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# Relationship Competency: An Exploration of Training and Relationship Assessment in an APA Doctoral Program

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Relationship Competency: An Exploration of Training and Relationship  
Assessment in an APA Doctoral Program

by

Jacquelyn M. Rodriguez

Presented to the Faculty of the  
Graduate Department of Clinical Psychology  
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in Clinical Psychology

Newberg, Oregon

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Relationship Competency: An Exploration of Training and Relationship Assessment in  
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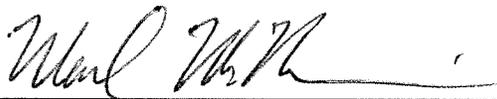
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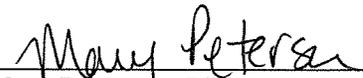
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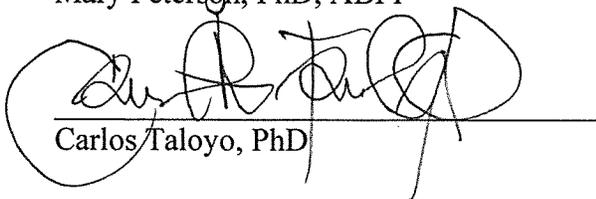


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## Relationship Competency: An Exploration of Training and Relationship

Assessment in an APA Doctoral Program

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**Abstract**

Relational competency is regarded as foundational to doctoral psychology training (Mangione & Nadkarni, 2010), yet defining this competency has proven to be an arduous and nebulous task. The connection between relationship competency and strong therapeutic alliance, combined with the lack of knowledge and research around effective assessment and training of the nontangible relational attitudes, knowledge, and skills begs for more research on the implementation of this competency. The aim of the current study was to examine the relationship between student therapists' technique and relational characteristics and therapeutic alliance outcome during 10 therapy sessions. Participants were 24 first year doctoral students in an APA-accredited doctoral program in clinical psychology. A Q-sort method was used to evaluate the students' therapeutic approach in working with undergraduate pseudo-clients. The Q-sort results were then factor analyzed, resulting in four distinct therapeutic process variables. Scores on these process variables were then used to explore which therapy techniques or characteristics

contribute most to therapeutic alliance, which is indicative of relationship competency.

Therapists who were rated higher on relational based factors did not show stronger therapeutic alliance or better therapeutic outcome than those rated higher on technical based factors. The only therapist characteristic found in this study that is shown to impact therapy outcome is the area of therapist intelligence. Nuanced secondary findings between therapist factors and therapy alliance were found and implications for future research are discussed.

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## **Chapter 1**

### **Introduction**

Relationship lies at the center of professional life for a psychologist (Despland, Yves, Martin, Thierry, & Veronique, 2009).

Relationship is the capacity to develop and maintain a constructive working alliance with clients and includes the ability to work in collaboration with others such as peers, colleagues, students, supervisors, members of other disciplines, consumers of services, and community organizations. The relational functioning of professional psychologists is greatly impacted by their awareness and connection to their own self-identity, (Peterson, 2007, p. 11).

Given the importance of relationship, it is not surprising that therapeutic alliance is the highest predictor of success in psychotherapy across all theoretical orientations and intervention methods (Despland et al., 2009; Norcross, 2011). As a basic condition for effective psychotherapy, strong therapeutic alliance encompasses an inherently collaborative and dynamic interpersonal process between the client and therapist that is directed toward shared goals and the conveyance of hope (Michel, 2011). Empathy, attachment, listening ability, openness, and respect for others are all crucial aspects in establishing a strong therapeutic alliance (Michel, 2011). While numerous client variables exist (e.g., motivation, the nature of various disorders, and so on), a client must be able to be his or her authentic self in therapy and perceive the therapist as genuine in order for a trusting alliance to be created (Norcross & Lambert, 2011). Once this secure base of

attachment is established, a bond is created between client and therapist that often lasts beyond termination (Michel, 2011).

Given that appropriate relationship between therapist and client is essential to building therapeutic alliance, what relational skills, knowledge, and attitudes are requisite in order to develop relational competency? The attempt to parse out the layers of relationship and define it as a competency has proven a difficult and laborious task for the National Council of Schools and Programs of Professional Psychology (NCSPP).

### **Training in Relational Competence**

Following the overall trend in psychology training toward a competency/benchmark model, the Competency Developmental Achievement Levels (DALs) of the NCSPP are widely used within APA accredited doctoral programs (NCSPP, 2007). Therefore, breaking down and understanding the components included in relationship has become important for assessment of this competency. The six domains created by which to assess relationship include professional demeanor, knowledge of self, knowledge of other, interpersonal connection, cultural adaptability, and ethics (NCSPP, 2007). The stated training that informs this competency involves shaping a student's attitude toward: (a) intellectual curiosity and flexibility, (b) open-mindedness, (c) belief in the capacity for change in human attitudes and behavior, (d) appreciation of individual and cultural diversity, (e) personal integrity and honesty, and (f) a value of self-awareness (McHolland, as cited in Mangione & Nadkarni, 2010). The education and development of interpersonal skills, including empathy, respect for others, and personal relatedness, are also viewed as essential to implement in curriculum design (NCSPP, 2007; Peterson, 2007).

### **Assessment and Training Challenges**

Professional psychology educators face unique challenges in training students in relational competence and in assessing the effectiveness of the training. First, the components that make up the relationship competency are notoriously broad and inclusive of many crucial, yet ambiguous, aspects of training and development (Mangione & Nadkarni, 2010; NSCPP, 2007). Whereas training in an assessment competency might involve mastering particular tests, including administration, scoring, and interpretation, when training students in a relational competency there is a risk of placing too little focus or training on the more intangible but essential aspects of relationship (Mangione & Nadkarni, 2010). Relatedly, though some competencies may be perceived as orthogonal in relation to other competencies, the relational competency is closely aligned with various other competencies. That is, relationship is a foundational competency that supports all other skills in training. Mangione and Nadkarni (2010) assert that it should act as a substrate under all other competencies and take its rightful place as foremost in the values of a doctoral training program as a normal part of curriculum (instead of training that is simply reserved for problematic students).

Second, it is apparent that defining and attempting to assess relationship is a nebulous process. Even with the development of the DALs and attempts to clearly define it, there is another dimension of relationship that does not seem to be captured on paper; this aspect is often “sensed” by faculty, training advisors, or students (Fouad et al., 2009; Mangione & Nadkarni, 2010). Research indicates that institutions screen students initially for a base level of relational skill and then rely mostly on implicit methods to train students in relationship (Mangione & Nadkarni, 2010). Therefore, even with this competency defined, the training and assessment

likely looks different across different training institutions. If, as research suggests (Fouad et al., 2009; Mangione & Nadkarni, 2010), there are multidimensional aspects of relationship that are nearly impossible to categorize and objectively assess, and these aspects are paramount to developing a strong and lasting therapeutic alliance, the question remains of how to train and/or assess students in these aspects of relationship in order to ensure the training of competent therapists.

Third, specific training in therapeutic alliance has often proven ineffective for improving psychotherapist-client alliance from the clients' or independent raters' points of view (Horvath, 2005). In one study, 57 clinicians across five community health clinics were randomly assigned to a brief alliance-training workshop or a delayed-training control condition. The psychotherapist-reported use of alliance strategies, psychotherapist-rated alliance quality after the first session, and the client engagement after four weeks were all measured as well as client and observer ratings. The results revealed no significant differences between the training and delayed-training conditions from the clients' or observers' perspectives. However, psychotherapists who received the alliance training were significantly more likely to rate the therapist alliance quality higher than psychotherapists in the control condition (Smith-Hansen, Constantino, Piselli, & Remen, 2011). These results suggest that psychotherapists' perception of alliance strength differs from objective raters' perceptions. Research in the assessment of therapeutic alliance has shown that client ratings of working alliance are generally better correlated with outcome in therapy than therapist ratings (Horvath & Symonds, 1991; Piper, Azim, Joyce, & McCallum, 1991), indicating that therapists tend to misjudge the quality of the alliance (Michel, 2011).

