

EXAMINING THE THERAPEUTIC COMPLIMENT WITH AFRICAN-
AMERICANS: A COUNSELING TECHNIQUE TO IMPROVE THE WORKING
ALLIANCE

A Dissertation

by

BRYAN THOMAS DUNCAN

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2007

Major Subject: Counseling Psychology

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ABSTRACT

Examining the Therapeutic Compliment with African-Americans: A Counseling
Technique to Improve the Working Alliance. (May 2007)

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The working alliance has received consistent empirical support relating the construct to psychotherapy outcome. There is no empirical research on any particular techniques that may prove useful at increasing the level of working alliance. In this study, the therapeutic compliment is defined, discussed, and compared with other therapeutic interventions to find its usefulness in therapy and its ability to impact the working alliance. 120 African-Americans from a large southwestern university and a medium southeastern university participated in this study by viewing one of six mock therapy sessions that had one of three different interventions: Therapeutic Compliment, Simple Compliment, and Advanced Accurate Empathy. The mock sessions were created to provide two levels of session relationship (high and low). The participants completed three measures, the Working Alliance Inventory, Hopefulness Scale, and Accurate Empathy Scale, to determine the perceptions of the different interventions. The study utilized multiple analyses of variances (ANOVAs) to compare the means of the three interventions.

Statistical significance was not found with overall general working alliance scores from the Working Alliance Inventory (WAI). The individual subscales of the WAI, goals, tasks, and bonds, however; did reveal significance when comparing the interventions across one level of the session relationship (high). The interventions were not statistically different from each other in terms of perceived hopefulness and empathy. No significance was found when comparing the interventions with perceived hopefulness of outcome or level of perceived empathy. The implications from this study include a first look at the use of complimenting in therapy and a first attempt to analyze a specific technique to create an influence on the working alliance. Further research is still needed to understand which techniques are more beneficial at creating an affect on the working alliance.

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CHAPTER I

INTRODUCTION

Many researchers and practitioners of different theoretical orientations have acknowledged the importance of the relationship that exists between client and therapist. This relationship has been viewed by some as a focus of therapy and a foundation for change (Bordin, 1979). Greenson (1967) first defined working alliance as the collaboration between client and therapist. Since this time, the concept of the working alliance was developed further by Bordin (1979) to include three constructs. They are:

- 1) an agreement between client and therapist on the goals of therapy (Goals),
- 2) collaboration between client and therapist regarding the relevance of tasks undertaken in therapy (Tasks), and
- 3) a personal bond between client and therapist (Bonds).

The importance of the working alliance has been acknowledged as significant in regards to outcome in psychotherapy (Horvath & Symonds, 1991). Others have provided further evidence to the effects of therapeutic bond between client and therapist to be a predictor of outcome (Orlinsky & Howard, 1986a; Orlinsky & Howard, 1986b; Saunders et al, 1989). Unfortunately, no specific therapeutic technique has been studied for its specific impact on the working alliance (Horvath, 1994). Therefore, the primary goal of this study is to identify a technique in therapy that might improve the perceived working

This dissertation follows the style of *The Journal of Counseling Psychology*.

alliance. The technique being considered in this study is the therapeutic compliment.

Complimenting has been incorporated in therapy by several theoretical orientations (de Shazer, 1980; Erickson, 1980; Selvini-Palazzoli et al., 1974); however, the concept of evaluation from the therapist has also been considered to be detrimental (Rogers, 1961). The therapeutic compliment used in this study is associated with two important components: 1) a positive evaluation from the therapist to the client about his/her behaviors, thoughts, or attributes (Sims, 1987; Wall et al., 1989) and 2) an advanced, accurate, empathic statement (Truax & Carkhuff, 1967). Wall et al. (1989) provided a conceptual article to highlight the importance of complimenting in therapy and its universality. The first component of the therapeutic compliment is the verbal statement of praise from the therapist to the client. The therapeutic compliment is intended to be more than just a tool to emphasize collaboration with the counselor. Complimenting is used to empower clients, promote change, and provide a stronger relationship between the counselor and client (Wall et al., 1989). The importance of this study is that it defines a therapeutic compliment and uses the above two components as a control variable.

Another component of this study is focusing on the importance of the ethnic identity of a specific minority population. Ethnic identity is crucial to self-concept and psychological functioning of ethnic group members (Gurin & Epps, 1975; Maldonado, 1975). The importance of this study highlights the need for therapists to identify with minority clients and create a better working alliance, especially when some sort of therapeutic rupture has occurred between the client and therapist. Kohut (1984) asserts

that by overcoming these empathic ruptures, the greatest amount of change can occur. Additionally, it is important to identify how different ethnic identity's may perceive the working alliance across interventions.

The research questions for this study are:

- 1) Is there a statistical difference between counseling technique and level of relationship on therapeutic alliance ratings with African-American participants?
- 2) Is the therapeutic compliment equivalent to accurate empathy at changing perceptions of the working alliance with African-American participants?
- 3) Is the simple compliment, as a technique, equivalent to the therapeutic compliment and advanced accurate empathy in its perceptions of the working alliance with African-American participants?
- 4) Is there a statistical difference between counseling technique and level of relationship on hopefulness ratings with African-American participants?
- 5) Is there a statistical difference between counseling technique and level of relationship on accurate empathy ratings with African-American participants?

The researcher hypothesizes for the first and second questions that the therapeutic compliment will be an effective therapeutic technique to change the perceived working alliance with African-American participants and be more effective than the accurate empathy intervention at raising the level of perceived working alliance, respectively. The researcher hypothesizes for the third question that the simple compliment will prove to be rated lower as a technique on working alliance scores. It is further hypothesized that the therapeutic compliment is an effective technique that will increase the hopefulness of

outcome with African-American participants. It is hypothesized that the therapeutic compliment will be equal to the accurate empathy intervention and greater than the non-therapeutic compliment in perceived empathy for the fifth question.

CHAPTER II

REVIEW OF THE LITERATURE

The Working Alliance

The concept of the working alliance between client and therapist dates back to early papers of Sigmund Freud (1913) where he offers the importance, in psychoanalysis, of the cooperative engagement in the therapeutic relationship. Other theorists and researchers have further incorporated the notion of the alliance (Bordin, 1979; Greenson, 1967; Horvath & Luborsky, 1993; Menninger, 1958; Orlinsky & Howard, 1986a; Sterba, 1934; Zetzel, 1956). The Working Alliance (Greenson, 1967) is a construct first used to operationalize the working relationship between the therapist and client. Since that time, the concept of the Working Alliance has been further developed by Edward S. Bordin (1979) and other researchers (e.g. Horvath, 1981, 2001; Horvath & Greenberg, 1986, 1989; Orlinsky & Howard, 1986a). Horvath and Bedi (2002) provide a thorough definition of the Working Alliance:

The alliance refers to the quality and strength of the collaborative relationship between client and therapist in therapy. This concept is inclusive of: the positive changeive bonds between client and therapist, such as mutual trust, liking, respect, and caring. Alliance also encompasses the more cognitive aspects of the therapy relationship; consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached. Alliance involves a sense of partnership in therapy between therapist and client, in which

each participant is actively committed to their specific and appropriate responsibilities in therapy, and believes the other is likewise enthusiastically engaged in the process. The alliance is a conscious and purposeful aspect of the relation between therapist and client. (p. 37)

This definition is in accordance with the definition set forth by Bordin (1979) and highlights the three major components of the working alliance: Goals, Tasks, and Bonds. Goals are an agreement between client and therapist upon the course of therapy and the direction therapy takes to meet the client's needs. The tasks of the working alliance constitute the manner in which client and therapist work on reaching goals. These are the activities that take place in therapy. The bonds refer to the mutual respect for each other and the sense of collaborative effort between the two (Bordin, 1979).

The Therapeutic Bond defined by Orlinsky and Howard (1986a) as the relationship that exists between the therapists and client as they fulfill the goals of therapy through the different tasks assigned has similar qualities to that of Bordin's (1979) model. They identify three major aspects that best describe characteristics of the therapeutic bond: (1) *role-investment*, which is the level in which the client and therapist are invested in the therapy process, (2) *empathic resonance*, which is the level in which the client and therapist seem to be on the same wavelength, and (3) *mutual affirmation*, which is the level of care for one's well-being that is experienced in therapy. The concept of therapeutic bond encapsulates other similar points of view (Kohut, 1977; 1984; Rogers, 1957) on the importance of relationships in therapy including Bordin's (1979) notion of the working alliance.

Orlinsky and Howard (1986a) outline the importance of the aspects of the Therapeutic Bond and address them individually. In *role-investment*, the important characteristic to consider is the level of engagement by both the client and therapist. If the therapist is invested in change and the client is not, then there will not be congruence in meeting the goals of therapy (Orlinsky & Howard, 1986a). They identify 12 of the 24 studies in which clients reported greater outcome with high levels of therapist engagement. None of the studies showed any positive outcome for therapist detachment. In regard to client engagement, 13 of 18 findings revealed a positive outcome with high involvement in therapy.

The aspect of *empathic resonance* “is usually indicated by a sense of being ‘on the same wavelength,’ a sense of mutual transparency—of being fully heard by, and fully hearing, the other person” (Orlinsky & Howard, 1986a, p. 344). This concept, as it is named, deals with the therapist’s ability to empathize with clients and to express this empathy. Moreover, there is an importance for the client to be attuned to their own feelings and to be able to express them as well (Orlinsky & Howard, 1986a). Half of the 86 studies identified by Orlinsky and Howard (1986a) indicate a positive relationship between outcome and therapists level of empathy.

The final aspect of Therapeutic Bond, *mutual affirmation*, is associated with a level of concern for the well-being of the client. This is a similar notion to the role of unconditional positive regard outlined by Rogers (1957). Orlinsky and Howard (1986a) present 94 findings and only 2 of these findings showed a significantly negative impact of a caring relationship.

The importance of the working alliance goes beyond being a framework for building a relationship, but has been established as important in relation to outcome in psychotherapy. Horvath and Symonds (1991) provided a meta-analysis of 24 different studies, revealing that the greater the level of working alliance, the greater the outcome. Moreover, their results indicate that the working alliance and outcome are not related to the type of therapy or treatment duration. The reported effect size from the meta-analysis was .26 which is equivalent to that of other psychotherapy variables (Horvath & Symonds, 1991). Martin, Garske, & Davis (2000) completed a similar exhaustive meta-analysis of 79 studies examining the working alliance and outcome. They reported an effect size of .22 with the correlation between alliance and outcome.

