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THE PERSON OF THE THERAPIST: THERAPISTS' PERSONAL CHARACTERISTICS AS PREDICTORS OF WORKING ALLIANCE AND TREATMENT OUTCOMES

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THE PERSON OF THE THERAPIST: THERAPISTS' PERSONAL CHARACTERISTICS AS PREDICTORS OF WORKING ALLIANCE AND TREATMENT OUTCOMES

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By

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ABSTRACT OF DISSERTATION

THE PERSON OF THE THERAPIST: THERAPISTS' PERSONAL CHARACTERISTICS AS PREDICTORS OF WORKING ALLIANCE AND TREATMENT OUTCOMES

Recent years has seen an increase in studies examining the unique contribution that the therapist has on treatment outcomes, which is commonly referred to as "therapist effects" (Barkham et al., 2017). Therapist effects on outcomes are believed to occur primarily via how the therapist's interpersonal and intrapersonal qualities influence the therapeutic relationship, which in turn influences outcomes (Wampold et al., 2017). The current study focused on professional self-doubt, counseling self-efficacy, and humility because of previous writings about their potential to influence therapists' interpersonal behaviors. Data was collected from Southwest Behavioral and Health Services (SBHS), a non-profit, comprehensive community behavioral health organization. A total of 46 therapists participated in the study. Therapists who agreed to participate completed demographic items, a measure of professional-self-doubt, counseling self-efficacy, and humility. Two client-rated outcome measures were used as dependent variables. The Session Rating Scale (SRS; Miller et al., 2002) and the Outcome Rating Scale (ORS; Miller & Duncan, 2000) were collected from clients at each session. Therapists' responses to these measures were matched with their de-identified archival client outcome data (N = 1, 817) using therapists' employee identification numbers. Multilevel modeling was used to determine how therapist personal characteristics predict client outcomes. Interestingly, there was a strong negative correlation between professional self-doubt and counseling self-efficacy (r = -.65). Results of the unconditional model for SRS indicated a lack of overall growth in SRS scores across treatment. Thus, no client or therapist level variables were modeled for this outcome measure. Approximately 5% of the variance in rate of growth for the ORS was between therapists. The most noteworthy finding was that when controlling for the effects of counseling self-efficacy, professional self-doubt was marginally significant, ($ß$ = 0.06, p = .063). Relative to the null model, this model explained approximately 50% of the variance in rate of growth in ORS scores at the therapist-level. However, when counseling-self-efficacy was removed from the model, professional self-doubt was no longer marginally significant ($ß$ = 0.04, p = .162). Overall, the findings indicate that the relationship between professional self-doubt and client outcomes is likely complex and warrants further research. The findings from the current study further efforts to more precisely describe therapist effects and gain insight into the mechanisms by which psychotherapy works.

KEYWORDS: Therapist Characteristics, Therapist Effects, Outcome, Professional Self-Doubt

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CHAPTER 1. INTRODUCTION

Psychotherapy appears to have considerable healing potential in that there is ample research to support its efficaciousness (Wampold & Imel, 2015). A noteworthy portion of this healing potential lies in the hands of the therapist. In actuality, more variance in treatment outcome arises from the "doer" than from the specific treatment approach employed (Norcross & Lambert, 2011). Recent years has seen an increase in studies examining the unique contribution that the therapist has on treatment outcome, which is commonly referred to as "therapist effects" (Barkham et al., 2017). The majority of studies have found that therapists account for approximately 3-15% of the variance in treatment outcome (Wampold & Owen, 2020).

Although this percentage may seem modest, it is important to consider the potential impact such an effect has in a real-word-setting (Imel et al., 2015). The mere existence of therapist effects implies that therapists can be ranked on the basis of effectiveness and that some clients will work with those at the higher end of that ranking (Barkham et al., 2017), whereas some clients will work with those therapists who tend to fall on the lower end of the distribution. Less effective therapists help considerably fewer clients compared to more effective therapists and exhibit more variable client outcomes. In comparison, highly effective therapists exhibit an ability to achieve increased benefit per session and yield more consistent treatment outcomes (Saxton et al., 2017; Wampold & Owen, 2020). Gaining insight into why some therapists perform better compared to others has emerged as an important area of research. The purpose of this study was to further explore the degree to which relevant therapist characteristics are associated with better client outcomes to further efforts to harness therapist effects.

The Person of the Therapist: Interpersonal and Intrapersonal Qualities

Therapist effects on treatment outcomes are believed to occur primarily via how the therapist's interpersonal and intrapersonal (i.e., views of the self) qualities influence the therapeutic alliance, which in turn influences outcomes (Wampold et al., 2017). Several authors have noted the reparative effects of clients feeling understood, identifying it as the primary mechanism of change within the therapeutic process (Norcross & Lambert, 2011; Wampold et al., 2017). Therefore, a crucial task for every therapist is to facilitate the development of a reparative relationship, which involves maintaining a stance of attuned responsiveness that provides the client with the experience of having one's subjective experience accepted and understood (McWilliams, 2004). There are several components involved in building an effective therapeutic relationship. Some of these components include empathy, warmth, verbal fluency, hopefulness, and are collectively referred to as "facilitative interpersonal skills" (Anderson et al., 2009; Norcross & Lambert, 2011). Research has demonstrated that global ratings of therapist "facilitative interpersonal skills" are strongly related to client outcomes (Anderson et al., 2009). Therapists who possess a greater ability to perceive and respond to the interpersonal nature of therapy achieve better client outcomes.

Interpersonal qualities are closely related to intrapersonal qualities, such that intrapersonal qualities shape relationship goals and ultimately guide behavior (Park et al., 2006). For example, individuals with low self-esteem tend to be motivated by their desire for acceptance and often respond to perceived interpersonal rejection by withdrawing from the situation (Park et al., 2009). In this way, self-perceptions can serve to enhance or hinder one's ability to form and maintain strong relationships. Although research on therapists' intrapersonal factors is limited, there is evidence that therapists' self-concepts

make an important contribution to the therapeutic process (e.g., Heinonen et al., 2014; Nissen et al., 2017). In fact, evidence suggests that intrapersonal qualities contribute more to therapeutic outcomes than other factors such as age, gender, theoretical orientation, and clinical experience (Wampold et al., 2017). Nevertheless, relatively few studies have focused on how these factors work to influence the therapeutic process. Psychotherapy researchers are primarily interested in intrapersonal qualities that seem to have strong ties to interpersonal functioning. Professional self-doubt, counseling self-efficacy, and humility are therapist factors of interest because of their potential to influence therapists' interpersonal behaviors.

Professional Self-Doubt

Self-doubt is an intrapersonal dimension that can have an influence on interpersonal outcomes. The experience of self-doubt likely engenders feelings of discomfort, which can lead to behaviors aimed at resolving the discomfort. Professional self-doubt in a psychotherapy context refers to doubts about one's ability to effectively help clients (Orlinsky & Rønnestad, 2005). A few Norwegian studies have shown that some degree of professional self-doubt might be beneficial to the therapeutic process (Nissen-Lie et al., 2013; Nissen-Lie et al., 2017). For example, one study in a naturalistic setting showed that clients of therapists with higher levels of professional self-doubt experienced greater improvements in interpersonal functioning (Nissen-Lie et al., 2013). Although these results seem paradoxical, the authors interpreted this finding by suggesting that a higher level of professional self-doubt is indicative of a tendency to be more reflective and intentional about one's professional practices. Previous research also suggests that the experience of professional self-doubt is most beneficial among

therapists who are more self-accepting and self-nurturing (Nissen-Lie et al., 2017). Increased acceptance and kindness toward the self likely allows therapists to maintain a non-defensive stance when experiencing self-doubt.

However, Odyniec and colleagues (2017) found that beginning therapists with higher levels of professional self-doubt yielded worse client outcomes. These contradictory findings provide empirical support that professional self-doubt's relationship with treatment outcomes is likely more complex than initially believed. The influence of professional self-doubt may depend on the presence or absence of other variables. Professional self-doubt has been conceptually linked to both efficacy beliefs and humility (Heinonen & Nissen-Lie, 2020). No previous research has explored the extent to which these constructs are empirically related to professional self-doubt, or how their presence influences the relationship between professional self-doubt and client outcomes. The sections below review the existing research on each of these construct's relationship with client outcomes, while also speculating about their relationship with processional self-doubt.