Moreover, specific skills training adversely affects positive alliance outcomes in certain situations (Michel, 2011). It appears that by focusing intently on specific skills, the psychotherapist can lose focus on the more foundational aspect of relationship. According to Michel (2011), the psychotherapist's focus should be on exploring the client's rich and personal inner world, especially in the initial phases of treatment; specific therapeutic techniques can then play a secondary role further on in treatment. These findings indicate that there are more multidimensional factors in the relationship competency that are related to therapeutic alliance than are often recognized, trained for, or assessed. It also emphasizes that relational competency is something that is difficult to train for and is far more complex than a list of concrete skills to be mastered.

Finally, among licensed psychologists a phenomenon exists of relying on one's own self-assessment of professional competency, including self-assessment of relational skills that inform therapeutic alliance (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012). However, self-assessment has been shown to be an inadequate and ineffective measure of actual competence (Dunning, Heath, & Suls, 2004; Kruger & Dunning, 1999), begging for a new model of professional competency assessment (Johnson et al., 2012). Research in social psychology has identified the Dunning-Kruger effect, which asserts that people who perform poorly in many social and intellectual domains are often unaware of how deficient their expertise actually is (Dunning, 2011). This type of deficit leads one to make mistakes and prevents him or her from realizing the mistakes he or she is making. Self-assessment is not only problematic for those with clear deficits in skill; self-deception is ubiquitous in assessing one's own competency regardless

of skill level (Johnson et al., 2012). This fact poses the question of what cues psychotherapists are using to determine whether their conclusions are right or wrong (Dunning, 2011).

Given these challenges in training for and assessing a relational competency in professional psychology, educators may find themselves in a quandary as they design and evaluate their training programs. Students may also sense the struggle of relationship training, demonstrated by research that indicates that students defined impaired peers as those who struggle with interpersonal relationships and articulated how the structure of training in their programs was inadequate to help these identified students (Oliver et al., 2004).

Considering that client opinions of the strength of therapeutic alliance differ from psychotherapists' opinions, it is possible that assessment from others would yield different data than self-assessment when it comes to relational competency. Specifically, psychotherapy clients may perceive more variation in psychotherapists' attitudes and pick up on different cues than psychotherapists experience in their relationship (Michel, 2011).

Training programs that have been shown to be successful in improving therapeutic alliance rely on sources of information that go beyond self-assessment. These sources include individual supervision that focuses on relational ruptures and the negotiated goals of therapy and includes reviewing video and/or audio recordings of the actual psychotherapy sessions (Michel, 2011). Fostering a professional community of dependence on others for feedback and competency evaluation is something that should be taught throughout training in order to challenge the reliance on self-assessment seen among most licensed psychologists (Johnson et al., 2012).

How, then, do professional psychology training programs promote and evaluate relationship while moving students beyond their instinctive reliance on self-assessment? Student engagement in relationship with peers and faculty, with the knowledge that one's interactions are subject to evaluation, is an important aspect of psychology graduate training for both student support and competency assessment (Mangione & Nadkarni, 2010). Student self-disclosure is part of this experience, but it may feel threatening to students because of the evaluative component. This creates an inherent challenge—perhaps even a paradox—of creating a safe environment in training programs for students to interact authentically with peers and faculty, showing vulnerability, while dealing with the fact that their competence is being evaluated based on these interactions. Self-reflection and self-awareness are important, but in a competency framework it is also necessary to actually observe a person performing. Ultimately, it is imperative that relationship be a centralized focus of training, as a foundational competency, in order to enhance the protection of the public, the profession of psychology, the programs, students, and faculty. “In this way, the department has to become a self-monitoring, self-reflective community with myriad possibilities for having, looking at, and evaluating relationships (Mangione & Nadkarni, 2010, p. 84).”

The strong connection between relationship competency and strong therapeutic alliance, combined with the lack of knowledge and research around effective assessment and training of the nontangible relational attitudes, knowledge, and skills begs for more research on the implementation of this competency. Relational therapeutic qualities are cited in the research as imperative to building relational alliance, which is, in turn, essential for successful therapeutic outcome (Michel, 2011; Norcross 2011). As previously mentioned, learning technical skills in

order to facilitate therapeutic alliance has not been found to be helpful and has even been reported to take the therapist's focus off of the relationship with the client, leading to poorer therapeutic alliance (Horvath, 2005; Michel, 2011). The purpose of this research is to discover to what extent the use of technical skills and relational characteristics of the therapist can be parsed out and assessed using a Q-sort method. This study hypothesized that a factor analysis on the Q-sort would reveal two distinct categories consisting of technical-based and relational based factors. A second hypothesis was that therapists who were rated higher on relational characteristics than skill-based techniques would show stronger therapeutic alliance (using patient self-report on the SRS) and better overall outcome in therapy (using patient self-report on the ORS).

## **Chapter 2**

### **Methods**

#### **Participants**

A total of 24 first year doctoral students and 6 fourth year doctoral students from an APA-accredited clinical psychology program participated in the evaluation of the relationship competency. Each first year student conducted 10 “pseudo therapy” sessions with two undergraduate volunteers as part of a required Clinical Foundations course, with a fourth year student acting in a supervisory role as their teaching assistant (TA). The undergraduate students volunteered to be pseudo-clients for class credit in an Introductory Psychology course. The six TAs participated in rating the therapy videos of their first year students using a Q-sort method roughly modeled after the Q-set method developed by Enrico Jones (Ablon, Levy, & Smith-Hansen, 2011). A total of 24 participants seeing two pseudo-clients each, for a total of 48 therapeutic relationships, were evaluated by the TAs.

#### **Instruments**

**Q-Sort.** See Appendix A. A Q-sort method of rating was used for assessment of relational competency in first year students. Jones developed a 100-item Psychotherapy Process Q-set, providing a language and rating system for a comprehensive clinical description of the therapist-client interaction adequate for quantitative analysis (Jones & Pulos, 1993). The items consist of statements about the therapist and client interaction and are used by a rater watching a video recording of an entire therapy session. Each rater is trained on how to look for each item in the session they are evaluating (e.g., given definitions and examples of each of the Q-set items)

and is asked to sort the Q cards into piles representing *most characteristic* of the session and *least characteristic* of the session. Inter-rater reliability for the Psychotherapy Process Q-set has been consistently satisfactory, ranging from .83 - .89 with two raters, to .89 - .92 with 3 to 10 raters (Jones & Pulos, 1993).

Based on the Q-set protocol of Jones, the primary researcher of this study developed a shorter Q-sort consisting of 10 items. Five of the Q-set items are statements about therapeutic relationship that stem from both Norcross's and Michel's respective research on factors specifically related to the building of therapeutic alliance (Michel, 2011; Norcross, 2011). The remaining five statements are descriptive of the application of technical skills stemming from client-centered therapy techniques that are taught in the first year students' Clinical Foundations course. Four of the 10 items in the Q-sort were taken from Jones' Psychotherapy Process Q-set (Jones & Pulos, 1993), as they fit within the research relevant to the present study.

