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An Exploratory Factor Analysis of the Humility in Counseling Scale

Jennifer Barker Santopietro

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AN EXPLORATORY FACTOR ANALYSIS OF THE HUMILTY IN COUNSELING SCALE

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Jennifer Barker Santopietro

College of Education and Behavioral Sciences
Department of Applied Psychology and Counselor Education
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Accepted by the Doctoral Committee

_____
Vilma (Betty) Cardona, Ph.D., Research Advisor

_____
Robyn Hess, Ph.D., Committee Member

_____
Angela Weingartner, Ph.D., Committee Member

_____
Darcy Copeland, Ph.D., Faculty Representative

Date of Dissertation Defense _____

Accepted by the Graduate School

_____
Jeri-Anne Lyons, Ph.D.
Dean of the Graduate School
Associate Vice President for Research

ABSTRACT

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As clients' needs grow in depth and complexity, it is imperative that counselor educators have a process for training counselors-in-training (CITs) to develop nuanced intrapersonal qualities and further prepare them for the challenges of the therapeutic relationship. Counseling skills are just one facet of clinical competence. Counselors-in-training must also develop their self-as-the therapist to gain competence in working with the client's emotional turmoil, life stressors, intersectionality, unique perspectives, and autonomy (Aponte et al., 2009). The purposeful application of clinical humility could be a catalyst to both scaffold and deepen learning experiences to foster intra- and interpersonal development. The purpose of this study was to develop a scale that measures clinical humility. Previously developed scales which measure humility have not focused on the subdomain of clinical humility studied with counselors/CITs. The Humility in Counseling Scale (HICS) was designed to fill this gap in the research and provide a tool to embed clinical humility into counselor education and supervision (CES) training. A self-assessment measure of clinical humility could be an important tool to evaluate intrapersonal components which strengthen counselor clinical training. The survey was administered to 386 practicing counselors and CITs. Following analysis of the psychometric properties, the results revealed a one-factor solution with three underlying facets of humility (flexibility, self-awareness, and openness). The HICS as a unidimensional measure of humility

holds promise to have scores which produce valid and reliable results. Future contributions to the field of CES include a variety of methods to implement the HICS into clinical training settings. Future implications for research include confirmatory factor analysis, comparative analysis, and qualitative studies.

This dissertation is dedicated to Dr. Christopher Sink, who sparked my interest in the topic of humility. This dissertation is also dedicated to Dr. Natalie Stipanovic, who demonstrated humility every time I was in her presence.

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CHAPTER I

INTRODUCTION

Preparing counseling students to develop effective clinical skills is essential to counselor educators. Clinical skills are the discrete actions that directly relate to the therapeutic process and are taught in structured classroom and practice-oriented settings (Whiston & Coker, 2000). Research in counselor education and supervision (CES) has had an overarching focus on training counselors in facilitating therapeutic change because it is so important to the effectiveness of the counseling relationship. Initially, CES researchers studied which of the counselor in training's (CIT) personality traits might lead to more effective therapeutic outcomes (Kazienko & Neidt, 1962; Mahan & Wicas, 1964; Wicas & Mahan, 1966). Ultimately, research into personality traitswas found to be statistically insignificant, yet the desire to substantiate characteristics of the counselor that are associated with positive counseling outcomes remained.

Counseling outcome research has identified the facilitative conditions and helping skills that are conducive to therapeutic change (Carkhuff & Truax, 1966). Foundational to this research were Roger's (1961) tenets of empathy, congruence, and unconditional positive regard which are essential to building a strong therapeutic alliance. The therapeutic alliance has been defined as the collaborative, purposeful work between counselor and client (Baldwin et al., 2007; Bordin, 1979; Wampold, 2001). Empathy has been defined as being aware of and experiencing the emotions and thoughts of others. Unconditional positive regard has been defined as accepting and valuing people without judgement. Congruence has been defined as consistency between a

person's ideal self and their actual experiences (Rogers, 1961). Rogers proposed that, when a CIT demonstrates these three conditions within the counseling relationship, a stronger therapeutic alliance would likely result.

Early research in facilitative conditions and helping skills indicated promising results with tangible application and, in turn, led to several decades of skills-based training research (e.g., Carkhuff, 1969; Carkhuff et al., 1970; Ivey et al., 1968). However, later in his life, Rogers stated that the three conditions of empathy, unconditional positive regard, and congruence were perhaps stressed too much in therapy and the self-of-the-therapist was stressed too little. During their interview with Carl Rogers, Baldwin asked about the use of self in therapy and Rogers replied, "Perhaps it is something around the edges of those three conditions that is really the most important element of therapy--when myself is very clearly obvious, present" (p. 45).

This perspective helped to propel another line of research that focused on the level of insight and awareness of the CIT. The more a CIT knows themselves on a psychological, cultural, and spiritual level, the more self-awareness they would have to meet the challenges their clients present (Aponte et al., 2009). Intrapersonal development deepens the CIT's self-awareness defined as the process of reflecting upon their personal experiences to gain a deeper understanding of how their biases and attitudes may impact the counseling relationship (Aponte & Kissil, 2012).

Developing clinical humility could be a catalyst for deepened self-awareness. Paine et al. (2015) conceptualized humility as a psychotherapeutic virtue, separate from a clinical skill stating, "humility is a term in reference to the sort of person the clinician is becoming rather than the skills they are proficient in" (p. 10). Watkins et al. (2018) described a process of developing humility via a person's willingness to assess their own personal characteristics, achievements,

mistakes, and limitations. Through analyzing one's self-experiences, a person could look within themselves, see what emerges, and then act upon what they discover. Paine et al. (2015) believed, if clinicians adopted a value system around cultivating humility, they would be better able to support the complexities that exist in the lives of their clients, their colleagues, and themselves.

Humility

Humility has been studied in the fields of leadership, religion, and psychology as a salient and sometimes paradoxical aspect of human character. Researchers from these fields have defined the embodiment of humility as accurately assessing oneself and one's imperfections, appreciating the value of all people and their unique contributions, being other-oriented, demonstrating openness to learning, regulating the need for status, and displaying modesty (Exline & Geyer, 2011; Owens et al., 2013; Tangney, 2000; E. L. Worthington et al., 2017). Subtypes of humility include cultural humility, intellectual humility, political humility, relational humility, and clinical humility. Paine et al. (2015) defined clinical humility as the therapist having accurate self-assessment, regulating self-focused emotions, recognizing limitations, and cultivating other-oriented emotions in a clinical setting.

However, in counselor training, the concept of clinical humility has seemed somewhat elusive. E. B. Davis and Cuthbert (2017) stated that, while there was convincing qualitative evidence that highly effective counselors exhibit clinical humility, there has seemed to be a lack of quantitative evidence of clinician humility. In part, this has been because there were no instruments developed to measure clinical humility. This study has addressed that gap in the research by developing and assessing the psychometric properties of a self-report measure of clinical humility. This type of instrument could potentially garner quantitative evidence of

counselor humility. A valid measure of clinical humility could increase CITs' awareness of developing humility. Understanding the factors of clinical humility could have practical application within CES clinical training in the areas of intrapersonal development, self-of-the-therapist, and the therapeutic alliance.

Clinical Training and Intrapersonal Development

The therapeutic alliance has been found to have the strongest impact on positive therapeutic outcomes as rated by clients (Baldwin et al., 2007; Bordin, 1979; Horvath & Symonds, 1991; Wampold, 2001). Within the last 20 years, some CES researchers have called for the field of CES to reconstruct clinical training to include the development of more complex clinical skills and a more comprehensive view of the therapeutic alliance (Grant, 2006; Whiston & Coker, 2000). Whiston and Coker (2000) and Grant (2006) discussed the importance of helping CITs to internalize effective therapeutic processes and complex relational skills such as empathic responding and empathic understanding. These researchers also believed it was important for CITs to learn to manage countertransference as part of building, repairing, and nurturing strong therapeutic alliances with their clients.

Horvath (2000) reviewed the therapeutic alliance both historically and conceptually, determining that, regardless of the technical skills, experience, or theoretical framework of the CIT, it was the client's subjective perception of the therapeutic alliance that had the most impact on therapeutic outcomes. The client's subjective perception was directly influenced by the CIT as a person, not just the skills exhibited by the CIT Building upon that research, Horvath et al. (2011) stated that therapists' contributions to the therapeutic alliance were critical. CITs were expected to have non-defensive reactions to client negativity and neither internalize nor ignore

clients' negative reactions. This way of being in the therapeutic alliance has required the CIT to know and regulate their intrapersonal struggles.

Aponte et al. (2009) noted the importance of therapists knowing themselves through their psychological, cultural, and spiritual struggles. As part of the process of knowing themselves, Aponte et al. stated that CIT's needed to process any feelings of past or current shame. Understanding feelings of shame requires self-evaluation. Embodying humility may be one way to facilitate accurate self-appraisal and could steer a person away from global negative self-evaluation (Sandage et al., 2017). A CIT who processes their feelings of shame that may be better able to realize what aspects of themselves they bring to therapeutic alliance. A CIT who develops clinical humility alongside working through shame may experience deepened intrapersonal development which could strengthen their self-of-the-therapist.

