Volume 37/Number 2/April 2015/Pages 95-108

INVITED ARTICLE

The invited article section of the *Journal of Mental Health Counseling* is intended to provide a platform for recognized leaders in mental health counseling and related fields to share ideas that might not otherwise find a voice in the literature. Authors are simply asked to share ideas that they believe are of importance and value to mental health counselors. Nominations for contributors may be addressed to the Editor.

We are honored that our invited author is Dr. John Sommers-Flanagan. A professor at the University of Montana, he is author of over 8 books and scores of articles. He is a popular presenter at national conferences and a member of the American Mental Health Counselors Association.

Evidence-Based Relationship Practice: Enhancing Counselor Competence

John Sommers-Flanagan

Defining mental health counselor competence is difficult. Unfortunately, professional definitions of competence often rely on abstract knowledge that is difficult for counselors to apply. This article highlights the history and terminology associated with the evidence-based movement in medicine, psychology, and counseling. Using this historical information as a foundation, a relationally-oriented, evidence-based practice model for achieving competence in mental health counseling is proposed. The model emphasizes such evidence-based relationship factors as (a) congruence and genuineness, (b) the working alliance, (c) unconditional positive regard or radical acceptance, (d) empathic understanding, (e) rupture and repair, (f) managing countertransference, (g) implementing in- and out-of-session (homework) procedures, and (h) progress monitoring. The purpose of the model is to articulate a distinctive and practical evidence-based approach that mental health counselors can wholeheartedly embrace.

Competence in mental health counseling is inevitably complex and multidimensional. Ironically, the complexity can become overwhelming when well-intended professionals work together to identify the knowledge and skills counselors need to be considered competent. A good example of this is the standards defined in 2009 by the Council for Accreditation of Counseling and

John Sommers-Flanagan is affiliated with The University of Montana, Missoula. Correspondence about this article should be addressed to Dr. John Sommers-Flanagan, Department of Counselor Education, University of Montana, Missoula MT 59812. Email: John.SF@mso.umt.edu.

Related Educational Program (CACREP, 2009). To establish competence in mental health counseling, the standards require that counselor training programs integrate into their curricula eight core knowledge-based standards and six specialty standards. The eight core standards are splintered into 67 learning objectives and the six specialty standards into 61 critical knowledge and skill components that must be measured as student learning outcomes (Minton & Gibson, 2012). To further elaborate the complexity, the American Mental Health Counseling Association (AMHCA, 2010) has its own Standards for the Practice of Mental Health Counseling.

The myriad standards mean that counselor educators and counseling students must determine exactly how the 128 CACREP competencies (many of which are clearly unrelated to actually doing counseling) and the AMHCA clinical and training standards together translate into mental health counselor competence. Although meeting this challenge can be intellectually exhilarating, moving from the standards to how mental health counselors should act in the room with clients is far from intuitive.

This article represents an effort to gather evidence-based practice (EBP) principles and describe them in terms of practical behaviors or approaches that contribute to counselor competence and positive client outcomes. Although considering the standards conceptually is necessary and sometimes helpful, the purpose of this article is to present a straightforward EBP model that can be tailored to fit different theoretical orientations and individual counselor styles.

WHAT IS EVIDENCE-BASED MENTAL HEALTH COUNSELING PRACTICE?

Historically, the counseling profession has not had a strong science or research emphasis (Sexton, 2000; Yates, 2013). In fact, a PsycINFO title search of the top five professional counseling journals revealed only 12 articles over the past 15 years that had "evidence-based" or "empirically-supported" in their titles (the journals were *Counselor Education and Supervision*, *Counseling Outcome Research and Evaluation*, *Journal of Counseling and Development*, *Journal of Mental Health Counseling*, and *Journal of Multicultural Counseling and Development)*. In a systematic review, Ray and colleagues (2011) reported that only 1.9% of articles in counseling journals are concerned with outcomes research. No wonder, as Yates (2013) wrote in *Counseling Outcome Research and Evaluation*, "Despite the recommendations for infusing outcome research and evidence-based practices (EBPs) into the counseling profession, there still exists uncertainty and confusion from educators and students about what EBP is" (p. 41).

