagnosis of personality*. New York: Roland.

Leong, F. T. L., & Gupta, A. (2008). Culture and race in counseling and psychotherapy: A critical review of the literature. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 320–337). Hoboken, NJ: Wiley.

Lepper, G., & Mergenthaler, E. (2007). Therapeutic collaboration: How does it work? *Psychotherapy Research*, *17*, 576–587.

Li, L. C., & Kim B. S. K. (2004). Effects of counseling style and client adherence to Asian cultural values on counseling process with Asian American college students. *Journal of Counseling Psychology*, *51*, 158–167.

Lichtenberg, J. W., Wettersten, K. B., Mull, H., Moberly, R. L., Merkey, K. B., & Corey, A. T. (1988). Relationship and control as correlates of psychotherapy quality and outcome. *Journal of Consulting and Clinical Psychology*, *45*, 322–337.

Ligiero, D. P., & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory, Research, Practice, Training*, *39*, 3–11.

Lopez, S. J., Magyar-Moe, J. L., Petersen, S. E., Ryder, J. A., Krieshok, T. S., O'Byrne, K. K., et al. (2006). Counseling psychology's focus on positive aspects of human functioning. *The Counseling Psychologist*, *34*, 205–227.

Lorion, R. P. (1973). Socioeconomic status and traditional treatment approaches reconsidered. *Psychological Bulletin*, 79, 263–270.

Lorion, R. P. (1974). Patient and therapist variables in the treatment of low-income patients. *Psychological Bulletin*, *81*, 344–354.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Cleghorn (Ed.), *Successful psychotherapy* (pp. 92–116). New York: Bruner/Mazel.

Luborsky, L., Crits-Cristoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs vs. a global rating method. *Journal of Nervous and Mental Disease*, *171*, 480–491.

Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology*, *54*, 32–39.

Mallen, M. J., Vogel, D. L., Rochlen, A. B., & Day, S. X. (2005). On-line counseling: Reviewing the literature from a counseling psychology framework. *The Counseling Psychologist*, *33*, 819–871.

Mallinckrodt, B. (1993). Session impact, working alliance, and treatment outcome in brief counseling. *Journal of Counseling Psychology*, *40*, 25–32.

Mallinckrodt, B. (1996). Change in working alliance, social support, and psychological symptoms in brief therapy. *Journal of Counseling Psychology*, *43*, 448–455.

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Patient Attachment to Therapist Scale. *Journal of Counseling Psychology*, *42*, 307–317.

Mallinckrodt, B., King, J. L., & Coble, H. M. (1998). Family dysfunction, alexithymia, and client attachment to therapist. *Journal of Counseling Psychology*, *45*, 497–504.

Malllinckrodt, B., & Nelson, M. L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology*, *38*, 133–138.

McIlveen, P. (2007). Counsellors' personal experience and appraisal of My Career Chapter. In 16th National Conference of the Australian Association of Career Counsellors. April, 2007, Perth, Australia. Retrieved June 21, 2009, from http://eprints.usq.edu.au/2549.

Meyer, B., & Pilkonis, P. A. (2002). Attachment style. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 367–382). New York: Oxford University Press.

Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: Reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. *Psychological Review*, *102*, 248–268.

Mohr, J. J., Gelso, C. J., & Hill, C. E. (2005). Client and counselor-trainee attachment as predictors of session evaluation and countertransference behavior in first counseling sessions. *Journal of Counseling Psychology*, *52*, 298–309.

Multon, K. D., Ellis-Kalton, C. A., Heppner, M. J., & Gysbers, N. C. (2003). The relationship between counselor verbal response modes and the working alliance in career counseling. *Career Development Quarterly*, *51*, 259–273.

Multon, K. D., Heppner, M. J., Gysbers, N. C., Zook, C., & Ellis-Kalton, C. A. (2001). Client psychological distress: An important factor in career counseling. *Career Development Quarterly*, *49*, 324–335.

Murray, S. L., Holmes, J. G., & Collins, N. L. (2006). Optimizing assurance: The risk-regulation system in relationships. *Psychological Bulletin*, *132*, 641–666.

Myers, R. A. (2004). Conferring as a way of knowing. *The Counseling Psychologist*, *32*, 128–133.

Nelson, D. W., & Baumgarte, R. (2004). Cross cultural misunderstandings reduce empathic responding. *Journal of Applied Social Psychology*, *34*, 391–401.

Nerdrum, P., & Ronnestad, M. H. (2002). The trainees' perspective: A qualitative study of learning empathic communication in Norway. *The Counseling Psychologist*, *30*, 609–629.

Nerdrum, P., & Ronnestad, M. H. (2004). Changes in therapists' conceptualization and practice of therapy following empathy training. *The Clinical Supervisor*, *22*, 37–61.

Netzky, W., Davidson, J., & Crunkleton, A. (1982). Pertinent consumer issues in choosing a counseling professional. *Journal of Counseling Psychology*, *29,* 406–413.

Nigro, T. (2004). Counselors' experiences with problematic dual relationships. *Ethics and Behavior*, *14*, 51–64.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Norcross, J. C. (2002b). Empirically supported therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 3–16). New York: Oxford University Press.

Nutt-Willliams, E., Hayes, J. A., & Fauth, J. (2008). Therapist self-awareness: Interdisciplinary connections and future directions. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 303–319). Hoboken, NJ: Wiley.

Nutt-Williams, E., & Hill, C. E. (1996). The relationship between self-talk and therapy process variables for novice therapists. *Journal of Counseling Psychology*, *43*, 170–177.

Orlinsky, D. E., & Ronnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association.

Packard, T. (2009). The 2008 Leona Tyler Award address: Core values that distinguish counseling psychology: Personal and professional perspectives. *The Counseling Psychologist*, *37*, 610–624.

Parham, T. A., & Helms, J. E. (1981). The influence of Black students' racial identity attitudes on preferences for counselor's race. *Journal of Counseling Psychology*, *28*, 250–257.

Patterson, C. H. (1966). *Theories of counseling and psychotherapy*. New York: Harper & Row.