Humility in Counselor Education and Supervision

Results from prior research in the fields of leadership, psychology, positive psychology, and theology have helped to generate a broad conceptualization of humility. Humility has been viewed as a virtue (Lavelock et al., 2014), a trait (Exline & Geyer, 2011; Exline & Hill, 2012), a personality factor (Ashton & Lee, 2008), and as a state of being (Kruse et al., 2017; Tangney, 2000). Sandage et al. (2017) noted that, while theoretical and empirical research of humility has expanded in recent years, most of this research has not been within therapeutic contexts. For example, specific to CES and this study, a keyword and title search for humility within the Counselor Education and Supervision Journal resulted in one article about supervisors' cultural humility and a few articles which mentioned cultural humility in relation to supervision. Sandage et al. (2017) discussed the emerging conceptualization and research on clinical humility.

However, these concepts have yet to be researched in depth within counseling literature or included within counseling standards.

The 2016 counseling standards from the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) has two counseling and helping skills standards related to helping CITs develop intrapersonal skills. These standards address CITs developing their personal style of counseling and recognizing their own attributes and behaviors that influence the counseling process. This author conducted a search of the course offerings of CACREP accredited clinical mental health counseling programs throughout the United States (at least 1 from every state plus several online programs; in total, the course offerings from 57 programs were reviewed).

Based upon course titles and brief course descriptions,it seemed that most of the counselor education programs seemed to offer some type of skills-based training. These courses were described by phrases such as foundational skills, skills lab, and basic counseling skills. Counseling skills are fundamental in early counselor development (Ridley et al., 2011) but solely focusing on skills-based training may occur at the expense of equally vital factors in counselor development such as the intra and interpersonal elements of the therapeutic alliance. One barrier to implementing intrapersonal development into CES clinical training has been that it was difficult to measure growth, which is important for determining learning outcomes (Caspersen et al., 2017). Having the ability to measure intrapersonal qualities such as clinical humility could help implement them into CES clinical training practices.

Conceptualizing and Measuring Clinical Humility

Researchers in the field of psychology have been leaders in the development of humility assessments, but there has been no consensus on how this construct should be measured. For

example, McElroy-Heltzel et al. (2018) reviewed 22 instruments that measured humility. They found that some of the instruments measured humility in a broad manner, some measured sub-domains of humility, some measured humility indirectly, and some measured state vs. trait humility. The authors systematically compared the instruments for content which resulted in eight possible domains of humility: (a) openness/lack of superiority, (b) other-oriented/unselfish, (c) admit mistakes/teachable, (d) interpersonal modesty, (e) accurate view of self, (f) global humility, (g) spiritual humility, and (h) regulate need for status (McElroy-Heltzel et al., 2018).

Hill et al. (2017) stated that measurement of a construct was futile without a strong conceptualization of the construct. Thus, efforts have been directed towards developing a consistent conceptualization of subdomains of humility by focusing on individual subdomains, such as clinical humility. Sandage et al. (2017) described humility in the clinical realm as a multi-dimensional construct with intra- and interpersonal factors including accurate self-perception, other-orientedness, openness, and the ability to know one's limitations. Further, Sandage et al. (2017) proposed the possibility of humility as an integral part of a widespread shift in clinical practice to include practices of acceptance such as mindfulness.Morgan (2005) described this shift as "a quality of active humility" (p. 142).

Developing Clinical Humility

It has been hypothesized that humility may be an integral part of social and self-regulation, allowing people to feel cohesion with others (D. E. Davis & Hook, 2014; Richmond et al., 2018). Van Tongeren et al. (2019), when conceptualizing humility as a broad construct, offered the perspective that embodying humility signals to others one's relational approachability, safety, and valuing of the other person. The authors proposed three hypotheses as to how humility may strengthen relationships. First was the social bonds hypothesis which

proposed that a humble approach to relationships helps with the formation, maintenance, and repair of relationships. Second was the social oil hypothesis which proposed that a humble approach to relationships helps to reduce conflict when there was a power differential. Third was the well-being hypothesis which proposed that a humble approach to relationships increases an individual's desire to engage with people who were different from themselves thus, expanding their social connections and personal growth.

E. B. Davis and Cuthbert (2017) discussed the subdomain of clinical humility and viewed self-regulation as a manifestation of embodying clinical humility. Particularly important to counseling is the self-regulation of the qualities and behaviors (positive and negative) which impact the therapeutic alliance. The authors proposed that these qualities and behaviors could be impacted by the presence or absence of clinical humility. Thus, CITs who embody high clinical humility would exhibit *more* positive qualities (flexibility, openness, warmth) and positive behaviors (affirming, collaborative, supportive) and *fewer* negative qualities (rigidity, manipulative) and negative behaviors (controlling, critical). The knowledge of the positive/negative behaviors and qualities may be considered elemental to effective counseling, however, the path to self-regulation would be personally nuanced by an individual's history, life experiences, culture, and psychological struggles. Developing clinical humility could be an integral and effective mechanism to help CITs self-regulate.

As noted, there have been efforts to conceptualize salient qualities which support the development clinical humility (i.e., flexibility, self-regulation, collaboration, openness, relational approachability) and Verdorfer (2016) described the behaviors exhibited by people who embody humility. These behaviors included requesting and using information from the environment to gain an accurate assessment of oneself, appreciating the contributions of others without feeling

threatened, and showing teachability through openness to feedback from others. When a CIT feels cohesion with others, it could be described as experiencing openness (D. E. Davis et al., 2012; Dwiwardani et al., 2017) and when a CIT forms strong bonds with people regardless of their convictions, it could be a demonstration of flexibility (Wei et al., 2014). When a CIT integrates information from the environment to gain accurate self-assessment, it could be described as experiencing self-awareness (E. B. Davis & Cuthbert, 2017), and when a CIT exhibits teachability and openness to feedback, it could be described as curiosity (Owens et al., 2013). Therefore, the proposed factors of clinical humility for this study were flexibility, curiosity, openness, and self-awareness. Developing and embodying clinical humility may help CITs facilitate the complexities of building and repairing the therapeutic alliance. The ability to measure clinical humility could help to clarify its relevance to developing the CIT's self-of-the-therapist and the therapeutic alliance.

Best Practice in Scale Development

Wren and Benson (2004) discussed three phases of scale development: the planning phase, the construction phase, and the quantitative evaluation phase. The empirical process of developing the Humility in Counseling Scale for this study included these three phases. The planning phase included a review of the literature to gain a broad theoretical foundation of the ideology and application of humility. The construction phase included conducting focus groups to determine possible factors of humility; examining scale items through a think-aloud process with participants from the field of counseling; and editing, re-writing, and discarding scale items. The third component was the focus of this study. An exploratory factor analysis was conducted to determine whether the instrument aligned with the theoretical constructs believed to underlie clinical humility.

Statement of the Problem

As clients' needs have grown in complexity, the field of CES must also evolve. Thus, it would be imperative that counselor educators have a process for training CITs to develop intrapersonal qualities which strengthen the CIT's self-of-the-therapist. A stronger sense of self would help CITs to lead to greater self-awareness (Pompeo & Levitt, 2014). Expanding upon counseling skills training to include development of clinical humility could be an effective means for counselor educators to foster increased CIT self-awareness and further prepare CITs for intricacies within the therapeutic relationship. Paine et al. (2015) proposed that humility may be relevant to clinical practice as a counselor virtue that integrates several different relational dynamics within the context of the therapeutic process. Thus, humility could be a catalyst to both scaffold and deepen learning experiences which facilitate self-of-the-therapist. A self-assessment measure of humility in counseling could be a foundational tool for CITs and counselor educators in intrapersonal development of self-of-the-therapist.

Statement of Purpose

The broad purpose of this study was to measure counselors' self-assessment of their clinical humility as it pertains to their self-of-the-therapist and the therapeutic alliance. Specifically, the Humility in Counseling Scale (developed for this study) was administered with practicing counselors, counselor educators, and CITs. These preliminary results were used to determine the factor structure of the instruments as well as its reliability. This work was carried out as one of the first steps in validating an instrument to measure clinical humility.

Significance of the Study

My review of the literature included 105 articles and book chapters retrieved from several research databases including Taylor and Francis Online, SAGE Journals Online, Wiley Online

Library, EBSCOhost, JSTOR, APA PsycNET, SAGE Research Methods, and Science Direct. Thisthorough review of the literature revealed a scarcity of research on clinical humility in the field of CES. E. B. Davis and Cuthbert (2017) stated that qualitative research studies of humility suggested the possibility that the embodiment of clinical humility differentiates most effective counselors from least effective counselors. However, the authors stated there was a need for quantitative research of clinical humility to determine if, and when, this characteristic was a determining factor of counselor effectiveness. Training CITs to develop intra- and interpersonal qualities is essential to counselor effectiveness. A valid and reliable scale to measure clinical humility could provide counselor educators with a compelling starting point for CIT intrapersonal development, could help to conceptualize future research to study the impact of clinical humility on therapeutic outcomes, and could facilitate the CITs' journey in developing the self-of-the-therapist.

Research Questions

The research questions and hypotheses for this study were as follows:

Q1 Do the subscales from the Humility in Counseling Scale demonstrate adequate internal consistency when administered to counselors/CITs?

H01 The Humility in Counseling Scale has a Cronbach's coefficient alpha of < .80 across the four subdomains of flexibility, openness, curiosity, and self-awareness.

Ha1 The Humility in Counseling Scale has a Cronbach's coefficient alpha of > .80 across the four subdomains of flexibility, openness, curiosity, and self-awareness.