In some ways it is right and good that professional counselors have a less scientific orientation than related disciplines. After all, mental health counseling evolved, in part, as an alternative to treatments provided by psychologists and psychiatrists (Gladding, 2012). This less rigorously scientific approach may partly explain why the public usually views professional counselors as

more "helpful, caring, friendly, . . . and understanding" than psychologists and psychiatrists (Warner & Bradley, 1991, p. 139). The purpose of this article is certainly not to make a case for professional counselors to become more rigidly scientific but rather to help them embrace practical and relevant scientific research while maintaining a friendly interpersonal style and a wellness-oriented professional identity (Mellin, Hunt, & Nichols, 2011).

Terminology

Like all words, the terms used to describe evidence-based counseling and psychotherapy are linguistic inventions designed to communicate important information. Unfortunately, evidence-based terminology has by now evolved into what might best be described as Babel-esque. Therefore, before outlining an evidence-based mental health counseling model, I look briefly into the politics, history, and usage of evidence-based terminology.

Evidence-based terminology originated in medicine, spilled over into psychology, and from there made its way to professional counseling, education, social work, prevention, business, and nearly every other corner of the first world. Recently I was at a conference where the keynote speaker described *not using purple on PowerPoint slides* as a best practice. Although no doubt the speaker's comments were based on something, I was not convinced that the something had anything to do with scientific research.

In mental health treatment, at least some of the confusion about EBP originated in 1986, when Gerald Klerman, then head of the National Institute for Mental Health (NIMH), remarked in a speech to the Society for Psychotherapy Research (perhaps with irony) that "We must come to view psychotherapy as we do aspirin" (quoted in Beutler, 2009, p. 308). Klerman was promoting the medicalization of psychotherapy as a means to compete for limited health care dollars. He was advocating scientific analysis and application of psychotherapy for specific ailments. The use of aspirin as his medical analogy was ironic because, although the active ingredient in aspirin (acetyl salicylic acid) is well-known, until the early 1980s little was known about how and why aspirin worked—and even today there remain mysteries about its mechanism of action and range of application. However, like aspirin Klerman's comments had a specific effect but also triggered gastrointestinal side effects in some professionals.

Klerman's comments (and the Zeitgeist) inspired Division 12 (the Society of Clinical Psychology) of the American Psychological Association (APA) to form a Task Force on Promotion and Dissemination of Psychological Procedures. This task force was in the business of *promoting psychological procedures* and eventually published guidelines for determining *empirically validated treatments* (APA Task Force, 2006). To be considered empirically validated, treatments had to be (a) manualized and (b) superior to a placebo or other treatment or proven to be equivalent to an established treatment in at least two "good" group design studies or in a series of single-case design experiments conducted by different investigators (Chambless and Hollon, 1998).

The work of Division 12 was extremely controversial. Ronald Fox (1995), a member of APA Division 29 (Psychotherapy), referred to it as "the rape of psychotherapy." The main complaint was about manualizing treatments, because manualization underemphasized the therapy relationship and privileged cognitive-behavioral treatments over all others. After a firestorm of criticism, Division 12 blinked, though barely. The division changed its terminology from *empirically validated* to *empirically supported* treatments but otherwise stayed the course. Empirically Supported Treatment (EST) is now common parlance for the most rigorously tested psychotherapy and counseling approaches.

Though the EST definition has thankfully been consistent, ESTs have proliferated. Division 12 now lists 58 different treatments for numerous mental disorders and medical problems. Although only one EST is available for borderline personality disorder (dialectical behavior therapy), seven are listed for treating depressive symptoms. The proliferation of ESTs has not fragmented mental health treatment but it does continue to undermine the core relationship factors that drive all counseling and psychotherapy approaches.

Over time, new and competing terminology loosened Division 12's tight grip on scientific expectations for ESTs. The new terminology emphasized that determining the effectiveness of counseling and psychotherapy should not look at psychological procedures alone. Although Klerman and Division 12 were keen on the medical-model idea that mental health practitioners should implement specific ESTs, more broad-minded writers and practitioners began using the term "evidence-based practice." This shift drove the conversation toward integrating unique client and unique practitioner characteristics into the evidence-based equation. In 2006, an APA Presidential Task Force (2006) officially defined Evidence-Based Practice (EBP) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273).

