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AN EXPLORATORY INVESTIGATION OF TELE-COUNSELING: LOOKING AT THE POWER OF THERAPEUTIC ALLIANCE IN IMPROVING WELLNESS.

A Thesis

by

JORGE ROSTRO

Submitted to the Graduate College of
The University of Texas Rio Grande Valley
In partial fulfillment of the requirements for the degree of

MASTER OF EDUCATION

December 2015

Major Subject: Guidance and Counseling

AN EXPLORATORY INVESTIGATION OF TELE-COUNSELING: LOOKING AT THE POWER OF THERAPEUTIC ALLIANCE IN IMPROVING WELLNESS.

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December 2015

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ABSTRACT

Rostro, Jorge. An Exploratory Investigation of Tele-Counseling: Looking at the Power of Therapeutic Alliance in Improving Wellness. Master of Education (M.Ed), December, 2015, 21 pp., 1 table, 1 figure, references 34 titles.

The present study explored the power of one tele-counseling session to elicit change within post wellness ratings scores and the relationship between clients' perceptions of relationship, goals and topics, approach and method, and overall session with clients' wellness ratings. Results indicated that the mean for post-session wellness was significantly greater than pre-test wellness ratings. The standardized effect size, d, was .43, indicative of a moderate effect size. No difference was found between client's perceptions of predictor variables with post-wellness rating scores. This study adds support for the use of tele-counseling services as one session might have the power to elicit change. Limitations, future research, and implications for research, education, and policy are discussed further.

DEDICATION

I would like to dedicate my thesis to my lovely wife whose inspiring and encouraging words have pushed me throughout the thesis journey. A journey that had many ups and downs and many sacrifices along the way. I could not have done it without you.

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I want to take this opportunity to thank everyone who helped me make this possible. I want to particularly thank my thesis chair, Dr. Javier Cavazos, as well as Dr. James Ikonomopoloous, and Dr. Pierre Lu for mentoring me and making much needed edits to make the manuscript worthwhile. Thank you for your patience and for believing in me when I doubted my work the most.

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CHAPTER I

INTRODUCTION

At the heart of counseling lies the need to establish a therapeutic alliance. Therapeutic alliance can be defined as counselor and client working collaboratively to establish treatment goals and treatment direction, feeling a sense of mutual understanding, and feeling trust that the counselor will be able to help (Bachelor, 2011). Therapeutic alliance begins to develop at the initial session and has been shown to have a positive correlation with treatment outcome. For example, higher levels of therapeutic alliance have been positively correlated with decrease in symptoms among clients with dissociative disorder and depression (Cronin, Brand, & Mattanah, 2014; Kuhlman, Tolvanen, & Seikkula, 2001; Smith, Gamble, Cort, Ward, He, & Tolbert, 2012). Other researchers have also found that therapeutic alliance can moderate treatment response for individuals with eating disorders and depressive symptoms (Stiles-Shield et al., 2013). Therapeutic alliance can also help predict outcomes for individuals undergoing outpatient substance abuse treatment and help reduce post-traumatic stress symptoms (Richardson, Adamson, & Deering, 2012; Wagner, Brand, Schulz, & Knaevelsrud, 2012).

Aside from having an effect on treatment outcomes, therapeutic alliance can help predict treatment adherence (Kennerly, 2014). A study that looked at physician-patient measures of alliance found a positive correlation between alliance and treatment adherence for patients treated for lupus (Bennett, Fuertes, Keitel, & Phillips, 2011). Similarly, a strong association between alliance and treatment adherence in patients diagnosed with chronic medical illnesses

has been found by other researchers (Fuertes et al., 2007). The helper-client alliance seems to be an important factor that moderates treatment outcome and treatment adherence. Therefore, therapeutic alliance is significant to study as it can impact treatment adherence in counseling, which in turn can moderate treatment outcomes and prognosis within counseling.

