

# Evidence-Based Relationship Factors: A New Focus for Mental Health Counseling Research, Practice, and Training

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**Kimberly K. Parrow**  
**John Sommers-Flanagan**  
**J. Sky Cova**  
**Hugo Lungu**

*Counselor educators and mental health counselors often have a lukewarm attitude toward counseling research and evidence-based practice. This attitude may be because of a perceived mismatch between evidence-based technical procedures and the relational orientation that most counselors value. To warm up mental health counselors' attitudes toward evidence-based research and practice, we propose a relationally oriented research agenda that focuses on integrating evidence-based relationship factors (EBRFs) into counselor training and practice. Eight EBRFs are defined and operationalized, and specific counselor behaviors are described. Reframing and refocusing counseling research on relational variables has the potential to support current counseling practices and inspire development of a counseling-specific research base. Recommendations for a rapprochement between counselor education research and mental health counseling practice are offered, including a list of brief measures that mental health counselors could introduce into their counseling practice.*

Counselor educators have sometimes criticized the rigor of their own research training (Fong & Malone, 1994; Galassi, Stoltz, Brooks, & Trexler, 1987). In fact, David Kaplan (2009), former chief professional officer of the American Counseling Association, once proposed that counselor education programs discontinue empirical research pursuits. Kaplan (2009) noted that counselors and counseling students often have low interest in research, weak motivation to conduct research, and minimal research training. Counseling researchers have also lamented (a) the paucity of counselor education outcomes research (Ray et al., 2011) and (b) the lack of knowledge about evidence-based practice within the counselor education profession (Yates, 2013).

Given this context, it is not surprising that many practicing mental health counselors have ambivalent feelings toward research and a lukewarm attitude

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*Kimberly K. Parrow, Department of Counselor Education, The University of Montana; John Sommers-Flanagan, Department of Counselor Education, The University of Montana; J. Sky Cova, Department of Counselor Education, The University of Montana; Hugo Lungu, Department of Counselor Education, The University of Montana.*

*Correspondence concerning this article should be addressed to John Sommers-Flanagan, College of Education and Human Sciences, University of Montana, Room 111, Missoula, MT 59812. E-mail: john.sf@mso.umt.edu*

toward evidence-based practice. Additionally, mental health counselors may be less enthusiastic about evidence-based approaches because evidence-based approaches are often, as Hatchet (2017) noted, conflated with empirically supported technical procedures: “A strong emphasis on the counseling relationship is also more congruent with the philosophical underpinnings of the counseling profession than the EST [empirically supported treatment] medical model” (p. 111). Capuzzi and Stauffer (2016) also emphasized that professional counselors focus on therapeutic relationship as the vehicle through which “client change occurs” (p. 4).

The perspectives of Hatchet (2017) and Capuzzi and Stauffer (2016) are consistent with the opening words from the Vision 20/20 consensus definition of counseling: “Counseling is a professional relationship” (Kaplan, Tarvydas, & Gladding, 2014, p. 366). Valuing and focusing on the therapeutic relationship is an orientation that uniquely distinguishes professional counseling from other professional disciplines (Kottler & Balkin, 2017). As Sommers-Flanagan (2015) wrote, “Relational acts are treatment methods” (p. 99).

Notwithstanding the lamentations regarding the insufficient state of counselor education research, some counselor educators have shared their passion for research (Guiffrida & Douthit, 2010). Others have offered recommendations for an evidence-based counselor education research agenda (Yates, 2013). Specifically, Guiffrida and Douthit (2010) recommended that “the counseling profession would be well advised to develop and foster a research genre ... reflective of counseling’s core values” (p. 23). Given that the therapeutic relationship is at the heart of mental health counseling, it makes logical sense to reframe and refocus counseling research, training, and practice on relationship factors in counseling.

To stimulate research productivity and to inspire mental health counselors to embrace the counseling relationship as evidence based, this article has three primary goals:

1. Define evidence-based relationship factors (EBRFs) and place them in their appropriate historical context.
2. Define and describe therapeutic relationship factors (i.e., EBRFs) that already have significant research support.
3. Describe a general counselor education research agenda and specific ways in which mental health counselors can collect practice-based evidence to support EBRF research.