As Yates (2013) described it, EBP has three aspects: (a) knowing and understanding current research; (b) the clinician's expertise; and (c) sensitivity to individual clients. EBP implies that effective clinicians thus bring together research knowledge, clinical wisdom and skill, and client sensitivity.

Already this article has highlighted a spaghetti bowl of evidence-related terminology: (a) Empirically Validated Treatment (now a historical footnote); (b) EST (as defined by Division 12); (c) Research Supported Treatment (a more general alternative); (d) Evidence-Based Treatment (an effort to respect diverse forms of scientific evidence, including qualitative data); and (e) EBP (a combination of research knowledge, clinical skill, and client factors). In 2007 the *Journal of Counseling and Development*, ACA's flagship journal, contributed to the terminological confusion by initiating a new section, "Best Practices," a name that soon became used generically. Unfortunately, as illustrated by the "purple" example, since there are no criteria for what constitutes a "best practice," determining what's best has become highly subjective, so the term is often used so inconsistently that it is nearly meaningless—somewhat like competing restaurants each claiming they have the best burger in town. That is why "best practices" is not discussed in this article.

FOUNDATIONS

Before describing the relationally-oriented EBP (ROEBP) model, let me emphasize two domains that serve as a foundation for all competent mental health practice: ethical practice and multicultural sensitivity.

Professional counselors must practice ethically. For mental health counselors this means, at minimum, abiding by the ethical codes of the ACA (2014) and the American Mental Health Counselors Association (AMHCA, 2010). Ponton and Duba (2009) referred to this commitment as a *covenant* professional counselors have with and for their clients, adding, "The covenant promise is made by professionals to society both individually and collectively" (p. 119). Practicing ethically requires that counselors engage in specific behaviors, some of which, such as informed consent, will be discussed later.

Derald Wing Sue and others have discussed how traditional theoretical perspectives must be modified or expanded to address cultural diversity (J. Sommers-Flanagan, Hays, Gallardo, Poyralzi, Sue, & R. Sommers-Flanagan, 2009). Clients should not be expected to adapt to their counselor's theory; rather, counselors should adapt their theory or approach to fit clients (Gallardo, 2013). Although multicultural competence is an ethical mandate, the need to embrace multicultural awareness, knowledge, and skills is also a practical reality. If mental health counselors grounded in the dominant culture are to provide effective treatment for diverse clients, they must make adaptations and engage in specific culturally sensitive behaviors, such as (a) providing services in the client's native language, (b) using self-disclosure and small talk to be more transparent, (c) obtaining a cultural consultation if needed, (d) providing services (e.g., childcare) that make it easier for clients to attend counseling, (e) aligning counseling goals with culturally-informed values, and (f) explicitly incorporating cultural content and cultural values into counseling (see Griner & Smith, 2006; Hays, 2008; Smith, Rodriguez, & Bernal, 2011).

Evidence-Based Counselor Competence

Given the nature of professional counseling and counselor identity, it seems obvious that mental health counselors should embrace a model for counseling competence and EBP that emphasizes therapeutic relationships. That is why the model I propose to enhance positive counseling outcomes considers together both theoretically and empirically supported relationship factors and specific interventions (procedures). As Norcross and Lambert (2011) emphasized, technical (procedural) and relational counseling and psychotherapy components are always interwoven. This led them to conclude that "treatment methods are relational acts" (p. 5).

Fortunately, although most theorists and practitioners do not think of it this way, the inverse is also true: Relational acts are treatment methods. The empirical support linking relationship factors with treatment outcomes is so strong, Norcross (2011) now refers to this phenomenon as empirically-supported or evidence-based relationships.

The reality is that relational acts and treatment methods are so closely interwoven that sometimes it is difficult in counseling to discern which is operating at a given moment (Lambert & Ogles, 2014). Consequently, the following ROEBP behavioral descriptions incorporate both relational and technical components. Some of the behaviors described may seem more abstract or attitudinal than concrete; this offers individual counselors more freedom of interpretation and ease of application. The ROEBP behavior list primarily focuses on evidence-based relationship factors, although these are nearly always teamed with technical procedures.