Now that we understand how therapeutic alliance impacts treatment, it is important to understand how therapeutic alliance develops over the course of treatment. Therapeutic alliance develops at the first session and continues to grow and decrease throughout subsequent sessions. While some scholars believe therapeutic alliance follows a liner model—that is to say that alliance steadily increases over therapeutic sessions—Ardito and Rabellino (2011) propose that therapeutic alliance follows a “U-shape” dimensional model. In their proposed “U-shape” dimensional model, alliance is higher between the first and third session. During the first and third session, the client develops a sense of trust that the counselor will be able to guide clients through presenting problems and work collaboratively to establish treatment goals for recovery (Ardito & Rabellino, 2011). The initial sessions also mark the foundation for duration of treatment (Ardito & Rabellino, 2011). During the second phase, the counselor confronts a client’s irrational thinking and behaviors. This can take a toll on the therapeutic alliance as the client may perceive confrontation as lack of support (Ardito & Rabellino, 2011). Thus, it becomes the counselor’s responsibility to repair this broken alliance to continue with therapy successfully (Ardito & Rabellino, 2011). Based on the U-shape model of therapeutic alliance, the authors suggest that measurements of alliance during initial and concluding sessions are better predictors of treatment outcome than middle sessions.

Therapeutic alliance has been studied within a face-to-face counselor-client relationship; however, because of technological advances, it is possible to provide distant counseling services

via email, phone, online groups, chat, and two way video. Current research has shown mixed findings regarding the strength of the therapeutic alliance established with such modes of online counseling. For instance, Cook and Doyle (2012) found no difference in therapeutic alliance formed between clients in face-to-face counseling and those in counseling via a chat based server. Similarly, Reynolds, Stiles, and Grohol (2006) compared therapeutic alliance between face-to-face counseling and email based counseling and found no statistical differences between groups. These studies suggest that therapeutic alliance can be established via online means. On the other hand, studies have found a weak therapeutic alliance in online counseling when compared to therapeutic alliance in face-to-face counseling (Busseri & Tyler, 2003; Knaevelsrud & Maercher, 2006; Leibert, Archer, Munson, & York, 2006). These results may be due to limitations of current studies—i.e., no randomization and diverse populations groups, which may account for differences in the alliance established.

Statement of the Problem

Most of the current research is limited to examining the therapeutic alliance formed when counseling is provided through email, chat, and online support groups. Few, if any research, has examined the therapeutic alliance formed when counseling is provided through two way video. Two way video is as close to face to face counseling because it provides live face to face communication between the client and counselor; however, it lacks elements of the in-vivo face to face interaction—i.e., physical proximity, reading of non-verbal cues, and tone of voice is filtered through speakers which are considered important for the establishment of therapeutic alliance (Leibert, Archer, Munson, & York, 2006). These differences may directly impact the establishment of the therapeutic alliance in distant counseling, which in turn can impact treatment adherence and treatment outcome. Thus, such differences are worth investigating

further. Based on the need for further research in this area, the goal of the present study is to investigate the following research questions:

1. Does tele-counseling influence client's wellness ratings after one session?
2. What is the relationship between clients' perceptions of relationship, goals and topics, approach and method, and overall session with wellness ratings?

Following Ardito and Rabellino's (2011) recommendations that initial sessions and concluding sessions are better predictors of treatment outcomes, the present study will take measurements of therapeutic alliance during the initial session. If therapeutic alliance is high during the initial session, then I expect higher treatment outcomes and an increase treatment retention for counseling sessions conducted via distant counseling. My hypothesis is consistent with other studies that have found positive correlations between alliance and treatment outcome as well as with treatment retention (Cronin, Brand, & Mattanah, 2014; Kuhlman, Tolvanen, & Seikkula, 201; Smith et al., 2012; Stiles-Shield et al., 2013; Wagner, Brand, Schulz, & Knaevelsrud, 2012).