Counseling Self-Efficacy

Psychotherapy training currently operates within a climate that stresses the importance of the acquisition of competence (Fouad et al., 2009). This emphasis on competence inevitably influences the thoughts and beliefs that are rewarded and nurtured throughout training and development. Efficacy beliefs are considered to be critical for therapist development because competence is said to require a therapist to be self-efficaciousness. Counseling self-efficacy is defined as "one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p. 180). It is generally assumed that counseling self-efficacy will facilitate

the acquisition and mastery of the skills that comprise the performative aspect of counseling, which will subsequently enhance client outcomes (Barden & Greene, 2015). This presumed relationship between counseling self-efficacy and client outcome is theoretically grounded in Social Cognitive Theory (Bandura, 1986), which states that behavior is influenced by one's expectations about the ability to perform the behavior successfully (i.e., self-efficacy). Individuals who have a strong belief that they can succeed in a given domain will be more likely to engage in activities related to the domain and persevere in the face of difficulty. Repeated studies involving a range of tasks have shown that task performance is indeed linked to beliefs about one's ability to achieve desirable outcomes. Specifically, as self-efficacy increases so does performance (Schunk & DiBenedetto, 2020).

Only a few studies have explicitly explored the relationship between counseling self-efficacy and client outcomes (e.g., Heppner et al., 1998; Reese et al., 2009). Heppner and colleagues (1998) explored the relationship between counseling self-efficacy and a range of treatment outcomes (e.g., working alliance, progress toward target goals). They found that counseling self-efficacy was unrelated to most treatment outcomes, and those associations that were significant were contrary from what would be expected (i.e., increased self-efficacy was associated with worse outcomes). Reese and colleagues (2009) found that supervisees' counseling self-efficacy ratings from the end of the year were associated with client outcomes for supervisees randomly assigned to a continuous feedback condition in contrast to supervisees in a no-feedback condition. Taken together, these results suggest that the relationship between self-efficacy and client outcomes is more complex than typically assumed. That is, increased counseling self-efficacy does

not necessarily lead to better client outcomes. One possible explanation for this is that when efficacy beliefs are unrealistically high, it may lead a therapist to continue using an approach despite indicators that one's efforts are not paying off. High self-efficacy beliefs that are not supported by positive feedback can result in negative outcomes (Bandura, 1997). This point seems particularly important in the context of psychotherapy, as research shows that client variables beyond the therapist's control account for the largest portion of the explained variance in psychotherapy outcomes (Norcross & Lambert, 2011).

A critical point is that therapy is a domain in which it is especially difficult to adopt a routinized approach. Therapists must learn to adapt and tailor interventions to the different needs and values of their clients. Thus, the overestimation of one's skills can hinder the reappraisal process by reducing openness to feedback (Knapp et al., 2017). This point has implications regarding the possible relationship between professional self-doubt and counseling self-efficacy. Self-efficacy is reappraised when doubts about one's competence arise (Bandura, 1997). Professional self-doubt supposedly increases a therapist's ability to tolerate feelings of incompetence and thus enhances therapeutic outcomes by guarding against defensiveness (Nissen-Lie et al., 2017). Therefore, professional self-doubt and counselor self-efficacy can possibly coexist and possess the potential to complement one another in a way that facilitates the therapeutic progress. Indeed, the collaborative stance necessary for a strong therapeutic alliance requires a willingness to acknowledge one's shortcomings (Paine et al., 2015).

Previous authors have proposed that highly effective therapists are able to locate and maintain an optimal balance between a self-questioning stance and confidence in

their therapeutic abilities (e.g., Nissen-Lie et al., 2017). This balance is believed to be manifested in the practice of returning to a listening or reflective stance when necessary (Knapp et al., 2017). Exploring the relationship between professional self-doubt and counseling self-efficacy will further efforts to understand how highly effective therapists are able to effectively merge these two qualities to enhance outcomes. Nevertheless, it is also possible that this optimal balance is better understood as being subsumed by another quality that is more capable of capturing the qualities of highly effective therapists: therapist humility.

Humility

Humility is a multi-faceted term, consisting of intrapersonal and interpersonal components (Paine et al., 2015). Previous authors have identified the following core features of general humility: (a) willingness and ability to accurately assess one's own personal characteristics and achievements; (b) a modest self-presentation; and (c) increased focus on others versus the self (Davis et al., 2011). The core features of humility are associated with several interpersonal virtues (e.g., patience, respect, empathy) that help foster strong relationships (Means et al., 1990; Peters et al., 2011). As a result, psychotherapy researchers have speculated that humility might underlie many of the characteristics and behavioral patterns associated with highly effective therapists (Davis & Cuthbert, 2017). For example, humility might help therapists maintain an other-oriented stance even in the face of professional self-doubt. Humility also likely helps therapists remain open to feedback and adjusting their therapeutic approach while maintaining an accurate and balanced view of the self (Davis & Cuthbert, 2017).

Research on the relationship between humility and client outcomes has focused on cultural humility (e.g., Hook et al., 2013; Owen et al., 2014; Owen et al., 2016).

Cultural humility is defined as maintaining a stance of curiosity, awareness, and openness when confronted with cultural issues (Davis et al., 2018). Findings indicate that cultural humility does have a positive influence on client-rated alliance and client outcomes (Mosher et al., 2017). No existing research has explored the relationship between general humility and treatment outcomes. However, humility appears to be closely related to other constructs previously linked to client outcomes. For example, humility encompasses facilitative interpersonal skills and has been compared to professional self-doubt (see Nissen-Lie et al., 2017).

The similarities between professional self-doubt and humility have been previously discussed (e.g., Wampold & Owen, 2020) but there are also important differences between these constructs that are rarely acknowledged. Humility encompasses an ability to recognize one's shortcomings while maintaining a sense of confidence in one's ability to effectively work with clients (Davis et al., 2018; Paine et al., 2015). Humility also incorporates a willingness to seek out help when needed (Paine et al., 2015). Professional self-doubt seems to be narrower, as it only encompasses the recognition of one's limits but not necessarily confidence in the ability to address them (i.e., self-efficacy).

Current Study

The current study sought to further research on therapist effects by examining the relationship between therapist characteristics and client outcomes. Professional self-doubt has emerged as an important construct in the literature, but research has yielded equivocal results and its relationship with other prominent constructs remains unclear. Given the increased focus on professional self-doubt, it seems important to clarify this construct's relationship with treatment outcomes and how it relates to two frequently mentioned

constructs: counseling self-efficacy and humility. As highlighted above, counseling self-efficacy and humility are believed to be associated with increased client outcomes. This study examined the degree to which each of the three therapist characteristics (i.e., professional self-doubt, counseling self-efficacy, and humility) influenced client-rated change across treatment. To gain insight into the conceptual relationships between the therapist characteristics, the relationships between professional self-doubt, counseling self-efficacy, and humility were also explored.

CHAPTER 2. METHOD

Procedure

Institutional review board approval was obtained for the current study. Data was collected from Southwest Behavioral Health Services (SBHS), a non-profit, comprehensive community behavioral health organization providing services to people living in Phoenix, Arizona metropolitan area, rural Maricopa County, Gila, Mohave, Coconino, and Yavapai Counties. SBHS provides clinical services to a diverse group of Medicaid insured clients at or below 100% of the federal poverty level through a wide variety of programs, including mental health and substance abuse treatments for youth and adults.