Q2 Do the items from the Humility in Counseling Scale demonstrate interpretable factorial validity?

H02 Following EFA rotation, the items comprising the factors will have factor loadings of < .35.

Ha2 Following EFA rotation, the items comprising the factors will have factor loadings of > .35.

Q3 What is the strength of association between demographic variables of age and CIT/practicing counselor and derived factor scores?

H03 The potential interaction effects of the demographic variables of age and CIT/practicing counselor will be nonsignificant ($p > .05$).

Ha3 The potential interaction effects of demographic variables of age and CIT/practicing counselor will be significant ($p < .05$).

Summary

Over the last 60 years of CES clinical training research, the major trends have included studying CIT personality traits, the consideration of facilitative conditions of the therapeutic alliance, and the relative importance counseling skills. However, examining how to support CITs to develop intrapersonal skills which strengthen their self-of-the-therapist has been relatively scarce in CES literature. Incorporating the development of clinical humility into CES clinical training through didactic experiences, both academic (i.e., skills classes, theory classes, group and individual counseling classes) and clinical (i.e. practicum and internship), could be an effective aspect of fostering CIT intrapersonal growth. Further, McMahon (2020) noted that the intentional cultivation of humility on the part of the CIT and clinical supervisor may be transformational to clinical supervision by aiding with developmental and power dynamics to supervisory diads. However, to conceptualize humility as part of the therapeutic and supervision process, CITs must first understand their own clinical humility. A valid measure of clinical humility may be essential to this process. The purpose of this study was to add to the empirical research of humility by helping to conceptualize the underlying factors of clinical humility, which this researcher proposed to be flexibility, openness, self-awareness, and curiosity.

Definition of Terms

Clinical Humility. A disposition of the clinician that helps to integrate relational dynamics between counselor and client. Clinical humility also serves as a balancing perspective between standards of practice and ethical codes by highlighting and valuing that there are limits to the counselor's knowledge (Paine et al., 2015).

Clinical Skills. Skills which are in direct relation to the therapeutic process and are taught in structured classroom and practice-oriented settings (Whiston & Coker, 2000).

Congruence. When a person experiences consistency between their ideal self and their actual experiences (Rogers, 1961).

Council for Accreditation of Counseling and Related Educational Programs (CACREP). An accrediting board for counseling programs with standards that advocate for a unified counseling profession to ensure that students graduate with a strong professional counselor identity (CACREP, 2015).

Counseling Process. The most complex stage of therapy in which the client recognizes patterns, feels the depth of emotions, and integrates new information. In this stage, the client experiences increased self-awareness and the sensation of psychic movement (De Rivera, 1992).

Counseling Relationship. The professional interpersonal relationship between counselor and client that affirms the client's emotions, experiences, and sense of self with openness, respect, and integrity (Erskine, 2018).

Counselors-in-Training: A student who is in the process of obtaining a graduate level, professional counseling degree.

Dimensionality. A scale's dimensionality is its factor structure which represents the nature and number of variables measured by the scale items (Furr, 2011)

Empathy. Being aware of and experiencing the emotions and thoughts of others. A counselor feels empathy when they experience what the client is feeling as if they were the client, but with the self-awareness that they are separate from the client (Rogers, 1961).

Exploratory Factor Analysis. Exploratory factor analysis (EFA) is effective in the initial scale development phase to analyze the underlying factors of the construct being measured and determines which factors are significant to the construct (R. L. Worthington & Whittaker, 2006).

Humility. Accurately assessing oneself and imperfections, appreciating the value of all people their unique contributions, being other-oriented, teachability, regulating the need for status, and displaying modesty (Exline & Geyer, 2011; Owens et al., 2013; Tangney, 2000; E. L. Worthington et al., 2017).

Intrapersonal Development. The awareness of multiple self-aspects and the capacity for emotion regulation (Jankowski et al., 2013).

Self-awareness. In counseling, self-awareness is the process of exploring and reflecting upon personal experiences to gain a deeper understanding of one's cultural influence on the counseling process and how biases and attitudes may impact the counseling relationship (Leach et al., 2010).

Self-of-the-therapist. A counselor develops their self-of-the-therapist by knowing the psychological, emotional, cultural, and spiritual challenges that have shaped their lives and how those challenges affect their current way of being. Further, the counselor must be self-aware with astute professional judgement of when to access and/or manage

personal life events, memories, emotions, and cultural experiences to facilitate the therapeutic process (Aponte et al., 2009).

Therapeutic Alliance. The collaborative purposeful work between counselor and client (Baldwin et al., 2007; Bordin, 1979; Wampold, 2001).

Unconditional Positive Regard. When a counselor accepts and supports a client regardless of what they say or do, they are showing unconditional positive regard (Rogers, 1961).

CHAPTER II

REVIEW OF THE LITERATURE

The overarching purpose of this chapter was to present humility as a compelling facilitative construct in the cultivation of self-of-the therapist. The structure of this chapter begins with an overview of the historical and current clinical training research trends within counselor education and supervision (CES). Next, the conceptualization, development, and measurement of clinical humility was examined within the context of CES clinical training, particularly CIT intrapersonal development as it pertained to developing self-of-the-therapist and the therapeutic alliance. Additionally, the chapter addresses the need for a quantitative measure of clinical humility which was a current gap in psychological research. Finally, various elements of scale development such as content and scale design were examined to set the stage for the creation and validation of the scale for this study.

Historical Overview of Training Counselors

Since its inception, scholars in the field of CES have researched many facets of how to train counselors to do counseling. I scanned titles and abstracts from articles of the Counselor Education and Supervision Journal from volume 1 in 1961 to volume 59 in 2020 to gain an historical overview of training students in the techniques, interpersonal qualities, and behaviors of the counseling process. I then reviewed seminal articles which created a framework of the major foci of counselor training.

The published research in the CES journal revealed an early focus on various personality dispositions of CITs as indicators of becoming an effective counselor. For example, Wicas and

Mahan (1966) administered three personality assessments to counselors who were then rated high and low by professional leaders and peers. Though there were several limitations with their study, the authors analyzed the results of the personality assessments and found that counselors with the highest ratings had the personality dispositions of patience, non-aggressiveness, concern about social progress, and appropriate self-control. Ultimately, the studies assessing counseling personality traits yielded mixed results and, in 1966, Demos and Zuwaylif stated that there were no psychological instruments that could effectively measure counselor personality traits. These findings diminished the potential efficacy of screening or evaluating CITs based upon personality traits.

Taking a differentiated approach, Freedman et al. (1967) studied the relationship between certain personality characteristics and the verbal responses of CITs in a counseling interview situation. They found that some personality characteristics such as flexibility, sociability and self-control had a high correlation with interview behaviors like probing, understanding, and interpretation. This set the stage for a shift in CES research to studying the facilitative conditions which positively impact the therapeutic alliance.

Training in Facilitative Conditions

Some of the earliest studies did not support the impact of formal counseling and reported that the measurable client outcomes were insignificant (Eysenck, 1992; Levitt, 1963). Studies of counseling outcomes found that there were no differences in the average outcomes of people who participated in counseling and those who did not. Counseling scholars Carkhuff and Truax (1966) desired to explain these substantiated conclusions so they analyzed the findings from two research studies. One study was from a hospital program for patients with schizophrenia in which the experimental group received formal counseling and the control group did not (Rogers,

1961; Truax, 1963). The other study was with two groups of junior high students who either received counseling guidance or not (Mink & Isaksen, 1959).

In both studies, Carkhuff and Truax (1966) found no difference between the therapeutic outcomes of clients who received formal counseling and of clients who did not receive formal counseling. However, they did discover something important to CES. At the conclusion of the therapeutic process in both studies, there was significant variability in both the positive and negative change criteria in the groups that received counseling. The patients with schizophrenia and the junior high students who participated in formal counseling experienced either positive or negative outcomes (Mink & Isaksen, 1959). These findings indicated that the interpersonal counseling relationship could be helpful or detrimental and laid the groundwork for the necessity of training CITs in *helpful* facilitation of the therapeutic process.

With Rogers's person-centered theory gaining prominence, counselor educators focused on training CITs in facilitative conditions such as empathy, respect, warmth, genuineness, concreteness, and unconditional positive regard. These facilitative conditions were believed to increase positive counseling outcomes. Culberson (1975) studied counselor effectiveness based upon the level (high or low) of the facilitative conditions offered by the counselor. Participant clients were given the Client-Level Indication Index which rated their level of interpersonal functioning (Culberson, 1975). Participant CITs were given the Communication-Discrimination index which rated their level of ability to communicate facilitative conditions (Carkhuff, 1969).

The results of the Culberson (1975) study indicated that, when CITs who were rated low in facilitative skills were paired with clients who rated low in interpersonal functioning (low-low), there was no significant client change. When CITs who were rated low were paired with clients who were rated high (low-high), there was *negative* change in the clients. Thus,

Culberson proposed two future implications from his study stating CITs should have at least minimal facilitative skills before seeing clients in practicum, and CITs should be trained to continue to develop counseling skills.

