Counseling is a helping profession in which a wide variety of client goals are addressed through a therapeutic relationship between counselor and client (American Counseling Association [ACA], 2010; 2014, Section A; Duncan & Moynihan, 1994). The therapeutic relationship can be defined as the quality of the bond between therapist and client, as well as the degree of agreement on the goals, methods, and overall approach to therapy (Miller & Duncan, 2004). The therapeutic relationship has been identified as a reliable and substantial contributor to client goal attainment, also called outcome effectiveness (OE), in thousands of studies (Duncan, Miller, Wampold, & Hubble, 2010; Orlinsky, Ronnestad, & Willutzki, 2004). Although the connection between therapeutic relationship and OE has been established, there is a paucity of research regarding the in-vivo factors and behaviors that can be used by counselors to intentionally foster the therapeutic relationship and create OE (Okiishi et al., 2006; Tannen & Daniels, 2010). Ongoing research regarding the intricate links between therapeutic relationship and OE is warranted, and tangible factors that allow counselors to intentionally build the therapeutic relationship should continue to be isolated.

Counseling is an empirically-supported method for achieving outcome effectiveness, regardless of the theory, technique, or method used (Ahn & Wampold, 2001; Chambless, 2002; Duncan et al., 2010; Hauser & Hays, 2012; Lambert, 2013; Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1983; Smith & Glass, 1977; Wampold et al., 1997). Specifically, counseling has been shown to produce better outcomes than no mental health intervention (Luborsky et al., 1975; Shapiro & Shapiro, 1982; Smith & Glass, 1977). Lambert (2013) conducted a comprehensive review of meta-analyses from 1971 to 2010 and concluded that clients who enter counseling are more likely to experience goal attainment than those who do not

receive mental health treatment. Overall, counseling is an effective way to help clients reach their goals.

Although we know that counseling is effective, and therapeutic relationship is intimately connected to OE, current research has just begun to explore exactly how this phenomenon occurs. Reese, Norsworthy, & Rowlands (2009) explored the relationship between therapeutic relationship and OE using the Partners for Change Outcome Management System (PCOMS) in which the Session Rating Scale (SRS; a measure of therapeutic relationship) and the Outcome Rating Scale (ORS; a measure of OE) were administered to clients at each session. Counselors used the information from the ORS and SRS to inform their practice. Reese et al. found that counselors who used the PCOMS system created significantly greater OE, but the way in which therapeutic relationship progresses across time and the point at which therapeutic relationship is the strongest predictor of OE is still unknown.

Counselor Educators are responsible for teaching theories of OE to counselors-in-training, and two theoretical frameworks have been highly supported: empirically-validated treatment and common factors theory. Supporters of empirically-validated treatment assert that the two main components of OE are the client's presenting problem and the use of an empirically-validated treatment (American Psychological Association [APA], 1995; Chambless et al., 1998; Ebner-Priemer, 2015; Fondacaro & Harder, 2014). Conversely, advocates of common factors theory assert that several universal components (e.g., client factors and therapeutic relationship) are present in all effective counseling experiences (Budd & Hughes, 2009; Duncan et al., 2010; Grencavage & Norcross, 1990; Rosenzweig, 1936).

Although both theories have offered some structure for understanding OE, neither theoretical framework has gained full support in the counseling field. However, a common

component of both frameworks is the therapeutic relationship (Budd & Hughes, 2009; Chambless & Hollon, 1998; Duncan et al., 2010; Hauser & Hays, 2010; Rosenzweig, 1936). The very definition of counseling describes the counselor and client joining together in a relationship (ACA, 2010). In common factors theory, the therapeutic relationship has been found to account for up to 35% of OE (Thomas, 2006) and was the single most frequently reported common factor noted amongst researchers and theorizers (Grencavage & Norcross, 1990). In empirically-validated treatment, the therapeutic relationship is the vehicle through which a counselor implements any empirically-validated treatment, and the therapeutic relationship is strengthened when counselors and clients agree on the particular treatment employed in counseling (APA Task Force, 2006; Bordin, 1979; Chambless & Hollon, 1998; Fireman, 2002; Miller & Duncan, 2004).