A survey was constructed using a web-based survey platform (i.e., Qualtrics) to collect therapist data. The first page of the survey welcomed potential participating therapists with a description of the study, an invitation to participate, information on their rights as participants, and a description of potential risks and benefits of the study. Therapists acknowledged their understanding of the provided information and agreed to participate by checking "Yes, I would like to participate in this study." Therapists who expressed a willingness to participate in the study were asked to provide their employee

identification number, which was later used to link their survey information to the archived information of their clients. Participating therapists completed demographic items and measures of professional-self-doubt, counseling self-efficacy, and general humility. Therapists were recruited to participate in the study during agency staff meetings. Therapists who had no closed therapy cases were considered ineligible to participate in the study. Interested and eligible therapists were invited to complete the survey online (e.g., via a Qualtrics link) or in person (i.e., paper version of the Qualtrics survey). All therapists who participated in the study elected to complete the survey in person during the agency staff meetings.

After collecting all therapist data, archived and de-identified data on client-rated treatment outcomes and demographics of clients who had worked with participating therapists were retrieved. The primary investigator sent the list of employee identification numbers of the therapists who participated in the study to a senior systems analyst at the site, who was not involved in the data collection process. Client data (i.e., client demographic information and client-rated outcomes) were then sent to the primary investigator using Barracuda Email Encryption Service. The client data was not identifiable, as the archived information did not include any names or identification numbers. SBHS comprehensively uses the Partners for Change Outcome Management System (PCOMS; Duncan, 2012) throughout its locations. PCOMS uses the Outcome Rating Scale (ORS; Miller & Duncan, 2000) to track outcomes and facilitate discussions with clients regarding their treatment progress and the Session Rating Scale (SRS; Duncan et al., 2003) to monitor the therapeutic alliance.

SBHS granted permission for data analysis from adult discharged cases (18 years

and older) between October 2014 and April 2020. Only outcome data from individual counseling sessions (excluding group and couples therapy) were included. Cross-classification of clients and therapists (i.e., clients seeing more than one therapist in the study) was avoided by retaining the episode of care in which the client attended the greatest number of sessions. Clients who saw more than one therapist in the data set typically saw one therapist in the sample for only one session compared to seeing another therapist for several sessions, making it easy to discern which episode of care should be retained.

Participants

Clients

The aforementioned parameters yielded a total of 1,939 client cases, who attended a mean number of 4.12 sessions (*SD* = 4.93, range = 1 to 59, *Mdn* = 2). The explore function in IBM SPSS Statistics (Version 26) was used to locate clients who were extreme outliers in terms of sessions attended (*n* = 122) and these clients were removed prior to conducting final analyses. Clients (*N* = 1,817) in the final sample were predominantly female (56.70%) and White (46.70%), ranging in age from 18 to 96 years (*M* = 36.57, *Mdn* = 34.00, *SD* = 13.50). Hispanics were the largest minority (15.70%) followed by Black (11.70%), other ethnic groups (4.90%), American Indian (1.40%), Asian or Pacific Islander (0.50%), Native Hawaiian (0.10%), and Pacific Islander (0.10%). Information about race and ethnicity was not provided for the remaining clients (18.90%). Clients in the final sample attended a mean of 3.13 sessions (*SD* = 2.47). Regarding primary diagnosis, depressive disorders (37.53%), trauma and stressor-related disorders (22.89%), and anxiety disorders (13.26%) were the most common. A mix of other diagnostic categories accounted for the remainder (see Table 1 for a full list).

Therapists conducted semi-structured intakes and determined a primary diagnosis by the third session. Information about comorbidity and medication status was not available.

Therapists

A total of 51 therapists completed the survey. Five therapists did not have any closed-client cases and were therefore excluded from final analyses, yielding a final sample of 46 therapists. Therapists were predominately female (80.40%) and were White (56.50%), Black (10.90%), Latinx or Hispanic (8.70%), Biracial or Multiracial (8.70%), Asian (6.50%), American Indian or Alaskan Native (4.30%), Native Hawaiian or Other Pacific Islander (2.20%), and prefer not to answer (2.20%). Therapists ranged in age from 23 to 67 years (M = 34.20, SD = 10.32).

Therapists came from a range of professional disciplines, including clinical/counseling psychology (50.00%), social work (32.61%), counselor education (8.70%), and other (e.g., community counseling, rehabilitation counseling; 8.70%). The majority (69.60%) were professional staff members, with the remaining therapists consisting of trainees. Nearly all of the therapists had a master's degree or higher (n = 43; 93.48%), while the remaining therapists were working toward a master's degree. Therapists ranged from having 1 to 24 years of experience (M = 4.48, SD = 4.76). However, 15 therapists (32.61%) did not provide a response to this item on the survey. Therapists were not asked to identify their theoretical orientation, but therapists at the site are encouraged to use brief treatment models (e.g., solution-focused, cognitive-behavioral). Clients are assigned to therapists primarily on the basis of availability. The average number of clients seen by each therapist was approximately 40 (Mdn = 21.50, SD = 47.44).

Measures

Therapist Measures

Professional self-doubt. Professional self-doubt was measured using a subscale from the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky et al., 1999), a comprehensive measure of therapist development. One section of the DPCCQ measures "difficulties in practice." Items on this subscale are rated on a scale that ranges from 0 (*never*) to 5 (*very often*). A sample item is "Lacking in confidence that you might have a beneficial effect on a patient." Although some studies have reported a three-factor structure for this scale (i.e., professional self-doubt, negative personal reaction, and frustrating treatment case), others have reported a two-factor structure (Nissen-Lie et al., 2013). Orlinsky and Rønnestad (2005) recommend using the following 5 items to measure professional self-doubt: (1) Lacking in confidence that you might have a beneficial effect on a patient; (2) Unsure how best to deal effectively with a patient; (3) Demoralized by your inability to find ways to help a patient; (4) Afraid that you are doing more harm than good in treating a patient; and (5) Unable to generate sufficient momentum. Previous studies have reported adequate internal consistency scores ranging from .77 to .80. (Odyniec et al., 2017; Orlinsky & Rønnestad, 2005). In the current study, internal consistency was .83.

Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). The COSE is a 37-item measure used to measure counseling self-efficacy. The inventory uses a 6-point Likert-type scale, ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), and consists of five subdomains: microskills, the counseling process, dealing with difficult client behaviors, cultural competency, and awareness of values. An example item is "I feel that I have enough fundamental knowledge to do effective counseling." Possible

scores range from 37 to 222 with a higher total score representing a higher perception of counseling self-efficacy. The COSE has demonstrated adequate convergent validity, in that previous research has found it to be positively correlated with measures of self-esteem and negatively correlated with measures of anxiety (Larson et al., 1992). Larson et al. (1992) reported an alpha of .93 for the total score. Internal consistently in the current study was .91.

The Expressed Humility Scale (Owens et al., 2013). The Expressed Humility Scale is a 9-item measure of humility. The scale is intended to measure three facets of humility: (a) willingness to view oneself accurately ("This person seeks feedback, even if it is critical"); (b) appreciation for the strengths and contributions of others ("This person takes notice of others' strengths"); and (c) teachability ("This person is willing to learn from others"). Respondents assess a target person on each item using a 5-point Likert format scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The scale was originally intended to be completed by an informant (e.g., supervisor) but can be altered to serve as a self-report measure. For example, "This person admits it when they don't know how to do something" is changed to "I admit it when I don't know how to do something." The current study used the self-report format. Previous studies have reported internal consistency scores for the total score ranging from .92 to .97 (Basford et al., 2014; Owens et al., 2013, Owens & Hekman, 2016; Zhang et al., 2015). In the current study, internal consistency was .67. Previous research has found the self-reported version of the measure to be positively correlated to openness (Owens et al., 2013).

Treatment Outcome Measures

Session Rating Scale (SRS; Miller et al., 2002). The therapeutic alliance was

measured using the Session Rating Scale (SRS; Miller et al., 2002). The SRS is comprised of four domains: relationship (how much the client feels heard by the therapist), goals and topics (how much clients feel they were able to work on the goals and topics they wanted to work on), approach or method (extent to which the therapist's approach was perceived as a good fit for the client), and overall quality of the session (overall fit of the session for the client). The SRS is administered at the end of every session and takes approximately 1 minute to complete. Items use a visual analog scale where clients make a mark on each of the four 10-cm scales. Marks toward the right indicate more positive evaluations, while marks toward the left indicate poor evaluations. Scores can range from 0 to 40. Previous research conducted with clients has demonstrated that scores are reliable, with Cronbach's alpha ranging from .88 to .96 (Campbell & Hemsley, 2009; Duncan et al., 2003; Gillaspy & Murphy, 2011; Reese et al., 2013). Internal consistency for the current study could not be calculated because only total SRS scores for each session were provided. The SRS has demonstrated moderate concurrent validity with the Helping Alliance Questionnaire (Luborsky et al., 1996) and the Working Alliance Inventory–Short Revised (Hatcher & Gillaspy, 2006; Reese et al., 2013).