Patton, M. J. (1994). Components of the counseling relationship–An evolving model: Comment on Gelso and Carter (1994). *Journal of Counseling Psychology*, *41*, 313–314.

Patton, M. J., & Kivlighan, D. M., Jr. (1997). Relevance of the supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology*, *44*, 108–115.

Peabody, S. A., & Gelso, C. J. (1982). Countertransference and empathy: The complex relationship between two divergent concepts in counseling. *Journal of Counseling Psychology*, *29*, 240–245.

Poston, J. M., & Hanson, W. E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment*, *22*, 203–212.

Prediger, D. J., & Garfield, N. (1988). Testing competencies and responsibilities: A checklist for counselors. In J. T. Kapes, & M. M. Mastie (Eds.), *A counselors' guide to career assessment instruments* (2nd ed.). Alexandria, VA: National Career Development Association.

Reandeau, S. G., & Wampold, B. E. (1991). Relationship of power and involvement of working alliance: A multiple-case sequential analysis of brief therapy. *Journal of Counseling Psychology*, *38*, 107–114.

Reis, H. T. (2007, August). What social psychologists would like to tell clinicians about close relationships. Division 8 Presidential Address, presented at the annual meetings of the American Psychological Association, San Francisco.

Reis, B. F., & Brown, L. G. (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the therapeutic dyad. *Psychotherapy: Theory, Research, Practice, Training*, *36*, 123–136.

Rochlen, A. B., Milburn, L., & Hill, C. E. (2004). Examining the process and outcome of career counseling for different types of career counseling clients. *Journal of Career Development*, *30*, 263–275.

Rogers, C. R. (1942). *Counseling and psychotherapy*. Boston: Houghton-Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95–103.

Rogers, C. R. (1963). Psychotherapy today or where do we go from here? *American Psychologist*, *17*, 5–16.

Rosenberger, E. W., & Hayes, J. A. (2002). Origins, consequences, and management of countertransference: A case study. *Journal of Counseling Psychology*, *49*, 221–232.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*, 412–415.

Rubino, G., Barker, C., Roth, T., & Fearon, P. (2000). Therapist empathy and depth of interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles. *Psychotherapy Research*, *10*, 408–420.

Rudikoff, L. C., & Kirk, B. A. (1959). Test interpretation in counseling. *Journal of Counseling Psychology*, *6*, 224–229.

Rusbult, C. E., & VanLange, P. A. M. (2003). Interdependence and relationships. *Annual Review of Psychology*, *54*, 351–375.

Safran, J. D., Muran, J. C., & Samstag, L. W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath, & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 225–255). New York: Wiley.

Samler, J. (1980). Where do counseling psychologists work? What do they do? What should they do? In J. M. Whitely (Ed.), *The history of counseling psychology*. Monterey, CA: Brooks-Cole. (Original work published 1964).

Sexton, H. (1996). Process, life events, and symptomatic change in brief eclectic psychotherapy. *Journal of Consulting and Clinical Psychology*, *64*, 1358–1365.

Sexton, H., Littauer, H., Sexton, A., & Tommeras, E. (2005). Building an alliance: Early therapy process and the client-therapist connection. *Psychotherapy Process, 15*, 103–116.

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist*, *22*, 6–78.

Singer, B. A., & Luborsky, L. (1977). Countertransference: The status of clinical versus quantitative research. In A. S. Gurman, & A. M. Razdin (Eds.), *Effective psychotherapy: Handbook of research* (pp. 433–451). New York: Pergamon Press.

Smith, E. J. (2006). The strength-based counseling model. *The Counseling Psychologist*, *34*, 13–79.

Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, *60*, 687–696.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *39*, 752–760.

Stevens, S. E., Hynan, M. T., & Allen, M. (2000). A meta-analysis of common factors and specific treatment effects across the outcome domains of the phase model of psychotherapy. *Clinical Psychology: Science and Practice*, *7*, 273–290.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). Are all psychotherapies equivalent? *American Psychologist*, *41*, 165–180.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, *15*, 215–224.

Strong, S. R. (1978). Social psychological approach to psychotherapy research. In S. Garfield, & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 101–136). New York: Wiley.

Strong, S. R., & Schmidt, L. D. (1970). Trustworthiness and influence in counseling. *Journal of Counseling Psychology*, *17*, 197–204.

Strupp, H. H., & Anderson, T. (1997). On the limitations of therapy manuals. *Clinical Psychology: Science and Practice*, *4*, 76–82.

Sue, D. W., Bernier, J. B., Duran, M., Feinberg, L., Pederson, P., Smith, E., et al. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, *10*, 45–52.

Sue, D. W., & Lam, A. G. (2002). Cultural and demographic diversity. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 401–421). New York: Oxford University Press.

Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*, 533–540.

Sundberg, N. D., & Littman, R. A. (1994). Leona Elizabeth Tyler (1906-1993). *American Psychologist*, *49*, 211–212.

Super, D. E. (1955). Transition: From vocational guidance to counseling psychology. *Journal of Counseling Psychology*, *2*, 3–9.

Swanson, J. L. (1995). The process and outcome of career counseling. In W. B. Walsh, & S. H. Osipow (Eds.), *The handbook of vocational psychology* (pp. 217–259). Mahwah, NJ: Erlbaum.

Swift, J. K., & Callahan, J. L. (2008). A delay discounting measure of great expectations and the effectiveness of psychotherapy. *Professional Psychology: Research and Practice*, *39*, 581–588.

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, *35*, 19–26.

Tinsley, H. E. A., & Bradley, R. W. (1986). Test interpretation. *Journal of Counseling Psychology*, *64*, 462–466.

Tinsley, H. E. A., Workman, K. R., & Kass, R. A. (1980). Factor analysis of the domain of client expectations about counseling. *Journal of Counseling Psychology*, *27*, 561–570.

Tokar, D. M., Hardin, S. I., Adams, E. M., & Brandel, I. W. (1996). Clients' expectations about counseling and perceptions of the working alliance. *Journal of College Student Psychotherapy*, *11*, 9–26.

Townes, D. L., Chavez-Korell, S., & Cunningham, N. J. (2009). Re-examining the relationships between racial identity, cultural mistrust, help-seeking attitudes, and preference for a Black counselor. *Journal of Counseling Psychology*, *56*, 330–336.