EVIDENCE-BASED RELATIONSHIP FACTORS

Each mental health counselor will inevitably display therapeutic relational factors in unique ways that may be difficult for other practitioners to replicate, because anything relational or interpersonal is alive, automatically unique, and therefore resists sterile descriptive language. Nevertheless, counselors can implement the following core relational attitudes and behaviors in their own unique manner and still adhere to EBP principles.

Congruence and Genuineness

In mental health counseling, the counselor is the instrument through which treatment is provided. This is probably why Rogers's original core condition of congruence (1957) is still central to counseling efficacy. However, because Natalie Rogers once told me (Sommers-Flanagan, 2007) that she believed very few mental health professionals in the U.S. really understand her father's work, let me make four brief points about congruence:

1. Rogers's three core conditions (congruence, unconditional positive regard, and empathic understanding) are at base attitudinal, not behavioral (Sommers-Flanagan, 2007). Although they manifest as behaviors, learning congruence, positive regard, and empathy skills without embracing the underlying attitudes is counter-productive. To enact these attitudes, counselors should prepare emotionally to be open and honest with clients. Paradoxically, being congruent in ways that facilitate positive outcomes requires more practice and less spontaneity. Congruence should be intentional and consistent with client goals.

2. Congruence implies honesty and openness and is an attitude and a behavior that ideally permeates everything that counselors say and do. D. W. Sue and D. Sue (2013) described counselor openness as especially important for practitioners working with diverse clients: if counselors are not open about who they are, culturally diverse clients may wonder if they will be oppressed in ways in which members of the dominant culture have previously oppressed them.

3. Congruence is especially important for those counseling youth, perhaps because developmentally the youth culture is a different culture

from the adult (Sommers-Flanagan & Bequette, 2013; Sommers-Flanagan & Sommers-Flanagan, 2007). In their extensive meta-analytic study of counseling delivered in school settings, Kolden, Klein, Wang, and Austin (2011) found counselor congruence to be an especially powerful predictor of positive outcomes.

4. For counselors to be optimally effective, congruence and genuineness should be integrated into what might otherwise be considered sterile and bland ethical procedures. For example, I recommend here that counselors use a personalized informed consent process. The reason for this is that clients form first impressions of counselors at or before first contact and these first impressions directly affect the therapeutic relationship. Consequently, competent, and therefore sensitive, counselors will use paperwork that, by conveying authenticity and warmth, facilitates engagement.

The Working Alliance

In 1979, Bordin described the working alliance as a three-dimensional and pan-theoretical therapeutic factor. The three dimensions were (a) forming an emotional bond; (b) counselor-client goal-consensus or agreement; and (c) task collaboration. Researchers have since affirmed that these working alliance dimensions contribute to positive treatment outcomes (Horvath, Re, Flückiger, & Symonds, 2011).

Forming an emotional bond. The formation of a positive emotional bond begins with informed consent, continues in the waiting room and during first impressions, includes creation of a pleasant and comfortable counseling space, and involves specific counselor responses throughout each session, such as empathic reflections, positive strength-based feedback, and validating feelings. It also involves letting clients talk about their problems and the past as they wish—even when the counselor is operating from an approach that typically does not place much value on gathering historical information, such as CBT or solution-focused counseling. For example, Judith Beck (2011) emphasized that cognitive-behavior therapists should talk freely with clients about the past either when the client is stuck or when clients want to talk about the past. This is one of the ways in which relational and technical aspects of counseling merge. For all theoretical perspectives—from existential to reality therapy to CBT—counselors take special care to bond with clients, and part of that bonding involves letting them talk about what they want to talk about.

Counselor-client goal-consensus. Mutual goals are central to all counseling. That is why one of the relational processes that has the most robust empirical support calls for counselors and clients working collaboratively to draw up a goal list on which both agree. All by itself goal-setting is associated with positive behavior change (Latham & Locke, 2006). Adler (see Carlson, Watts, & Maniacci, 2006) emphasized that counselor and client aligning goals was an important early task in counseling.