CHAPTER II

METHOD

Participants

Participants were recruited from mental health clinics in the southern region of the United States who sought mental health services. Data was gathered from twenty-five clients who received treatment via tele-counseling (N = 25). All client data resulting from research measures was included in the present study. The entire sample consisted of twenty-five clients who sought mental health services. Demographic characteristics are summarized in Table 1. The tele-counseling group consisted of 25 participants (15 women and 10 men) with an average age of 39.48 years (*SD*=16.81). Of these participants, 21 identified themselves as Hispanic, 3 as White, and 1 as African American. Twenty participants were diagnosed with a mood disorder, 1 with a substance abuse disorder, 2 with psychotic disorders, 1 with anxiety disorder, and one participant resulted in a no diagnosis.

Clients were invited to participate in the study before their initial session and asked to read and sign consent form. After providing consent, each client completed the Outcome Rating Scale. At the end of their session, participants were asked to complete the Demographic Questionnaire, a Session Rating Scale, and a post Outcome Rating Scale.

Instrumentation

Demographic questionnaire

The demographic questionnaire was designed by the principal investigator. Questions on the demographic questionnaire focused on participants' age, sex, ethnicity, education level, current diagnosis, length in treatment, primary language, and time spent on social media. Three open-ended questions were included at the bottom of the demographic form: (1) Was there anything particular that you liked about today's session?; (2)Was there anything particular that you disliked about today's session?; and (3) Additional Comments.

Therapeutic alliance

The Session Rating Scale (Johnson, Miller, & Duncan, 2000) is a four-item visual analogue scale which asks participants to rate sessions by placing a mark on the line nearest to the description that bests fits their experience (Duncan et al., 2003). Participants are asked to rate four dimensions of their session (i.e., relationship, goals and topics, approach or methods, and overall). At the end of each visual analogue scale are statements about how participants related to therapy; these statements serve as anchors for each of the four-item scales. Each visual analogue line measures ten centimeters. To score the Session Rating Scale a ruler is used to measure the distance, to the nearest tenth of a centimeter, between the beginning of the visual analogue line and the mark made by the participant. Scores are recorded on the form each individual dimensions and an overall score is also calculated by adding all four dimensions of the scale. The following dimensions are used to measure therapeutic alliance.

Relationship—the "Relationship" dimension of the scale is measured by asking participants how well they felt understood and respected by the therapist.

Goals and Topics—the "Goals and Topics" dimension of the scale is measured by asking participants on whether or not issues that participants wanted to talk about and work on were addressed by the therapist

Approach and Method—the "Approach and Method" dimension of the scale asks participants to rate whether or not the approach the therapist took was a good fit.

Overall—the "Overall" dimension of the scale is measured by asking participants if the session was right for them.

Preliminary psychometric properties for the SRS yielded an internal consistency of .88 (Duncan et al., 2003). Similarly, Campbell and Hemsley (2009) found an internal consistency of .93 for the SRS scale. The internal consistency has compared favorably to other established scales of similar constructs (i.e., The Helping Alliance Questionnaire II (.90) and the Outcome Questionnaire-45 (.95) (Campbell & Hemsley, 2009; Duncan et al., 2003). Test re-test reliability for the Session Rating Scale has yielded a Pearson's r of .64 (Duncan et al, 2003).

Duncan et al. (2003) calculated concurrent validity using Pearson product-moment correlations between the SRS and the HAQ II total score. The results yielded a correlations of *.48* ($p < .01$) which provides evidence of concurrent validity with similar instruments. Similarly, other researchers found strong concurrent validity for the SRS scale (Campbell & Hemsley, 2009). In summary, evidence of strong concurrent validity and reliability estimates make this instrument of clinical utility.

Wellness Ratings

The "Outcome Rating Scale" is a four item visual analogue scale which asks participants to rate their general well-being on four dimensions (individual, interpersonal, social, and overall well-being) by marks to the left of the scale indicative of low levels and marks to the right of the

scale indicative of high levels. As with the Session Rating Scale, a ruler is used to measure the distance, to the nearest tenth of a centimeter, between the beginning of the visual analogue line and the mark made by the participant. Scores are recorded on the form for each individual dimensions and an overall score is also calculated by adding all four dimensions of the scale. Preliminary psychometric properties yielded a coefficient alpha of .93 for the Outcome Rating Scale (Miller, Duncan, Sparks, & Claud, 2003). Similarly, Campbell and Helmsley (2009) found an internal consistency of .90 for the outcome rating scale. Concurrent validity was calculated by correlating the Outcome Questionnaire 45.2 with the Outcome Rating Scale which yielded a correlation of .59 (Miller et al., 2003), suggesting a moderate concurrent validity. This result is consistent with Campbell and Helmsley who also found a moderate concurrent validity between the OQ-45.2 and the Outcome Rating Scale. In summary, evidence of strong concurrent validity makes this instrument of clinical utility