Tracey, T. J. (1986). Interactional correlates of premature termination. *Journal of Consulting and Clinical Psychology*, *54*, 784–788.

Tracey, T. J., & Hays, K. (1989). Therapist complementarity as a function of experience and client stimuli. *Psychotherapy*, *26*, 462–468.

Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy*. Chicago: Aldine.

Tyler, L. E. (1953). *The work of the counselor*. New York: Appleton-Century-Crofts.

Tyrrell, C. L., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment states of mind. *Journal of Consulting and Clinical Psychology*, *67*, 723–733.

Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist*, *62*, 878–885.

Vasquez, M. J. T., Lott, B., Garcia-Vasquez, E., Grant, S. K., Iwamasa, G. Y., Molina, L. E., et al. (2006). Personal reflections: Barriers and strategies in increasing diversity in psychology. *American Psychologist*, *61*, 157–172.

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist*, *31*, 253–272.

Wampold, B. E. (2007). Psychotherapy: "The" humanistic (and effective) treatment. *American Psychologist*, *62*, 857–874.

Wampold, B. E., Lichtenberg, J. W., & Waehler, C. A. (2002). Principles of empirically supported interventions in counseling psychology. *The Counseling Psychologist*, *30*, 197–217.

Watson, J. C., & Geller, S. (2005). An examination of the relations among empathy, unconditional positive regard and congruence in cognitive-behavioral and process-experiential psychotherapy. *Psychotherapy Research*, *15*, 25–33.

Wei, M., & Heppner, P. P. (2005). Counselor and client predictors of the initial working alliance: A replication and extension to Taiwanese client-counselor dyads. *The Counseling Psychologist*, *33*, 51–71.

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice*, *2*, 45–69.

Whiston, S. C., Brecheisen, B. K., & Stephens, J. (2003). Does treatment modality affect career counseling effectiveness? *Journal of Vocational Behavior*, *62*, 390–410.

Whiston, S. C., Lindeman, D. L., Rahardja, D., & Reed, J. H. (2005). Career counseling process: A qualitative analysis of experts' cases. *Journal of Career Assessment*, *13*, 169–187.

Whiston, S. C., & Rahardja, D. (2008). Vocational counseling process and outcome. In S. D. Brown, & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 444–461). Hoboken, NJ: Wiley.

Whitely, J. M. (Ed.). (1980). *The history of counseling psychology*. Monterey, CA: Brooks-Cole.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, *24*, 190–195.

Wiggins, J. S. (1982). Circumplex models of interpersonal behavior in clinical psychology. In P. C. Kendall, & J. N. Butcher (Eds.), *Handbook of research methods in clinical psychology* (pp. 183–221). New York: Wiley.

Wrenn, C. J. (1966). Birth and early childhood of a journal. *Journal of Counseling Psychology*, *13*, 485–488.

Young, R. A., & Valach, L. (2009). Evaluating the process and outcomes of vocational counseling: An action theory perspective. *L'Orientation Scolaire et Professionnelle*, *38*, 281–306.

Young, R. A., Valach, L., & Domene, J. F. (2005). The action-project method in counseling psychology. *Journal of Counseling Psychology*, *52*, 215–223.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., et al. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology*, *33*, 569–585.

Zilber, S. M., & Osipow, S. H. (1990). Leona E. Tyler. In A. N. O'Connell, & N. F. Russo (Eds.), *Women in psychology: A bio-bibliographic sourcebook* (pp. 335–341). Washington, DC: American Psychological Association.

Zlotnick, C., Elkin, I., & Shea, M. T. (1998). Does the gender of a patient or the gender of a therapist affect the treatment of patients with major depression? *Journal of Consulting and Clinical Psychology*, *66*, 655–659.

CHAPTER

4 Theory and Research for Counseling Interventions

Martin Heesacker *and* James W. Lichtenberg

Abstract

This chapter describes the role of psychological theory and its relation to counseling practice, with a special emphasis on counseling psychology's unique opportunity to enhance the integration of science and practice in psychology. Improving science–practice integration is presented as critical to fulfilling counseling psychology's claim that its interventions are science-based. The chapter discusses psychological theory generally, and the pathways (both scientific and clinical) through which theory influences counseling interventions. It reviews both the theoretical and research bases of treatment, with a particular focus on how treatments are evaluated. This includes a focus on efficacy, effectiveness, and meta-analytic studies, and how new treatments develop and are accepted by the field; and a focus on differences between practitioners and researchers in their acceptance of treatments as established practice. Matching specific, theoretically distinct, evidence-based treatments to specific client problems is contrasted with the theory-integrating, common factors approach. The chapter closes with a series of future directions for reducing the science–practice gap in counseling psychology.

Keywords: science–practice integration, theory and meta-theory, treatment efficacy and effectiveness, empirically supported interventions, common factors

> The disconnect between much of clinical practice and the advances in psychological science is an unconscionable embarrassment for many reasons, and a case of professional cognitive dissonance with heavy costs.
>
> —Mischel, 2009, p. i

The author of the chapter's opening quote, Walter Mischel, is one of psychology's most respected theorists and researchers, and so it should come as no surprise that his influence extends beyond psychology. His 2009 editorial in a major psychological journal triggered an editorial in *Nature* entitled "Psychology: A Reality Check," which sent a similar message throughout the scientific community: "There is a moral imperative to turn the craft of psychology—in danger of falling, Freud-like, out of fashion—into a robust and valued science informed by the best available research and economic evidence" (Abbot, 2009, p. 847). Echoing the alarms sounded by Mischel and Abbot, a recent science column by Sharon Begley in *Newsweek* magazine entitled "Ignoring the Evidence: Why Do Psychologists Reject Science?" (http://www.newsweek.com/id/216506) sent the message to the American public that psychological psychotherapy is not science-based. This message, distributed to ever-widening groups of psychology's stakeholders, challenges a fundamental tenet of the discipline: Namely, that psychological interventions are applications of psychological science.

Notwithstanding the above criticisms of psychological psychotherapy, counseling psychology has a unique and important opportunity to move forward as an applied specialty by fostering the integration of the science and practice that may be less available to other applied specialties in psychology.