Empathy

Empathy is a term that has long been used in the field of psychology. Its beginnings come from the word *Einführung*, a German word used in the field of aesthetics to mean the projection of feelings into the people and things they perceive (Listowel, 1933). Titchener (1909) coined the term empathy and defined it as a “process of humanizing objects, of reading or feeling ourselves into them” (Titchener, 1924, p. 417). Since this time, empathy has been made popular by many researchers and theorists and has been considered an important part of therapy (Duan & Hill, 1996).

The rate of research on empathy has decreased over the years. Duan and Hill (1996) outline several notions on the reason for this decrease in empathy research. Notably they mention that there is a lack of valid measures of empathy. They do point out that the focus of Rogers’ definition of empathy has possibly been consumed by other

constructs such as the therapeutic or working alliance. “Therapist empathy is sometimes considered to be one component of the working alliance” (Duan & Hill, 1996, p. 266).

Bordin (1980) hypothesized that empathy, the second component of a therapeutic compliment, is a requirement for developing a working alliance with the client. Notably, the scores of working alliance measures have correlated positively with empathy ($r = .60$ to $.80$) (Horvath, 1981). Kohut (1978) states, “Empathy, the accepting, confirming, and understanding human echo evoked by the self, is a psychological nutrient without which human life, as we know and cherish it, could not be sustained” (p. 705). Egan (1994) defined advanced accurate empathy as a deeper level of empathy that focuses on our unused resources. Empathy has been expressed as an essential part of therapy and integrated in mild to highly advanced forms.

Accurate empathy is an advanced counseling skill. Rogers (1957) alludes to a definition of empathy that makes accuracy a necessity of empathy. Empathy is more than identifying with a client, but an accurate understanding of the client. Barrett-Lennard (1993) identifies three parts of accurate empathy: 1) reception and resonance, 2) communication and expression of empathy, and 3) client understanding. Hoisington (2003) identifies five different levels of empathy: Instinctual, Basic, Subtle, Skilled and Advanced. “Advanced empathy focuses not just on problems, but also on unused or partially used resources. Effective helpers listen for the resources that are buried deeply in clients and often have been forgotten by them” (Egan, 1994, p. 180). The counselor intends to make the implicit explicit through advanced empathy so that clients can recognize themselves in what is said by the therapist (Egan, 1994). Barrett-Lennard

(1993) stated that the expression of empathy is not limited to simple reflection and is open to other forms of expressing empathy to clients. Barrett-Lennard stated:

No reason is seen for sensitive restatement to be the only effective channel for communicating empathy, especially in caring relationships or among persons from the same bonded community or linguistic-expressive subcultures. Nor is it the only avenue to express empathy in therapy. (p. 8)

There are other avenues for using empathy, and the therapeutic compliment is a possible technique to be used.

Compliments in Therapy

The use of complimenting as a technique in counseling has been established (de Shazer, 1980; Erickson, 1980; Selvini-Palazzoli et al., 1973). The therapeutic compliment used in this study is associated with two important components: 1) a positive evaluation from the therapist to the client about his/her behaviors, thoughts, or attributes (Sims, 1987; Wall et al., 1989) and 2) an advanced, accurate, empathic statement (Truax & Carkhuff, 1967). Wall et al. (1989) provided a conceptual article to highlight the importance of complimenting in therapy and its universality. The therapeutic compliment is intended to be more than just a tool to emphasize collaboration with the counselor. Complimenting is used to empower clients, promote change, and provide a stronger relationship between the counselor and client (Wall et al., 1989). Compliments can be used in all stages of therapy, from beginning to end. Wall et al. (1989) identified compliments to create condition for successful therapy. This is accomplished by (a) building rapport between client and therapist, (b) demonstrating an

understanding of the client's reported presenting problem, and (c) establishes an accepting collaborative context for therapy. As a change agent, complimenting can eliminate dependency upon the therapist and help clients move towards less complacency (Wall et al., 1989).

The well-known hypnotherapist, Milton H. Erickson, provided many interesting interventions with clients that are intended to suggest change (Gunnison, 1990). An influential technique used by Erickson, and other hypnotherapists, is the concept of "yes sets." A yes set "forms the basis for the idea of a compliment as facilitating client cooperation" (Wall et. al, 1989, p.159). The technique involves the creation of a series of statements for which the client must accept. For example, "Most people feel comfortable when they relax" is intended for the client. This statement is intended for the client to agree and accept for him or herself. The nature of the compliment, a positive evaluation of the client's behaviors, thoughts, or attributes (Sims, 1987), is often received positively and can be used as a "yes set" for the client (Wall et al, 1989).

Erickson was also a proponent of reframing in his hypnosis. Reframing opens the possibilities of different perceptions of self (Lankton, 1980; Lankton & Lankton, 1983) and an understanding of other possibilities (Erickson & Rossi, 1981).

The classic case is Tom Sawyer, forced to spend a tedious day whitewashing the fence and fearing an even worse calamity, ridicule by the other boys. The perfect redefining question [reframing] of "*How often does a boy get the opportunity to whitewash a fence?*" [italics added] turns the ridicule of others to

envy and soon he is being paid by the other children for the “opportunity” to do his work for him. (Beahrs, 1982, p. 72)

Gunnison (1990) provides an example of another reframe that might be used in therapy that also meets the qualifications of a therapeutic compliment. “You know I can hear your sadness and loss and at the same time I sense a very deep courage inside of you that you can draw upon. Isn’t it interesting that we can discover strengths we didn’t realize we had during times of travail and pain?” (p. 451). Thus, reframing is an effective strategy for changing perceptions (Lankton, 1980; Lankton & Lankton, 1983) and can be used in the form of a therapeutic compliment. Minuchin (1974) identifies reframing as an effective tool for joining in therapy which a) reduces resistance, b) changes the views the family may have about the perceived problem behavior, c) allow the therapist to ally with the family, and d) strengthens the potential influence the therapist may have with the family based on the established relationship.

Solution Focused Brief Therapy, a well-known theoretical approach to therapy, was made popular by de Shazer (1980, 1982) and associates at the Brief Family Therapy Center in Milwaukee. This approach utilizes complimenting as a vital technique in its approach. The original intention of this technique was to strengthen the position of the therapy team working behind the two-way mirror as the therapist returned from meeting with them during the team break. Later it has been established that the compliment also provides an opportunity of acceptance by the client of the message that is relayed to them. For example, de Shazer (1980) provides an illustration of providing a compliment to a family before assigning them a metaphorical task to complete prior to the next

session. Because the metaphorical task in this example, a water-pistol duel between mother and daughter, can be viewed as extreme or absurd, the compliment increased the likelihood that the task would be completed (de Shazer, 1980).

In the theoretical approach to Solution Focused therapy, there are three types of roles that the client may take in their interaction with the therapist: visitor, complainant, or customer. It is noted that complimenting and praising clients is a technique used “with all cases . . . regardless of the type of client-therapist relationship, and throughout the treatment process” (Berg & Miller, 1992, p. 101). Complimenting is not a tool used to show kindness; rather, it is based on the information presented by clients and can reinforce what the client has already mentioned to be important (De Jong & Berg, 2002).

De Jong and Berg (2002) identify two types of complimenting that can be used, direct and indirect. Direct complimenting is a positive evaluation of, or reaction to the client that is made by the therapist. This form of communication can express admiration for accomplishments and confirms what the client has already been feeling (De Jong & Berg, 2002). Indirect compliments tend to take the form of a question, which implies that the client can answer by providing their own compliment to their abilities, strengths and resources (De Jong & Berg, 2002).

Positive connotation is a similar concept to complimenting that was intended for family counseling by the Milan Group (Selvini-Palazzoli et al., 1975). The idea is that a positive intention or outcome of the symptomatic behavior is highlighted to avoid a feeling of being rejected or disqualified. The symptomatic behavior of the family tends to be their desire to not change their current functioning and feeling stuck in a desire for

homeostasis (Umbelino, 2003). This approach provides a paradoxical intervention for the identified patient by approving the behaviors of all the family members that are relevant to the symptoms of the identified patient (Selvini-Palazzoli et al., 1974, 1975).

Positive connotation works on several levels but begins by creating a balance among family members and creating equal levels in the family system, preventing any division or sub-grouping from taking place. Secondly, this approach acknowledges that the symptomatic behaviors hold the family together and influences the way that they think about themselves. A third aspect of this approach is that it allows the therapist to ally him/herself with the family. By having greater connection with the family, the therapist then has the ability to help influence change in family behavior. Finally, positive connotation binds the family in a paradox expressed by the question, “Why does the cohesion of the group that therapists define as ‘good’ have to be gained by the existence of the patient?” (Selvini-Palazzoli et al., 1975, p.70).

Thus, positive connotation brings about change in the family system by following a behavior prescription of homeostasis that has been accepted, paradoxically, by the therapist (Selvini-Palazzoli et al. 1975; Umbelino, 2003). Some have thought of positive connotation as a trick aimed at the family (Umbelino, 2003); however, Selvini-Palazzoli et al. (1974) find that creating an alliance with the family is not a trick or ploy due to its relevance in creating similar goals and tasks in therapy. Positive connotation values the nature of the family’s desire for homeostasis and finds the positive qualities of this desire (Selvini-Palazzoli, 1975).

Umbelino's (2003) article provides an interesting use of positive connotation as a method or technique under a narrative theoretical orientation. In the narrative approach, according to White (2000), pointing out positives, providing positive reinforcement, praising, awarding congratulations, and providing affirmations can be seen as appealing remedies to much of the pathology that exists in people's lives. Umbelino (2003) revisits positive connotation in applying it to her narrative approach.

This speaks to the nature of complimenting being a useful technique that can be applied across theoretical orientations (Burnham, 1992). Moreover, its ability to create a collaborative bond and relationship between client and therapist and further enhance the goals and tasks used in therapy (Minuchin, 1974; Selvini-Palazzoli, 1975; de Shazer, 1980; Erickson, 1980).