Procedures

Following Institutional Review Board Approval, participants were recruited to participate from a mental health clinic in the southern region of the United States who sought mental health services. All participants were informed that participation was voluntary and that their participation would not affect their mental health services in any way. Participants who agreed to partake in the study signed the informed consent. Participants were then asked to complete the Outcome Rating Scale which served as a pre-test measure. After completion of their session, participants were asked to complete the Demographic Questionnaire, Session Rating Scale, and a post Outcome Rating Scale.

CHAPTER III

RESULTS

A paired-samples t-test was conducted to evaluate whether participants' wellness ratings increased as a result of one tele-counseling session. As shown in Figure 1, the results indicated that the mean for post-session wellness (*M* = 18.33, *SD* = 11.24) was significantly greater than pre-test wellness ratings (*M* = 16.47, SD = 11.40), *t* (22) = -2.09, *p* = .05 The standardized effect size, *d*, was .43, indicative of a moderate effect size. Additionally, a multiple regression analysis was conducted on post-session wellness ratings based on perceptions of the relationship, goals, approach, and overall sub-session. There was not a statistically significant relationship between predictor variables and post-session ratings, *F* (4, 18) = .90, *p* = .48. A small effect size of R^2 = .17 was noted, indicating that 17% of variance was accounted for in the model.

CHAPTER IV

DISCUSSION

The present study explored two research questions: 1). Does tele-counseling influence client's wellness ratings after one session? and 2).What is the relationship between clients' perceptions of relationship, goals and topics, approach and method, and overall session with wellness ratings? The present study found that one tele-counseling session had the power to increase wellness rating scores and found a moderate effect size (*d*=.43). This suggests that one tele-counseling session has potential to elicit significant change in a client's sense of personal wellbeing and in turn might produce a positive treatment outcome. Such findings are also evident in face-to-face counseling as Rezner, Rezner, and Dutkiewicz (2014) found that one face-to-face counseling session produced higher compliance rates with health screenings than individuals who did not receive any counseling. It appears that one face-to-face counseling session is similar to one tele-counseling session in that they both can elicit change in a client, despite their being differences in the mode through which counseling is provided.

A multiple regression analysis was conducted on post-session wellness ratings based on perceptions of the relationship, goals, approach, and overall sub-session to determine predictors of wellness rating scores. This study found no statistically significant relationship between predictor variables and post-session ratings. One of the primary limitations of this study is the small sample size (N = 25) which could account for finding no statistical differences between predictor variables and post session ratings. Other factors, not measured on the scale, which

could account for the increase in wellness ratings scores after one session include the variables of hope, empathy, and treatment expectations. Yalçın and Malkoç (2015) found that hope was a mediating factor between meaning of life and subjective wellbeing. Individuals in the present study sought mental health treatment for the first time. Initially, they could have had a lower sense of hope. Niles, Hyung, Balın, and Amundson (2010) describe a Hope Centered Model for Career Development that can be used in face-to-face counseling to help individuals manage and adapt better to work related situations. Niles et al. (2010) state that hope is needed to address challenges and report that higher levels of hope lead to more effective problem solving. Establishing hope within the tele-counseling session may similarly lead individuals to problem solve better, potentially leading to higher reports of well-being.