It is the purpose of this chapter to review current issues in counseling theory and intervention practices to facilitate a positive, creative, comprehensive, and productive dialog that will result in a more complete integration of science and practice in counseling psychology. This, in turn, will serve as a model for other specialties, highlighting effective ways to address the important disciplinary challenge of the integration of the science and practice of psychology and the furthering of a science-based profession.

Theory As the Key to Science–Practice Integration

> There is nothing more practical than a good theory. (Kurt Lewin, 1952, p. 169).

The key premise of this chapter is that psychological *theory* holds perhaps the greatest promise for the successful integration of counseling psychology science and practice. Theory is what researchers and practitioners have in common: Researchers often are drawn to theory development and validation, whereas practitioners often are drawn to the application of theory. Ideally, researchers and practitioners work in tandem to produce knowledge that helps the common good (see Cialdini's [1980] full cycle social psychology for a description of the reciprocal relationship between researchers and practitioners in theory development, refinement, validation, and application). Because a valuing of theory is what counseling psychology's researchers and practitioners share, allocating effort toward understanding the state of the theoretical art and addressing the challenges researchers and practitioners face with regard to theory is likely to pay the richest dividends by maximizing the link between counseling psychology's science and its practice.

In this chapter, we discuss the nature and development of theories within psychology generally and the translation of theories into counseling interventions. In the process, we will be addressing both the theoretical and scientific bases of treatment, how new treatments develop, and how they come to be accepted by the specialty. We will also address documented differences between practitioners and researchers with regard to acceptance of treatments as established practice. All of this will be done with respect for differing perspectives and contexts, and in the service of facilitating the complete integration of counseling psychology science and practice, knowing that the process will be imperfect and ongoing.

What we will *not* do is ascribe antiscience motives to practitioners of counseling psychology or antipractice motives to researchers in counseling psychology. Unfortunately, for practical reasons, we will not have the space to review specific theories *per se*. That is done in other chapters in this volume and in other publications. Instead, our focus will remain on the broader landscape of science–practice integration.

What Is a Theory?

Counseling interventions are mostly based on scholarly theories (Brooks-Harris, 2008, p. 4), but what *is* a theory? A theory (also known as a *symbolic model*, according to Ford and Urban, 1998, p. 6) is a description of some aspect of the natural world. This description can be verbal, mathematical, or both. A scientific theory is presented in a manner that allows its utility to be assessed by comparing the description to empirical observation. The assessment of theory by comparing its description to empirical observation is called the *scientific method*, and it is through this method that theory is validated. Theory and method often operate recursively in science.

Scientific theories can be basic or applied. *Basic theories* describe elements of the natural world that may or may not have any direct application to the betterment of the natural world, but instead have as their primary objective a better understanding of nature—whether practically useful or not. Basic theories have often been developed and tested without regard to application, and yet basic theories often later trigger important applications. In contrast to basic theory, *applied theory* seeks to describe aspects of the natural world that can be applied to create a benefit or reduce a cost. For example, Schachter and Singer's (1962) two-factor theory of emotion is a basic theory that posits that emotion results from one's cognitive processing and assessing of one's physiological responses. On the other hand, Albert Ellis' rational emotive behavior therapy theory (Ellis & Dryden, 2007) is an applied theory that describes how unwanted emotion may be reduced or eliminated by disciplining oneself to cognitively process experience rationally.

Why Does Theory Matter?

Other than the fact that most counseling interventions are theory-based, why do counseling psychologists care about theory? As mentioned earlier, theory provides an excellent pathway through which the work of scientists and practitioners can be

complementary. This is true for four reasons. First, personality theories and other behavior-relevant basic science theories often tie very closely to theories of psychotherapy. For example, Carl Rogers' (1957) self theory, a basic science theory, ties closely to his theory of psychotherapy, which endeavors to provide the conditions under which a client's ideal self may be realized fully. Another example is John Holland's theory of vocational behavior (Holland, 1997). Holland's work emphasizes person-by-environment fit, that in turn ties closely with his theory of career counseling, which endeavors to provide clients with insights regarding their work and career interests and aspirations, and to match those with jobs and careers.

A second reason that theory can reduce the scientist–practitioner divide is that a theory is, in essence, a story. Likewise, clients very frequently tell stories as part of therapy, and psychotherapists frequently work with, challenge, and help alter the narratives or stories that may contribute to or sustain client dysfunction.

There is a third reason theory may reduce this divide between researchers and practitioners of counseling psychology. Theory represents a common factor among scholars of psychology. Likewise, theory represents a coherent narrative about the nature of change and the nature of problems and problem resolution, and thus constitutes a common factor across nearly all recognized psychotherapeutic approaches.

A final reason why a focus on theory may reduce the science–practice divide is that theory, as discussed earlier, appeals to both scientists and practitioners. The process of direct service delivery (e.g., intense, personal interactions; ambiguity of outcome) is generally less appealing to researchers than to practitioners. Likewise, the process of psychological research (e.g., research design, advances in statistical analyses) often is less interesting to practitioners than to researchers. In contrast, a focus on theory, especially on narrative theory, holds interest and appeal for both groups.

Appealing to both scientists and practitioners are a host of important *intellectual* reasons for a theory focus. Perhaps the most important of these is that theory provides causal explanations that are critical for effective counseling and psychotherapy. These causal explanations include explanations for how clients developed into the people they are, and how they developed the functions and dysfunctions they present in counseling. They also include explanations of how and under what conditions clients change from dysfunctional behavior and to more functional behavior. Virtually every major theory of psychotherapy describes client development and the processes and conditions for change.

How Theory Influences Practice

According to Ford and Urban (1998, p. 6), "A set of transformation rules is required to map the meaning of the symbol onto the phenomenon represented [in a theory] because their relationship is completely arbitrary." In practice, this means that theories must be transformed into specific interventions. *Constructs* that are part of a theory have to be transformed into action. Descriptions of *processes* posited by a theory likewise must be transformed into specific actions or measures. These operationalizations of theory are required for theory to translate into practice. Likewise, operationalization is required for scientific assessment of the utility and validity of a theory.