Hopefulness

Hope, as an important part of mental health, has been encouraged for some time. Menninger (1959), in his address to the American Psychiatric Association, wrote:

Are we not now duty bound to speak up as scientists, not about a new rocket or a new fuel or a new bomb or a new gas, but about this ancient but rediscovered truth, the validity of Hope in human development—Hope, alongside of its immortal sisters, Faith and Love? (p. 491)

Positive expectations are essential to good mental health and mental health deficiencies are a result of a lack of this goal-directed expectation (Menninger, 1959). Others have reiterated this notion by stating that hope is critical for psychological change (Frank,

1961, 1973; Frank & Frank, 1991). Yalom (1995) emphasized the importance of hope by including it as one of the therapeutic factors important for change in therapy.

Ethnic Identity

The study of ethnic identity has been a part of psychological research for some time (Phinney, 1990). Most research in diversity has been in the study of comparison between groups (Phinney, 1990); however the importance of understanding one's own group and the connection one has with that group is important in the concept of self. Phinney (1990) provides a review of literature of 70-refereed journals from 1972 to 1990. In this article she finds several definitions of ethnic identity and conceptual frameworks to theorize ethnic identity.

Tajfel (1981) provides a complete definition for ethnic identity: "that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership" (p.255). Authors have disagreed on where the emphasis of ethnic identity should be placed. Some have stated emphasis should be placed on the common values and attitudes (White & Burke, 1987, p. 311), sense of belonging (Singh, 1977; Ting-Toomey, 1981; Tzuriel & Klein, 1977), or attitudes toward one's own group (Parham & Helms, 1981; Teske & Nelson 1973). Researchers have shared a broad definition of ethnic identity, yet the specific attributes that characterize ethnic identity have differed widely (Phinney, 1990).

The most research identified by Phinney (1990) failed to identify a theoretical framework but most of the ones that did, followed one of three broad perspectives: social

identity theory, acculturation and culture conflict, and identity formation. Social identity theory was conceptualized by social psychologists. One of the major tenets of social identity theory is that well-being is determined by a sense of belonging to identifiable groups (Lewin, 1948). The theory states that simply belonging to a group can provide a positive self-concept. Ethnic groups are inherently different in the realm of group identity (Tajfel, 1978). This difference is caused because a dominant group holds the characteristics of an ethnic group in low self-esteem. Low-status groups then may seek to identify more with the dominant group, yet this can result in negative psychological consequences and less acceptance of their ethnic identity (Tajfel, 1978). Lastly, the social identity theoretical framework highlights the notion that problems can arise for individuals that participate in two cultures. Both Lewin (1948) and Tajfel (1978) state that the conflict in attitudes, values, and behaviors between their own and different groups is likely problematic for identity formation in ethnic groups.

The difference between individual changes and group changes as a result of interaction between ethnic groups and the majority group is the basis for the acculturation and culture conflict theoretical framework. Within this framework, two models exist: a linear, bipolar model and a two-dimensional model. In the linear model there is strong ethnic identity at one end of the continuum and strong mainstream ties at the other end (Andujo, 1988; Makabe, 1979; Simic, 1987; Ullah, 1987). The assumption with this model is that by strengthening one end is a lessening of another. This model assumes that an increase in acculturation is a lessening of ethnic identity.

The alternative model is the two-dimensional model (see Table 1). This model posits that acculturation is a two-dimensional process, in which the ethnic culture that an individual is born with and the new or dominant culture must be considered, and act independent of each other (Phinney, 1990). This lends the possibility of four possible orientations with ethnic group identification (Berry et. al, 1986). A strong identification with both the traditional culture and the dominant culture is indicative of integration or *biculturalism*. Identification with the majority culture and a weaker identification with the traditional ethnic culture indicates *assimilation*. Identification with only the traditional ethnic group indicates that the individual is *embedded* in their culture. When an individual has identification with neither group it suggests *marginality*.

TABLE 1 Two-Dimensional Model of Acculturation and Ethnic Identity

Identification with majority group	Identification with ethnic group	
	Strong	Weak
Strong	Acculturated	Assimilated
	Integrated	
	Bicultural	
Weak	Ethnically identified	Marginal
	Ethnically embedded	
	Separated	
	Dissociated	

The last theoretical framework mentioned by Phinney (1990) is Ethnic Identity Formation. The earliest theory of identity formation comes from Erickson's (1968) theory of ego identity formation. Erickson's theory that identity comes to individuals over time through a period of exploration and experimentation that typically takes place

during adolescence. The ego identity model, proposed by Marcia (1966,1980), proposes that there are four ego identity states based on the amount of exploration and whether they have made a decision or commitment to their identity (see Table 2). A person who has made a commitment without exploration and based on in place values is *foreclosed*; one who has neither engaged in exploration nor made a commitment is said to be *diffuse*. A person in the process of exploring and has yet to make a commitment is in *moratorium*; a strong commitment to identity following a period of exploration is one who has *achieved identity*.

TABLE 2 Marcia's Ego Identity Model

Exploration	Commitment	
	High	Low
High	Achieved Identity	Moratorium
Low	Foreclosed	Diffused

Phinney and Alipuria (1996) studied ethnic identity development in college students. They measured ethnic identity in four different racial groups across ethnic identity search and commitment, the importance of ethnic identity, and relation between ethnic identity and self-esteem. African-Americans scored the highest in the ethnic identity search ($\chi = 2.67$) followed by Mexican-Americans ($\chi = 2.46$), Asian-Americans ($\chi = 2.20$), and European-Americans ($\chi = 1.98$). There was no clear distinction on level of commitment across the different ethnic groups. The importance of ethnic identity was compared to four other distinct identities (occupational, sex role, religious, and political).

Ethnic Identity averaged as fourth across the four ethnic groups. However, for African-Americans, ethnic identity was tied for third with religious identity, behind occupational and sex role identities. Compared to the European-American group, ethnic identity was significantly lower. Self-esteem was found to be correlated with ethnic identity search across all four ethnic groups, but the highest correlations were found among the minority groups.

Cross Racial Counseling Dyads

The research in cross-racial dyads among client and therapist has found mixed evidence in relation to outcome. Matching racial dyads has been found to increase rapport (Banks, 1972) as well as client perception of counselor effectiveness (Gardner, 1972). Other research has shown greater satisfaction with racial matching and dissatisfaction with treatment when cross-racial dyads exist (Wolken, Moriwaki, & Williams, 1973). Wade and Bernstein (1991) found that racial matching was not near as important as sensitivity to the differing cultures that exist between client and therapist with female African-American clients. Additionally, Atkinson, Furlong, & Poston (1986) reported that racial matching was not a priority for counselors and was less important than counselor education, similar attitudes, similar personality, and counselor age. This sample included participants who were not clients receiving therapy.

Sue, Fujino, Hu, Takeuchi, and Zane (1991) reported data collected from the Los Angeles community mental health system, which included 600,000 participants and spanned from 1973-1988. Their data indicated that racial matching for African-Americans did not lower client drop-out rates as it did with other minority groups.

Similarly, Proctor and Rosen (1981) found that client attrition and treatment satisfaction were not changed by client-therapist racial matching with eight male African-American clients. Jones (1982) created a well designed study that utilized all four racial combinations between therapist and client (White-White, White-African-American, African-American-African-American, and African-American-White). There was a trend for African-American clients paired with White therapists to prematurely terminate their counseling, although these results were not significant. Coleman, Wampold, and Casli (1995) conducted a meta-analysis of minorities' ratings of similar and dissimilar ethnicity of their therapists and clients. Their results indicated that ethnic minorities prefer therapists to be of a similar ethnic background. When determining counselor competence, ethnic similarity was not as highly rated; however, when therapist characteristics are not known, clients will prefer ethnically similar therapists (Coleman et al., 1995).

The Present Study

While there are numerous studies on the working alliance and its benefits on therapeutic outcome, there exists no empirical evidence to provide insight into possible specific interventions that can be used to help improve this relationship between the client and therapist. The particular intervention of complimenting is used in therapy and has been apart of more recent theoretical approaches, yet there has not been any previous research into any possible gains or losses from such an interaction. It has been strictly theoretical. Since there is a high drop-out rate in counseling for African-Americans this is important research and additional concern that practitioners should consider.

The present study seeks to test the hypotheses that:

- 1) Is there a statistical difference between counseling technique and level of relationship on therapeutic alliance ratings with African-American participants?
- 2) Is the therapeutic compliment equivalent to accurate empathy at changing perceptions of the working alliance with African-American participants?
- 3) Is the simple compliment, as a technique, equivalent to the therapeutic compliment and advanced accurate empathy in its perceptions of the working alliance with African-American participants?
- 4) Is there a statistical difference between counseling technique and level of relationship on hopefulness ratings with African-American participants?
- 5) Is there a statistical difference between counseling technique and level of relationship on accurate empathy ratings with African-American participants?

CHAPTER III

METHOD

Participants

The participants for this study included 120 African-Americans from a medium sized southeastern university and a large southwestern university. Male and female participants (69 females and 51 males) were used in this study and they had a mean age of 20.56 years of age. Participation was optional and participants could choose to be eligible for a drawing for one of two 40-dollar gift certificates.

Measures

Working Alliance Inventory-Short Form

The Working Alliance Inventory-Short Form (WAI-S; Hovarth and Greenberg, 1989; Tracey and Kokotovic, 1989) is an instrument designed to measure the interaction quality of the relationship between the client and the therapist. The short form is a 12-item questionnaire that is completed by the client. To score the WAI for the purposes of analysis in this study, a total alliance score and three subscales were used.

The WAI-S was developed from the original Client version of the Working Alliance Inventory. The 12 items were selected for having the highest goodness of fit based on a hierarchical, bi-level model indicating that the WAI-S assesses three aspects of the working alliance (Tasks, Goals, and Bonds), and the overall alliance. It is reported to have a reliability estimate from the pilot study ranging from .85 to .88 on the Client version of the WAI (Tracey & Kokotovic, 1989). The internal consistency estimates for

the client and therapist versions produced a coefficient alpha ranging from .83 to .98 (Tracey and Kokotovic, 1989). Horvath and Greenberg (1994) reported the reliability estimates for the individual subscales to be lower than the estimates of the overall instrument, ranging from .62 to .92.