To further examine CIT facilitation skills, Carkhuff et al. (1970) studied the training sequence of counselor-responsive (empathy, respect, unconditional positive regard) and counselor-initiated (confrontation, immediacy) facilitative conditions with CITs. The CITs received 30 hours of training that included modeling, role-playing, and feedback in both the responsive and initiated facilitated conditions. While there was no significance found in the training sequence of the facilitative skills, the results of the study found the 30 hours of training to be overall effective. This exemplified what soon became a shift within the field of CES to skills-focused clinical training (Carkhuff et al., 1970).

Skills-Based Training

Building upon facilitative conditions research, CES scholars began to study the application of a microskills training model in CES programs. Seminal to this research was the work of Ivey et al. (1968) who stated the primary goals of microcounseling as (a) provide pre-practicum students unlimited practice with counseling skills without the risk of harming clients and (b) integrate theory and practice. Ivey et al. conducted three studies with CITs utilizing video recorded 5-minute counseling sessions with volunteer “clients” focusing on specific counseling skills. The three skills focused on in the study were attending behavior, reflection of feelings, and summarization of feelings. The results of all three studies were that CITs experienced a significant increase in their ability to perform the counseling skills they were taught as measured by self and client ratings. Ivey et al. acknowledged that part of the success of the microskills training was due to the positive reinforcement given by the supervisor to the CIT when the skills

were observed. Thus, further research was needed to study skill retention and generalizability into actual counseling sessions.

In addition to the concerns of skill retention and generalizability, some researchers (Fuqua & Gade, 1982; Mahon & Altmann, 1977) raised concerns over the lack of empirical research into the efficacy, consistency, and application of skills-practice training models. Fuqua and Gade stated that there was inconsistency in the training approaches (role-play, video, feedback, and modeling) within CES and that these approaches had not been adequately researched for efficacy. Mahon and Altmann stated similar concerns with inconsistency in training, particularly with overstating research findings as effective which only had short-term effects. Despite these concerns, skills-based training became widespread amongst counseling programs. In 1985, Kurtz et al. stated, "No helping profession has been more decisive than counseling in determining the content and format of interpersonal helping skill training" (p. 249).

Training in the Therapeutic Alliance

Currently, skills-based training has remained foundational to CIT early practicum experience. All 50 counseling programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) I reviewed currently incorporated some type of skills-based training for CITs. However, in June of 2000, the Counselor Education and Supervision Journal had a special section titled, "Special Section: Reconstructing Clinical Training: In Pursuit of Evidence Based Practice." This section featured an empirically based discussion authored by Whiston and Coker (2000) who proposed several components they felt were essential to the clinical training of CITs, particularly in developing the therapeutic relationship. The authors noted that, while the 1994 CACREP standards had a helping relationships section, there was no specific standard addressing the therapeutic relationship.

Therefore, Whiston and Coker (2000) proposed three components that were essential to training CITs in the complexities of developing the therapeutic relationship. First, they suggested training CITs in an interactive, collaborative method to build the therapeutic relationship, like the Working Alliance Model (Bordin, 1979; Sexton & Whiston, 1994). Second, they discussed the importance of increasing the counseling skillfulness of CITs by training them in both basic skills and more complex clinical skills like paradoxical intention and experiential confrontation (Orlinsky et al., 1994). Finally, they felt it was essential to increase the cognitive complexity of CITs by differentiating clinical training to meet CITs at their developmental level (Claiborn et al., 1995).

Grant (2006) also stressed the importance of training CITs in the complexities of the therapeutic relationship and stated that clinical training must evolve to meet the increasingly complex issues the collective client population are presenting with (i.e., complex trauma, chaotic family structures, increased suicidality, multiple mental health issues, etc.). Citing findings from Wampold's (2001) study which showed more variance between CITs implementing an intervention than the variance between different interventions, Grant stressed the need for training CITs who were consistent in their clinical effectiveness.

Congruent with Whiston and Coker (2000), Grant (2006) believed that CITs must be trained to build the therapeutic alliance. Grant emphasized the need for CITs to learn to manage countertransference as this could positively or negatively impact the therapeutic alliance. Gelso and Hayes (1998) as cited in Grant (2006) discussed self-insight, self-integration, anxiety management, empathy, and conceptualizing skills as the components of managing countertransference. These components required training the CIT to develop a strong sense of self (i.e., self-of-the-therapist to cultivate complex clinical and relational skills). However, these

skills would lack efficacy if the CIT did not develop their self-of-the-therapist from which to draw upon in the therapeutic relationship (Baldwin, 1987).

Training in Self-of-the-Therapist

In conjunction with the 60 years of CES research into what a CIT's personality was, what conditions the CIT created for counseling, and what skills a CIT exhibited, there have been a small percentage of studies into what the CIT was experiencing internally. For example, a few studies revealed a desire of some counselor educators to train CITs in constructs which fostered deeper self-reflection such as CIT values, philosophies, family of origin, culture, and ideal/judged self, (Kelly, 1990; Kratochvil, 1969; Lawson et al., 1995; Redfering, 1973; Strickland, 1969). Mahon and Altmann (1977) also stressed that more attention needed to be given to CIT's self-reflection and internal experiences. Citing Combs (1969) and perceptual psychology, the authors were one of the few published researchers in the CES journal who discussed using self-as-an-instrument in the counseling process (Mahon & Altmann, 1977). However, in comparison to the literature from the fields of family therapy and clinical psychology, there was a paucity of specific research within CES literature into training CITs to develop their self-of-the-therapist.

Published in family therapy literature, Aponte et al. (2009) believed it was important for CITs to work on knowing and gaining mastery of themselves to meet the challenges presented by clients in the therapeutic relationship. Though muted and not center stage, the CIT's personal self was active within the counseling session responding empathetically, prompting, and sometimes distracting and interfering (Orlinsky et al., 2020). Although it is important for CITs to learn to distinguish between their professional and personal selves, there are moments in which CITs

experience congruence between their professional and personal selves and begin to feel alive and spontaneous in their counseling work (Orlinsky et al., 2020)

This congruence of personal and professional selves has been aligned with Person-of-the-Therapist Training Model (POTT) which considers common elements of the human experience and addresses the whole person--their histories, personal journeys, assets, and vulnerabilities--when training therapists (Aponte et al., 2009). Person-of-the-Therapist Training Model (POTT) has supported CITs to grow in a more conscious connection with themselves. Through their own emotional wounds, CITs have begun to understand and empathize with more intuitive depth their clients' vulnerabilities.

Aponte et al. (2009) stated that the CIT's emotional wounds made up the *signature themes* of their lives and engaging in growth and change around these signature themes helped the CIT develop their self-of-the-therapist. Aponte et al. stressed that it was vital for CITs to be empathetic to their vulnerabilities to gain self-acceptance of their signature themes. Gaining self-acceptance of their signature themes helped the CIT to work through shame and, thus, engage more genuinely in the therapeutic alliance (Aponte et al., 2009).

Working through shame and gaining self-acceptance have not been clearly defined processes. Grant (2006) and Aponte et al. (2009) both specified personal therapy and experiential learning methods as means to facilitate CITs' personal growth and self-acceptance. Jankowski et al. (2013) differentiated this process further and drew upon the work of Kerr and Bowen (1988) stating that an individual's capacity for the differentiation of self (DoS) increases self-regulation of emotions in the intra- and interpersonal dimensions. Sandage et al. (2017) described DoS as the ability to relate flexibly and self-regulate emotions with others across differences. The authors found humility to be an expression of DoS as it related to other psychological processes

such as the regulation of pride and shame (Sandage et al., 2017). Thus, training CITs to embody clinical humility could be a crucial component to the development of their self-of-the-therapist.

Clinical Humility

Over the last 2 decades, social science researchers have contributed to the growing body of literature on the topic of humility. Many researchers have studied humility as a broad construct (Chancellor & Lyubomirsky, 2013; D. E. Davis & Hook, 2014; Exline & Geyer, 2011; Exline & Hill, 2012; Tangney, 2000, 2002; Van Tongeren et al., 2019). Others have studied subdomains of humility such as cultural humility (Hook et al., 2013; Mosher et al., 2017; Owen et al., 2016; Richmond et al., 2018), relational humility (D. E. Davis et al., 2011, 2012, 2017), and clinical humility (E. B. Davis & Cuthbert, 2017; Hill & Sandage, 2016; Lavelock et al., 2014; Paine et al., 2015; Sandage et al., 2017)

The humility subtype, clinical humility, was the focus of this dissertation study. Paine et al. (2015) viewed clinical humility as a psychotherapeutic virtue that may facilitate therapeutic change through optimizing positive human functioning, opening one's perspective to diverse worldviews, and integrating the relational dynamics between client and counselor. Similarly, Sandage et al. (2017) described clinical humility not as a counseling skill but as the counselor's way of being with self and clients. Van Tongeren et al. (2019) stated, "We readily see the importance of integrating humility into clinical and counseling settings" (p. 466). They encouraged future research to study the connection between humility and pro-relational traits and to develop and test clinical humility interventions. The relevance of researching clinical humility has been introduced and establishing the conceptualization of clinical humility would strengthen the research.

