

**THE ETHICAL AND RELATIONAL IMPLICATIONS OF PROFESSIONAL
DISCLOSURE PRACTICES FOR CERTIFIED REHABILITATION COUNSELORS**

By

Todd T. Lewicki

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ABSTRACT

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The practice of professional disclosure involves the acknowledgement of the client's right to autonomy and benefits client outcomes through fidelity, veracity, informed choice, the therapeutic relationship, and genuineness. Professional disclosure is hypothesized to strengthen establishment of an effective therapeutic relationship which leads to improved client outcomes. The Certified Rehabilitation Counselor (CRC) credential signifies that the CRC is well-prepared to practice in the field and operates consistently with the Commission on Rehabilitation Counselor Certification (CRCC) 2010 Code of Professional Ethics. Little is known about CRC therapeutic relationship outcomes relative to the use of professional disclosure practices, especially since the issuing of the 2010 CRCC Code of Professional Ethics for Rehabilitation Counselors. The purpose of this study was to review CRC use of the practice of professional disclosure, and its relationship to the therapeutic relationship with the client. The study utilized the results of an online survey of 249 CRCs responding to questions on the Real Relationship Inventory-Therapist (RRI-T) and the Professional Disclosure Survey-Modified (PDS-M) instruments. Simultaneous multiple regression analyses were performed between the demographic data and the two instruments. A simple linear regression was performed on the ability of the PDS-M to predict outcomes on the RRI-T. The simultaneous multiple regressions yielded relatively non-significant results, but the simple linear regression resulted in a significant effect ($F(1,197)=23.4, p<.001$), indicating that professional disclosure practices of the CRC

enhance the therapeutic relationship (genuineness) with the client. Implications for the field via education, training, supervision, and future research are discussed.

Keywords: CRC, ethics, informed consent, professional disclosure, rehabilitation counselor, therapeutic relationship

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This dissertation is dedicated to two wonderful women whom I have been fortunate enough to have in my life, through their seemingly endless capacity for unconditional love, thoughtfulness, caring guidance, and the belief that opportunities for success in achieving what an individual sets out to achieve are all but limitless and guaranteed when you have dedication, faith, and compassionate support. In recognition, I am thankfully and immeasurably indebted to my mother Rosalie A. Lewicki, and my wife Antoinette M. Lewicki for being these wonderful women and make this dedication on their behalf.

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KEY TO ABBREVIATIONS

ADA	Americans with Disabilities Act
CDTE	Consumer-Directed Theory of Empowerment
CORE	Council on Rehabilitation Education
CRC	Certified Rehabilitation Counselor
CRCC	Commission on Certification of Rehabilitation Counselors
CRCE	Certified Rehabilitation Counselor Examination
ICC-VR	Theory of Informed Consumer Choice in Vocational Rehabilitation
PDS	Professional Disclosure Survey
PDS-M	Professional Disclosure Survey-Modified
RECITE	Rehabilitation Counselor Initiated Transfer of Empowerment
RRI-T	Real Relationship Inventory-Therapist
TPB	Theory of Planned Behavior
TRA	Theory of Reasoned Action

Chapter One

Introduction

The facilitation of informed client decision-making in health care has been a foundation for understanding informed consent in rehabilitation counseling (Carlisle & Neulicht, 2010). Over a decade ago, the rehabilitation counseling field considered informed decision making to be a relatively new concept (Blackwell & Patterson, 2003). Insofar that the informed consent process is the rehabilitation counseling field's acknowledgement of client right to autonomy, it is also a further expression of recognition of the autonomy and dignity of the client through the embrace of the working alliance, empowerment, choice, and independence as key principles in its service philosophy (Patterson, Patrick & Parker, 2000). Embedded in informed consent is the concept of professional disclosure, the process of communicating relevant information to clients to engage them in understanding and agreeing to the elements involved in rehabilitation counseling services (CRCC, 2010). With this philosophy in mind, Kosciulek (2005) identified three underlying assumptions of client choice: 1) an informed client is the best authority on his or her service needs, how to best meet these needs and whether they are being met; 2) service delivery environments can incorporate choice and control; and 3) client direction should be available to all. The belief in autonomy and choice should be based in the recognition of the client's right to choose his or her own goals and that rehabilitation counselors should utilize their efforts and processes to help the client in reaching these goals (Tarvydas, Addy, & Fleming, 2010).

Exercising control over one's life choices is directly related to individual autonomy. The client-oriented approach to decision-making diverges from the paternalistic medical model in that it is empowerment-oriented and relies on the judgment and decisions of the client (Woolf et

al., 2005). This focus on client autonomy is directly related to informed consent (Waller & Repko, 2008), which is the client's right to consent to participate in and make informed and independently-respected decisions with respect to rehabilitation services (Blackwell & Patterson, 2003). Autonomy is one of the six ethical principles fundamental to the spirit of caring and respect as described by the Code of Professional Ethics for Rehabilitation Counselors (CRCC, 2010). Thus, the client has a right to receive information about the nature and outcome of rehabilitation counseling services and to engage in informed choice and consent.

Clients rely on the ethical nature of the rehabilitation counselor and the information they possess regarding services and as a result, the rehabilitation counselor has an obligation to provide them this information (Blackwell & Patterson, 2003). It is through this information sharing that the client is given an opportunity to review, discuss and consent to engaging in the counseling process. The treatment relationship is thought to be enhanced when the rehabilitation counselor clearly defines throughout the counseling process and through professional disclosure, ongoing communication of the type of services being provided in addition to the client's rights and responsibilities within it (Blackwell & Patterson, 2003; Carlisle & Neulicht, 2010). The rehabilitation counselor should be knowledgeable in informed choice processes to assist the client in becoming empowered and exerting greater control and influence over the choices and directions of their own life (Kosciulek and Wheaton, 2003).

Clients also expect that the skills and behavior of the counselor will affect their lives to the positive. The counselor as an entity in the client counselor relationship is a therapeutic instrument (Hayes et al., 1998). Bedics, Comtois, Atkins, & Linehan (2012) concluded that the importance of the counselor in maintaining a positive stance toward the client, the use of counselor warmth and autonomy as interactive traits, positions the client for an improved

outcome. This relates to a combination of the recognition of the respect and dignity for clients in treatment with a psychological treatment interwoven into the encounter, as Chwalisz (2001) noted. The rehabilitation counseling relationship has sought to engage the client in empowered and informed life choices, inclusion and independence (Kosciulek and Wheaton, 2003). Research on attitudes of clinical workers regarding expected client outcomes has shown a positive effect on client improvement in medical studies (Adcock, Goldberg, Patterson, & Brown, 2000).

Statement of the Problem

It is the rehabilitation counselor's responsibility to engage the client in as much decision-making autonomy as possible (Hagen-Foley, Rosenthal & Thomas, 2005). Carlisle & Neulicht (2010) note that the Commission on Rehabilitation Counselor Certification (CRCC), in its 1987 Code of Professional Ethics, first mentioned professional disclosure, but did not cover it in depth. As the CRCC issued its 2001 Code of Professional Ethics, informing the client had evolved to include the recommendation that the client receive information on counselor credentials as well as the purpose, limitations, benefits and risks of services, but had no implementation requirement; rather a recommendation that this information be provided in a written format when testing individuals (Blackwell, Autry, & Gugliemo, 2001). The process by which the rehabilitation counselor followed this recommendation greatly varied in practice and in outcome.

Shaw, Chan, Lam and McDougall (2004) acknowledged the importance of adequate professional disclosure and noted an increase in the number of ethics complaints in this area. Due to a lack of knowledge on prevalence of the use of informed consent, the CRCC Ethics Committee recommended a study look at current processes and potential best practices to better

understand how professional disclosure was being implemented within the field of rehabilitation counseling. It was found that there was great variability in the content and use of professional disclosure forms, leading to the potential for added liability and accountability problems. The findings revealed that rehabilitation counselors did not regularly inform their clients on the limits of confidentiality and situations involving a legal duty to report situations of abuse or neglect. Informed consent, insofar as it was connected to client autonomy, choice, empowerment, and the working alliance, was not used with enough of a standard, predictable approach to quantify that the client right to disclosure at service initiation and throughout was used effectively or in any consistent fashion.

In 2010, CRCC issued its most current Code of Professional Ethics (CRCC, 2010) to date. One of the most significant changes to the 2010 code was that written professional disclosure became a requirement (Carlisle & Neulicht, 2005). Furthermore, the 2010 code indicates “rehabilitation counselors need to recognize diversity and embrace a cultural approach in support of the worth, dignity, potential, and uniqueness of individuals with disabilities within their social and cultural context” (CRCC, 2010, p.1). The 2010 code also underscores the principle of autonomy through the respect of the rights of clients “within their social and cultural framework” (p. 2). Thus, informed consent processes and cultural competence are both viewed as important mechanisms in the rehabilitation counselor’s effort to engage and empower the client.

The Shaw et al. (2004) study indicated that the field of rehabilitation counseling lacked knowledge in the prevalence of professional disclosure practices to the client. Tarvydas and Barros-Bailey (2010) used an open-ended survey with 240 CRCs and Canadian CRCs regarding current and anticipated ethical dilemmas in the field. The analysis of the respondents’ reports

showed that three of the top four ethical concerns included confidentiality and exceptions to confidentiality, autonomy and client choice, and the client relationship. Each of these areas of concern is related to professional disclosure. The issue of the adequacy of informed consent and limits of confidentiality stood out in light of third-party referral, payer, and referral sources. Kosciulek (2007) also noted that valid models are needed to guide development, implementation, and evaluation of disability and rehabilitation services and that little information exists regarding constructs that could be useful in conceptualizing ways to examine and enhance informed consumer choice.

The failure in appropriate disclosure of counselor credentials as well as the purpose, limitations, benefits and risks of services has the potential for resulting in far-reaching and deleterious outcomes for all persons involved, including loss of client trust in the counselor, service disruption and malpractice lawsuits (Baerger, 2001; Woody, 2000). Kosciulek and Wheaton (2003) noted that an effective working alliance was a primary factor in all successful counseling practices. Also referred to as the therapeutic alliance, the working alliance is defined as the bond between the client and the counselor, agreement on goals, consensus on therapeutic tasks and has been found to be significantly related to treatment outcome (Carter, 2006). Thus, the therapeutic relationship is a part of the alliance and, being central to successful treatment outcomes, is built upon a trusting bond that should be strengthened by a well-implemented informed choice process.

Purpose of the Study

The field of rehabilitation counseling has had a responsibility to address client empowerment for informed choice by embedding it in the rehabilitation process itself (Breeding, 2008). Rehabilitation counseling practitioners, educators and researchers have engaged in

numerous studies including role and function studies, training needs, the future of the profession, and student perception of the amount of time devoted rehabilitation counseling activities in an attempt to better define rehabilitation counseling as a true profession (Zanskas & Strohmer, 2010; Muthard & Salamone, 1969; Rubin, 1984; Chan et al., 2003; Leahy 2009; Lustig & Strauser 2008, 2009). One key trait in establishing the effectiveness of the rehabilitation counselor is measured by their ability to make relational connections with clients (Koch, McReynolds, & Rumrill, 2004). However, little is known about rehabilitation counselor professional disclosure practices and the effect these have in the therapeutic relationship, as there have been few studies on this area, especially since the issuing of the 2010 CRCC Code of Professional Ethics for Rehabilitation Counselors.

Kosciulek and Wheaton (2003) hypothesized that an effective therapeutic relationship leads to productive informed choice in the rehabilitation counseling process. It was this writer's contention that certified rehabilitation counselor use of the informed choice process of professional disclosure would serve to contribute to and strengthen the cultivation of a genuine relationship with the client and strengthen the transference of empowerment to the client. Revisiting and subsequently advancing the current knowledge and practice of certified rehabilitation counselors (CRC) relative to the interaction of these processes was warranted, given the lack of studies in this area, especially in relation to the influence of the informed consent requirement in the 2010 CRCC Code of Professional Ethics for Rehabilitation Counselors (referred to hereafter as "the 2010 Code"). Thus, the purpose of this study was to review the CRC use of the practice of professional disclosure, and its potential relationship to client empowerment through a strengthened therapeutic relationship.

Research Questions

This study attempted to address a gap in the rehabilitation counseling literature relating to the influence of the rehabilitation counselor empowerment orientation on rehabilitation counselor practices relating to informed consent requirements (professional disclosure), as defined by the 2010 Code. Ostensibly, the study sought to review the relationship between the rehabilitation counselor's professional disclosure practices and whether they correlated with an enhanced therapeutic relationship.

1. How do the following rehabilitation counselor demographic characteristics predict/affect the rehabilitation counselor's use of informed consent?
 - a. The age of rehabilitation counselor.
 - b. The gender of the rehabilitation counselor.
 - c. The race of the rehabilitation counselor.
 - d. The education level of the rehabilitation counselor.
 - e. The experience level of rehabilitation counselor.
 - f. The job setting of rehabilitation counselor.
 - g. The job title of rehabilitation counselor.
2. How do the following rehabilitation counselor demographic characteristics predict/affect the rehabilitation counselor's use of the real relationship?
 - a. The age of rehabilitation counselor.
 - b. The gender of the rehabilitation counselor.
 - c. The race of the rehabilitation counselor.
 - d. The education level of the rehabilitation counselor.
 - e. The experience level of rehabilitation counselor.
 - f. The job setting of rehabilitation counselor.

- g. The job title of rehabilitation counselor.
- 3. How well do rehabilitation counselors that exhibit more positive scores on the professional disclosure survey-modified predict positive opinions on use of the real relationship-therapist inventory with the client?

Definition of Terms

Certified Rehabilitation Counselor (CRC). The credentialing process issued by the Commission on Rehabilitation Counselor Certification, recognized as the oldest and most established certification mechanism in the counseling and rehabilitation disciplines in the United States. The CRC standards and examination content represents the education level, experience, and knowledge competencies required of rehabilitation professionals to provide rehabilitation counseling services to persons with disabilities (Leahy, Chan, Sung, & Kim, 2013).

Commission on Rehabilitation Counselor Certification (CRCC). The credentialing body established in 1973 to ensure accountability and promote the quality of rehabilitation counseling services to persons with disabilities (Saunders, Barros-Bailey, Rudman, Dew, Garcia, 2007).

Common Factors. Common elements in counseling, such as the healing context, the working alliance, and belief in the rationale for treatment and in the treatment itself, are the important therapeutic aspects that enhance or create the opportunity for change (Ahn & Wampold, 2001).

Empowerment. The attainment of identity goals and the psychological aspect of the self-perception that an individual has in them a capacity to influence his or her environment (Daniels, 2002).

Informed Choice. Information that has been provided to, understood, and used by the client for the purpose of making a choice established through on engaging the client in the informed consent process (Entwistle, Sheldon, Sowden, & Watt, 1998).

Informed Consent. A process of communication between the rehabilitation counselor and client for the purpose of the authorization or decision by the client to pursue a particular direction in services based upon an appreciation and understanding of the facts and implications of an action (CRCC, 2010).

Professional Disclosure. The act of sharing the information needed to understand the nature and characteristics of the counseling process, with a goal of supporting and advancing autonomous decision-making (Shaw & Tarvydas, 2001).

Real Relationship. The personal relationship that is thought to exist between individuals as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other (Gelso et al., 2005).

Rehabilitation Counselor. Counselors that are ethically obligated to act in ways that contribute to the empowerment of persons with disabilities with resources that lead to the best possible outcomes in the least restrictive environments; facilitate the rehabilitation process through use of a unique set of holistic skills in assisting persons to reach their highest level of psychosocial functioning; and embrace a philosophy that results in clients achieving personally fulfilling, socially meaningful, emotionally healthy independent lives (Stebnicki, 2009).

Therapeutic Relationship. Relationship components in the therapy relationship that include counselor and client mutual feelings and attitudes, the working alliance, empathy, goal consensus, collaboration, countertransference management, positive regard, and congruence; all

are thought to contribute to treatment outcome (Kivlighan, Gelso, Hummel, Ain, & Markin, 2014).

Working Alliance. The level of alliance between the counselor and client that includes three parts; 1) the affective bonds between client and counselor, 2) the mutually agreed upon goals, 3) and the level of task teamwork and personal rapport during the service process (Bordin, 1979).

Chapter Two

Literature Review

The purpose of this study was to review the CRC orientation toward the therapeutic relationship with the client and their perception of the benefit the professional disclosure use has on this relationship. Accordingly, a thorough literature review was necessary to explore the concepts and their relative importance when considering aspects of empowerment, informed choice, shared decision-making, the 2010 Code, and ethical behavior. Additionally, the review included the role of the rehabilitation counselor in using informed consent practices and the influence that counselor perspectives (i.e. relational attitude) had on the client-counselor relationship on service delivery and potential outcomes. Definitions of terms have been included prior to this literature review, and where appropriate and in subsequent sections as well. This review occurred in support of the need for further research in the area of rehabilitation counselor informed consent practices and the potential these practices have on establishing the best possible environment for positive client outcomes.

Johann Wolfgang von Goethe (1749-1832), a German writer, captured what one could view as a prerequisite to the rehabilitation counselor's perspective on dignity and respect toward the client: "If you treat an individual as he is, he will remain how he is. But if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be" (goodreads, n.d.). The self-fulfilling prophecy, arguably what Goethe was inadvertently referring to, is an important concept that is relevant in the relationship with the client. The self-fulfilling prophecy refers to the symbolic idea that once something is defined as real, it is also real in its consequence (Wiley, 2003). Thus, this research attempted to speak to the counselor-client interaction and the contributions that counselor perspectives can have on managing the

therapeutic relationship and more specifically, the impact that this orientation and the empowering effect informed consent theoretically can have on strengthening outcomes.

Common Factors

Coined by Saul Rosenzweig in 1936, common factors theory has been studied and has gained legitimacy in psychotherapeutic practice (Wampold et al., 1997). Numerous therapeutic techniques and practices exist and Rosenzweig's common factor theory cites that common factors are largely responsible for the efficacy of the psychotherapy. Common factors are interactive relational elements not thought to belong to any specific therapy but rather are shared properties possessed by all treatment techniques. Lambert and Ogles (2004) separated common factors into three categories: support factors, learning factors and action factors. Support factors include catharsis, identification with therapist, mitigation of isolation, positive relationship, reassurance, release of tension, structure, therapeutic alliance, therapist/client active participation, therapist expertness, warmth, respect, empathy, acceptance, genuineness and trust. Learning factors include advice, affective experiencing, assimilating problematic experiences, cognitive learning, corrective emotional experience, feedback, insight, rationale, exploration of internal frame of reference, and changing expectations of personal effectiveness. Action factors include behavioral regulation, cognitive mastery, encouragement of facing fears, taking risks, mastery efforts, modeling, practice, reality testing, success experience and working through.

Common factor research focuses on the influence of support factors which are responsible for approximately 9 times more variability in outcomes than the specific (dismantled) treatment factors (Wampold, 2001). Common factors are present in the interaction between the counselor and client. These factors include allegiance (counselor commitment to belief the therapy is helpful to the client), the relationship (client's affective relationship with the

counselor, client's motivation to collaborate with the counselor, the counselor's empathic response to the client, and client and counselor agreement on goals and tasks), warmth, acceptance, non-judgment, respect, affirmation and recognition; all are used in an effort to strengthen the therapeutic relationship, build trust and rapport and establish the therapeutic alliance (Wampold, 2001; Jorgenson, 2004; Leibert, 2011). Fischer and Knapp (1977) showed that the more self-actualized the counselor, the more effective they were at communicating high levels of empathy, warmth and genuineness, conditions associated with factors that indicate an effective helper. Several researchers conceptualize the therapeutic alliance as a common factor and refer to it as the "quintessential integrative variable" (Martin, Garske, & Davis, 2000, p. 438).

Wampold et al. (1997) conducted a meta-analysis of multiple psychotherapeutically-oriented component studies to test whether there was any difference between these psychotherapy treatments. This study and a subsequent 2001 meta-analysis of 27 studies employed a component-based dismantling design (Ahn & Wampold, 2001). A dismantling design involves the removal of a specific ingredient that is thought have the specific component important to the success of the therapy. The design was then compared to the design including all treatment components. The difference between the two designs in terms of outcome would be hypothesized to be either due to the non-specific factors (i.e. common factors present in all psychotherapies) or the dismantled component (factors specific to the psychotherapy techniques). The results showed that both sets of meta-analyses did not yield any evidence that the dismantled (specific) components directly contributed to the beneficial outcome of psychotherapy (Ahn & Wampold, 2001).

The studies found that there was no difference between the component (specific) treatments to the outcome, supporting the idea that the lack of difference between the treatments meant all shared common elements were useful in the treatment process. Wampold's (2001) meta-analysis of psychotherapy efficacy reached the conclusion that 70% of psychotherapeutic effects were attributable to common factors, 8% were connected to specific treatments, and the remaining 22% were due to client differences. Chwalisz (2001) remarked on a study completed by Lambert in 1992 which concluded that 30% of client improvement was specifically due to the therapeutic relationship. 15% of improvement was determined to be due to unique factors in specific therapies and another 15% was due to the client's expectations. The final 40% was related to factors in the client and his or her environment (Jorgenson, 2004). Common elements within the psychotherapy used and the therapeutic relationship are therefore, notable and consistent contributors to outcome (Martin, Garske, & Davis, 2000).

The benefits of common factors being present in all psychotherapies is supported by research evidence gained in the study of these elements (Ahn & Wampold, 2001). Common factors operate in all forms of psychotherapeutic treatment where the client has the opportunity to bring about change in his or her life. With increased trust and an enhanced sense of security, the client is thought to be able better understand their own struggle, reframe previously troubling fears, and work through interpersonal problems to a positive outcome (Lambert & Ogles, 2004). "Clinicians who practice using a common factors approach to counseling enlist their clients' strengths, resources, and unique points of view, because these factors are highly associated with counseling outcomes" (Leibert, 2011, p.134).

The Working Alliance and the Therapeutic Relationship

In general over numerous studies, when asked what they found helpful in psychotherapy, clients have routinely identified the therapeutic relationship (Norcross, 2010). Clients have not specifically focused on particular techniques as being the most effective factors, but rather the relationship with their counselor. While the client is not expected to be aware of the mechanisms contained within various psychotherapeutic techniques, it is important to note that they valued the relationship with the counselor, a cornerstone to the therapeutic relationship. Najavits and Strupp (1994) conducted a study with 16 therapists who were assigned clients with different difficulty levels (i.e. clinically challenging to treat). After 25 sessions, the therapists were evaluated with respect to outcome, length of treatment and therapist in-session behavior. Comparatively, clients with better outcomes had therapists who used more positive and relational behaviors rather than technical skills alone. Najavits and Strupp concluded that basic human capacities such as warmth and affirmation may be central to effective psychotherapeutic intervention.

In two separate studies, psychologists were asked to reflect on their own experiences in psychotherapy (Bike, Norcross, & Schatz, 2009; Norcross, Dryden, & DeMichele, 1992). Most frequently, the psychologist responses identified the following as valuable: warmth, empathy, the personal relationship, the significance of transference and countertransference, and therapist qualities of humanness, reliability and commitment. Identification of these common factors both separately and repeatedly in numerous studies underscores their substantial and consistent contribution to psychotherapy outcomes (Norcross, 2010). Further, the research speaks to the clinical value of implementing positively-oriented common factors in addition to the relational alliance between the client and counselor. Bordin suggested that this alliance is a necessary prerequisite for change in all forms of psychotherapy (Safran & Muran, 2000)

Bordin (1979) possesses perhaps the oft-most cited definition of this quintessential integrative variable: the working alliance. He cites it as being a collaborative and interdependent relationship between the client and the counselor based on the development of an attachment and a shared commitment to the goals and tasks of counseling (Bordin). This definition is founded on a belief that the alliance makes it possible for the client to accept and follow through with the counseling based on a sense of ownership and empowerment in the process (Horvath & Symonds, 1991). Therapeutic alliance is defined by Vasquez (2007) as; “the quality of involvement between therapist and client, as reflected in their task teamwork and personal rapport, and the therapist’s contribution to the alliance is an important element of that involvement” (p. 878). Meissner (2006) pointed out a large number of clinicians ignore the therapeutic relationship aspects of their treatment interventions.

Bordin (1979) discussed the working alliance via a conceptual framework that is expected to converge approaches to psychotherapy, i.e. the concept of the working alliance is pantheoretical (i.e. present in all therapies): 1) all psychotherapies have embedded working alliances and are differentiated by the kind of work each alliance requires; 2) therapy effectiveness is a function of the strength of the working alliance; 3) different psychotherapies make different demands of the client and counselor; and, 4) the strength of the working alliance is a function of the goodness of fit between the alliance demands and the personal characteristics of the client and counselor. This conceptual framework of the working alliance is directed by agreement between the client and the counselor on goals, collaboration on tasks, and the bond.

The rehabilitation counselor is well positioned to effectively engage with the client through the working alliance goals, tasks and bonds elements. Rehabilitation counselors have traditionally sought to assist the client through empowerment strategies that include choice,

control, mutuality and involvement, sharing of power, joint responsibility and self-determination (Power, 2006). Bordin's (1979) goal element of the working alliance underscores the rehabilitation counseling value of involvement and choice through client goals being laid out in collaboration with the rehabilitation counselor. Tasks include the agreed upon therapeutic elements that will be present in the service represented as a collaborative agreement on what treatment the counselor will be expected provide to the client. Lastly, the relationship, or bond between the counselor and the client, refers to the relational elements contained in the treatment such that there exists levels of trust from the client and responsiveness from the counselor.

Based on the importance of this bond-relationship element, the working alliance may be understood in terms of the demands present within this association and how the strength of this bond allows for the establishment of goals and accomplishment of tasks. Human relationships, not being technical endeavors, require that authenticity be facilitated through genuineness with the client and not be something that the counselor uses the scope of their professional role to hide from (Fife, Whiting, Bradford, & Davis, 2014). The essence of this bond is captured in a quote from Warner and Olson (1981, p. 501): "Fortunately, we are often guided in our professional roles more by our deep human responsiveness to people than by our theories. As a result, good things frequently happen."

The working alliance also referred to as the therapeutic alliance as well as the therapeutic relationship, as a part of many decades of process and outcome research, has achieved a reasonable status in the field of psychotherapy (Castonguay, Constantino & Holforth, 2006). The practice of psychotherapy, where two individuals engage in a verbal and symbolic exchange, is a uniquely human relational experience (Wampold, 2007). Addis (2002) suggested that research-practice relationships could be studied with a focus on attitudes, beliefs and stereotypes

and on the way these relationships operate. Further, the knowledge base regarding actual clinical practices in services is limited (Addis, 2002). Individual factors, including clinician attitudes, are ineffectively studied in current literature (Gaudiano, Brown, & Miller, 2011).

The therapeutic alliance has been considered in many studies to be the most consistent and robust in the prediction of positive counseling outcomes (Duff & Bedi, 2010). The ability to form an alliance is potentially the single most important factor to determining the therapist's effectiveness (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). The importance of the therapeutic alliance is not to be understated in the client-counselor relationship. It has repeatedly been discovered to be a predictor of treatment outcome, making it a vital component to the provision of services (Crits-Christoph, Connolly-Gibbons, & Hearon, 2006). The rehabilitation counseling field has yielded a scarcity of studies that specifically address and measure the contribution of the therapeutic relationship to client outcomes (McCarthy & Leierer, 2001; Lustig, Strauser, Rice & Rucker, 2002; Strauser, Lustig, & Donnell, 2004; Wagner & McMahon, 2004). Despite a large amount of empirical support on the therapeutic relationship across many related behavioral fields, research on the relationship between rehabilitation counseling style and outcome remains limited (Wagner & McMahon, 2004). A shortage of research exists around rehabilitation counseling processes that incorporate client input, and without this meaningful knowledge, the field is at a disadvantage for serving clients in a collaborative capacity, a key intervention in building the therapeutic relationship (McCarthy & Leierer, 2001). The nurturing relationship has been identified as a theme important to clients in the rehabilitation counseling process.

Lustig et al. (2002), studied the effect of therapeutic relationship within the context of the state-federal rehabilitation system and found that there was a positive correlation of therapeutic

relationship with vocational rehabilitation services. The study concluded that through facilitation of this relationship, there existed the possibility that outcomes would be improved. Similar results were found in persons with intellectual deficits who were employed at the conclusion of rehabilitation services reported a stronger relationship than those persons that were unemployed (Strauser et al., 2004). Donnell, Strauser, and Lustig (2004) reviewed therapeutic alliance and rehabilitation outcomes for persons with severe mental illness (SMI). The findings suggested a treatment benefit when a strong working alliance was developed. Counselors needed to be aware of the importance in actively engaging their clients and developing a relationship that benefits the rehabilitation process, as those persons with SMI that were employed at rehabilitation service conclusion rated a stronger therapeutic alliance (Donnell et al., 2004).