Outcome Rating Scale (ORS; Miller & Duncan, 2000). The ORS is a 4-item measure of global psychological functioning. The items are based on the subscales of the Outcome Questionnaire - 45 (OQ-45; Lambert et al., 1996): individual (personal well-being), interpersonal (family, close relationships), social (work, school, friendships), and overall (general well-being) functioning. Items use a visual analog scale where clients make a mark on each of the four 10-cm scales, which reflects the degree to which they

have experienced distress in those areas over the past week. The ORS is administered prior to the start of each session and takes approximately 1 minute to complete. Marks toward the left indicate more distress and those on the right indicate less distress. Scores can range from 0-40, with lower scores reflecting more distress. The measure is available electronically or in paper-based format. Previous research has reported reliability estimates for the ORS ranging from .82 to .92 in clinical samples (Duncan & Reese, 2015). Internal consistency for the current study could not be calculated because only total ORS scores for each session were provided. Correlations between the ORS and the OQ-45 have ranged between .53 – .74 (Gillaspy & Murphy, 2011).

Analytical Strategy

Descriptive data was analyzed using IBM SPSS Statistics (Version 26). Pearson product-moment correlations were run between each of the primary variables in the study. HLM 8 software was used to conduct linear multilevel modeling (MLM; Hox, 2010; Raudenbush & Bryk, 2002) to evaluate therapist effects. MLM was used due to the nested data structure (i.e., sessions nested within clients nested within therapists). Ignoring the nested structure of the data is problematic because many statistical analyses (e.g., OLS regression) assume independence of observations, but nested data violate this assumption. Violating the assumption of independence leads to smaller standard errors and a corresponding increase in Type I error (i.e., rejecting the null hypothesis when the null is true; Hox, 2010). Additionally, individual-level analyses cannot adequately capture the role of group-level factors. MLM allows psychotherapy researchers to distinguish clients' and therapists' contributions to the treatment process, which then allows determination of how these two sources predict outcomes (Kahn, 2011).

Clients completed measures of process (i.e., SRS) and outcome (i.e., ORS) for each session they attended. Therapist responses to the measures were matched with their client outcome data using therapist and site identification numbers. "Time" (session number, first session set at zero) was included as an independent variable, resulting in what is called a 3-level growth model. Separate models were tested for each of the dependent variables (i.e., SRS and ORS). Assumptions underlying MLM growth curve analyses for change, such as normally distributed residuals and homogeneity of variance, were assessed. Full maximum likelihood estimation was used in all multilevel models. First, two unconditional growth models were conducted, which only included the "time" variable. The unconditional models were used to determine whether significant variation existed between the therapists with respect to the dependent variables. The equation for both unconditional models was:

Level 1: $Y_{tij} = \pi_{0ij} + \pi_{1ij}(\text{Session}) + e_{tij}$

Level 2: $\pi_{0ij} = ß_{00j} + r_{0ij}$

$\pi_{1ij} = ß_{10j} + r_{1ij}$

Level 3: $ß_{00j} = \Upsilon_{000} + u_{00j}$

$ß_{10j} = \Upsilon_{100} + u_{10j}$

At Level 1, Y_{tij} is the dependent variable score repeatedly measured at session t for client i treated by therapist j, π_{0ij} is the intercept (e.g., initial status), π_{1ij} is the growth rate for client ij across sessions, and e_{tij} is the residual or error term indicating the deviation of each individual score from their mean score. The Level 2 equations represent variability in between-client growth. Each client's intercept, π_{0ij}, is modeled as the group mean initial status, $ß_{00j}$, plus each individual's deviation from their respective group mean, r_{0ij}.

Each individual's slope (i.e., rate of growth), π_{1ij}, is a function of the average rate of growth of the individual's group, $ß_{10j}$, plus each individual's growth parameter's deviation from the average rate of change, r_{1ij}. At Level 3, between-therapist growth is modeled. The group mean initial status, $ß_{00j}$, is a function of the grand mean for initial status, Υ_{000}, and a residual u_{00j}. A group's slope, representing rate of growth, $ß_{10j}$, is a function of the mean rate of growth for all groups, Υ_{100}, and the group residual, u_{10j}. Using the results of the unconditional models, the therapist variability was calculated as the intraclass correlations (Kreft & de Leeuw, 1998). A stepwise backward deletion approach was then used to answer the research questions. All therapist characteristics were entered into the model at the third level and grand mean centered to facilitate interpretation.

CHAPTER 3. RESULTS

Means, standard deviations, and bi-variate correlations for each of the therapist characteristics measured are presented in Table 2. Results of the unconditional model for SRS indicated a lack of overall growth in SRS scores across treatment (see Table 3). Thus, neither client nor therapist level variables were modeled for this outcome measure.

Results of the unconditional model for ORS indicated significant variability in growth among clients and therapists (see Table 4). Approximately 5% of the variance in rate of growth was between therapists. There was a negative correlation between initial status and rate of growth at the client level (r = -.39) and the therapist level (r = -.46), suggesting that a higher ORS score at the beginning of treatment (i.e., less distress) was associated with a slower rate of improvement. This finding also indicates that clients became increasingly similar in their outcomes as treatment progressed. A stepwise

backward deletion approach was subsequently used for model testing.

None of the therapist characteristics were significant when all three variables were placed in the model. Humility was the first variable removed from the model because it did not make a significant contribution to predicting improvement in ORS scores (i.e., $p > .05$) and was the least powerful predictor of ORS scores. The second model examined consisted of professional self-doubt and counseling self-efficacy on the intercept and slope at level three. Examining this model showed that, when controlling only for the effects of counseling self-efficacy, professional self-doubt was marginally significant, ($ß = 0.06$, $p = .063$; see Table 5). If you imagine two therapists one unit apart in professional self-doubt, clients working with the therapist higher in professional self-doubt will improve .06 points per session faster than clients working with the therapist lower in professional self-doubt, when controlling for counseling self-efficacy. Relative to the null model, this model explained roughly 50% of the variance in rate of growth in ORS scores at the therapist-level. As can be seen in Table 7, when counseling-self-efficacy was removed from the model, PSD was no longer marginally significant ($ß = 0.04$, $p = .162$). Relative to the null model, this model explained 55.6% of the variance in rate of growth in ORS scores at the therapist-level.

Table 1

Diagnosis Information of Client Sample

Diagnosis	*n*	%
Depressive Disorders	682	37.53
Trauma and Stressor Related Disorders	416	22.89
Anxiety Disorders	241	13.26
Bipolar Disorders	150	8.26
Schizophrenia Spectrum and Other Psychotic Disorders	107	5.88
Substance-Related Disorders	77	4.23
Neurodevelopmental Disorders	72	3.96
V-Codes	29	1.60
Personality Disorders	12	0.66
No Diagnosis Provided	11	0.61
Impulse Control Disorders	10	0.55
Obsessive-Compulsive Disorder	6	0.33
Unspecified Feeding and Eating Disorders	2	0.11
Somatic Symptom Disorder	2	0.11

Note. N = 1,817. Depressive Disorders = Major Depressive Disorder, Dysthymia, Depressive Disorder due to a medical condition, Unspecified Depressive Disorder; Trauma and Stressor Related Disorders = Posttraumatic Stress Disorder and Adjustment Disorder; Anxiety Disorders = Social Anxiety Disorder, Generalized Anxiety Disorder, Panic Disorder, Anxiety Disorder due to a medical condition, and Unspecified Anxiety Disorder; Bipolar Disorders = Bipolar I Disorder and Bipolar II Disorder; Schizophrenia Spectrum and Other Psychotic Disorders = Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Psychotic Disorder due to a medical condition. Substance-Related Disorders = Alcohol Use Disorder, Cannabis Use Disorder, Opioid Use Disorder, and Stimulant Use Disorder; Neurodevelopmental Disorders = Intellectual Disability, Attention-Deficit/Hyperactivity Disorder, and Unspecified Neurodevelopmental Disorder; V-Codes = any V-code diagnosis; Personality Disorder = Borderline Personality Disorder and Personality Disorder due to a medical condition; Impulse Control Disorders = Intermittent Explosive Disorder and Unspecified Impulse Control Disorder.