Conceptualizing Clinical Humility

Within social science literature, a broad conception of humility has been described as accurately assessing oneself and imperfections, appreciating the value of all people their unique contributions, being other-oriented, teachability, regulating the need for status, and displaying modesty (Exline & Geyer, 2011; Owens et al., 2013; Tangney, 2000; E. L. Worthington et al., 2017). Clinical humility has been regarded by some researchers as a core ethical value of master therapists, and some expert counselors have shared humility as a marker of expertise through the recognition of their own fallibility (Dlugos & Friedlander, 2001; Freeman, 2004; Jennings et al., 2005; Rønnestad & Skovholt, 2013; Senyshyn, 2011). Kottler and Carlson (2013) interviewed renowned psychologist, Arnold Lazarus, who discussed the topic of humility and therapists who do not practice what they preach. Lazarus stated, "I think the first thing these people need is a big dose of humility. I've listened to therapists imply that they are using advanced science, or they have x-ray vision or something. We all need a lot more humility" (p. 40). Lazarus's plea for more humility was inspiring and understanding the factors which fostered clinical humility would be helpful to the process of embodying it.

McElroy-Heltzel et al. (2018) contributed to the conceptualization of clinical humility by conducting a content review of 22 instruments which measure humility. To date, there are no published instruments which measure clinical humility, thus, their content review was not specific to clinical humility. However, the analysis of the scale item content produced valuable information which aligned with the broader definition of humility described previously (other-oriented, teachable, accurate self-assessment, valuing all people). Similarly, Sandage et al. (2017) stated that clinical humility has both intrapersonal and interpersonal components. They proposed several components of clinical humility including having an accurate self-appraisal,

openness to feedback, and emotion regulation (intrapersonal); and being other-oriented and flexibly relating to others (interpersonal). Thus, a possible conceptualization of clinical humility was that it was comprised of the factors of openness, flexibility, self-awareness, and curiosity.

Openness

Researchers studying subtypes of humility have proposed that both intra- and interpersonal openness may be correlates of humility (D. E. Davis et al., 2012; Leary et al., 2017). Leary et al. (2017) discussed intrapersonal openness in the context of intellectual humility and described it as being open to others' views, open to feedback, and having a lack of rigidity with one's own beliefs. D. E. Davis et al. (2012) discussed interpersonal openness in the context of relational humility and described it as being other-oriented, demonstrating a genuine interest in the welfare and lives of others. Being other-oriented, open to feedback, and having a lack of rigidity could be important aspects of clinical humility for CITs to develop. Further, clinical humility manifested through openness may help the CIT accept alternative values and attitudes; consider new ideas and contradictory information; and integrate feedback from supervisors, peers, and clients (Leary et al., 2017; C. Sink, personal communication, January 15, 2020; Tangney, 2002).

Flexibility

Psychological flexibility in the context of clinical humility has helped CITs to engage in critical thinking to adjust their attitudes and decisions as they learn new information. Zmigrod et al. (2019) described a psychologically flexible mind as a personal characteristic that helped people recognize their own fallibility and avoid succumbing to biased decision making. Specific to counselor training, Wei et al. (2014) stated that CITs often experience anxiety and self-critical thoughts during counseling sessions. Psychological flexibility has helped CITs to observe and

accept negative internal experiences rather than react to them, which, in the framework of clinical humility, has helped CITs regulate accurate self-appraisal.

Self-Awareness

Self-awareness has been an aspect of metacognition, an internal mechanism which monitors and controls behaviors, and has helped people adjust and adapt their beliefs about the world (Lou et al., 2017). Self-awareness has been referenced through an individual's retrieval of episodic memories, their past personal events, and their previous judgments of situations (Lou et al., 2017). In the context of counseling, CIT self-awareness has been developed through the exploration and reflection of personal experiences. This has led to the CITs' deeper understanding of their cultural and personal influence on the therapeutic process. Self-awareness also has helped the CIT to understand and how their biases and attitudes may impact the therapeutic alliance (Leach et al., 2010; Suthakaran, 2011).

Relatedly, self-reflection has invoked self-awareness and has been operationalized as a metacognitive skill which included observation, interpretation, and evaluation of one's thoughts, emotions, and actions (Bennett-Levy & Lee, 2012; Pompeo & Levitt, 2014). In the context of clinical humility, engaging in self-reflective practices to enhance self-awareness may help CITs learn to manage countertransference during counseling sessions. Similar to psychological flexibility, if CITs engage in self-reflective practices, it could increase their capacity for awareness of the thoughts, feelings, and behaviors happening in the immediate experience of the therapeutic alliance (B. Orrision, personal communication, January 16, 2020; Pompeo & Levitt, 2014).

Curiosity

Contemporary researchers have defined curiosity as a psychological construct underpinning human proclivity for pursuit of knowledge, learning, and cognitive engagement (Mussel, 2013; Noordewier & van Dijk, 2017). As with flexibility and self-awareness, curiosity has been linked to self-regulation, which was relevant to clinical humility (Kashdan et al., 2004). When CITs receive information that was contrary to their own beliefs, it could be dysregulating. If CITs approached these situations with curiosity to increase their understanding of the information and expand their cognitive complexity around contrary information, this dysregulation may be minimized (A. Reiter, personal communication, January 23, 2020).

In the context of clinical humility, two types of curiosity have been relevant. Diversive curiosity was a drive to understand a wide range of information to obtain a well-rounded picture of the human experience. This type of curiosity had led to the understanding and problem solving of novel ideas within the clinical context (Hardy et al., 2017). Empathic curiosity was the process of being engaged in the felt meanings and emotions a client was experiencing and linking curious questions to the client's non-verbal experience (McEvoy et al., 2012).

Clinical Humility and Counselor Training

Acknowledging that mental health services have often been provided from a medical model emphasizing authority and expertise, Sandage et al. (2017) proposed that a humble approach may be a more effective training model when addressing the complexities of the therapeutic process. The authors described several ways in which a humble approach might manifest in clinical training. For example, training CITs to be cognizant of the power dynamics which exist in the therapeutic relationship was rooted in clinical humility. Some post-modern theories (i.e., feminist, narrative, queer, and relational psychoanalytic) have explicitly addressed

power dynamics, and a humble approach to clinical training would address therapeutic power dynamics across all theoretical orientations. Embodying clinical humility has helped the CIT to step aside from feelings of self-importance and engage as a collaborative partner in the therapeutic alliance.

Sandage et al. (2017) also proposed that clinical training in a humble approach encouraged CITs to develop a tolerance for ambiguity and a stance of not knowing. Counseling skills have been just one facet of clinical competence. Counselors-in-training must also gain competence in working with the client's emotional turmoil, life stressors, intersectionality, unique perspectives, and autonomy. It could be tempting for CITs to want to offer strategies and interventions to their clients as a means of comfort for the client's complex emotions. However, training CITs to have a humble approach could move them beyond the certainty of skills compliance to the uncertainty of not knowing--of responding to clients' perspectives with flexibility, presence, and awareness. Embedding clinical humility into CES training could cultivate this optimal intrapersonal development (Paine et al., 2015).

Clinical Humility and Training in the Therapeutic Alliance

There are multifaceted differences between client and counselor which could add complexity and fragility to developing an interpersonal relationship. The complexity and fragility could have been underscored by a CIT's emotional reactions and concerns that were different from the client (Paine et al., 2015). Clinical training in basic counseling skills (e.g., reflection, concreteness, immediacy, summarization, etc.) has generally been the first step in training CITs to develop the therapeutic alliance (Orlinsky et al., 1994). Counseling skills training has been instrumental to the organization and flow of the counseling session. Paine et al. proposed that clinical humility may support clinical skills training by facilitating processes which address

relational complexity. However, the authors clarified that developing clinical humility was a process that was distinctly different than the compliance of learning counseling skills.

One such process of expressing clinical humility within the therapeutic alliance has been when the CIT developed an active stance of other-orientedness. Sandage et al. (2017) described this process as the CIT letting go of the counselor being the expert about the client and embracing an ethical stance of differentiating their perspective of the client's struggles from the client's perspective of their struggles. This allowed for an intersubjective joining between CIT and client. Intersubjective joining in counseling has been an agreement that existed between the client and CIT based upon the dynamic moments between them in session. Embodying the proposed factors of clinical humility--flexibility, self-awareness, openness, and curiosity--may help the CIT to build upon empathic attunement to deepen their understanding about the client's subconscious conflicts, emotions, struggles, and life meanings.

Another process of expressing clinical humility within the therapeutic alliance has been through managing difficult emotional reactions from countertransference. Aponte et al. (2009) stressed that countertransference should be viewed not as an obstacle but rather a facilitator of the therapeutic alliance stating that CITs need to "actively contribute from their life experience to the formation of a relationship that supports the technical structure of the therapeutic process" (p. 383). This technical structure has been rooted in the therapeutic alliance, the collaborative and purposeful work of the CIT and client. Thus, within a purposeful alliance, managing countertransference with clinical humility was not to ignore or suppress it. Rather, the CIT could utilize proposed factors of clinical humility such as self-awareness and flexibility to facilitate an accurate self-appraisal of what they were experiencing. Then, the CIT could draw upon that process to engage authentically in the therapeutic alliance (Sandage et al., 2017).