A confirmatory factor analysis was performed to find the best goodness of fit for three models being tested (Tracey and Kokotovic, 1989). They reported a goodness of fit index (GFI) of .88 for the WAI-S on the bi-level model. The bi-level model assesses three unique aspects of the alliance and a general alliance dimension. Horvath & Greenberg (1989) applied a multitrait-multimethod matrix to evaluate convergent and discriminant validity. The validity scores were .53, .76, and .80 for the Bonds, Tasks, and Goals scales, respectively. There is evidence of convergent validity and limited support of discriminant validity. An article by Busseri and Tyler (2003) indicated that the WAI and WAI-S were highly correlated. Furthermore, the predictive validity for the WAI and WAI-S were also similar, so they concluded that the WAI and WAI-S were interchangeable.

An Exploratory Factor Analysis (EFA) was conducted in this study to examine the scores from the African-American sample's responses on the WAI-S. The EFA found evidence that three separate subscales exist in the WAI-S. However, the majority of items loaded under one component. Specifically item 4 loaded under component two and item 10 loaded under component three. The cronbach's alpha for this analysis was .855. The results of the EFA can be seen in Table 3.

TABLE 3 Exploratory Factor Analysis with Working Alliance Inventory and African-American Sample

WAI Items	Component		
	1	2	3
1	.724	.069	-.054
2	.763	.022	-.066
3	.665	.016	.018
4	-.006	-.022	-.970
Reverse 4*	-.007	.005	.966
5	.825	.069	-.012
6	.849	-.104	.042
7	.727	-.034	.113
8	.861	.066	-.067
9	.822	-.024	.020
10	-.004	-.994	-.013
Reverse 10*	.004	.994	.013
11	.870	-.102	.055
12	.853	.039	-.039

* Items 4 and 10 are reverse scored

Hopefulness Scale

The Hopefulness Scale (HS) is a self-report instrument designed to measure an individual's perceived hope and optimism. The HS measures two specific areas for each individual, overall hopefulness and hope related to the previous counseling session.

There are currently no reliability or validity statistics for this particular measure. It was developed by Collie Conoley as a measure of perceived hope in outcome and hope based on individual session.

Accurate Empathy Scale

The Accurate Empathy (AE) Scale (Truax, 1961; Truax and Carkhuff, 1967) is designed to measure the level of accurate empathy that is observed in a counseling session. Accurate empathy is operationalized as the level of sensitivity a counselor has for expressed and deeper feelings of a client and the verbal ability of the counselor to convey this understanding. The scale has nine stages with one being the lowest (Inaccurate responses to obvious feelings) and nine being the highest (Always accurate to obvious and deeper feelings with regard to intensity and content). Some of the responses in this study by participants included more than one response of the level of accurate empathy present in the session. The researcher scored the highest level of accurate empathy reported by the participants. This would mean that for some of the responses, some participants could have marked the highest and the lowest level or all of the different levels for of empathy. For each of these instances, the highest level marked was recorded.

Truax (1961) reports a reliability estimate for the AE scale to be .87. A study by Truax & Carkhuff (1965) uses the AE scale for one therapist with three different clients. The reported Ebel intraclass reliability estimate is .78. The validity estimates were determined to have a correlation of .67 on a 7-point semantic differential of understanding from “understand” to “not understand” (Shapiro, 1968).

Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992) is a self-report measure developed to assess ethnic identity. Ethnic identity was operationalized by Tajfel (1981) as an integral part of an individual's self-concept that is composed of that individual's knowledge of their social group and the value and emotional significance with attachment to that social group. This MEIM is composed of 14 items that assess three aspects of ethnic identity: positive ethnic attitudes and sense of belonging (5 items); ethnic identity achievement (7 items); and ethnic behaviors or practices (2 items). The remaining items are intended to assess self-identification and the ethnicity of parents. Included in this measure is a 6-item Other Group Orientation subscale. This particular subscale does not contribute to one's ethnic identity, but may affect one's social identity.

The overall reliability (coefficient alpha) of the 14-item MEIM was .90 for a college sample. The reliability for the 5-item Affirmation/Belonging and Ethnic Identity Achievement subscales were reported as .86 and .80, respectively. No reliability coefficients were reported for third subscale, Ethnic Behaviors; however, a separate study did indicate that the Ethnic Behaviors subscale did increase the overall reliability of the MEIM. The separate 6-item scale for other-group orientation showed lower reliability than the entire ethnic identity measure. The reliability coefficient for this subscale was .74. A factor analysis was conducted using a squared multiple correlations as estimates of commonalities (Phinney, 1992). The results of this factor analysis

indicated that there is a distinct single factor for ethnic identity and another single factor for other-group orientation.

Differences among ethnic identity were found across demographic variables. Phinney (1992) used an ANOVA and Tukey paired comparisons with different ethnic groups across her samples. For the college sample, the Black participants had significantly higher ethnic identity scores than Whites and Hispanics. No statistical significance was shown in comparison with ethnic identity and gender, socioeconomic status, or academic achievement in the college sample.

Stimulus

The researcher produced six video segments to be viewed by the undergraduate volunteers in this study. The video segments incorporated a 2.5 minute vignette of a portion of a mock counseling session. Two doctoral students from the Counseling Psychology program of Texas A&M University were used to play the “therapist” and the “client” for all six video segments. The content of the therapy session was similar across all six segments. Three of the video segments included a client-therapist interaction that was designed as “high” in perceived relationship and the other three video segments were designed to be perceived as “low” in perceived relationship. The three “high” relationship videos had a different intervention; either the therapeutic compliment, advanced accurate empathic statement, or non-therapeutic or simple compliment. Similarly, the same interventions will be used for one of the three “low” therapeutic relationship video segments. (See Appendix A for session transcripts).

Video Segment 'A1' included the therapeutic compliment that was designed to be perceived as high in therapeutic relationship. During this video segment, the intervention of the therapeutic compliment was used; a positive evaluation from the therapist to the client about his/her behaviors, thoughts, or attributes with an advanced, accurate empathic statement. The level of therapeutic relationship for the content of the session was rated as "high" by external raters. The external raters are licensed psychologists from a university counseling center from a mid-sized southeastern university. Video Segment 'A2' included the therapeutic compliment intervention, but was designed to be perceived as low in therapeutic relationship. The content of the counseling session was rated as "low" in perceived relationship by the raters (See Appendix A for the sample therapeutic compliment).

Video Segment 'B1' included a non-therapeutic or simple compliment that was designed to be high in therapeutic relationship. This video segment (B1) was different from A1 because the intervention made by the counselor was a compliment without an empathic statement. The positive evaluation that comprised the compliment was similar to that of Video Segments A1 and A2; however, there was no advanced, accurate empathic statement. This video segment was rated as "high" in therapeutic relationship by my outside raters.

The non-therapeutic or simple compliment was included in Video Segment 'B2,' which was designed to be low in therapeutic relationship. The content of the counseling session was rated as "low" in perceived relationship by the raters (See Appendix A for the sample non-therapeutic or simple compliment).

Video Segment 'C1' included an advanced, accurate empathic statement as the intervention and was designed with content that was high in therapeutic relationship. The content of this video segment was rated as "high" in therapeutic relationship. Video Segment 'C2' was designed to be low in therapeutic relationship and utilized the advanced accurate empathy statement as its intervention. The content of the session was rated to be low in therapeutic relationship by outside raters. (See Appendix A for the sample advanced, accurate empathic statement).

Five psychologists from the Counseling and Psychological Services Center at Appalachian State University acted as external raters of the video segments created by the researcher. The psychologists are currently licensed in the state of North Carolina and the minimum number of years having been licensed is four years. The raters evaluated the level of therapeutic relationship to be either "high" or "low" by watching the session vignette, but they did not watch the interventions with the sessions. The raters all viewed the "high" relationship session to be a close relationship between therapist and client and the "low" relationship was rated to be low in a close relationship.

Procedure

The researcher recruited African-Americans to participate in the current study, from predominantly African-American campus organizations and in public areas from a medium sized southeastern university and a large southwestern university. The researcher contacted and scheduled potential African-American participants and met with them individually to gain consent to participate in the study and discuss the possible benefits of participating. The participants completed a demographics page and the MEIM

prior to viewing the video segment. Next, the participants were randomly assigned to view one of the six video segments.

Following the observation of the video segment, the researcher instructed the participants to complete the measures of this study. The participants were instructed to “Answer the remaining questions for the study and to answer each question as if you were that client and that was your counselor.” The participants’ completed measures, placed them in an envelope and returned it to the researcher.

Design

The proposed study utilizes an analogue experimental research design. It is a simulated portion of a counseling session and controls for the magnitude of the delivery of the therapeutic compliment and level of working alliance. The dependent variables are the working alliance, hopefulness of outcome, and accurate empathy. There are two independent variables in this study; therapeutic intervention (therapeutic compliment, simple non-therapeutic compliment and advanced accurate empathy) and therapeutic relationship of the session (high and low). The subjects were randomly assigned to one of the six groups resulting in 20 participants per group.

Statistical Analyses

Multiple univariate analyses of variance (ANOVA) were used to analyze the data collected in this study. A two-way ANOVA was conducted with the therapeutic intervention and therapeutic relationship as the independent variables. This design was used because there are multiple independent variables that affect the dependent variables, yet the dependent variables are independent of each other. Additionally, Huberty and

Morris (1989) highlight that multiple univariate analyses are appropriate due to the nature of this study being exploratory in nature, as new treatment and outcome variables are being studied. Additionally, a one-way ANOVA was used to compare the interventions across one level of relationship.

CHAPTER IV

RESULTS

The present study utilized an analogue design by asking African-American participants (n = 120) to view video segments of a counseling session and to respond as if they were the client and they had just viewed their counselor. The participants completed an ethnic identity measure and the samples from the different cells produced similar means in ethnic identity. Descriptive tables of the ethnic identity of the participants can be found in Appendix C. All of the sample groups scored with a relatively strong ethnic identity (Phinney, 1992).

Chapter IV addresses the results of the five research questions. Each research question is listed below and discussed.

- 1) Is there a statistical difference between counseling technique and level of relationship on therapeutic alliance ratings with African-American participants?
- 2) Is the therapeutic compliment equivalent to accurate empathy at changing perceptions of the working alliance with African-American participants?
- 3) Is the simple compliment, as a technique, equivalent to the therapeutic compliment and advanced accurate empathy in its perceptions of the working alliance with African-American participants?
- 4) Is there a statistical difference between counseling technique and level of relationship on hopefulness ratings with African-American participants?

