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Measures for Counseling Practice Evaluation (MCPE):

An Outcome Tool for Evaluating Effectiveness

Throughout the Counseling Process

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Abstract

Psychometric measures woven into the counseling process were used to collect data on 83 clients during intake, after each session, at termination, and at follow-up in a counselor training clinic over the period of one year. Multivariate analysis indicated that clients significantly improved ($F(2) = 6.74, p = .002$) with the following means from sessions one through three, respectively, ($M = 28.21, SD = 4.11; M = 29.79, SD = 4.4; M = 30.62, SD = 4.53$). This finding suggested that the clients saw progress being made in all three sessions, but saw significantly more progress after each of the three sessions. Clients' perceptions of their ability to handle similar future problems significantly increased as 77%/81.7% of the clients indicated greater ability to cope with moods, 67.7%/76.3% of the clients reported better control over actions and, 86%/89.5% of the clients revealed greater ability to recognize and work through concerns at posttest and follow-up, respectively.

Measures for Counseling Practice Evaluation (MCPE):

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Throughout the Counseling Process

Due to demands for accountability by public policy makers, insurance companies, and other third-party payers, counselors are facing increasing challenges and pressures to demonstrate that their interventions are effective. Partially in response to this trend, counselor educators have been concerned more than ever before with demonstrating empirically the multilevel effectiveness of their counseling interventions and teaching those evaluative skills to their students (Sexton, Whiston, Bleuer, & Walz, 1997). To this end, the principle of accountability has become a standard in the counseling field and provides some guidance, but it is no longer enough. This principle of accountability requires that a counseling intervention be defined clearly and that success be demonstrated using objective and measurable criteria (Steenbarger & Smith, 1996). The focus of this principle is establishing a causal relationship between the counseling intervention and the client outcome. This level of accountability, however, in the current authors' view, would include a standard that requires an assessment of client needs before counseling begins. It also must include scales that clinicians and counselor trainees can use to improve their counseling skills. Moreover, it must address the issue of cost effectiveness.

These more recent demands, beyond basic accountability, on counselors in practice and on those who train counselors have raised the bar of credibility. It is no longer good enough to demonstrate that counseling is beneficial. Today, insurance companies, health maintenance organization's (HMO), and public policy makers are demanding that counseling be effective, cost efficient, and delivered in as few sessions as possible. If counselors are unable to provide evidence of the multilevel effectiveness of their therapeutic services, there will be little recourse

if counseling is viewed as a quasi-treatment intervention and left out of comprehensive treatment regiments.

Review of Literature

To begin empirically testing counseling interventions, the selection of an appropriate research method is paramount. The experimental design is an excellent method for identifying causal relationships but it has inherent problems when used to determine the effectiveness of counseling (Seligman, 1995). The strength of the experimental approach (i.e., random assignment, rigorous controls, outcomes that can be precisely measured, single-blind designs, and treatments that are standardized) makes it difficult to use outside of a laboratory (Cherry, 2000). Another excellent method is the *one-group pretest posttest* design, but it also has intrinsic design problems. When using this research design, standard measures (e.g., the Beck Depression Inventory) have been used to determine change in depression score from pre-test to posttest. The results of the pre-test and posttest comparison, however, are not convincing evidence that the change was more than situational (Seligman).

To overcome the problems with the *one-group pretest posttest* design, Seligman (1995) suggested using an *effectiveness study* approach anchored by a set of flexible measures and scales to assess client needs at pre-treatment and post-treatment. As he observed, an effective battery of scales that are reliable and valid could be used to determine treatment outcomes under natural conditions. Seligman held that counselors would need to include a detailed behavioral history and a global improvement assessment to provide a complete picture of the effect of the counseling intervention. In his vision, these instruments would ideally be used as part of the diagnostic process before treatment begins and as a part of the termination process as treatment comes to an end. According to Seligman, using an extensive battery of psychometric

instruments to measure multiple characteristics that may change while a person is involved in counseling will overcome many of the problems intrinsic in a *one-group pretest posttest* design.

When using Seligman's (1995) approach, it is important that the client clearly and specifically identify his or her treatment issues. By being specific, behavioral, and measurable, the identified issues can serve as a baseline or as a part of the pre-test that will help in determining the treatment outcome (Gillig & Cingel, 2008; Prochaska & Norcross, 1999). Based on Seligman's proposition, the set of measures used in this study was designed to provide an intake assessment of the client's needs that also can be used at termination and follow-up to help determine outcome.