Finally, another process of clinical humility within the therapeutic alliance was when the CIT demonstrated respectful openness toward their clients (Owen et al., 2016). Respectful openness was expressed by the CIT through working collaboratively with clients using a prosocial orientation, considering the unique intersection of clients' various aspects of their identities (culture, ethnicity, spirituality), and how they impact the therapeutic alliance (Hook et al., 2013; Tong et al., 2019). In action, this expression of clinical humility might look like the CIT stepping aside from the explicit communication within the session and listen more to the clients' implicit and non-verbal communications (B. Orrison, personal communication, December 11, 2019; Sandage et al., 2017). In this way, counselors displayed a tolerant, patient, responsive, non-judging, supportive and forgiving nature (Ashton et al., 2014; Owen et al., 2016; Tong et al., 2019). Carl Rogers alluded to this type of openness when he connected closely to hisinner-most intuitive self, stating that it felt as though his inner spirit reached out and touched the inner spirit of the client. He believed those moments were when "profound growth and healing and energy are present" (Baldwin, 1987, p. 50).

Clinical Humility and Developing the Self-of-the-Therapist

Aponte and Kissil (2012) stated that, throughout the history of counseling research, there has been recognition that the counselor brings more to the therapeutic process than skills and theoretical orientation. However, research studies into developing the self-of-the-therapist have primarily been published only within family therapy literature. Aponte and Kissil believed that training CITs to develop their self-of-the-therapist was essential to effective counseling. They also acknowledged that, while many clinicians and researchers support the importance of developing the self-of-the therapist, there were varying perspectives on the steps needed to train CITs in using their whole self in counseling.

More traditional, medical models of clinical training have considered the CIT's emotional and personal struggles as a potential hinderance to their counseling which needed resolution. Aponte and Kissil (2012), however, viewed CITs' emotional, spiritual, physical, and cultural struggles as part of their signature themes that they would carry with them throughout their work as a counselor. The authors believed that training CITs to work with and through their signature themes would strengthen their self-of-the-therapist and increase counseling efficacy. Aponte and Kissil described this perspective by stating,

> Helping therapists acknowledge and understand their struggles, accept their humanity and feel comfortable "going there" emotionally as needed, positions them not only to gain greater mastery of themselves to implement their therapeutic tasks, but also to free and motivate them to indeed work on their personal issues, which of course makes more of their selves available for the work of therapy. (p. 162)

Helping CITs accept their humanity and gain comfort with experiencing difficult emotions could be facilitated by clinical humility. Sandage et al. (2017) discussed clinical humility as a tool for reframing intense emotional reactions. Reframing included normalization, learning, amends, and self-compassion. In the context of the proposed factors of clinical humility, flexibility, self-awareness, openness, and curiosity could help the CIT engage in the reframing process. For example, having the cognitive flexibility to think about shame in the context of the greater community could help the CIT normalize shame and ease feelings of being alone with their shame (Sandage et al., 2017). Having the curiosity to learn about the circumstances surrounding the shame would help the CIT be open to accepting those circumstances (Sandage et al., 2017). Further, having self-awareness of their actions would help the CIT acknowledge responsibility and take action to repair relationships (Sandage et al., 2017).

Finally, being open to self-compassion would hlelp the CIT welcome kindness towards their self while facing the source of shame (Sandage et al., 2017).

Carl Rogers, in an interview with Baldwin (1987) on the use of self in therapy, stated that CITs needed to recognize that they were flawed and imperfect people, which made them vulnerable. In that same interview, Rogers went on to say that only when CITs accepted this vulnerability as flawed individuals, were they truly able to help others (Baldwin, 1987). Clinical humility may be a source of hope and sanctuary for a CIT experiencing feelings of shame or emotional dysregulation (Sandage et al., 2017). Aponte et al., (2009) considered it essential for CITs to reflectively engage their self-of-the-therapist to deepen the therapeutic process with their clients. Self-reflection for CITs involved intrapersonal exploration of experiences, emotions, and challenges they have faced (i.e., signature themes) which facilitated a greater understanding of a client's struggles. (Aponte et al., 2009; B. Orrison, personal communication, January 16, 2020; Pompeo & Levitt, 2014).

A good example of an active reflective process was outlined in a qualitative study by Melton et al. (2005). The authors asked CITs to listen to a recent counseling session and reflect upon their inner dialogue that was occurring at various points within the session. Melton et al. stated that it should be expected that CITs would experience varying emotional reactions during counseling sessions and that direct instruction as to how these emotions were influencing the session was vital to increasing self-awareness. Further, the authors stated that, in CES, change within a CIT was generally thought to occur primarily with experience. However, the authors believed that relying on time spent and experience to facilitate change could cause CITs to miss the rich opportunity to explore their affect in greater detail. Melton et al. (2005) went on to state that, without a more in-depth exploration of CITs' inner experiences, CES supervision may

default to the dichotomies of positive/negative emotional experiences rather than the varied emotions which influence the therapeutic process.

Rather than expect all dysregulated experiences would be resolved (Aponte & Kissil, 2012), clinical humility could facilitate the CIT to engage with, not merely react to, their present-day struggles. The factors of clinical humility could guide self-reflective practices which were embedded into clinical training. For example, if a CIT was feeling stuck with a client, the CIT could be encouraged to think flexibly about their client and themselves as to the signature themes that were impeding the therapeutic process and the ones which may facilitate it. Likewise, if a CIT was feeling trepidatious about a client who presented as skeptical of counseling and the CIT's abilities, the CIT could be encouraged to reflect with self-awareness as to the emotions of their inner dialogue during the session and remain open as to how that dialogue could inform their way of being in the session (Melton et al., 2005). A valid manner to measure clinical humility could build upon qualitative conceptualization and help solidify its viability to clinical training.

Measuring Humility

E. L. Worthington (2008) described humility as a quiet virtue that was not a singular characteristic but a multi-dimensional construct with intra- and interpersonal components. Social science scholars who studied the underlying components of humility have further conceptualized humility to have subdomains (e.g., intellectual, relational, and cultural; Hill et al., 2017). Interestingly, researchers have found that the subdomains of humility were not highly correlated with each other. This finding prompted the question as to whether the subdomains were derived from humility or better described as learned skill sets or convictions. Thus, Hill et al. stated that

there was much empirical research to be done, and this empirical research required valid and reliable measures of humility.

McElroy-Heltzel et al. (2018) and Hill et al. (2017) reviewed over 20 instruments measuring humility. They reviewed several instruments measuring a broad scope of humility, instruments measuring state vs. trait humility (Kruse et al., 2017), an instrument measuring expression of humility, and several instruments measuring subdomains of humility. These subdomains included intellectual humility, cultural humility, spiritual humility, CEO humility, and relational humility. Paine et al. (2015) discerned humility in the therapeutic setting as different than clinical competence and stated that contemporary developments in mental health services suggested the potential importance of clinical humility. Some of these developments have included greater recognition of the efficacy of incorporating client feedback and seeking professional consultation to improve practice, greater recognition of monitoring counselor self-criticism, and greater recognition of incorporating collaborative and rupture-repair processes with clients (Paine et al., 2015). This set the stage for future research into clinical humility as a subdomain of humility.

Hill et al. (2017) stated that, as of 2017, there had not been any published measures of clinical humility. Further, most instruments measuring humility had not been specifically studied within a therapeutic setting. One exception was the Cultural Humility Scale which measured clients' perceptions of their counselor's humility (Hook et al., 2013). Higher scores on the scale were positively associated with a strong therapeutic alliance and counseling outcomes (Hill et al., 2017). These findings indicated plausibility that clinical humility could also positively impact the therapeutic alliance and counseling outcomes and supported the need for a scale to measure clinical humility.

Measuring Clinical Humility

McElroy-Heltzel et al. (2018) stated that assessing specific domains of humility, not just measuring the broad scope of humility, was vital to furthering humility research. These authors explained that specific assessment of humility subdomains predicted more variance than assessments of general humility. The authors stated that measuring general humility was somewhat akin to personality assessment and assessing distinct subdomains of humility would be more predictive of that specific domain.

This author reviewed several research databases to ascertain in what professional fields humility researchers had their studies published and to gain a sense of the context of the research. The databases reviewed included Taylor and Francis Online, SAGE Journals Online, Wiley Online Library, EBSCOhost, JSTOR, APA PsycNET, SAGE Research Methods, and Science Direct. This author found that the research of humility had occurred primarily in the fields of psychology, theology, multicultural studies, and organizational leadership.

Within psychology research, the literature focused on measuring humility as both a personality trait and a virtue that could have positive value to people who embodied it. These studies relied primarily upon participants that were undergraduate college students, paid participants from an internet platform like Amazon's Mechanical Turk (MTurk; Ashton & Lee, 2008; Rowatt et al., 2006), or with a select number of people considered to be master therapists, teachers, or practitioners (Dlugos & Friedlander, 2001; Freeman, 2004; Jennings et al., 2005; Kottler & Carlson, 2013; Rønnestad & Skovholt, 2013). Further, most publishedstudies were assessing humility in a broad sense or assessing one of the subsets of humility like cultural, intellectual, or relational humility. Thus, what was missing were studies measuring clinical humility with participants that were in the counseling/psychology field.

Measuring Clinical Humility in Clinical Training

The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) helping skills standard 2.5.F states that the CES curriculum will teach CITs "characteristics and behaviors which influence the counseling process" (Section 2, p. 1). The word "characteristics" seemed to denote intrapersonal skills and the word "behaviors" seemed to denote interpersonal skills. Homrich et al. (2014) proposed that CES should adopt standards of conduct for expected CIT behavior. The authors discussed the importance of professional gatekeeping as guided by ethical codes to protect clients and the professional integrity of counseling. Further, they discussed *gateslipping*, which was passing a CIT onto the next gate-checking phase of their counseling program even when there were questionable concerns about the CIT's development. Homrich et al. proposed that standards of conduct could help prevent gateslipping and provide a framework for more in-depth counselor training.