The previous studies focused on different aspects of disability (intellectual deficits and severe mental illness) as variables in the study of the therapeutic alliance. Lustig, Weems, and Strauser (2004) also looked at general location, that is, urban or rural, as factors in determination of the strength of the therapeutic alliance. This study found that persons who had more severe disabilities were older, experienced worse employment outcomes and had a weaker therapeutic alliance with their rehabilitation counselor in both urban and rural settings. However, rural clients in general are at a greater disadvantage in terms of employment opportunities. Clients with better service outcomes tend to be more satisfied with the therapeutic alliance (Bjornsgard, Ruud, and Friis, 2007). Thus, the perception of the therapeutic alliance influencing the service outcome appears to be connected to whether the client is able to have their expectations met in the service delivery process.

It has been questioned whether the strength of the therapeutic alliance is influenced by counselor behaviors, or that the counselor behaviors are amplified as a result of the therapeutic

alliance (Duff & Bedi, 2010). Causal influence between the alliance and the outcome has been debated. It has been theorized that the alliance may not be causal to outcomes, as it could be the client's contributions to the alliance, or that early symptom change creates the alliance, and that the alliance may help the client generally feel better, but will not affect symptomatology (Laska, Gurman, & Wampold, 2013). These studies clearly indicate the importance of the therapeutic alliance as a factor in outcome. It is however, especially important to explore the concept of causal influence. Clinical improvement may influence a positive alliance (Crits-Cristoph et al., 2007).

To best determine causality with therapeutic alliance and symptom change, it should be assessed early in treatment as clinical improvements may precede growth of the alliance (Kazdin, 2009). There is question as to whether the research as of yet has established a causal relationship between the strength of the therapeutic alliance and positive client change. In an attempt to address this debate, Baldwin, Wampold, and Imel (2007) conducted a multi-level model study with 331 clients seen by 80 counselors to determine the role of client and counselor variability in the alliance. The study found that counselors who were able to form a better alliance with their client generally had a better outcome. The study also revealed that clients who formed a better alliance with a certain counselor did not have better outcomes than clients with a worse alliance with the same counselor. Duff and Bedi (2010) question whether there is potentially another, as of yet unknown factor that influences the relationship between counselor and client behaviors and the therapeutic alliance. Thus, it is supported that there is a need for increased research within the counselor-client relationship to better define the properties of this causal relationship (Horvath, 2005). However, there is growing evidence that more effective counselors form better

alliances, have better facilitative interpersonal skills, and engage the client in an emotionally activated relationship (Laska, Gurman, & Wampold, 2013).

The Real Relationship

Carl Rogers defined necessary and sufficient conditions for therapeutic change as including the client being in a state of incongruence, client and counselor psychological contact, and the counselor orientation toward positive regard for the client and an empathic frame of reference (Kolden, Klein, Wang, & Austin, 2011). Eugster and Wampold (1996) conducted a study to determine which elements in the psychotherapy process predicted judgments by the counselor and client about whether the session was useful, valuable, good, or whether there were differences between the groups. The study concluded that the counselor felt positively when they perceived themselves as effective, and not overly transparent or personally involved in the relationship (appropriate boundaries). The client felt positively when they felt involved, that they were making progress, and perceived the counselor as relating to them as a person, within the context of a genuine relationship.

As Duff and Bedi (2010) questioned whether there was another, unknown factor that influenced the relationship between counselor and client therapeutic alliance, others had already began theorizing on these components as going beyond Bordin's (1979) traditional definition of the tasks, goals, and bond in the working alliance, to include the personal relationship. Hatcher and Barends (2006) note that there has been confusion with alliance theory and that it had largely lost its definition. The alliance is considered indistinguishable from the overall relationship between the client and counselor and suggested that alliance and relationship have been thought to be, or at least presented as synonymous. Horvath (2009) cautioned that the working alliance should not be used to operationalize the relationship and that they are separate constructs.

Greenson was possibly the earliest researcher to identify a model that theorized the importance of the relationship as consisting of interrelated parts, the most important of which was referred to as the real relationship (as cited in Gelso & Carter, 1994, p. 296). Gelso (2014) referred to three interlocking elements as belonging to a tripartite model of the therapeutic relationship, consisting of a real relationship, a working alliance (consistent with Bordin's 1979 model), and a transference configuration (client transference and counselor countertransference).

The real relationship has been defined as “the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other” (Gelso et al., 2005, p. 641). In the therapeutic relationship, there exists the central importance of the client and the counselor and the unfolding relationship between the two. The overall relationship is thought to be larger than the working alliance (Gelso, 2014). This dimension of the overall relationship is considered to be independent of the concept of transference, which will subsequently be explained, has a tendency to distort reality between individuals.

The real relationship is seen as having two specific features that give it definition: genuineness and realism (Gelso & Carter, 1994). Genuineness is the ability and willingness to be authentic, open and honest. Realism involves perceptions that are clear of distortion from transference and other related defenses; seeing the person realistically, rather than the projections of what one may wish for or fear (Marmarosh et al., 2009). This means that the client and the counselor in this state of genuineness and realistic perception are able to see each other in an accurate and clear way. This real relationship is said to exist in all therapeutic encounters and affects the counseling process and outcome in certain ways depending on the relative strength of the relationship. The real relationship, unlike the working alliance (which focuses on the

collaborative work aspects (tasks, goals, and bonds) in counseling between client and counselor), is based on the experience between two people. The real relationship is theorized to exist from the first moment of contact between the client and counselor and is reflective of the personal connection between the two (Lo Coco, Gullo, Prestano, & Gelso, 2011). Wampold and Budge (2012) asserted that the way the real relationship yields positive outcomes is through the beneficial effect of being connected to another human being; most significantly a person who is invested in the other's well-being and that this notion is perceived, understood, and trusted as genuinely existing.

Transference is a concept contained within the therapeutic relationship that involves the displacement of feelings from one person to another, usually associated with the transference of attitudes associated with a parent or parents (Safran & Muran, 2000). These feelings can be positive or negative. Gelso (2014) also defined transference as the experiences and perceptions of the client toward the counselor that are shaped by the client's past and their psychological makeup, which involves displacement of their feelings attitudes and behaviors that belong to an earlier and more significant relationship. Gelso et al. (2005) discovered that counselor's ratings of the strength of the real relationship had a negative correlation with negative transference. This finding has been consistent with other studies that found counselor-perceived negative transference was predictive of psychotherapy process and outcome variables (Marmarosh et al., 2009). Transference can generally be viewed as a form of resistance to treatment, as the reasoning behind its use is usually connected to concealing awareness from that which is too painful to openly acknowledge consciously (Gelso & Carter, 1994). Gelso and Carter theorized that the alliance relationship influences the conscious experience and expression of transference, and thus, the stronger the alliance, the more the client is potentially able to become aware of

positive and negative affect that is connected to transference, and to be able to safely explore those issues in the context of the alliance.

Countertransference was a term first introduced by Sigmund Freud to explain the counselor's reaction to the client's transference (Hayes et al., 1998). This construct relates to reactions on the part of the counselor in which their unresolved conflicts, usually unconscious, are present (Norcross, 2010). In 2007, Gelso and Hayes defined countertransference as "the therapist's internal and external reactions that are shaped by the therapist's past and present emotional conflicts and vulnerabilities" (as cited in Gelso, 2014, p.123). It is generally the client's behavior that serves as the trigger. The countertransference interaction hypothesis, according to Gelso (2014), describes that whatever serves to activate these vulnerabilities in the counselor is a highly individual issue, much like the individually-motivated factors that would activate the client's transference processes.

The counselor and his or her use of the self is a therapeutic instrument and is influenced by countertransference (Hayes et al., 1998). Hayes et al. (1998) conducted 127 interviews in a qualitative study on brief therapy and countertransference with 8 psychologists. The analysis of the interviews yielded three domains that are relevant to countertransference: origins (family issues, needs and values, cultural, and therapy specific issues), triggers (client content, therapist comparison of client to others change in therapy structure, therapist assessment of progress in therapy, and therapist perception of client and their emotions), and manifestations (categories of approach, avoidance, negative feelings and treatment planning). The findings concluded that countertransference originated in the therapists' unresolved conflicts related to family issues, needs and values, therapy constructs such as performance in session and termination, and cultural issues; all of which were triggered by different stimuli. While Hayes et al. (1998)

suggest that these findings could guide future studies, they also acknowledge the difficulty with defining and operationalizing countertransference. They suggest the following for future empirical scrutiny: “When a client stimulates an area of unresolved conflict in a therapist, the degree to which the conflict is resolved within the therapist will relate directly to the extent to which the therapist uses his or her countertransference therapeutically” (p. 479). This suggests that the therapist, if successful in managing their countertransference, can enhance self-insight, self-integration, anxiety management, empathy and conceptualizing ability (Norcross, 2010), and use this enhanced understanding of self to aid in his or her understanding of the client and their impact on others (Gelso, 2014).

It is thought that the real relationship influences the ways in which the working alliance and transference/countertransference unfold and influence treatment effectiveness (Marmarosh et al., 2009). The working alliance has been thought to come out of the real relationship. Studies that have looked at the correlation between the working alliance and the real relationship have found moderate to large effect sizes in overlap of the constructs (Gelso et al., 2005, $r=.47$; Marmarosh et al., 2009, $r=.66$; and Kelly et al., 2010, $r=.79$). Many studies that have been completed regarding the working alliance have noted that when the alliance construct was measured early in treatment, it was found to be correlated with outcome (Fischer & Knapp, 1977; Horvath, Del Re, Flukiger, & Symonds, 2011). The idea that the working alliance (and its correlated overlap with the real relationship) as being significant is important in that the client begins to benefit from treatment very early in the process (Kivligham & Shaughnessy, 2000). Thus, as the client and counselor begin to form an early alliance, key common factor constructs that enhance the therapeutic relationship such as empathy, positive regard, genuineness, should

be utilized to strengthen the potential for a positive outcome, and further empower the client toward reaching his or her goals.

The Empowerment Philosophy of the Rehabilitation Counselor Practice

The therapeutic relationship and empowerment philosophies have a long history in rehabilitation counseling. Scully, Habeck, and Leahy (1999) conducted an investigation to identify important knowledge and skill areas that disability management practitioners believed were related to effective disability management. Two hundred-forty four participants responded to questions on the Disability Management Skills Inventory (DMSI). Respondents identified the importance of preparedness in elements of facilitative counseling, including the therapeutic relationship. Central in this domain was the importance of addressing psychosocial issues and the need to minimize disability and its effects, which is linked to the goal of client empowerment. Empowerment has been defined as the attainment of identity goals and that the psychological aspect of empowerment includes the self-perception that an individual has in them a capacity to influence his or her environment (Daniels, 2002). Empowerment is an active and participatory process by which individuals are able to gain greater control over their own life and its intended direction (Peterson, 2014). Daniels (2002, p. 214) also points out that counselor effectiveness is dependent on the characteristics of the individual and that “because mental health professionals strive to empower others, it is important for these individuals to be empowered themselves.” The counselor must possess this quality in order to be able to share it with the client. The field of rehabilitation counseling has identified certain priority goals among which include maximizing independence, normalization, and empowerment (Houser, Hampton, & Carriker, 2000).

The theoretical underpinnings of the rehabilitation counseling philosophy and goals are centrally focused on the concept of empowerment, including the incorporation of the empowerment philosophy via the federal disability legislation in the Rehabilitation Act Amendments of 1973 (Frain, Tschopp, & Bishop, 2009), and in the Rehabilitation Act Amendments of 1992 (Houser, Hampton, & Carriker, 2000). Kosciulek (1999) discussed empowerment via consumer direction in disability policy and the perspective that persons with disabilities have the inherent authority to make choices, regardless of the nature or extent of their disability. Client empowerment is linked to consumer direction via the enhancement of the rehabilitation counselor and client partnership (i.e. the working alliance) to work toward a more positive rehabilitation outcome and client satisfaction. In expressing the concept's importance, Kosciulek states; "Consumer direction is a construct of great interest to the field of rehabilitation because it relates directly to the empowerment of people with disabilities" (p. 8).

Client empowerment is an important rehabilitation philosophy as the concept seeks to assist the client in enhanced personal control (i.e. power and choice) and improved ability to access resources (Kosciulek, 1999). Empowerment has also been conceptualized and operationalized by Rogers, Chamberlain, Ellison, and Crean (1997) to include internal (psychological) and social factors. Psychological factors include sense of control, competence, responsibility, participation and future orientation, and social factors included control over resources, interpersonal, work, organizational skills and an ability to navigate through society.

Empowerment relates to the individual's possession of the traits necessary to recognize, deliberate, choose, set, and pursue personal goals for the purpose of attaining power and resources. Clients with a disability in western society have tended to remain poorer, less educated, and less employed when compared to the general population (Kosciulek, 1999). The

role of the rehabilitation counselor is critical to facilitating the enhancement of the empowerment of the client, and underscores the value of rehabilitation counselors who are “empowerment oriented” and adept at establishing and strengthening the therapeutic relationship. Frain, Tschopp, Bishop (2009) looked at the rehabilitation outcomes of work status, adjustment to disability, functional ability, and quality of life, relative to empowerment. Empowerment variables were identified as self-efficacy, self-advocacy, competence, and self-perceived stigma. 114 persons with a disability were surveyed in these empowerment areas and a multiple regression analysis was completed on rehabilitation outcome areas. Adjustment to disability ($R^2=.40$) and quality of life ($R^2=.41$) had significance ($p<.001$) with medium effect sizes, and work status ($R^2=.19$) yielded a smaller effect size, but was still statistically significant ($p<.05$). Functional status failed to yield a significant result ($p=.42$). Frain, Tschopp, and Bishop note that; “From a practitioner’s point of view, this suggests the reason we (rehabilitation counselors) work to facilitate empowerment in our clients is not to help them understand how important some things should be to them, but rather to help clients feel a sense of satisfaction and control over these important areas of life” (p. 33).

Empowerment is a central aspect to the work of improving human lives and includes a sense of personal control, which has been linked to improved health and well-being (Cattaneo & Chapman, 2010). The work of the rehabilitation counselor is considered an empowering practice due to the empowerment philosophy of the field. Power (2006) notes that through rehabilitation planning and informed choice, the participation of the client creates an opportunity for empowerment and engagement in the rehabilitation process. The rehabilitation counselor must reframe the relationship with the client to acknowledge the importance of the client in the

decision-making process, bringing into play the redistribution of power between the client and the counselor (Gill, Kewman, & Brannon, 2003).

This contention is supported by findings from Kosciulek and Merz (2001), who completed a structural analysis of the consumer-directed theory of empowerment. The study hypothesized that through the rehabilitation counseling service process, there would be greater consumer direction due to higher levels of empowerment and as a result, higher quality of life. Consumer direction was defined as the ability of consumers with disabilities to control and direct rehabilitation services, participate in policy-making, have a variety of service options, and the availability of appropriate service information. One hundred-fifty nine consumers with disabilities who were receiving services at a clubhouse-model community rehabilitation program (CRP) participated. The Consumer Direction Questionnaire (CDQ) was used to measure consumer direction in CRP program operation and service provision. The study found statistically significant ($p < .05$) small to moderate positive effects between consumer direction and empowerment (.13) and empowerment to quality of life (.34). The study recommended further inquiry in other service settings in order to look at the effect that increased consumer direction in the rehabilitation process might have on consumer community integration, empowerment and quality of life. Thus, the ability of the rehabilitation counselor to provide services that are oriented toward increased consumer direction (i.e. ability to direct service options, and receive important-related information) is very important in its relationship to increased empowerment and quality of life.

The work, and thereby the empowerment efforts of the rehabilitation counselor have routinely been viewed as having a positive effect on client empowerment; denoting the mission of the rehabilitation counselor as one of ensuring the inclusion of client empowerment as a

necessary and primary function in service provision. There has been agreement between rehabilitation counselors and clients that rehabilitation goals are better achieved when there is maximum client involvement in the development and use of services (Chan, Shaw, McMahon, Koch, & Strauser, 1997). Emphasizing the counselor-client collaboration in rehabilitation empowers the client and also improves client autonomy and sense of meaningfulness (Lustig, Rosenthal, Strauser, & Haynes, 2000). The rehabilitation counselor should be individually empowered (Daniels, 2002) and possess the skill to engage the client in a trusting therapeutic relationship, thereby enhancing their own empowerment style. The counselor should possess these skills in order to be able to share it with their clientele and thereby enhance individual and informed choice and consent. The field of rehabilitation counseling has identified empowerment of the client as a priority goal (Houser et al., 2000).

Client Rights, Professional Disclosure, Informed Consent, and Informed Choice

Choice and control are highly valued constructs that are reflective of individual autonomy, identity and independence (Kosciulek, 2004). Professional disclosure is the act whereby information is shared with the client regarding the nature and characteristics of the counseling process for the purpose of addressing informed and autonomous decision-making (Shaw & Tarvydas, 2001). Professional disclosure is a blend of informed consent and counselor best practices. One (informed consent) is often a product of the efforts of the other (professional disclosure), i.e. a client being provided with information regarding the goals and objectives of services allows the individual to consent or decline to receiving those services and thereby, make an *informed choice*. It could be said that without the counselor informing the client about services and service risks and benefits through professional disclosure, there is no chance for the client to provide *informed consent*. Beauchamp (2011) notes that the client's right of self-

decision shapes the boundaries of the necessity to inform. The right to informed consent can be successfully expressed only if the client possesses enough information to enable a choice that is consistent with their needs and expectations. The doctrine of informed consent provides the client with choices that would otherwise be absent, lending to the possibility that in the absence of such information from which to consent, harm may be brought in not possessing information necessary to know what the service entails. Informed consent as a process indicates that one way harm may occur to an individual is through the failure to disclose information that could have resulted in non-consent to treatment (Schultz, 1985).

Empowering a person means providing that person with the chance to make choices regarding his or her own life. This opportunity to choose and to control one's life is greatly valued in that it is reflective of the personal qualities of autonomy, identity and independence (Kosciulek, 2007). Engaging the client in individual choice has existed since the consumer rights movement in the early 1970s and was initiated through legislation (Patterson et al., 2000). This legislation includes the 1973 Rehabilitation Act, the 1986 Rehabilitation Act Amendments and the 1990 Americans with Disabilities Act (ADA). New wording, such as *individualized* focused priorities on client choice, as were many of the elements of the acts (i.e. client assistance programs, individualized plan for employment, and consumer councils) (Patterson et al., 2000). The ADA further emphasized client meaningful choice by addressing individual preferences revolving around recreation, living space, supported employment and other quality of life related activities.

Informed consent entered into more common use in the 1970s and was initially related to a physician's duty to provide information to the patient before obtaining their consent to be treated with a procedure and was further emphasized by malpractice litigation (Shaw &

Tarvydas, 2001). Informed choice was officially introduced into rehabilitation services by the Rehabilitation Act Amendments of 1992 and extended by the Rehabilitation Act Amendments of 1998 to make informed choice a mandatory procedure and to ensure that each individual in rehabilitation programming received information regarding the availability and scope of services such that informed choices could be made about individually selected and directed goals and objectives services (Patterson et al., 2000). Preceding this legislation in 1972 was the case of client welfare in *Canterbury v. Spence*, which concluded that clients should be given information that any reasonable person in similar circumstances would necessitate (Somberg, Stone, & Claiborn, 1993). The client has legal and ethical rights (right to autonomy) to information about the nature and possible outcomes of services that they may choose to receive (Blackwell & Patterson, 2003).

Kosciulek (2007) defined informed consumer choice as “a process during which an individual sets goals, gathers information, considers a range of options and then takes responsibility for selecting the option that best meets his or her criteria” (p. 44). The 2010 CRCC Code of Professional Ethics defines and differentiates *professional disclosure* as: “the process of communicating pertinent information to clients in order for clients to engage in informed consent, and *informed consent* as: “a process of communication between rehabilitation counselors and clients that results in the authorization or decision by clients based upon an appreciation and understanding of the facts and implications of an action” (CRCC, 2010, p. 39). These definitions are consistent with the contention that client informed consent occurs as a result of client informed choice.

Professional disclosure is distinguished from informed consent in that it can be thought of as a combination of informed consent and counseling best practice (Shaw & Tarvydas, 2001).

Informed consent is the result of efforts to provide information to the client that is pertinent to the counseling process so that the client may have the best opportunity to fully understand the implications and the choices that he or she must make throughout being involved in receiving services. This is especially salient in light of respecting client rights to privacy of their clinical record, and in order to explain that this rule is not universal, legal limits needed to be explained in order to avoid litigation and therapeutic relationship impasse (Shaw & Tarvydas).

Professional disclosure has its ties to legal processes in protecting the client and the counselor's interests in treatment, but also has offered the opportunity to strengthen the therapeutic relationship through honest and advance discussion on pertinent issues.

Professional disclosure statements have also been referred to as informed consent statements (Carlisle & Neulicht, 2010). For the field of rehabilitation counseling, informed consent first appeared in the 1987 CRCC code of ethics as a mention. By 2001, the CRCC code of ethics expected that informed consent for clients occur at the beginning of services and then throughout as needed. This expectation covered written and oral methods, but no language was included to require the consent be in written form. Next, the CRCC Professional Code of Ethics was revised and issued in 2010 with the most significant changes to informed consent (Carlisle & Nuelicht). Informed consent was now required both orally and in writing in review with the client. This requirement is expected at the start of services and should be revisited as needed throughout the counseling relationship. Elements required within the consent include: "qualifications, credentials, experience, purposes, goals, techniques, limitations, the nature of the potential benefits and risks of the service, confidentiality and limits to confidentiality, contingencies for service continuation should the counselor become incapacitated, fees and

billing arrangements, records preservation and release policies, as well as risks associated with electronic communication and legal issues” (Carlisle & Nuelicht, p. 220).

Professional disclosure, informed consent and informed choice are interrelated concepts and are grounded in the ethical principle of autonomy (Blackwell & Patterson, 2003). There are typically three critical, necessary, and preexisting elements that most descriptions of informed consent possess and differentiate it from the active-informing process of professional disclosure: a) information, b) voluntariness, and c) competency (Shaw and Tarvydas, 2001; Pinals, 2009). These three components are generally related to Beauchamp’s discussion of conditions present (i.e. understanding, intentionality, and voluntariness) in the theory of autonomous action (2010), and Cottone and Tarvydas’ (2007) three legal elements of informed consent: capacity, comprehension and voluntariness. Information refers to the type and quality of information being provided to the client. Intentionality refers to the client’s acquisition of the necessary information in relation to the necessary aspects and consequences of the action. The information should be straightforward and easy to understand. This should at the very least include information on the nature and purpose of the services provided, in addition to the potential risks and benefits of those services and the availability of any alternatives. Thus, it is necessary to have sufficient information and have the ability to understand it (comprehension).

Voluntariness refers to not subjecting the client to any kind of pressure or coercion in the process of making a decision regarding services, that is, to act freely in the decision-making process (Cottone & Tarvydas, 2007). Coercion can generally be thought of as an external influence, that is, the process of one person’s actions affecting the actions of another (Beauchamp, 2010). Also related to coercion in terms of external influence on the individual is that of persuasion (counselor giving reasons to follow through with a procedure when the client

is ambivalent) and manipulation (the counselor non-persuasively getting the client to do what he or she wants through altering the client's understanding of a situation in an attempt to motivate them to do what the counselor wants) (Beauchamp). These forms of influence can be subtle through rushing a client to sign a consent form, providing biased examples to sway the client, not providing alternative forms of treatment, or acting as though the client is incapable of making a sound decision independently (Shaw & Tarvydas, 2001).

Competency is a critical concept in informed consent in that it refers to the capacity with which an individual needs to accurately perceive the situation, evaluate potential solutions, and reach a decision based on sound rationale (Shaw & Tarvydas, 2001). This requires planning in the form of understanding the implications of a series of events that would be utilized in order to complete an action (Beauchamp, 2010). For intention to be present, the client must possess a sense of the concept of the act, even though the outcome may not match expectations, which speaks to how the client may assess the odds of success of a series of actions intended to yield an expected outcome. Further, the ability to make a rational decision is connected to the client's capacity (Cottone & Tarvydas, 2007). This means the act is motivated by a sense of confidence in one's own actions in reaching the intended outcome. This concept is important due to the difficult nature of agreeing on what competency is. There are differences between legal and clinical competency, the former being connected to legal statute and the latter to subjective clinical opinion. Further, the perception, or determination of competency may be driven by cultural differences, developmental disabilities, or change over time, declining or being altered through the aging process, catastrophic injury, or acquired mental illness.

While these three components generally comprise autonomous action, there are consequences based on the various degrees with which each is intrinsically possessed and

successfully implemented. Client competence is a necessary condition to making decisions autonomously and conversely, any limit to client competence also further limits the ability to appropriately consent to a service when certain elements of capacity, comprehension, or voluntariness are compromised, or affected due to dementia, psychological trauma, traumatic brain injury, intellectual disability, or other similar conditions (Cottone & Tarvydas, 2007). Thus, it is important to consider the assessment of competence prior to initiating any form of informed consent and informed choice with the client.

There are no well-accepted standards for the determination of incompetency, but the criteria should be achieved through the capacity with which the individual possesses and their appropriate degree of individual autonomy and rational decision making (Appelbaum, Lidz, & Meisel, 1987). Competence usually is focused on an individual's ability to make rational and deliberate decisions based on a clear understanding of their circumstances and the implications these decisions have on their well-being (Ford, 2006). Counselors should maintain an up to date knowledge regarding the changing research regarding cognitive capacity and related decision-making processes (Pope & Vasquez, 2011). Individuals experiencing physical, cognitive, or emotional impairment may be too vulnerable and not fully capable of understanding the implications of the proposed treatment or research and may require an individual who has been legally authorized (i.e. competent by proxy) to consent for the individual. This person is referred to as a legal guardian or personal representative and engages in what is called proxy consent (Ford).

However, clients that may not have the full capacity to consent remain individuals that should be engaged in the decision-making process. Each individual still has his or her own likes and dislikes, preferences and non-preferences and their opinions should still be solicited,

recognized, and respected, provided they are not a danger to themselves or others (Ford, 2006). This also means that the individual should still be afforded the respect of hearing the same information that his or her personal representative would receive regarding the benefits and risks of participating in services or research. The counselor should also make sure that services are delivered in such a way as to be tailored to the client's abilities; these include considering the client's: a) verbal (oral and reading) and cognitive abilities, b) ability to see and hear, c) emotional state, d) primary spoken language, e) degree of fatigue or illness, and f) distractibility or attentional ability (Cottone & Tarvydas, 2007). The individual's agreement to participate, or decline (i.e. informed refusal) after being given this explanation in the most appropriate configuration, is referred to as *assent*, and if the individual who was deemed incompetent does not agree, their wishes should still be respected and as long as the lack of treatment does not cause themselves or others substantial harm (Ford). In the case of informed refusal, the counselor should ethically address the situation by determining if they should proceed, even if legally it is appropriate to do so (Cottone & Tarvydas).

Professional Disclosure's Conceptual Link to the Therapeutic Relationship

The facilitation of client empowerment, choice, and independence are well-connected and important rehabilitation components (Carlisle & Neulicht, 2010). An empowered individual is someone who is able to make choices and have autonomous control and independence in his or her life (Kosciulek, 2007). External influences such as agency regulations, lack of accessibility, poor support quality and stereotypical attitudes have had a limiting effect on decision-making for individuals with disabilities. A functional working alliance between the client and counselor is considered a vital and necessary element for positive change (O'Sullivan, 2012). One key to therapeutic success has been found to be related to having an open and honest exchange with the

client (Kress, Hoffman, Adamson, & Eriksen, 2013). Colling and Davis (2005) stressed that the basis of disclosure and informed consent is to ensure that the client and counselor, in engaging in the therapeutic relationship, should be all inclusive with information. Further, the rehabilitation counselor should use all necessary methods (i.e. professional disclosure) to assist the client in understanding his or rights and responsibilities as well as the agency's.

The informed consent process has a connection to the therapeutic alliance, and attempts by the counselor to inform the client and engage them in shared decision making should have a positive effect on the establishment of trust, openness, respect and an enhanced therapeutic relationship. Pinals (2009) notes that if used properly, informed consent can enhance the therapeutic alliance and help improve treatment follow through. Lidz, Appelbaum and Meisel (1988) discuss a process model of informed consent as an integral and continuous part of the relationship between the client and the counselor as needing to be embedded in the treatment process; it is intended to be continuous and ongoing. The process model assumes that the client is an active member in decision making regarding their treatment. As decisions are not made at only one point in time, the expectation in the process model is that the decisions between the client and counselor are being continually made, which necessitates an ongoing dialogue. This ongoing dialogue should be an opportunity to discuss expectations, values, illness questions and the benefits, risks, advantages and disadvantages of available treatments.