### **WHAT ARE EVIDENCE-BASED RELATIONSHIP FACTORS?**

Most mental health counselors are aware of the push to use empirically supported approaches in counseling and psychotherapy, partly because doing so is advised in the American Counseling Association’s (2014) and American Mental Health Counselors Association’s (2015) ethical codes. These approaches, collectively referred to as empirically supported treatments, are manualized and largely consist of cognitive-behavioral therapies (Blankenship,

2017). In contrast, mental health counselors are less aware of research suggesting that the counseling relationship includes measurable factors that are roughly equivalent or superior to technical procedures in predicting positive outcomes (Wampold & Imel, 2015). To emphasize the research-based equivalency of therapeutic relationship factors, Norcross (2002) described them as “empirically supported therapy relationships” (p. 3).

EBRFs are similar to, but different from, microskills. Microskills are specific counseling skills (e.g., questions, paraphrases) that are taught in individual units and “later integrated into meaningful gestalts” (Ivey & Authier, 1978, p. 9). Although microskills are conceptually related to counseling outcomes, individual microskills, practiced separately, have not been explicitly linked to positive outcomes (Ridley, Mollen, & Kelly, 2011). For example, although the stand-alone microskill of paraphrasing may be a part of what contributes to therapeutic relationship development and positive outcomes, mastering and using paraphrasing alone is not viewed as an evidence-based practice.

EBRFs are measurable relationship factors that are, by definition, empirically linked to positive counseling and psychotherapy outcomes. Historically, EBRFs were a subset of nonspecific factors in psychotherapy (Lambert & Ogles, 2014). Nonspecific factors are interactions or experiences occurring during counseling or psychotherapy that contribute to positive outcomes but that (a) are not theoretically distinctive and (b) are not directly measured or monitored in outcomes research. Early on, Ziskind (1949) referred to nonspecific factors as “unknown” factors that had “evaded definitive analysis” (p. 285).

After decades of counseling and psychotherapy research, most researchers, theorists, and practitioners have shifted away from using the term *nonspecific factors*, referring instead to *common factors* (Lambert, 1992; Wampold & Imel, 2015). Common factors are pan-theoretical and are believed to account for why many different approaches to counseling all produce positive outcomes (Luborsky, Singer, & Luborsky, 1975). Many different common factors exist (Frank, 1961; Lambert, 1992). For example, Grencavage and Norcross (1990) reviewed 50 studies and identified 89 common factors.

Although common factors remain a focus of research and practice, EBRFs are a unique subset of common factors, especially pertinent to mental health counseling. As Lambert (1992) described in his review of therapeutic factors, some common factors do not primarily involve the counselor–client relationship. For example, positive expectations, extra-therapeutic factors, and specific techniques are all common factors, but they do not require relational interactions. However, as is obvious in most therapeutic situations, relational interactions can activate (or suppress) the non-relational common factors (i.e., client expectations, access to extra-therapeutic factors, and effectiveness of specific technical interventions). Overall, EBRFs can be separated from other common factors in three ways. First, EBRFs are not nonspecific; they have been, to some extent, operationalized and measured. Second, EBRFs are not



uniformly common to all counseling approaches. Third, EBRFs are distinctly relational.

To promote integration of EBRFs into mental health counseling research, practice, and training, in the following section, we review eight EBRFs. Each EBRF is defined. Concrete examples of how they work in counseling practice are also provided.

### EIGHT EVIDENCE-BASED RELATIONSHIP FACTORS AND THEIR BEHAVIORAL MANIFESTATIONS

The EBRFs included in this review are (1) congruence, (2) unconditional positive regard (UPR), (3) empathic understanding, (4) cultural humility, (5) the working alliance (i.e., the tripartite dimensions of positive emotional bond, goal consensus, and task collaboration), (6) rupture and repair, (7) countertransference, and (8) progress monitoring (PM). Although these EBRFs all have research support, in some cases the support is more conclusive (e.g., empathy), and in other cases the support is less conclusive (e.g., cultural humility).

#### *Congruence (Authenticity)*

Relationship factors in counseling naturally begin with person-centered core conditions (Rogers, 1957, 1961). Although it is tempting to simply advise counselors to “act like Carl Rogers,” over 70 years of research and theoretical development have more precisely specified how counselors can exhibit congruence, UPR, and empathic understanding. Specifically, research on core conditions includes empirical evidence that empathy and positive regard are demonstratively effective, with congruence identified as probably effective (Kirschenbaum & Jourdan, 2005; Norcross & Lambert, 2018).