Empathy has also been found to influence treatment outcome in face-to-face counseling. Feller and Cottone (2003) stressed the importance of empathy within the counselor-client relationship to elicit positive treatment outcomes. The present study was limited to examining only four predictor variables (perceptions of relationship, goals and topics, approach and method, and overall session ratings) and did not examine empathy. However, empathy could play a vital role in increasing wellness ratings in tele-counseling sessions as it does for face-to-face counseling. Empathy expressed by counselors can lead to the development of attachment styles in the client-counselor relationship, which has been found to predict session ratings. Mohr, Gelso, and Hill (2005) found that attachment styles of the client-counselor relationship predicted client's session ratings. Thus, future research should examine the role of empathy and attachments styles as predictor variables for wellness to determine if such variables moderate ratings for tele-counseling sessions.

It is important to note that participant's comments on the demographic questionnaire reveal that individuals were not concerned about the mode in which they received counseling. Comments written on the demographic questionnaire regarding factors they liked about the session indicate that participants were more focused on the traits and skills of the therapist than the mode of counseling. Sample comments written in the demographic form included: "Was able to talk to someone who understood me," "Very respectful," "Was very professional, understanding, kind, very well informed," and "Counselor was easy to talk to and very likeable." The comments reveal that counselor's personality qualities are being projected beyond the screen and that technology is not hindering the counselor's personality traits from being perceived by the counselor, suggesting that tele-counseling may not be so different than face-to-face counseling. Qualitative studies should investigate differences and similarities between face-to-face counseling and tele-counseling to see if any major difference or similarities exists among client's perceptions which could contribute to treatment outcomes.

Limitations

Perhaps one of the most significant limitations of this study includes the sample size for the tele-counseling group (N = 25). Drawing a larger sample size for tele-counseling group will allow the researchers to draw stronger conclusions, which in turn would make results more applicable to the general population. Another limitation is that researchers were unable to control for treatment providers' differences in experience level. Some providers had years of experience providing counseling services via tele-counseling while others did not. Treatment providers also differed in age and gender; however, such differences would occur at random and thus might not impact results. Future research studies should control for treatment providers' experience level, age, gender, and ethnicity to determine if such influence wellness. Moreover, this study

investigated treatment outcome over one session and did not measure subsequent sessions to determine if significant change exists. Future research should track wellness to determine if changes are sustained over the course of tele-counseling treatment

Clinical Implications

The following study has implications for practice, policy, and education. This study adds support to the efficacy of tele-counseling services within clinical practice. Mental health agencies or private mental health practitioners might consider using tele-counseling services. Using such mode of counseling can help alleviate start-up costs associated with opening up an independent practice. Tele-counseling could be delivered through the comfort of the therapist home without having a need to pay office space. For example, Psychology Today, an online website which offers online counseling services, charges $29.95 per month, regardless of the number of clients seen. Individuals who seek online mental health services can access the website and review the listed therapist profiles. Individuals can then send an online request for an appointment. In comparison to office space which typically range in the hundreds of dollars, online websites charge much less and offer a larger clientele. Thus, tele-counseling could make it easier for therapists to open their practice by reducing start up costs and could help expand their clientele.

Implications for policy include expanding the use of tele-counseling services to underserved populations. In a report compiled for Congress on the Nations Substance Abuse and Mental Health Workforce Issues, 77% of counties in the nation were considered to have a shortage of mental health workers (Hyde, 2013). Using tele-counseling can help alleviate shortage of mental health workers by making mental health care accessible to underserved populations. Policy should focus at allotting funds that would fund technology for such

underserved counties and in doing so making mental health care accessible to more individuals. Policy should also focus at implementing a tele-counseling licensing board that would allow for practitioners to conduct counseling across state lines. Consequently, this would help with alleviating counties with shortage of mental health workers. This study also has implications for education. As the use of technology increases among the population, educators should consider adding "tele-counseling" courses to current counseling curriculum. These courses should focus on teaching about ethical guidelines that guide tele-counseling services, strategies and skills to conduct such online services, and educators should incorporate in-vivo exposure to online counseling during their practicum and internship experience. Currently, the Texas State Board of Examiners of Professional Counselors does not require any coursework or previous training in tele-counseling as part of the licensure requirements. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) does not require any coursework in tele-counseling for programs to be accredited. Therefore, educators can advocate for such accrediting bodies to implement coursework in tele-counseling to educate competent counselors who are capable of implementing counseling trends.