5) Is there a statistical difference between counseling technique and level of relationship on accurate empathy ratings with African-American participants?

The independent variables investigated in this study were session relationship (high and low) and therapeutic intervention (therapeutic compliment, non-therapeutic compliment, and advanced accurate empathy). The dependent variables were the working alliance, hopefulness of outcome, and accurate empathy. The design selected was multiple 2 x 3 analyses of variance (ANOVA), which yielded 6 cells (n = 20 per cell). Prior to conducting the analyses, the assumptions of normality and homogeneity of variance were tested. The Kolmogorov-Smirnov tests show that the distribution of scores for the Working Alliance Inventory (WAI) total score and the Tasks subscale of the WAI were normal. The skewness and kurtosis scores for the Goals Scale of the WAI, the Bonds Scale of the WAI, the Hopefulness Scale (HS) and Accurate Empathy Scale (AES) fell within the range +3 to -3, which falls in the range of accepting the normal distribution assumption (Glass and Hopkins, 1996). Therefore, the results of this data can be trusted based on this assumption. Using Levene's Test of Equality of Error Variances across dependent variables, these data met the assumption of equal variances. The tests of normality and homogeneity of variances are listed in Table 4 and Table 5, respectively.

TABLE 4 Tests of Normality for the Working Alliance Inventory, Hopefulness Scale, and Accurate Empathy Scale

Dependent Variables	Kolmogorov-Smirnov(a)			Skewness		Kurtosis	
	Statistic	Df	Sig.	Statistic	Standard Error	Statistic	Standard Error
WAI	.060	120	.200*	-.087	.221	-.579	.438
Goals	.085	120	.032	-.060	.221	-.237	.438
Tasks	.062	120	.200*	-.039	.221	-.720	.438
Bonds	.083	120	.039	-.210	.221	-.576	.438
HS	.099	120	.006	-.542	.221	-.361	.438
AES	.170	120	< .001	.148	.221	-1.361	.438

* This is a lower bound of the true significance.

a Lilliefors Significance Correction

TABLE 5 Levene's Test of Homogeneity of Variance for the Dependent Variables

Dependent Variables	F	df1	df2	Sig.
WAI	1.133	5	114	.347
Goals	1.032	5	114	.402
Tasks	0.888	5	114	.492
Bonds	0.518	5	114	.762
HS	1.106	5	114	.361
AES	1.455	5	114	.210

The means and standard deviations were computed for the overall working alliance dependent variable with the interventions. The three different subscales of the WAI were computed as well: Goals Subscale, Tasks Subscale, and Bonds Subscale. Additionally, the scores for the hopefulness dependent variable with the interventions were computed, as well as the accurate empathy dependent variable with the interventions. This information is provided in Table 6.

TABLE 6 Scores for the Therapeutic Compliment, Non-Therapeutic Compliment, and Advanced Accurate Empathy Interventions for Participants in the High and Low Relationship Groups with the Working Alliance Inventory (WAI), WAI Goals Subscale, WAI Tasks Subscale, WAI Bonds Subscale, Hopefulness Scale, and Accurate Empathy Scale

Dependent Measures	Relationship Level	Interventions					
		Therapeutic Compliment		Non-Therapeutic Compliment		Advanced Accurate Empathy	
		Mean	SD	Mean	SD	Mean	SD
WAI - Total	High	60.50	11.637	53.75	8.258	59.60	12.271
	Low	42.20	10.496	39.25	11.088	37.90	10.872
WAI – Goals Subscale	High	19.65	4.146	18.20	3.037	20.00	3.387
	Low	15.65	2.978	13.40	3.589	14.15	3.856
WAI – Tasks subscale	High	20.30	4.975	17.15	3.573	19.85	5.081
	Low	12.10	4.800	12.40	3.872	11.45	4.032
WAI – Bonds subscale	High	20.55	3.734	18.30	3.629	19.75	4.756
	Low	14.45	4.685	13.45	4.740	11.90	4.388
Hopefulness Scale	High	5.50	2.236	5.40	2.458	6.25	2.197
	Low	4.75	2.807	4.80	2.966	4.00	2.991
Accurate Empathy Scale	High	52.70	7.801	50.80	9.180	51.20	10.641
	Low	44.05	12.275	41.35	9.938	37.45	11.157

Questions 1-3

The first three questions examined the therapeutic compliment on the working alliance without controlling for the relationship level from the session content. All three questions utilized similar analyses and are thus grouped together. Specifically the first question examined whether there was a statistically significant difference between therapeutic techniques and relationship level on the therapeutic alliance ratings and the second question compared the therapeutic compliment with advanced accurate empathy in their ratings of the working alliance. The third question examined whether the non-therapeutic compliment was as effective as the therapeutic compliment and advanced accurate empathy on the working alliance. Multiple 2 (high relationship session/low

relationship session) x 3 (therapeutic compliment/non-therapeutic compliment/advanced accurate empathy) ANOVAs were used to answer the first question. First, ratings of the overall working alliance as the dependent variable yielded a significant main effect for relationship [$F(1, 114) = 84.02, p < .001$], but no significant main effect for the intervention [$F(2, 114) = 2.03, p > .10$] and no significant interaction effect [$F(2, 114) = 1.10, p > .10$]. Based on the partial eta square statistic, the relationship effect accounted for 43% of the variance and the intervention and interaction effects accounted for 3% and 2% of the variance, respectively. The Adjusted R-square for this analysis was .417 which is moderate in size (Cohen, 1992). The ANOVA summary can be found in Table 7.

TABLE 7 Ratings of the Interventions and Relationship Level on the Overall WAI Scores

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Power
Corrected Model	10618.275(a)	5	2123.655	18.055	<.001	.442	1.000
Intervention	476.250	2	238.125	2.025	.137	.034	.410
Relationship	9882.675	1	9882.675	84.021	<.001	.425	1.000
Interaction	259.350	2	129.675	1.102	.335	.019	.240
Error	13408.850	114	117.621				
Total	310679.000	120					
Corrected Total	24027.125	119					

a R Squared = .442 (Adjusted R Squared = .4178)

Three more ANOVAs were conducted comparing the individual subscales of Goals, Tasks, and Bonds of the WAI with independent variables. The results from the Goals subscale found significance with the relationship main effect [$F(1, 114) = 57.61, p$

< .001], but no significance for the intervention effect [$F(2, 114) = 2.89, p > .05$], or the interaction effect [$F(2, 114) = .693, p > .10$]. The partial eta square for this analysis found 34%, 5%, and 1% of the variance accounted for by the relationship, intervention, and interaction effects, respectively. The Adjusted R-square for this analysis was .334 which is moderate in size (Cohen, 1992). The ANOVA summary can be found in Table 8.

TABLE 8 Ratings of the Interventions and Relationship Level on the Goals Subscale of the WAI

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	804.342(a)	5	160.868	12.954	<.001	.362
Intervention	71.717	2	35.858	2.888	.060	.048
Relationship	715.408	1	715.408	57.611	<.001	.336
Interaction	17.217	2	8.608	.693	.502	.012
Error	1415.650	114	12.418			
Total	36257.000	120				
Corrected Total	2219.992	119				

a R Squared = .362 (Adjusted R Squared = .334)

The results from the Tasks subscale found significance with the relationship main effect [$F(1, 114) = 77.51, p < .001$], but no significance for the intervention effect [$F(2, 114) = 1.05, p > .10$], and the interaction effect [$F(2, 114) = 2.14, p > .10$]. The partial eta square for this analysis found 40% of the variance accounted for by the relationship main effect. One percent and four percent of the variance was accounted for by the intervention and interaction effects, respectively. The Adjusted R-square for this analysis was .399 which was moderate in size (Cohen, 1992). The ANOVA summary can be found in Table 9.

TABLE 9 Ratings of the Intervention and Relationship Levels on the Tasks Subscale of the WAI

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	1644.942(a)	5	328.988	16.782	<.001	.424
Intervention	41.317	2	20.658	1.054	.352	.018
Relationship	1519.408	1	1519.408	77.505	<.001	.405
Interaction	84.217	2	42.108	2.148	.121	.036
Error	2234.850	114	19.604			
Total	32865.000	120				
Corrected Total	3879.792	119				

a R Squared = .424 (Adjusted R Squared = .399)

The results from the Bonds subscale found significance with the relationship main effect [$F(1, 114) = 62.34, p < .001$], but no significance for the intervention effect [$F(2, 114) = 1.92, p > .10$], and interaction effect [$F(2, 114) = 1.20, p > .10$]. The partial eta square for this analysis found 34%, 3%, and 2% of the variance accounted for by the relationship, intervention, and interaction effects, respectively. The Adjusted R-square for this analysis was .348 which was moderate in size (Cohen, 1992). The ANOVA summary can be found in Table 10.

TABLE 10 Ratings of the Interventions and Relationship Levels on the Bonds Subscale of the WAI

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	1296.200(a)	5	259.240	13.716	<.001	.376
Intervention	72.650	2	36.325	1.922	.151	.033
Relationship	1178.133	1	1178.133	62.335	<.001	.354
Interaction	45.417	2	22.708	1.201	.305	.021
Error	2154.600	114	18.900			
Total	35726.000	120				
Corrected Total	3450.800	119				

a R Squared = .376 (Adjusted R Squared = .348)

To answer questions two and three, a one-way ANOVA was used taking the responses from the participants solely from the high relationship group. The total scores from the WAI did not yield significance [$F(2, 57) = 2.28, p = .112$]. However, all three subscales of the WAI found statistical significance: Goals [$F(2, 57) = 6.97, p < .01$], Tasks [$F(2, 57) = 16.95, p < .001$] and Bonds [$F(2, 57) = 11.64, p < .001$]. The ANOVA summary table can be found in Table 11. A post hoc comparison (Tukey) was conducted to determine where the significance was located and to identify which therapeutic intervention, specifically was different from the others. The post hoc results yielded a significant difference in the Goals subscale between the therapeutic compliment and the non-therapeutic compliment ($p < .01$). In the Tasks subscale the non-therapeutic compliment was found to be significantly different than both the therapeutic compliment ($p < .001$) and the advanced accurate empathy ($p < .01$) interventions. The Bonds

subscale results also found a significant difference between the non-therapeutic compliment intervention and the therapeutic compliment ($p < .001$) and advanced accurate empathy ($p < .05$) interventions. The scores for the therapeutic compliment intervention were comparable to the scores from the advanced accurate empathy intervention. The simple compliment did not have the same effect on perceived working alliance as the therapeutic compliment and the advanced accurate empathy intervention. The summary of the post hoc data can be found in Table 12.