Goal-consensus or alignment looks different from different theoretical perspectives. In CBT, counselors collaborate with clients to generate a problem list. This approach may be too medical a model or too negative for some counselors. Nevertheless, generating a problem list gives the counselor an opportunity to listen empathically while sorting out client priorities. It also provides an opportunity to transform problems into goals. From a solution-focused perspective, counselors can make a goal list instead of a problem list. However, some clients may be naturally inclined to use problem language, at least early in counseling. Either way, the process should be collaborative and interactive. Collaborative generation of a mutually agreed problem or goal list is an evidence-based approach that all competent counselors should learn to employ, using their own style and theoretical orientation.

Task collaboration. In psychotherapy, tasks and techniques are also referred to as procedures. Later I discuss procedures more thoroughly, but for now, even if counselors are employing a highly relational approach, it is still crucial to engage clients in specific tasks, activities, or procedures that are conceptually linked to solving their problems and achieving their goals. This may be a more implicit process, as when a solution-focused counselor helps clients identify and elaborate on exceptions, or more explicit, as when counselors teach clients how to make decisions using a four-step problem-solving process.

Though engaging clients in therapeutic tasks involves applying specific techniques, it quickly becomes relational. From the evidence-based relationship perspective, which specific procedures to apply is far less important than how they are applied. They must be applied collaboratively:

1. The procedure—such as progressive muscle relaxation, Socratic questioning, or eye movements—must be explained clearly and linked to client goals (a psychoeducation process).

2. Before the procedure is employed in the session, the client gives explicit permission or informed consent (e.g., "Is it okay with you if we try out this progressive muscle relaxation technique?"). This permission-seeking interaction is sometimes referred to as an invitation for collaboration.

3. This part of the relational piece is crucial: after implementing the task or procedure, evidence-based counselors intermittently check in with clients (e.g., "What was your reaction to the role play we just tried?"). This requires sensitivity, empathic listening skills, and reassurance. Again, it makes no difference whether the specific task or procedure is free association (psychoanalytic theory), active listening and encouragement of the emergence of the self (as in person-centered counseling), reflecting as-if (Adlerian counseling), mindfulness meditation (cognitive-based mindfulness therapy), or another option. The point is that the relational activity of working together on a task contributes to positive outcomes.

Unconditional Positive Regard or Radical Acceptance

Originally, Rogers (1957) described unconditional positive regard as the counselor "experiencing a warm acceptance of each aspect of the client's experience" (p. 98). This is, of course, immensely difficult—often impossible. Though unconditional positive regard is easy and natural when counselor and client values are aligned, the competent counselor recognizes that there will be many discrepancies, small or large, between what the counselor thinks is right and what the client thinks is right. I recall a Pakistani Muslim supervisee who reported that hearing people talk about being gay or lesbian made her feel physically nauseated. To her credit, she worked through this (over a period of two years) and was able to embrace an accepting attitude.

I also recall an extremely liberal supervisee who was counseling a young woman shortly after Obama's 2008 election. The supervisee had spent several nights celebrating his election. A few days later she came running (literally) to my office in grave distress: her young female client had just finished a long and disturbing tirade about Obama's election that ended, "I just hope someone assassinates Obama." My "we-should-just-let-everyone-be-themselves" supervisee was frightened by her powerfully judgmental feelings. In both cases, listening with warm acceptance was far from easy but eventually deeply rewarding.

Rogers was so far ahead of his time that his ideas about positive regard and acceptance faded for years, only to return with an empirical and practical vengeance. Now, many therapy approaches explicitly embrace and incorporate positive regard and acceptance (e.g., motivational interviewing, dialectical behavior therapy, and acceptance and commitment therapy). These approaches emphasize not only counselor acceptance of the client but also helping clients come to accept themselves.

In particular, I've found Marsha Linehan's dialectical behavior therapy concept of radical acceptance (1993) very helpful. As someone who has logged many counseling hours with clients whose behaviors are challenging, remembering radical acceptance helps me greet even the most extreme and disagreeable (to me) client statements with a genuine accepting response (usually something like, "Thanks so much for sharing that with me and being so honest about what you think").

There are and should be limits to being accepting in counseling. When speaking of her father, Natalie Rogers made this clear (Sommers-Flanagan, 2007). She noted that although he firmly believed that all feelings and emotions were acceptable, he did not accept all behaviors. This is an important distinction that we have rephrased as "siding with the client's emotion, but not the behavior" (Sommers-Flanagan & Sommers-Flanagan, 2007). Not surprisingly, this takes us to Rogers's third core condition, empathic understanding.