An increasing body of literature has emphasized the role of the collaborative nature of the client-counselor relationship and client feedback when evaluating progress and outcome (Andersen, 1992; Andersen, 1993). Berrios & Lucca (2006) suggested that counselors expand the parameters of scientific research to include more practical methods that are carried out in natural settings.

In particular, various studies have attempted to use the client's own assessment as a basis from which to evaluate the relationship between pretreatment change and outcome (Lawson, 1994; Throckmorton, Best, & Kiley, 2001). In the current study, the position is taken that a next step lies in going beyond pre-test and post-test data and, instead, evaluating information about changes that take place throughout the counseling process. If clients are asked to evaluate the counselor's work and the effectiveness of sessions during the treatment process, then counselors can use such feedback in practical ways to modify treatment plans, redirect subsequent sessions, and assess their own levels of clinical performance (Andersen, 1993). This variation in client feedback can also be used to support findings about the outcomes of counseling interventions.

The addition of feedback from the client during the counseling process goes beyond Seligman's proposal and improves on a major weakness in his conceptualization. It is also practical to include scales for collecting feedback from clients at the end of the counseling session. There is value in developing and testing a research tool designed to measure the effectiveness of treatment throughout the counseling process. Such an endeavor speaks to Rogers's (2002) call for research that ties in closely with practice by focusing on questions that arise clinically that offer empirical support for counseling practice. Accordingly, we have developed the Measures for Counseling Practice Evaluation (MCPE) tool.

In this endeavor, the MCPE was developed for this study based on Seligman's proposal with the added set of measures based on Anderson's (1992) observations to be used after each counseling session to collect clinical and empirical feedback about his or her progress during the counseling sessions and to provide feedback to the counselor or counselor trainee about the client's view of the counselor's skills and effectiveness (Goss & Rose, 2002). The MCPE was also used as a summative evaluation tool to ascertain the effectiveness of the counseling intervention with each client and to determine the overall effect of the clinical intervention by a counselor.

Based on the literature, there was the strong possibility that previous counseling experience could affect counseling outcomes in the future. For example, while counselors and clients had moderately similar recall of significant counseling events at the beginning of counseling, after 10 sessions they had almost perfect concurrence on their recollection of significant events and on their reasoning for selecting these events. Since clients learned to think like counselors over time, those with previous counseling experience are likely to benefit more rapidly from future counseling than clients without previous experience (Kivlighan & Arthur,

2000). According to Tryon (2002), having a history of prior counseling correlates positively to client/counselor rapport. Prior counseling experiences were especially relevant when the counselor was a trainee. Clients who had received prior counseling were more likely to be engaged by trainees than clients with no previous counseling. Further, Liebert (2006) indicates that while the most extensive improvements happen early in treatment, more severe issues have better results with the benefits of treatment over time.

Purpose of the study

The purposes of this study were the following: a) to develop a set of brief user-friendly measures that could be managed by counselors throughout the course of treatment and used as summative measures when counseling ended; b) to include in the set of measures and scales that could be used to determine outcome effectiveness for the population of clients served by a clinic providing counseling services, and; c) to include in the set of measures, scales that could be used by counselors and counselor trainees to rate their skills. The set of psychometric scales were developed for use in client assessment, to evaluate each counseling session, to rate the counselor skills used in each session, to determine the outcome effectiveness with individual clients, and to determine the outcome effectiveness for the entire population of clients served by a counselor training clinic.

Central Research Questions

The central research questions of this study consisted of the following:

1. What are the primary reasons clients seek counseling?
2. What is the intensity of the emotional distress that clients bring to counseling?
3. Do clients expect improvement on the issues that brought them for counseling?

4. Will there be a difference in clients' expected progress and perceived progress made in counseling from the pre-session through termination and follow-up?
5. Will clients have the perception that their counselor used effective counseling skills?
6. Will there be a relationship in the view of progress held by counselor trainees and clients when compared over the three sessions?
7. Will clients indicate their counselor acquired new skills or improve their skills when measured at termination and follow-up?

Method

Sample

Seven counselor trainees and 83 clients were involved in this study. There were 28 male clients (34%) and 55 female clients (66%). Clients ranged in age from 18 to 53 with a mean age of 23 and a median age of 21. All clients were Caucasian, full-time undergraduate students in a small private liberal arts college in the Midwest. The counselor trainees were graduate students pursuing a masters degree in counseling in a program that met the educational requirements for licensure as a professional counselor. Three of the counselor trainees were male and four were female with an average age of 32. Six counselor trainees were Caucasian and one Asian.