The therapeutic relationship is a key component to strong outcomes for counselors-in-training. Grant (2006) reported that Counselor Educators were responsible for teaching counselors-in-training how to build, maintain, and repair the therapeutic relationship in order to work with complex clients. Consequently, time should be dedicated throughout counselor training courses to teach ways in which the therapeutic relationship can be intentionally fostered with clients.

Counselors-in-Training and the Therapeutic Relationship

It is important to note that the therapeutic relationship builds over time, and outcome effectiveness generally increases as therapeutic relationship increases (Miller et al., 2006). Additionally, therapist level of training, age, or theoretical orientation does not directly relate to client outcome effectiveness (Beutler et al., 2004; Duncan et al., 2010; Miller, Hubble, & Duncan, 2007; Okiishi et al. 2006). Counselor Educators need to know the ways in which

counselors-in-training can use therapeutic relationship to facilitate OE, and additional factors that might contribute to this relationship should be explored.

Additional research regarding therapeutic relationship and OE in neophyte counselors could contribute to improved counselor education techniques. Crits-Christoph et al., (2006) trained five inexperienced counselors (1-3 years post-licensure) on alliance-fostering therapy. The researchers found that these counselors' clients experienced significantly-improved quality of life across time. Reese et al. (2009) applied the PCOMS program to counseling students, and encouraged additional research on this population. It is important to explore the relationship between therapeutic relationship and OE in a sample of counselors-in-training in order to better understand the connection between these variables at this level of experience.

The purpose of this study is to explore the nuanced relationship between the therapeutic relationship and OE in master's-level counselors for purposes of informing counselor education practices. Two research questions have been created. First, what is the relationship between therapeutic relationship in each session and OE? It was hypothesized that therapeutic relationship within each session would be positively related to OE. Second, at what session is therapeutic relationship the greatest predictor of OE? It was hypothesized that therapeutic relationship at the last (i.e., third) session would be the greatest predictor of OE because therapeutic relationship typically builds over time. The variables that will be used to answer the research questions are therapeutic relationship at session one, therapeutic relationship at session two, therapeutic relationship at session three, and OE.

Methods

Power analysis conducted using G*power were used to determine that a total sample of 77 counselor and client pairs across three sessions were needed in order to have power of .80,

alpha of .05, and a medium effect size (.15 f^2 and .25 f). A medium effect size has been reported in the therapeutic relationship literature (e.g., Crits-Christoph et al., 2006) and OE literature (e.g., Horvath & Symonds, 1991) as a substantial indicator of effect.

Participants

Data for 77 counselor-client pairs across three sessions were collected from an existing database in a counselor training clinic at a state university in the southeastern United States. The counselors were master's-level students in their first year, second semester of training; undergraduate students served as the clients. This database consisted of 414 potential participant pairs, but only 95 met the study requirements: each counselor-client pair must have a minimum of three sessions, all three sessions must have at least 45 minutes of counselor-client interaction, and all data for each session must be complete.

A random number sequence from 1 through 95 was identified, and the first 77 pairs were included in the final dataset. Of the 77 counselor and client pairs included in the study, 8 counselors were in the database just once, 16 counselors were included twice, 9 counselors were included three times, 1 counselor was included 4 times, and one counselor was included 6 times. Each time any counselor was included in the database, it was with a different client.

The majority of clients met with their counselors three times due to clinic requirements, but counselor and client pairs who only met with one another for a total of three sessions (i.e., the third session was also the termination session) did not provide adequate sample size. Therefore, counselor and client pairs that met for 3 to 13 sessions (mean=5.6, *sd*=2.2) were included, although data for just the first three sessions were used for this study to maintain consistency.