Through ongoing dialogue (i.e. the process model) the client-counselor relationship is thought to be enhanced and client autonomy and greater gains in the therapeutic alliance are maximized (Pinals, 2009). The counselor should consistently ensure that the client is presented with and has an understanding of the type of services being provided, certain limits to the relationship (i.e. confidentiality) and client rights and responsibilities (Shaw & Tarvydas, 2001).

Research supports that use of informed consent processes tend to be beneficial by reducing clients' anxiety, improving recovery more quickly, enhancing awareness of risks associated with the treatment, and follow through with the treatment plan (Pope & Vasequez, 2011).

Handelsman (1990) conducted a study that looked at the impressions the client had of their psychologist when written information about treatment was provided, in addition to experience level. The results of the study supported experienced psychologists that used informational forms early in treatment with their clients were viewed more favorably and seen as more trustworthy. Conversely, those less-experienced psychologists that did not use informational sheets were rated less favorably. Lastly, when less-experienced psychologists used the forms, clients rated them more favorably and saw them as more experienced.

Somberg et al. (1993) surveyed the beliefs and practices of therapists concerning the use of informed consent processes. The study had found the therapists had indicated a number of reasons for not including professional disclosure in their regular practice. Typically, if the therapist perceived importance of an issue over another (e.g. limits of confidentiality versus treatment alternatives), they were more likely to discuss it with the client. The study suggested that the therapist's impression of the importance of an issue and whether the client should be informed was a prevailing method of how the client was included in the decision-making process, the decision was not guided by any ethical practice. Mullins and Roessler (1998) completed a study where the focus was to identify high priority rehabilitation counseling tasks related to improved placement rates for individuals with severe disabilities. Respondents in the study rated the fourth lowest element as ensuring that clients understood their rights and responsibilities in the rehabilitation process (informed consent). Shaw, Chan, Lam, and McDougal (2004) also found that rehabilitation counselors did not commonly use a written

professional disclosure statement with their clients. These studies point to the importance of infusing the informed consent process throughout service delivery, given its relative absence as recent as 10 years ago.

While some reasons for not informing the client included concerns for client welfare or the timing associated with completing an assessment and having the information necessary to proceed, the importance of professional disclosure as a catalyst to informed consent has clearly evolved to be recognized as a key ethical component to counselor practice. Clients whose role in decision making matched their preferred role were more likely to be satisfied in services (King & Moulton, 2006). Client involvement in decision-making improves client autonomy, inclusion and overall well-being. Counselors have indicated that openness, caring and empathy are important personal characteristics (Mullins & Roessler, 1998), and when adding the development of knowledge and skills to understand client needs, the roles of the therapeutic relationship and professional disclosure present an opportunity to the rehabilitation counselor to become the evidence-based practice that contributes to improved outcomes for the client.

A central factor to successful rehabilitation counseling practices is an effective working alliance (Kosciulek & Wheaton, 2003). This is an excellent predictor for outcomes when there is agreement and collaboration between the client and counselor on goals. When the rehabilitation counselor employs professional disclosure with the client, they are engaging the client in an empowerment process. Rehabilitation counselors need to ensure that the client clearly understands the type of services being provided, and the benefits, risks, and limitations contained therein (Shaw & Tarvydas, 2001). Professional disclosure should be employed throughout the service delivery process. It is an important means of sharing power with the client and has significant implications for the delivery of clinical services, especially for individuals with

severe disabilities who have experienced the disenfranchising effects of stigma, marginalization and prejudice relating to their condition (Somberg et al., 1993). Individuals with disabilities have often been denied the chance to control the most basic aspects of their lives (Kosciulek, 2004). Control has often been restricted by external influences such as agency regulations, poor supports, or stereotypical attitudes. This illustrates that informed choice is a construct that has important implications on ethical, clinical, and professional development grounds.

Professional Disclosure's Place in Rehabilitation Counseling Ethical Principles

Rehabilitation counselors have received increasingly sophisticated guidance regarding ethical standards via the 2010 CRCC Code. The Code brought more clarity to expectations on client informed consent. Rehabilitation counselors are called to exercise sound ethical decision-making in all situations. They should gather, analyze, think through, and plan around the determination of the most ethical course of action when presented with challenging scenarios (Shaw & Lane, 2008). Tarvydas and Barros-Bailey (2010) conducted a study of the results of a survey of the CRCC Ethics Committee which were used in large part to contribute to the CRCC's Code Revision Taskforce and Ethics Committee in the CRCC Code revisions that became the now most current (replacing the 2001 Code) 2010 Code. From the qualitative analysis of the responses, the overall 2001 Code sections where the most ethical dilemmas were contained were; A. Counseling Relationship, B. Confidentiality, and D. Professional Responsibility. These three Code sections accounted for 80.3% of the responses for the all Code sections, and thus, possessed the issues the respondents felt were critical issues within rehabilitation counseling. The top most received responses for ethical incidents and dilemmas that had resulted in a citation: 1) client welfare, 2) right to privacy, and 3) client rights. The 2010 Code was the result of the best empirical evidence available on ethical practice in

rehabilitation counseling and featured enhanced standards relating to professional disclosure and informed consent and roles and relationships with clients, among others (Tarvydas, Cottone, & Saunders, 2010).

Empowerment, choice, and independence are directly related to ethical principles (Carlisle & Neulicht, 2010). The 2010 Code treats professional disclosure and informed consent much more extensively, and as a result, affords the rehabilitation counselor a greater opportunity to establish a strong therapeutic relationship with the client through these processes. When taken on the whole, professional disclosure applies to beneficence (doing good) and nonmaleficence (doing no harm) through the promotion of client choice, justice (a group of norms for the fair deliverance of benefits, risks and costs) in recognizing all individuals have choice, regardless of condition, fidelity (adherence to one's promises, loyalty) through promotion of available choice, veracity (commitment to truth and honesty) through honesty in representation of choices, and autonomy (respecting the decision-making capacity of autonomous persons) through the provision of the information necessary to make an informed choice (Cottone & Tarvydas, 2007; Carlisle & Neulicht, 2010; Kress et al., 2013). Parent (as cited in Kosciulek, 2004, pp. 3-4) stated that "it has become increasingly evident that the powerlessness and lack of self-direction often felt by people with disabilities are more frequently related to the attitudes and practices of caregivers, service providers...rather than to any limitations or impairments resulting from the disability itself."

Theoretical Framework

There are a number of different theoretical frameworks that focus on aspects of the therapeutic relationship, professional disclosure, and consumer empowerment. Kosciulek and Merz (2001) investigated the consumer-directed theory of empowerment (CDTE) to assess the

level of consumer direction in a community rehabilitation program, including consumer community integration, empowerment and quality of life. To add additional empirical data, Kosciulek (2005) continued critical evaluation of the CDTE, by testing the structure of the framework in a vocational rehabilitation context. The CDTE model included the model variables in the Kosiulek and Merz study, but neither studied rehabilitation counselor influence or considered the working alliance. Kosciulek (2005) noted in his study that the study results suggested counselors focus on increasing consumer direction. Kosciulek (2007) also tested the hypothesized structure of the Theory of Informed Consumer Choice in Vocational Rehabilitation (ICC-VR Model). The model laid out the hypothesis that informed choice in the vocational rehabilitation process would lead to better consumer outcomes through the interactions of organizational performance, informed consumer choice and consumer satisfaction. Breeding (2008) conducted an experiment to study the effect of work interest profiling in vocational assessment on career decision self-efficacy and work locus of control as indicators of client empowerment. The study included conceptualizing the effect of model variables such as the working alliance and informed choice that led to empowerment in rehabilitation counseling. Breeding recommended that future research needed to address empowerment on vocational development given its vital concern to individuals with disabilities. Kosciulek and Wheaton (2003) included the rehabilitation counselor in his rehabilitation counseling empowerment framework. In this model, it was hypothesized that the presence of an effective counselor-client working alliance was a necessary condition for the facilitation of informed choice, and that this was one ingredient for increasing client empowerment.

Houser et al. (2000) suggested that the Social Role Theory could be used to enhance the use of empowerment concepts in rehabilitation counseling. The social role is considered a part

of an overall system of an individual that is organized around expectations in relation to a set of values that direct interaction with one or more alters the relative roles. Houser et al. included a discussion on the contextual view which explains that there is a person-environment interaction which influences outcomes. The Social Role Theory recognizes that interactions are sequenced into a series of interactions between persons and their environment and are composed of patterns. The prevailing intention of this theory in rehabilitation counseling is to empower clients in their relative environments where the rehabilitation counselor and client are equally involved in decision-making processes. Thus, the basis for the Social Role Theory is to enhance client empowerment through hierarchically-neutral counselor-client interactions in the appropriate context which is intended to alter the role of each, thereby enhancing client empowerment.

Lastly, the theories of planned behavior (TPB) and reasoned action (TRA) were discussed by Perkins et al. (2007) as viable in the examination and change of clinician behavior. Both theories are built on the idea that the behaviors an individual performs can be predicted from the individual's intention to behave in a certain way. In the theory, there are three factors internal to the clinician: attitude, subjective norms, and perceived behavioral control. Attitude is the individual's perception about the costs and benefits of engaging in a behavior. The second factor, subjective norms, consist of two parts; beliefs about the behavior and what the individual perceives that others think the individual should do, and second, the individual's level of motivation to follow through with this perception from others. The third factor refers to self-efficacy in that the individual believes that he or she can carry out the behavior with a positive outcome. These three factors lead to behavioral intentions, or the individual's intent to behave in a certain way, or not behave in a certain way based on whether or not the individual thinks they can succeed. Lastly, the behavior is initiated. The TPB and TRA as presented in this proposal

are intended to focus on the rehabilitation counselor behavior relative to their theorized orientation to the real relationship component within the therapeutic alliance with the client.

Thus, given that no one model fit the focus of this proposal, the intent was to create an amalgamated model that capitalized on the theories of planned behavior, reasoned action and social learning, and incorporated Kosciulek and Wheaton's (2003) rehabilitation counseling empowerment framework. The framework (see Figure 1), is entitled the *Lewicki Rehabilitation Counselor-Initiated Relational Model of Informed Choice and Transferred Empowerment*.

Model

The theories of TPB and TRA as presented by Perkins et al. (2007) have been incorporated into the Lewicki Model of Rehabilitation Counselor-Initiated Transfer of Empowerment and Relational Informed Choice (ReC-ITERIC, or "ReCITE") (see Figure 1) and is conceptualized as intrapersonal, with the rehabilitation counselor. However, prior to the rehabilitation counselor internal processes, external influences, such as the counselor's place of employment, the CRCC or applicable laws, affect practice and will also impact the rehabilitation counselor's behavior in implementing informed consent.

Relative to professional disclosure, the rehabilitation counselor brings his or her expected values (attitude) to the client-counselor relationship and consists of perceptions around the advantages and disadvantages of initiating a behavior, potentially in this case, the ability to engage the client in professional disclosure. Secondly, the rehabilitation counselor will consider that the client comes with the perception of what might be expected in the interaction and whether the rehabilitation counselor is sufficiently motivated internally to meet this perceived client expectation (subjective norms). Thirdly, the rehabilitation counselor possesses beliefs around self-efficacy, or the belief that he or she can successfully perform the behavior that has

been considered (perceived control-around successful initiation of professional disclosure and the resulting informed consent).

Next, the ReCITE Model incorporates the real relationship component of the therapeutic relationship as presented by Gelso and Carter (1994). The real relationship is said to exist from the first contact between the client and counselor and reflects the personal connection between the two (Lo Coco et al., 2011). The way the real relationship results in positive outcomes is through the beneficial effect of being connected to another individual who is invested in the other's well-being. To this individual, the investment is perceived, understood, and trusted as genuinely existing (Wampold & Budge, 2012). Thus, in the ReCITE Model, the real relationship is conceptualized as the rehabilitation counselor's orientation toward, or belief in the value of the strength of the therapeutic relationship and use of it as a tool that has additive and positively impactful influence on client service outcomes.

The TRA and TPB theories are reintroduced where the rehabilitation counselor then makes a determination and intends, through the real relationship orientation, to interact in such a way as to maximize the relational features of genuineness and realism. Marmarosh et al., (2009) described genuineness as the ability and willingness to be an authentic individual, and realism as being able to see the individual realistically rather than an idealized version of the individual. Lastly, the rehabilitation counselor initiates the inter-personal behavior with the client.

The working alliance is an important factor to successful rehabilitation counseling service outcomes when there is agreement and collaboration on goals between the client and counselor (Kosciulek & Wheaton, 2003). The rehabilitation counselor should utilize professional disclosure to empower the client in exerting greater control and influence over their choices and directions (autonomy) (Kosciulek and Wheaton). When professional disclosure is used with the

client, an empowerment process has been concurrently activated alongside the therapeutic relationship. This professional disclosure process ensures that the client is provided with ongoing dialogue and explanation regarding the benefits, risks, and limitations of services (Shaw & Tarvydas, 2001), resulting in informed choice. It is an important means of sharing power with the client and has significant implications for empowerment. The client-counselor therapeutic relationship is conceived as having an overlapping relationship with client informed choice. Thus, the area of overlap between these two constructs is referred to as *transferred client empowerment*.

Specifically, the overlapping circles, as mentioned, are thought to be concurrent processes. That is, one construct is theorized to influence the other, but directionality is not an issue in the ReCITE model, rather that both are interacting in a positive fashion to create a transfer of empowerment. The client empowerment is considered to be transferred because the study focus is in looking at the rehabilitation counselor use of the real relationship expression in conjunction with the ethical process of informed consent and informed choice use, which is also rehabilitation counselor initiated. Empowerment is then “transferred” to the client, where the process becomes iterative, or repeated; affording an opportunity to refine and optimally address service outcomes, and thus, “ReCITE” the empowerment process. According to Houser et al. (2000), the Social Role Theory is organized around expectations in relation to a set of values that direct interaction between individuals as roles change over time, based on social learning inherent in the interaction. The model explains that these interactions evolve between the individuals (rehabilitation counselor and client), their environment, and a relationship is developed based on learning about the client’s expectations around service outcomes.

Lewicki Model of Rehabilitation Counselor-Initiated Transfer of Empowerment via Relational Informed Choice (“ReCITE”)

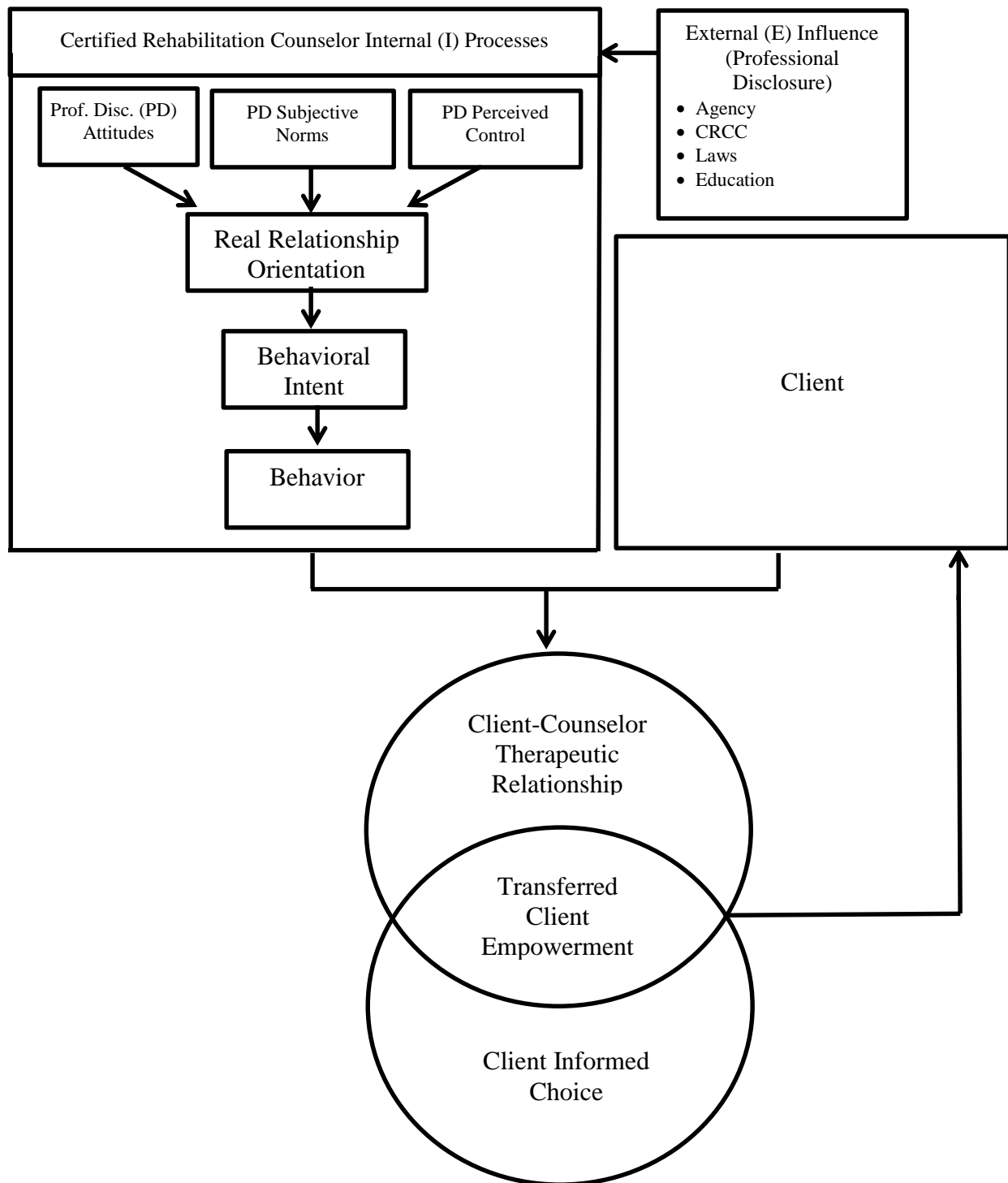


Figure 1: Framework for conceptualizing the role of the real relationship and professional disclosure in client empowerment

Summary

The literature has established that the presence of a positive working alliance between a counselor and client relates to improved outcomes and is considered a critical element for positive change (O'Sullivan, 2012). Variables such as level of education and experience appear to relate to improved alliance, and in general, less has been known about the traits of rehabilitation counselors who play an important part in facilitating client choice and the therapeutic relationship. Shaw, et al. (2004) surveyed the rehabilitation counselor's use of professional disclosure practices and found that many kinds of information considered important in the informed consent process was not disclosed to clients, particularly at the beginning of services. Carlise and Neulicht (2010, p.223) note; "By transferring knowledge to someone who has the capacity to consent and is provided the opportunity for voluntary choice, rehabilitation counselors demonstrate the highest standards of practice and enhance not only evaluation experiences but the client-counselor relationship."

There have been no known studies since the Shaw et al. (2004) study that looked at rehabilitation counselor use of professional disclosure, which precedes ascertaining the influence of the 2010 Code and its changes to rehabilitation counselor practice. Further, while studies have focused attention on the therapeutic or working alliance, there are fewer studies that have looked at the relationship component within the alliance, particularly factors that relate to rehabilitation counselor traits that contribute positively. This was the theme of Kosciulek and Wheaton's (2003) discussion on stressing the importance of the development of research that reviews the alliance and professional disclosure process in light of empowering the client. Breeding (2008) stressed that rehabilitation counselors and agencies should make client empowerment a priority by providing the client the necessary information and knowledge

through proactive interventions. Finally, there appears to be a research opportunity for the field of rehabilitation counseling to gain knowledge and insight into the practices of rehabilitation counselors who are employing professional disclosure practices with adherence to the 2010 Code and the effect this has on the therapeutic relationship and ultimately, the transfer of empowerment to the client.

Chapter Three

Methods

This study, through the online administration of two surveys, sought insight into CRC perceptions regarding the real relationship component of the therapeutic alliance and opinions on use of professional disclosure processes. The chosen method for the study was quantitative in order to address an in-depth statistical analysis of the Likert-scale response items in the two instruments. Open-ended questions were used to provide an opportunity to address CRC responses in a qualitative capacity and to identify any potentially unaddressed areas of importance that could be the basis for future research. The study used an ex-post facto design. The ex-post facto design was used due to the recognition that there are many extraneous variables that were operating on the dependent variables of this study. The predictor, or independent variables in this study, according to the ex-post facto design, have occurred at some point in the past and are not under the control of the researcher, and thus, the effects of these independent variables were studied in light of the fact that they have already occurred or are in the process of occurring (i.e. age, gender, race/ethnicity, education, experience, job setting, and job title). This design has been considered one of the most frequently utilized in rehabilitation counseling research (Bolton & Parker, 1998).

It is felt that the study results will provide further insight into the value of the CRC's use of the real relationship and professional disclosure that are used and to identify and prioritize the potential for future research to continue addressing the interactive and relational qualities of the CRC as a form of possible evidence-based practice. The study results have implications for educators, counselors, administrators, and policy-makers in light of the identification of training needs and best practices. This methods chapter will address the questions of the research, the

participants involved, the sampling process, data collection instruments and procedures, independent and dependent variables, reliability and validity, data analysis procedures, study limitations and any anticipated ethical issues.

Research Questions

The study focused on exploring the CRC's perspectives on real relationship components of the therapeutic alliance with the client as well as the potential relationship these have with professional disclosure in the theorized enhancement of empowerment in the client. The research questions were as follows:

1. How do the following rehabilitation counselor demographic characteristics, when considered simultaneously predict/affect the rehabilitation counselor's use of informed consent?
 - a. The age of rehabilitation counselor.
 - b. The gender of the rehabilitation counselor.
 - c. The race of the rehabilitation counselor.
 - d. The education level of the rehabilitation counselor.
 - e. The experience level of rehabilitation counselor.
 - f. The job setting of rehabilitation counselor.
 - g. The job title of rehabilitation counselor.
2. How do the following rehabilitation counselor demographic characteristics, when considered simultaneously predict/affect the rehabilitation counselor's use of the real relationship?
 - a. The age of rehabilitation counselor.
 - b. The gender of the rehabilitation counselor.

- c. The race of the rehabilitation counselor.
 - d. The education level of the rehabilitation counselor.
 - e. The experience level of rehabilitation counselor.
 - f. The job setting of rehabilitation counselor.
 - g. The job title of rehabilitation counselor.
3. How well do rehabilitation counselors with more positive scores on the professional disclosure survey-modified predict positive opinions on use of the real relationship-therapist inventory with the client?

Participants

The participants of interest were rehabilitation counselors who had attained their CRC designation. The Commission on Rehabilitation Counselor Certification (CRCC) is the largest rehabilitation counseling organization and currently has over 16,000 certificants (About CRCC, n.d.). It is one of the longest standing and most established credentialing bodies in the counseling profession (Saunders, Barros-Bailey, Chapman, & Nunez, 2009). The CRCC sets the standard for quality rehabilitation counseling services through this certification program. CRCs are required to renew their certification every five years, either through re-examination or by meeting specific ongoing educational requirements. The Certified Rehabilitation Counselor Examination (CRCE) has changed and improved over time with contributions from empirical research and exam development processes (Saunders et al.). This refinement process is ongoing in order to allow for the CRCE to maintain and enhance its validity and reliability. The CRCE process ensures that in awarding the CRC credential, only the most well-prepared rehabilitation counselors will hold this designation. The demographic characteristics of the CRC respondents

will also be gathered. Thus, the CRC as a participant in this study is most representative of the profession's goals, efforts and ethical practices.

Sample Size

An appropriate sample size needed to be considered for this study. First, in order to generalize the results to the greater population, there needed to be an unbiased sample (Muijs, 2011) that is representative of the CRC population. The CRCC allows for the request of the release of CRCs whom have agreed to have their contact information made available for research projects in accordance with the project design (CRCC, 2014). A request was made of the CRCC to allow the use of CRC contact information for the purpose of conducting the research. This sample selection process was randomized, per CRCC processes and as a result, the sampling design was considered single stage in that CRCC, in having access to the information, sampled their database directly in one stage (Creswell, 2009) and provided the opportunity to generalize to the greater CRC population. In order to calculate the sample size, an a priori determination was completed as it was more important to consider the power of the test *before* collection of the data (Hinkle, Wiersma, & Jurs, 2003). Power was considered before data collection to address the probability of failing to reject the null hypothesis when it is false (Type II). The minimum sample size was calculated to be 128 when taking into account alpha ($\alpha=.05$), the power ($1-\beta$) of the test (.80) and the effect size (.50). According to Cohen (1992), an effect size of .50 is considered medium. The sample size of 128 provided the greatest sensitivity in the data analysis that the outcome was actually due to interaction from the independent variables (Creswell, 2009).

Data Collection Instruments

The concept of common factors and the client-counselor alliance can be traced back to as early as the mid-1930s (Rozenweig, 1936). The alliance has been one of the most extensively researched subjects in the psychotherapy research literature. A database search using key words like alliance, helping alliance, working alliance, and/or therapeutic alliance yielded over 7,000 items (Horvath, Del Re, Fluckiger, & Symonds, 2011). Given the view of the importance of the therapeutic alliance, the relationship between therapist and client was a primary focal point for further review.

Gelso and Carter (1985) placed a focus on the strength of the relationship component of the therapeutic alliance in counseling. The client-counselor relationship has been viewed as an extremely important component in treatment, but the real relationship between the client and the counselor appears to have been the least examined (Gelso & Carter, 1994). In review of the rehabilitation counseling literature, there have been no instruments used to review the potential impact of the real relationship on the client in service provision. This was further underscored by the relative absence of instruments in rehabilitation counseling literature that have reviewed the counselor's attitudes toward the real relationship. Gelso et al. (2005) developed and validated the Real Relationship Inventory-Therapist Form (RRI-T) to address the clinician's perspectives on this component within the therapeutic alliance.

Real Relationship Inventory-Therapist Form.

Gelso et al. (2005) defined the real relationship as; "the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that benefit the other" (p. 641). The RRI-T (see Appendix B) is a 24-item inventory that contains statements to which the clinician responds on a five point Likert scale (i.e. *Strongly Agree=5 to Strongly Disagree=1*). The RRI-T reduces the 24 items

into two-grouped domains, *Genuineness* (the ability to be authentic and who one truly is) and *Realism* (the perceiving of the other in ways that befit him or her, rather than as idealized representations). The construct also includes two other aspects that are each embedded in genuineness and realism: magnitude and valence. Magnitude refers to how much genuineness and realism are present in the relationship. Gelso et al. believe that the magnitude of genuineness should increase as work progresses and the magnitude of realism should be greater at the beginning and end points of treatment. Valence refers to how positive or negative the feelings are of the individual toward the other. Positive feelings, for example, include liking, caring, non-romantic love, and respect. Negative feelings are largely the opposite of the positive feelings. Combined, magnitude and valence refer to the strength of the relationship.

In the initial validation of the instrument, the coefficient alpha values were; Realism=.79 and Genuineness=.83, and total score=.89. The coefficient alpha is a measure of internal consistency, or the degree to which the set of components is interrelated (Rykov & Marcoulides, 2011). The reliability coefficient is the means by which the precision of an instrument may be compared (Thorndike & Thorndike-Crist, 2010). Reliability is important, but it is only as a needed condition for the measurement of validity, and generally the higher the reliability, the more confidence that it measures with consistency.

Validity is the most important property for a test to have (Thorndike & Thorndike-Crist, 2010). The RRI-T was validated against other measures that have also been purported to measure the working alliance (Gelso et al., 2005). The subdomains Genuineness and Realism in addition to the total scores, all correlated significantly ($p<.05$) with the Working Alliance Inventory (WAI), the Session Evaluation Questionnaire Depth and Smoothness subscales, Emotional insight and Intellectual insight. Lastly, a confirmatory factor analysis of the two

domains was reviewed to test whether a two-factor model best fit the data. The analysis resulted in the determination that distinguishing between the two domains was actually not necessary given an interfactor correlation of .986 in the two-factor model. Despite this high correlation, Gelso et al. recommended maintaining the two subscales due to the thinking that these two domains could potentially behave differently over time. For purposes of this current proposal, the recommendation to combine the two subdomains will be followed.

The RRI-T contains six items that reflect the ratings of the counselor's own reactions, 11 items include ratings of their clients' reactions, and 7 reflect ratings of the client-counselor relationship (Gelso et al., 2005). The 24 items yielded an overall mean of 3.75 (on a 1 to 5 scale). Gelso et al. utilized the five-point Likert scale due to the thinking that the real relationship in practice should tend to be scored more positively. The researcher has considered this rationale and will use the same scale.