TABLE 11 One-way ANOVA of the Therapeutic Interventions from the High Relationship Subgroup

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Power
WAI	Between groups	537.300	2	268.650	2.275	.112	.074	.444
	Within groups	6729.550	57	118.062				
	Total	7266.850	59					
Goals	Between groups	164.033	2	82.017	6.974	.002	.197	.913
	Within groups	670.300	57	11.760				
	Total	834.333	59					
Tasks	Between groups	684.433	2	342.217	19.95	<.001	.373	1.000
	Within groups	1150.550	57	20.185				
	Total	1834.983	59					
Bonds	Between groups	380.633	2	190.317	11.63	<.001	.290	.992
	Within groups	932.100	57	16.353				
	Total	1312.733	59					

TABLE 12 Tukey Post Hoc Comparison of Difference of Means of Therapeutic Compliment (TC), Non-Therapeutic Compliment (NC), and Accurate Empathy (AE) Interventions

Dependent Variable	intervention	intervention	Mean Difference	Standard Error	Sig.
Goals	TC	NC	4.000*	1.084	.001
		AE	1.450	1.084	.381
	NC	TC	-4.000*	1.084	.001
		AE	-2.550	1.084	.057
	AE	TC	-1.450	1.084	.381
		NC	2.550	1.084	.057
Tasks	TC	NC	8.200*	1.421	<.001
		AE	3.150	1.421	.077
	NC	TC	-8.200*	1.421	<.001
		AE	-5.050*	1.421	.002
	AE	TC	-3.150	1.421	.077
		NC	5.050*	1.421	.002
Bonds	TC	NC	6.100*	1.279	<.001
		AE	2.250	1.279	.192
	NC	TC	-6.100*	1.279	<.001
		AE	-3.850*	1.279	.011
	AE	TC	-2.250	1.279	.192
		NC	3.850*	1.279	.011

* The mean difference is significant at the .05 level.

Question 4

Question 4 of this study examines the perceptions of the therapeutic compliment on hopefulness. A 2 (high relationship session/low relationship session) x 3 (therapeutic compliment/non-therapeutic compliment/advanced accurate empathy) ANOVA with hopefulness of outcome as the dependent variable yielded a significant main effect for relationship [$F(1, 114) = 32.09, p < .001$], but no significant main effect for the intervention [$F(2, 114) = 1.57, p > .10$] and no significant interaction [$F(2, 114) = .714, p$

>.10]. Based on the partial eta square statistic, the relationship effect accounted for 22% of the variance and the intervention and interaction effects accounted for 3% and 1% of the variance, respectively. The scores did not indicate the therapeutic compliment to be more successful at creating an effect on the perceived hopefulness of outcome. The ANOVA summary can be found in Table 13.

TABLE 13 Ratings of the Interventions and Relationship Levels on the Hopefulness of Outcome Scores

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	3861.942(a)	5	772.388	7.330	<.001	.243
Intervention	330.067	2	165.033	1.566	.213	.027
Relationship	3381.408	1	3381.408	32.088	<.001	.220
Interaction	150.467	2	75.233	.714	.492	.012
Error	12013.050	114	105.378			
Total	272655.000	120				
Corrected Total	15874.992	119				

a R Squared = .243 (Adjusted R Squared = .210)

Question 5

Question 5 examined whether the potential clients perceived a difference in empathy between the interventions. A 2 (high relationship session/low relationship session) x 3 (therapeutic compliment/non-therapeutic compliment/advanced accurate empathy) ANOVA with accurate empathy as the dependent variable yielded a significant main effect for relationship [$F(1, 114) = 6.25, p < .05$], but no significant main effect for the intervention [$F(2, 114) = .001, p > .90$] and no significant interaction [$F(2, 114) =$

1.20, $p > .10$]. Based on the partial eta square statistic, the relationship effect accounted for 5% of the variance and the intervention and interaction effects accounted for less than 1% and 2% of the variance, respectively. The ANOVA summary can be found in Table 14.

TABLE 14 Ratings of the Interventions and Relationship Levels on the AES Scores

Source	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	59.867(a)	5	11.973	1.731	.133	.071
Intervention	.017	2	.008	.001	.999	<.001
Relationship	43.200	1	43.200	6.246	.014	.052
Interaction	16.650	2	8.325	1.204	.304	.021
Error	788.500	114	6.917			
Total	3990.000	120				
Corrected Total	848.367	119				

a R Squared = .071 (Adjusted R Squared = .030)

CHAPTER V

DISCUSSION AND CONCLUSIONS

Questions 1-3

The current study analyzed the benefit of a particular therapeutic intervention, the therapeutic compliment, and its ratings on the working alliance when the level of relationship of a counseling session was one of two scenarios: 1) high level of relationship or 2) low level of relationship. The first question addressed whether there is merit to using this intervention across levels of relationship. It was hypothesized that the therapeutic compliment would change the perceptions of the working alliance. The second question examined the comparison of the perceptions of a therapeutic compliment to advanced accurate empathy as an intervention, and how each would be rated on the working alliance between client and counselor. It was hypothesized that the therapeutic compliment and advanced accurate empathy would be perceived on the working alliance in a similar manner. The third question examined the comparison of the perceptions of the therapeutic compliment to a simple non-therapeutic compliment. The third hypothesis stated that the non-therapeutic or simple compliment would be rated lower on the working alliance than other interventions.

Multiple two-way ANOVAs were used to identify whether the therapeutic compliment was rated differently on the overall working alliance scores or any of the subscales of the Working Alliance Inventory. The therapeutic compliment was not found to create a positive or negative change on the overall working alliance scores or any of

the subscales of the WAI. The therapeutic compliment was compared against counseling sessions where the relationship between the client and therapist was high and low. The therapeutic compliment was not perceived differently in either of these scenarios.

Statistical significance was found along the independent variable of relationship level (high and low). This variable was part of the manipulation aspects of the study and was used to highlight whether the interventions were perceived differently in both strong and low relationship situations. The videos were created by the researcher and rated by external raters as having either “high” or “low” relationship. The statistical significance found indicates that they were rating measurable differences between the two sessions and supports the distinctions of “high” and “low” relationship of the videos created by the researcher. Session transcripts of the videos can be viewed in Appendix A.

Although the therapeutic compliment was not perceived as a strong intervention on the overall working alliance across different levels of relationship it is important to note that the relationship main effect accounted for 37% of the variance, leading to a lower amount of effect to be measured by the interventions themselves. This results in the majority of the effect of the study to be attributed to the relationship level rather than the intervention level of the study.

Additionally, the intervention cannot be viewed as completely lacking in quality or potential use based solely on its level of significance due to the nature of ANOVA being simply a comparison of means (Huck, 2000). The robust nature of the Adjusted R-square of the sample meeting the assumptions for conducting an ANOVA asserts that by raising the sample size of each comparison group, the likelihood of statistical

significance increases. According to Cohen (1992), a more appropriate sample size would have been 35 participants per group, thus raising the total sample from 120 to 210 participants.

It is important to note the difference between the WAI total scores and the subscales of the WAI. None of the scores found statistical significance, yet the scores from Goals and Bonds subscales were considerably better than the Tasks subscale. The best way to understand this notion would be that the sessions may have included more context related to the areas of bond and goals in therapy, rather than focused on the techniques that would be used to reach the goals of therapy. This is not a conclusion that Tasks is not an important facet of the working alliance.

The second and third questions were addressed using a one-way ANOVA between the three interventions across the high relationship group only. The results were not significant for the total WAI scores; however, the scores from the three subscales of the WAI, Goals, Tasks and Bonds, were statistically significant. The therapeutic compliment is similar in comparison to that of advanced accurate empathy across the subscales of the WAI. The non-therapeutic compliment was rated lower than the other two interventions, thus indicating that a simple compliment is perceived lower as a tool to create an affect on the working alliance. In fact, the therapeutic compliment is the better intervention on rating of all three subscales of the WAI.

The therapeutic compliment and advanced accurate empathy scores indicated that they have an equal ratings on the working alliance in a session. It has been asserted by Bordin (1980) that empathy is a requirement for developing the working alliance. Other

researchers contend that the notion of empathy has simply involved into constructs such as the working alliance (Duan & Hill, 1996). Whichever way that empathy and the working alliance are viewed, there is agreement that they work together. More importantly, the therapeutic compliment, being constructed with accurate empathy, has a place in the therapist's repertoire of interventions.

The third question examined the simple compliment and whether it had similar ratings on the working alliance. The simple compliment was significantly different from the therapeutic compliment intervention and the advanced accurate empathy intervention. A possible explanation for the failure of simple complimenting in therapy is the lack of connection with the client. Complimenting is generally intended to evoke a positive response from the recipient (Sims, 1987), yet the simple compliment can create impairments in the relationship with clients. The level of empathy provided in the therapeutic compliment creates a more accurate understanding of the client's current emotional state and provides an explanation of meaning behind the compliment. The lack of empathy in a simple compliment may indicate a misunderstanding of the client's feelings.

Question 4

The overall hopefulness in outcome as a result of the different interventions was examined. The therapeutic compliment was hypothesized to create greater hopefulness of a positive outcome. A two-way ANOVA was used to analyze the results of the relationship and intervention main effects on the overall hopefulness of outcome. The

results of this analysis indicate that the therapeutic compliment is not a strong intervention for increasing the level of hopefulness of outcome.

Similar to all of the other analyses, the relationship main effect was included to provide different types of relationship levels in session. There was a statistically significant main effect, indicating a difference between the two relationship level mean scores. However, questions in this particular study are focused specifically on interventions rather than the strength of the relationship in the session prior to the intervention.

Question 5

The purpose of the question was to examine if the particular interventions used were rated differently on perceived level of observed accurate empathy. It was hypothesized that the therapeutic compliment and advanced accurate empathy interventions would obtain higher scores on observed accurate empathy and that the non-therapeutic compliment would obtain lower scores on empathy. A two-way ANOVA was used to compare the scores of the Accurate Empathy Scale (AES) with the intervention and relationship main effects. The relationship main effect was found to be significant using the ANOVA. This result indicates that the participants did view the low and high relationship video tapes differently. However, the participants did not clearly identify a change in level of empathy based the different interventions presented; therapeutic compliment, simple compliment, or advanced accurate empathy..