Sixty-six of the counselors (85.7%) were female, and 11 (14.3%) were male. Fifty-seven counselors (74%) identified as Caucasian, 19 counselors (24.7%) identified as African American, one counselor (1.3%) identified as Asian American. Twenty-two counselors reported their ages (*M*=23.2, *SD*=3.3, range 22 to 35). The demographics of the sample were representative of the population of counselor trainees in this program.

Similar to counselors, the majority of the 77 clients were female (*n*=56, 72.7%); 21 clients (27.3%) were male. The clients identified primarily as Caucasian (*n*=49, 63.6%), followed by African American (n=20, 26%), then Hispanic (*n*=3, 3.9%), Asian American (*n*=2, 2.6%), Middle Eastern (*n*=1, 1.3%), Multiracial (*n*=1, 1.3%), and other (*n*=1, 1.3%). Age was reported by all 77 clients, and the average age was 21.8 years old (*SD*=4.8, range 18 to 54).

Measures

Clients completed the Outcome Rating Scale (ORS) at the beginning of each session and the Session Rating Scale (SRS) at the end of each session with their counselor. The scores were then entered into the clinic database. IRB approval and counselor/client consent were obtained to use the database for research purposes. The researchers adhered to the ACA (2014) Code of Ethics at all times. The measures used in this study form the basis of the PCOMS system as mentioned above (Duncan, 2012; Reese et al., 2009), and counselors used the information to proactively address deficiencies in the therapeutic relationship or outcomes during clinical practice. However, they did not formally integrate the data using any computer software or standardized approach.

Outcome effectiveness. The ORS is a general measure of client wellbeing and was used to measure the variable of OE. Miller and Duncan (2004) created the four-item ORS as a general measure of client wellbeing in individual functioning, interpersonal relationships, and social

performance. The total client ORS score for each session was calculated by adding together each of the four-item scores to create a score ranging from 0 to 40. Adequate construct validity has been determined through correlations with measures such as the Outcome Questionnaire-45 (Bringhurst, Watson, Miller, & Duncan, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003), as well the ability to differentiate between a clinical and non-clinical sample (Miller et al., 2003). Additionally, the ORS has been found to have high internal validity (Cronbach's alpha .93 or above; Bringhurst et al., 2006; Miller et al., 2003).

To determine client OE for the current study, the client's ORS score at first session was subtracted from the ORS score at third session, which indicated the amount of change toward the goal during their time in counseling and determined the effectiveness of counseling. This resulted in a number between 40 and -40. Larger positive numbers indicated high total OE or greater movement toward achieving one's goals regarding overall functioning, while a value of zero indicated no change in OE. Negative numbers indicated movement away from goals or unhelpful client change.

Therapeutic relationship. Similar to the ORS, the SRS 3.0 is a succinct, four-item, client-completed measure of therapeutic relationship developed by Miller, Duncan, and Johnson (2000). Using the SRS, clients report the level of respect and understanding within the relationship, agreement with the therapist on goals and topics, agreement with the therapist on approach and method, and an overall rating of the session (Miller et al., 2000). Duncan et al. (2003) found a Cronbach's coefficient alpha of .88 to determine that all four items work together to form a global assessment of therapeutic relationship.

An independent study conducted by the Center for Clinical Informatics on 15,000 SRS administrations was used to find an internal reliability coefficient alpha of .96 (Miller & Duncan,

2004). Duncan et al. (2003) explored validity of the SRS by correlating 420 SRS scores with the Helping Alliance Questionnaire II and found a Pearson product-moment correlation of .48 ($p <$ .01). This indicates the two measures assess similar, but unique constructs. Predictive validity has been demonstrated through positive correlations between the SRS and client OE (Duncan et al., 2003; Miller & Duncan, 2004; Miller, Duncan, Brown, Sorrell, & Chalk, 2006).