Instruments

The MCPE consists of eight psychometric scales developed for this study by two counselor educators and three counselor trainees. These scales were constructed after examining scales and instruments previously developed for relevant purposes. The list of scales and instruments below were carefully reviewed to insure some degree of content and construct validity:

1. *The Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV;* American Psychiatric Association, 1994).
2. Child Behavior Checklist for Ages 4-16 (Achenbach, 1981).
3. Youth Self-Report for Ages 11-18 (Achenbach & Edelbrock, 1981).
4. Stony Brook Child Psychiatric Checklist-3R (Gadow & Sprafkin, 1994).
5. Personal Problems Checklist for Adults (Schinka, 1984).
6. Children's Problems Checklist (Schinka, 1985).

Measures for Counseling Practice Evaluation (MCPE)

The following were the psychometric measures woven into the counseling process that were used to collect data on clients.

Qualitative Instrument

Pre-session Questionnaire. The Pre-session Questionnaire (PQ) asked clients to list the three major reasons for seeking counseling from a list of eight categories of issues (Educational, Family, Feeling Sexual, Social, Spiritual, Thinking, and Vocational). Each category of issues contained an average of 21 specific concerns (e.g., *hopelessness* from the Feeling category, *awkwardness when meeting people* from the Social category, and *being easily distracted* from the Thinking category) as examples to be used in treatment planning.

Quantitative Instruments

Expected Progress Scale. The Expected Progress Scale (EP) asked clients what progress they expected to make on each of the top three categories of issues as a result of counseling. The EP scale was a one-question rating scale with a range from 1 to 9 where 1 indicated *no progress* and 9 indicated *significant progress*. The EP was also administered before the client began counseling.

Concern About Issues Scale. The Concern About Issues Scale (CI) asked about how much concern clients felt about each of the top three categories of issues today and the past week. The CI Scale was a one question rating scale with a range from 1 to 4 where 1 indicated *somewhat concerned* and 4 indicated *extremely concerned*. The CI was also administered before the client began counseling.

Client's Perceived Progress Scale. The Client's Perceived Progress Scale (PP), a rating scale similar to the EP scale was administered at termination and following the one month follow-up. The PP scale asked about the same top three categories of issues and used the same one question rating scale as the EP. The PP question, however, was stated in the past tense with a range from 1 to 9 where 1 was *significantly worse* and 9 equaled *significantly improved*.

Counselor Trainee Reflection Scale. The Counselor Trainee Reflection Scale (TRS) was a self-assessment instrument where counselor trainees indicated how satisfied they were with various aspects of the session. For example, item #3 asked counselor trainees "How useful was today's session in helping the client recognize and work through his/her concerns?" The TRS was administered after each counseling session and was completed by the counselor trainees. The TRS consisted of four ratings questions with a range from 1 to 9 where 1 indicated *very little* and 9 indicated *very much* and one question asking how the session could have been improved.

Counseling Session Reflection Scale. The Counseling Session Reflection Scale (CRS) was a client assessment instrument where clients indicated how satisfied they were with various aspects of the session. For example, item #3 asked clients "How useful was today's session in helping you recognize and work through your concerns?" The CRS was administered after each counseling session and was completed by the clients. The CRS consisted of four ratings questions with a range from 1 to 9 where 1 equaled *very little* and 9 equaled *very much* and one question

asking how the session could have been improved. Both the TRS and CRS scales used parallel items that were slightly rephrased to be applicable to the counselor and rephrased for the client.

Counselors Trainee Skills. The Counselors Trainee Skills Scale (CTS), a Likert type scale, was administered at termination of the counseling sessions and at follow-up. The CTS measures the degree to which clients believed their counselor used effective counseling skills. For example, item #2 asked clients to rate the extent to which they agreed or disagreed that their counselor was competent (knew what he/she was doing). This scale consisted of eight items with scores ranging from 1 to 5 with 1 indicating clients strongly agreed that their counselor used effective skills and 5 indicating they strongly disagreed..

Client's Skills. The Client's Skills Scale (CS), also a Likert type scale, was administered at termination of the counseling sessions and at follow up. The CS measures the clients' perceptions of skills they gained from the counseling experience. For example, item #2 asked clients to rate the extent to which they agreed or disagreed that they gained greater ability to cope with their moods. This scale consisted of five items with scores ranging from 1 to 5 with 1 indicating clients strongly agreed that they had learned to use effective skills and 5 indicating they strongly disagreed..

Procedure

This study was approved of by the University Human Subjects Committee with all counselor trainees receiving regular individual and group supervision by a licensed professional counselor who was also a faculty member. Data were collected over the course of one year. Undergraduate students voluntarily seeking services at the counselor training clinic were asked to participate in the study. Students were informed of the availability of counseling services available campus-wide by word of mouth, news announcements, brochures, presentations, etc.