In review of the questions on the RRI-T, it was decided to not change any of the questions in any way as the inventory is intended to review clinician attitudes toward the real relationship. The certified rehabilitation counselor is one such clinician who comes from a long history well-connected with the clinical helping profession. The Rehabilitation Counseling Consortium (as cited in Maki & Tarvydas, 2010, p.4) states: "A rehabilitation counselor is a counselor who possesses the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with persons with disabilities to achieve their personal, social, psychological, and vocational goals." Three qualitative questions will be added at the end of the RRI-T: "What client and counselor factors do you think contribute to a therapeutic relationship?", "How should the rehabilitation counselor use these?", and, "How do you feel the

professional disclosure affects the therapeutic relationship with the client?” to explore additional feedback the CRC may have.

Importantly, the RRI-T is an instrument whose authors have provided upfront permission to use the instrument (Gelso et al., 2005). The form states that test content may be reproduced and utilized for non-commercial research and for educational purposes without seeking written permission.

Professional Disclosure Survey-Modified.

The professional disclosure survey (PDS) was used by Shaw, et al. (2004) to examine the professional disclosure practices of rehabilitation counselors in the public and private sectors. This form is the product of the efforts of the CRCC and as such, permission is required before utilizing it. The PDS was used with 261 CRC respondents in examining professional disclosure practices, which pre-dates the 2010 CRCC Code. Since this time, there have been no studies involving the effect that the 2010 CRCC Code (given its emphasis on elevating the importance of informed consent) has had on CRC professional disclosure.

The process for the study involved gathering data for five sections: 1) demographics, 2) items representing what might be included on disclosure forms (including how often in the service process), 3) order and rank reasons for use (or not) of written disclosure forms, 4) CRC opinions regarding professional disclosure, and 5) questions related to state mandates on professional disclosure.

The PDS instrument was developed after a comprehensive review of counseling, psychology, and rehabilitation counseling literature on professional ethics, risk management and professional opinion (Shaw et al., 2004). The members of the CRCC Ethics Committee reviewed the instrument to determine the representativeness and appropriateness of the items as

they related to rehabilitation counseling professional disclosure. The reviewers possessed extensive rehabilitation counseling experience, or were rehabilitation counseling educators. This process was treated as a pilot study, to address recommendations for changes to the PDS. While the instrument has not received an empirically-driven validation process, this process appears to have met face validity expectations. Face validity, or the appearance of reasonableness, is not considered a sufficient condition for the use of an instrument, but it may be considered necessary when the voluntary cooperation of the respondents is important (Thorndike & Thorndike-Crist, 2010). If the respondents view that the instrument is being used for what it was stated its use was to be, this may assist the respondents in supplying more sincere responses.

Section Four of the PDS was of interest for this study. This was for two reasons; the first was the scale. The opinion scale of the PDS is a five-point Likert scale ranging from *1=high to 5=not at all*. The second reason for interest in the opinion scale of the PDS was that Section Two asks for responses that do not have a clear universal meaning, making the responses nominal data. Nominal data means that numbers take the place of names (Thorndike & Thorndike-Crist, 2010). The nominal data consists of responding to non-standard timeframes relative to client services (i.e. intake, plan development, treatment, and discharge) and (all clients, as needed, and not given). These categories represent a different data type and would not be amenable to an analysis with the responses on the RRI-T, due to the RRI-T Likert-scale data.

Section Four of the PDS contains 9 questions that asked respondents to rate their opinions regarding professional disclosure practice statements. The scale (*1=high, 2=somewhat, 3=no opinion, 4=not very, and 5=not at all*), does not match the scale proposed for the RRI-T, but the scale for the PDS opinion survey could be modified to accommodate and match the RRI-T scale with a 5-point Likert scale (*5=Strongly Agree, 4=Agree, 3=Neutral, 2=Disagree, and*

1=Strongly Disagree). A review of the 9 PDS opinion questions also appeared to be incomplete, likely because certain areas were already addressed in section two of the study. A decision was made to modify and expand the original 9 questions to 26 (see Appendix C). The decision was made to enhance the questions in order to keep the overall set of questions in the survey at a reasonable level (versus using the section two total of 43 questions alone), in that when considering the RRI-T (24 questions), the PDS (26 questions) and demographics (8), constitutes a total of 58 questions.

In addition to seeking approval from CRCC for modification of the PDS section four, and obtaining approval from the Michigan State University Institutional Review Board (IRB), the modified instrument was shared with university professors whose area of expertise included ethical issues and professional disclosure. The purpose for engaging this process was to seek feedback and utilize their input in a pilot review. Dong, MacDonald-Wilson, and Fabian (2010) indicated that the development of a survey instrument involved the following: identification of survey items from a comprehensive analysis of empirical studies on the reasonability of the construct of interest, input from a research team, and pilot testing of the instrument. Thus, the PDS-modified survey required further review in order to ascertain its full utility from a reliability and validity standpoint.

To address the validity of the modified instrument, the researcher presented a discussion on the influence in rewording the statements, the basis for adding the questions, and requested the input of experts with extensive knowledge in professional disclosure on the modified instrument and a brief pilot to review response characteristics. Thorndike and Thorndike-Crist (2010) noted that statements should be clear and brief and present only one idea. Edwards (1957), as presented by Thorndike and Thorndike-Crist (p. 363), created a list of suggestions that

have been found to improve summative attitude scale construction: 1) refer to the present, 2) avoid factual statements, 3) make sure statement can be interpreted one way, 4) do not use filler statements, 5) avoid universally endorsed statements, 6) include statements the cover the range of the construct, 7) keep wording clear and simple, 8) keep statements short, 9) statement contains one thought, 10) avoid absolutes like *all* or *none*, 11) use words like *only*, *just*, *etc.* with care, 12) statements should contain a simple sentence structure, 13) avoid difficult to understand words, and 14) do not use double negatives.

With the suggestions of Edwards' model (1957) in mind, the statements were reviewed and reworded. The results of the PDS study from Shaw et al. (2004) listed a brief report on the responses to nine inquiries into rehabilitation counselor opinion; the report did not include the specific questions, but rather a dialogue on what was asked. For example, the noted area stated; "participants agreed that professional disclosure is important" (p. 44). This was re-worded in the modified questionnaire to read: "The practice of professional disclosure in rehabilitation counseling is important." A similarly worded statement refers to disclosure in treatment as "useful." Next, the questionnaire refers to the client needing to know; this was re-worded for clarity to read "clients have a right to know about their treatment."

The next two statements were placed ahead of the original fifth question due to the typical flow of the beginning of services. "I verbally discuss professional disclosure with my clients", and "I provide written disclosure to my clients" were selected in this order due to the 2010 CRCC Code indicating throughout that informed consent be discussed (provided verbally) and information provided (written). While research has indicated providing professional disclosure throughout the treatment process, the beginning of treatment is critical to information sharing and informed consent. Next, an indication that Shaw et al. (2004) asked about the

comfort level of the counselor in discussing limits to confidentiality, the statement was changed to “I discuss limits to confidentiality in treatment” as the word “comfortable” appears to be a construct that is vague for a psychometrically sound interpretation of counselor opinions.

Shaw et al. (2004) also reported on responses to questions on the negative effects of treatment. To address attention to potential negative as well as positive outcomes from receiving, this was split into two statements as informed consent also consists of a discussion on benefits as well as risks (Carlisle & Nuelicht, 2010). As such, the statements read: “I discuss the possible risks (and separately, benefits) associated with receiving treatment.” This allows for the respondent to answer to each regarding their attitudes toward each. The next statement was an addition not originally represented in the section four part of the Shaw et al. report, but addressed survey flow. “I verbally discuss the alternatives to treatment” was chosen given its original representation in section two of the study in the risks/benefits domain.

The next two statements remained in the modified version and address the rehabilitation counselor’s perception of how the client might perceive the disclosure process. “Professional disclosure could affect my client’s willingness to disclose freely” and “professional disclosure portrays the rehabilitation counselor as cold and uncaring” were not substantively modified in any way that would change the meaning of the question. Additionally, “my employer enforces the practice of professional disclosure” was not changed. “The CRCC Code of Professional Ethics influences how I use professional disclosure” was added to look at the CRC’s opinion on whether the CRCC Code plays a role via external agency influence in informed consent practices in the course of their professional practice. The final survey element was also taken from a construct in section two of Shaw et al. (2004). Three qualitative questions were added: “*In general, how have informed consent practices positively affected services to clients?*”, “*In*

general, how have informed consent practices positively affected services to clients?”, and *“In general, how does professional disclosure affect the informed consent process?”* to further explore CRC feedback in an open-ended format.

The new modified PDS Survey (PDS-M) was then shared with a small group of experts with a high degree of familiarity to professional disclosure and informed consent elements. The purpose was to request from each individual their input and feedback on the modified PDS Opinion Survey to add to the potential for greater validity of the modified instrument. The research received the input and feedback and was integrated into a modified PDS Survey (PDS-M).

Lastly, to address the issue of instrument flow relative to the questions, the researcher sought one last layer of feedback from colleagues. This was issued to them via an online survey format (Qualtrics) with a request for their feedback. The feedback addressed and potentially improve upon statement flow and any final suggestions. Once this was received, the PDS-M was utilized as the survey gathered opinion on professional disclosure practices.

Procedures

The procedures for the study began with IRB approval due to research involving human subjects. The expectation was to receive IRB approval prior to requesting of CRCC an email list of potential CRC participants in the study. The CRCC required the following: a written research proposal that outlines the scope and purpose of the project, the request for the email list, the intended use of the email list, a detailed project timeline, a copy of Michigan State University’s approval of the IRB, and a copy of the instruments being used to obtain information for project completion (CRCC, 2014).

Next, the CRCC was requested to provide an email list containing a random sample of CRCs from the CRC database that represents those individuals that are willing to receive emails for the purpose of research (CRCC, 2014). While there are currently over 16,000 CRCs, only 11,000 have consented to receive emails with requests of this sort. Generally, email-based survey opportunities are less successful than regular mail-based surveys, theoretically because fewer individuals tend to read their email (Birnbaum, 2004). In more recent studies in the rehabilitation counseling field, response rates to online surveys ranged between 12% and 21% (Wood & Estrada-Hernandez, 2012; Zanskas & Strohmer, 2011). Birnbaum indicated that in psychological research, 22% is the typically expected response rate for internet-based surveys, but that it is possible to increase the response rate through reminder emails. Thus, it is thought that obtaining an email database of approximately 1,000 CRCs will satisfy the likelihood that the response rate will fall somewhere between 12% and 22% and arrive at the necessary minimum number of respondents in order to achieve the greatest statistical sensitivity and reduce the possibility of Type I (rejecting the null hypothesis when it is actually true) and Type II errors (accepting the null hypothesis when it is actually false) (Weinfurt, 1995).

An email was sent to each CRC on the list inviting them to participate in the research survey which was open for a period of one month, through Qualtrics (Qualtrics.com), an online provider of electronic survey data collection and analysis software. Since the CRCC was willing, the researcher arranged for one (1) continuing education credit to be awarded to those persons who participated and complete the survey. The email contained a link to the RRI-T and PDS-M survey, and an informed consent stipulation (Appendix E) to explain the purpose of the research, what was asked of the participant, the possible benefits and risks, privacy and confidentiality considerations, the right to participate or withdraw, compensation, if any,

connected to involvement in the study, and where to direct any questions or concerns. For reasons of thoroughness, the same informed consent statement was listed at the top of the survey and consent was considered obtained if the CRC proceeded with the survey.

The survey timeframe opened for a total period of one month. After one week lapsed, a second email reminder (along with thanks for those who had already participated) was sent out at the beginning of the second week, indicating the time remaining for the survey to remain open and the opportunity to participate. A third and final email was sent at the beginning of the fourth week indicating the closure date of the survey and prompting for one last opportunity to participate (along with thanks for those who had already participated). The survey was closed at that time and the data did not contain any individually identifiable information. The data was kept secure and password protected and accessible only by the researcher.

Variables and Data Analysis

Once the survey timeframe concluded, the data was imported from the Qualtrics database into the IBM Statistics Package for the Social Sciences (SPSS) Statistics version 20.0. Before the data analysis could be completed, the data was reviewed for errors, completeness and any missing values. First, the demographic data was analyzed separately from the two instruments to review the descriptive properties (mean, median, mode, frequency) of the respondents. Variables were named for appropriate reporting out of the data. The data between the two instruments is discrete (only certain values are present), in that both utilize a 5-point Likert scale, with values of *5=strongly agree, 4=agree, 3=neutral, 2=disagree, 1=strongly disagree*. Raykov and Marcoulides (2011) indicated to first run and analyze the associated observed score frequencies and histograms to note the overall distribution properties of the data. In observing distributions, it will be helpful to note how closely to normal the distribution is, while the majority of scores in

a normal curve are expected to fall around the center of the distribution, as movement away from this center occurs, there is greater variance or deviation (Field, 2005).

The data in the analysis was treated as interval in that the data was measured along a scale where the intervals were equal (Field, 2005). For questions 1.a.-1.g. and 2.a.-2.g., multiple regression analyses were used. Multiple regression is generally used when an attempt to predict a dependent variable (dependent variables for questions 1 and 2 include domain scores on the RRI-T and PDS-M) using two or more nominal variables (Grimm & Yarnold, 1995). Because the influence of each independent variable (demographic data) was not known, the following question was asked: Taking all the Xs (independent variables (IV)-demographics) together, how much better can we predict Y (dependent variables (DV)-scores on the RRI-T and PDS-M)? Next, upon review of these results, the R^2 estimate of total variance was reviewed to ascertain the potential variance explained by all of the variables taken together. The regression coefficient, b , was analyzed to seek insight into what happens to the dependent variable when the independent variable moves up by one. Thus, the analysis was able to look at the relationship of a one standard deviation increase in experience to scores on the RRI-T or PDS-M.

The final question was; “Do rehabilitation counselors that exhibit more positive scores on the PDS-M predict outcomes on the RRI-T?” A simple regression analysis was run with the third question to see if PDS-M predicts RRI-T use. This multiple regression analysis treated the demographic variables and PDS-M scores as IVs and RRI-T scores as the DV. The underlying theory was that rehabilitation counselors who place more emphasis on professional disclosure utilize the therapeutic relationship more effectively. The purpose of the use of the multiple regression analysis with this data was utilized to refine rehabilitation counselor knowledge regarding these questions.

In order to address the issue of PDS-M instrument reliability and validity a Cronbach's Alpha test was run to determine internal consistency, or the degree to which the parts within the instrument were correlated as measuring the same construct (Vogt, 2007). This correlation ranges from 0.0 (lowest) to 1.0 (highest). A practical measure of validity (the accuracy of the research), in the scope of this study is content validity. Content validity is concerned with whether the instrument is measuring what it says it is measuring. Vogt recommends that the method to address this is through obtaining the opinion of experts on the topic. Thus, this review, as was stated in the Data Collection Instruments section, occurred prior to the study, but was included in the subsequent analysis to report these results.

Study Limitations

The study design involved the survey of CRCs online. This meant that the potential limitations here include that there was no real control in place that would guarantee that the person who completed the exam was actually the targeted CRC. While this likelihood seems relatively small, it was worth noting as a possibility. Related to this was the chance that distraction during the survey administration that the CRC may encounter could affect their ability to complete the survey, to complete it fully and accurately, or to share it with other persons such that the other individual's opinion influences the CRC to answer differently.

The ex-post facto design was used due to the independent variables in this study having occurred at some point in the past and have not been under the control of the researcher, and thus, the effects of these independent variables is studied in light of the fact that they have already occurred (Bolton & Parker, 1998). This was considered a limitation due to the fact that randomized control trials are considered the highest in research quality and evidence (Chan et al., 2012).

Another limitation was that the study design could be limited in its overall scope, in that the conceptual components of empowerment are difficult to fully define and may not be apparently available to empirical examination (Daniels, 2002). However, the ongoing identification of the various conceptual components of empowerment in the literature served to add to the growing body of work and evidence that shed further light onto the latent constructs that exist within this area of research. Empowerment in this study was considered a conceptually connected construct in that through examination of the literature, it was implied that through the positive actions of the rehabilitation counselor, the client would experience a certain, yet unknown degree of empowerment. Thus, client empowerment was loosely related to the potential outcomes in this study, but strongly imply, as evidenced by a thorough literature review, that client empowerment was a potential outcome.

This research study also contained a key limitation identified by Gelso et al. (2005) that noted that the study exclusively looked at the counselor's responses to the RRI-T. In the therapeutic relationship, there also exists the client. Thus, the client evaluation of the same relationship (the Real Relationship Inventory-Client) was important to correlate with the RRI-T. For purposes of this study, this limitation was allowed due to the interest in reviewing rehabilitation counselor perceptions toward the relationship and the use of informed consent.

A final potential limitation was relative to the professional disclosure process, which involved the TPB and TRA through the attitudes, norms and perceived control of the rehabilitation counselor. The ReCITE model conceptualized the rehabilitation counselor as possessing these three qualities as the primary motivators for choosing to use professional disclosure effectively. The model may need further conceptualization for all appropriate

constructs to be fairly represented and measurable, i.e. behavioral intent as a concept requires further measurement attention in the model and was conceptually connected.

Chapter Four

Findings

As previously indicated in Chapter 1, the field of rehabilitation counseling has a responsibility to address client empowerment through the rehabilitation process and the use of informed choice (Breeding, 2008). A key trait in establishing the effectiveness of the rehabilitation counselor is measured by their ability to make relational connections with clients (Koch, McReynolds, & Rumrill, 2004). However, little is known about rehabilitation counselor professional disclosure use as a predictor of the therapeutic alliance. Thus, this study examined rehabilitation counselor orientation toward the cultivation of a genuine relationship with the client as being strengthened through the use of the professional disclosure process.

This chapter was organized in terms of steps taken toward computation of internal consistency reliability via Cronbach's coefficient alpha for the PDS-M, response rate, data screening procedures, respondent demographic description and comparison to CRCC data, the three research questions that were posed, and the types of statistical analyses that were used. The results were reported on the demographic characteristics as independent variables on the dependent variable, the RRI-T. Second is a discussion on the assessment of the internal consistency reliability of the PDS-M and a report on the results of the demographic characteristics as independent variables on the dependent variable, the PDS-M. Each of the first two research questions also included three qualitatively-based questions further exploring the topic areas; each area will also be reported as to the identified themes. Lastly, a report was made on the use of the professional disclosure process as a predictor of the therapeutic alliance.

The Statistical Package for the Social Sciences (SPSS), version 20.0 was used to conduct all analysis processes throughout this study. Multiple regression was used to analyze all three

questions. Multiple regression is appropriate to use when predicting a single continuous variable (the independent variable) using two or more continuous or categorical variables (the dependent variables) (Licht, 1995). Given the study had no previous concept as to which demographic variables would create the best prediction equation, a simultaneous multiple regression was used for the first two research questions (Leech, Barrett, & Morgan, 2015). The final analysis was a simple regression, with the RRI-T as the dependent continuous variable and the PDS-M acting as the predictor, or independent variable.

Internal Consistency Reliability of the PDS-M

Shaw et al. (2004) conducted a survey in order to ascertain the professional disclosure practices of rehabilitation counselors. The CRCC Professional Disclosure Survey (PDS) was developed by the authors after an in depth review counseling, psychology, and rehabilitation literature relative to professional ethics, including the use of professional disclosure forms. The survey was then forwarded to the CRCC Ethics Committee for review of the draft and input as to the relevance of the elements and how representative these were to the professional disclosure practices of rehabilitation counselors. Based on feedback from this review, the PDS was comprised of five sections that would explore these practices in detail. Section 1 of the PDS included demographics of the respondents. Section 2 included items that would potentially be on a professional disclosure form and looked at the circumstances and timing under which disclosure information would be provided. Section 3 sought a ranking for the use (or lack thereof) of informed consent with the client. Section 4 elicited responses regarding opinions on professional disclosure, and Section 5 explored respondent's requirements on professional disclosure from the state in which they were employed.

Section 4 was the area of focus for the further development of the instrument that became the PDS-M in this study. The rationale for developing this section into its own instrument included its use of a 5-point Likert scale, which is currently used by the RRI-T, allowing for comparison, as well as providing the basis for a comprehensive definition of the professional disclosure construct which was based on development of the instrument by practicing rehabilitation counselors or rehabilitation counselor educators with extensive clinical backgrounds as well as a review by the CRCC Ethics Committee (Shaw et al., 2004).

The CRCC is the owner of the Professional Disclosure Survey (PDS) instrument. Thus, the CRCC was contacted and subsequently provided permission to review and extract the Section 4 content for further development and use in this study. Appendix C includes the modified version of Section Four, resulting in the Professional Disclosure Survey-Modified (PDS-M) used in this study. In order to enhance the validity of the PDS-M, the instrument questions were cross-walked to the original Section Four questions to ensure that the intent of each question was retained. The CRCC 2010 Code of Professional Ethics was used to develop and refine all questions in the PDS-M. Secondly, three Ph.D. level certified rehabilitation counselor practitioners and educators were contacted via e-mail and asked to provide feedback on the PDS-M instrument. This feedback was incorporated into the instrument and became the basis for the pilot. The pilot online survey was conducted with 8 Michigan State University (MSU) advanced Ph.D. students for the purpose of obtaining additional feedback on the PDS-M and the intent of each question.

The PDS-M was subsequently incorporated into the overall survey process. Because the PDS-M was not a validated instrument, the previously-mentioned procedures were followed to obtain evidentiary support for the validity of the measure. Evidence for the validity of an

instrument is difficult to obtain (Morgan, Leech, Gloeckner, & Barrett, 2013). However, reliability is a necessary prerequisite for validity, but is not the sole measure for reliability (Muijs, 2011). First, Cronbach's coefficient alpha was chosen to calculate the internal consistency reliability of the PDS-M, as it is a multiple-item scale and one administration of the instrument is sufficient to obtain this measure (Leech et al., 2015). The PDS-M score is composed of 26 items that were rated on a 5-point Likert scale, from strongly agree (5) to strongly disagree (1). The purpose of obtaining the internal reliability via Cronbach's alpha was to determine whether the 26 items interrelate well enough to use them together as a variable that appropriately represents the construct of professional disclosure in rehabilitation counseling, and to lend evidence to the instrument's validity and to address parsimony (using a few variables as possible to explain the variance), given that Cronbach's alpha is sensitive to the number of items included in the measure of intercorrelation (Muijs, 2011). It was important that there be sufficient statistical justification that the instrument contains good internal structure and has content evidence, which refers to whether the PDS-M content was a reasonable representation of measuring the professional disclosure construct (Morgan et al., 2013).

The Cronbach's alpha was run on the PDS-M and resultant data was analyzed to determine whether it was a reliable scale for use in the study. The number of valid cases for the test was $n=184$ (92.5%), with 15 (7.5%) not meeting criteria to be included. The item-total statistics was consulted to determine whether there were any repetitious questions that could potentially be removed to enhance the original Cronbach's alpha of .876. If the correlation is moderately high to high (i.e. .40 or higher), it will be appropriate to keep as it will contribute as a good component (Leech et al., 2015). It was determined to be appropriate to remove the three questions; *Professional disclosure could affect my client's willingness to disclose freely*

(PDSM_6), *Professional disclosure information provided to clients is difficult to understand* (PDSM_11), and, *During the process of professional disclosure with my clients, I engage in relying less on formal procedures to establish my client's competency* (PDSM_25) due to each possessing an item-total correlation of $<.40$ (i.e. 0.049, 0.070, and, 0.157; respectively). The resulting Cronbach's alpha of .889 indicates that the PDS-M has very good internal consistency reliability, as it is above 0.70 (Leech et al., 2015).

Four additional questions; *Professional disclosure portrays the rehabilitation counselor as cold or uncaring*, *Clients have a great need to know about professional disclosure*, *The 2010 CRCC Code of Professional Ethics influences how I use professional disclosure*, and *The professional disclosure process tends to take from the limited time I have to provide services to my clients* also had correlations below .40 (.238, .304, .269, and .294; respectively), but would reduce the Cronbach's alpha by .001 to .003 if deleted from the model and were kept in as a result. A new PDS-M aggregate measure was re-run with the questions PDSM_6, PDSM_11, and PDSM_25 removed.

Response Rate

The CRCC provided permission for the use of the data set in this study. A total of 1,250 email addresses of current CRCs was obtained for the purpose of emailing each CRC an invitation to participate in the survey via the Qualtrics online survey software (Qualtrics.com). Of the 1,250 emails sent, 93 "bounced back," that is, were found to be no longer active email accounts identified as undeliverable for a resultant sample total of 1,157 potential respondents. Of the 1,157 participants, 245 responded to the survey, for a response rate of 21.2%. It was also worthy of note that approximately 33% of the emails that were sent were opened as reported by the Qualtrics software, with the remaining 67% not being opened. However, since the survey

was sent anonymously where two follow-up reminders were sent, it could not be determined if the average number of persons not opening the survey was a duplicated or unduplicated number.

Response rates to online surveys in the rehabilitation counseling field have ranged between 12% and 21% (Wood & Estrada-Hernandez, 2012; Zanskas & Strohmer, 2011). It was necessary to attain the necessary minimum number of respondents within this range of 12% to 21% in order to achieve the greatest statistical sensitivity and reduce the possibility of Type I (rejecting the null hypothesis when it is actually true) and Type II errors (accepting the null hypothesis when it is actually false) (Weinfurt, 1995). As previously was noted, the minimum sample size was originally calculated to be 128 when taking into account alpha ($\alpha=.05$), the power ($1-\beta$) of the test (.80) and the effect size (.50). Cohen (1992) indicated an effect size of .50 is considered medium. The sample size of 128 provides the greatest sensitivity in the data analysis that the outcome is actually due to interaction from the independent variables (Creswell, 2009).

Screening and Preliminary Analysis of Initial Dataset

The data, prior to proceeding with the statistical analyses, needed to be screened to ensure that it met the basic assumptions of parametric data. Parametric tests assume the following: the data is normally distributed (the probability of a variable that is known to have a frequency distribution where most scores are in the middle and with similar numbers of low and high scores), homogeneity of variance (the variance is the same throughout the data), interval data (data measure along a scale in which the intervals are equal), and, independence (the choices or behaviors of one respondent do not affect the choices or behavior of another respondent) (Morgan et al., 2013; Field, 2009).

First, a frequency distribution of the RRI-T and the PDS-M data was run. It was noted that 45 cases had missing data. This data was located within the dataset and was subsequently removed due to its lack of completeness. Box and whisker plots and histograms were generated to review for the presence of possible outliers and determine the properties of the data, i.e. whether it met the assumptions of normality. Additionally, Levene's Test for Homogeneity of Variance and a Shapiro-Wilk test were also run, respectively, to determine the homogeneity of variance within the distribution, as well as to compare the scores to a normally distributed set of scores with the same mean and standard deviation to determine whether the distribution in the sample is significantly different from a normal distribution (Field, 2009).

Upon review of the box and whiskers plot for the PDS-M scores, there were no identified outliers. For the RRI-T scores, it was found that there was the presence of one outlier with a mean score of 1.38 that went beyond the range of the low-end of the whisker, identifying it as an extreme outlier. This outlier was located within the data and reviewed for reasons for the variance. The case met the criteria for an outlier in that most questions were answered to the negative (strongly agree) without any pattern other than consistently answering negatively. To answer in such a manner on the RRI-T would indicate that this respondent did not value the relationship with the client in any capacity measured on the instrument. As a result, the outlier was removed from the data.

Prior to data removal, histograms and P-P plots for the RRI-T and PDS-M were reviewed for visual review of the data distributional properties. The RRI-T had a mean of 3.6 (SD=.47) and a median of 3.63, indicating a negative skew of -.417. The kurtosis was leptokurtic (peaked) at 1.761. The aforementioned outlier with the mean of 1.38 was visible in the histogram, along with a nearly-formed second mode of 3.0. The PDS-M data had a mean of 3.87 (SD=.48) and a

median of 3.88, with a negative skew of -.131. The kurtosis was -.662, or less peaked and more platykurtic. If the skewness is more than 1.0 or less than -1.0, the distribution is likely markedly skewed and it could be important to consider transforming the data (Leech et al., 2015). Both the RRI-T and PDS-M distributions do not violate this general rule but the assumptions for the normality of the data are not fully complete.

A P-P plot was also examined for the RRI-T and the PDS-M. This graph plots the cumulative probability of a variable against the cumulative probability of a normal distribution (Field, 2009). If the data is normal in comparison to the normal distribution, there will be a straight line of plotted dots following the diagonal. A visual review of the Normal P-P plot of the RRI-T scores exhibits a general diagonal pattern with some slight positive and negative variance from the normal plot. The Normal P-P plot of the PDS-M also has a similar pattern, but is less negatively and positively pronounced, again generally following the normal diagonal plot.