Empathic Understanding

Counselors may be thoroughly familiar with Rogers's ideas about empathy and the robust empirical support for empathy as a contributor to positive coun-

seling outcomes. However, beyond the technical mechanics of communicating empathy by paraphrasing, reflecting feelings, interpretation, and validating feelings (see Sommers-Flanagan & Sommers-Flanagan, 2014), there is a less intuitive aspect of empathy as an evidence-based therapeutic factor.

It turns out that the personal feelings of counselors and how they rate their own empathy are relatively unimportant. What matters is whether and how much clients experience their counselors as empathic. This is a crucial distinction. It is all too easy for all humans—counselors not excepted—to focus on their side of an interpersonal experience. When it comes to whether empathy is a facilitative therapy condition, it is the client's judgment of whether the counselor was empathic that predicts positive outcomes. This is appropriate because when counselor empathy is appraised, what matters most is the client's rating or evaluation. This empirical outcome should help motivate us to consistently focus on the client's experience, not our own.

Rupture and Repair

Getting it wrong is a natural part of life, and counseling. In most counseling situations, there will be empathic misses, poorly timed disclosures, and intermittent disengagement. These should be viewed as inevitable. And as in many other areas of life, tension in the counselor-client relationship offers both danger and opportunity.

The danger is that counselors will ignore, overlook, or be unaware of relationship tensions or ruptures, in which case clients will be more likely to drop out of counseling, with adverse effects on outcomes. But the chance to correct our missteps is an unparalleled therapeutic opportunity. It involves the powerful process of self-correction and refocusing on the client and the counselor-client relationship. This is such a substantial opportunity that Heinz Kohut (1984), who developed self-psychology, considered repair to be the most healing of all therapeutic interventions. Although there are many ways to repair or work through relationship ruptures, there are two overarching approaches:

1. **Acknowledgement and Mirroring:** Acknowledgement involves verbally noticing when clients correct or contradict the counselor. For example, in response to a reflection of anger-focused feeling, the client might say: "I'm really not all that angry about my dad drinking so much; mostly I feel numb." Mirroring involves a verbal correction like, "Okay then, I didn't have that quite right. You feel more numbness than anger. Your response to your dad feels pretty numb."

2. **Apology and Mirroring:** An apology, combined with mirroring empathy, might be more appropriate when a client appears upset about something the counselor said or did. It involves saying something like, "I'm very sorry. I got that wrong. You're not feeling angry at all . . . just pretty darn numb."

In many ways, therapeutic ruptures and repair opportunities are a revisiting of unconditional positive regard. Thus, when there is conflict, dis-

agreement, or client disengagement, counselors are afforded the opportunity to communicate the message that "Although it's not easy, I am committed to hearing what YOU have to say and to trying to understand your perspective so I can help you through your unique personal challenges. Therefore, I will make corrections based on your feedback and subsequently realign myself with what you're experiencing and your counseling goals." This is a critically important message, conveyed through interaction and not verbally, that helps ensure that counselor and client are maintaining their joint focus on healthy and helpful counseling goals.

Managing Countertransference

Thirty years ago Steve de Shazer (1984) not only reported that "resistance" had died as a therapeutic concept, he held a funeral for it in his backyard. Similarly, some counselors and psychotherapists might like to bury the whole idea of countertransference, putting it out of sight, out of mind. However, renaming or ignoring constructs will not make them go away.

Whether or not counselors like or believe in countertransference, the research on it is clear: Sometimes counselors have emotional and behavioral reactions to clients. Sometimes these reactions may have more to do with the counselor than the client. This is a broad and general definition of countertransference.

Counselors have been found to be more effective when they are aware of and deal with their own unresolved emotional and behavioral reactions (Hayes, Gelso, & Hummel, 2011). Personal counseling or psychotherapy, clinical supervision, participation in peer supervision groups—such practices can help counselors become aware of and gracefully work through their countertransference reactions.