All clients were informed of the nature of counseling services and accountability procedures. All clients read and signed a Confidentiality Agreement and Informed Consent form that counselor trainees reviewed with them prior to their first session. As was routine prior to and after the study, potential clients were screened and any of those with issues outside of our scope of practice (i.e., actively suicidal, intoxicated, experiencing severe mental or emotional disorders) were appropriately referred. Referral was necessary once during the study. No clients dropped out without completing the initial session with the number of sessions ranging from one to 25 sessions ($M = 5.70$, $SD = 4.1$).

Standardized instructions were used in data collection from intake to follow-up. Data collected on intake included demographics and information about prior mental health services. Clients also were asked to complete a 46 item health inventory. The following summarizes the standardized instructions utilized in the study.

At the beginning of the first session, directions were given by counselor trainees to clients for filling out the Intake Assessment form (IA), the Pre-session Questionnaire (PQ), the Expected Progress Scale (EP), and the Concern About Issues Scale (CI). At the end of the first session, directions were given by counselor trainees to clients for making any desired changes on the PQ.

At the end of each session, instructions were followed to set the next counseling appointment or to set up a one month follow-up session for those clients who did not require more sessions. Also, directions were given by counselor trainees to clients for completing the Counseling Session Reflection Scale (CRS).

At the last session, clients were given directions by counselor trainees for completing the termination questionnaire consisting of the Client's Perceived Progress Scale (PP), the

Counselors Trainee Skills Scale (CTS), and the Client's Skills Scale (CS). Directions for scheduling a one month follow-up session were given to clients.

At the one month follow-up session, directions were given by counselor trainees to clients for completing a follow-up questionnaire consisting of the PP Scale, CTS Scale, and the CS Scale. For those clients who did not keep their one month follow-up session, they were called and the follow-up questionnaire was completed by phone. If they were not available by phone, clients were sent a cover letter, provided with a self-addressed stamped envelope, and asked to complete the follow-up questionnaire and return it to the counselor training clinic.

Data Analysis

Qualitative

Percentages of client-selected issues were obtained from a checklist consisting of eight categories of issues.

Quantitative

Clients were asked to rate the intensity of the emotional distress of their three major issue categories from a list of eight issue categories. A mean rating was calculated for each of three major reasons for seeking counseling.

The expectation of receiving help with a serious problem has been identified by Lambert and Cattani-Thompson (1996) and Hubble, Duncan, and Miller (1999) as the single most important feature leading to successful clinical outcomes across multiple counseling and therapy models. Clients were asked to predict how much progress they expected to make on each of the top three categories of issues as a result of counseling. Percentages of expected progress were gathered.

To determine if there was a change from the *expectation of progress* scores on the EP scale taken before counseling began, the *perceived progress* scores on the PP scale scores at termination and at follow-up were compared using the General Linear Model (GLM) for Repeated Measures.

Clients were asked to rate their perceptions that the counselor trainee used effective counseling skills. Percentages of client-perceived counselor trainee effectiveness were reported.

To determine if there was a significant change in clients' and counselors' view of progress made during the first three sessions, the General Linear Model (GLM) for Repeated Measures was used to compare clients' (CRS scale) scores over the first three sessions and the trainees' (TRS) scores over the same three sessions. Mauchly's test of sphericity determines if the data meet normalcy assumptions and can be used in a GLM Repeated Measure procedure. It tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is proportional to an identity matrix.

To determine if the counseling experience was helpful to clients, measures were analyzed within and between the three major time periods (pretreatment, during treatment, and after treatment). In addition to measures about the counseling experience, a number of demographic characteristics that could confound the meaning of the statistical analysis were also included in the analysis.

Controlling for Differences among Clients

Although, there are a plethora of individual characteristics that could affect counseling outcomes as much as the counseling experience itself, the following characteristics were thought to be especially important: previous counseling experience, counseling contact hours, perception of counselor's skills, and expected progress. These measures, which were thought to be

important to counseling outcomes, were used to test the degree of homogeneity of the clients in this study. If statistically significant differences were found among the clients on any of these variables, then the relevant variable(s) were to be used as control variables in the final multivariate repeated measures analysis. By using these variables as control variables, effectively removing any differences among group members, a truer picture of the contribution of the counseling experience could be developed.