So, psychotherapy practice can be understood as the advancement of theory by transforming theory into practice. In turn, observations resulting from the transformation of theory into practice inform theory and often provide necessary correction to theory (see Cialdini, 1980).

The importance of this process of theory to operation (or intervention) and back to theory cannot be overstated. A theory is no better than the quality of the operations used to implement and evaluate it. A psychotherapeutic approach that is judged to be ineffective may be judged that way for three distinguishable reasons: the theory is wrong, the operationalization of the theory is wrong, and/or the measures of the theory's effectiveness are invalid. Likewise, theories of psychotherapy can wrongly be judged to be valid if the operationalization was unfaithful to the theory and yet the operation produced a beneficial outcome, or if the measures of the theory's effectiveness are invalid and yet inaccurately yielded results that indicate client improvement. Again, collaboration between scientists and practitioners, this time on how to operationalize theory so that it improves practice, is essential in reducing the science–practice divide.

Addressing Theory-related Challenges

Having opined that focusing on theory is arguably the best approach to maximizing the link between counseling psychology's science and its practice, we must also readily admit that counseling psychology has to address and overcome two theory-related challenges to achieve that goal: the proliferation of theories, which is a challenge because it creates

a psychotherapeutic Tower of Babble, in which counseling psychologists do not enjoy a common conceptual language; and what has come to be known as the *common factors perspective*, which is a challenge to the notion that specific theories and their posited change mechanisms even matter in psychotherapeutic intervention and change.

OVERCOMING CHALLENGES ASSOCIATED WITH THEORY PROLIFERATION

An interesting and perplexing theory-related challenge involves the proliferation of theories that exist in the field, with their concomitant interventions and techniques. In the mid-1960s, Garfield (writing in 1989) collected a list of over 60 different approaches to therapy—each grounded in some more or less explicitly stated theory explaining the nature and bases for clients' psychological problems and the mechanisms by which change in those problems could be effected. A few years later, a report of the Research Task Force of the National Institute of Mental Health (NIMH, 1975) noted over 130 different types of psychotherapy. Five years after that, Herink (1980) published an account of over 200 different forms of therapy, and within 6 years of Herink's publication, Kazdin (1986) referred to over 400 different therapeutic techniques! Although it is not clear whether the list of theories in counseling and psychotherapy has gotten bigger or smaller, it *is* clear that counseling theories exist in a welter of forms and with a variety of different conceptual and empirical justifications. The diversity-valuing ethic at the heart of counseling psychology allows the counseling psychologist to embrace this nearly incomprehensible diversity, even while recognizing that some theories are better scientifically supported than others and that some are more readily useful in application than others.

Diversity celebration notwithstanding, the proliferation of theories constitutes a real challenge to science–practice integration and must be addressed. One approach to proliferation begins by asking which core assumptions and intellectual roots may unite subgroups of theories of counseling and psychotherapy. It is our perspective that theories of counseling and psychotherapy, like other scientific theories, emerge from and are embedded in broader meta-theories, which often reflect the zeitgeist prevalent in the era of their development. By *meta-theory*, we are referring to certain structural properties of the theories they subsume—properties including the basic assumptions and types of laws proposed, the determinants of behavior, units of analysis, issues concerning the consistency/specificity of behavior, developmental/contemporaneous parameters of the theory, and strategies of research. In the history of science, meta-theories have been referred to as *paradigms* (Kuhn, 1970).

These structural properties, viewed in combination, form the bases of a variety of different theories of and approaches to counseling and psychotherapy that populate the field—theories and approaches that are often discontinuous and incompatible with one another in significant ways. When considering the diversity of theories, it is not possible to know which one best represents a true picture of human functioning, but what *is* possible to acknowledge is that different groups of theories reflect often radically different ways of construing human events. In short, these construal differences determine what can be observed and what practicing counseling psychologists decide to do about those observations.

Three meta-theoretical positions provide architecture for understanding more simply the welter of theories within counseling and psychotherapy. These three meta-theoretical positions are typically labeled *personologism, situationism*, and *interactionism* (Endler & Magnusson, 1976). Bowers (1973) has noted that there is a chronological order to their appearance, with each representing the zeitgeist of its historical period, and with each intended to serve a corrective function with regard to challenges unmet by the previously held view. As mechanisms of change, theories of counseling and psychotherapy derive from, or at least are reflective of, these three meta-theoretical positions. Although it is tempting to view each of these positions as representing a discrete and homogeneous cluster, there are notable differences among the theories and models subsumed within each perspective, despite certain fundamental paradigmatic structural similarities among them.

Personologism or the *personological paradigm* ($B = f P$) represents the earliest meta-theoretical position. Characteristic of this paradigm is the assumption that behavior (B) is a function (f) of the person (P). This is the position that Cronbach (1957) identified as *correlational psychology*, but which could be construed in other terms, such as differential psychology, trait psychology, and psychodynamic theory. The common element in this paradigm is the attribution of internal, dispositional, "psychodynamic" factors as the primary causal determinants of behavior.

Although there are a variety of different dispositional domains (e.g., aptitudes and traits) and

constructs (e.g., psychoanalytic constructs), as well as methodological differences within each of the theories subsumed under this meta-theory, certain consistent consequences have followed from this particular paradigm: First, the concept of causality is essentially a linear, unidirectional one emanating from some internal source. Behavior is primarily "pushed" from within. Second, the types of laws derived are of a response–response (R–R) variety, with the intent being to discover consistent individual response patterns across different situations—with inconsistent response patterns usually attributed to the presence of a higher-order or more genotypic trait (Allport, 1966). And third, although the units of analysis may vary in conceptual size and clarity across theories within this paradigm, they invariably involve some internal, dispositional system of intervening or mediating constructs such as traits, needs, cognitive abilities, dynamic constructs (instincts).

As Endler and Magnusson (1976) suggest, the B = *f*P paradigm has had a tremendous impact in personality research, particularly in the myriad of person measurement strategies. Consequently, the measurement of alleged R–R consistencies has had enormous effects in the applied areas of counseling, selection, classification, and psychodiagnosis (e.g., the assessment of vocational interests, personality traits and dispositions, needs, aptitudes, and abilities).