Data Analysis

The data were collected from a preexisting Microsoft Excel database and directly imported into the IBM Statistical Package for the Social Sciences 21 (SPSS) for analyses. Descriptive statistics were completed prior to running the main analyses to identify the nature of the data and to explore the demographic characteristics of the sample. There was limited information about counselor age, but there was no other missing data, as complete data sets were a criterion for inclusion in the study.

Pearson correlations were used to determine test-retest reliability of each administration of the ORS and the SRS (see table 1). Correlations ranged from .57 to .89. The correlations between ORS 1 and 3 and SRS 2 and 3 were significant ($p<.001$). Lower correlations indicate greater change between administrations, and supports the sensitivity of the instruments. Test-retest reliability might be high when no significant change has been experienced in the counseling process.

Table 1

Reliability Coefficients for Assessment Measures

Assessments	Pearson r	Significance
ORS 1 and ORS 2	.57	7.473
ORS 2 and ORS 3	.63	6.253
ORS 1 and ORS 3	.42	0.000
SRS 1 and SRS 2	.68	1.315
SRS 2 and SRS 3	.87	0.000
SRS 1 and SRS 3	.69	5.079

Results

Research Question One

For the first research question (i.e., what is the relationship between therapeutic relationship in each session and OE) a linear multiple regression with therapeutic relationship at first, second, and third sessions predicting OE was used (see table 2). Before running the regression, the data were checked for the necessary assumptions. Independence of observations was confirmed (d = 2.360). Multicollinearity was not a concern (VIF= 1.995-4.401, tolerance=.227-.501). Additionally, linear relationships between OE and therapeutic relationship as session one, two, and three were identified; OE was normally distributed, and the analysis was conducted.

Table 2

Summary of Linear Multiple Regression Analysis for Therapeutic Relationship on Outcome Effectiveness

	Outcome Effectiveness	
Variable	*t*	β
Therapeutic Relationship 1	-3.947	-.565**
Therapeutic Relationship 2	.963	.202
Therapeutic Relationship 3	2.405	.512*
r^2	.250	
F for change in r^2	8.090**	

Note: *p<.05 **p<.001

The overall regression model was significant (F=8.090, p=.000). The model explained 25% of variance in OE (r=.500, r^2=.250). Therapeutic relationship at first session significantly, negatively predicted OE (β = -.565, t=-3.947, p=.000), and therapeutic relationship at third session significantly predicted OE in a positive direction (β = .512, t=2.405, p=.019). However, therapeutic relationship at second session did not significantly predict OE (β = .202, t=.963, p=.339). As therapeutic relationship at first session increased, OE decreased by .565, and as therapeutic relationship at third session increased, OE increased by .512. As such, the hypothesis was partially accepted; therapeutic relationship within session one and three is related to OE, and therapeutic relationship at session three is positively related to OE.

Research Question Two

For the second research question (i.e., at what session is therapeutic relationship the greatest predictor of OE) a stepwise multiple regression (with multicollinearity analysis) was used to predict OE from therapeutic relationship in each session (see Table 3). The multicollinearity analysis was necessary because it was expected that therapeutic relationship in

each session would be related. Therapeutic relationship at first, second, and third sessions was loaded into the regression at the same time using a stepwise entry method. As such, only significant predictors were used in the final model, providing a more accurate portrayal of the variable relationships (Allen, 1997).

Table 3

Summary of Stepwise Multiple Regression Analysis for Therapeutic Relationship on Outcome Effectiveness

	Outcome Effectiveness	
Variable	*t*	β
Therapeutic Relationship 1	-3.831	-.534*
Therapeutic Relationship 3	4.774	.666*
r^2	.240	
F for change in r^2	11.683*	

Note: *p<.001

Before running the regression, the data were checked for the necessary assumptions. Independence of observations was confirmed (d = 2.407). Additionally, multicollinearity was not a concern (VIF= 1.895, tolerance=.528). Finally, a linear relationship between therapeutic relationship and outcome effectiveness was identified, and the analysis was run with the data in its original form.