For their study, Homrich et al. (2014) asked CES faculty from CACREP institutions to rank items in order of importance for professional, interpersonal, and intrapersonal behaviors. Some of the intrapersonal items included in the study that correlated with the proposed factors of clinical humility (in rank order) were: exhibit awareness of personal beliefs, values, strengths, and limitations and their influence on professional performance (self-awareness); maintain openness to differences in ideology (openness); participate in self-reflection and exploration (curiosity); solicit and respond respectfully to feedback from others (openness); explore personal reactions (self-awareness); and demonstrate flexible and adaptable thinking (flexibility; Homrich et al., 2014).

Homrich et al. (2014) described intrapersonal skills as internal functions within the CIT which directly contributed to the enhancement or impediment of effective counseling. The

authors found that the educators who participated in the study agreed about the rank and importance of the interpersonal and professional behaviors more so than the intrapersonal behaviors. The authors attributed this agreement upon professional and intrapersonal behaviors to the frequency with which these topics were studied in CES literature and to the observable and measurable nature of these behaviors (Homrich et al., 2014).

Focusing future CES research on the development intrapersonal skills which strengthen the self-of-the-therapist could be an important preventative component to gateslipping. Branson et al. (2015) discussed the unique demands placed upon CITs to gain academic skills as well as grow in their personal and professional awareness while engaged in their training programs. The authors stated the need for training programs to be proactive in the evaluation of CITs on professional behaviors (i.e., participation, time management, ethical behaviors, assuming responsibility, communicating respect for diverse perspectives) as well as the evaluation of CITs' commitment to deepening their self-awareness and personal growth.

When the need for remediation arose, Branson et al. (2015) proposed creating performance improvement plans with specific behavioral interventions and goals for the CIT. The authors discussed supportive interventions for remediating observable professional behaviors, however, interventions for deepening self-awareness were more elusive. For example, the authors presented a case study of a CIT who required a remediation plan that included observable components such as increased supervision and training in safety planning, and intrapersonal components such as developing cognitive complexity and building a tolerance for ambiguity. The intrapersonal components of the remediation plan would have been difficult to measure. Having the ability to measure progress with intrapersonal components could strengthen the implementation integrity of CIT remediation plans and prevent future gateslipping.

Self-Report Measures of Humility

Previously published scales which measure a broad conceptualization of humility or subdomains of humility utilize both self-report and other report design, although the majority have been self-report. Both designs have presented different challenges. Scores from self-report scales may negatively impact validity due to social desirability bias and scores from other report scales may combine other aspects of likeability with humility (McElroy-Heltzel et al., 2018). There has been a common concern amongst psychological researchers about self-enhancement bias. However, there was research evidence to the contrary. Kim et al. (2018) conducted a meta-analytic review of the means from 152 independent samples from self-report and other-report personality trait assessments. The authors found a surprising amount of accuracy with self-reporting and found only one small effect of self-enhancement on one personality indicator.

Baumeister et al. (2007) stated that the self-report of emotions, intentions, thoughts, and behavior was effective for furthering knowledge of attitudes and emotional experiences, yet they lamented the lack of studies measuring observable behaviors in psychological research. They discussed a common research issue: reporting results from observable behaviors leads people to question why the behavior happened yet reporting results from measuring inner processes does not seem to lead people to question whether the inner processes would impact future behavior (Baumeister et al., 2007).

McElroy-Heltzel et al. (2018) shared similar concerns with self-report measures of humility and proposed triangulating self-report with behavioral indicators. Given that self-report has been the primary measurement thus far for humility and its subdomains, it would be empirically necessary to have a valid measure of clinical humility as a starting point for expanded future research (Ashton et al., 2014; Hill et al., 2017). The self-report measure created

for this study did have behavioral aspects. Fifteen of the items were asking the participant to consider and report a behavior (i.e., learn, seek, search, adjust) and 6 of the items could be observable by others (i.e., work with others, allow others to lead, seek consultation). These items could be used in a future other-report capacity.

Best Practice in Scale Development

Fowler (2014) discussed the decisions researchers made when striving for optimal survey design. These included decisions regarding sampling, question design, and data collection. The sampling frame, sample size, sample design, and response rate would require careful exploration for sampling. For question design, the extent to which previous literature and research would inform the questions must be considered. For data collection, the means of collecting data (i.e., internet, email, social medias) must be considered for cost and feasibility. The Humility in Counseling Scale (HICS) has carefully considered decisions regarding each of these areas which will be elucidated in Chapter III.

Planning Phase of Scale Development

The three phases of scale development included the planning phase (review the literature and previous scales to conceptualize the construct), the construction phase (create the item pool and response format), and the quantitative evaluation phase (data collection, examine dimensionality and psychometric properties; Furr, 2011; Wren & Benson, 2004). Clark and Watson (1995) described the planning phase as twofold: (a) crystallizing the conceptualization of the construct to be measured and (b) an extensive review of the literature previously developed scales which measure the construct. Clark and Watson (1995) stated that the importance of a comprehensive literature review for scale development could not be overstated. The review

would help clarify the content and concept of the construct, identify issues with previously developed instruments, and determine if a new scale was in fact needed.

Construction Phase of Scale Development

The construction phase should begin with creating the item pool with the initial item pool should be broad and cover all aspects of the content (Clark & Watson, 1995). Writing the item pool should be an iterative process with conceptual and psychometric review along the way (Clark & Watson, 1995). The item pool for the HICS was developed following the protocol proposed by Fowler (2014) which was to conduct focus groups, write an initial set of items, do a critical review of items to detect errors, hold individual cognitive interviews about the items (not a replication of actual data collection), put the items into an instrument, and pre-test the survey using an approximation of the data collection procedures.

Quantitative Evaluation Phase of Scale Development

The quantitative phase essential to this study was factor analysis. Factor analysis is especially useful in psychological research with multi-item inventories that measure attitudes, personality constructs, and cognitive schemas (Floyd & Widaman, 1995). Factor analysis helps to identify the underlying dimensions which represent the theoretical constructs of the domain being assessed. The analysis procedure produces factor loadings of the latent variables (underlying dimensions) which predict the measured variable (domain being assessed). Further, the analysis procedure also produced factor loadings of correlations amongst the latent variables (Floyd & Widaman, 1995).

Factor analysis also provides insight into the variance structure of the scale. The analysis procedure sorts the variance associated with the latent variables (common variance) and the

variance associated with the measured variable and random error variance (unique variance; Floyd & Widaman, 1995). Exploratory analysis procedures include extracting, retaining, and rotating factors for an interpretable direction of the theoretical construct being measured. Factor analysis works optimally with careful item selection measured on an interval scale, such as a Likert Scale (Floyd & Widaman, 1995). The items on the HICS were measured by a 5-point Likert Scale.

Scale Validity

Clark and Watson (1995) outlined three essential steps for investigating the construct validity of a scale: (a) communicate the theoretical concept of the scale, (b) develop a way to measure the hypothetical concepts, and (c) empirically test the relations between the constructs. Loevinger (1957) described three components of item selection that would be essential to the structural validity of a scale. One was an empirical component in that the items selected were manifestations of the theoretical conceptualization of the construct. Another was that the items were presumed to have intercorrelation with each other, and a third component was that the item responses would reflect the latent variables (underlying dimensions; Loevinger, 1957, as cited in Clark & Watson, 1995).

Psychometric Instrument Use in Counselor Education and Supervision

Counselor educators have utilized diverse methods to assess CIT growth and performance. These methods included standardized assessments, supervisor evaluations, formative and summative assessment in academic courses, performance appraisal, and psychometric instruments (Tate et al., 2014). Although no single method would be sufficient, Tate et al. stated that psychometric instruments could provide reliable and valid assessment

within CES programs. However, the authors stated that psychometric instruments were underutilized within CES clinical training. Further, the authors stated that the use of psychometric instruments allowed counselor educators to engage in meaningful aggregation of data from psychometric assessment to support effective clinical training. For example, if an assessment revealed a weakness in a few areas across many CITs, clinical training in those areas could be enhanced (Tate et al., 2014). Similarly, psychometric assessment allowed for disaggregation of data to differentiate and scaffold clinical training for specific needs of individual CITs.

Tate et al. (2014) discussed the paucity of psychometric instruments with predictive validity available for counselor educators to use in clinical training. The authors proposed that instrument development (either new creation or strengthening existing instruments) could help to meet the expectations of CIT performance accountability as well as monitoring the continuous improvement of CITs (Tate et al., 2014). A valid measure of clinical humility could be a clinical training tool to measure the intrapersonal development of CITs and a means of differentiating training of more complex clinical skills.

Potential Impact of the Humility in Counseling Scale

Although the interpretation of therapeutic constructs could be subjective, infusing the concept of clinical humility into CES clinical training could be a viable method for CES faculty to facilitate CIT intrapersonal development. Based upon prior research and theoretical reflection, clinical humility seems to have underlying components that could provide a tangible focus for CITs to develop their self-of-the-therapist. If, after data analysis, the proposed factors of clinical humility (i.e., flexibility, self-awareness, openness, and curiosity) do, in fact, measure clinical

humility, the HICS could be an effective tool to measure growth in CITs' integration of clinical humility into the counseling relationship.