Rogers (1961) defined congruence as occurring “when the psychotherapist [counselor] is what he [sic] is, when in the relationship with his client he is genuine and without ‘front’ or façade, openly being the feelings and attitudes which at the moment are flowing *in him*” (Rogers, 1961, p. 61; emphasis in original). Congruence requires self-awareness and open expression, sometimes involving self-disclosure.

Counselor manifestations of congruence should not be mysterious or opaque, but instead ostensibly visible to clients. Two technical strategies for being congruent include (1) acknowledgment of reality (Sommers-Flanagan & Sommers-Flanagan, 2017) and (2) counselor immediacy (Young, 2017). Acknowledging reality may be as simple as an opening statement that takes note of obvious relationship dynamics and invites genuine client responses: “I know we’re meeting for the first time. We don’t know each other, and that can feel awkward at first.” Immediacy occurs when counselors speak about something happening in the here and now of a session. It might include a self-disclosure statement such as “I feel sad as you talk about the pain of losing your husband.” Although immediacy has been labeled a microskill, immediacy and

acknowledgment of reality are both specific examples of how mental health counselors strive to hold an overarching attitude of authenticity.

### ***Unconditional Positive Regard***

Rogers (1961) described UPR as “the extent that the therapist finds himself [*sic*] experiencing a warm acceptance of each aspect of the client’s experience ... [I]t means there are no conditions of acceptance ... It means a ‘prizing’ of the person [and] ... a caring for the client as a separate person” (p. 98). UPR involves counselors communicating to clients that they are accepted for who they are (Rogers, 1957). As W. R. Miller and Rollnick (2013) described, when clients feel accepted for who they are, they are more able to focus on personal change. Researchers from various theoretical stances have affirmed that UPR facilitates client change (Suzuki & Farber, 2016).

UPR involves the mental health counselor’s display of interest and respect toward clients, who in turn must perceive and judge the display accordingly; therefore, identifying concrete examples of UPR is challenging. Different clients will consider different counselor behaviors as representing UPR. Most counselor training texts recommend that UPR be communicated indirectly. For example, counselors-in-training are instructed to avoid making direct UPR statements like “I prize you as a separate and valuable person” (Sommers-Flanagan & Sommers-Flanagan, 2017).

UPR involves treating clients as independent beings whose emotions and perspectives are of intrinsic value. UPR requires that counselors show interest in and validate their clients’ unique experiences. Despite Rogers’s avoidance of questioning, one way that contemporary counselors show UPR is to use open questions (or prompts) to ask clients to elaborate on their emotionally important and meaningful experiences. Questioning can be used as part of a session summary (e.g., “What stands out to you as most important from our session today?”) or as part of a second or third session opening (e.g., “What do you remember from our last session that seemed important to you?”). To facilitate UPR, open questions should focus on session content that has significant emotional meaning to clients.

Another UPR technical behavior involves counselors asking clients for permission (W. R. Miller & Rollnick, 2013). This could involve counselors asking clients for permission to give feedback or try a therapeutic task/activity. After asking permission, counselors further display UPR when they listen carefully and responsively to client reactions. A counselor might say, “You’ve talked about conflicts with your romantic partner. It might be useful for us to brainstorm different ways to respond. Would you be willing to do some brainstorming with me?” Again, although learning to use questions is part of microskills training, using questions to intentionally express respect and invite collaboration can communicate interest and respect (Sommers-Flanagan & Sommers-Flanagan, 2017).

## *Empathic Understanding*

Rogers (1957) defined empathic understanding as the ability “to sense the client’s private world as if it were your own, but without ever losing the ‘as if’ quality” (p. 99). Empathic understanding facilitates the therapeutic alliance; empathy is considered a robust predictor of positive counseling outcomes (Elliott, Bohart, Watson, & Greenberg, 2011). Some writers have claimed that because effective counseling always involves an effort to experience and express an understanding of clients, all effective interventions must include at least some degree of empathy (Sommers-Flanagan & Sommers-Flanagan, 2017).

Empathic responding is multidimensional. Empathy includes but is not limited to (a) emotional mirroring, (b) cognitive perspective taking, and (c) emotional regulation and expression (Elliott et al., 2011). Empathic counselors use their emotions, along with voice tone, facial expressions, and words, to convey to clients that they “sense” what clients are feeling (Clark, 2010). For example, when clients are experiencing and expressing sadness, empathic counselors often feel sadness too, in a way described as *emotional mirroring*. Additionally, empathic counselors can take on their client’s cognitive perspective, making statements like “When I hear you talk about your father’s criticism of your sexuality and I imagine myself in your shoes, I feel rejected and ashamed. I wonder if that’s some of what you felt and still feel now?” Elliot et al. (2011) noted that mirroring client emotions and taking on client perspectives naturally activate counselor emotions. Consequently, to provide an empathic response, some degree of counselor emotional self-regulation is needed.