Thus far, through general visual review, the data was not completely violating tests of normality. However, it was prudent to continue with a confirmatory statistical procedure to determine whether the distributions of the RRI-T and the PDS-M on the whole individually deviate from a comparable normal distribution (Field, 2009). The Shapiro-Wilk test was chosen to complete this test. This statistical test will look at the hypothesis the RRI-T and PDS-M sample data have been drawn from a population with a normal distribution (Vogt & Johnson, 2011). The Shapiro-Wilk test was chosen because the sample size for this study is not large ($n=199$) (Raykov & Marcoulides, 2008). The null hypothesis H_0 was that the data has come from a normally distributed population. The results of the Shapiro-Wilk test indicated that the RRI-T was significant $D(203)=.974$, $p<.001$ and that the PDS-M was significant at $D(203)=.985$, $p<.05$. Thus, the null hypothesis H_0 that the data came from a normally distributed population

was rejected and the results suggest the presence of non-normality in the distribution at this point in the review of the properties of the sample data.

Lastly, Levene's test for homogeneity of variance was used to test that the variances were the same throughout the data (Field, 2009). The null hypothesis H_0 was that the difference between the variances is zero. Thus, if $p \leq .05$, the assumption of the homogeneity of variances will have been violated. In order to run the test, *gender* was used as the factor. For the RRI-T, the variances were equal for males and females, $F(1, 201) = .737$, $p > 0.05$, and for PDS-M scores, the variances were also not significantly different, $F(1, 201) = .853$, $p > 0.05$. Thus, the null hypothesis H_0 for both the RRI-T and the PDS-M were retained and the assumption of the homogeneity of variances was kept.

The last two assumptions, measuring data at a minimum at the interval level, and independence were addressed (Field, 2009). The data in the RRI-T and the PDS-M were treated as interval data in that the data was rated along a 5-point Likert scale where the change from 1 to 2 was treated the same in importance as a change from 4 to 5, for example. Independence meant that the data from different participants were independent from one another in terms of influence (Field). Due to the nature of the data collection (online survey), it was highly unlikely that independence was violated, and thus, one respondent's answers were not influenced by another respondent's answers.

Once review of the assumptions of the data was complete, the outlier in the RRI-T was removed as the result was not indicative of what answers the CRCs were responding with, given its extreme nature. Additionally, the respondents responsible for the formation of the near-second mode were examined. There were no outstanding traits to the data that might give additional insight and the other responses that were given to other questions in the survey

appeared to be consistent with the general range for responses. Thus, in all, there were 46 lines of data removed and the data was re-run to address whether the data was normal, and to proceed with further data analysis.

Review of Normality Assumptions in Complete Dataset

Descriptive statistics were re-run for the complete dataset to begin the review of normality. Neither the RRI-T nor the PDS-M had any missing data. The RRI-T mean was 3.61 (SD=.44), median was 3.67 and the mode was 3.67. The minimum score was 2.76 and the maximum score was 4.51. The skewness of the RRI-T was also found to be .060, or nearly no skew. Because the mean, median, mode were very close values, and the skewness was very low, it was assumed that the data was normally distributed when these assumptions were met (Leech et al., 2015). As an additional assurance, the Shapiro-Wilk test was run again. The RRI-T results were $D(199)=.990, p>0.05$. As the null hypothesis H_0 was that the data came from a normally distributed population and the results of the Shapiro-Wilk test support this assumption with the null hypothesis being retained. The Levene's test for homogeneity of variance also confirmed equal variance through the RRI-T data, $F(1, 197)=.001, p>0.05$ by retaining the null hypothesis H_0 . Lastly, a boxplot and normal Q-Q chart was run for the RRI-T data. The boxplot showed no outliers, and the normal Q-Q plot for the RRI-T showed that the data fell fairly well along the normal diagonal, with some very slight deviation up and down, indicating that the kurtosis (-.237) differs slightly from the normal distribution (Field, 2009). As a result, the RRI-T data appeared to safely fit the assumptions for normality.

The PDS-M mean was 3.88 (SD=.47), the median was 3.88, and the mode was 3.88. The minimum PDS-M score was 2.65 and the maximum was 4.85. The skewness value was slightly negatively skewed at -.126. According to Leech et al. (2015), this data was also considered

approximately normal. The Shapiro-Wilk test for the PDS-M was $D(199)=.985$, $p>0.05$. Thus, the null hypothesis H_0 was that the data came from a normally distributed population and the results of the Shapiro-Wilk test supported this assumption with the null hypothesis being retained. The Levene's test for homogeneity of variance also confirmed equal variance through the PDS-M data, $F(1, 197)=.532$, $p>0.05$ by retaining the null hypothesis H_0 . Lastly, a boxplot and normal Q-Q chart was run for the PDS-M data. The boxplot showed no outliers, and the normal Q-Q plot for the PDS-M showed that the data fell fairly well along the normal diagonal, but with some very slight deviation up and down at three points on the normal diagonal, indicating that the kurtosis (-.664) differs slightly from the normal distribution (Field, 2009). As a result, the PDS-M data appeared to safely fit the assumptions for normality.

Respondent Demographic Characteristics

As had been discussed, it was necessary to reduce the data sample size in order to address non-responses and the one outlier, resulting in a sample size of 199. It is also worth noting that 73% ($n=145$) of the respondents indicated as having an active caseload, whereas 27% ($n=54$) noted they did not have a caseload. While this was not explored in this study, it could affect outcomes. Table 1 shows the demographic breakdown for respondents with respect to gender, age, race/ethnicity, education, and years of experience. Of the 199 certified rehabilitation counselors who fully responded, 68.3% ($n=136$) were female, and 31.7% ($n=63$) were male. With respect to age, 7.5% ($n=15$) indicated being less than 30 years of age, 16.1% ($n=32$) indicated an age of 30-39, 21.1% ($n=42$) noted an age of 40-49, 34.2% ($n=68$) reported an age of 50-59, and 21.1% ($n=42$) noted an age of 60 or greater. Respondent race/ethnicity was reported as the following: White/Caucasian, 77.4% ($n=154$); Black/African American, 9.5% ($n=19$); Hispanic/Latino American, 3.5% ($n=7$); Prefer Not to Answer, 3.0% ($n=6$); American

Indian/Alaskan, 1.5% (n=3); Two or More Races, 1.5% (n=3); Other, 1.5% (n=3); Asian Indian, 1.0% (n=2); Asian Alone, 0.5% (n=1); and Missing, 0.5 (n=1).

Table 1: *Comparison of Respondent and CRC Demographic Variable Characteristics*

	Respondents		CRCs	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Gender				
Male	63	31.7	4,371	26.2
Female	136	68.3	12,330	73.8
Age				
< 30	15	7.5	1,336	8.0
30-39	32	16.1	3,197	19.1
40-49	42	21.1	3,733	22.3
50-59	68	34.2	4,244	25.4
60+	42	21.1	4,198	25.1
Race/Ethnicity				
Asian Alone	1	0.5	405	2.4
American Indian/Alaskan	3	1.5	89	0.5
Asian Indian	2	1.0	5	0.03
Black/African American	19	9.5	1,736	10.4
Hispanic/Latino American	7	3.5	745	4.5
White/Caucasian	154	77.4	13,055	78.1
Two or More Races	3	1.5	185	1.1
Prefer Not to Answer	6	3.0	433	2.6
Other	3	1.5	10	0.06
Missing	1	0.5	22	0.13
Education				
Doctorate	6	3.0	-	-
Masters	190	95.5	-	-
Missing	3	1.5	-	-
Years of Experience				
0-5 Years	38	19.1	-	-
6-10 Years	33	16.6	-	-
11-20 Years	50	25.1	-	-
21-30 Years	43	21.6	-	-
31+ Years	33	16.6	-	-
Missing	2	1.0	-	-

As for education level, 95.5% (n=190) of the respondents indicated that had attained a Master's degree, 3.0% (n=6) had a doctorate degree, and 1.5% (n=3) were indicated as missing. For Years of Experience, 19.1% (n=38) of the respondents indicated that the number of years of experience in the rehabilitation field was 0-5 years. In the 6-10 year range, 16.6% (n=33) of the respondents categorized themselves. As for respondents indicating 11-20 years of experience, this comprised 25.1% (n=50) of the population. There was 21.6% (n=43) of the sample indicated possession of 21-30 years of experience; 16.6% (n=33) were in the 31 years or greater category, and 1.0% (n=2) were missing a response.

Next, as represented in Table 2, respondents were asked to indicate what their current job setting was. The job setting choices were matched to be consistent with the CRCC (2014) set of demographics. As such, the CRC respondents were to indicate was job setting in which they work. The largest percent of respondents, 30.7% (n=61) indicated their job setting was a State/Federal Rehabilitation Agency; 7.0% (n=14) work in a College or University setting; 13.1% (n=26) work in Private-For-Profit Rehabilitation, as well as the Other category; 6.5% (n=13) indicated working in a Private-Not-For-Profit setting; 6% (n=12) in a Worker's Compensation setting; and 5.5% (n=11) work in a Mental Health Center or Psychiatric Facility. Following these respondents were individuals that did not total as large a sample. There was 3.5% (n=7) that noted working in the Veteran's Benefits Administration; 3.0% (n=6) in a Medical or Rehabilitation Hospital; 2.0% (n=4) work in the Kindergarten-12th grade education system; and at 1.5% (n=3), the following six settings were noted as workplaces: Corrections Facility, Veteran's Health Administration, Corporate Environment, Insurance Company, Student, and Unemployed. Lastly, 0.5% (n=1) indicated being Retired.

Table 2: *Comparison of CRC Sample and CRC Population Demographic Characteristics: Job Setting*

	Sample		Population	
	<i>n</i>	%	<i>n</i>	%
Job Setting				
Corrections Facility	3	1.5	57	0.3
Veterans Health Administration	3	1.5	79	0.5
Retired	1	0.5	92	0.6
Corporate Environment	3	1.5	251	1.5
Worker's Compensation Setting	12	6.0	308	1.8
Veterans Benefits Administration	7	3.5	355	2.1
K-12 Schools	4	2.0	325	2.0
College or University	14	7.0	1,654	10.0
Medical or Rehabilitation Hospital	6	3.0	364	2.2
Mental Health Ctr/Psych. Facility	11	5.5	619	3.7
Insurance Company	3	1.5	419	2.5
State/Fed Rehabilitation Agency	61	30.7	4,717	28.2
Private Not-For-Profit Rehab	13	6.5	980	5.9
Private-For-Profit Rehab	26	13.1	2,704	16.2
Student	3	1.5	697	4.2
Unemployed	3	1.5	770	4.6
Other	26	13.1	2,159	12.9

Respondents, as shown in Table 3, also indicated their job title as chosen from a list of titles consistent with the CRCC (2014) categorization of jobs of CRCs. The largest group of respondents, at 25.1% (n=50) of the sample, identified themselves as Vocational Rehabilitation Counselors; 16.6% (n=33) identified themselves as being Rehabilitation Counselors; 12.6% (n=25) were Other; and 11.1% (n=22) indicated being an Administrator, Manager, or Owner. The next largest group of respondents, at 4.5% (n=9) was shared by the Case Manager and Mental Health Therapist categories. Counselors was the next group at 3.0% (n=6) of the sample population. The following four job title categories were each 2.5% (n=5) of the sample: Educator/Professor, Forensics Expert/Witness, Rehabilitation Consultant/Specialist, and

Supervisor (Rehabilitation Staff). The Disability Coordinator, Social Worker, and Vocational Evaluator each comprised 1.5% (n=3) of the sample population. The Addictions Counselor, Return to Work Specialist, Student, and Training/Policy/Staff Development each comprised 1.0% (n=2) of the sample population; the smallest percent of respondents, at 0.5% (n=1) each were: Care Coordinator, Care Manager, Disability Examiner/Reviewer, Job Development/Placement, Retired, Student Services, Transition Specialist, and Unemployed.

Table 3: *Comparison of CRC Sample and CRC Population Demographic Characteristics: Job Title*

	Sample		Population	
	<i>n</i>	%	<i>n</i>	%
Job Title				
Addictions Counselor	2	1.0	65	0.4
Administrator/Manager/Owner	22	11.1	1,037	6.4
Care Coordinator	1	0.5	23	0.1
Care Manager	1	0.5	43	0.3
Case Manager	9	4.5	348	2.1
Counselor	6	3.0	145	0.9
Disability Coordinator	3	1.5	58	0.4
Disability Examiner/Reviewer	1	0.5	18	0.1
Educator/Professor	5	2.5	546	3.3
Forensics/Expert Witness	5	2.5	109	0.7
Job Development/Placement	1	0.5	193	1.2
Mental Health Therapist/Counselor	9	4.5	211	1.3
Rehabilitation Consultant/Specialist	5	2.5	28	0.2
Rehabilitation Counselor	33	16.6	4,574	28.0
Retired	1	0.5	85	0.5
Return to Work Specialist	2	1.0	30	0.2
Social Worker	3	1.5	108	0.7
Student	2	1.0	2,263	13.9
Student Services	1	0.5	37	0.2
Supervisor (Rehabilitation Staff)	5	2.5	849	5.2
Training/Policy/Staff Development	2	1.0	54	0.3
Transition Specialist	1	0.5	38	0.2
Unemployed	1	0.5	360	2.2
Vocational Rehab Counselor	50	25.1	1,735	10.6
Vocational Evaluator	3	1.5	233	1.4
Other	25	12.6	3,132	19.2

Comparison to CRCC demographic characteristics.

The CRCC demographic characteristics were included in Tables 1-3 where appropriate to illustrate properties of the total population of the 16,708 CRCs (CRCC, 2014) in relation to the sample list of 1,250 CRCs that was randomly drawn by the CRCC and provided for this study. Gender, Age, Race/Ethnicity, Job Setting and Job Title were available for comparison. In Table

1, the CRC population total was 73.8% (n=12,330) female, and 26.2% (n=4,371) male. The study sample comparison was roughly 5.0% larger for male respondents (31.7%) and 5.0% less for females (68.3%). The Age demographic variable showed that the sample population for 50-59 year old respondents was 9.8% larger as compared to the CRC population which had a 25.4% (n=4,244) representation. Beyond this, the Age in the sample distribution was very close to in percentage to the overall CRC population percentage breakdowns, only varying 4.0% in the 60 year of age and over category and 0.5% in the less than 30 years of age population. For Race/Ethnicity, the percentages between the sample and the total population were very close, with the largest difference being the Asian Alone population with 2.4% in the CRC population and 0.5% in the sample.

A visual examination of CRC sample characteristics compared to CRC population characteristics in the Job Setting demographic category showed good similarity in terms of percentages represented from category to category. Lastly, as the sample pulled from the CRC total population was random, there were some differences in the Job Title demographic. The Student population represents 13.9% (n=2,263) of the total CRC count, whereas the sample has 1.0% (n=2) of students represented. Thus, an inspection of the CRC sample data in comparison to the overall CRC population data appeared to be reasonably similar relative to the percentages represented in each category as illustrated in Tables 1-3.

Summary of RRI-T Means and Standard Deviations

Table 4 shows the RRI-T means and standard deviations, sorted by whether the question appeared to be driven by whether the response was externally or internally driven. This was done to address attaining further insight into the ReCITE model relative to the CRC internal (I) and external (E) processes. For a question to be externally driven, it was defined as an influence

external to the CRC, such as how the client perceives the CRC. For a question to be considered internal, it referred to the CRC's perception or opinion on the topic area. It should be noted that grouping the questions by internal or external was for the purpose of organizing and conceptualizing the ReCITE model.

There were 10 questions grouped as external. The minimum went from 3.12 to a maximum of 3.90. The average mean response was 3.53, indicating a measure of agreement between *neutral* (3) and *agree* (4). The questions that were reverse-scored were marked with "reverse scored," however, the score does not change the analysis, only the interpretation.

For the external group, the question, *My client is able to see me as a real person separate from my role as a therapist* (M=3.73) had the largest standard deviation at 0.91, followed by; *My client has little caring for who I "truly am,"* (M=3.14) at 0.88, and *My client feels liking for the "real me"* (M=3.47) at 0.87. This indicated that the data points were more distant from the mean, and that the mean may not be an accurate representation of the data (Field, 2009). There appeared to be greater variability in the answers to these questions, potentially indicating greater differences in opinion.

There were 14 questions grouped as internal. The minimum went from 2.60 to a maximum of 4.23. The average mean response was 3.67, indicating a measure of agreement between *neutral* (3) and *agree* (4). The questions that were reverse-scored were marked with "reverse scored," however, the score does not change the analysis, only the interpretation.

For the internal group, the question, *I feel there is a "real" relationship between us aside from the personal relationship* (M=3.05) had the largest standard deviation at 1.01, followed by; *I hold back significant parts of myself* (M=2.60) at 1.00, and *There is no positive connection between us* (M=3.85) at 0.92. This indicates that these data points are also more distant from the

mean, and that the mean may not be an accurate representation of the data (Field, 2009). In other words, there appears to be greater variability in the answers to these questions, potentially indicating greater differences in opinion. In comparing the external and internal groupings, it appears that there is greater variability in the internal group, and a broader minimum and maximum range of means, potentially referring to greater degrees of agreement with questions that directly affect the CRC.

On the whole, CRCs responded positively to the RRI-T. This was defined by creating a cutoff at 3.55. Because the Likert-scale was from 1 (strongly disagree) to 5 (strongly agree), a 3.55 would indicate greater movement toward being in agreement with the RRI-T statements (i.e. a 3 was neutral, whereas a 4 was agree). The RRI-T scores categorized as low (3.54 or lower) was 86 (43.2%) and those categorized as high was 113 (56.8%). The low score mean was 3.20 (SD=0.24) and the high score mean was 3.92 (0.28).

Table 4: *Internal vs. External Grouping, Mean, and Standard Deviations for RRI-T Questions*

(*n*=199)

	<i>E/I</i>	<i>Mean</i>	<i>SD</i>
1. My client is able to see me as a real person separate from my role as a therapist.	E	3.73	0.91
2. My client and I are able to be genuine in our relationship.	I	4.04	0.71
3. My client feels liking for the "real me."	E	3.47	0.87
4. My client genuinely expresses his/her positive feelings toward me.	E	3.65	0.85
5. I am able to realistically respond to my client.	I	4.23	0.66
6. I hold back significant parts of myself. (Reverse scored)	I	2.6	1.00
7. I feel there is a "real" relationship between us aside from the personal relationship.	I	3.05	1.01
8. My client and I are honest in our relationship.	I	3.73	0.72
9. My client has little caring for who I "truly am." (Reverse scored)	E	3.14	0.88
10. We feel a deep and genuine caring for one another.	I	2.93	0.83
11. My client holds back significant parts on him/herself. (Reverse scored)	E	3.12	0.86
12. My client has respect for me as a person.	E	3.9	0.67
13. There is no genuinely positive connection between us. (Reverse scored)	I	3.85	0.92
14. My client's feelings toward me seem to fit who I am as a person.	I	3.58	0.68
15. I do not like my client as a person. (Reverse scored)	I	4.02	0.80
16. I value the honesty of our relationship.	I	4.01	0.75
17. The relationship between my client and me is strengthened by our understanding of one another.	I	3.73	0.77
18. It is difficult for me to express what I truly feel about my client. (Reverse scored)	I	3.6	0.87
19. My client has unrealistic perceptions of me. (Reverse scored)	E	3.46	0.77
20. My client and I have difficulty accepting each other as we really are. (Reverse scored)	I	3.85	0.71
21. My client distorts the therapy relationship. (Reverse scored)	E	3.77	0.77
22. I have difficulty being honest with my client. (Reverse scored)	I	4.11	0.70
23. My client shares with me the most vulnerable parts of him/herself.	E	3.44	0.85
24. My client genuinely expresses a connection to me.	E	3.57	0.81

Note. E=External Influence, I=Internal Influence.

Summary of PDS-M Means and Standard Deviations

Table 5 shows the PDS-M means and standard deviations, sorted by whether the question appeared to be driven by whether the response was externally or internally driven. This was done to address attaining further insight into the ReCITE model. For a question to be externally driven, it was defined as an influence external to the CRC, such as those standards established in the 2010 CRCC Code. For a question to be considered internal, it referenced the CRC's perception or opinion on the topic area that would be perceived as attitudinally-driven. It should be noted that grouping the questions by internal or external was for the purpose of organizing and conceptualizing the ReCITE model.

There were 15 questions grouped as external. The minimum went from 3.22 to a maximum of 4.45. The average mean response was 3.87, indicating a closer measure of agreement (4). For the external group, the question, *I provide written professional disclosure to my clients* (M=3.77) had the largest standard deviation at 1.21, followed by; *Including information on the risks associated with electronic communication.* (M=3.55) at 1.16, and *Including the possible risks associated with receiving services* (M=3.54) at 1.14. This indicated that the data points were more distant from the mean for each question, and that the mean may not be an accurate representation of the data due to this variance (Field, 2009). There appeared to be greater variability in the answers to these questions, indicating greater difference in opinion. Thus, questions with higher standard deviations would be areas of importance for educational opportunities, clarification, and CRCC ethics development/reinforcement.

There were 11 questions grouped as internal. The question means went from a minimum of 3.37 to a maximum of 4.49. The average mean response was 3.90, indicating that there was generally agreement (4) on the questions. For the internal group, the question, *Professional*

disclosure could affect my client's willingness to disclose freely (M=3.57) had the largest standard deviation at 1.04, followed by; *Relying less on formal procedures (e.g. questions to the client to determine factual comprehension of relevant service information) to establish my clients' competency* (M=3.37) at 0.97; and *Professional disclosure information provided to clients is difficult to understand* (M=3.37) at 0.96. Again, indicated that these data points were also more distant from the mean, and that the mean may not be an accurate representation of the data (Field, 2009). According to this, the larger the standard deviation, the greater distance from the mean. In other words, there appears to be greater variability in the answers to these questions, potentially indicating greater differences in opinion. In comparing the external and internal groupings, it appears that there is greater variability in the external group, and roughly equal minimum and maximum range of means. The larger variability in the external category may potentially relate to the CRC ambivalence relating to the externally-driven CRCC ethical elements relating to professional disclosure.

On the whole, CRCs responded positively to the PDS-M. This was defined by creating a cutoff at 3.55. Because the Likert-scale was from 1 (strongly disagree) to 5 (strongly agree), a 3.55 would indicate greater movement toward being in agreement with the PDS-M statements (i.e. a 3 was neutral, whereas a 4 was agree). The PDS-M scores categorized as low (3.54 or lower) was 42 (21.1%) and those categorized as high was 157 (78.9%). The low score mean was 3.22 (SD=0.21) and the high score mean was 4.13 (0.39).

Table 5: *Internal vs. External Grouping, Mean, and Standard Deviations for PDS-M Questions*
(*n=199*)

	<i>E/I</i>	<i>Mean</i>	<i>SD</i>
1. The practice of professional disclosure in rehabilitation counseling is important.	I	4.44	0.72
2. The practice of professional disclosure is useful in informing my clients about the nature of services I provide and the issues that arise during the rehabilitation counseling relationship.	I	4.49	0.68
3. My employer enforces the practice of professional disclosure.	E	3.79	1.05
4. I verbally discuss professional disclosure with my clients.	I	4.24	0.83
5. I provide written professional disclosure to my clients.	E	3.77	1.21
6. Professional disclosure could affect my client's willingness to disclose freely.	I	3.57	1.04
7. Professional disclosure portrays the rehabilitation counselor as cold or uncaring.	I	3.90	0.78
8. Clients have a great need to know about professional disclosure.	I	3.84	0.93
9. Professional disclosure should be used throughout the rehabilitation counseling relationship with the client.	I	4.03	0.90
10. The 2010 CRCC Code of Professional Ethics influences how I use professional disclosure.	E	3.81	0.86
11. Professional disclosure information provided to clients is difficult to understand.	I	3.37	0.96
12. The professional disclosure process tends to take from the limited time I have to provide services to my clients.	I	3.60	0.96
13. Discussing the limits of confidentiality.	E	4.45	0.66
14. Including my qualifications, credentials, and relevant experience.	E	4.03	0.91
15. Including an explanation on the expected frequency and length of services.	E	4.21	0.80
16. Covering contingencies for service continuation should I become incapacitated or die.	E	3.22	1.10
17. Including information on fees and billing arrangements.	E	3.54	1.12
18. Including information on record preservation and release policies.	E	3.93	1.02
19. Including information on the risks associated with electronic communication.	E	3.55	1.16
20. Including information on legal issues affecting services.	E	3.72	1.05
21. Including the possible risks associated with receiving services.	E	3.54	1.14
22. Including the possible benefits associated with receiving services.	E	4.24	0.74
23. Including the alternatives to treatment.	E	3.73	0.90
24. Providing information on the nature and purpose of services to be provided.	E	4.50	0.59
25. Relying less on formal procedures (e.g. questions to the client to determine factual comprehension of relevant service information) to establish my clients' competency.	I	3.37	0.97
26. Communicating the consequences to my clients should any of them fail to follow through with their services.	I	4.06	0.91

Note. E=External Influence, I=Internal Influence.

Dummy Coding

Prior to beginning the simultaneous multiple regression analysis for the RRI-T and the PDS-M, six of the seven independent variables needed to be dummy coded. Because this group of six independent variables (the predictors) were categorical and almost all possessed more than two categories (with exception of Education and Gender), each needed to be dummy coded, a method of representing groups of persons with zeros and ones (Field, 2009). The regression model needed to be constructed where the predictor variables had two categories, i.e. either possessing the trait, or not possessing the trait. For example, females would be equal to one (being female) and the rest (males) would be equal to zero (or, not female). Each category for each variable was also dummy coded in a similar fashion; and thus, each element (or grouping) within a variable was given a one, where the remaining elements within the variable were given a zero, e.g. Black/African American=1, and all other elements =0; White/Caucasian=1, and all other elements=0.

In order to have a reliable regression model, there needed to be sufficient data within the variables (Field, 2009). Given that the bigger the sample size, the better the analysis for the size of the effect that is expected. Field indicated that there should be at least 10-15 cases of data per predictor, and as a result, this general rule was used in order to adequately group elements within variables and create the dummy variables. Further, where appropriate, the principle of parsimony was used. With parsimony, the smaller the number of predictor variables acting on the outcome variable is to be preferred when the explanations to choose from are equally good except for the simplicity involved (Vogt & Johnson, 2011). This meant that the power of the analysis with fewer independent variables is increased and the probability of Type II error is decreased (Licht, 1995).

The variables Gender and Years of Experience did not require any dummy coding. Age was dummy coded into categories, Age: Under 30-39, Age: 40-49, Age: 50-59, and Age: 60 and up. For Race/Ethnicity, the categories were grouped as follows: Asian Alone, American Indian/Alaskan, Asian Indian, Black/African American, Hispanic/Latino American, Two or More Races, Prefer Not to Answer and Other were grouped into one dummy variable (NonWhiteCauc) due to low frequency count (n=44). The White/Caucasian category was regarded as the reference or baseline group. Because the distribution for Education was almost all Master's respondents at 95.5% (n=190), there was not enough remaining in the Doctorate group at 3.0% (n=6). The Education variable was not considered as a result of a lack of a comparison group to code.

The Job Title variable contained 26 jobs (see Table 3) in which CRCs were employed. Saunders, Barros-Bailey, Chapman, and Nunez (2009) offered CRC job title groupings and CRC practice setting categories. Etheridge, Rodgers, and Fabian (2007) also discussed the multifaceted roles that the rehabilitation counselor plays in the service system. These studies were used to condense the categories for this analysis. For Job Title, the following four categories emerged: Rehabilitation Counseling (the comparison variable), Supervisor/Administrator, Vocational Services, and Other Job Not Classified. Rehabilitation counseling and Vocational Services was kept separate because the respondents were allowed to indicate their job role in the survey, and Etheridge et al. note that the rehabilitation counselor is moving away from more traditionally-connected work settings like the state-federal vocational rehabilitation system, to newer roles and specialty areas such as the private arena, forensic work, consulting and disability management, so, the categories were created with this guidance.

Job Setting as a variable that contained 17 distinct categories (see Table 2). Saunders, Barros-Bailey, Chapman, and Nunez (2009) offered CRC job title groupings and CRC practice setting categories. The categories that emerged were: Private/Insurance Sector, Education/Medical/Mental Health/Other, and State/Federal System (comparison variable). Saunders et al., note that the fastest growing setting for CRCs was the Private/Insurance sector. The Private/Insurance sector category comprised 38% (n=76) respondents and the State/Federal System, at 38% (n=75) account for 76% (n=151) of the respondent classifications. This loosely matched the account made by Saunders et al. for these top two categories. The subsequent simultaneous multiple regression analyses for the RRI-T and the PDS-M will utilize the 10 identified dummy-coded variables and the one continuous variable.