**Session Rating Scale (SRS).** See Appendix B. The SRS is a widely used 4-item, in-session assessment of therapeutic alliance that allows a client to rate his or her experience at the end of a given session. Scores below 36 (out of 40) indicate negative or problematic experiences of the therapy alliance (Duncan et al., 2003). The SRS demonstrates an internal consistency rating of  $\alpha = .88$  and test-retest reliability of  $r = .64$ , as well as concurrent validity of  $r = .48$  when compared to a well-established measure, the Helping Alliance Questionnaire II (Duncan et al., 2003; Luborsky et al., 1996). The SRS's measurement of therapeutic relationship is based on the Working Alliance Inventory - Short Form (WAI-S; Busseri & Tyler, 2003; Tracey & Kokotovic, 1989) and emphasizes three aspects of relationship including the affective bond, agreement on tasks during sessions, and agreement about the ultimate goals of the session. All

three of these subscales within the WAI-S exhibit strong internal consistency ( $\alpha = .90, .92,$  and  $.90$ ; Tracey & Kokotovic, 1989). As compared with the WAI-S, the SRS demonstrates moderate concurrent validity ( $r = .63$ ) and strong internal consistency ( $\alpha = .93$ ; Campbell & Hemsley, 2009).

**Outcome Rating Scale (ORS).** See Appendix C. The ORS is a widely used four-item, in-session self-report assessment of therapeutic outcome (Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS was adapted from the Outcome Questionnaire – 45 (OQ-45), a measure for client progress in therapy looking at individual, relational, and social domains (Lambert et al., 1996). The ORS boasts high internal consistency ( $\alpha = .93$ ), moderate test-retest reliability ( $r = .66$ ), and moderate concurrent validity ( $r = .59$ ) with the OQ-45 (Campbell & Hemsley, 2009).

### **Procedure**

During the winter of 2014, with the support of the Director of Clinical Training, the 6 fourth year TAs and the 24 first year students conducting pseudo therapy were informed about the conditions of the study and gave written consent to participate (see Appendices D & E). Students were informed that all materials would be de-identified before viewed by this researcher and that they would have the option to receive a summary of the results of the study upon completion. The primary researcher in this study conducted a training with the TAs, educating them on how to interpret and rate the Q-set statements while doing the Q-sort for their first year students' videotaped pseudo therapy sessions. TAs were given specific examples of what to look for in the videotaped sessions and how to rate the items. Each Q-set item is printed on a separate card so that TAs can easily manipulate the cards to sort them into one of four piles ranging from *most characteristic* to *least characteristic*. As with the Jones Q-set, raters are

forced to approximate a normal distribution by requiring TAs to place two cards in the *most characteristic* pile, three in the *somewhat characteristic* pile, three in the *slightly characteristic* pile, and two in the *least characteristic* pile. A training case, in which all TAs independently completed the Q-sort for the same therapy video, revealed an inter-rater reliability average of  $r = .64$ , indicating marginally acceptable consistency among raters.

TAs completed the Q-sort on a total of 144 sessions combined, including 46 ratings of video 2 with their respective clients, 2 ratings of session 3, 47 ratings of session 5, 1 rating of session 6, and 48 ratings of session 9. Additionally, each first year student collected SRS data during each of the 10 therapy sessions and ORS data during the first and last therapy sessions.

Each first year student's Graduate Record Examination (GRE) score, which was submitted prior to admissions to the clinical psychology program, was gathered, de-identified, and used in data analysis.

### Chapter 3

#### Results

##### Q-Sort

A total of 144 psychotherapy sessions were evaluated using the Q-sort method (48 psychotherapy relationships, 3 sessions each). For each of these sessions the 10 Q-set items were scored ranging from 1 (most characteristic) to 4 (least characteristic). To identify the skill-based or relationship-based Q-set items that most strongly characterized the 144 sessions, 10 item means and standard deviations were calculated for individual Q-set items (see Table 1). The most common Q-set characteristic noted in the ratings of the sessions is “T clarifies, restates, or rephrases C’s communication” (Q6,  $M = 3.32$ ,  $SD = .88$ ). The least commonly rated characteristic is “T is attuned to subtle indications of changes or ruptures in the therapeutic relationship” (Q5,  $M = 1.1$ ,  $SD = .4$ ). Multivariate analyses of variance (MANOVA) revealed differences within the Q-set items, Wilks’  $\lambda (9,134) = .063$ ,  $p < .001$ , justifying a profile analysis where the mean of each item is compared with the adjacent item using paired-sample  $t$ -tests. Items that are significantly higher than the following item are identified in Table 1.

A principal component factor analysis with varimax (orthogonal) rotation was conducted in order to verify that the Q-set items fit the technical and relational variables intended when the items were developed. However, the factor analysis revealed four different factors within the Q-set items (see Table 2 for factor loadings). Because each of the four factors had both positively and negatively loaded items, labels were developed to indicate the bipolarity of the factors (see

Table 1

*Rank Ordering of Q-Set Items and Their Means and Standard Deviations*

Q-Item	<i>M</i>	<i>SD</i>
Q6 T clarifies, restates, or rephrases C's communication	3.32	.88
Q8 T uses body language and non-verbal communication to demonstrate attending	3.22	.85
Q9 T summarizes C's experiences*	3.05	.84
Q1 T is sensitive to C's feelings, attuned to C; empathic	2.83	.73
Q2 T conveys a sense of nonjudgmental acceptance*	2.71	.77
Q3 T displays a genuine sense of self (vs. "playing a role")	2.43	.9
Q7 T emphasizes C's feelings in order to help him/her experience them more deeply	2.33	.73
Q4 T conveys respect for C's understanding of his or her inner world/experiences*	2.25	.79
Q10 T makes a connection between two things previously unrecognized by C*	1.78	.94
Q5 T is attuned to subtle indications of changes or ruptures in the therapeutic relationship	1.1	.4

*Notes.* N = 143 psychotherapy sessions. T = Therapist, C = Client. Possible scale responses for each item range from 1 to 10, with 1 = *Most Characteristic*, 2 = *Somewhat Characteristic*, 3 = *Slightly Characteristic*, 4 = *Least Characteristic*. Q-items ranked in order of most frequently attributed to observed therapist to least frequently attributed to observed therapist. \*Item is significantly higher than the following item, using a pair-samples *t*-test ( $p < .05$ ).

Table 3). Factor names are developed as follows: Authentic Self vs. Professional Self, Acceptance vs. Interpretation, Exploring Depth vs. Non-Verbal Attending, and Attuned to Relationship vs. Attuned to Client.

All of the bipolarity of Q-set items within the factors separated into technical versus relational variables except for Factor 4, which included two relational variables that loaded opposite of each other (Q1 and Q5).

Table 2

*Factor Analysis Loadings of Q-Set Items*

Q-Item	Factors			
	1	2	3	4
Q1 T is sensitive to C's feelings, attuned to C; empathic	.26	.07	.17	-.68
Q2 T conveys a sense of nonjudgmental acceptance	.31	.65	-.16	-.29
Q3 T displays a genuine sense of self (vs. "playing a role")	.5	.42	-.1	.18
Q4 T conveys respect for C's understanding of his or her inner world/experiences	.18	.08	-.62	.31
Q5 T is attuned to subtle indications of changes or ruptures in the therapeutic relationship	.18	.1	.11	.71
Q6 T clarifies, restates, or rephrases C's communication	-.79	.02	.15	-.05
Q7 T emphasizes C's feelings in order to help him/her experience them more deeply	.32	-.68	.12	-.26
Q8 T uses body language and non-verbal communication to demonstrate attending	.02	.07	.83	.17
Q9 T summarizes C's experiences	-.8	.08	-.04	.15
Q10 T makes a connection between two things previously unrecognized by C	.05	-.73	-.38	-.01

*Notes.* T = Therapist, C = Client. Q-set items 1 through 5 are relational variables and 6 through 10 are technical variables.