The overall model was significant (F=11.683, p=.000) and explained 24% of the variance in OE (r=.49, r^2=.240). Therapeutic relationship at second session was non-significant and did not load into the final model. Therapeutic relationship at third session loaded highest and significantly predicted OE in a positive direction (β = .666, t=4.774, p=.000), and therapeutic relationship at first session loaded second-highest and significantly predicted OE in a negative direction (β = -.534, t=-3.831, p=.000). As therapeutic relationship at third session

increased, OE increased by .666; as therapeutic relationship at first session increased, OE decreased by .534. As such, the hypothesis was accepted; therapeutic relationship at third session was a stronger predictor of OE than therapeutic relationship at first or second session.

Discussion

It was confirmed through this study that therapeutic relationship is the strongest positive predictor of OE as it progresses over time. Overall, therapeutic relationship accounted for approximately 24% of OE. The current findings align with previous findings in which therapeutic relationship was expected to account for anywhere from 10% (Tracey, 2003) to 30% (Miller, Duncan, & Hubble, 1997) of OE.

Therapeutic Relationship Across Sessions

It was found that high therapeutic relationship at the first session was negatively related to OE, therapeutic relationship at the second session was not significantly related to OE, and therapeutic relationship at third session was positively related to OE. The relationship between therapeutic relationship at session one and OE seems complicated, but can be explained through previous research findings and the findings of the preliminary analyses. First, OE was calculated by subtracting a client's ORS score (a measure of general wellbeing) at session one from ORS at session three. As such, OE indicates the extent to which clients' wellbeing improved across three sessions.

In the preliminary analyses, it was found that clients with ORS scores above the clinical cutoff at session one had significantly lower OE scores. Mathematically, this makes sense because higher ORS scores at session one left less room for growth and improvement at session three. It was also found in preliminary analyses that, for this sample, ORS scores at session one were significantly correlated with SRS scores at session one; as ORS increased SRS increased.

Clients with high ORS scores at session one also had high SRS scores at session one, and high SRS scores at session one were negatively related to final OE. The negative relationship between therapeutic relationship at session one and OE was present because clients with high therapeutic relationship at session one also had high ORS scores at session one and less overall room for improvement on OE.

Unlike sessions one and three, therapeutic relationship at session two was not a significant negative or positive predictor of OE. DeRubeis and Feeley (1990) found that therapeutic relationship at session two did not predict reduction of depressive symptoms in a sample of 25 clients. Feeley, DeRubeis, and Gelfand (1999) also found that therapeutic relationship at session two did not predict outcomes in clients with depression. It is possible that session two simply builds upon session one, and prepares clients for more significant change in session three.

Finally, in the current study, session three was the strongest predictor of OE. At this point in counseling, therapeutic relationship had significantly improved from the first session for the general sample. In preliminary analyses, it was found that the final ORS scores at session three were significantly lower for those who initially scored below the clinical cutoff, but the total difference between ORS at session one and ORS at session three (i.e., OE) was greater for those who scored below the clinical cutoff at intake. As such, it can be concluded that, by session three, those who scored below the clinical cutoff on ORS at session one had experienced larger OE, and those who did not score below the cutoff had experienced steady, yet smaller, gains in OE across sessions. Additionally, the greatest increase in therapeutic relationship was from session one to session three, and OE was calculated using the difference in ORS scores from session one to session three. It is possible that therapeutic relationship at session three was

the most significant predictor of OE because the majority of clients had experienced the majority of their changes in therapeutic relationship and OE by the third session.

Overall, Miller and Duncan (2004) explained that early increases in therapeutic relationship were strong predictors of increases in OE. However, the researchers also explained that as therapeutic relationship increases, so does OE, and vice versa. As such, it is also possible that therapeutic relationship at sessions four and beyond would have been stronger predictors of OE than session three. However, that information was not collected for the current study. Overall, the current study supports the notion that therapeutic relationship is significantly related to OE, and counselors-in-training should take care to build therapeutic relationship with their clients in each successive session, regardless if it is initially high or low.