Table 2

Means, SD, and Correlations for Predictor Variables

Variable	*M*	*SD*	1	2	3
1. PSD	1.48	0.61	-	-.65**	-.25
2. CSE	4.77	0.32			.36*
3. Humility	4.72	0.15			

Note. PSD = Professional Self-Doubt; CSE = Counseling Self-Efficacy; *SD* = standard deviation; ** = Correlation is significant at the .01 level; * = Correlation is significant at the .05 level.

Table 3

Results of Unconditional Model for SRS Scores

Fixed Effect	Coefficient	*SE*	*t*-ratio	*df*	*p*-value
Average Initial Status, γ_{000}	38.21	0.25	153.58	45	< .001
Average Session Growth Rate, γ_{100}	0.10	0.07	1.57	45	.124
Random Effect	Variance	*df*	χ^2	*p*-value	
Level 1					
Temporal Variation, *e*	5.70				
Level 2					
Initial Status, r_0	4.47	1133	2442.36	<.001	
Rate of Growth, r_1	0.08	1133	1600.92	<.001	
Level 3					
Therapist Mean Initial Status, u_{00}	2.06	41	532.28	<.001	
Therapist Mean Growth Rate, u_{10}	0.13	41	290.28	<.001	

Note. SRS = Session Rating Scale; *SE* = Standard Error.

Table 4

Results of Unconditional Model for ORS Scores

Fixed Effect	Coefficient	*SE*	*t*-ratio	*df*	*p*-value
Average Initial Status, γ_{000}	22.69	0.32	71.75	45	< .001
Average Session Growth Rate, γ_{100}	0.78	0.08	10.07	45	< .001
Random Effect	Variance	*df*	χ^2	*p*-value	
Level 1					
Temporal Variation, *e*	19.64				
Level 2					
Initial Status, r_0	56.38	1137	5674.30	< .001	
Rate of Growth, r_1	1.10	1137	1736.05	< .001	
Level 3					
Therapist Mean Initial Status, u_{00}	1.49	41	82.02	< .001	
Therapist Mean Growth Rate, u_{10}	0.05	41	57.33	.046	

Note. Outcome Rating Scale = ORS; *SE* = Standard Error.

Table 5

Effects of PSD and CSE on ORS Scores

Fixed Effect	Coefficient	*SE*
Model for initial status, π_0		
Intercept, γ_{000}	22.72	0.32
PSD, γ_{001}	0.18	0.11
COSE, γ_{002}	0.02	0.03
Model for session growth rate, π_1		
Intercept, γ_{100}	0.81	0.07
PSD, γ_{101}	0.06	0.03
COSE, γ_{102}	0.00	0.01

Note. PSD = Professional Self-Doubt; CSE = Counseling Self-Efficacy; ORS = Outcome Rating Scale; *SE* = Standard Error.

Table 6

R^2 for Effects of PSD and CSE on ORS Scores

Model	Initial Status	Rate of growth
Null	1.491	.054
Full	1.338	.027
R^2	.103	.500

Note. PSD = Professional Self-Doubt; CSE = Counseling Self-Efficacy; ORS = Outcome Rating Scale; R^2 = Null-Full/Null.

Table 7

Effects of PSD on ORS Scores

Fixed Effect	Coefficient	*SE*
Model for initial status, π_0		
Intercept, γ_{000}	22.74	0.31
PSD, γ_{001}	0.10	0.09
Model for session growth rate, π_1		
Intercept, γ_{100}	0.81	0.07
PSD, γ_{101}	0.04	0.03

Note. PSD = Professional Self-Doubt; ORS = Outcome Rating Scale; *SE* = Standard Error.

Table 8

R^2 for Effects of Professional Self-Doubt on ORS Scores

Model	Initial Status	Rate of growth
Null	1.491	.054
Full	1.474	.024
R^2	.01	.556

Note. Professional Self-Doubt; ORS = Outcome Rating Scale; R^2 = Null-Full/Null

CHAPTER 4. DISCUSSION

Professional self-doubt has emerged as an important construct in the therapist effects literature. Previous research has yielded inconsistent results, suggesting that professional self-doubt likely has a complex relationship with treatment outcome. This study aimed to clarify professional self-doubt's role in the therapeutic process by examining how professional self-doubt operates with related constructs: counseling self-efficacy and humility.

This study found that 5% of the variance in clients' ORS scores was due to differences between therapists. That is, the clients of some therapists achieved better outcomes compared to the clients of other therapists. Although in the range of other studies on therapist effects, this effect is on the lower end of those found in previous studies (Saxton et al., 2017; Wampold & Owen, 2020). The extent to which the three predictors could account for the therapist effect in clients' ORS scores was subsequently examined.

Professional Self-Doubt

The most noteworthy finding was that when the shared variance between professional self-doubt and counseling self-efficacy was controlled for, the unique contribution of professional self-doubt was a marginally significant predictor of clients' ORS scores. This relationship is difficult to explain and calls into question what precisely professional self-doubt is measuring. The strong, negative correlation found between counseling self-efficacy and professional self-doubt implies that professional self-doubt is somewhat analogous to therapists' subjective efficacy. Regardless, professional self-doubt was only marginally significant in the current study, which is inconsistent with

previous findings demonstrating significant positive (e.g., Nissen-Lie et al., 2013) and negative (Odyniec et al., 2017) associations between professional self-doubt and client outcomes. It is noteworthy that other authors have explained these directional discrepancies by highlighting differences between the samples of therapists used. For example, Odyniec and colleagues (2017) attributed their findings to the fact that they used novice therapists, stating that self-doubt might serve as a distressing distraction among novice therapists. Indeed, it likely takes time to cultivate the ability to use one's self-doubt effectively (Fouad et al., 2009; Hatcher, 2015). Perhaps professional self-doubt at earlier stages in development is more likely to lead to feelings of anxiety and incompetence, which might impede the therapeutic process (Odyniec et al., 2017; Shoffner, 2009).

Differences between therapists and the settings in the current study and those in previous studies could explain the lack of a significant finding in the current study. For example, previous research on professional self-doubt has been conducted in training clinics and public outpatient clinics outside of the United States. Contextual and cultural differences in psychotherapy likely play an important role in how professional self-doubt influences the therapeutic process. The current study took place in a community mental health agency located in the United States that serves low-socioeconomic clients, which may have influenced the findings in several ways. For example, therapists' beliefs about socioeconomic status have the potential to introduce biases into the therapeutic processes. Negative biases about socioeconomic status may prompt therapists to attribute blame for less favorable outcomes to clients rather than questioning their own therapeutic approach (Dougall & Schwartz, 2018).

The outcome measure used in the current study should also be taken into consideration, as previous research indicates that the outcome measure selected can have a powerful influence on studies of therapist effects (Schiefele et al., 2017). Importantly, previous studies have found a significant relationship between trait-based professional self-doubt and client-rated alliance and interpersonal problems but not symptomology (e.g., Odyniec et al., 2017). To my knowledge, this study was the first study on professional self-doubt to use the PCOMS. Thus, in addition to more research with diverse samples of therapists, more research is needed with different outcome measures.