Situationism or the *situational paradigm* (B = *f*E) is the second meta-theoretical paradigm, appearing partly in reaction to the inadequacies of the personological paradigm. Situationism stipulates that behavior (B) is a function (*f*) of factors in the environment (E) or situations in which people find themselves. This is the position that Cronbach (1957) identified as *experimental psychology*, with its primary intent being to explain behavioral variability as a function of differences in environmental conditions. In contrast to the B = *f*P paradigm, which searches for consistency in response patterns across situations, the situational paradigm assumes that human behavior is considerably malleable, with the behaviors or forms of behavior that people take being primarily a function of external stimulus factors. It is a structure that has been somewhat slower in deve1oping, but as Moos (1973, 1974) described, a number of different systems utilize quite different units of analysis developed to describe environmental factors (e.g., contingencies of reinforcement, environmental "presses," and organizational patterns).

As a general research approach, situationism concerns itself with treatment differences, rather than individual differences. In effect, Cronbach (1957) has noted that both personologism and situationism have an affinity for the variables that the other view ignores. However, they are similar in the sense of being linear, unidirectional models of attributing causality, the only difference being the *source* of cause. In the situational view, the source is external and behavior is "pulled" from the organism; hence laws of the S–R type result.

In a more applied and strategic sense, this view typically frames questions that address "what treatment conditions are more effective in producing X?" Treatments, of course, can be construed in a variety of ways, ranging from complex educational/therapeutic conditions and manipulations of single independent variables in highly controlled experimental designs, to traits of others as external sources of influence.

Perhaps the most specific applications of this paradigm to the domain of counseling have been the behavior therapies—the application of general learning theory principles (operant, respondent, and social modeling) to the amelioration of behavioral problems and disorders. In each case—be it the application of respondent conditioning principles to the extinction of a school phobia, operant conditioning principles to the shaping of career exploration behaviors, or modeling for increasing social skill behaviors—counseling constitutes the "experiment," and the counselor's intervention constitutes the "experimental treatment." The counselor in essence controls, manipulates, determines, and causes (in accord with the professed learning principles invoked) the change in the client's behavior. It is the counselor, serving as a benevolent and therapeutic (albeit deterministic) environment, who *causes* the client to change.

A situationist has a perspective on events that is radically different from that of the personologist. The view of the personologist is that the counselor, although providing certain "core" therapeutic conditions, is *not* the cause of client change per se; rather that change is generated by (or pushed from) the client as a consequence of the client's own intrapersonal dynamics, traits, dispositions, and self-actualizing tendencies. Viewing the same change phenomena, the situationist holds that the core conditions, as well as other counselor behaviors, elicit, modify, determine, and cause the behavior change of the client. That is, to a situationist, the situation, not the client, determines client change (Truax, 1966).

Although many counseling psychologists reject the mechanistic formalisms of situationism as

expressed in the behavior therapies, the B = *f* E paradigm may find its way into their reasoning in more subtle ways. As Powers (1973a) notes; "A humanistic (counselor) . . . may reject the idea that painful stimuli act on a passive nervous system to cause an organ to secrete adrenalin, but he may be perfectly willing to say that stress acts on a person to make him anxious" (p. 1).

Running throughout this particular psychological paradigm (frequently referred to as *scientific psychology*) is a particular concept of cause and effect. The cause, the immediate physical cause of what a person does, lies outside the person. Whether what is outside the client is the family, school, or some other environment to which the cause and maintenance of a client's disturbance or dysfunction is attributed, or whether what is outside the client is a benevolent other attempting to change the client in some "therapeutic" direction, the assumption is that the best the client can do is to modulate the connections from the stimulus (environment/situation) that is the cause, to the behavior or behavior change that is the effect. In the best tradition of experimental psychology, the strategy for research and practice in counseling with this paradigm is to determine the "main effects" of treatments—with little or no regard to individual differences among clients.

The *interactional paradigm* (B = f Person × Situation) can, in certain respects, be regarded as a synthesis of the personological and situational paradigms (i.e., it considers the interaction of person and situational factors as the main source of behavioral variation). Although the most recent of the three meta-theoretical paradigms, the interactional paradigm is not a new general meta-theory, as Ekehammar's (1974) historical review points out. Its application to and integration into counseling psychology has come about through the work of personality psychologists (Bowers, 1973; Endler & Magnusson, 1976; Harvey, Hunt, & Schroder, 1961; Mischel, 1976), counseling process researchers (Hertel, 1972; Lichtenberg & Hummel, 1976; Raush, 1965; Tracey, 1993), therapy practitioners (Cashdan, 1973; Claiborn & Lichtenberg, 1989; Haley, 1963; Strong & Claiborn, 1982; Watzlawick, Weakland, & Fisch, 1974), and family and marital researchers and practitioners (Madanes, 1981; Raush, Barry, Hertel, & Swain, 1974; Watzlawick & Weakland, 1977).

Although variations on the interactional paradigm may employ different units of analysis and do so in differing theoretical domains, they nonetheless have a core commonality in their concept of causality. These views all posit a mutual and reciprocal (interactive) system of causality or influence between the person and environment, such that causality is not a function of one or the other but a process of mutual constraint or influence. A logical consequence of this view is that the behavior of any individual may vary in its consistency, depending upon the nature of the individual and the situation in which the individual is performing. Thus, the focus is not on simple R–R or S–R consistencies, but on patterns or systems of behavioral chains that may be relatively stable within any given person–environment combination but which also may show different patterns between other person–environment combinations (i.e., there may be instability across combinations) (see Claiborn & Lichtenberg, 1989). The paradigm of interactionism reflects a cybernetic, closed-loop feedback model in as much as "responses are dependent on present and past stimuli in a way determined by the current organization of the nervous system . . . But it is equally true that stimuli depend on responses according to the current organization of the environment and the body in which the nervous system resides" (Powers, 1973b, p. 351).

In short, behavioral variation represents an adaptive process that is governed by feedback emanating from the interaction of both internal and external sources. Consequently, the model of the person is not one of being strictly internally driven or externally controlled but one of simultaneously being influenced as well as being influential. From this view, the usual dichotomies of internal–external, proactive–reactive, and the like are rendered nonsensical.