Limitations

Clients completed the SRS at the end of each session in the presence of their counselor, and it is possible that some clients might have rated the therapeutic relationship higher due to the desire to please or be liked by their counselor. One of the four items on the SRS allowed the client to rate the extent to which the material they wanted to discuss was addressed in session. However, during session one, counselors were instructed by the clinic director to complete specific intake paperwork, which limited counselors' abilities to address the topics most important to the client. As such, SRS scores for session one might have been lower than SRS scores for sessions two and three due to intake paperwork requirements.

Although the reliability and validity of the ORS and SRS have been supported through empirical research (e.g.,Bringhurst et al., 2006; Duncan et al., 2003; Miller et al., 2000; 2003; 2006; Miller & Duncan, 2004), there is still some question about the psychometric properties of these instruments. For example, Halstead, Youn, and Armijo (2013) questioned the reliability of

the ORS and the sensitivity of the instrument, as it is often administered on a weekly basis. The authors indicated that the reliability alpha of .85 could be considered insufficient in high-stakes testing, but Duncan and Reese (2013) indicated that the definition of sufficient can be relative and based upon the purpose of the research. Additionally, lower test-retest reliability could indicate higher sensitivity to change across sessions. Regardless, Halstead et al. (2013) and Duncan and Reese (2013) agree that the brevity of the ORS renders the instrument clinically useful, but reliability of the measures should be considered when interpreting data derived from this instrument.

An additional limitation for this study could be the result of collecting data from a limited, pre-existing database. As a result of meeting the stringent inclusion criteria, some counselors were included in the database multiple times with several different clients. It is possible that the inclusion of multiple counselors could have skewed the data.

In addition to the limited amount of counselors, the preexisting database only included 95 counselor and client pairs that met the stringent study criteria, and 77 pairs were chosen from those eligible pairs. This means that 337 counselor and client pairs were not included in this study, and 319 were excluded due to missing data or not meeting other criteria. It is impossible to determine whether those who were excluded from the final sample differed from those included in any significant ways.

Implications for Counselor Educators

Therapeutic relationship at the first session was a negative predictor of OE in this study. It was determined that this was likely due to a high initial sense of client wellbeing and limited opportunity for clients to experience a large increase in OE across sessions. As such, counselors-in-training should know that their first encounter with a client is important, but high therapeutic

relationship at the first session might be associated with lower levels of mental health distress and less notable improvements in OE across time.

Although some clients enter counseling with a pronounced ability to trust the counseling process and embrace a strong therapeutic relationship, not all clients are so open to the process. Class time can be dedicated to teaching strategies that will allow counselors-in-training to establish an initial working relationship and continually improve the therapeutic relationship with each successive meeting (especially from session two to three). Counselors can learn concrete methods for building the therapeutic relationship in every session; even if the therapeutic relationship starts strong, it can always be improved.

Counselors can actively build the therapeutic relationship with clients by regularly discussing aspects of the relationship at the end of each session (Miller et al., 2006; Reese et al., 2009; Schmidt, 2014). In the current study, counselors-in-training used feedback from the SRS in order to guide their professional growth across time, and the therapeutic relationship did increase across time as a general trend. Although some have questioned whether clients would provide honest feedback directly to the counselor, Miller et al. (2000) reported that clients were generally open and honest with their therapists when completing and discussing the SRS at the end of session. As such, counselor educators can teach counselors-in-training to have open conversations with clients regarding the therapeutic relationship. Counselors might use immediacy to assess the therapeutic relationship (e.g., "How do you feel about our relationship and me as a helper?"). Alternatively, counselors can use a more formal measure such as the SRS to methodically gather information about the therapeutic relationship (Schmidt, 2004).