An additional consideration is the extent to which an optimal level of professional self-doubt exists. Specifically, is there a point at which professional self-doubt becomes primarily detrimental? The current sample of therapists more closely aligns with those found in Nissen-Lie and colleagues (2010, 2013, 2017) studies, in that our sample consisted of a mix of graduate trainees and professional staff members with a mean of approximately 5 years of experience providing psychotherapy. Yet the mean professional self-doubt score in the current study was considerably higher than that obtained in Nissen and colleagues research (M = 1.24). The mean professional self-doubt score for therapists in the current sample was actually closer to the sample of trainees in the Odyniec et al. (2017) study (M = 1.52). This suggests that levels of professional self-doubt between trainees and more experienced professionals can be similar and that it is not necessarily the amount of professional self-doubt that is relevant, as professional self-doubt did not appear to impair therapists' performance in the current sample. What likely matters most is how therapists respond to feelings of self-doubt (i.e., the actions they take to address it).

Counseling Self-Efficacy

Neither counseling self-efficacy nor humility uniquely predicted clients' ORS scores. The non-significant relationship between counseling self-efficacy and client-outcome is difficult to explain. Mastery experience is believed to be the strongest influence on efficacy beliefs (Bandura, 1997). The PCOMS system is intended to provide therapists with continuous feedback about their performance so that they can make adjustments and the current study did find that there was significant growth in clients' ORS scores over the course of treatment. Given that the current study used archival client outcome data, theory would predict that therapists with better client outcomes would have endorsed having higher levels of counseling self-efficacy. Nevertheless, previous studies on the relationship between counseling self-efficacy and client outcomes have been scarce and inconsistent (Mesrie et al., 2018). Perhaps the relationship between the two variables depends on the extent to which therapists receive and respond to the feedback mechanism used (Reese et al., 2009). Another consideration is that exploring the relationship between therapist's self-efficacy beliefs and client's perception of treatment outcomes is antithetical to effective practice. This approach establishes the client as the object of the therapist's action rather than as a collaborator in a joint venture (Bandura, 1997). It may be more productive to focus on the continual flow of reciprocal mutual influence between the therapist and the client. Specifically, exploring collective efficacy may be more appropriate for future studies. That is, it may be more helpful to explore the extent to which therapist-client dyads believe they can accomplish therapeutic goals through working together.

Humility

Humility also did not significantly predict ORS scores. Additionally, humility was

not correlated with professional self-doubt, which is incongruent with recent writings about their suspected conceptual overlap (e.g., Wampold & Owen, 2020). It is important to reframe from drawing any firm conclusions about the relationship between humility and client outcomes from the current findings for several reasons. First, previous research demonstrating a positive relationship between therapists' cultural humility and client outcomes has used observer-rated measures, while the current study used a self-report measure of humility. Although the Expressed Humility Scale has yielded similar ratings when compared to the observer-rated version within organizational settings (Owens, 2013), research demonstrates that therapists' reports of their interpersonal functioning is a particularly poor predictor of client outcomes (Wampold & Owen, 2020). Given that humility captures a broad range of interpersonal and intrapersonal skills, it may be particularly difficult for therapists to gauge their own level of humility. Some researchers have questioned the validity of humility self-report measures, highlighting that the act of rating oneself highly on a positive virtue is incompatible with humility (Hill et al., 2017). Furthermore, the development of valid measures of general humility is still in infancy. Thus, more research is needed on this topic.

Limitations

These findings should be interpreted in light of several limitations. The first concerns the inability to assess the relationship between therapist characteristics and process-related variables. The therapeutic alliance is believed to play an important role in the therapeutic process (Wampold et al., 2017). Unfortunately, the SRS did not capture significant growth in client-rated alliance, which prohibited further exploration of how therapist characteristics influence alliance scores. The overall initial mean SRS score was notably high, and scores tended to remain high across sessions, which is a common

finding in studies using the PCOMS (e.g., Reese et al., 2013). The SRS has yielded weak correlations with other longer, well-established measures of the therapeutic alliance, suggesting that it may be limited in its ability to fully track therapeutic alliance (Murphy et al., 2020).

Another limitation is that the constructs in the current study were operationalized as stable characteristics and therefore were not contextualized within specific cases. That is, therapists were not asked to consider their work with specific clients. It is easy to imagine situations in which therapists' self-perceptions fluctuate and vary according to different cases, time, and many other factors. Indeed, there is some evidence that the experience of professional self-doubt fluctuates across clients (Odyniec et al., 2017). Although no research exists, it is also likely easier to take a humble stance with some clients compared to others and self-efficacy may vary across clients. Yet these traits probably operate on a continuum of stable characteristics to state-dependent experiences, which has yet to be fully determined. Thus, in accordance with the majority of previous studies on these variables, the constructs were treated as global and stable in the current study.

Previous research indicates that therapists' developmental level influences the relationship between at least two of the therapist characteristics (i.e., professional self-doubt and counseling self-efficacy) examined and client outcomes. The current sample of therapists included therapists of varying developmental levels, but the small sample size prohibited any group comparisons. More research is needed clarifying how therapists' developmental level influences the relationship between these constructs and client outcomes.

Conclusions about causality cannot be drawn regarding the marginally significant association found between professional self-doubt and clients' ORS scores when controlling for counseling self-efficacy. It is unclear whether therapists with a tendency to doubt themselves achieve better client outcomes or whether higher levels of professional self-doubt represent a response to client outcomes.

There are also several limitations typical of a naturalistic study. For example, it is recommended that with sample sizes of around 50 therapists, each therapist should have seen at least 20 clients (Schiefele et al., 2017). Although therapists in this study saw an average of 40 clients, there was considerable variability in the number of clients seen by each therapist and some therapists saw fewer than 20 clients. Nevertheless, the difficulty obtaining optimal sample sizes in naturalistic studies is well documented and the sample sizes for clients and therapists in the current study are comparable to other naturalistic studies (Wampold & Owen, 2020).

The naturalistic nature of the study also limits the ability to control for extraneous factors and retrieve relevant information. For example, information about comorbidity and medication status were unable to be obtained. It is also unlikely that all clients were randomly assigned to therapists in the study, as clients can request therapists with certain expertise. The site primarily operates within a brief therapy format, but clients still experienced treatments of varying types and lengths. Nonetheless, the naturalistic nature of the study makes the findings more generalizable to other clinical settings.

Conclusions and Clinical Implications

Despite the previously discussed limitations, the current study has several important clinical implications. This study was the first to investigate the association between professional self-doubt and client outcomes within the United States. This study

was also the first to explore professional self-doubt alongside other related constructs that are considered important to psychotherapy training and practice. Counseling self-efficacy has long been endorsed as an important characteristic for therapists and humility is an emerging construct in the psychotherapy literature (Hook et al., 2017). However, some of these characteristics seem antithetical, leading to confusion about which qualities we should be endorsing and striving to embody as therapists. The findings from this study are an initial step toward gaining clarity regarding how these characteristics relate to each other. Taken holistically, the research on professional self-doubt indicates that, under certain circumstances, professional self-doubt might enhance client-rated outcomes that are interpersonal in nature (e.g., therapeutic alliance, clients' interpersonal functioning). However, further clarification with diverse therapist samples is needed to discern under what circumstances professional self-doubt benefits these outcomes, as well as the extent to which professional self-doubt influences more distal client outcomes.

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Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love yourself as a person, doubt yourself as a therapist?. *Clinical Psychology & Psychotherapy, 24,* 48-60. doi:10.1002/cpp.1977

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Owens, B. P., Johnson, M. J., & Mitchell, T. R. (2013). Humility in organizations: Implications for performance, teams, and leadership. *Organization Science*, *24*, 1517–1538. https://doi.org/10.1287/orsc.1120.0795

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Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology, 3,* 157–168. http://dx.doi.org/10.1037/a0015673

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Schunk, Dale H, & DiBenedetto, Maria K. (2020). Motivation and social cognitive theory. *Contemporary Educational Psychology, 60,* 101832. https://doi.org/10.1016/j.cedpsych.2019.101832

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Wampold, B. E., Baldwin, S. A., Holtforth, M. g., & Imel, Z. E. (2017). What characterizes effective therapists? In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others?: Understanding therapist effects* (pp. 37-53). Washington, DC, US: American Psychological Association.

Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting & Clinical Psychology, 73,* 914-923. doi:10.1002/jclp.20110

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. New York: Routledge.

Wampold, B. E., & Owen, J. (2020). Therapist effects: History, methods, magnitude, and characteristics of effective therapists. [Manuscript in preparation].

Zhang, Y., Waldman, D. A., Han, Y. L., & Li, X. B. (2015). Paradoxical leader behaviors in people management: Antecedents and consequences. *Academy of Management Journal, 58*, 538-566. https://doi.org/10.5465/amj.2012.0995

VITA

Alyssa Laura Clements

PROFESSIONAL EXPERIENCE

Predoctoral Psychology Intern, July 2020 - Present

- Auburn Student Counseling and Psychological Services (APA-Accredited)

EDUCATION

University of Kentucky (UK)
Doctorate of Philosophy, Expected May 2021

- Major: Counseling Psychology
- Dissertation: "The Person of the Therapist: Therapists' Personal Characteristics as Predictors of Working Alliance and Treatment Outcomes" (Defense November 19, 2020)

Augusta University (AU)
Master of Science, May 2014

- Major: Clinical Psychology Track

Augusta University (AU)
Bachelor of Science, May 2012

- Major: Psychology

PEER-REVIEWED PUBLICATIONS

Nieves, H., **Clements-Hickman, A. L.**, & Davies, C. C. (In Press). The effect of a parent empowerment program on parental stress, satisfaction, and length of stay in the neonatal intensive care unit. *Journal of Perinatal and Neonatal Nursing.*

Clements-Hickman, A. L., & Reese, R. J. (2020). Improving therapists' effectiveness: Can deliberate practice help? *Professional Psychology: Research and Practice. Professional Psychology: Research and Practice.* Advance online publication. https://doi.org/10.1037/pro0000318

Hands, K., **Clements-Hickman, A. L.**, & Davies, C. C. & Brockopp, D. (2020). The effect of hospital-based childbirth classes on women's birth preferences and fear of childbirth: A pre and post-class survey. *The Journal of Perinatal Education, 29,* 134-142.

Clements-Hickman, A. L., Wilson, J., Wright, L., & Davies, C. C. (2019). Developing a research friendly hospital-based environment: A fellowship model focused on graduate students. *Journal of Nursing Administration, 49,* 624-627.

Clements-Hickman, A. L., Dschaak, Z., Hargons, C. N., Kwok, C., Meiller, C., Ryser-Oatman, T., & Spiker, D. (2019). Humanity in homelessness: A social justice consultation course for counseling psychology students. *Journal for Social Action in Counseling and Psychology, 10,* 34-48. [Authors listed in alphabetical order to reflect equal contribution]

She, Z., Duncan, B. L., Reese, R. J., Sun, Q., Shi, Y., Jiang, G., . . . **Clements-Hickman, A. L.** (2018). Client feedback in China: A randomized clinical trial in a college counseling

center. *Journal of Counseling Psychology, 65*, 727-737.

Reese, R. J., Gismero González, E., **Clements-Hickman, A. L**., Clemons, J. M., Farook, M. W., & Conoley, C. W. (2017). The psychotherapy researcher–practice relationship: Through a clinical supervision lens. *Counselling Psychology Quarterly*, *30*, 290-307.

Slavin-Mulford, J., **Clements, A.,** Hilsenroth, M., Charnas, J., & Zodan, J. (2016). An examination of generalized anxiety disorder and dysthymia utilizing the Rorschach inkblot method. *Psychiatry Research*, *240*, 137-143.

BOOK CHAPTERS

Reese, R. J., Gismero-Gonzalez, E., **Clements-Hickman, A. L.,** Clemons, J. M., Farook, M. W., & Conoley, C. W. (2019). The psychotherapy researcher–practice relationship: Through a clinical supervision lens. In J. D. Paquin (Ed.) *Clinician-researchers in psychotherapy: Careers engaged in both practice and research*. New York: Routledge.

MANUSCRIPTS UNDER REVIEW

Clements-Hickman, A., L., Hollan, J., Drew, C., Hinton, V., Reese, R. J. (Under Review). The use of telehealth in behavioral health and educational contexts during COVID-19 and Beyond. [Authors listed in alphabetical order to reflect equal contribution]

Clements-Hickman, A. L., Douglas, D. A., Murphy, E., & Hollan, J. (Revise and Resubmit). Untangling the role of the advisory alliance in promoting research development: Apprentice to scientist-practitioner.

Hollan, J. M., Bowling, W., Reese, R. J., Redmayne, K., **Clements-Hickman, A. L.,** Leibowitz, N., & Hull, T. D. (Revise and Resubmit). The effectiveness of two-way messaging for rural users: A cohort comparison study.

PUBLISHED IN PROFESSIONAL NEWSLETTERS

Ryser-Oatman, T., & **Clements-Hickman, A. L.** (2019). Walk the Walk, Talk the Talk, Do the Work: Recommendations for conducting research with diverse populations. *Psychotherapy Bulletin, 54*(3), 41-46.

Muir, H., & **Clements-Hickman, A. L.** (2018). The uphill climb: A student's guide to gaining relevant skills for acceptance to clinical/counseling doctoral programs. *Psychotherapy Bulletin*, *53*(2), 33-43.

Clements-Hickman, A. L. (2018). Turning points in training: Self-reflection, growth edges, and strengths. *Psychotherapy Bulletin, 53*(1), 23-26.

AWARDS, SCHOLARSHIPS, AND FELLOWSHIPS

- APA Society for the Advancement of Psychotherapy Student Poster Award Finalist (2020)
- Baptist Health Lexington Research Fellow (2019)
- APA Society for the Advancement of Psychotherapy Student Poster Award Winner (2018)
- Baptist Health Lexington Research Fellow (2018)
- The Faculty and Spouse Club Scholarship Nominee, Augusta University (2013)
- Valedictorian, Augusta University (2012)

RESEARCH FUNDING ACTIVITY

- Turner-Thacker Dissertation Grant, UK (2019; $1000)
- Charles J. Gelso Psychotherapy Research Grant (2019; $5000, Funding Not Awarded)
- Conference Funding, UK Department of Educational, School, and Counseling Psychology (2019; $650)
- Conference Funding, UK Department of Educational, School, and Counseling Psychology (2018; $650)
- Conference Funding, UK Department of Educational, School, and Counseling Psychology (2017; $650)
- The Georgia College Counseling Association Presidents' Grant (2014; $700)

PAPER AND POSTER PRESENTATIONS

Clements-Hickman, A. L., Reese, R. J., Bohanske, B. (2020, August). *The Person of the Therapist: Therapists' Personal Characteristics as Predictors of Working Alliance and Treatment Outcomes*. Poster presented at the annual meeting of the American Psychological Association Conference, Virtual. (Division 29 Student Poster Award Finalist)

Clements-Hickman, A.L. (2019, August). *Considering humility and cultural humility from a training perspective.* In R. J. Reese (Chair), From humility to telepsychology: Contemporary practices in therapy through a multicultural lens. Symposium presented at the annual meeting of the American Psychological Association, Chicago, IL.

Clements-Hickman, A. L. (2019, August). Discussant. In C. Hargons (Chair), Amplifying marginalized voices: Teaching social justice through counseling psychology consultation. Symposium presented at the annual meeting of the American Psychological Association, Chicago, IL.

Clements-Hickman, A. L., Spiker, D. A., Murphy, E., Hollan, J. M., & Hughitt, R. (2019, August). *Understanding research productivity: The role of the advisory relationship and research self-efficacy?* Poster presented at the annual meeting of the American Psychological Association Conference, Chicago, IL.

Hollan, J. M., Bowling, W., Murphy, E., **Clements-Hickman, A. L.,** Redmayne, K., & Reese, R. J. (2019, August). The effectiveness of Talkspace for rural users: A SMS text psychotherapy service. Poster presented at the annual meeting of the American Psychological Association Conference, Chicago, IL.