Previous Counseling Experience

As discovered earlier in this analysis, clients with previous counseling experience utilized more counseling hours than clients without previous counseling experience. To avoid the possibility, in the final analysis, that the difference in contact hours made the difference in the counseling outcome, the number of contact hours was controlled for in the final GLM analysis. Additionally, two other measures were statistically different for these clients and counselors. The second session and third session Counselor Trainee Reflection Scale scores were also controlled for in the final GLM analysis.

Hours in Counseling

The client's expectations for help with their First Category of issues was analyzed while controlling for hours in counseling and the second session and third session Counselor Trainee Reflection Scale scores. Using this method to control variance, mathematically all of the clients had the same number of hours in counseling and the same scores on the second session and third session Counselor Trainee Reflection Scale.

Reliability of the MCPE

The reliability of the scales that comprise the MCPE was considered in light of the recognition that similar scales are used to measure opinions from two different populations. In

this study, for example, similar scales were used to measure change perception of client progress on the part of both the counselor trainee and the client. Using a scale in this way raises the question about the reliability of the questionnaire within the two different populations. This is a concern because the characteristics that are expected to change for the most part depend on knowledge of the existence of the characteristics being described by the questions. To address this possibility, the alpha coefficients for each scale for each session for both groups were examined. For session one, the alpha reliability coefficient for the CRS was .66 and the alpha reliability coefficient for the TRS was .84. Session two alpha coefficients were: CRS = .80 and TRS = .61. By the third session, the scales were producing better reliability coefficients, and the reliability coefficients had stabilized for both groups (CRS = .85 and TRS = .87). The increase in reliability of the scales by the third session probably indicated that both clients and counselor trainees had a clearer understanding of the questions asked on the scales. The CTS scale had eight items and produced the same reliable alpha coefficient at both termination and follow up ($\alpha = .88$). The CS scale had lower, but still acceptable, results at both termination ($\alpha = .68$) and at follow-up ($\alpha = .63$).

Results

Qualitative

To determine the “reason for seeking counseling” (Pre-session Questionnaire [PQ]) and the “intensity of the emotional distress caused by the problem” (Concern About Issues Scale [CI]), the PQ listed eight broad categories of issues that typically bring people to counseling. Concerns listed under the *feeling* category were identified by 34 (41%) of the clients as being the most critical issue bringing them to counseling. The *family* category was identified by 18 (21.7%). The *education* category was selected by 12 (14.5%). The remaining 19 clients

identified issues under the *sexual*, *social*, *thinking*, and *vocational* categories as being the most critical category of issues bringing them to counseling. No clients identified the *spiritual* category as a primary reason for coming to treatment.

Quantitative

The level of concern over the issues that brought these clients to counseling was viewed by 64 (77.1%) of them as *extremely important* or *very important*.

In addition to the primary category of issues that brought the students to counseling, 80 of the 83 clients listed a secondary category of issues that contributed to their seeking counseling. Among the secondary categories, the *feeling* category was identified by 22 (27.5%), the *social* category by 18 (22.5%), and the *family* category by 18 (22.5%). The remaining 22 clients identified the *sexual*, *educational*, *vocational*, and *thinking* categories (listed here in descending order of percentages). One person identified the *spiritual* category as a secondary issue. Of the 80 students who selected a secondary category of issues, 43 (52%) rated it as *extremely important* or *very important*.

Along with listing a primary and secondary category of issues, 62 clients listed a third category of issues that contributed to their seeking counseling. The *thinking* category was identified by 14 (22.6%), the *social* category was identified by 13 (21.0%), the *educational* category was identified by 11 (17.7%), and the *family/home* category was identified by 9 (14.5%). The remaining 13 clients identified the *feeling*, *spiritual*, *vocational*, and *sexual* categories (listed here in descending order of percentages).

The clients in this study came to counseling with high expectations for improvement: 78 (94%) expected *significant improvement* or to *improve* on their most important First Category of issues. Among the 79 clients who listed a Second Category of issues, 70 (89%) expected to make

significant improvement or *improve* as a result of counseling. Of the 62 clients who indicated a Third Category of issues, 44 (71%) expected to make *significant improvement* or *improve*.

On the clients' First Category of issues, the GLM for Repeated Measures analysis found no statistically significant difference between the progress the 82 clients expected to make and the progress they believed they made after counseling ended ($F(2) = .449$, $p = .64$). The data meet assumptions about sphericity (Mauchly's $W(2) = .997$, $p = .929$). On their Second Category of issues, listed by 79 clients, the GLM for Repeated Measures again found no difference between the three measures ($F(2) = 1.79$, $p = .177$). However, the data on the Second Category of issues did not meet assumptions about sphericity (Mauchly's $W(2) = .651$, $p = .000$). It is advisable to use caution when drawing meaning from this finding. The clients listing a Third Category of issues was too small a group for a multivariate analysis to yield reliable information, so this category of issues was not analyzed beyond a look at the percentages presented earlier.