Working alliance and empathy are related (Bordin, 1980; Duan & Hill, 1996), yet the results from this analysis were far worse in measuring perceived empathy. This

could easily be explained by the limitation of the measure used in this study. There are not any strong measures of empathy from an observer's perspective (Duan & Hill, 1996), thus making it difficult to evaluate in the counseling session. The measure used in this study was developed by Truax and Carkhuff in 1967.

Limitations

There are numerous limitations that are associated with this particular study. The most prevalent limitation of this study is the issue of measurement and design. A therapeutic intervention is done by the therapist and directed towards the client with some desired effect (Egan, 1994). It is difficult to measure or determine the strength or ability of an event that is very quick. This study attempted to outline the intervention by switching camera angles to highlight the importance of that event, yet it will be impossible to tell if one is measuring the intervention or the entire session that took place before the intervention. The intervention is such a brief moment of the session being viewed and there could be other variables that interfere in attention to the specific intervention being used. This effect was highlighted by the use of a "high" and "low" relationship level with the interventions.

The second limitation of this study is related to the use of the relationship independent variable. The relationship variable seems to have interfered in the ability to answer the questions of this study which were focused on the interventions. The relationship level of this study accounted for the majority of the effect in this study. Therefore, the study confirmed the difference in the two videos but the effect was low in the comparison of the interventions. This study could have benefited in using only one

relationship level or by having two independent studies of low relationship and high relationship factors. To analyze such a study, a greater sample size would have been needed.

With regards to measurement, the Accurate Empathy Scale (AES) (Truax, 1961; Truax & Carkhuff, 1967) had notable limitations in this study. First, the AES was developed as an observational measure of the level of empathy in a counseling session, and was intended to be used by professionals in the field of psychology. It was not intended to be scored by laypersons. Secondly, many participants (37 of 120 or 30.8%) did not understand the instructions well enough and marked several responses rather than one. For example, they would mark the lowest level of empathy and the highest level of empathy being present. The measure is intended to mark the one that is seen. By marking the lowest and highest levels of empathy, there is a disparity in measuring the empathy of the session. This measure may not be suitable for laypersons and an alternative instrument for measuring level of empathy by clients should be explored.

Another limitation of this study would be the sample size. The minimum number of participants of each cell was used ($n = 20$). Had there been a greater sample size the study could have increased the level of significance. To increase the sample size, a comparative ethnic group would have been helpful. Had an additional 120 European-American participants been used as well, there would have been enough of a sample size (Cohen, 1992) to compare the data without the relationship main effect and there would have been a comparative ethnic group that could have been used. Typically, African-American college students score lower on ethnic identity than European-American

counterparts (Phinney & Allipuria, 1996), yet they are the highest in actively pursuing activities and events related to ethnic identity.

Future Research

Future research to explore specific interventions that may impact the working alliance is necessary. This study is only a beginning in looking at a new technique but also whether certain interventions can be measured for their impact. An important implication for future research is to find a way to measure the specific interventions themselves or to eliminate the “high” and “low” relationship variables and make them independent studies. The studies could then be compared through the use of effect sizes and confidence intervals. In addition, further research should implement more study of the therapeutic compliment and other interventions with a sample currently receiving therapy. This would afford the opportunity to compare the small nature of an intervention with a total outcome of therapy.

The therapeutic compliment, as an intervention, needs further exploration as well. Due to the limited nature of the results and the limitations that exist in this study, it would be important for researchers to find greater empirical support for the use of therapeutic complimenting as a common intervention in therapists’ tool belts. Additionally, a greater variety in the sample should be used as complimenting might be more effective in one culture and less effective in another. Additionally, the therapeutic compliment might function differently with other cultures.

Summary

Understanding the use of complimenting in therapy is an important task due to its current practice by several therapeutic models (Selvini-Palazzoli et al., 1974; de Shazer, 1980; Erickson, 1980; Berg & Miller, 1992; De Jong & Berg, 2002). The current study provides a better definition of the therapeutic compliment and provides considerations for its use. Previous definitions of how to construct compliments for individuals in therapy does not exist. The previous definitions used for complimenting in therapy, simply provide encouragement for its use and the reader must assume its construction. More specifically, this study looks at the empirical merit of using compliments in a therapeutic manner with clients rather than a theoretical or philosophical foundation for its practice.

Finally, this study is a first attempt at providing insight into what types of interventions might be beneficial in increasing the level of working alliance with clients. The working alliance is a well known and well researched concept and acknowledged as a component to increasing positive outcomes, yet past research has not provided empirical research on what specific interventions provide a direct effect in helping increase the working alliance. This study provides a model for future research and provides suggestions for furthering this needed research.

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APPENDIX A
TRANSCRIPTS OF VIDEOS USED

VIDEO A1 – Therapeutic Compliment Intervention (in bold and italics below) in the High Working Alliance Session

CLIENT-You know I've really been thinking about what we discussed last session, and I think that's it. I really do. I think I need to put myself out there more. I need to socialize

THERAPIST-You need to get out there, huh?

CLIENT-I do. I feel like, you know, I want ... Even though I feel like that; it is so... it is so hard to get out there. I mean it really is. That is something I wanted us to work on.

THERAPIST-Yeah

CLIENT-How do I get out there? How do I do it? I mean I have definitely tried it in the past, and it's just really hard.

THERAPIST-So you're excited about trying these new things out, but you're kind of unsure about how they are going to go, maybe.

CLIENT- Yeah, Yeah, (head nodding). Um... I'm worried, I guess sometimes I get worried because you know I feel that from, you know, past experiences when I tried to get myself out there that maybe people won't accept me for who I am and I never fit in.

THERAPIST-So you put yourself out there, and you didn't feel like you were accepted.

CLIENT-Yeah, Yeah, and that is so frustrating. It's like I'm not, I don't necessarily like to be the one in the mix or just always have to be the one that's. I just want to be who I am. It seems like for some people that isn't good enough. You know, they don't say "he's quiet, and it takes a little while to get to know him. They just kind of judge you and when you don't meet that they don't want you there.

THERAPIST-So you feel like you want to be yourself, but then when you are yourself they're just not going to have anything to do with you. Is that what you are saying?

CLIENT-I think so. They want me to be somebody else.

THERAPIST-So how would you like for them to act?

CLIENT-I guess just more accepting. To want to get know me versus get to know the person they think I should be. If they could do that, that I guess, I would like that.

THERAPIST-From all the stuff that you've been talking to me about, I just really want to say that I think you are a very brave person for coming in here and talking about all these things that are kind of scary and that you are unsure about. And that are generally require you to be vulnerable with me. I just think you are a very brave person for doing that.*

VIDEO A2 – Therapeutic Compliment Intervention in the Low Working Alliance Session

CLIENT-I'm not quite sure this counseling thing is working for me man.

THERAPIST-yeah

CLIENT-I'm still... what do I. I need certain things... I need to know how to help; I need help with this thing. That's not really happening. I'm frustrated.

THERAPIST-It's kind of difficult. It's been difficult for you in here.

CLIENT-That's not exactly it. I came because I was having a hard time getting out there. I don't necessarily fit in with a lot of people. Um...and it hurts when I do try to get out there and do some things. And people want to judge me...judge me before they even know me.

THERAPIST-So you feel like people are judging you.

CLIENT-Maybe, but it's more than that...It's just like I'm trying to do this thing. And I'm trying to get out there. And I've been trying to get from you why, or what I need to do or how do I fix this, and I'm not sure.

THERAPIST-So you just feel like you're trying to get the answers on how to change things.

CLIENT-Yeah, I am because you know, I'm trying to put myself out there and I'm trying to do these things, and it is scary doing it. And that's why I just think this counseling thing is not going to work. I don't think what I need I'm going to get here. It's not going to happen.

THERAPIST-What do you think we ought to do more of?

CLIENT-Man, just help me with this thing. I don't think this is going to work man, honestly.

THERAPIST- *From all the stuff that you've been talking to me about, I just really want to say that I think you are a very brave person for coming in here and talking about all these things that are kind of scary and that you are unsure about. And that are generally require you to be vulnerable with me. I just think you are a very brave person for doing that.**

VIDEO B1 – Simple Compliment Intervention in the High Working Alliance Session

CLIENT-You know I've really been thinking about what we discussed last session, and I think that's it. I really do. I think I need to put myself out there more. I need to socialize

THERAPIST-You need to get out there, huh?

CLIENT-I do. I feel like, you know, I want ...Even though I feel like that; it is so...it is so hard to get out there. I mean it really is. That is something I wanted us to work on.

THERAPIST-Yeah

CLIENT-How do I get out there? How do I do it? I mean I have definitely tried it in the past, and it's just really hard.

THERAPIST-So you're excited about trying these new things out, but you're kind of unsure about how they are going to go, maybe.

CLIENT-Yeah, Yeah, (head nodding). Um...I'm worried, I guess sometimes I get worried because you know I feel that from, you know, past experiences when I tried to get myself out there that maybe people won't accept me for who I am and I never fit in.

THERAPIST-So you put yourself out there, and you didn't feel like you were accepted.

CLIENT-Yeah, Yeah, and that is so frustrating. It's like I'm not, I don't necessarily like to be the one in the mix or just always have to be the one that's. I just want to be who I am. It seems like for some people that isn't good enough. You know, they don't say

“he’s quiet, and it takes a little while to get to know him. They just kind of judge you and when you don’t meet that they don’t want you there.

THERAPIST-So you feel like you want to be yourself, but then when you are yourself they’re just not going to have anything to do with you. Is that what you are saying?

CLIENT-I think so. They want me to be somebody else.

THERAPIST-So how would you like for them to act?

CLIENT-I guess just more accepting. To want to get know me versus get to know the person they think I should be. If they could do that, that I guess, I would like that.

THERAPIST-*Well, I think you are a really great guy.**

VIDEO B2 – Simple Compliment Intervention in the Low Working Alliance Session

CLIENT-I’m not quite sure this counseling thing is working for me man.

THERAPIST-yeah

CLIENT-I’m still... what do I. I need certain things...I need to know how to help; I need help with this thing. That’s not really happening. I’m frustrated.