Future Studies

Future research should look at the degree to which wellness is altered over the course of tele-counseling treatment and compare that to a face-to-face group to examine differences. Second, studies should control for treatment providers' experience level, age, gender, and ethnicity to determine if such differences influence wellness. Moreover, looking at other predictor variables, such as hope, could help researchers determine variables important in eliciting change within an online population. Researchers should also consider conducting qualitative interviews and focus groups with participants in tele-counseling. In-depth interviews

will provide clients an opportunity to share meaningful moments and experiences from tele-counseling. Finally, researchers can use a single-case design to measure weekly progression in wellness. It would be interesting to examine how the U-shape therapeutic alliance hypothesis applies to online counseling and to wellness rating scores after subsequent sessions.

CHAPTER V

CONCLUSION

The present study examined the influence of one tele-counseling session to elicit change among clients and found that one tele-counseling session has potential to increase wellbeing. Overall, this study adds support to the efficacy of tele-counseling services, concluding that positive treatment outcomes might occur from online modes of counseling. Our study found no significant difference between predictive variables (Relationship, Goals, Approach, & overall Fit) and post wellness ratings. Moreover, this finding warrants further research and a larger sample size to determine variables that could account for changes in post-wellness ratings.

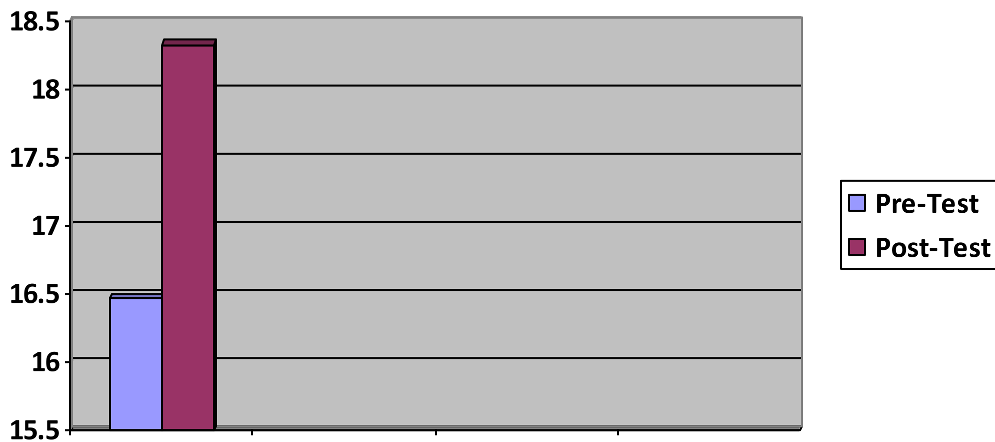
TABLE I & FIGURE I

Table I. Participant Demographic Characteristics

Characteristics	Tele-Counseling (n = 25) n	%
Gender		
Male	10	40%
Female	15	60%
Race		
Hispanic	21	84%
White	3	12%
African American	1	4%
Diagnosis		
Mood Disorder	20	80%
Substance Use	1	4%
Psychosis	2	8%
Anxiety	1	4%
No Diagnosis	1	4%

	M	*SD*
Age	39.48	16.81

Figure 1: Mean Differences between Pre and Post Session



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BIOGRAPHICAL SKETCH

Jorge Rostro graduated from Wabash College, in Crawfordsville Indiana, in 2011 with a Bachelor of Arts in Psychology. During his undergraduate years, he studied abroad at the University of Aberdeen in Aberdeen, Scotland UK. It was in his undergraduate years that he began to develop interest in mental health and an interest in research. He conducted undergraduate research during his senior year in the area of cognitive psychology and child psychology. Jorge continued his education at The University of Texas at Rio Grande Valley, in Brownsville, TX, where he graduated with a Master's degree in Guidance and Counseling in 2015 and is currently a Gates Millennium Alumni.

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