Another important feature that influences counseling outcomes is the client's perception of the counselor's psychotherapeutic skills. Based on the Counselor Trainee Skills (CTS) scale, the counselor trainees received high scores at both termination and follow-up:

(a) empathic/caring (90% at termination and 90% at follow up), (b) competent (88%/97%), (c) did not talk too much (83%/87%), (d) genuine/honest (91%/85%), (e) not too quiet/passive (89%/87%), and (f) involved/interested (89%/90%), did not miss the point (88%/83%), non-judgmental (86%/88%).

Comparison of perceptions of progress across sessions. The Counseling Session Reflection (CRS) and Counselor Trainee Self-Reflection (TRS) are Likert-type scales intended to measure the counselor trainee's and client's perceptions of progress made during each

counseling session. Means for the CRS and TRS were compared for the first three counseling sessions. Statistical analysis after session three was not carried out because a significant number of clients chose not to continue beyond the third session.

Clients' perceptions of progress. When the experience of the clients (CRS) in sessions one through three were compared, the Multivariate Tests (such as the Hotelling's Trace) showed a significant change over the first three sessions ($F(2) = 6.74, p = .002$). The data meet assumptions about sphericity (Mauchly's $W(2) = .981, p = .582$). In this analysis, the means over the three sessions were: session 1: $M = 28.21, SD = 4.11$; session 2: $M = 29.79, SD = 4.4$; session 3: $M = 30.62, SD = 4.53$.

Counselor trainees' perception of progress. Change over the first three sessions also occurred on the counselor trainee's TRS score. The GLM for Repeated Measures produced a Hotelling's Trace, indicating there a significant change over the first three sessions ($F(2) = 34.19, p = .000$). Mauchly's test of sphericity determines if the data meets assumptions to be used in a GLM Repeated Measure procedure. Unfortunately, the data gathered by the TRS did not meet assumptions about sphericity (Mauchly's $W(2) = .981, p = .006$). As a result, conclusions drawn from this scale with this population of counselor trainees should be done cautiously. The following means were found from sessions one through three, respectively, ($M = 28.21, SD = 4.11; M = 29.79, SD = 4.4; M = 30.62, SD = 4.53$) suggesting that the counselor trainees could have noticed a discernable increase in progress after the first session.

Comparing clients' and counselors' agreement on progress across sessions. When the view of progress by the counselor and client are compared over the three sessions using the CRS and the TRS (both scales use the same items), the degree of agreement can be obtained. After the first session, clients reported a statistically significant more positive perception of progress

during the counseling session than did the counselor trainees ($t(71) = 4.14$, two tailed $p = .000$). The mean score for the clients ($M = 28$, $SD = 4.3$) was higher than that of the counselors ($M = 25.7$, $SD = 4.3$).

After session two there was no significant difference between how clients and counselors viewed progress in that session ($t(68) = 1.7$, two tailed $p = .078$). The mean score for the clients ($M = 29.7$, $SD = 4.1$) was not significantly higher than that of the trainees ($M = 28.8$, $SD = 2.5$).

For session three, there was again a significant difference between how clients and counselor trainees viewed the progress made in the session ($t(59) = 2.2$, two-tail $p = .032$). Clients believed that more progress had occurred ($M = 30.7$, $SD = 4.5$) than trainees ($M = 29.6$, $SD = 3.9$).

Did the clients acquire new skills or did they improve their skills? The termination questionnaire and follow-up questionnaire asked the clients to rate the extent to which they gained five skills as a result of the counseling sessions. The skills and percent indicating agreement or strong agreement were: (a) better insight into and understanding of my concerns (at termination 92.3%, and at follow-up 95%); (b) greater ability to cope with my moods (77%/81.7%); (c) better control over my actions (67.7%/76.3%); (d) greater ability to recognize and work through my concerns (86%/89.5%); and (e) better ability to communicate my concerns to my counselor (84.6%/87%). Using the above five items as a scale to measure the clients' perceptions of whether they acquired new skills or improved their skills and comparing the means at termination and follow-up to determine the stability of their view at termination, the analysis found no statistically significant difference ($t(42) = .572$, $p = .571$). At follow-up, the clients' perceptions that they had made progress during counseling did not change. Specifically,

the clients as a group indicated they were better able to cope with their moods and that they gained better insight into and understanding of their own concerns.