Researchers and practitioners have identified three primary empathic responses: (1) reflection of feeling, (2) interpretive reflection of feeling, and (3) feeling validation (Egan, 2014; Sommers-Flanagan & Sommers-Flanagan, 2017; Young, 2017). Reflection of feeling occurs when counselors notice and restate client surface emotions. For example, when clients begin crying, counselors might say, “You’re feeling sad right now.” Feeling reflections are uncomplicated and communicate recognition and appreciation for client emotional states.

Interpretive reflections of feeling may focus on underlying emotions. Egan (2014) referred to this counselor response as “advanced empathy” (p. 182). Advanced empathy (a.k.a. interpretive reflection of feeling) occurs when counselors reflect feelings/emotions that may lie underneath the client’s more obvious speech content or surface emotions. If a client nonverbally shows anger through clenched fists, but does not verbally express it, the counselor might say, “As you speak, I also see some anger.”

Feeling validation is defined as an emotionally oriented counselor response that goes beyond simple reflection to validate client emotions as natural or normal. In contrast, reflective empathic responses are prototypically nonjudgmental; counselors act as mirrors, reflecting the emotion, without judging it as good, bad, normal, or abnormal. However, using feeling validation, many counselors also use empathy to affirm their clients’ emotional expe-



riences (Sommers-Flanagan & Sommers-Flanagan, 2017). To a crying client, a counselor might state, “It seems perfectly natural for you to feel sad right now.”

### **Cultural Humility**

Cultural humility includes three interpersonal dimensions: (1) an other-orientation instead of a self-orientation, (2) respect for others and their values, and (3) an attitude of non-superiority (Hook, Davis, Owen, Worthington, & Utsey, 2013). Cultural humility has research support. Clients who viewed as counselors higher in cultural humility rated the counselor–client alliance higher and perceived their outcomes as better (Davis et al., 2016; Hook et al., 2013).

Counselors who exhibit multicultural humility address cultural diversity with sensitivity and respect. This sensitivity and respect includes broaching multicultural differences. *Broaching* is defined as the ability of a counselor to recognize the potential influence of sociopolitical factors on the client’s experience and to display behaviors that invite clients to openly discuss issues of ethnicity, race, and culture (Day-Vines et al., 2007). For example, when working with a Native American client, a counselor might say, “I’m interested in knowing more about you and your culture and anything about you and your culture that you think might be important in our work.” Although limited, evidence exists for the positive influence of broaching on the counseling relationship (Burkard, Knox, Groen, Perez, & Hess, 2006; Choi, Mallinckrodt, & Richardson, 2015; Day-Vines et al., 2007).

Culturally humble counselors also acknowledge gaps in their knowledge and ask clients for relevant information. For example, a counselor working with a Latino man who was drinking heavily might ask, “I’ve heard that sometimes the concept of ‘machismo’ is related to Latino men using alcohol, but I don’t know if that’s true for you. What would you say about that?” When counselors acknowledge limits in their cultural knowledge, the counseling alliance and outcomes may be more positive.

Counselors with attitudes of cultural superiority are likely to have more counseling dropouts, a poorer working alliance, and less positive outcomes (Hook et al., 2013; Sue & Sue, 2016). Counselors with attitudes of cultural superiority hold beliefs that their cultural way of being is preferable or superior. For example, a counselor with an individualistic cultural orientation might insist that clients with collectivist orientations set individual goals in session. In other words, counselors who overcome their conscious or unconscious tendency to operate as if their cultural perspectives are superior create stronger working relationships and have better outcomes with clients who are culturally diverse (Hook et al., 2013). Although it is often difficult to operationalize what “acting culturally superior” looks like, counselors who are culturally humble tend to (a) show respectful interest in their clients’ cultural diversity; (b) be open-minded and accepting of cultural, sexual, and religious diversity; (c) offer research-based advice tentatively; and (d) avoid pairing advice with self-disclosure (Sommers-Flanagan & Sommers-Flanagan, 2017).