## Correlations

Once the therapy process factors were established, they were correlated with ORS and SRS scores at the beginning, middle, and end of psychotherapy. This is a process similar to that used by Jones and Pulos (1993), but on an abbreviated scale. Therapist GRE scores were also correlated to ORS and SRS ratings. The means and standard deviations for all SRS scores are reported in Table 4. Correlations are reported in Table 5.

Table 3

*Q-Set Item Factor Names and Loadings*

Q-Set Item	Loading
<b>Factor 1: Authentic Self vs. Professional Self</b>	
Q3 T displays a genuine sense of self (vs. "playing a role")	.50
Q6 T clarifies, restates, or rephrases C's communication	-.79
Q9 T summarizes C's experiences	-.80
<b>Factor 2: Acceptance vs. Interpretation</b>	
Q2 T conveys a sense of nonjudgmental acceptance	.65
Q7 T emphasizes C's feelings in order to help him/her experience them more deeply	-.68
Q10 T makes a connection between two things previously unrecognized by C	-.73
<b>Factor 3: Exploring Depth vs. Non-Verbal Attending</b>	
Q4 T conveys respect for C's understanding of his or her inner world/experiences	-.62
Q8 T uses body language and non-verbal communication to demonstrate attending	.83
<b>Factor 4: Attuned to Relationship vs. Attuned to Client</b>	
Q5 T is attuned to subtle indications of changes or ruptures in the therapeutic relationship	.71
Q1 T is sensitive to C's feelings, attuned to C; empathic	-.68

*Notes.* T = Therapist, C = Client.

Table 4

*SRS Item Means and Standard Deviations*

Item	<i>M</i>	<i>SD</i>
SRS 1: Relationship	9.34	.93
SRS 2: Goals and Topics	9.14	1.12
SRS 3: Approach or Method	9.09	1.18
SRS 4: Overall	9.24	1.01
SRS Sum	36.3	5.82

*Notes.* SRS = Session Rating Scale. SRS scores are reported for the 144 sessions on which Q-sort ratings were completed. Scores for individual item numbers are on a scale of 0 to 10, 10 being the highest score. The maximum Sum score is 40.

Table 5

*Factor Correlations*

Factors	SRS 1	SRS 2	SRS 3	SRS 4	SRS Sum	Initial ORS	Final ORS	GRE-V
F1	.26	-.02	-.02	.05	.09	-.18	-.2	.06
F2	-.16	-.16	-.25**	-.2	-.12	-.06	-.18	-.36**
F3	.01	-.04	.04	-.02	.0	-.12	-.23	-.05
F4	-.08	-.08	-.17	-.1	-.08	-.33*	-.26	.08
<b>GRE</b>								
GRE-V	.18	.18	.12	.16	.03	.11	-.1	
GRE-Q	.11	.13	.1	.13	-.03	.11	-.21*	
GRE-AW	.07	.03	.03	.06	-.06	.1	-.26**	

*Notes.* \* Correlation is significant at the .05 level. \*\* Correlation is significant at the .01 level. SRS = Session Rating Scale. Each number next to the SRS indicates a particular question on the SRS form (1-4). ORS = Outcome Rating Scale, GRE = Graduate Record Examination, V = Verbal Reasoning, Q = Quantitative Reasoning, AW = Analytical Writing.

No relationship was found between the overall SRS sum and any of the four therapist factors. However, a small correlation was observed between therapist factor 2 and the client's rating of the therapist's approach and method in session (SRS item 3) ( $r = -.252$ ). The more accepting a therapist was (Factor 2), the lower the approach/method score is on the SRS, suggesting that clients preferred the therapist to emphasize feelings and make interpretations rather than practice nonjudgmental acceptance of the client. At least in this sample, more therapist direction in the session helps the client feel good about the therapist's approach and method to therapy. Additionally, correlational results suggest that the higher the client's initial overall ORS score, the more the therapist focused on the client instead of the relationship between client and therapist ( $r = -.328$ ), suggesting that the therapists tended to focus more on the individual client when the client was in less distress.

Further, therapists who emphasize interpretation over acceptance, using skills Q7 (T emphasizes C's feelings in order to help him/her experience them more deeply) and Q10 (T makes a connection between two things previously unrecognized by C), have higher GRE scores than therapists who did not use these skills as often ( $r = -.358$ ). Additionally, final ORS scores were negatively correlated to the quantitative and analytical writing GRE scores of the therapists ( $r = -.210$ ,  $r = -.264$ , respectively), indicating that the better a therapist performs in non-verbal intelligence, the worse the client reports that he or she does in therapy.

## **Chapter 4**

### **Discussion**

The results failed to support this study's first hypothesis that two distinct categories consisting of technical-based and relational-based factors would be revealed in the Q-sort. Additionally, therapists who were rated higher on relational based factors did not show stronger therapeutic alliance or better therapeutic outcome than those rated higher on technical based factors, disconfirming our second hypothesis.

Though this study did not confirm our hypotheses, some secondary findings are worth considering both for their potential clinical implications and for direction in future research.

#### **Therapists Factors**

We anticipated two factors to emerge based on Q-set item selection: one for relational skills and one for technical skills. Instead, we found four factors, and three of the four showed a bipolarity that distinguished relational from technical skills. This factor structure is intriguing and has implications for future work. For example, one of the factors suggests that the more a therapist practices nonjudgmental acceptance in session, the less active they are in emphasizing the client's feelings and making interpretations. Additionally, the factor analysis indicates that the more a therapist explores depth with the client about his or her inner experience, the less the therapist practices non-verbal attending skills. Further, therapists who display a genuine sense of self tend to make less clarifications, restatements, and summaries of the client's experiences during session. Finally, the more a therapist is attuned to subtle indications of change or rupture

in the therapeutic relationship, the less empathic, sensitive to the client's feelings, and attuned to the client he or she appears to be. This last example indicates that relational attunement to the therapeutic relationship is perceived by independent raters to come at the cost of the therapist's attunement to the individual client, or vice versa.

The four factor results indicate that relational characteristics may not be able to be cleanly categorized together. For example, therapists who practice nonjudgmental acceptance are not necessarily exploring depth with clients or displaying a genuine sense of self. This finding suggests that the relationship competency may contain multiple factors that do not overlap. Some therapists may be relationally competent in some areas but not in others. Personality characteristics or maturity may affect competency or development in these different areas. For example, a therapist may display a genuine sense of self but may not naturally practice nonjudgmental acceptance due to a lack of maturity and experience with self and others. The results of this study also indicate that we do not know which relational therapist factors are actually most helpful for successful therapy outcome.