Data Analysis: Quantitative and Qualitative

Simultaneous multiple regression analysis: RRI-T.

Simultaneous multiple regression was used to determine the contributions of all predictor variables (demographic variables) simultaneously to determine their effect on the dependent variable, the RRI-T. This method was chosen in that in the real world, there are multiple independent variables (i.e. demographic traits, etc.) that are present and interacting in potentially influencing behavior relative to some dependent variable. Thus, a simultaneous multiple regression was conducted to determine whether the linear combination of gender, age, race/ethnicity, years of experience, job setting, and job title predict RRI-T scores.

In an examination of the descriptive data, the means, standard deviations and intercorrelations of the outcome and predictor variables were examined. The descriptive data for the predictor (demographic) variables have been reported previously in the demographics section. The diagonal correlation matrix contain the values of r and is useful for getting an initial

idea of the relationship of the predictor variables and the outcome variable, as well as the relationship of the predictors among themselves (intercorrelation). This helped in getting an early idea about the potential for multicollinearity and the relationship of the predictor variables to the outcome variable, and whether it was appropriate to continue analysis of the model. Field (2009) indicated that if there is no substantial correlation between the predictors, there should be no multicollinearity, that is, if the correlation was less than 0.9. The correlation between Setting: Private/Insurance and Setting: Education/Medical/Mental Health/Other was $r = -0.51$, $p < .01$; the correlation between Setting: Education/Medical/Mental Health/Other and Setting: State/Federal was $r = -0.52$, $p < 0.01$; the correlation between Years of Experience and Age: Under 30 to 39, was $r = -0.56$, $p > 0.05$. Since these correlations are less than 0.9, there is no cause to consider multicollinearity as an issue.

There were other predictors where the correlations were significant. None of them exceeded $r = 0.47$ (Setting: Education/Medical/Mental Health/Other and Job: Other) the coefficients were relatively small, which meant it was likely that the predictors were measuring different things (Field, 2009). Table 6 shows the predictor that had the highest positive correlation with the outcome variable (RRI-T) was Job: Other, at $r = 0.13$, $p > .05$, which was not a significant result. None of the predictor variables were correlated significantly with the outcome variable with the exception of Job: Other nearly reaching significance ($p < 0.05$) at $p = 0.064$. To determine whether further analysis would be beneficial, the simultaneous multiple regression was run to examine the model significance and the contribution of Job: Other to it. Neither the model nor Job: Other yielded a significant result. It was determined that none of the predictor variables in the model would best predict an RRI-T outcome and the simultaneous multiple regression was not pursued any further.

Table 6: *Means, Standard Deviations, and Intercorrelations for RRI-T, PDS-M, and Predictor Variables (n=196)*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11	12	13	14
RRI-T	3.61	0.44	0.03	-0.02	0.01	-0.03	0.11	-0.08	-0.04	-0.01	-0.07	0.13*	0.04	-0.01	-0.05	0.02
PDS-M	3.94	0.52	-0.39	0.10	-0.03	-0.02	0.06	-0.05	0.02	-0.07	0.03	0.04	-0.04	-0.08	0.13**	-0.02

Note. *Job: Other, $p=0.064$; **Age: 50 to 59, $p=0.07$. Both were reviewed for potential contribution to their respective regression models.

Qualitative data analysis: RRI-T.

Following the RRI-T quantitative portion of the survey data, there were three qualitatively-based questions asked to gather themes related to the therapeutic relationship construct: 1) *What client and counselor factors do you think contribute to a therapeutic relationship?*; 2) *How should the rehabilitation counselor use these?*; and 3) *How do you feel that professional disclosure affects the therapeutic relationship with the client?* Each of the question responses was gathered and codes and themes were created qualitatively, using the data transformation approach. This approach allowed the researcher to concurrently compare quantitative and qualitative data and to help further qualify the survey results (Creswell, 2009).

Prior to this analysis, a series of steps was taken to check the validity and accuracy of the qualitative findings. A cross-check of the coding was performed with another doctoral candidate who was already employing a qualitatively-based design, in order to increase the validity due to increased familiarity with qualitative procedures and analysis. Cross-checking was used to arrive at intercoder agreement, a procedure Creswell (2009) recommended in order to represent accurate findings from the standpoint of the researcher, the participants, and the readers as it related to the conclusions coming from the analysis. Based on the cross-checking procedure, over 90% of the codings and findings were in agreement. Creswell indicated that the coding should be in agreement at least 80% of the time for good qualitative reliability. Next, Creswell indicated that the researcher should discuss bias and discrepant information that affect theme formation. Bias, in the sense of this analysis, could potentially be affected by the biases that the researcher had. Discrepant information that may emerge in the data includes themes that counter the prevailing direction of the overall data. These elements were considered in the qualitative analysis.

RRI-T qualitative question 1.

Respondents were asked to comment on traits in both the client and the counselor that contribute to the therapeutic relationship. There was a total of 206 themes extracted from the respondent replies, and many responses did not differentiate between client and counselor characteristics, but indicated the traits alone, and thus, results are represented in this combined format. The quantitative portion of the analysis looked for the potential influence of CRC respondent characteristics to predicting the outcomes on the RRI-T. While the quantitative analysis did not yield significant results, the analysis of the qualitative data showed consistency with this finding in that one respondent indicated an answer that related to that of *demographics* (n=1, 0.5%) as a contributor.

The top five responses were individual traits, and the other two were processes (in order of most to least response): *genuineness/empathy* (n=79, 38.3%, trait), *honesty* (n=41, 19.9%, trait), *role clarity* (n=30, 14.6%, process), *trust* (n=13, 6.3%, trait), and *communication* (n=12, 5.8%, process). These five items accounted for 85.0% of the overall responses, seeming to support the idea that the greater contributors to the therapeutic relationship are not demographic characteristics, but internal traits possessed, developed, and expressed by the client and counselor during interactions. *Role clarity* was referred to as such because the CRC respondents indicated that professionalism and appropriate boundaries were important contributors to the therapeutic relationship. Lastly, *communication* referred to transparency, effective use of empathy, and the use of effective counseling techniques. *Communication* was viewed as a mechanism that with the appropriate skills, boundaries, and messages could be conveyed to enhance the relationship. The remaining 15% of the themes in the responses included *openness to change*, *attitude*, *cultural competence*, *encouragement*, *listening skills*, *counselor control*, *acceptance*, *collaborative*

perspective, commonality, diagnosis, frequency of meeting, person-centered approach, rapport, timeliness, and natural supports.

RRI-T qualitative question 2.

There was a total of 161 responses to this question (*How should the rehabilitation counselor use these?*). The top five categorized responses for this question were: *build trust* (n=33, 20.5%), *active helping* (n=29, 18.0%), *professionalism* (n=26, 16.1%), *consistency* (n=13, 8.1%), and *role clarity* (n=12, 7.5%). *Building trust* and *active helping* were closely related in terms of content, but *building trust* typically was associated with engaging the client, through active listening, being respectful, and building an emotionally safe environment through engagement. The difference between these two themes appeared to be that active helping was focused on active aspects of the helping relationship such as working to understand the client's perspective, building on positives, using motivational interviewing techniques and working with the client to build coping techniques. *Professionalism* referred to counselor responses centered on ethical practices, identifying client needs and goals, being unbiased, and pacing work with the client so as to not make the experience feel emotionally threatening. *Role clarity* repeated itself again as a theme and responses were categorized here that related to communicating clearly about boundaries and expectations in services. The last of the top five, *consistency*, referred to counselors using the same techniques, making a particular approach a part of each session, and consistently using with each client. The remaining 29.8% of the themes related to *communication, person-centered perspective, role modeling, particular counseling techniques, self-awareness, following protocols, collaborating, creating a safe environment, cultural competence, evidence-based practice use, encouragement, knowledge, nonjudgmental attitude, and standards of care.*

RRI-T qualitative question 3.

There was a total of 171 response to this question (*How do you feel that professional disclosure affects the therapeutic relationship with the client?*). The top five themes constituted 89.5% of the respondents and were: *Personal relationship* (n=84, 49.1%), *professional role clarity* (n=30, 17.5%), *helpful* (n=21, 12.3%), *improves trust* (n=10, 5.8%), and *not helpful* (n=8, 4.7%). *Personal relationship* was coded as such in that many of the responses related directly to what appeared to be a misunderstanding of the question to pertain to *personal disclosure* as opposed to the process of professional disclosure. This was arrived at due to statements that referred to the client needing to see the counselor as a “real person” as well as a counselor, or that this approach should be used sparingly, or never. This lent potential evidence to theorize that some respondents answered with the belief that a therapeutic relationship is formed via personal as opposed to professional disclosure. Secondly, *professional role clarity* referred to, similar to the previous two qualitative questions, the appropriate setting of boundaries, expectations, counselor competencies and the elements involved in professional disclosure. This was more consistent with what professional disclosure should entail. The third theme, *helpful*, was connected to CRC comments that the process itself is simply helpful. The fourth theme was that professional disclosure resulted in *improved trust*. The fifth theme related to other respondents indicating it was *not helpful* (indicating the opposite of the previous theme). Other themes that constituted the last 12.3% of themed responses were: *professionally informs, depends, decision-making, empowerment, growth, understanding, professionally helps with limited resources, professional requirement, professionally too formal, and, professionally helps in training.*

Simultaneous multiple regression analysis: PDS-M.

Simultaneous multiple regression was also used to determine the contributions of all the predictor variables (demographic variables) simultaneously to determine their effect on the dependent variable, the PDS-M. This method was chosen as it is consistent with the simultaneous regression analysis completed with the same predictor variables and the RRI-T. Thus, a simultaneous multiple regression analysis was conducted to determine whether the linear combination of Gender, Race/Ethnicity, Years of Experience, Setting: Private/Insurance, Setting: Education/Medical/Mental Health/Other, Job: Supervisor/Administration, Job: Vocational Services, Job: Other, Age: Under 30 to 39, Age: 40-49 and Age: 60+ would predict PDS-M scores.

In an examination of the descriptives, Table 6 (displayed previously) shows the means, standard deviations and intercorrelations of the outcome and predictor variables. The descriptive data for the predictor (demographic) variables have been reported previously in the demographics section. A diagonal correlation matrix showed the values of r and was useful for getting an idea of the relationship of the predictor variables and the outcome variable, as well as the relationship of the predictors among themselves (intercorrelation). This helped in getting an early idea about the potential for multicollinearity. As noted, Field (2009) indicated that if there was no substantial correlation between the predictors ($r > 0.9$), there should be no multicollinearity. The correlation between Years of Experience and Age: Under 30 to 39 was negatively correlated ($r = -0.56, p < .05$); the correlation between Setting: Private/Insurance and Setting: Education/Medical/Mental Health/Other, was also negatively correlated ($r = -0.51, p < .01$); the correlation between Setting: Education/Medical/Mental Health/Other and Setting: State/Federal, was also negatively correlated ($r = -0.52, p < .01$). Since these correlations were less than 0.9, there was no cause to consider multicollinearity as an issue.

There were also other predictors where the correlations were significant between the predictor variables in the PDS-M analysis. None of them exceed $r=0.47$ (Setting: Education/Medical/Mental Health/Other and Job: Other ($r=0.47, p<.01$)) the coefficients were relatively small, which meant it was likely that the predictors were measuring different things (Field, 2009). None of the predictor variables were correlated significantly with the outcome variable with the exception of Age: 50 to 59 nearly reaching significance ($p<0.05$) at $p=0.07$. To determine whether further analysis would be beneficial, the simultaneous multiple regression was run to examine the model significance and the contribution of Age: 50 to 59 to it. It was determined that because this predictor variables might contribute to predicting a PDS-M outcome, and the simultaneous multiple regression was pursued to examine its effect. None of the other predictor variables were correlated significantly with the outcome variable, lending evidence that the overall model would not yield a significant result.

The VIF and tolerance were examined to review further evidence to refute or support the potential existence of multicollinearity in the data. A VIF of 10 was a value that would raise concern, Myers noted (as cited in Field, 2009, p. 796). Bowerman and O'Connell (as cited in Field, p. 242) noted that an average VIF substantially above 1 might indicate a biased regression. Multicollinearity was considered a problem as indicated by Field, when tolerance values were below 0.2. The VIF range for the PDS-M multiple regression model ranged between 1.06 and 2.15, with an average of 1.5, and tolerance statistics ranged from 0.50 to 0.94, indicating that it was unlikely there is any multicollinearity problem within the data.

Casewise diagnostics was also run in the PDS-M model. This analysis showed three cases with standardized residuals less than -2 and one greater than 2 (Field, 2009). It was expected that 95% of the cases would have standardized residuals within ± 2 and that no more than 1% of the

cases should exceed 2.5. That meant that the sample ($n=199$) in this study should be expected to have approximately 10 cases that meet this assumption, and no greater than two cases that violate the 2.5 standardized residual value. The casewise diagnostics revealed that there was a total of four cases that exceeded the ± 2 range and no cases that had standardized residuals greater than 2.5. Thus, this study sample appears to be consistent with what Field considers to be an accurate model.

Lastly, the Durbin-Watson statistic was considered. Field (2009) noted that values can range between 0 and 4 and a value of 2 indicated the residuals were uncorrelated. The Durbin-Watson value generated in the PDS-M model summary was 2.12, which indicated that the adjacent residuals were uncorrelated. Thus, the data did not appear to have enough statistical support to warrant further review for the presence of confounding outliers.

The null hypothesis, H_0 , was that the predictor variables, simultaneously considered do not explain any of the association between the predictor variables and the outcome variable (i.e. the analysis provided little or no evidence that the null hypothesis was false). The model summary showed that the multiple correlation coefficient (R), when using all predictors simultaneously, was 0.22. Table 7 showed the R^2 value to be 0.05; the adjusted R^2 was -0.01, indicating that the model may be predicting only approximately 5% of the variance in the PDS-M. Only one predictor variable was found to contribute significantly within the model. The model suggested that the variable, Age: 40 to 49, when using Age: 50 to 59 as the comparison variable, performed more poorly on the PDS-M ($p < .05$). According to Leech et al. (2015), when the partial correlation value was squared, an indication of the unique variation (the amount of variation not explained by any other variable) of the predictor variable within the model would be given. The partial correlation value for Age: 40 to 49 was -0.154, and when squared is 0.24, indicating that

this predictor was responsible for 2.4% of the unique variance in the model. Thus, as the Age: 40-49 variable ($b=-0.23$) increases by one unit, PDS-M scores decrease by 0.23 units, when compared to Age: 50-59. Field (2009) noted that this would only be true when the effects of the other predictor variables were held constant.

As with the RRI-T analysis, there were 11 predictor variables used, and reducing this number could help in determining a better fit and to explain more of the variance in the outcome variable. Reducing the multiple regression analysis to a smallest number of predictors needed, would be warranted (Leech et al., 2015). Based on the assessment of the data and the simultaneous regression analysis, as shown in Table 5, there was sufficient evidence that the null hypothesis, H_0 , should be retained and the conclusion was that the introduction of the simultaneous predictor variables of Gender, Race/Ethnicity, Years of Experience, Setting: Private/Insurance, Setting: Education/Medical/Mental Health/Other, Job: Supervisor/Administration, Job: Vocational Services, Job: Other, Age: Under 30 to 39, Age: 40-49 and Age: 60+ do not yield a statistically significant effect on the PDS-M, other than the individual contribution of 2.4% of the unique variance that Age: 40 to 49 has when compared to Age: 50 to 59.

Table 7: *Simultaneous Multiple Regression Analysis Summary for Demographic Predictor Variables on PDS-M (n=196)*

Variable	<i>B</i>	<i>SEB</i>	β
Constant	4.08	0.14	
Gender	-0.06	0.08	-0.06
Race/Ethnicity	0.11	0.09	0.09
Years of Exp.	-0.01	0.01	-0.13
Setting: Priv./Ins.	0.05	0.09	0.05
Setting: Ed./Med./MH/Oth.	0.09	0.10	0.08
Job: Sup. /Admin.	0.08	0.12	0.06
Job: Voc. Services	0.09	0.09	0.08
Job: Other	0.09	0.12	0.07
Age: Under 30 to 39	-0.20	0.12	-0.17
Age: 40 to 49	-0.23	0.11	-0.19*
Age: 60+	-0.06	0.11	-0.05
Note. $R^2=0.05$; $F(11,184)=0.86$, $p>0.05$; Age 40 to 49, $t(184)=-2.12$, $p<0.05$. * $p<0.05$.			

Qualitative data analysis: PDS-M.

Following the PDS-M quantitative portion of the survey data, there were three qualitatively-based questions asked to gather themes related to the therapeutic relationship construct: 1) *In general, how do professional disclosure practices positively affect service to clients?*; 2) *In general, how do professional disclosure practices negatively affect service to clients?*; and 3) *In general, how does professional disclosure affect the informed consent process?*

Each of the question responses was gathered and codes and themes were created qualitatively, using the data transformation approach.

PDS-M qualitative question 1.

There was a total of 181 responses to this question (*In general, how do professional disclosure practices positively affect service to clients?*). The top five responses constituted 87.3% of all respondent themes and were: *informs* (n=103, 56.9%), *role clarity* (n=30, 16.6%), *trust* (n=12, 6.6%), *communication* (n=9, 5.0%), and *none* (n=4, 2.2%). The theme *informs* followed previous responses related to the RRI-T questions and focused on how this added to practicing informed choice, having a better understanding of the expectations embedded in the counseling process, understanding rights and acting as a foundation for expectations in the service relationship. The theme *role clarity*, actively showed as a theme in response to many questions in the RRI-T and PDS-M, pertained again to clarity of expectation, boundaries in services as well as the associated risks and benefits. *Trust* pertained to the use of honesty and transparency to build a sense of emotional safety and trust. Relating to the counselor, improving understanding and opening up were attributed to the *communication* theme. *None* as a theme pertained to the respondent not seeing any benefit associated. Additional themes making up the remaining 12.7% included: *compliance, empowerment, personal relationship, effective, administrative burden, control, safety, decision-making, unsure, limits services, adds to outcomes, personal growth, choice, and collaboration.*

PDS-M qualitative question 2.

There was a total of 171 responses to this question (*In general, how do professional disclosure practices negatively affect service to clients?*). The top five responses constituted 87.7% of all respondent themes and were: *Therapeutic gap* (n=44, 25.7%), *no negative effect*

(n=43, 25.1%), *too confusing* (n=35, 20.5%), *too formal* (n=20, 11.7%), and *personal relationship* (n=8, 4.7%). The *therapeutic gap* theme related to issues the CRC respondents felt would impede the therapeutic relationship. Among these included issues such as hesitance to talk openly, makes the client feel inferior, turns clients off and they refuse to participate, trust is difficult to obtain, may not engage in full disclosure, and may be discouraged regarding the length of treatment needed or wanted. Next, *no negative effect*, simply referred to the CRC respondent's perception that professional disclosure did not negatively affect service to their clients. The theme *too confusing* meant that the perception was that the client would become overwhelmed by the information, feel intimidated, the quality of the explanation of professional disclosure may lead to further confusion (dependent on individual client ability to understand), discouragement, or anxiety about services. *Too formal* referred to the sense that the construct of professional disclosure was too business-like, more focused on the paperwork aspect of the job and not client-focused. The last theme in the top five, *personal relationship*, as had surfaced as a top theme in previous questions, referred to caution about crossing boundaries from the professional to the personal. Lastly, the remaining themes included: *opting out*, *time consuming*, *neutral*, *affected by culture*, *controls services*, *poor execution*, *impacts benefits*, *adds to mistrust*, and *uninformed*.

PDS-M qualitative question 3.

There were 166 responses for this question (*In general, how does professional disclosure affect the informed consent process?*). The top five comprised 85.5% of all responses. The top five themes included: *adds understanding* (n=57, 33.1%), *positive and related* (n=55, 32.0%), *helpful* (n=16, 9.3%), *not helpful* (n=15, 8.7%), and *role clarity* (n=4, 2.3%). *Adds understanding* referred to how professional disclosure feeds the informed consent process in terms of important information that goes to the client for the purpose of empowerment, information sharing, and

trust-building. *Positive and related* mainly referred to professional disclosure enhancing the informed consent process or that the two “go hand in hand.” This appeared to speak to the recognition that professional disclosure was seen as adding to the overall informed consent process, but focused on the relationship between the two. The theme *helpful* simply referred to the professional disclosure process as being a positive contributor to explaining the rehabilitation counseling service delivery process. Conversely, the theme *not helpful* referred to the opposite, where the CRC respondent viewed the professional disclosure process as not contributing to informed consent. *Role clarity* again, as a response to previous questions, referred to the client being educated on the boundaries and the role of the counselor. The remaining themes comprising the 14.0% that were not in the top five included the following: *overwhelming, not understood/confusing, necessity, choice, both good and bad, undecided, personal relationship, legal protection, individualized, enhances evidence-based practices, educates the counselor, and consistency*.

Simple linear regression: PDS-M as a predictor of RRI-T.

A simple linear regression was run to explore whether the PDS-M was predictive of RRI-T outcomes. As was previously shown, assumptions of linearity and normal distributions were assessed and found to be met. The model summary shows the R and R^2 values. R has a value of 0.33 and R^2 has a value of 0.11. Because there was only one predictor, this was a simple correlation between the PDS-M and the RRI-T (Field, 2009). This meant that the PDS-M accounted for 11% of the variation in the RRI-T, and that 89% of the variation could not be explained by the PDS-M alone. The ANOVA table shows that the result is significant, $F(1,197)=23.4, p<.001$. This was supportive of there being less than a 0.1% chance that an F -ratio this size would ever happen if the null hypothesis were true.

Table 8 shows the results of the simple linear regression analysis summary for the PDS-M predicting the RRI-T. The unstandardized regression coefficient B for predicting RRI-T score outcomes was 0.28 and the standardized coefficient (β) was 0.33, with $p < .001$. The null hypothesis H_0 that there was no association between the PDS-M scores and RRI-T scores could be rejected, and it could be said that 11% of the variance in RRI-T scores was predicted by PDS-M scores. Because the correlation was $\beta = 0.33$, this was considered a medium effect by Cohen (1998). Thus, if the predictor PDS-M scores increase by one unit, the RRI-T scores would be expected to increase by 0.28 units.

Table 8: *Simple Linear Regression Analysis Summary for PDS-M Predicting RRI-T (n=196)*

Variable	B	SEB	β
Constant	2.50	0.23	
PDS-M	0.28	0.06	0.33***

Note. $R^2 = 0.11$; $F(1, 197) = 23.4$, *** $p < .001$.

RRI-T subscale contribution to PDS-M.

While the previous analysis looked at the contribution of the PDS-M on the RRI-T, finding there to be a significant relationship, the RRI-T included subscales, *Realism* and *Genuineness* (Marmarosh et al., 2009). As a result, the multiple regression analysis was extended to further review the effect of these subscales on the PDS-M. Previously, it was noted that *Genuineness* is the ability for an individual to be authentic and real; *Realism* is seen as perceiving another individual as he or she is, rather than the projections placed on that person (Gelso, 2002). Table 9 shows means, standard deviations, and intercorrelations for the PDS-M and the *Realism*

and *Genuineness* subscales. Both subscales were found to be significantly ($p<0.0001$) correlated to PDS-M.

Table 9: *Means, Standard Deviations, and Intercorrelations for PDS-M, and RRI-T Subscale Predictor Variables (n=199)*

Variable	<i>M</i>	<i>SD</i>	1	2
Constant	3.94	0.52	0.28**	0.34**
Realism Subscale	3.66	0.45	-	0.83**
Genuineness Subscale	3.56	0.48	-	-

** $p<0.0001$.

This simultaneous combination of variables yielded a multiple correlation coefficient (R) of 0.34 ($R^2=0.11$) and the adjusted R^2 was 0.11, indicating that 11% of the variance in the PDS-M outcomes could be predicted by the subscales *Realism* and *Genuineness*. From the ANOVA analysis, Table 10 shows that $F=12.6$ is significant ($p<0.0001$). This is indicated that the combination of the subscales significantly predicts PDS-M outcomes. Upon further examination in Table 10, it was also shown that the *Genuineness* ($t=2.71$, $p<0.01$) subscale was the only predictor between the two that was contributing anything of significance to the outcome when considered simultaneously. The null hypothesis, H_0 that there was no association between the RRI-T subscale scores and PDS-M scores could be rejected, and it could be said that 11% of the variance in PDS-M scores was predicted by the RRI-T subscale model. *Genuineness* appears to be the only significantly contributing subscale ($\beta=0.32$) to influencing outcomes on the PDS-M,

with a medium effect (Cohen, 1988). Thus, if the *Genuineness* subscale increases by one unit, then the model would predict that PDS-M outcomes will increase by 0.34 units.

Table 10: *Simultaneous Multiple Regression Analysis Summary for RRI-T Subscale Predictor Variables on PDS-M (n=199)*

Variable	<i>B</i>	<i>SEB</i>	β
Constant	2.64	0.29	
Realism Subscale	0.02	0.14	0.02
Genuineness Subscale	0.34	0.13	0.32**

Note. $R^2=0.11$; $F(2, 196)=12.6$, $p<0.001$; Genuineness, $t(199)=2.71$, $p<0.01$.
 ** $p<0.01$.

PDS-M effect on genuineness subscale.

Lastly, a simple regression analysis was completed on treating the PDS-M as the predictor variable for the outcome of the subscale *Genuineness*. A simple linear regression was run to explore whether the PDS-M was predictive of the RRI-T subscale *Genuineness* subscale outcomes. The model summary shows the R^2 value. R has a value of 0.34 and R^2 has a value of 0.11. This meant that the PDS-M accounted for 11% of the variation in the *Genuineness* subscale, and that 89% of the variation could not be explained by the PDS-M alone. The ANOVA table showed that the result was significant, $F(1,197)=25.3$, $*p<.0001$.

Table 11 shows the results of the simple linear regression analysis summary for the PDS-M predicting the *Genuineness* subscale. The unstandardized regression coefficient B for predicting *Genuineness* subscale score outcomes was 0.32 and the standardized coefficient (β) was 0.34, with $p<.0001$. The null hypothesis H_0 that there was no association between the PDS-

M scores and *Genuineness* subscale scores was rejected, and it can be said that 11% of the variance in *Genuineness* subscale scores was predicted by PDS-M scores. Because the correlation was $\beta=0.34$, this was considered a medium effect by Cohen (1998). Thus, if the predictor PDS-M scores increase by one unit, the *Genuineness* subscale scores would be expected to increase by 0.32 units.

Table 11: *Simple Linear Regression Analysis Summary for PDS-M Predicting Genuineness (N=196)*

Variable	<i>B</i>	<i>SEB</i>	β
Constant	2.31	0.25	
PDS-M	0.32	0.06	0.34*

Note. $R^2=0.11$; $F(1,197)=25.3$, $*p<.0001$.

Effect of presence of caseload on RRI-T and PDS-M scores.

Whether the CRC had a caseload or not was gathered as a demographic dimension in this study. It was not considered in the simultaneous multiple regression, but was considered a potentially valuable variable to include, given that results could have been swayed by whether the CRC had a caseload; indicating at least anecdotally that CRCs with a caseload might be more sensitized to the 2010 Code as it related to clinical standards relative to the ongoing interaction with clientele. There were 54 (27.1%) CRC respondents that indicated not having a caseload.

The descriptives were run for this group as well as for the group with a caseload, relative to the responses on the RRI-T and the PDS-M. Table 10 shows a comparison of the descriptive data between the two groups. The mean response for the *with caseload* group for RRI-T scores

was 3.63 (SD=0.44) with a minimum score of 2.46 and a maximum score of 4.58, where the mean response for the *without caseload* group was 3.57 (SD=0.47) with a minimum score of 2.50 and a maximum score of 4.71. Additionally, the mean response for the *with caseload* group for PDS-M scores was 3.93 (SD=0.51) with a minimum score of 2.74 and a maximum score of 4.96, where the mean response for the *without caseload* group was 3.97 (SD=0.54) with a minimum score of 2.61 and a maximum score of 5.00.

An inspection of this data revealed very little difference between the two data groupings. To explore whether the *With* or *Without Caseload* variable was contributing to the regression model, it was included into the original model and the simultaneous multiple regression was run again. The *With Caseload* variable was found to not contribute significantly to the RRI-T model ($t(154)=1.76, p>0.05$), however, it was near significant, at $p=0.08$. The *With Caseload* variable was also found to not contribute significantly to the PDS-M model ($t(154)= -0.31, p>0.05$).