THERAPIST-It’s kind of difficult. It’s been difficult for you in here.

CLIENT-That’s not exactly it. I came because I was having a hard time getting out there. I don’t necessarily fit in with a lot of people. Um...and it hurts when I do try to get out there and do some things. And people want to judge me...judge me before they even know me.

THERAPIST-So you feel like people are judging you.

CLIENT-Maybe, but it’s more than that...It’s just like I’m trying to do this thing. And I’m trying to get out there. And I’ve been trying to get from you why, or what I need to do or how do I fix this, and I’m not sure.

THERAPIST-So you just feel like you’re trying to get the answers on how to change things.

CLIENT-Yeah, I am because you know, I’m trying to put myself out there and I’m trying to do these things, and it is scary doing it. And that’s why I just think this counseling thing is not going to work. I don’t think what I need I’m going to get here. It’s not going to happen.

THERAPIST-What do you think we ought to do more of?

CLIENT-Man, just help me with this thing. I don’t think this is going to work man, honestly.

THERAPIST- *Well, I think you are a really great guy.**

VIDEO C1 – Advanced Accurate Empathy Intervention in the High Working Alliance Session

CLIENT-You know I’ve really been thinking about what we discussed last session, and I think that’s it. I really do. I think I need to put myself out there more. I need to socialize

THERAPIST-You need to get out there, huh?

CLIENT-I do. I feel like, you know, I want ...Even though I feel like that; it is so...it is so hard to get out there. I mean it really is. That is something I wanted us to work on.

THERAPIST-Yeah

CLIENT-How do I get out there? How do I do it? I mean I have definitely tried it in the past, and it's just really hard.

THERAPIST-So you're excited about trying these new things out, but you're kind of unsure about how they are going to go, maybe.

CLIENT- Yeah, Yeah, (head nodding). Um...I'm worried, I guess sometimes I get worried because you know I feel that from, you know, past experiences when I tried to get myself out there that maybe people won't accept me for who I am and I never fit in.

THERAPIST-So you put yourself out there, and you didn't feel like you were accepted.

CLIENT-Yeah, Yeah, and that is so frustrating. It's like I'm not, I don't necessarily like to be the one in the mix or just always have to be the one that's. I just want to be who I am. It seems like for some people that isn't good enough. You know, they don't say "he's quiet, and it takes a little while to get to know him. They just kind of judge you and when you don't meet that they don't want you there.

THERAPIST-So you feel like you want to be yourself, but then when you are yourself they're just not going to have anything to do with you. Is that what you are saying?

CLIENT-I think so. They want me to be somebody else.

THERAPIST-So how would you like for them to act?

CLIENT-I guess just more accepting. To want to get know me versus get to know the person they think I should be. If they could do that, that I guess, I would like that.

THERAPIST-*So what it sounds like you have been talking about is how when you get around other people and you allow yourself to be vulnerable and behave in different ways that are uncomfortable; it is kind of scary for you.**

VIDEO C2 – Advanced Accurate Empathy Intervention in the Low Working Alliance Session

CLIENT-I'm not quite sure this counseling thing is working for me man.

THERAPIST-yeah

CLIENT-I'm still... what do I. I need certain things...I need to know how to help; I need help with this thing. That's not really happening. I'm frustrated.

THERAPIST-It's kind of difficult. It's been difficult for you in here.

CLIENT-That's not exactly it. I came because I was having a hard time getting out there. I don't necessarily fit in with a lot of people. Um...and it hurts when I do try to get out there and do some things. And people want to judge me...judge me before they even know me.

THERAPIST-So you feel like people are judging you.

CLIENT-Maybe, but it's more than that...It's just like I'm trying to do this thing. And I'm trying to get out there. And I've been trying to get from you why, or what I need to do or how do I fix this, and I'm not sure.

THERAPIST-So you just feel like you're trying to get the answers on how to change things.

CLIENT-Yeah, I am because you know, I'm trying to put myself out there and I'm trying to do these things, and it is scary doing it. And that's why I just think this counseling thing is not going to work. I don't think what I need I'm going to get here. It's not going to happen.

THERAPIST-What do you think we ought to do more of?

CLIENT-Man, just help me with this thing. I don't think this is going to work man, honestly.

THERAPIST- *So what it sounds like you have been talking about is how when you get around other people and you allow yourself to be vulnerable and behave in different ways that are uncomfortable; it is kind of scary for you.**

**interventions are in bold and italics*

APPENDIX B
MEASURES

Multigroup Ethnic Identity Measure*

In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic, Black, Asian-American, Native American, Irish-American, and White. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.
(4) Strongly agree; (3) Agree; (2) Disagree; (1) Strongly disagree

- _____ 1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.
- _____ 2. I am active in organizations or social groups that include mostly members of my own ethnic group.
- _____ 3. I have a clear sense of my ethnic background and what it means for me.
- _____ 4. I think a lot about how my life will be affected by my ethnic group membership.
- _____ 5. I am happy that I am a member of the group I belong to.
- _____ 6. I have a strong sense of belonging to my own ethnic group.
- _____ 7. I understand pretty well what my ethnic group membership means to me.
- _____ 8. To learn more about my ethnic background, I have often talked to other people about my ethnic group.
- _____ 9. I have a lot of pride in my ethnic group and its accomplishments.
- _____ 10. I participate in cultural practices of my own group, such as special food, music, or customs.
- _____ 11. I feel a strong attachment towards my own ethnic group.
- _____ 12. I feel good about my cultural or ethnic background.
13. My Ethnicity is

- (a) Asian, Asian American, or Oriental
- (b) Black or African American
- (c) Hispanic or Latino
- (d) White, Caucasian, European, not Hispanic
- (e) Native American
- (f) Mixed; parents are from two different groups
- (g) Other (*write in*) _____

14. My Father's Ethnicity is (use letters from above) _____

15. My Mother's Ethnicity is (use letters from above) _____

* The name of the measure was removed during data collection

Working Alliance Inventory-Short Form*

On the following page there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counselor). As you read the sentences mentally insert the name of the therapist in place of the _____ in the text. Circle the response that seems most accurate for you after having seen the video. Work fast, your first impressions are the ones we would like to see.

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in _____'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

* The name of the measure was removed during data collection

Hopefulness Scale*

After every meeting please circle the answer that best fits. Answer as honestly as you can. How I feel right now.

1. Overall I believe that life is worthwhile even though at times I may feel doubtful.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

2. I am feeling that I will know what to do to improve my situation.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

3. I feel confident that through my efforts, I will make significant progress.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

4. My future looks bright.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

5. The things I am doing or will be doing will help me.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

6. I believe that life will be better for me.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

What I thought about the session.

- 1) Right now I feel this session was worthwhile.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

- 2) This session gave me new ways of seeing my problems.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

- 3) I'm confident I'll get relief from my problem.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

- 4) The things we did in session will help me make the changes I want.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

- 5) In this session, I gained a deeper understanding of my problems.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

True	Is True	Accuracy	True	Not True
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6) I believe the session helped me.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

7) During this session, I was willing to work hard on my problems.

Absolutely True	Maybe Feel This Is True	Uncertain of Accuracy	Probably Not True	Absolutely Not True
-----------------	-------------------------	-----------------------	-------------------	---------------------

* The name of the measure was removed during data collection

Accurate Empathy Scale*

Please read all of the following statements below. Place a mark (√) next to the number that you feel most corresponds to the counselor that you viewed on the video segment.

- _____ 1) Inaccurate responses to obvious feelings.
- _____ 2) Slight accuracy toward obvious feelings. Ignores the deeper feelings.
- _____ 3) Often accurate toward obvious feelings. Concern with deeper feelings and occasionally accurate with regard to them.
- _____ 4) Often accurate toward obvious feelings. Concern with deeper feelings and fairly often accurate with regard to them although spotted by inaccurate probing.
- _____ 5) Always accurate toward obvious feelings. Frequently accurate toward deeper feelings although occasionally misinterpreting them.
- _____ 6) Always accurate toward obvious feelings. Frequently accurate toward the content but not the intensity of deeper feelings.
- _____ 7) Always accurate toward obvious feelings. Frequently accurate toward deeper feelings with regard to both content and intensity, but occasionally misses the mark of depth of intensity. May go too far in direction of depth.
- _____ 8) Always accurate toward obvious feelings. Almost always accurate toward deeper feelings with respect to both content and intensity. May occasionally hesitate or err but correct quickly and accurately.
- _____ 9) Always accurate toward obvious feelings and unerringly accurate and unhesitant toward deep feelings with regard to both content and intensity.

* The name of the measure was removed during data collection

APPENDIX C
ADDITIONAL ANALYSES TABLES

TABLE 15 Multigroup Ethnic Identity Measure (MEIM) Scores for the Therapeutic Compliment, Non-Therapeutic Compliment, and Advanced Accurate Empathy Interventions for Participants in the High and Low Relationship Groups

Relationship Level	Interventions					
	Therapeutic Compliment		Non-Therapeutic Compliment		Advanced Accurate Empathy	
	Mean	SD	Mean	SD	Mean	SD
High Relationship	39.50	4.894	40.05	5.916	40.10	5.748
Low Relationship	41.35	3.602	40.90	4.436	40.40	4.430

VITA

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EDUCATION

Texas A&M University, Doctor of Philosophy, 2007
Counseling Psychology
APA Accredited Program
Dissertation title: *Examining the Therapeutic Compliment with African-Americans: A Counseling Technique to Improve the Working Alliance*

The University of Oklahoma, Master of Education, 2002
Community Counseling

Texas Tech University, Bachelor of Arts-Psychology, 2000

CLINICAL EXPERIENCE

Pre-doctoral Psychology Internship, August 2005-July 2006
Appalachian State University, Boone, NC

- Provide individual, group, couples, and family counseling to students with mental health needs.
- Provide diagnostic assessments to clients, write integrated assessment reports, and provide assessment feedback to clients.
- Provide on-call, after hours, and weekend emergency services for university community, particularly addressing suicidal ideation and sexual assault.
- Provide outreach programs to university groups.
- Chair of Online Therapy Committee. Coordinated exploration of benefits, research, methods, and needs to implement such service by the Counseling Center.

PROFESSIONAL ASSOCIATIONS

American Psychological Association – Student Member
American Counseling Association – Student Member