Implementing In- and Out-of-Session Procedures

Consistent with the medical model, proponents of ESTs and EBP emphasize the importance of employing specific psychological or behavioral procedures with clients. Among empirically supported procedures are relaxation, exposure, behavioral activation, and problem-solving (Sommers-Flanagan & Sommers-Flanagan, 2012). Some procedures, such as eye movement desensitization reprocessing (EMDR), also have significant empirical support even though it is not clear whether the eye movements themselves or other parts of the tightly controlled EMDR protocol are the "active" ingredients.

As noted, in many or most cases it may not be the procedures themselves that effect change. It may simply be the counselor and client working together to move the client toward positive personal goals. However, as articulated elsewhere, procedures grounded in theory, even indirect procedures like free association, are integral to counseling and inseparable from the therapeutic relationship (Sommers-Flanagan & Sommers-Flanagan, 2012). Often, engaging in procedures together not only gives counselors and clients something to

do (important in a doing-oriented culture) but simultaneously deepens the alliance and provides valuable assessment information.

As behaviorists would be eager to explain, if generalizing learning outside of individual counseling sessions is important, then counselors should not only use procedures during sessions but also engage clients in out-of-session homework. Not surprisingly, research outcomes are consistent with this behavioral mantra. Counselors who strive to embrace EBP principles will offer clients homework assignments that are evidence-based or theoretically supported; perhaps even more important, though, client homework should also be meaningful and doable.

Progress Monitoring

Progress monitoring (PM) is a relatively new phenomenon on the evidence-based scene. PM is robustly related to positive outcomes and relatively easy to apply (Meier, 2015). Although it is not covered by many professional counseling publications, all practicing counselors should integrate some form of PM into their practice.

PM simply means that, formally or informally, counselors consistently check with clients about how things are going. Data from empirical studies consistently show, however, that practitioners who use formal PM rating scales tend to have both more favorable outcomes and fewer negative outcomes or treatment failures (Meier, 2015). From a relationally-oriented counseling perspective, though, using a specific process or outcome measure (e.g., the Session Rating Scale) is likely less important than working collaboratively with clients to determine whether they perceive the counseling process and procedures to be helpful.

CONCLUDING COMMENTS

Mental health counselors can and should integrate evidence-based approaches into their practice. Although it might be useful for counselors to seek training in ESTs, embracing evidence-based relationships as a core component of counselor competency is more consistent with professional counselor identity. The purpose of making this distinction, and providing the information in this article, is to advocate for an alternative evidence-based identity—one that counselors can more wholeheartedly embrace.

In this article I focused on nine relational factors that are empirically linked to positive counseling outcomes. This is only a beginning. Research will continue. For space reasons I neglected several dimensions of counselor-client relational interactions that are consistent with professional counselor identity. For example, other than a brief discussion of PM, I did not address the potential merits and problems of formal assessment. In the future I would hope for a more distinct assessment model that specifies how counselors interact with clients, emphasizing transparency and collaboration. But that discussion must wait for another day. Until then, I wish you all the best as you incorporate relationally-oriented evidence-based counseling principles into the exceptionally important services you provide.

REFERENCES

American Counseling Association (2014). *ACA Code of Ethics*. Alexandria, VA: Author.

American Mental Health Counselors Association. (2010). *Code of ethics*. Retrieved from www.amhca.org/assets/news/AMHCA_Code_of_Ethics_2010_w_pagination_cxd_51110.pdf

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271–285.

Beck, J. S. (2011). *Cognitive behavioral therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Beutler, L. E. (2009). Making science matter in clinical practice: Redefining psychotherapy. *Clinical Psychology: Science and Practice*, *16*, 301–317.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*, 252–260. doi:10.1037/h0085885

Carlson, J., Watts, R. E., & Maniacci, M. (2006). *Adlerian therapy: Theory and practice*. Washington, DC: American Psychological Association. doi:10.1037/11363-000

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting & Clinical Psychology*, *66*, 7–18.

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 standards*. Retrieved from http://www.cacrep.org/

de Shazer, S. (1984). The death of resistance. *Family Process, 23*, 79–93.

Erickson, M. H. (1964). The confusion technique in hypnosis. *American Journal of Clinical Hypnosis, 6*, 183–207.

Fox, R. E. (1995). The rape of psychotherapy. *Professional Psychology: Research and Practice*, *26*, 147–155.