### **Secondary Correlations of Interest**

The clients in this study who had therapists who used more verbal emphasis on the client's feelings and interpretation rated the therapist's approach/method for the session higher than clients who had therapists who practiced more nonjudgmental acceptance. This finding suggests that clients prefer the therapist to be more verbally active or directive in session, at least within a short-term 10-session model. The therapists in this study were learning and practicing Rogerian therapy skills and were instructed to follow the client's lead in session while avoiding being directive or solution-focused. This non-directive approach may have been frustrating to

clients who preferred a more active style in therapy, which may explain why a skill-based approach appears to be perceived by clients as a better approach, though there is no evidence that this produces superior outcome in therapy. Therapists in this study who verbally emphasized the client's feelings and used interpretation had higher overall GRE scores than therapists who did not use these skills as often. This finding may suggest that people who have higher levels of intelligence are more apt to make connections between two things previously unrecognized by the client and to emphasize the client's affect. This makes sense given that individuals with high Verbal Reasoning GRE scores are able to analyze and draw conclusions from discourse, identify the author's perspective and/or assumptions, understand multiple levels of meaning, distinguish major from minor points, and understand relationships among words and among concepts (Educational Testing Service, 2015). Interpretation and emphasis of affect are also the only therapist skills that correlated with higher scores on the approach/method question on the SRS. However, the results show that the stronger the therapist is in nonverbal intelligence, the worse his or her client reports to be doing at the end of therapy. High scores on the quantitative reasoning and analytical writing sections on the GRE indicate that one is able to interpret and analyze quantitative information, solve problems using mathematical models, articulate complex ideas, examine the evidence for claims, and sustain a well-focused, coherent discussion (Educational Testing Service, 2015). If one is skilled in these areas but lacks the ability to decipher the other's perspective, nuanced meaning, and relationships among words and concepts, the therapist may struggle to establish and maintain effective therapeutic alliance, resulting in poorer outcome.

While these findings may anecdotally shed light on therapy outcome, they should be viewed cautiously because of the low magnitudes of the correlations observed. Though statistically significant, the correlations account for only a miniscule amount of variation. While the evidence is not strong enough to assert that higher scores on quantitative reasoning and analytic writing sections of the GRE mean that one will not succeed in clinical training, it is important to note that in some cases one may struggle with the more verbal, nuanced aspects of relationship, possibly impeding therapeutic success.

This study also suggests that therapists focus more on the client as an individual versus attending to the client-therapist relationship when the client starts out with greater satisfaction across multiple domains of his or her life (higher initial ORS scores). Again, this finding should be viewed cautiously because of the small correlations observed, but one possible explanation for this is that when clients are higher functioning, therapists' countertransference may be less apparent or intense, hence not signaling awareness of the relational dynamics and possible ruptures and need for repair within the therapeutic relationship. Understanding that this tendency occurs with clients who are higher functioning is relevant for clinical training of doctoral candidates, who often complete their initial year of training with clients experiencing minimal distress, where focus on the management of the relational dyad may not be emphasized because the therapist may not experience it as a pressing issue. This lack of focus on the relationship could prove to be detrimental in future clinical experiences if the therapist never receives instruction and training on this aspect of therapy, which is imperative to the development of therapeutic alliance and success (Michel, 2011).

### **Training Implications**

The current study carries implications for training in doctoral psychology programs, including admissions considerations, student support, and foundational skills training. While higher overall intelligence is linked to positive therapeutic outcome, students who score higher on analytical writing and quantitative reasoning scores than verbal reasoning scores on the GRE may struggle with nuanced layers of communication and understanding in relationship. Psychology doctoral programs may want to proceed cautiously with applicants who fit this profile, even though they may look impressive on paper and be able to articulate ideas well. While this study does not suggest that such applicants do not have capacity to develop relational characteristics and succeed in training, it is important for doctoral programs to recognize that these students may need extra support in developing specific relational ability and understanding.

The finding that students are shown to have difficulty attending to rupture and repair in the therapeutic relationship with low distress clients is poignant for early training, as students often work with pre-screened, low distress clients in their first year of graduate school. Paying attention to countertransference and learning how to use oneself as a tool in therapy is an important foundational element of training that may get overlooked if students do not become aware of their own countertransference with clients in low distress. Since therapists-in-training may not be alerted to pay attention to rupture and repair through their own awareness of countertransference feelings with such clients, they likely need specific guidance and thorough training in this area. Focused training on self-awareness from the beginning of graduate school is important if students are going to continue to build onto this skillset throughout their training. Additionally, research in this study suggests that relational characteristics are imperative for

developing therapeutic alliance and succeeding in relational competency, yet doctoral programs often focus on technical skills training in the first year of their programs, viewing relational characteristics as more advanced skills that will develop as time goes on. As foundational as these characteristics are, the training and development of these traits and skills should take their place at the forefront of clinical psychology training early on, where they can lay the foundation for continued development throughout training and identify and provide support for students who struggle in these areas.

### **Limitations**

There are many limitations to the present study, including the short-term therapy upon which outcome was based, in addition to a non-clinical client population that was prescreened and in low-distress. The SRS scores, which was the only measure of therapeutic alliance in this study, were self-report and had a significant ceiling effect. Additionally, the student therapists were in their first year of clinical training and they may not have demonstrated the skills or relational characteristics as clearly as experienced therapists might have. Further, the TAs who completed the Q-sort for the first year students were not expert researchers and had no prior experience rating therapists' skills or attributes. Finally, the correlations that were found in this study were mild to moderate, necessitating caution about over interpretation of results.

Another limitation is in the use of self-report measures for both therapeutic alliance and overall therapy outcome. Self-report provides a depiction of how the client perceives aspects of therapy and outcome, which has inherent value in understanding how the client feels about his or her experience. Depending on the goals of the client in therapy, this may suffice for measurement of therapy alliance and outcome (i.e., short-term, symptom reduction models).

However, if the mode of therapy is depth, insight-oriented psychotherapy, the client relies on the therapist's expertise to engage in ways that reach past the client's conscious experience, requiring measurement of therapy outcome that do not rely exclusively on face-value self-report from the client or therapist. If, as research suggests, people's own self-assessment has been shown to be an inadequate and ineffective measure of actual competence (Dunning et al., 2004; Kruger & Dunning, 1999; Johnson et al., 2012), this raises as suspect the idea that clients' own self-assessment reports a complete depiction of their underlying health and functioning. Additionally, for clients who are not experiencing acute distress, there is little room for the impact of therapy on their own health or growth to be captured in a self-report measure, leading to a dramatic ceiling effect. The present study exhibits these limitations, as clients consisted of a pre-screened, low-distressed undergraduate student population. The ceiling effect of the SRS for the present study is noted and reported in Table 4.

### **Directions for Future Research**

While this study points to interesting areas to continue to research, it also reinforces the idea that the relationship competency is complex, nebulous, and involves multidimensional factors that are difficult to recognize, train for, and assess. Measuring therapy outcome through ways other than self-report is imperative for future research, such as using the Shedler-Westen Assessment Procedure (SWAP; Shedler & Westen, 2007) or assessing characterological change through pre and post therapy personality assessment and projective measures. Future studies with larger samples from clinical populations could continue to explore the impact of different areas of intelligence on therapeutic alliance and outcome, impacting how training programs screen applicants for admission and how they focus relationship competency training for individuals

who might struggle with more nuanced aspects of relationship and communication. Additionally, qualitative research remains an important avenue for collecting nuanced data about an individual's relational capacity, and may act as a precursor to the measurement of this ambiguous competency benchmark.

Further research on the four factor solution could be conducted by creating more Q-items and using the Q-sort on more experienced therapists, with the goal of further parsing out technical and relational variables and testing to see if more of the relational variables string together. The factor loadings could then be correlated with more sophisticated outcome measures in order to decipher which factors affect successful therapy outcome.