OVERCOMING CHALLENGES ASSOCIATED WITH A COMMON FACTORS PERSPECTIVE

The previous section of the chapter described, compared, and contrasted three meta-theoretical paradigms. The goal of the section was to show how these meta-theoretical paradigms can be used to categorize the welter of existing theories into a much smaller number of more manageable groups, thus facilitating the link between science and practice. In this section we discuss what is arguably the most important theoretical challenge facing counseling psychologists in recent times—the call to turn away from concentrating on specific psychotherapy theories, and focus instead on an integrating and superordinate meta-theoretical perspective known as the *common factors perspective*. This challenge comes from several sources. Meta-analyses of psychotherapy outcome studies (e.g., Smith & Glass, 1977), common factors

approaches (e.g., Frank & Frank, 1991), and critiques of the randomized clinical trials approach to empirically supported treatments (ESTs; e.g., Wampold, 2001) raise important questions regarding the validity of theoretical claims concerning how client psychotherapeutic change occurs in therapy and the sources of that therapeutic change.

Meta-analyses have revealed that, generally speaking, psychotherapies based on very different and often incompatible claims regarding client development and the nature of client change nonetheless perform similarly to one another on key client outcome variables. Moreover, meta-analytic evidence fails to support the notion that tailoring the theory to the specific type of client and type of presenting problem improves psychotherapy outcomes. The common factors perspective emphasizes that nonspecific and contextual factors, rather than factors unique to a particular theory, are largely responsible for client change. The common factors perspective raises the possibility that the specifics that distinguish one theory (or meta-theory) from another are largely irrelevant to whether theory-based psychotherapy is effective (see Baker, McFall, & Shoham, 2009 for an alternate perspective on common factors). Wampold's (2001) critique of randomized clinical trials of theory-based psychotherapies is based on the finding that the favorability of psychotherapy outcomes was *uncorrelated* with the level of the ostensible "active ingredient" of change posited by the theory. In other words, whether clients got better or worse was unaffected by whether the therapy had been successful in engaging the client in those processes that the theory holds to be required for change. These findings present important issues on which counseling psychology scientists *and* practitioners must collaborate as they grapple with the role and nature of theory in psychotherapy. Furthermore, these findings suggest that research efforts should switch from trying to determine which therapeutic approach is "the best approach" to trying to understand why the current wide array of theory-based therapies fail to produce differential outcomes, why matching treatments to client concerns has failed to enhance outcomes, and why putative mechanisms of client change have not been reliably associated with differential psychotherapeutic outcomes. These questions are of critical importance in the science and practice of counseling psychology. Cooperation among, not Balkanization of, scientists and practitioners of counseling psychology is required to understand and respond effectively to these provocative and challenging findings.

Science–Practice Integration Challenges Associated with Therapeutic Outcomes

EYSENCK'S INITIAL OUTCOME STUDY

A notable first attempt to examine the evidence on the effects of therapy was conducted in 1952, by Hans J. Eysenck. The evaluation of the efficacy of therapy requires that the effects of treatment be compared with a no-treatment control group. To conduct his evaluation, Eysenck compared the outcomes found in 24 studies of psychodynamic and eclectic psychotherapy with spontaneous remission rates (i.e., rate of improvement in client functioning—the remission of symptoms—without benefit of therapeutic intervention) using two control groups. The control or comparison groups used consisted of severely neurotic clients receiving mainly custodial care in a state mental hospital and disability claimants who had been treated by general practitioners. The results of Eysenck's study were disconcerting, finding that clients who received psychodynamic or eclectic therapy improved less than did those in his control/comparison no-treatment condition. Not only did it appear that therapy was ineffective—it might actually be harmful. The alarm one might experience in response to today's widely publicized concern about the scientific basis of psychotherapy is but an echo of the alarm psychologists undoubtedly experienced with the publication of Eysenck's findings.

EFFICACY VERSUS EFFECTIVENESS

The determination of therapy outcomes involves a variety of issues and considerations. Efficacy and effectiveness are two ways in which the outcome of counseling and psychotherapy are discussed. *Efficacy* refers to the therapeutic benefits found in comparing the treatment and a no-treatment control group within the context of a controlled clinical study. In contrast, *effectiveness* refers to the benefits of therapy that occur in the context of actual counseling practice. In the former instance, the question is whether a treatment or intervention is found to achieve a greater benefit for clients than no treatment. If so, the treatment is said to be "efficacious." In the latter instance, the question is how effective is counseling for those clients who seek and receive treatment within the community.

It has been argued that clinical studies create an artificial context in which the therapy that takes place is not characteristic of how treatments are provided in actual practice with actual clients. Consequently, finding that a treatment is efficacious cannot be assumed to mean that it is effective

(i.e., will be beneficial to clients in practice settings). Although there is merit in this criticism, effectiveness findings are generally compromised by the absence of a control group within a practice setting against which to compare client therapeutic gains. As a result, it may not be possible to determine whether the benefits derived by clients receiving counseling in community settings are the result of the treatment or of some extraneous factors.

In the consideration of counseling and psychotherapy outcomes, it is important to ask, "When is an outcome significant?" The significance of therapy outcomes can be evaluated in several ways. Outcomes can be evaluated for their statistical significance, and they can be evaluated for their clinical significance or clinical relevance.

STATISTICAL SIGNIFICANCE

Two types of statistical significance may be considered when evaluating therapy outcomes. The first has to do with differences between or among treatment groups. The second has to do with the changes experienced by individuals within those groups.

Between-group differences are examined by comparing the outcomes of two different approaches to therapy (e.g., a new approach to therapy vs. an established approach), or by comparing the outcome of a specific therapeutic approach with a placebo treatment or a nontreatment (wait-list) group (i.e., a control group). Whatever the comparison, if the research is designed to rule out extraneous factors as competing explanations for the change, statistical procedures may be used to determine whether the observed differences that appear between groups (i.e., their respective outcomes) can reasonably be attributed to differences in the administered treatments, or whether it is more reasonable to conclude that the differences are due to chance (e.g., sampling differences). If the difference between the outcomes of the treatment group and the comparison group is in the expected direction and unlikely to be due to chance sampling differences, then we may conclude that the difference is statistically significant. In other words, the treatment group was more efficacious and yielded a statistically better outcome than did the comparison group.