Redmayne, K., Conoley, C. W., Zetzer, H., **Clements-Hickman, A. L**., Hollan, J. M., Murphy, E., & Reese R. J. (2019, August). *Evaluating outcome trajectories and clinical significance.* Poster presented at the annual meeting of the American Psychological Association Conference, Chicago, IL. (Division 29 Student Poster Award Winner)

Clements-Hickman, A. L. (2018, August) *Considering deliberate practice: An effective way to promote supervisee skill development?* In R. J. Reese (Chair), Considerations for providing excellent supervision: From social justice to deliberate practice. Symposium presented at the annual meeting of the American Psychological Association, San Francisco, CA.

Clements-Hickman, A. L., Hollan, J. M., Spiker, D. A., & Reese, R. J. (2018, August). *Do*

clinical supervision process outcomes predict client outcomes? Poster presented at the annual meeting of the American Psychological Association Conference, San Francisco, CA. (Division 29 Student Poster Award winner)

Clements-Hickman, A. L., David, D., Ryser-Oatman, T., & Toland, M. D. (2018, August). *Dimensionality of the patient version of the Working Alliance Inventory-Short Form Revised.* Poster presented at the annual meeting of the American Psychological Association Conference, San Francisco, CA.

Clemons, J. M., **Clements-Hickman, A. L.,** Goodwin, R., Lengerich, A. J., Farbook, M. W., Hong, S.,…Reese, R. J. (2018, August). *Effectiveness, satisfaction, and feasibility of a mobile health application for distress*. Poster presented at the annual meeting of the American Psychological Association Conference, San Francisco, CA.

Clements-Hickman, A., Clemons, J. M., Reese, R. J., Gismero-González, E., Farook, M. W., & Conoley, C. W. (2017, August). *The psychotherapy researcher-practice relationship: Through a clinical supervision lens.* Poster presented at the annual meeting of the American Psychological Association Conference, Washington, D.C.

Minnah, F. W., Brown, H. M., Hong, S., Clemons, J., Lengerich, A. J., **Clements-Hickman, A. L.**, & Reese, R. J. (2017, August) *Clients' experiences of providing feedback in psychotherapy: A qualitative study*. Poster presented at the annual meeting of the American Psychological Association Conference, Washington, D.C.

Clements, A., Dixon, M., Hutto, B., Jalilnasab, S., & Richards, L. (2014, March). *Playtime pow-wow: Development of children's turn-taking.* Poster presented at the Phi Kappa Phi Student Research and Fine Arts Conference, Augusta, GA.

Clements, A., Haywood, C., Dixon, M., Hutto, B., Jalilnasab, S., Richards, L., & Hartmann, Q. (2014, March). *Conversational turn-taking among three and five year olds.* Poster presented at the annual conference of the Southeastern Psychological Association, Nashville, TN.

Clements, A., Slavin-Mulford, J., & Hilsenroth, M. (2014, January). *Integrative dynamic treatment for depression and borderline conditions applied to a college population.* Paper presentation presented at the annual conference of the Georgia College Counseling Association, Savannah, GA.

Lamn, K., **Clements, A.**. & Hammock, G. (2013, November) *Is beauty good enough?: Perceptions of attractiveness and positive social characteristics based on sexual orientation.* Poster presented at the annual conference of the Society of Southeastern Social Psychologists, Augusta, GA.

Reeves, R. A., Chelsey, L., & **Clements, A. L.** (2013, February). *Celebrity worship, desire for fame, materialism, and social media use*. Poster presented at the annual conference of the Southeastern Psychological Association, Atlanta, GA.

INVITED PRESENTATIONS AND WORKSHOPS

Clements-Hickman, A. L. (2019, September). *The role of the advisory alliance in promoting research development*. Talk presented to academics and healthcare professionals at Baptist Health Lexington, Lexington, KY

Clements-Hickman, A. L., Dschaak, Z., Kwok, C., Meiller, C., Ryser-Oatman, T., & Spiker, D. (2018, May). *Humanity in homelessness: A collaboration between The Office of Homelessness Prevention and Intervention and the University of Kentucky*. Presentation of findings from consultation project given to employees and stakeholders of The Office of Homelessness Prevention and Intervention and the general community.

Clements-Hickman, A. L., Dschaak, Z., Kwok, C., Meiller, C., Ryser-Oatman, T., & Spiker, D. (2018, May). *They're there step by step: A collaboration between Step By Step and the University of Kentucky*. Presentation of findings from consultation project given to the staff at Step By Step, a non-profit organization designed to help young single mothers.

Clements-Hickman, A. L. (2017, September). *Ally training development workshop.* Workshop presented to the University of Kentucky Department of Educational, School, and Counseling Psychology, Lexington, KY.

Clements, A. L. (2015, April). *Personality dimensions and interpersonal relationships in the workplace.* Talk presented to medical students at the University of Augusta, Augusta, GA.

Clements, A.L. (2014, March). *Coping with test anxiety*. Talk presented to students at Augusta University, Augusta, GA.

Clements, A.L. (2014, March). *Mindful eating: Cultivating healthy eating behavior*. Workshop presented to students at Augusta University, Augusta, GA.

RESEARCH-BASED SERVICE

- Ad Hoc Reviewer for *Journal of Nursing Administration* (2018 - 2020)
- Baptist Health Lexington Research Council member (2018 -2020)
- Group Outcomes Measures Development Committee member (2019)

TEACHING EXPERIENCE

Instructor: August 2019 – March 2020
Education Program, Baptist Health Lexington

Graduate Teaching Assistant: August 2019 – December 2020
UK Department of Psychology

Graduate Teaching Assistant: January 2019 – May 2019
UK Department of Educational, School, and Counseling Psychology

Instructor of Record: August 2016 – May 2019
UK Department of Educational, School, and Counseling Psychology

Graduate Teaching Assistant: August 2012– May 2014
AU Department of Psychological Sciences

COMMITTEES AND UNIVERSITY-BASED SERVICE

- Student Development Committee, Society for the Advancement of Psychotherapy: (2018 – Present)
- Student Mentorship Program Development Committee, Society for the Advancement of Psychotherapy: (2018 – Present)
- Annual student awards reviewer, Society for the Advancement of Psychotherapy: (2018 – Present)
- UK Student Campus Representative, Division for Health Psychology: (2020 – Present)
- Academic Spring Conference Planning Committee, Kentucky Psychological Association: (2018)
- Interview day panelist for UK Counseling Psychology Doctoral Program: (2018)
- Proposal Reviewer for the annual convention, Society for Counseling Psychology: (2017 – Present)
- Peer mentor, UK Counseling Psychology Program: (2017 – Present)

CLINICAL EXPERIENCE

Predoctoral Intern: July 2020 – Present
Auburn University Student Counseling and Psychological Services, Auburn, AL

Practicum Counselor: August 2019 – May 202
Clarity Counseling Services (Private Practice), Lexington, KY

Practicum Counselor: August 2018 – June 2019
Eastern State Hospital (Inpatient Psychiatric Hospital), Lexington, KY

Practicum Counselor: August 2017 – June 2018
Veterans Affairs Medical Center, Leestown Division, Lexington, KY

Practicum Counselor: August 2016 – May 2017
UK Counseling Center, Lexington, KY

Counselor: August 2014 – August 2015
AU Counseling Center, Augusta, GA

Clinician: June 2014 – October 2014
Transitions of Augusta (Private Practice), Augusta, GA

Practicum Counselor: January 2014 – May 2014
AU Counseling Center, Augusta, GA

Practicum Counselor: August 2013 – December 2013
Augusta Pain Center, Augusta, GA

SUPERVISION EXPERIENCE

Supervisor of Master's-Level Students: (August 2017 -May 2019)
UK Department of Educational, School, and Counseling Psychology

Supervisor of Doctoral-Level Practicum Students: (August 2020 – Present)
Auburn University Student Counseling and Psychological Services

CONSULTATION EXPERIENCE

Research Consultant: April 2019 - August 2020
Fayette County Mental Health Court, Lexington, KY

Research Consultant: January 2018 – May 2018
Office of Homelessness Prevention and Intervention, Lexington, KY

Research Consultant: January 2018 – May 2018
Step By Step, Lexington, KY