Once an appropriate measurement for the relationship competency is established, research on correlation between success in the relationship competency and other competencies should be done. If a clinical psychology doctoral student has strong ability in the relationship competency, research indicates that he or she will likely perform better across all competencies than peers who struggle with the relationship competency (Mangione & Nadkarni, 2010). Research looking into the nuanced data among these competencies could help decipher how they are related. Additionally, self-reflection, curiosity, flexibility, open-mindedness, and the ability to be one's genuine self are all paramount for the development of relational competency (Mangione & Nadkarni, 2010; Michel, 2011; Norcross & Lambert, 2011) and are also all areas of growth encouraged and developed in a depth-oriented therapy. Studying the impact of student's personal therapy on the development of their relationship competency and consequently to therapy alliance and outcome would be an interesting area of research. This

research could have an impact on the level of encouragement or requirement of clinical psychology programs for their students to engage in their own therapy.

Investigating how clinical psychology doctoral programs are currently training and assessing for the relationship competency could shed light on current practices and opinions of faculty and students around this issue. Learning about admissions standards, benchmark requirements, and training/remediation in individual programs may open communication channels within programs about the need and difficulty in this area of training. It is important to assess the current status and attitudes about training in order to thoughtfully develop this competency area. Additionally, amidst the pressure to accept and retain students for financial reasons within programs, relationship competency should remain at the center of importance for admission criteria and ongoing performance evaluation, as it is imperative to success in various other competency areas (Mangione & Nadkarni, 2010).

### **Conclusion**

The relationship competency is presumably connected to therapeutic alliance, therapy outcome, and success in graduate training, but continues to require research around effective assessment and implementation of this competency into clinical doctoral training. While the current study aimed to separate this complex competency into relationship and technical factors in order to understand relational characteristics that impact success in therapy, a more complicated structure was found. The finding of four different relational factors suggests that there are different aspects to relationship competency that do not necessarily overlap. Further, the only therapist characteristic found in this study that is shown to impact therapy outcome is the area of therapist intelligence.

The relationship competency remains as both the substrate that underlies success in therapy and other competencies in clinical psychology graduate school training, as well as the most complex and difficult competency to assess and train for. This study's modest findings and limitations beg for further research in this area to expand our understanding of relational characteristics, measurement and training of them, and their impact on therapy outcome. If relationship lies at the center of professional life for a psychologist, as Despland et al. (2009) suggests, therapist relational capacity and characteristics should take its place in the research and in graduate training as an area of prominent examination and focus.

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**Appendix A**

**Q-Sort Items**

1. T is sensitive to P's feelings, attuned to P; empathic
2. T conveys a sense of nonjudgmental acceptance
3. T displays a genuine sense of self (vs. "playing a role")
4. T conveys respect for P's understanding of his or her inner world/experiences
5. T is attuned to subtle indications of changes or ruptures in the therapeutic relationship
6. T clarifies, restates, or rephrases P's communication
7. T emphasizes P's feelings in order to help him/her experience them more deeply
8. T uses body language and non-verbal communication to demonstrate attending
9. T summarizes P's experiences
10. T makes a connection between two things previously unrecognized by P

**Appendix B**

**Session Rating Scale (SRS V.3.0)**

Name _____	Age (Yrs): ____
ID# _____	Gender: _____
Session # ____	Date: _____

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

**Relationship**

I-----I

**Goals and Topics**

I-----I

**Approach or Method**

I-----I

**Overall**

I-----I

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**Appendix C**

**Outcome Rating Scale (ORS)**

Name _____ Age (Yrs):__ Gender_____
Session # __ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

**Individually**

(Personal well-being)

I-----I

**Interpersonally**

(Family, close relationships)

I-----I

**Socially**

(Work, school, friendships)

I-----I

**Overall**

(General sense of well-being)

I-----I

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## Appendix D

### Informed Consent (First Year Student)

**Purpose of this study:** To gain information regarding training experiences in relationship competency and to explore therapist characteristics that are related to therapeutic alliance.

**Procedure:** You are being asked to give your consent for your Clinical Foundations TA to observe and categorize different therapeutic characteristics in your videotaped sessions with your pseudo clients, to be collected by this researcher. Your consent is also asked for obtaining your aggregate SRS/ORS scores from your 10 sessions with each pseudo client, as well as use of your GRE score upon entrance to the GDCP, for correlational purposes.

Additionally, your TA will be asked to fill out a Likert-type questionnaire pertaining to your relational characteristics according to their observation.

There is no time-commitment beyond your existing requirements for Clinical Foundations required to participate in this study.

**Confidentiality:** All materials (including TA observation, questionnaire, SRS/ORS, and GRE scores) will be de-identified and given an identification number for tracking purposes before this researcher sees them. Your TAs will not see any of your identified materials other than what they personally fill out. The information from this study will be kept secure and private in a locked filing cabinet. While results may be reported or published, there will be no identifying information that could connect you to the results.

**Discomfort and risks from participation:** Feelings of discomfort can arise with any type of personal or professional evaluation or assessment. The purpose of this study is purely for education about relationship competency training and results will not be used in any way that will reflect on you personally. There are no anticipated risks from participation in this study.

**Voluntary Nature of the Study:** Your participation is completely voluntary. By signing below, you are giving your consent to participate in this study.

**Compensation:** Participants in this study have the opportunity to receive the final results per request. If interested, contact Jacqi Rodriguez, M.A., at [jrodriguez11@georgefox.edu](mailto:jrodriguez11@georgefox.edu).

By signing on the line below, you agree to the terms of this informed consent page.

## **Appendix E**

### **Informed Consent (TA)**

**Purpose of this study:** To gain information regarding training experiences in relationship competency and to explore therapist characteristics that are related to therapeutic alliance.

**Procedure:** You will be asked to fill out an 11-item Likert-type questionnaire about the first year students in your TA group pertaining to their relational characteristics based on your observation. You will then be asked to participate in a short training with this researcher about how to use a 10-item Q-sort, with which you will be instructed to observe and categorize different therapeutic characteristics in three of each of your students' therapy videos throughout the semester.

**Confidentiality:** All materials will be de-identified and given an identification number for tracking purposes before this researcher sees them. The information from this study will be kept secure and private in a locked filing cabinet. While results may be reported or published, there will be no identifying information that could connect you to the results.

**Discomfort and risks from participation:** Feelings of discomfort can arise with any type of personal or professional evaluation or assessment. The purpose of this study is purely for education about relationship competency training and results will not be used in any way that will reflect on you or the student you are assessing personally. There are no anticipated risks from participation in this study.

**Voluntary Nature of the Study:** Your participation is completely voluntary. By signing below, you are giving your consent to participate in this study.

**Compensation:** Participants in this study have the opportunity to receive the final results per request. If interested, contact Jacqi Rodriguez, M.A., at [jrodriguez11@georgefox.edu](mailto:jrodriguez11@georgefox.edu).

By signing on the line below, you agree to the terms of this informed consent page.

## Appendix F

### Curriculum Vitae

# JACQUELYN M. RODRIGUEZ

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## EDUCATION

- Present      **Doctoral Student in Clinical Psychology Program:** George Fox University, Graduate Department of Clinical Psychology (**APA-Accredited**), Newberg, Oregon  
 Advisor: Mark R. McMinn, PhD, ABPP/CL  
**Doctoral Dissertation, Prelim Passed:** *Relationship Competency: An Exploration of Training and Relationship Assessment in an APA Accredited Doctoral Program*
- 2013      **Master of Arts, Clinical Psychology:** George Fox University, Graduate Department of Clinical Psychology (**APA-Accredited**), Newberg, Oregon
- 2009      **Bachelor of Arts, Psychology:** Trinity Western University, Langley, British Columbia
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## SUPERVISED CLINICAL EXPERIENCE

- 2015 - Present **Internship**  
*Pre-doctoral Psychotherapy Intern*  
**Norwich University Counseling and Psychological Services, Northfield, Vermont**  
*Populations:* University students, staff, faculty.  
*Clinical Duties:*
- Conduct weekly and twice weekly psychoanalytically informed therapy with students, faculty, and staff with a caseload of around 25 patients.
  - Administer cognitive, personality, and neuropsychological assessments to patients and compose integrated reports with case conceptualizations and treatment recommendations.
  - Provide individual and couples therapy.
  - Supervisors: Melvin E. Miller, Ph.D., Certified Analyst, Polly Young-Eisendrath, Ph.D., Certified Jungian Analyst, Stella Marrie, Ph.D., Gladys Agell, Ph.D., Shannon Carter, Psy.D., Jake Rusczyk, Ph.D.; four hours of weekly individual supervision.