## *The Working Alliance*

Originally a psychoanalytic construct (Zetzel, 1956), the working alliance was later redefined as a tripartite, pan-theoretical therapeutic factor (Bordin, 1979), including three distinct dimensions: (1) positive emotional bond, (2) goal consensus, and (3) task collaboration.

**Positive emotional bond.** Horvath and Bedi (2002) defined a positive emotional bond as “the positive affective bonds between client and therapist, such as mutual liking, respect, and caring” (p. 41). In contrast to Rogerian core conditions, the emotional bond is bidirectional and exclusively focuses on positive affect. The counselor–client bond can look similar to a healthy and secure attachment relationship. It might include an increased sense of security when two people are in proximity, a positive anticipation of meeting, and feelings of comfort associated with thinking of the attachment figure (Bowlby, 1988).

Many different counselor behaviors can communicate or promote positive emotional bonds. These include, but are not limited to, (a) warm greetings from the counselor; (b) counselor statements that express positive feelings, like “I’m glad you’re here” or “I look forward to working with you”; (c) positive nonverbal expressions such as smiling and handshakes (when appropriate); and (d) in-session activities (e.g., deep breathing, mindfulness, progressive muscle relaxation) that involve self-soothing or relaxation (Horvath, Del Re, Flückiger, & Symonds, 2011).

**Goal consensus.** Alfred Adler identified “goal alignment” as essential to effective psychotherapy (Carlson & Englar-Carlson, 2017). Empirical research has affirmed Adler’s proposition (Tryon & Winograd, 2011). Goal consensus is defined as “consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached” (Horvath & Bedi, 2002, p. 41). Goal consensus includes an explicit discussion of the client’s goals for counseling, agreement to work on accomplishing these goals, and identification of specific goal-related behaviors that might be associated with counseling.

Regardless of theoretical orientation, mental health counselors can and should engage in behaviors that explicitly focus on client problems and/or goals at the beginning, middle, and end of counseling. This process starts with informed consent and continues to the termination session. Goal consensus and continuous tracking of how well the treatment plan fits client goals are so robust that they are written into the AMHCA’s (2015) ethical code.

Informed consent and intake forms may be used to initiate goal collaboration. Counselors who specifically elicit clients’ concerns are likely to enter into a collaborative goal formulation process. Additionally, during an initial or intake interview, counselors should formally open the session using prompts like “What are the concerns that bring you to counseling?” “If we have a successful meeting, what will we accomplish?” or “Let’s talk about what you would like to achieve in counseling” (Sommers-Flanagan & Sommers-Flanagan, 2017).



Beyond initial sessions, checking in on client perceptions of counseling process/progress is beneficial. Counselors might ask, “Does it feel like the work we’re doing is on track?” Even after goals are identified, it is not unusual for clients to ramble off topic and into storytelling. Given the research, counselors should regularly check in to make sure that session content is consistent with mutually identified goals.

**Task collaboration.** Task collaboration is a process where both parties engage in counseling tasks that are relevant and helpful in moving clients toward identified goals. Frank (1961) viewed task collaboration as engaging in a culturally sanctioned ritual that both counselor and client believe will facilitate improvement. Consistent with Frank (1961), mental health counseling tasks should be interesting, relevant, and culturally sanctioned. Counselors who engage in task collaboration adjust assigned tasks to align with client preferences, expectations, and cultural context (Arnd-Caddigan, 2012).

When engaging in task collaboration, counselors use a joint process to determine and enhance client participation. For example, a menu of potential tasks might be described, followed by a request for client feedback: “We’ve talked about several methods for relaxation. Which one fits best for you?”

Task collaboration also involves therapeutic debriefing. Debriefing prompts include “What’s your reaction to the feedback I just shared with you?” “How did practicing mindfulness go this past week?” or “What thoughts and feelings came up as we discussed the repeating themes and patterns in your romantic relationships?”

### ***Relationship Ruptures and Rupture Repair***

Safran and Muran (1996) defined ruptures as “[p]atient behaviors or communications that are interpersonal markers indicating critical points in therapy for exploration” (p. 447). Ruptures are also called *strains* (Bordin, 1979), *impasses* (Elkind, 1994), or *resistance* (Leahy, 2001). Previous researchers have noted that relationship ruptures between counselor and client are linked to negative outcomes and clients dropping out of counseling (Safran, Muran, & Eubanks-Carter, 2011). Also, training in relational rupture repair has been reported as an effective means of improving counseling outcomes (Safran et al., 2011).