Gallardo, M. E. (2013). Context and culture: The initial clinical interview with the Latina/o client. *Journal of Contemporary Psychotherapy*, *43*, 43–52.

Gladding, S. T. (2012). *Counseling: A comprehensive profession* (6th ed.). New York: Pearson.

Griner, D., & Smith, T.B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy*, *43*, 531-548.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 239–258). New York, NY: Oxford University Press.

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association, Washington, DC. doi:http://dx.doi.org/10.1037/11650-000

Horvath, A. O., Re, A. C. D., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 25–69). New York, NY: Oxford University Press.

Kohut, H. H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.

Kolden, G. G., Klein, M. H., Wang, C., & Austin, S. B. (2011). Congruence/genuineness. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 187–202). New York, NY: Oxford University Press.

Lambert, M. J., & Ogles, B. M. (2014). Common factors: Post hoc explanation or empirically based therapy approach? *Psychotherapy*, *51*, 500–504.

Latham, G. P., & Locke, E. A. (2006). Enhancing the benefits and overcoming the pitfalls of goal setting. *Organizational Dynamics*, *35*, 332–340. doi:10.1016/j.orgdyn.2006.08.008

Linehan, M. (1993). *Cognitive behavioral therapy of borderline personality disorder*. New York, NY: Guilford Press.

Meier, S. T. (2015). *Incorporating progress monitoring and outcome assessment into counseling and psychotherapy: A primer*. New York, NY: Oxford University Press.

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling and Development*, *89*, 140–147.

Minton, C. A. B., & Gibson, D. M. (2012). Evaluating student learning outcomes in counselor education: Recommendations and process considerations. *Counseling Outcome Research and Evaluation*, *3*, 73–91.

Norcross, J. C. (Ed.). (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.,). New York, NY: Oxford University Press.
Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*, 4–8. doi:10.1037/a0022180
Ponton, R. F., & Duba, J. D. (2009). The ACA Code of Ethics: Articulating counseling's professional covenant. *Journal of Counseling and Development, 87*, 117–121.
Ray, D. C., Hull, D. M., Thacker, A. J., Pace, L. S., Swan, K. L., Carlson, S. E., & Sullivan, J. M. (2011). Research in counseling: A 10-year review to inform practice. *Journal of Counseling & Development, 89*, 349–359.
Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.
Sexton, T. L. (2000). Reconstructing clinical training: In pursuit of evidence-based clinical training. *Counselor Education and Supervision, 39*, 218–227. doi:http://dx.doi.org/10.1002/j.1556-6978.2000.tb01234.x
Smith, T. B., Rodríguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology, 67*, 166–175.
Sommers-Flanagan, J. (2007). The development and evolution of Person-Centered Expressive Art Therapy: A conversation with Natalie Rogers. *Journal of Counseling and Development, 85*, 120–125.
Sommers-Flanagan, J., & Bequette, T. (2013). The initial interview with adolescents. *Journal of Contemporary Psychotherapy, 43*, 13–22.
Sommers-Flanagan, J., Hays, P., Gallardo, M., Poyrazli, S., Sue, D. W., & Sommers-Flanagan, R. (2009, August). *The initial interview: Essential principles and techniques with diverse clients.* Symposium presented at the annual meeting of the American Psychological Association, Toronto, Ontario.
Sommers-Flanagan, J., & Sommers-Flanagan, R. (2007). *Tough kids, cool counseling: User-friendly approaches with challenging youth* (2nd ed.). Alexandria, VA: American Counseling Association.
Sommers-Flanagan, J., & Sommers-Flanagan, R. (2012). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (2nd ed.). Hoboken, NJ: Wiley.
Sommers-Flanagan, J., & Sommers-Flanagan, R. (2014). *Clinical interviewing* (5th ed.). Hoboken, NJ: Wiley.
Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.
Warner, D. L., & Bradley, J. R. (1991). Undergraduate psychology students' views of counselors, psychiatrists, and psychologists: A challenge to academic psychologists. *Professional Psychology: Research and Practice*, 22, 138–140. doi:http://dx.doi.org/10.1037/0735-7028.22.2.138
Yates, C. (2013). Evidence-based practice: The components, history, and process. *Counseling Outcome Research and Evaluation, 4*, 41–54.