The four constructs measured with the SRS can help counselors-in-training identify concrete methods to continually improve the therapeutic relationship. The first item on the SRS

can be used to start a conversation regarding the extent to which clients feel heard, understood, and respected (Miller et al., 2000). Sometimes, a lack of self-confidence, feelings of anxiety, and other sources of distraction can inhibit counselors from genuinely joining with their clients in the here-and-now. Buser, Buser, Peterson, and Seraydarian (2012) found that mindfulness techniques can help counselors focus on the present moment, actively attend to their clients, and experience thoughts and feelings in a nonjudgmental way.

Some mindfulness activities that might help counselors-in-training improve their attending behaviors can be practiced in class. First, students can be directed to sit quietly and notice three sounds in their environment. Then, counselors-in-training can be directed to notice three smells, and then three objects that they see. Alternatively, counselors-in-training can be guided to sit quietly and notice their breath. Counselors can spend three minutes meditating upon the sensation of breathing in and out; when other thoughts enter the mind they are acknowledged and dismissed nonjudgmentally, and focus is returned to the breath. Both of these activities help to clear the mind and orient the counselors-in-training to the present moment.

Another mindfulness exercise to improve attending behaviors might include a counselor educator providing each counselor-in-training with a raisin or other small food object. Counselors can be directed to hold the raisin and notice the color, texture, and smell. Then, they can place the raisins in their mouths and notice the texture, temperature, and taste. Counselors should be directed to stay present in the current moment, releasing all judgment and worries, and form an appreciation for the here-and-now.

Counselor educators can access a plethora of mindfulness activities in workbooks and on the internet in order to help counselors-in-training learn about this helpful technique for fostering the therapeutic relationship. Counselors-in-training can then replicate the mindfulness activities

learned in class before sessions with clients. A parallel process might even occur in which counselors share mindfulness techniques with clients and practice them in session when appropriate.

Additional items on the SRS are used to determine if the counselor is addressing the goals that the client feels are most important in a way that works well for the client (Miller et al., 2000). In order to address this portion of the therapeutic relationship, counselors must learn to meet clients at their current developmental levels and trust the long-term nature of the counseling process; counselors might feel compelled to rush through the therapeutic process, but clients should be guided toward insight at their own paces. Experiential coursework (e.g., interactive video labs, role plays) can be used to help counselors-in-training with their pacing in session and their abilities to trust the long-term therapeutic process (Schmidt, 2014). Especially with role plays, students gain insight and provide feedback to one another from the perspective of the counselor as well as the client.

Counselor educators can explain to counselors-in-training that counseling is an art and a science. The client's unique life circumstances and presenting problems will inform an individualized treatment plan in which the therapeutic relationship is at the core, and empirically-validated treatments are intentionally implemented at a pace that is comfortable for the counselor and client. Counselors should use mindfulness techniques in order to be fully present with the client and should pull on past experiences to intentionally and creatively foster the therapeutic relationship.

Conclusion

The results of this study and others (e.g., Miller et al., 2006) can be used to support the idea that therapeutic relationship improves across time, and is positively related to OE in later

sessions. Counselors-in-training could explain to clients that they are likely to experience the greatest OE if they meet for more than one or two sessions. Counselor Educators should also advocate for counselors-in-training who typically see clients for just one session (e.g., a brief counseling setting or an employee assistance program). Administrators and supervisors should be informed that approximately one-quarter of client OE is related to an increase in therapeutic relationship across time with any particular counselor.

Counselors-in-training often feel as though they are not effective with their clients. Folkes-Skinner, Elliott, and Wheeler (2010) found that supportive education and supervision can help counselors-in-training understand the importance of the therapeutic relationship and build more confidence in their clinical skills. Counselor educators and supervisors should educate counselors-in-training about common factors theory, empirically-validated treatments, and the common link of the therapeutic relationship in producing OE. Counselors-in-training can be trained to utilize mindfulness skills, peer feedback, supervision, and continuous client feedback in order to intentionally build the therapeutic relationship with their clients. Future researchers should continue to explore additional counselor, client, and therapeutic factors that work synergistically to improve the therapeutic relationship and produce greater OE.

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