- One hour of weekly group supervision.
- Two hours of weekly didactics.

2014 - Present **Pre-internship**

*Psychology Student*

*Kaiser Permanente Northwest, Salem, Oregon*

*Populations:* Various; Community population served.

*Clinical Duties:*

- Consult with multi-disciplinary team regarding health status, assessment results, and treatment implications for psychiatric and medical conditions.
- Intervene using evidence-based treatments such as interpersonal therapy, time-limited psychodynamic therapy, motivational interviewing, cognitive therapy, and solution-focused therapy.
- Administer neuropsychological assessments to patients and compose integrated reports with case conceptualizations and treatment recommendations.
- Provide individual, couples, and group therapy with patients.
- Supervisors: Catherine E. deCampos, PsyD, CFNP, Robert Schiff, PhD; weekly individual supervision.
- Consultants: Timothy Neary, PsyD, Adriane Sanchez, PsyD; weekly consultation and didactic training.

2013 - Present **Supplemental Practicum**

*Behavioral Health Consultation Team: On-Call Emergency Department*

*Providence Newberg Medical Center, Newberg, Oregon*

*Willamette Valley Medical Center, McMinnville, Oregon*

*Populations:* Various; Community population served.

*Clinical Duties:*

- Provide 12-hour behavioral health consultation services for emergency department and medical/surgical unit one day per two weeks.
- Assess patients for suicidality, homicidality, chronic pain, dementia, and mental status examination, and various other psychological factors affecting medical care.
- Advise hospital staff to discharge or psychiatrically hospitalize patient.
- Arrange inpatient psychiatric placement and transportation for patients who meet criteria for hospitalization.
- Hours: On-call 12 hours every other week, hours of direct service vary.
- Supervisors: Mary Peterson, PhD, ABPP/CL, William Buhrow, Jr, PsyD, Joel Gregor, PsyD; weekly group supervision that includes case presentation and case discussion.

2013 - 2014 **Practicum II**

*Psychology Trainee*

*Oregon State Hospital, Salem, OR*

*Populations:* Severely and persistently mentally ill forensic patients.

*Clinical Duties:*

- Consult with patients and a multi-disciplinary team regarding assessment results and treatment implications for psychiatric and neuropsychological conditions.
- Intervene using motivational interviewing, supportive psychodynamic, insight-oriented intervention, and relational interventions.
- Administer comprehensive psychological assessments to patients and compose integrated reports with case conceptualizations, diagnostic formulations, and treatment recommendations.
- Provide individual, group, and milieu therapy with patients.
- Monthly onsite didactic training and case presentation.
- Present four clinical cases to a supervisory clinical team.
- Supervisors: Carlene Shultz, PsyD, Brian Hartman, PsyD; weekly individual and group supervision.

2012 - 2013

**Practicum I*****Student Therapist******New Urban High School /Clackamas School District, Clackamas, Oregon****Populations:* Adolescents: alternative high school and middle school students.*Clinical Duties:*

- Served middle and high school students experiencing a wide range of clinical pathology, relational problems, disabilities, and developmental problems.
- Provided individual psychotherapy and co-facilitated group psychotherapy.
- Participated in consultation with school staff, assessment meetings with parents, students, and individualized education plan teams, and group curriculum planning.
- Conducted comprehensive intelligence and cognitive assessments, including structured interviews, observations, and report writing.
- Supervisor: Fiorella Kassab, PhD; weekly individual and group supervision.

2011 - 2012

**Prepracticum*****Student Therapist******University Health and Counseling Center: George Fox University, Newberg, Oregon****Populations:* Young adults: college students.*Clinical Duties:*

- Provided outpatient services to undergraduate students including clinical interview, diagnosis, and individual psychotherapy.
- Conducted intake interviews.
- Administrative responsibilities included report writing, weekly chart notes, case presentations, and consultation.
- Formulated diagnostic impressions, treatment plans, and case formulations.
- Presented clinical case to a supervisory clinical team.
- Supervisor: Mary Peterson, PhD, ABPP/CL

- Consultant: Michael J. Vogel, MA; weekly consultation.
- 

### NATIONAL PRESENTATIONS

**Rodriguez, J. R.**, Birch, R., Galuza, T., & McMinn, M. R. (2013, August). *Religious and Spiritual Diversity Training at Explicitly Religious Doctoral Programs*. Poster presented at the annual meeting of the American Psychological Association, Honolulu, HI.

Block, M. M., Goetsch, B. L., Birch, R. F., **Rodriguez, J. M.**, McMinn, M. R. (2013, August). *Researcher practitioner gap: Bridging the gap in anorexia nervosa treatment*. Poster presented at the annual meeting of the American Psychological Association, Honolulu, HI.

McMinn, M. R., Birch, R., Galuza, T., & **Rodriguez, J. M.**, (2013, April). *A comparison of religious and spiritual diversity training at religious and other institutions*. Paper presented at the annual meeting of the Christian Association of Psychological Studies, Portland, OR.

Gerdin, T. A., Uhder, J., **Rodriguez, J. M.**, & Modrell, J. (2013, April). *The religious nature of life longings in old age*. Poster presented at the annual meeting of the Christian Association of Psychological Studies, Portland, OR, and at the annual meeting of the American Psychological Association, Honolulu, HI.

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### RESEARCH EXPERIENCE

2013 - Present **Program Evaluation Consultant:** George Fox University, Newberg, Oregon

- Conducted evaluation to assess student attitudes and barriers related to usage of an EPPP preparation program implemented into student curriculum. Presented findings to faculty at George Fox University.

2012 - 2013 **Additional Research:** *Religious and Spiritual Diversity Training at Explicitly Religious Doctoral Programs*.

Coauthors: Mark McMinn, PhD, ABPP/CL, Ryan Birch, BA, Timofey Galuza, BA

**Current Status:** Submitting for publication.

- An empirical investigation comparing the Vogel et al. (2012) findings of diversity training in doctoral programs in the American Psychological Association with that of explicitly religious doctoral programs in the American Psychological Association.

2012 - Present **Doctoral Dissertation, Prelim Passed:** *Relationship Competency: An Exploration of Training and Relationship Assessment in an APA Accredited Doctoral Program*. George Fox University, Newberg, Oregon

Committee Members: Mark McMinn, PhD, ABPP/CL (Chair), Mary Peterson, PhD, ABPP/CL, Carlos Taloyo, PhD

**Preliminary Defense Passed:** December 10, 2013

- An empirical investigation examining what relational characteristics of the therapist is related to therapeutic alliance and the implications for relationship competency training.