Table 12: Means and Standard Deviations for CRCs With ($n=145$) and Without ($n=54$)

Caseloads

Variable	<i>M</i>	<i>SD</i>	Min	Max
With Caseload				
RRI-T	3.63	0.44	2.46	4.58
PDS-M	3.93	0.51	2.74	4.96
Without Caseload				
RRI-T	3.57	0.47	2.50	4.71
PDS-M	3.97	0.54	2.61	5.00

Chapter Five

Discussion

Summary of Study

The purpose of this study was to review the CRC use of the practice of professional disclosure, and its potential relationship to the formation of a strengthened therapeutic relationship, a key trait to establishing the effectiveness of the rehabilitation counselor (Koch, McReynolds, & Rumrill, 2004). To enhance its standing as a profession, rehabilitation counseling practitioners, educators and researchers have engaged in numerous studies including role and function studies, training needs, the future of the profession, and student perception of the amount of time devoted rehabilitation counseling activities (Zanskas & Strohmer, 2010; Muthard & Salamone, 1969; Rubin, 1984; Chan et al., 2003; Leahy 2009; Lustig & Strauser 2008, 2009). Kosciulek and Wheaton (2003) hypothesized that an effective therapeutic relationship leads to productive informed choice in the rehabilitation counseling process. However, little has been known about rehabilitation counselor tendencies toward strengthening the therapeutic relationship (a known contributor to positive service outcomes) relative to the use the informed consent practice of professional disclosure, as there have been few studies in this area, especially since the issuing of the 2010 CRCC Code of Professional Ethics for Rehabilitation Counselors.

It is the rehabilitation counselor's responsibility to engage the client in as much decision-making autonomy as possible (Hagen-Foley, Rosenthal & Thomas, 2005). Shaw et al. (2004) acknowledged the importance of adequate professional disclosure. The current CRCC Code of Professional Ethics (CRCC, 2010) included significant changes from previous code versions to the 2010 code that included requiring written professional disclosure (Carlisle & Neulicht, 2005).

The Shaw et al. (2004) study indicated that the field of rehabilitation counseling lacked knowledge in the prevalence of professional disclosure practices provided to the client. Thus, the therapeutic relationship is a part of the alliance and, being central to successful treatment outcomes, is built upon a trusting bond that should be strengthened by a well-implemented professional disclosure process.

This study utilized two instruments with the CRCs to operationalize and measure two constructs, the real relationship component of the therapeutic alliance, through the RRI-T (developed by Gelso et al., 2005), and professional disclosure, through the PDS-M. The real relationship component, the personal relationship that is thought to exist between individuals as reflected in the degree to which each is genuine with the other and perceives the other in ways that benefit the other (Gelso et al.), is theorized as existing within the therapeutic alliance that is expected to develop between the client and counselor. The PDS-M instrument was operationalized to measure the professional disclosure construct as adapted from the Shaw et al. (2004) survey on informed consent and professional disclosure practices. The Cronbach's alpha that was performed on the PDS-M indicated the instrument had high internal consistency reliability at .889.

Both instruments were put into a single survey format online via the survey software Qualtrics (Qualtrics.com) and imported into the IBM Statistics Package for the Social Sciences (SPSS) Statistics version 20.0 and analyzed via simultaneous multiple regression and simple linear regression to examine the potential for the identified demographic traits of Gender, Race/Ethnicity, Years of Experience, Setting: Private/Insurance, Setting: Education/Medical/Mental Health/Other, Job: Supervisor/Administration, Job: Vocational

Services, Job: Other, Age: Under 30 to 39, Age: 40-49, Age: 60+, and the PDS-M to predict significant outcomes as it related to the RRI-T.

Theoretical frameworks and processes were examined and incorporated into a combined model for this study. Houser et al. (2000) suggested that the basis for the Social Role Theory was to enhance client empowerment through hierarchically-neutral counselor-client interactions in the appropriate context which is intended to alter the role of each, thereby enhancing client empowerment. Kosciulek (2007) also tested the hypothesized structure of the Theory of Informed Consumer Choice in Vocational Rehabilitation (ICC-VR Model). The model laid out the hypothesis that informed choice in the vocational rehabilitation process would lead to better consumer outcomes through the interactions of organizational performance, informed consumer choice and consumer satisfaction. The theories of planned behavior (TPB) and reasoned action (TRA) were discussed by Perkins et al. (2007) as viable in the examination and change of clinician behavior.

The TPB and TRA are predicated on the behaviors performed by an individual being predicted from that individual's intention to behave in a certain way. Relative to counselor behavior, this included attitude, subjective norms, and perceived behavioral control. Given that no one model fit the focus of this study, the intent was to create a combined model that capitalized on the theories of planned behavior (TPB), reasoned action (TRA) and social learning, and incorporated Kosciulek and Wheaton's (2003) rehabilitation counseling empowerment framework, which was entitled the "Lewicki Model of Rehabilitation Counselor-Initiated Transfer of Empowerment via Relational Informed Choice ("ReCITE")."

CRC Relationship Orientation

The first part of the data analysis was to look at the contribution of CRC demographics, relative to the RRI-T to help provide insight into the ReCITE model. The simultaneous multiple regression that examined the relationship of CRC respondent demographic traits to the RRI-T did not have a specific hypothesis as the intention was to explore the contributions of all predictors at the same time. The null hypothesis, H_0 was that the predictor variables, simultaneously considered would not explain any of the association between the predictor variables and the outcome variable. The alternative hypothesis, H_A , was that when simultaneously considered, the combination of demographic characteristics would explain the association between the predictor and outcome variables. The null hypothesis, H_0 was retained, with $F(11,184)=0.470, p>.05$. None of the demographic variables, entered simultaneously, yielded a significant effect. Despite this result, the responses to each question were reviewed for further insight into CRC perspectives on RRI-T elements.

The results of the analysis on the RRI-T portion of the study, showed the CRCs typically agree ($M=3.6, SD=0.45$) with elements associated with the real relationship portion of the therapeutic alliance. The range went from a minimum of 2.46 to a maximum of 4.71. While the range covers 2.25 points on the 5-point Likert scale, the mode was 3.67, indicating that the CRC responses, on the whole were more consistent with having a positive opinion toward the real relationship with clients served, than negative, or disagreement with RRI-T components. CRC respondents indicated with greater agreement that they were able to respond realistically to their client, that both are able to be genuine in the therapeutic relationship, honesty is valued and shared between the counselor and client. CRCs indicated that they did not have difficulty in being honest with their clients, that they like their clients as persons, that there is a genuine

connection, that there is little difficulty in accepting each other as they are, and that the relationship is strengthened by understanding each other.

The open-ended question portion (qualitative) of the RRI-T indicated consistency with the RRI-T responses. CRCs noted that the traits of being genuine, honest, trust, communicative and clear role boundaries were valued the greatest as contributors in the therapeutic relationship. CRCs felt these skills and traits should be used to build trust, to actively help the client, enhance professionalism, clarify boundaries, and bring about consistency in the counselor client service interaction.

There were five questions on the RRI-T where the CRC expressed less agreement, on average being closer to the score of 3 (neutral). CRCs expressed neutrality around the client perceiving the CRC as not caring about who the counselor truly is, and that the client holds back significant parts of him or herself. CRC-focused questions where there was some neutrality and slight disagreement included feeling like there was a real relationship between the counselor and client, that there was genuine care for one another, and that the CRC holds back significant parts of him or herself.

In Figure 1, the ReCITE model, reviewed rehabilitation counselor internal processes as they related to real relationship orientation, behavioral intent and behavior. These are theorized to exist within the CRC, both formed by attitudes toward others, college curriculums, supervision, and training. While this study did not seek specifically analyze each construct area via a path analysis (i.e. showing paths along which causal relationships progress) (Vogt & Johnson, 2011), it sought to add insight into processes that conceptually related to client empowerment and decision-making. However, as has been discussed, CRCs anecdotally valued elements that were consistent with successfully building a therapeutic alliance, in using honesty, genuineness, clarity,

and actively helping (Carter, 2006; Lambert & Ogles, 2004; Baerger, 2001; Wampold, 2001). As the CRC utilized elements consistent with a positively oriented therapeutic relationship, the ReCITE model viewed this as an opportunity to transfer this strengthened therapeutic alliance to the client in the form of increased empowerment, all influenced from external guidance (agency policy and procedure, CRCC Code, laws, curriculums, supervision, trainings) as well.

Potential factors affecting CRC views on the therapeutic relationship.

Leahy, Chan, & Saunders (2003) noted that depending on the diverse workplace settings of the rehabilitation counselor, there were different opinions about the type of knowledge and job domains that were necessary to perform the job functions. The results of the present study underscore the variable settings in which CRCs are employed. As such, Leahy et al. noted the potential for fragmentation of job-related skills due to the multitude of settings where the rehabilitation counselor worked and thereby increased the likelihood that the role-focus for each rehabilitation counselor, depending of work setting, could be different. Many counselors noted that job development and placement knowledge were among the most important knowledge domains for successful practice. Rehabilitation counselors need many skills which should be used effectively to ensure that their clientele are satisfied with the services provided (Rubin & Roessler, 2008).

The rehabilitation counselor, according to Roessler and Mullins (1995), should engage in the four Cs of rehabilitation counseling: counseling, coordinating, consulting, and case recording. Rubin and Roessler (2008) also note that the rehabilitation process is complex and consists of four phases: evaluation, planning, treatment, and termination. Leahy et al. (2003) noted that there were a number of new knowledge and task areas to take into account when considering the diversity of the role of the rehabilitation counselor. Etheridge et al. (2007) supported the growing

contention that the role of the rehabilitation counselor was wide and varied by noting due to the ADA, the licensure movement, and emerging disability populations. The rehabilitation counselor was to be regarded as a consultant, a private practitioner and a disability manager. In fact, Rubin and Roessler indicated that the rehabilitation counseling field has spent too much time on debating whether the rehabilitation counselor is a counselor or a coordinator. Etheridge et al. argue that rehabilitation counselors must be prepared with the necessary knowledge and skills in order to be competitive in the job market and effectively serve persons with disabilities.

CRCs and Professional Disclosure

The next part of the data analysis was to look at the contribution of CRC demographics, relative to the PDS-M to also help provide insight into the ReCITE model. The simultaneous multiple regression that examined the relationship of CRC respondent demographic traits to the PDS-M did not have a specific hypothesis as the intention was to explore the contributions of all predictors at the same time. The null hypothesis, H_0 was that the predictor variables, simultaneously considered do not explain any of the association between the predictor variables and the outcome variable. The alternative hypothesis, H_A , was that when simultaneously considered, the combination of demographic characteristics would explain the association between the predictor and outcome variables. The null hypothesis, H_0 was retained, with $F(11,184)=0.86, p>.05$. One of the demographic variables, Age: 40 to 49, yielded a significant contribution to the prediction equation, $t(184)=-2.12, p<0.05$ when compared to the reference variable of Age: 50 to 59, indicating that persons in the comparison group are expected to perform better as it pertains to professional disclosure practices. Responses to each question were reviewed for further insight into CRC perspectives on PDS-M elements.

The analysis showed that when considering all demographics simultaneously, there was not a significant effect in the model. The Age: 40 to 49 variable was found to be responsible for 2.4% of the unique variance in the model. As the Age: 40-49 variable ($b=-0.23$) increases by one unit, PDS-M scores decrease by 0.023 units, when compared to Age: 50-59. The overall model effect ($R^2=0.05$) is much smaller than typical (Leech et al., 2015). None of the other age groups yielded a significant result compared to the Age: 50-59 group, and thus, age as a factor appears to have minimal impact on professional disclosure, but marginally so if the CRC is between the ages of 50 and 59.

The results of the analysis on the PDS-M portion of the study, using a 5-point Likert scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree), showed that CRCs typically agree ($M=3.94$, $SD=0.52$) with elements associated with the real relationship portion of the therapeutic alliance. The range went from a minimum of 2.61 to a maximum of 5.0. While the range covers 2.39 points on the 5-point Likert scale, the mode was 3.65, indicating that the CRC responses, on the whole were more consistent with having a positive opinion toward the ethical constructs within the professional disclosure process, than negative, or disagreement with PDS-M components. None of the means for the PDS-M questions was below 3 (neutral), generally indicating agreement with the questions. CRCs responded most positively with providing information to clients on the nature and purposes of services ($M=4.50$, $SD=0.59$), discussing the limits of confidentiality ($M=4.45$, $SD=0.66$), that the process of professional disclosure is important ($M=4.44$, $SD=0.72$), that professional disclosure is discussed verbally ($M=4.24$, $SD=0.83$), including risks and benefits ($M=4.24$, $SD=0.74$) and the expected length and frequency of services (4.21, $SD=0.80$).

The question “*The CRCC Code of Professional Ethics influences how I use professional disclosure*” was added to look at the CRC’s opinion on whether the CRCC Code plays a role via external agency influence in informed consent practices in the course of their professional practice. CRCs responded with slightly less than “*agree*” ($M=3.77$, $SD=1.21$) for providing written professional disclosure to their clients. This was somewhat in contrast to the 2010 Code, which indicates that “rehabilitation counselors have an obligation to review with clients orally, in writing, and in a manner that best accommodates any of their limitation, the rights and responsibilities of both rehabilitation counselors and clients” (CRCC, 2010, p. 6). Additionally, CRC respondents indicated less than “*agree*” ($M=3.81$, $SD=0.861$) that the 2010 Code influences how they use professional disclosure. CRC responses were closer to neutral ($M=3.37$, $SD=0.96$) as it pertained to feeling that information given to clients was difficult to understand. Other questions where the responses on average were closer to neutral included relying less on formal procedures to establish client competency ($M=3.37$, $SD=0.97$) and covering contingencies for service continuation should the CRC become incapacitated or die ($M=3.22$, $SD=1.10$).

Generally, the PDS-M responses were close to the responses from the Shaw et al. (2004) study that reviewed the opinions of counselors regarding professional disclosure practice statements. However, the CRC respondents in this current study expressed more concern over professional disclosure portraying the rehabilitation counselor as cold or uncaring ($M=3.90$, $SD=0.78$) and affecting the client’s willingness to disclose freely ($M=3.57$, $SD=1.04$). Conversely, the Shaw et al. study showed that these questions mattered less.

There has existed a need to more specifically define the beliefs of counselors as it relates to the ethical nature of professional actions (Tarvydas, Leahy, & Saunders, 2004). The 2010 Code was the result of the best empirical evidence available on ethical practice in rehabilitation

counseling and featured enhanced standards relating to professional disclosure and informed consent and roles and relationships with clients, among others (Tarvydas, Cottone, & Saunders, 2010). Tarvydas and Barros-Bailey (2010) conducted a study of an ethics survey that included a qualitative analysis of the responses, which revealed that the overall 2001 Code sections where the most ethical dilemmas were contained were; A. Counseling Relationship, B. Confidentiality, and D. Professional Responsibility. These three code sections accounted for 80.3% of the responses for the all code sections.

The qualitative responses to the PDS-M indicated a strong CRC perspective toward using professional disclosure to inform and clarify boundaries and expectations with clients. The concerns surrounding the use of professional disclosure included the sense of formality, confusion, the therapeutic gap it could create, and the perception that this process crosses the line with respect to personal boundaries. This result was surprising in that responses here seemed to imply that professional disclosure and personal disclosure were synonymous. This could potentially speak to a lack of adequate understanding of what professional disclosure is and its place within appropriate ethical procedures.

Conversely, there were CRCs that felt that professional disclosure was a positive process with little negative effect, but that the wording in the statement should be clear and understandable. Most CRCs use professional disclosure to inform their clients, clarify roles and improve trust. More CRCs (n=167) appeared to provide verbal professional disclosure to their clients than provide it in written form (n=125). While the study was not specific to looking at group differences, it is worth noting that the 2010 Code expects this process to occur in written format.

External influences, such as education, agency policy and procedure, the 2010 Code, professional evolution, statutes and regulations affect the responsibilities and liabilities of the rehabilitation counselor (Shaw et al., 2004). Relative to the ReCITE model, these are seen as integral influences in forming and further evolving the CRC's attitudes and professional actions. As such, the ReCITE model starts with these influences and conceptually relates to attitudes, norms, and the perception of control as it relates to informed consent processes. Based on the formation of these three factors, it was envisioned in this study that the three areas (attitudes, subjective norms and perceived control) as they relate to the TRA and TPB, helps guide the counselor, through their own relational orientation, to engage in behaviors that form the therapeutic relationship, empower the client and thereby enhance informed choice. However, in the resulting analysis of the demographic components, it was found that there was no effect to a very small effect, and thus, demographic variables do not appear to be adequate predictors in a study such as this one.

Relevance of Professional Disclosure as a Relationship Catalyst

The null hypothesis, H_0 , for examining the PDS-M as a predictor of the RRI-T in the simple linear regression, was that there was no association between the PDS-M scores and RRI-T scores. This test was to help determine whether there was evidence that professional disclosure contributed significantly to the prediction of the real relationship component in the therapeutic alliance. A functional working alliance between the client and counselor is considered a vital and necessary element for positive change (O'Sullivan, 2012). One key to therapeutic success has been found to be related to having an open and honest exchange with the client (Kress, Hoffman, Adamson, & Eriksen, 2013). Thus, in the ReCITE model, an important feature was the

relationship of professional disclosure as a necessary contributor to the therapeutic relationship with the client.

The null hypothesis H_0 that there was no association between the PDS-M scores and RRI-T scores was rejected in favor of the alternative hypothesis H_A , and can be said that 11% of the variance in RRI-T scores was predicted by PDS-M scores. According to Cohen (1988) an R^2 value of 0.11 yields a medium effect. More to the point, the *Genuineness* subscale contributed significantly. The more self-actualized the counselor, the more effective communication occurred with high levels of empathy, warmth and genuineness, conditions associated with factors that indicate an effective helper (Fischer & Knapp, 1977). Colling and Davis (2005) stressed that the basis of informed consent is to ensure that the client and counselor, in engaging in the therapeutic relationship, include information and education in the interaction. This was important in reviewing this study's results in that it was consistent with Wampold's (2001) meta-analysis of psychotherapy efficacy research where the conclusion was that 70% of psychotherapeutic effects were attributable to common factors (therapeutic alliance, empathy, warmth, genuineness, etc.). Common elements within the counseling method used, and the therapeutic relationship are therefore notable and consistent contributors to outcome (Martin, Garske, & Davis, 2000). Kosciulek and Wheaton (2003) hypothesized that an effective therapeutic relationship would be related to productive informed choice in the rehabilitation counseling process. Thus, the finding of significance of the relationship of the PDS-M as a predictor of RRI-T results was a moderate indicator and suggests that effectively used professional disclosure has a positive effect on the therapeutic relationship, and further its possible contribution as a construct that enhances and empowers client outcomes.

Figure 2 represents a reconceptualization of the of the ReCITE model based on study findings and insights gained. The study reviewed the concept that elements within the model were externally motivated and internally driven. For the RRI-T, the externally related questions, there was a lower positive average response, indicating that due to the nature of the question, it was less appropriate for the CRC to have an opinion on the topic (i.e. “*My client feels liking for the ‘real me’.*”). Therefore, externally-driven influences over time may lead to the CRC’s internalized self-concept as far as how they may feel a client would feel toward them based on experience with other clients.

For the RRI-T questions grouped as internal, there was a higher level of agreement among the CRC respondents. These statements related to the CRC attitude toward their clients as it related to concepts of connectedness, realism, and genuineness. Internal factors are seen as being influenced by the CRC’s attitude toward persons with a disability, general perspective toward others, experiences with others, internal drive toward altruism, etc. Thus, as the RRI-T relates to the ReCITE model, external influences would include educational opportunities in the university and work settings, as well as continuing education opportunities geared toward improving clinical knowledge and capacity that is thereby internalized and operationalized by the CRC for use with the client.

The same process was used to conceptualize the role of the PDS-M in the ReCITE model. There were 26 questions in the PDS-M, and 15 were grouped as external and 11 as internal. Generally, between external and internal questions, there was agreement, but each had greater variability. Because of this greater variability for the external group, it would be indicative of the possibility of greater ambivalence in use of established 2010 Code requirements, how agencies enforce them, and how rehabilitation counselors are educated on the presence and necessity of

professional disclosure. The internally-grouped question variance may also more importantly speak to the CRC feeling less confident in recognizing and intervening in situations that have ethical implications in the professional disclosure realm.

It is important to consider external and internal influences in the ReCITE model, as the prevailing idea is that the quality of education, supervision guidance, agency policy and procedure, and continuing education should have a relationship to the CRC's internalization of these processes as well as the ability to understand, recognize and master context-appropriate use of ethical (including professional disclosure) constructs in the provision of services to persons with disabilities. Ethical systems have the responsibility of being as inclusive of the values contained in a diverse society and CRCs should be prepared to face these challenges to the greatest extent possible (Henricksen & Trusty, 2005).

Re-Envisioned Lewicki Model of Rehabilitation Counselor-Initiated Transfer of Empowerment via Relational Informed Choice (“ReCITE”)

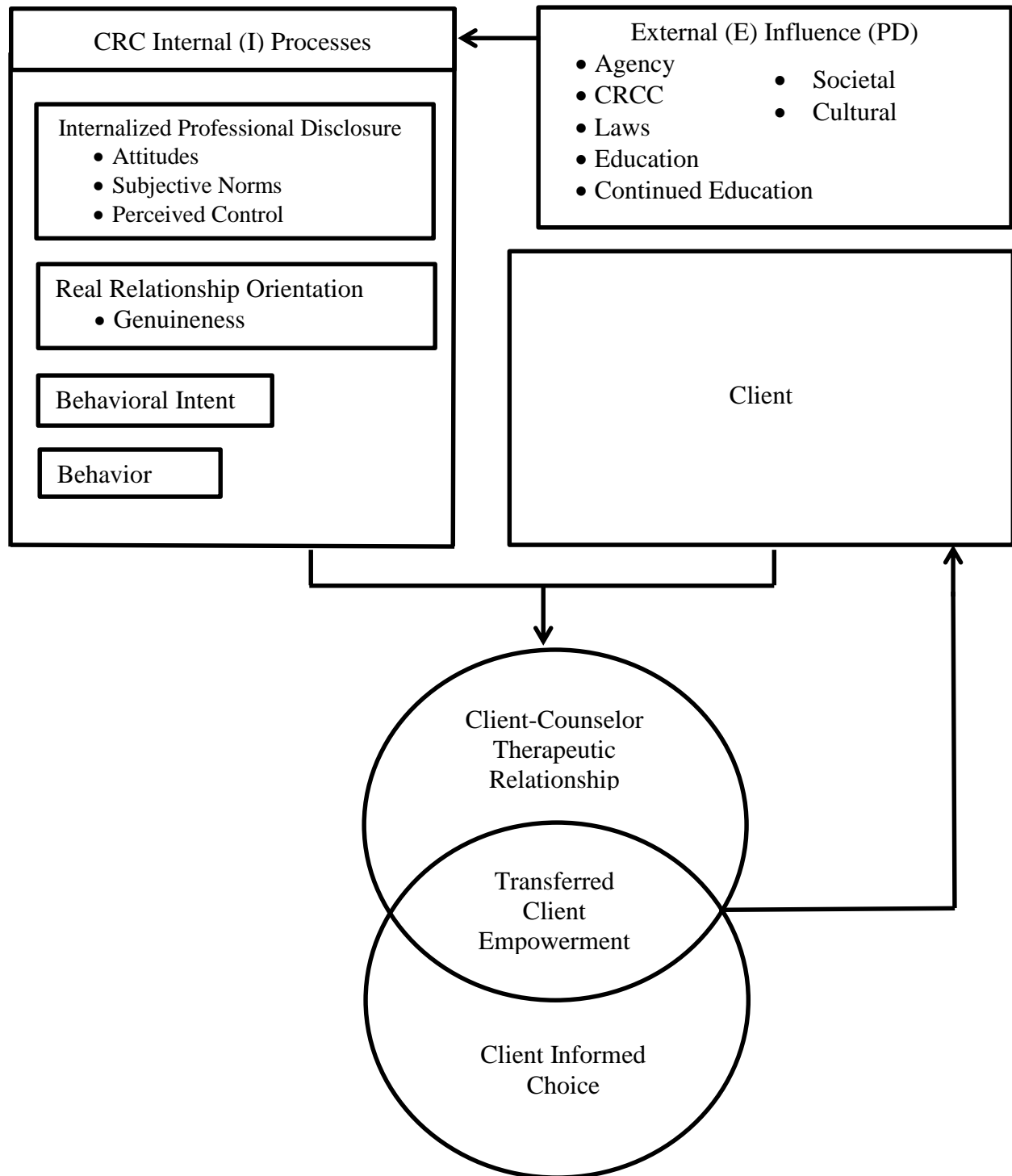


Figure 2: Re-envisioned framework for conceptualizing the role of the real relationship and professional disclosure in client empowerment

The ReCITE model must endeavor to account for the higher level constructs that would serve to fully inform the model itself. Brofenbrenner's ecological model has been applied to counseling learning environments (Lau & Ng, 2014) and contains many of the constructs of the ReCITE model. Brofenbrenner noted that learning is a function of social interaction, and as Lau and Ng further theorize, the more developed and experienced the student, the more likely complex social, learning, and training experiences will be encountered. As the CRC has these experiences externally (agency policy and procedure, societal, cultural, CRCC, formal education, continuing education, and laws), the CRC becomes more informed and educated and is able to employ, from a greater knowledge base, effective ethical practices that will enhance the counselor-client relationship. Thus, the CRC will be able to internalize these external experiences along with the CRC attitudes, subjective judgment, perception of control, and expression of genuineness to lead to appropriate professional ethical behavior and to the enhanced client-counselor therapeutic relationship.

The ReCITE model should, most importantly focus on pedagogies designed to inform and train the rehabilitation counselor, whether at the pre-credential level (university-level education, supervision or credential level (supervision, continuing education). Educators of counselors must play an active role in educating rehabilitation students to help them make decisions and to grow (Glosoff & Cottone, 2010). The rehabilitation counseling student must also be allowed to struggle in order to learn and grow, and to most importantly, internalize ethical dilemmas and the constructs needed to operationalize a system toward their resolution (Nelson & Neufeldt, 1998). Not only is it necessary for rehabilitation counselor educators to clearly understand their obligation to assess the skills of their students, but they should also maintain competence (Glosoff & Cottone). This is also underscored by the fact that while education is vital, it is lifelong in that

all rehabilitation counselors must continue to be informed on scientific and professional information in order to adequately perform their roles (i.e. journal reading, collaboration, supervision, continuing education).

Limitations

There were a number of potential limitations to address within this study. The first was the possibility that the non-significant results for the demographic predictor variables may have to do with the increasing number of specialty areas in which the rehabilitation counselor operates. As was shown in this study, there were numerous settings from which the sample was comprised, as well as the CRC population characteristics (CRCC, 2014). There has been continuous growth in the rehabilitation counseling field, and as the roles and responsibilities of the rehabilitation counselor have expanded, into traditional (state and federal systems, rehabilitation centers, worker's compensation, insurance) and non-traditional settings employee assistance, disability management, school transition, university disability centers, hospitals and clinics) (Etheridge et al., 2007), there exists the possibility that work setting may influence how professional disclosure and the therapeutic relationship are viewed and implemented. This was partly supported in a study by Kosciulek (2007) that suggested that community rehabilitation program quality in the areas of leadership, strategic planning and consumer focus directly affect the level and quality of consumer choice. Tarvydas, Leahy, and Saunders (2004) noted in a study of CRCs and national certified counselors (NCC) that a potential limitation was that only counselors holding either certification were surveyed and were selected randomly. The authors concluded that the reader should be cautious in extending conclusions to the entire population, despite, in the case of this study, that the CRC respondents appeared to be a matching subset of the greater CRC population. This should still be treated with caution.

The data in the RRI-T showed nearly bimodal data where the second mode was 3.0. There was not sufficient evidence to remove these responses from the study, but keeping them in meant accepting the potential limitation that there were some CRCs that either did not believe in, or utilize the therapeutic relationship in their service-philosophy with clients due to this neutral rating. Related to this was the possibility that the real relationship component, as theorized by Greenson was that the therapeutic relationship consisted of interrelated parts, the most important of which was referred to as the real relationship (as cited in Gelso & Carter, 1994, p. 296). Gelso (2014) noted three interlocking elements belonging to a tripartite model of the therapeutic relationship, consisting of a real relationship, a working alliance (consistent with Bordin's 1979 model), and a transference configuration (client transference and counselor countertransference). Thus, it is possible that the construct of the real relationship may have a variable level of effect on the therapeutic relationship relative to the type (i.e. setting, job type) that the CRC is a part of.