Researchers have identified two rupture subtypes: confrontation and withdrawal. Confrontation occurs when clients directly express anger or dissatisfaction with counseling or the counselor; withdrawal occurs when clients emotionally or cognitively disengage from the counseling process (Safran & Muran, 1996). Both rupture types often involve small exchanges (rupture markers) that signal reduced alliance quality. Ruptures provide opportunities to clarify client interpersonal patterns across relationships (Safran et al., 2011).

The first step in rupture repair involves verbally noticing client confrontation or withdrawal behaviors (e.g., “I notice you seem more quiet than usual. Is there anything between us that you’d like to talk about?”). Ruptures can be related to counselor rigidity. Consequently, one useful counselor response is

to show flexibility. If a client becomes quiet or expresses irritation, it may be important to explicitly express openness to changing therapeutic direction.

Mental health counselor options for dealing with alliance ruptures include (a) repeating the therapeutic rationale, (b) changing counseling tasks or goals, (c) clarifying misunderstandings, and (d) exploring relational themes (Safran et al., 2011; Sommers-Flanagan & Sommers-Flanagan, 2017). Behaviors that facilitate repair typically signal to clients that their counselor is open to hearing about disappointment or frustration with counseling. Specifically, when clients are welcomed to assert their differing perspectives and the counselor responds non-defensively and validates the client's experience, relational connection is deepened (Safran et al., 2011).

### *Countertransference*

Freud originally described countertransference as a part of the inner experience of the analyst. He postulated that unresolved, unconscious feelings within the analyst diminished objectivity, posed a threat to treatment, and thus should be avoided (Friedman & Gelso, 2000; Hayes, Gelso, Hummel, & Hilsenroth, 2011). Throughout the subsequent decades, countertransference morphed to include any conscious reactions to transference, clients, and other therapeutic situations (Friedman & Gelso, 2000, Tishby & Wiseman, 2014). Currently, definitions of countertransference range from the original narrow view of unconscious, unresolved responses to a broad, totalistic view including all feelings, thoughts, and behaviors (Tishby & Wiseman, 2014). Further, in spite of its potential danger to counseling, countertransference is now considered natural, unavoidable, and potentially helpful to case formulation (Friedman & Gelso, 2000; Hayes et al., 2011).

Countertransference has become a pan-theoretical construct. When mental health counselors of all theoretical orientations develop awareness of their countertransference, they are more likely to minimize the threat countertransference can impose on the therapeutic process. Further, researchers have found that countertransference awareness and management reduce countertransference reactions and may improve outcomes (Hansen, 1997; Hayes et al., 2011).

To address countertransference, mental health counselors need to be open to and aware of the possibility that their reactions to clients can adversely affect the counseling process and outcome. Beyond awareness, counselors also regularly seek consultation and/or supervision to address their countertransference. Supervision can also prompt an examination of hidden manifestations of countertransference and normalize the experience of suppressed feelings toward clients (Hansen, 1997). Additionally, when addressing countertransference, mental health counselors "own" their reactions in way that are not blaming of clients. Based on a meta-analysis, Hayes et al. (2011) suggested that counselors and psychotherapists can mitigate their countertransference reactions by improving empathic ability, engaging in self-care, being open to insights about themselves, and acknowledging reactions and mistakes.

### ***Progress Monitoring***

Consistent with the preceding seven EBRFs, PM requires that counselors check in with their clients to determine if the counseling process and progress are adequately meeting client expectations. To some extent, every EBRF involves PM, because clients are the best experts on their counseling experiences. PM integrates client feedback into counseling, regardless of counselor theoretical orientation (Meier, 2015). Although PM has characteristics similar to previously described EBRFs, research on PM as a separate relational factor in counseling is voluminous, and evidence demonstrating its association with positive outcomes is robust.

Researchers have labeled PM a “demonstrably efficacious” treatment practice (Feinstein, Heiman, & Yager, 2015; Shaw & Murray, 2014). As counselors monitor client progress, clients offer feedback about relational issues and technical procedures. Client feedback can then be used to guide modifications in relationship interaction and techniques employed.

The most straightforward counselor-related PM behaviors involve regular and ongoing use of formal PM measures (e.g., the Outcome Rating Scale and Session Rating Scale; S. D. Miller, Duncan, Sorrell, & Brown, 2005). Informal PM may consist of regularly using questions or prompts, such as “Are we focusing on what you want to focus on in our sessions?” or “Let’s check back in on our goals today.” PM is linked to client reports of wellness and positive outcomes (Feinstein et al., 2015).