Although the treatment outcome of one group may differ significantly from that of another group, this does not necessarily mean that the change that occurred was itself significant. Indeed, it is conceivable that the treatment group did not change at all, but rather that the comparison group became significantly worse, relative to the treatment group. To evaluate the statistical significance of change within the treatment group (i.e., the statistical significance of its outcome), a different approach is needed. In this approach, a group's pretreatment performance on some relevant outcome variable is evaluated against its post-treatment performance on the same variable. If the difference between the pre- and post-treatment assessments is in the expected direction and not attributable to chance differences in the measurement of the outcome variable (measurement error), then the change (or outcome) is said to be statistically significant.

CLINICAL SIGNIFICANCE

The statistical significance of outcome research findings can provide empirical support for different treatment approaches, but Ogles, Lambert, and Masters (1996) noted that "statistically significant differences between groups do not necessarily indicate meaningful or clinically significant differences between groups or for individuals within the groups" (p. 77). That is to say, although the treatment outcome for one group may differ from that of another and be in the desired direction, such a finding may not be *clinically* meaningful. For example, although a treatment for depression might produce in a group of clients therapeutic change that is significantly different statistically from that of a placebo treatment, this does not necessarily mean that those who received the treatment are no longer depressed or are experiencing a better quality of life. Furthermore, a statistically significant within-group pre–post difference does not necessarily mean that the individuals who received the treatment are meaningfully improved. It simply means that their post-treatment scores are reliably different from their pretreatment scores.

Several approaches to the evaluation of clinically relevant change have been proposed. Researchers have suggested that evidence that treated clients are indistinguishable from a nondisturbed reference group is probably the most convincing evidence of clinically meaningful change. This notion has been extended to a proposed standardized statistical method involving two criteria for assessing clinical significance (Jacobson & Truax, 1991). First, the treated client should be more likely identifiable as a member within a distribution of healthy persons than of a distribution of disturbed or troubled individuals. Second, the client change must be reliable; that is, it must be large enough that the pre-to post-treatment change cannot be attributable

to measurement error—a criterion for which they have developed a *reliable change index* that can be statistically computed. Notwithstanding the above discussion, statistical significance, rather than clinical significance, is the manner in which outcome efficacy is generally reported.

META-ANALYSIS

Eysenck's (1952) study was not without critiques, as the study suffered from serious design problems. Responding to the challenge to therapy implied by Eysenck's study, numerous reviews of aggregated efficacy studies of counseling and psychotherapy were conducted during the 1960s and 1970s. Although having their own methodological problems, these subsequent studies generally contradicted those of Eysenck and instead yielded findings supportive of therapy's efficacy.

Over the years, examinations of the efficacy of counseling and psychotherapy have reached different and even contradictory conclusions. It is noteworthy that these earlier reviews of the outcome literature often lacked objectivity and replicability. They generally involved narrative descriptions of each study included in the review, an evaluation of the results in terms of the type of evidence offered with respect to therapy outcome, and then an implicit summing up of the findings to render an overall conclusion about therapy's effectiveness. However, with the hundreds of outcome studies now available for consideration in concluding therapy's effectiveness (outcome), how to turn the thousands of pieces of evidence that derive from all of these studies into an integrated summary of the benefits of counseling and psychotherapy is problematic.

Although a single outcome study will reveal information about the benefits received by the participants of that study, the answer to the broad question, such as "Is counseling/psychotherapy effective?" requires the examination of the body of research that has addressed this question. More recent inquiries into therapy efficacy have used the statistical method of meta-analysis to examine the aggregated results of hundreds of different studies that have compared counseling/psychotherapy with a control group. Briefly, meta-analysis consists of a set of statistical procedures that allow researchers to gain a comprehensive picture of the research on a research question and an unbiased answer to the research question. Through meta-analysis, outcome data from many individual counseling and psychotherapy outcome studies are systematically aggregated, allowing the findings to be analyzed to achieve an answer to the larger question of whether therapy is effective. Unlike the research methods used in individual studies, for which the client/participants serve as data points for analysis, meta-analysis uses the summary statistics from individual studies as the data points for analysis. Although not without detractors, meta-analytic procedures provide a methodology to assemble an overall picture of therapy's effectiveness (relative to no therapy or a placebo treatment) and allow investigators to compare studies using different approaches to therapy to investigate the relative efficacy of different treatments.

The first meta-analysis of the outcome of psychotherapy was conducted by Smith and Glass (1977). They analyzed the results of 375 published and unpublished therapy outcome studies. The results of their study produced an effect size of .68, which suggests that an average client receiving therapy would be better off (i.e., improved) than 75% of untreated (control group) clients. Although their results suggest that a proportion (34%) of untreated clients also improved (i.e., spontaneous remission), the success rate for those receiving treatment was 66%, leading them to conclude that the research showed the beneficial effects of counseling.

As with the challenges to Eysenck's methodology and findings, there have been critics of and challenges to Smith and Glass' meta-analytic findings. Subsequent meta-analyses of the therapy outcome literature have challenged the validity of those criticisms, while at the same time providing rather convincing support for the absolute efficacy of counseling and psychotherapy. Therapy is not effective for every one who seeks it, but the likelihood of someone benefitting from therapy is high, and outcomes are generally much better than for those left untreated.

The finding that a particular treatment is effective or efficacious is *not* compelling evidence that the theory is correct; rather, it is only evidence that the treatment worked. Why the treatment works—its mechanism of change—and whether that comports with the theory presumed as the basis for the treatment is an entirely different matter (Horan, 1980; Kiesler, 1966).

An unfortunate tendency of intervention developers is to cite literature that supports the *efficacy* of their interventions as also supporting the role of the theorized causal *mechanisms* of their interventions. Findings that support an intervention's efficacy may simply reflect the influence of common or nonspecific factors in producing the change. As Wampold, Lichtenberg, and Waehler (2005)