Previous counseling experience. Among the clients in this study, 36 (47%) had been in counseling previously. Of these, 20 had been in treatment for one month or less. Eleven clients had been in treatment for one month, and eight clients of the 36 had previously been in treatment for over a year. The average number of months in treatment was ($M = 20.4$, $SD = 16$), with a median of 3.5 months. The minimum previous treatment experience was one session and the maximum was 78 months. The remaining 47 participants (53%) had not been in counseling before.

A statistical comparison of the two groups: *clients with previous counseling* and *clients with no previous counseling experience*, showed that clients with no previous counseling experience were scored lower by their counselors after the second and third counseling sessions than clients who had previous counseling experience. The two groups were different on three of 14 measures: (1) Session 2 Counselor Trainee Reflection Scale (TRS) (no previous counseling, $M = 28.68$, $SD = 2.83$) (previous counseling, $M = 29.14$, $SD = 2.19$) ($t(69) = .768$, two tailed $p = .034$), (2) Session 3 TRS (no previous counseling, $M = 28.87$, $SD = 2.46$) (previous counseling, $M = 30.29$, $SD = 2.73$) ($t(60) = 1.48$, two tailed $p = .017$), and (3) Counseling hours received during this treatment experience (no previous counseling, $M = 4.26$, $SD = 2.47$) (previous counseling, $M = 7.30$, $SD = 5.03$) ($t(54) = -.341$, two tailed $p = .001$).

Counseling contact hours. Based on the number of contact hours, experienced-clients used three more counseling sessions than clients with no previous counseling experience. During this study, the mean number of treatment contact hours per client was ($M = 5.70$, $SD = 4.1$). There were a minimum of one contact hour and a maximum of 25.75 contact hours per client.

The median number of contact hours was 4.9. Because of the significant difference between contact hours for clients with counseling experience and clients with no counseling experience, contact hours was controlled for in the final analysis. Based on the number of contact hours by gender, female clients used about the same number of counseling sessions ($M = 5.7, SD = 3.7$) as males ($M = 5.7, SD = 4.4$) ($t(80) = -.001$, two tailed $p = .999$).

Discussion

The use of an intake questionnaire to gather needed client identification information, data on the client's problem, and information on the severity of the client's problems is not a new idea. The use of a termination and follow-up questionnaire to measure the client's progress in counseling has been around for quite a while. The notion of a feedback loop to the counselor about the usefulness of the intervention being used is also not novel. Neither is the idea of measuring the skills that the client gained from the counseling experience. Yet, there are few instances reported in the counseling literature where a set of psychometric scales are used for client assessment, to evaluate each counseling session, to rate the counselor skills used in each session, and for determining the outcome effectiveness for the population of clients served by a clinic. The current study differs from other outcome studies in so far as the clinician played an interactive role with the participant; the clients' feedback informed the researcher's subsequent interventions, which in turn, shaped the clinicians' interventions. Hoshmand (1989) views research as intervention with the researcher as the primary instrument for data collection and data analysis. The purpose of clinical research is not merely to obtain data and outcome measures but rather to inform the clinician's subsequent practice and thereby change and help the client change the outcome.

The major problem inherent in showing the effectiveness of a counseling intervention is that the data gathered on the client and the intervention must be quantifiable and the severity must be measured across clients in a uniform way. This makes scale development difficult. Even so, quantifying behavioral changes and client problems have long been required by managed care agencies in relationship to individual problems clients bring to counseling. As Seligman (1995) suggested, in the current study the clinical scales were so intricately woven into the natural activities of the counseling process that the data gathering procedures needed for both client assessment and program evaluation were, and need to be, seamless.

It is important to note that development of the PQ, CI, and PP scales, specifically allowed for the flexibility of examining client outcomes for a wide range of therapeutic issues and diverse counseling approaches. Development of the specific concerns (21 on average) in the eight categories of issues involved careful consideration of earlier scales and instruments with special attention to selecting red flag indicators from diagnostic categories pertinent to college students drawn from the *DSM-IV*. Unlike clinical research that compares the effectiveness of one type of intervention (i.e., Cognitive Therapy) with another type of intervention (i.e., Brief Solution Focused Therapy) on a specific issue (i.e., depression), this study took a more eclectic approach. In the counselor training program housing the clinic where the study was conducted, students learned various therapeutic approaches as their training did not favor one particular paradigm. Therefore, we did not dictate the type of therapy the trainees utilized with their clients. Nor did we see value in limiting treatment to one specific type of client concern because clients with a wide range of issues were seen in the clinic. By allowing clients to select from among the specific concerns in the eight categories of issues on the PQ, there was the flexibility to examine client progress using the CI at intake and the PP at termination and follow-up regardless of the

concerns which clients presented with. This flexibility in instrumentation fills a gap in outcome evaluation research and allows for comparisons across sessions. For example, in this study a cumulative and beneficial effect of counseling was noted. There was a significant change in both clients' and counselor trainees' view of progress made during the first three sessions and clients saw progress being made in all three sessions with significantly more progress after each of the three sessions. Further, those clients who expect to receive help are often successful. In this study the majority of the clients expected to make improvement on all of the issues for which they sought counseling.