Given that a wellness focus is consistent with professional identity in counselor education, obtaining client feedback on wellness is a unique way mental health counselors can monitor progress. Wellness questions might include “On a scale of 0 to 10, with 10 representing the best you could possibly feel, how would you rate yourself today?” Additionally, goal attainment scaling fits with a goal-oriented client feedback system (Lewis, Larson, & Korcuska, 2017).

Individually, the EBRFs presented here are identifiable and measurable constructs, each with its own growing research base. Although more research is needed to deepen our understanding of exactly how EBRFs manifest in counseling and how they exert a positive influence on outcomes, to date, the EBRFs reviewed here are significantly linked to positive therapeutic outcomes. As a whole, the eight EBRFs represent a comprehensive research agenda for counseling as counseling professionals continue to anchor our identity in the counseling relationship.

### **BRINGING EVIDENCE-BASED RELATIONSHIP FACTORS INTO COUNSELOR EDUCATION RESEARCH, TRAINING, AND PRACTICE**

Quantitative and qualitative study of EBRFs and their relationship to counseling process and outcomes is an elegant fit for a future counselor education research agenda (Sommers-Flanagan, 2015; Yates, 2013). Although some counselor educators already conduct EBRF research (Davis et al., 2016), EBRFs



have not been formally or informally identified as a core research or practice domain for professional counselors. For example, a search for “evidence-based” in the abstracts of the *Journal of Mental Health Counseling* from 1990 to the present revealed 14 hits, only two of which referred to evidence-based therapeutic relationship factors (Hatchett, 2017; Sommers-Flanagan, 2015). As a relatively young discipline, counselor education in general and mental health counseling in particular stand to benefit from a more intentional and focused research agenda. Without such an agenda, counselor educators may limit their influence in the broader community of mental health professionals.

Counselor education literature focusing on EBRFs may be limited for a number of reasons, including the tendency of master’s-level counseling practitioners to undervalue the research enterprise (Fong & Malone, 1994; Wester & Borders, 2014). However, consistent with Hatchett (2017), we believe that the paucity of evidence-based articles in counseling journals is partly because counselors associate the terms *evidence-based*, *empirically supported*, and *research-based* with technical procedures related to the medical model. Additionally, some counseling researchers may be unaware of EBRF research, or they may inaccurately view EBRFs as falling within the psychology discipline.

If and when counseling professionals recognize that their existing relational behaviors in counseling also qualify as evidence based, interest in and proliferation of evidence-based relational research and practice integration may naturally follow. Additionally, consistent with the purpose of this article, helping mental health counseling researchers and practitioners become more aware of EBRFs is necessary. In the spirit of facilitating awareness of the relevance of EBRF research to mental health counseling practice, the first step in promoting EBRF research is to share knowledge back and forth from academics to mental health counseling practitioners.

The next step is to encourage mental health practitioners to collect practice-based evidence. Practice-based evidence involves practitioners routinely using standardized assessments to solicit client feedback and collect counseling outcomes evidence. To begin this practitioner–researcher collaboration, mental health counselors could select EBRF measures that are especially consistent with their interests. Practical, brief, and psychometrically sound instruments are available for all of the EBRFs, including, but not limited to, (a) for congruence, UPR, and empathic understanding, the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 2015); (b) for cultural humility, the Cultural Humility Scale (Hook et al., 2013); (c) for the three dimensions of the working alliance, the Working Alliance Inventory (Horvath & Greenberg, 1989); (d) for relationship ruptures, the Alliance Negotiation Scale (Doran, Safran, Waizmann, Bolger, & Muran, 2012); (e) for countertransference, the Inventory of Countertransference Behavior (Friedman & Gelso, 2000); and (f) for PM, the Outcome Rating Scale and Session Rating Scale (S. D. Miller et al., 2005).

Historically, there has been a gap between counseling and psychotherapy research and counseling and psychotherapy practice (Sommers-Flanagan & Sommers-Flanagan, 2018). For good reason, mental health counselors have not embraced mechanistic and manualized empirically supported counseling procedures. However, with the advent of empirical evidence supporting therapeutic relationship factors, there is an opportunity for rapprochement between counseling researchers and practitioners. We invite you to join with us to produce and publish meaningful mental counseling research: research that focuses on the core of our professional identity—the counseling relationship.

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