It appeared that many CRCs (49.1%) in question 3 of the RRI-T open-ended questions (i.e. *How do you feel that professional disclosure affects the therapeutic relationship with the client?*) answered with responses that were consistent with the belief that professional disclosure was in fact *personal disclosure*. For example, the responses; “*Professional disclosure can help a client to see the counselor as a "real person" who has personal or professional obstacles to overcome as well;*” or, “*You must keep boundaries in mind and not share too much. Also ask yourself for whose benefit are you sharing this information. Is it for yourself or the client?*” These were examples that strongly hinted at the CRC respondent as confusing the term professional disclosure with personal disclosure, and thus, this could have affected how responses to questions on the PDS-M were made, despite the definition of professional disclosure being embedded in the survey.

Also, a potential limitation was that the survey asked RRI-T questions first, including the open-ended questions, then moved on to the PDS-M and related open-ended questions. This may be relevant in that the order of the instruments could have affect how subsequent answers were formulated on the part of the CRC. This also related to the potential that the study design being ex-post facto, may have affected the result in that the CRCs were studied after the variables may have had their effect and could not be controlled for in an experimental fashion (some or many demographics would be near-impossible to control for) (Vogt & Johnson, 2011).

Additionally, parsimony, according to Vogt and Johnson (2011) referred to improving the power of an analysis through use of a smaller number of predictor variables on the outcome variable. The number (11) of predictor variables in this study likely affected the power in the analysis, or the ability of the simultaneous multiple regressions used in the analyses to detect the relationship among the variables.

Recommendations

As a critical feature, the presence and adherence to a set of ethical standards has been used to determine the status of a profession (Tarvydas, Leahy, & Saunders, 2004). The status of the rehabilitation counseling profession was given further depth, clarity and legitimacy via the 2010 Code expectations relating to the ethical practices of professional disclosure and informed consent (CRCC, 2010). Further, Carlisle and Neulicht (2010) stated that ethical principles and the rehabilitation counselor-endorsed client outcomes of empowerment, choice, and independence are directly related. The 2010 Code expands on professional disclosure and informed consent more extensively and enables the rehabilitation counselor a greater opportunity to establish a strong therapeutic relationship with the client through these processes. This was one of the areas of

focus of this present study which sought to explore the relationship of professional disclosure to the real relationship component of the therapeutic relationship.

Tarvydas (2012) referred to this study's use of external influences as *internal standards of the profession* and *external regulatory standards*. *Clinical practice standards* was used relative to this study's use of internal influences. The extent to which ethics is expected to be employed is a function of whether it is some mixture of aspirational (educational institutions, professional organizations) or mandatory (certification bodies, state licensure boards, and court system). When viewed as a continuum, aspirational ethics is driven by educational and professional organization standards, and within professional organizations and certification bodies, such as the CRCC, drive mandatory ethical processes by way of the CRC being bound (i.e. mandatory) to uphold those standards because of the credential awarded to the CRC. Mandatory ethics involves adherence to remaining in compliance with the standards that keep the CRC safe from legal action and professional condemnation. Aspirational ethics involves reflection on the effects of a dilemma or situation, the welfare of the client, and on the profession.

Fidelity and veracity, two of the six principles in the 2010 Code relate to the mix between mandatory and aspirational ethics. Rehabilitation counselors should be educated on seeing the connection of professional disclosure to these principles. These principles are ethical elements required by the CRCC and involve reflection on actions best taken in order to ensure client welfare. Fidelity is to remain faithful and keep the promises and trust placed by the client in the CRC. Thus, the implication of the effect that professional disclosure has on fidelity is the expectation that the client will be informed is keeping fidelity (faithful adherence) to the expectation that the 2010 Code has on the client in being provided professional disclosure both verbally and in writing.

Veracity is honesty, and in the case of this study, it is in providing detailed professional disclosure and being clear as to whom, for example, will have access to client files (Tarvydas, 2012). Thus, use of mandatory ethical principles means that the CRC is able to ensure safety relating to decision-making within the confines of the ethical principles as well as to enter into thoughtful consideration as to the effect that the principles of fidelity and veracity may have on the behavior and welfare of the client. In light of this study, it has been shown that when professional disclosure is used, the ethical principles of autonomy, fidelity, and veracity are upheld, and result in an improved therapeutic relationship (genuineness). Thus, respecting the client's right to govern their own life, and to respect their right to privacy and to receive and hear all needed information for the counseling experience, leads to an ingredient that Rogers (1957) referred to as a necessary condition for change (client views the counselor as genuine). Counselors should strive to achieve genuineness with their clients (Kolden et al., 2011). This, in effect, means that not only should the CRC show an accepting attitude, but tailor their relational approach to meet the client's expectations and not treat every client the same way (Taber, Leibert, & Agaskar, 2011). Kolden et al. see this as serving an attachment function (i.e. bonding) as well as a behavior guide for the therapeutic relationship.

The rehabilitation counseling profession has continued to evolve. From the 1987 Code, professional disclosure was merely mentioned, to the 2001 Code, where it was recommended to be provided to clients in written form, to the 2010 version of the code that now requires that professional disclosure be in written form, the field has been tasked with increased responsibility and expectation to practice legally, ethically, and professionally (Carlise & Neulicht, 2010; Shaw et al. 2004). This study suggests that despite the evolution of the rehabilitation counseling field, CRC respondents varied in terms of agreement with different aspects of the PDS-M. This points

to the presence of varying levels of belief in the processes as delineated in the 2010 Code and potential confusion as to the differences between professional and personal disclosure, also further raising the potential that the construct is not being used to its fullest, or possibly that ethical boundaries are being overlooked. This has not been proven, but should be cautionary with respect to CRC perspectives and attitudes relating to the topic.

Providing clients written professional disclosure statements has been a requirement since the 2010 Code, and previous to that, Shaw et al. (2004) found that the use of written disclosure statements was not a common practice among rehabilitation counselors. CRCs in this study continued to show a varied use of the requirement. In response to this variation, one recommendation is that students in rehabilitation counseling receive training in contextually-appropriate and specialty-specific education and training in both broad and targeted areas of rehabilitation counseling ethics. Education, whether at the university education level, supervision, or continuing education, need to emphasize clearly what professional disclosure is as evidenced by the potential that some CRCs in this study appeared to confuse it with personal disclosure. Tarvydas et al. (2004) note that the formulation of a pedagogical approach be created to allow for a systematic and titrated exposure of students to different degrees of ethical situations and ambiguities to enhance ethical decision-making. Tarvydas (2012) has utilized case study examples in the illustration of the use of ethical models to further effective pedagogy on the topic. Role modeling, role plays, discussions and workshops are also recommended forms of teaching rehabilitation counselors the intricacies of ethical principles (Glosoff & Cottone, 2010).

Kocet (2005) discussed the ethical mandate for counselors to be culturally competent and develop ethical decision-making models. The Tarvydas Integrative Model for Ethical Behavior is proposed as a model that should be used in addressing a balance between the issues in the ethical

dilemma and collaborating with the rightful individuals in the situation (Tarvydas, 2012). The model includes four stages in the integration of ethical behavior: 1) interpreting the situation, 2) formulating an ethical decision, 3) selecting and action, and 4) planning and executing the selected course of action. In teaching this model, the rehabilitation counselor will be able to engage in a more thoughtful process that will assist in addressing all necessary ethical principles involved in professional disclosure and will preserve the dignity and integrity of all persons involved in the ethical scenario. Furthermore, teaching this model, in addition to others, as a component to the Council on Rehabilitation Education (CORE)-accredited curriculum ensures attention to the CORE ethics-related standards.

The transcultural model of ethical decision-making was a model that had been adapted from the Tarvydas Integrative Model for Ethical Behavior (Garcia, McGuire-Kuletz, Froehlich, & Dave, 2008). Significant aspects of multicultural theory were added in order to adequately address the presence and influence of cultural factors when considering the facts related to the ethical dilemma. While not the primary scope of this study, it is recommended that the ethical decision-making models that are taught also include a strong multicultural component given the position of importance that multicultural processes has in rehabilitation counselor preparation (Glosoff & Cottone, 2010; Henricksen & Trusty, 2005; Fischer & Chambers, 2003).

The 2010 Code also indicates that education curriculums should infuse ethical content throughout the program. This also includes effective knowledge on what other educators are covering in their courses. Tarvydas and Barros-Bailey (2010) acknowledge that simple knowledge of ethical standards is not enough, but that a more complex system of delivery of teaching and application of the standards and related resources within a context of specific ethical decision-making processes is vital.

The 2013 CORE accreditation manual for master's level rehabilitation counseling programs also contains important elements used to determine a university's fidelity to standards around ethical principles (CORE, 2013). This study recommends a relationship between CORE-accredited programs and their respective core curriculum areas involving professional identity and ethical behavior, especially in relation to the formation of the therapeutic relationship. CORE standards are aligned toward mandatory and aspirational ethical program development at the university level and it is important that the teaching institution develop these standards fully and with attention toward infusing ethical standards throughout the entire program and keep it as a central program focus (Glosoff & Cottone, 2010; Tarvydas & Barros-Bailey, 2010; Mullins & Roessler, 1998).

Relating to the recommendation of curriculum development to respond to this gap, supervision and training are identified suggestions. Supervision should be used to guide, inform, educate, and assist the rehabilitation counselor to inform their clients. Bernard and Goodyear (2009) indicate that the supervisee should be as well informed as their clients in terms of informed consent. Supervision is important to teach professional boundaries, help address reduction of liability (i.e. preventing malpractice), improve clinical judgment and decision-making, and to ultimately responsibly monitor client welfare (Sherry, 1991). Training also serves to address specialty-specific areas within rehabilitation counseling. Given the continuous growth for rehabilitation counselors in private non-profit and private for profit sectors, as well as, hospitals, mental health settings, employment settings and state/federal settings, the rehabilitation counselor must be able to manage professional challenges appropriately to use new knowledge and skills effectively (Etheridge et al., 2007). Thus, in light of this study, it was found that CRCs varied in their perspectives on professional disclosure. This varied perspective places the CRC in

a potentially vulnerable position whereby through inconsistent provision of informed consent processes, important CRCC Code mandates are missed, placing both the counselor and client in vulnerable positions.

Colling and Davis (2005) have noted that informed consent ensures that the client and counselor engage in the therapeutic relationship. As other research has noted the importance of the alliance as an ingredient for positive client change (Kress, Hoffman, Adamson, & Ericksen, 2013; O'Sullivan, 2012; Pinals, 2009), the present study has shown that this relationship exists between professional disclosure enhancing the therapeutic relationship, and more so the significant effect that professional disclosure has on CRC genuineness and vice versa. Thus, CRC responses in this study are informative in that many positives from the therapeutic relationship and professional disclosure (i.e. trust, honesty, genuineness, professionalism, and role clarity) are consistent with extant research. Openness, caring, empathy, choice, unconditional positive regard, and empowerment are not only important ingredients to an effective therapeutic alliance, but are directly related to ethical principles and are thus, elevated in their importance on humanistic levels (Carlisle & Neulicht, 2010; Kosciulek & Wheaton, 2003; Mullins & Roessler, 1998; Rogers, 1957).

The present study showed that many CRCs were aware of the value of therapeutic-alliance and relationship building traits, as well as (despite differences in opinion that existed) the benefit or at least necessity of providing professional disclosure. It is recommended from this study that the CRC also receive education (via supervision, training, and educational curriculums) relative to the positive effect that professional disclosure has on the formation of the important therapeutic alliance, including the relationship of genuineness in the process. A strengthened alliance is thought to lead to improved outcomes (Kosciulek, 2007). Thus, CRC knowledge should be

enhanced effectively to stress the importance of the ethical requirement of professional disclosure, and its connection to the positive effect it will have on genuineness in the therapeutic relationship and the resulting contribution as a construct that empowers client outcomes.

Implications for Future Research

Rehabilitation counseling research has not fully studied this interactive process and the ultimate goal is to better understand the role that ethical practices play in strengthening the therapeutic alliance and the effect these combined phenomena have on enhancing client outcomes more effectively when maximized in coordinated fashion (as in the ReCITE model). The therapeutic alliance, in particular, the genuineness component within it, has been found to be a consistent predictor of treatment outcomes, but the variable roles of the counselor and client have not yet been fully clarified (Baldwin, Wampold, & Imel, 2007). As in the present study, professional disclosure processes were found to be significant, with a moderate effect. The recommendation also exists as an opportunity where only the counselor role has been investigated. Kelley, Fuertes, Gelso, Marmarosh, and Holmes-Lanier (2010) also investigated the real relationship in the context of the client through the development of a similar measure. Findings supported early reliability and validity of the Real Relationship Inventory-Client (RRI-C) as a measure of client perception of the therapeutic relationship. The ReCITE model needs this input in order to advance its potential for legitimacy with respect to this series of interactions among constructs, individuals, and influences.

While age showed to be a significant factor in the PDS-M, it was for the Age: 40-49 when compared to the Age: 50-59 group, but to a small degree. However, CRCs aged 50 and over currently constitute 50.5% of all CRCs and the 30-49 age group constitutes 41.4%, with the remainder being younger than 30 years of age (8.1%). These numbers speak to a very important

and experienced groups of persons entering into the early retirement age range. Given the statistically significant positive outcome for the 50-59 age group, it may stand to reason that quality experience, supervision, teaching, and training will become unavailable (or at least less accessible) for younger generations of CRCs that will benefit from learning of the methods, traditions, history, momentum, and strong identity established by these persons. This is but one recommendation in that age proved to be an important factor, but the lack of results from the other demographic groupings may indicate a number of issues. The first may relate to study design and variable groupings. While the numbers for multiple regression analysis were sufficient, the lack of significance may indicate that there is need to improve variable grouping methods. The demographic predictor variables, simultaneously considered did not explain any of the association between the predictor variables and professional disclosure or real relationship scores. As Beutler (1997) had noted that there has been a decline in the study on individual characteristics and that it is time to reintroduce the counselor and client into the study. The findings on the qualitative questions for both the RRI-T and the PDS-M suggest that in addition to improved demographic conceptualization, the study of specific trait effects appears to be advised (Kelley et al., 2010). Genuineness, empathy, trust, respect, rapport, clarity, and honesty were all noted to be positive and desired mechanisms acting in service to the therapeutic alliance and professional disclosure in the present study and it stands to reason that these constructs (i.e. traits or qualities) would be an addition to future studies looking at the empowering effect that the interaction of ethical influences have on the formation of the therapeutic relationship, and resulting client empowerment.

Respecting the rights and dignity of the client are embedded in the 2010 Code of Professional Ethics for Rehabilitation Counselors as the six ethical principles of autonomy,

beneficence, fidelity, justice, nonmaleficence, and veracity are based on the spirit of caring, respect, welfare, appreciation of cultural diversity (CRCC, 2010). Thus, ethics involves the best care with the best-informed of intentions for the client, a clear empowerment perspective. Gelso (2002) called the real relationship the “something more” of psychotherapy. The results of this study suggest that ethical practices such as professional disclosure do predict outcomes as it relates to the formation of the therapeutic relationship and improve the creation of a genuine environment. Future studies should focus on further review and analysis of these traits, strengthening curriculums and developing programs to train rehabilitation counselors, and as well as the client contribution to the ReCITE model through confirmatory factor analysis and structural equation modeling to test the casual strength of these latent variables. Further, it is possible to enhance the PDS-M through the development of subscales that increase review of the elements within the Tarvydas Integrative Model for Ethical Behavior (Tarvydas, 2012).

Conclusions

Rogers (1957) viewed the trait of genuineness as a necessary condition for client change, and the trait of being trusted (fidelity) is typically an expected outcome of counselor ethical practices of competence, informed consent, confidentiality, power, and social justice (Ivey, Ivey, & Zalaquett, 2012). In general, while there was not a statistically significant effect with the CRC demographic characteristics predicting RRI-T outcomes, the anecdotal qualitative data themes and the question by question analysis showed that the CRC was interested in practices that were consistent with processes that enhance the therapeutic relationship. The *Genuineness* subscale and professional disclosure outcomes were significantly related, lending support to the importance of the ethical process of information sharing (autonomy, fidelity, and veracity).

Given the large number of responsibilities and expectations a rehabilitation counselor must successfully implement and manage, demographic factors may not be as salient an area of investigation. Depending on job setting and job type, the potential outcome relating to the CRC perspective on formation of the therapeutic alliance, may vary. The necessity of the multitude of roles that the rehabilitation counselor must play means that counseling, coordinating, consulting, and case recording, and many other competencies need to be developed to a level of adequacy in order to ethically serve and meet the needs of persons with disabilities (Rubin & Roessler, 2008). Beutler (1997) noted that there has been a decline in research regarding therapist job experience, training and a wide variety of other characteristics as it relates to demographic traits. Thus, the lack of significance in results relating to the simultaneous multiple regression of CRC demographic characteristics on the RRI-T necessitates that further research be conceptualized and implemented relative to CRC demographic traits, training, treatment types, as well as specifically separated by job setting and job type due to the varying areas of focus.

Informing the client, as represented in the 2001 Code, had evolved to include the *recommendation* that the client be given information on counselor credentials as well as the purpose, limitations, benefits and risks of services, which also included a *recommendation* that this information be provided in a written format when testing individuals (Blackwell, Autry, & Gugliemo, 2001). This change likely resulted in greatly varied practices in comparison of CRCs, because it was not a requirement at that time. In 2010, the CRCC issued its most current Code of Professional Ethics (CRCC, 2010) to date. One of the most significant changes to the 2010 code was that written professional disclosure became a requirement (Carlisle & Neulicht, 2005). Based on the variation of responses in this study, it appears that there is not strong consensus in all required areas of professional disclosure as identified in the 2010 Code (as evidenced by the range

of mean aggregate responses of 2.61 to 5.00, and SD range of 0.59 to 1.21). Added to the non-significant findings (with exception of Age: 40 to 49) of the simultaneous multiple regression of the demographics on the PDS-M, this portion of the study suggests that CRCs anecdotally (via the qualitative questions on the PDS-M), if not somewhat varied, appreciate the importance of professional disclosure, but the statistical analysis does not indicate significance in that the predictor variables, when simultaneously considered do not explain any of the association between the predictor variables and the outcome variable, likely indicating that implementation of adequate professional disclosure is not occurring.

The findings of this study support the contention of the self-fulfilling prophecy that once something is defined as real, it is also real in its consequences (Wiley, 2003). The ethical practice of professional disclosure is thought to address the client's right to exercise autonomy through the gaining of knowledge about the service process, and thereby, improving the therapeutic relationship (and consequently, the therapeutic alliance). Fidelity and veracity are important ethical principles connected to professional disclosure, informed consent, and the therapeutic alliance. Through using professional disclosure, in providing the opportunity for voluntary choice, remaining faithful to the rehabilitation counselor ethical process, and in providing honest, detailed disclosure, CRCs demonstrate the highest standards of ethical practice and enhance the client-counselor relationship (Carlise & Neulicht, 2010). Thus, this study's results suggest that the CRC-client interaction and the contributions that CRC ethical processes have an important and positive effect on managing the therapeutic relationship, genuineness, and more specifically, the impact that this orientation and the empowering effect professional disclosure theoretically have on strengthening client outcomes.

APPENDICES

Appendix A

Permission to Use Real Relationship Inventory



Real Relationship Inventory—Therapist Form

PsycTESTS Citation:

Gelso, C. J., Kelley, F. A., Fuertes, J. N., Marmarosh, C., Holmes, S. E., Costa, C., & Hancock, G. R. (2005). Real Relationship Inventory—Therapist Form [Database record]. Retrieved from PsycTESTS. doi: 10.1037/t01773-000

Test Shown: Full

Test Format:

24 items; 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Source:

Gelso, Charles J., Kelley, Frances A., Fuertes, Jairo N., Marmarosh, Cheri, Holmes, Stacey E., Costa, Catarina, & Hancock, Gregory R. (2005). Measuring the Real Relationship in Psychotherapy: Initial Validation of the Therapist Form. *Journal of Counseling Psychology*, Vol 52(4), 640-649. doi: 10.1037/0022-0167.52.4.640

Permissions:

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Appendix B

Real Relationship Inventory-Therapist Form (RRI-T)

Please complete the items below in terms of your relationship with your client or patient. Use the following 1–7 scale in rating each item, placing your rating in the space adjacent to the item.

- | | Strongly
Agree | Agree | Neutral | Disagree | Strongly
Disagree |
|---------|---------------------------|--------------|----------------|-----------------|------------------------------|
| | 5 | 4 | 3 | 2 | 1 |
| ___ 1. | | | | | |
| ___ 2. | | | | | |
| ___ 3. | | | | | |
| ___ 4. | | | | | |
| ___ 5. | | | | | |
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| ___ 23. | | | | | |
| ___ 24. | | | | | |

Note. Realism subscale items = 1, 3, 5, 7, 9, 12, 14, 15, 17, 19, 20, 21; Genuineness subscale items = 2, 4, 6, 8, 10, 11, 13, 16, 18, 22, 23, 24. Reverse scored items 6, 9, 11, 13, 15, 18, 19, 20, 21, and 22.

Added question:

1. What client and counselor factors do you think contribute to a therapeutic relationship?
2. How should the rehabilitation counselor use these?
3. How do you feel that professional disclosure affects the therapeutic relationship with the client?

Appendix C

Professional Disclosure Survey-Modified (PDS-M)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

1. The practice of professional disclosure in rehabilitation counseling treatment is important.
2. The practice of professional disclosure in rehabilitation counseling treatment is useful in informing my clients about the nature of services provided and matters that arise during the rehabilitation counseling relationship.
3. My employer enforces the practice of professional disclosure
4. I verbally discuss professional disclosure with my clients.
5. I provide written professional disclosure to my clients.
6. Professional disclosure could affect my client's willingness to disclose freely.
7. Professional disclosure portrays the rehabilitation counselor as cold or uncaring.
8. Clients have a great need to know about professional disclosure.
9. Professional disclosure should be used throughout the rehabilitation counseling relationship with the client.
10. The 2010 CRCC Code of Professional Ethics influences how I use professional disclosure.
11. Professional disclosure information provided to clients is difficult to understand.
12. The professional disclosure process tends to take from the limited time I have to provide services to my clients.

During the process of professional disclosure with my clients, I engage in...

13. Discussing the limits of confidentiality.
14. Including my qualifications, credentials, and relevant experience.
15. Including an explanation on the expected frequency and length of services.
16. Covering contingencies for service continuation should I become incapacitated or die.

17. Including information on fees and billing arrangements.
18. Including information on record preservation and release policies.
19. Including information on the risks associated with electronic communication.
20. Including information on legal issues affecting services.
21. Including the possible risks associated with receiving services.
22. Including the possible benefits associated with receiving services.
23. Including the alternatives to treatment.
24. Providing information on the nature and purpose of services to be provided.
25. Relying less on formal procedures (e.g. questions to the client to determine factual comprehension of relevant service information) to establish my client's competency.
26. Communicating the consequences to my clients should any of them fail to follow through with their services.

Added qualitative questions:

1. In general, how do professional disclosure practices positively affect service to clients?
2. In general, how do professional disclosure practices negatively affect service to clients?
3. In general, how does professional disclosure affect the informed consent process?

Appendix D

Demographic Information Form

1. What is your gender?

- 1) Male
- 2) Female

2. What is your age?

(Write In)

3. What is your Race/Ethnicity?

- 1) White/Caucasian
- 2) Black or African American
- 3) Hispanic/Latino American
- 4) American Indian/Native American
- 5) Asian
- 6) Native Hawaiian or Other Pacific Islander
- 7) Two or More Races
- 8) Other (Please specify)

4. What is your highest completed level of education?

- 1) Masters
- 2) Ph.D.

5. What was your academic major related to your highest completed degree?

- 1) Rehabilitation Counseling
- 2) Rehabilitation Psychology
- 3) Counseling (Mental Health)
- 4) Counseling (Substance Abuse)
- 5) Psychology
- 6) Social Work
- 7) Special Education
- 8) Vocational Evaluation
- 9) Behavioral Analysis/Treatment
- 10) Business Administration
- 11) Health Care Administration
- 12) Sociology
- 13) Human Resources
- 14) Other (Please specify)

6. How many years of experience in the rehabilitation counseling field do you have?

(Write in)

7. How many years of experience in your current work setting do you have?

(Write in)

8. What is your current work setting?

- 1) Student
- 2) Center for Individuals with Developmental Disabilities
- 2) Private Not-For-Profit Rehabilitation
- 3) College/University
- 4) Corporate Environment
- 5) Corrections Facility/Program
- 6) Independent Living Facility
- 7) Insurance Company
- 8) K-12 Education
- 9) Medical Center or Rehabilitation Hospital
- 10) Workers' Compensation Setting
- 11) Community Mental Health Center
- 12) Inpatient Psychiatric Facility
- 13) Substance Abuse Treatment Facility
- 14) Halfway House
- 15) Private For-Profit Rehabilitation
- 16) State Rehabilitation Agency
- 17) Veterans Benefits Administration (VBA)
- 18) Veterans Health Administration (VHA)
- 19) Client Advocacy Organization
- 20) Retired
- 21) Unemployed
- 22) Other (Please specify)

9. What is your job title?

- 1) Rehabilitation Counselor
- 2) Administrator/Manager
- 3) Supervisor
- 4) Rehabilitation Consultant
- 5) Rehabilitation Case Manager
- 6) Professor/Instructor
- 7) Vocational Specialist
- 8) Disability Management Specialist
- 9) Job Placement Specialist
- 10) Other (Please specify)

Appendix E

Research Participant Informed Consent

1. Purpose of research:

You are being asked to participate as a research participant in an internet-based survey study of certified rehabilitation counselor (CRC) perceptions on the real relationship as a part of the therapeutic alliance in treatment, and use of informed consent/choice. You have been selected as a participant in this study because you have been identified as a CRC. Your participation in this study will take about 20 minutes of your time.

2. Type of participant involvement:

You are being asked to take a moment to complete this internet-based survey. There are three parts and a total of 48 questions to answer. You can save your answers by clicking the next button. In addition, you have the option to save your responses and log out and return to the survey where you left off. However, you will be unable to go back and change your answers once you have submitted them since no identifying information will be included with your responses.

3. Potential benefits:

Your participation in this study may help generate data useful for better understanding CRCs attitudes toward the therapeutic relationship and how this may affect informed consent practices and client empowerment through services. Further, it is anticipated that the findings from this study have the potential to both inform and enhance the clinical training curricula of master's rehabilitation counseling programs in the areas of counseling skill development, supervision and training.

4. Potential risks:

The questions being asked should pose no risk to you and, as there is no identifying information being collected about you, your responses will remain anonymous within the aggregated data.

5. Privacy and confidentiality:

The data for this project will be kept confidential. All data will be collected via the internet using the online survey program, Qualtrics. Access to Qualtrics is password protected. Only the involved researchers will have access to the password needed to access the data. The researchers will maintain your privacy throughout the research process by ensuring you are automatically assigned an ID number that is unknown to the researchers. No identifying information will be stored with the data. The only identifying information will be your email address that is linked to your survey on Qualtrics and will be used only for sending email reminders to complete this survey. All the data will be imported and stored on one of the researcher's computers for data analysis. The computer and data files are password protected to ensure protection of all

participant data. Only the researchers and Michigan State University Institutional Review Board will have access to the data. The results of this study may be published or presented at professional meetings, but the identities of all research participants are anonymous.

6. Your rights to participate, decline, or withdraw:

Participation in this research study is completely voluntary at all times. You have the right to say decline or change your mind at any time and withdraw. There are no consequences in withdrawing or not completing the survey; your responses will not be included in the data. You may choose not to answer certain questions or stop participation at any time.

7. Costs and compensation for participation:

There are no costs to you to participate in this study. Also you will not receive any other form of compensation for participating in this study, however, you may be eligible for one (1) continuing education credit for participation in this study.

8. Contact persons for the study:

If you have any questions about this study, or prefer an alternative method for taking this survey (e.g., by phone or hard copy), please contact the researcher, Todd Lewicki, Michigan State University, 455 Erickson Hall, East Lansing, MI 48824, phone: 989-737-8524, or email: lewickit@msu.edu.

If you have any questions and concerns about your role and rights as a research participant, you can also contact the responsible project investigator, Dr. Michael Leahy, Michigan State University, 455 Erickson Hall, East Lansing, MI 48824, phone: 517-432-0605, or e-mail: leahym@msu.edu.

If you would like further information, offer input, or would like to register a complaint regarding this research study, you may also contact (anonymously if you wish) the Michigan State University Human Research Protection Program at 517-355-2180, Fax 517-432-4503, e-mail irb@msu.edu, or regular mail: 408 West Circle Drive Room 207 Olds Hall, MSU, East Lansing, MI 48824.

By proceeding into the survey, you are voluntarily agreeing to participate in this research study.

Thank you for your time and participation in this study.

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