The analysis for the first and second categories of issues, particularly the first category of issues, suggested that the clients' expected outcome before starting counseling did not differ from the view of progress made at termination and the clients did not change their minds about the progress made in counseling at the one month follow-up interview. This makes a strong empirical case for stating that the counseling provided clients was effective in the view of the client and counselor.

In order to trouble-shoot and continue to improve methodology, the researchers held focus groups with the counselor trainees after each semester. During focus groups, trainees were asked: "Regarding the journals which you have been keeping on the new accountability procedures, which things seem to be working effectively?" and "Regarding the journals which you have been keeping on the new accountability procedures, which things seem to be limiting effectiveness?" Using focus groups to evaluate the methodology for assessing clinical effectiveness was intended to apply to the research process itself the same concern for openness, soliciting feedback, and continuous improvement that was done in designing methods for assessing counselor and clinical effectiveness. Just as the counselors can benefit

from this move towards inclusion of as many participants' voices as possible in obtaining feedback about effectiveness, so can we as researchers in our efforts to enhance our own methodologies.

When asked about what has been working or not working with the accountability procedures, all counselor trainees agreed that it was helpful to schedule clients to come in half an hour early and that allowing one and one-half hour for the first session was preferable and helped clients to not feel rushed. All counselor trainees agreed that the sharing of the Counselor Trainee Reflection Scale (TRS) and the Counseling Session Reflection Scale (CRS) completed by counselor trainees and clients at the end of all sessions, respectively, helped with feelings of closure of the sessions. The TRS and CRS were seen by two counselor trainees as being extremely helpful in that they provide the client immediate opportunity for feedback and to check and see if the counselor and client agreed. The intake assessment that included the Pre-session Questionnaire (PQ), the Expected Progress Scale (EP), and the Concern About Issues (CI) scale was seen as very useful in helping clients focus on problems right away. The counselor trainees saw the revisions made on the Termination/Follow-up Questionnaire that included the Counselors Trainee Skills (CTS) scale and the Client's Skills (CS) scale, as being helpful in that duplication items were eliminated. Several of the counselor trainees felt they gained more confidence in their skills when they discovered their clients rated their skills higher than they did. It was recommended by one counselor trainee that the intake assessment be limited to problems which concern clients today, not every problem they ever had. Two counselor trainees each reported one of their clients felt somewhat burdened by the paperwork. It was reported that while one client was hesitant, he eventually filled out the forms and this interaction helped to provide insight into the client's personality style. The researchers perceived that having the accountability procedures in place helped with more effective supervision practices.

Limitations and Implications for Further Research

While clients were males and females and ranged in age from 18 to 53, all were Caucasian, full-time undergraduate students in a small private liberal arts college in the Midwest. Counseling was limited to individual counseling methods. Consequently future studies should be done in different regions with a more diverse clientele. Also, the procedures will need to be modified in different settings including marital, couples, family, and group counseling.

Implications for Counselors and Counselor Educators

In this study, 80% of the clients who entered counseling were very or extremely concerned about their most critical set of issues. Moreover, 94% of the clients expected to make significant improvement or to improve. After an average of six sessions, based on data from scales and measures that met the assumptions about data used in a multivariate analysis, clients reported that they had made the progress in counseling that they had hoped to make. An average of six sessions was also cost efficient, especially when considering the high level of perceived progress made by the clients.

In a purely capitalistic business environment, consumers drive markets. The value consumers place on a service depends on the service meeting some perceived personal need. In this study the clients not only expected a great deal of help, but they received it. These clients recognized that they both improved and gained new skills that would help them deal with similar problems in the future.

Part of the responsibility of counselor educators in preparing students for clinical practice includes preparing them to work effectively within a rapidly changing and often confusing managed care environment (Gale, A.U. & Austin, B.D., 2003). A focus on defining and measuring clinical issues as well as using the qualitative information that has been traditionally

used to determine counseling outcomes will provide students with another tool for helping their clients. If counselors can deal with questions about the degree of client improvement that can be expected, both the client and the counselor will fare much better in a bottom-line oriented and accountability-driven health care environment.

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