- 2012 - 2015    **Research Team Member:** George Fox University, Newberg, Oregon  
Chair: Mark R. McMinn, PhD, ABPP/CL  
Meet bi-monthly to discuss and evaluate progress, methodology, and design of group and individual research projects.
- Assist team members in research design, data collection, and analysis.
  - Areas of team focus: Integration of psychology and Christianity; spirituality; positive psychology of food; technology in professional psychology; pastoral care; religion; client-therapist relationship; and marital support in the military.
- 2012            **Qualitative Data Rating Consultant:** *The Religious Nature of Life Longings in Old Age*
- Categorized qualitative data and coded it into numeric form.

**RELEVANT TEACHING & ACADEMIC APPOINTMENTS**

- 2014 - 2015    **Lecturer**  
**Graduate Level Course: Psychodynamic Psychotherapy – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
*Love, Sex, and Refinding: An Exploration of Attachment, Individuation, and Transcendence in the Therapeutic Dyad*  
Professor: Nancy Thurston, PhD, ABPP/CL
- 2014 - 2015    **Teaching Assistant**  
**Graduate Level Course: Clinical Foundations to Treatment – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
Professor: Glenna Andrews, PhD
- 2014 - 2015    **Peer Oversight**  
**Graduate Level Oversight: Supervision and Management – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
Professor: Rodger Bufford, PhD
- 2014 - 2015    **Teaching Assistant**  
**Graduate Level Course: Psychodynamic Psychotherapy – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
Professor: Nancy Thurston, PhD, ABPP/CL
- 2015            **Multicultural Awareness Discussion Guest Speaker/Panel Member**

**Graduate Level Course: Multicultural Psychotherapy – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
Professor: Winston Seegobin, Psy.D.

- 2013      **Lecturer**  
**Graduate Level Course: Personality Assessment – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
*Understanding the Millon Clinical Multiaxial Inventory/ How to Integrate Multiple Personality Assessments into One Report*  
Professor: Nancy Thurston, PhD, ABPP/CL
- 2013      **Teaching Assistant**  
**Graduate Level Course: Personality Assessment – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
Professor: Nancy Thurston, PsyD, ABPP/CL
- 2012 - 2013      **Teaching Assistant**  
**Supportive Position to the Director of Clinical Training – George Fox University, Graduate Department of Clinical Psychology, Newberg, Oregon**  
Professor: Carlos Taloyo, PhD
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#### ACADEMIC SERVICE

- 2012 - 2015      **Peer Mentor:** George Fox University, Newberg, Oregon
- Assist first year PsyD student in transition to graduate school by providing academic and professional guidance and support.
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#### RELATED WORK AND VOLUNTEER EXPERIENCE

- 2011-2012      **Billing Administrator:** Harden Psychological Services, Beaverton, Oregon
- Performed all billing duties for three mental health professionals using an online computer billing system.
  - Created and generated financial reports, including preparing reports for payroll.
  - Worked with clients and insurance companies to obtain, verify, and maintain patient data and insurance information for each client.
  - Appealed insurance claims and continuously managed all claims in process.
  - Invoiced clients and kept current on HIPAA standards.
- 2010 - 2011      **Women's Ministry Leader:** Pearl Church, Portland, Oregon
- Met individually with diverse women and provided support and spiritual guidance.

- Met monthly with a team of women to help encourage and develop their areas of interest in leadership.
- Attended multiple leadership trainings and received twice monthly pastoral mentoring.
- Planned spiritual retreats.

Fall, 2005      **Semester Abroad in Klaipeda, Lithuania**

- Studied undergraduate psychology courses at Lithuania Christian College, an English speaking International College

### PROFESSIONAL MEMBERSHIPS

2014 – Present American Psychological Association Division 39: Psychoanalysis  
 2013 – Present Society for Exploration of Psychoanalytic Therapies and Theology  
 2013 - Present Christian Association for Psychological Studies, Student Affiliate  
 2011 - Present American Psychological Association, Student Affiliate

### SELECTED PROFESSIONAL TRAININGS & EDUCATION

#### *PSYCHODYNAMIC TRAININGS*

- October 2015      **“The Play’s the Thing: Purpose, Pattern, and Process in Jungian Dream Interpretation.”**  
*Vermont Association of Psychoanalytic Studies, Stowe, Vermont*  
 Sherry Salman, PhD, Jungian Analyst
- 2014 - 2015      **Fundamentals of Psychoanalytic Psychotherapy**  
*Oregon Psychoanalytic Center, Portland, Oregon*
- A monthly case consultation/reading group facilitated by members of the OPC; 10 month duration.
- 2012 - 2015      **Clinical Team:** Consultation group that meets weekly to present and discuss cases from various clinical perspectives.  
 Consultants: Wayne Adams, PhD, ABPP/CL; Mark McMinn, PhD, ABPP/CL; Marie-Christine Goodworth, PhD; Nancy Thurston, PhD, ABPP/CL
- 2013 - 2015      **Psychodynamic Discussion Group:** Society that meets monthly to present and discuss cases from a psychodynamic perspective.  
 Consultant: Kurt E. Free, PhD
- April 2014      **American Psychological Association Division 39 Spring Meeting**  
 New York, New York
- July 2013      **Rorschach Immersion: Basic Course in Rorschach**

*Massachusetts School of Professional Psychology, Boston, Massachusetts*

Terrie Burda, PsyD

- 35-hour introduction to the Rorschach using the Exner scoring method.

- April 2013     **Psychoanalysis and Motivational Systems: A New Look**  
*Christian Association of Psychological Studies, Portland, Oregon*  
James Fosshage, PhD, ABPP
- January 2013     **Embodied Experiences**  
*The Oregon Psychoanalytic Center, Portland, Oregon*  
Mary Target, PhD
- 2012 - 2013     **Psychoanalytic Reading Group:** Student society that meets monthly to read and discuss psychoanalytic books and articles.
- Oct 2012        **The Skillful Soul of the Psychotherapist: Master Clinicians and Theologians in Dialogue**  
*Danielsen Institute, Boston University, Boston, Massachusetts (via online attendance)*  
Salman Akhtar, MD; Nancy McWilliams, PhD, ABPP; David Wallin, PhD

*SPIRITUAL INTEGRATION TRAININGS*

- March 2013     **The Person of the Therapist: How Spiritual Practice Weaves with Therapeutic Encounter**  
*George Fox University, Newberg, Oregon*  
Brooke Kuhnhausen, PhD
- Oct 2012        **Treating Gender Variant Clients: Christian Integration**  
*George Fox University, Newberg, Oregon*  
Erika Tan, PsyD
- March 2012     **Mindfulness and Christian Integration**  
*George Fox University, Newberg, Oregon*  
Erika Tan, PsyD

*OTHER SELECTED TRAININGS*

- Feb 2012        **Thoughtful Psychopharmacology**  
*George Fox University, Newberg, Oregon*  
Michael Tso, MD
- May 2013        **Using Tests of Effort in Psychological Assessment**  
*George Fox University, Newberg, Oregon*  
Paul Green, PhD

- May 2013     **Assessing Mild Cognitive Impairment and Dementia**  
*George Fox University, Newberg, Oregon*  
Mark Bondi, PhD, ABPP
- January 2013   **African American History, Culture and Addictions & Mental Health Treatment**  
*George Fox University, Newberg, Oregon*  
Danette C. Haynes, LCSW; Marcus Sharpe, PsyD
- Nov 2012     **Sexual Identity**  
*George Fox University, Newberg, Oregon*  
Erika Tan, PsyD
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## REFERENCES

References from current academic advisor or clinical supervisors can be provided upon request. Please send an email to [jrodriguez11@georgefox.edu](mailto:jrodriguez11@georgefox.edu) for contact information.