Scales developed by counselors to be utilized in CES have the potential to strengthen pedagogy, measure CIT growth, foster improved counseling outcomes, and support gatekeeping. However, there were no published scales which measured clinical humility. Thus, the HICS has potential to facilitate future CES research into the impact of clinical humility on several clinical training areas such as CIT intrapersonal development, the therapeutic alliance, and the development of the CITs' self-of-the-therapist.

Summary

The field of CES has a more than a 60-year history of research and knowledge for educators to draw upon when developing the clinical skills of CITs. However, funneling that knowledge into observable and measured CIT growth could be an overwhelming process, particularly with CIT intrapersonal development. Focused clinical training which strengthens the CIT's self-of-the-therapist could help to build a strong foundation for intrapersonal growth. Introducing clinical humility as an integral part of the intrapersonal process could help CITs embody an open, flexible, curious, and self-aware approach to the therapeutic alliance. A quantitative measurement of clinical humility could help illuminate its relevance in CES clinical training.

CHAPTER III

METHODOLOGY

This chapter describes the methodology of constructing the Humility in Counseling Scale (HICS) and the quantitative process of analyzing the HICS for common factors and reliability. The chapter begins with the research statement, followed by the research design including the research questions and hypotheses. Next, a synopsis of the research procedures including data collection, target population, sampling frame, and sampling procedures are discussed. This is followed by an analysis of the instrumentation to be used in this study. Finally, the intended methods of data analysis chosen to answer each research question are presented.

Research Statement

The aim of this study was to develop an instrument which produces valid and reliable scores to measure clinical humility with counselors. This study expanded upon humility assessment research by creating an instrument specific to measuring the subdomain of clinical humility. Clinical humility has been defined as a disposition of the clinician that helps to integrate relational dynamics between counselor and client (Paine et al., 2015). The Humility in Counseling Scale (HICS) is a self-report measure designed to uniquely assess counselors' dispositions of clinical humility. There has been a lack of psychometric assessment within counselor education and supervision, particularly assessment which could support the intrapersonal development of counselors-in-training (Tate et al., 2014). This study has a possible

future implication of enhancing clinical training within counselor education and supervision through the psychometric assessment of clinical humility.

Research Design

This study was a quantitative research study using survey method. Considering that the purpose of this study was to develop a new scale, survey method was identified as efficacious to obtain an adequate number of responses for data analysis (Remler & Van Ryzin, 2015). At the time of this study, there were no existing measures of clinical humility. Thus, the design of this study centered around the components of new scale development and interpreting the construct of clinical humility. This approach was consistent with previous studies that developed self-report measures of humility and, thus, could add to the empirical literature on the topic.

To address the goal of interpreting the construct of clinical humility, the current study used exploratory factor analysis (EFA) to determine the underlying factor structure of the construct. Utilizing the statistical procedures within EFA to extract latent factors helped this researcher decipher their relevance to the construct of clinical humility. Further, this researcher examined the psychometric properties of the scores of the HICS to interpret factorial validity and internal consistency reliability with the targeted population. The next section presents the research questions and hypotheses guiding this study.

Research Questions and Hypotheses

The research questions and hypotheses for this study were as follows:

Q1 Do the subscales from the Humility in Counseling Scale demonstrate adequate internal consistency when administered to counselors/CITs?

H01 The Humility in Counseling Scale has a Cronbach's coefficient alpha of $< .80$ across the four subdomains of flexibility, openness, curiosity, and self-awareness.

Ha1 The Humility in Counseling Scale has a Cronbach's coefficient alpha of > .80 across the four subdomains of flexibility, openness, curiosity, and self-awareness.

Q2 Do the items from the Humility in Counseling Scale demonstrate interpretable factorial validity?

H02 Following EFA rotation, the items comprising the factors will have factor loadings of < .35.

Ha2 Following EFA rotation, the items comprising the factors will have factor loadings of > .35.

Q3 What is the strength of association between demographic variables of age and CIT/practicing counselor and derived factor scores?

H03 The potential interaction effects of the demographic variables of age and CIT/practicing counselor will be nonsignificant ($p > .05$).

Ha3 The potential interaction effects of demographic variables of age and CIT/practicing counselor will be significant ($p < .05$).

Research Procedures

Data Collection

This researcher obtained approval from the Institutional Review Board (IRB; Protocol Number 2010013812; see Appendix A) and verification of the research subject (see Appendix B) from the University of Northern Colorado for this study. Following IRB approval, the HICS was electronically distributed via multiple internet databases (see sampling frame). Participants received a link to access the survey via Qualtrics, a software which helps create surveys and collect the data. Demographic information was collected at the beginning of the survey, followed by the 31-item HICS (see Appendix C). The first page of the survey had a consent form for the participants to read (see Appendix D). The survey was confidential, and no names were collected. The participants were instructed that, if they moved forward to complete the survey, that was acknowledgment of their consent. Access to the data was restricted to the researcher through the University of Northern Colorado's password protected Qualtrics system.

Targeted Population

The participants were Master's and doctoral counselors-in-training (CITs) and practicing counselors. This researcher aspired for approximately 50% of the participants to represent counselors in training (CIT) and 50% of the participants to represent practicing counselors. Earnest effort was made (reaching out to counseling training programs and counseling practices from every region of the United States) to include participants who represented diverse demographics including geographic location, age, ethnicity, gender, educational institution accreditation, and work setting. The CITs represented students from CACREP and non-CACREP accredited counseling training programs. The practicing counselors represented counselor educators, pre-licensed counselors/school counselors, Licensed Professional Counselors, and Professional School Counselors. Participants with other licensures (i.e., Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and Licensed Rehabilitation Counselor) were excluded as it would have been difficult to control for the differences in clinical training requirements.

Sampling Frame

This study utilized a well-established ratio of 5 to 10 respondents per questionnaire item (Mvududu & Sink, 2013). Thus, this researcher aimed for 350-400 participants. The participants were invited (see Appendix E) from counseling listservs such as CESNET (listserv for counselor educators and supervisors) and ASCA Scene (listserv of the American School Counselor Association), counseling-specific Facebook groups and Reddit groups, and emails to counseling program coordinators asking permission to distribute the survey via their program listserv.

Sampling Procedures

This researcher utilized both convenience and snowball sampling procedures to obtain an adequate sample size. Snowball sampling for this study entailed participants sharing the Qualtrics link with other CITs/practicing counselors who were their colleagues or acquaintances. Snowball sampling could be efficacious when large numbers of responses were desired (Remler & Van Ryzin, 2015). Convenience sampling for this study entailed this researcher inviting potential participants via the previously mentioned electronic resources. Although snowball sampling and convenience sampling could have generalizability limitations, every effort was made by this researcher to obtain an adequate sample of diverse participants that were representative of the larger CIT, practicing counselor, and counselor educator population in the United States.

Instrumentation

The instrument used for this study was the Humility in Counseling Scale. This instrument was created specifically for this study. While it could be assumed that participants from the counseling field would have little incentive to respond to an anonymous survey from a socially desirable lens, the name of the scale was changed to *Counselor Disposition Scale* when it was distributed to participants. This was a mild deception that the construct being measured was humility. Participants responding in a socially desirable manner was an inherent research concern with self-report instruments, and this mild deception helped to reduce the likelihood that participants would respond in a manner to highlight their perceived humility. As disposition is a neutral term, it seemed less likely to incentivize respondents to answer questions in a certain manner.

Humility in Counseling Scale

The HICS had 31 randomized scale items which were measured on a 5-point Likert scale, 1= *Strongly Disagree,* 2 = *Disagree,* 3 = *Neutral,* 4 = *Agree,* 5 = *Strongly Agree.* Based upon extensive review of the literature, the scale items represented the proposed factors of clinical humility: curiosity (seven items), flexibility (seven items), openness (eight items), and self-awareness (nine items). The scale development teamed aimed for an equal number of scale items per factor, but following the results of the pilot study, a few scale items which lacked variance were removed. Additionally, a couple scale items were removed based upon recommendations from the expert review. Finally, the HICS had an eight-question demographic section (e.g., gender, ethnicity, age, in-practice or CIT, licensure, work setting, geographic location, and CACREP accreditation status of graduate training) for the purposes of gathering data that allowed for comparative analysis amongst demographic groups. The following is a brief description of the item development process for the HICS.

Item Development Process for the Humility in Counseling Scale

The empirical process of developing the HICS began as a collaborative effort between this researcher and a faculty researcher in Counselor Education and Supervision (CES), Dr. Christopher Sink. Dr. Sink proposed researching the phenomena of counselor humility during a professional presentation and then collaborated with this researcher to begin the scale development process with a literature review of humility (C. Sink, personal communication, March 21, 2018). In reviewing the literature, this researcher did not find any published instruments measuring clinical humility, and the existing humility instruments did not measure aspects of humility relevant to the counseling relationship. This necessitated the development of

the HICS. In January of 2019, two more doctoral student researchers were added to the scale development team.

Focus groups and think-alouds/cognitive interviews were conducted by this researcher which provided valuable input into scale item creation (see Appendix F). Next, a pilot version of the HICS was administered to a small sample of counselors-in-training (CITs) and practicing counselor participants. Revisions to individual scale items were made based upon their feedback and a preliminary data analysis was conducted (see Appendices G and H). The preliminary analysis suggested strong inter-item correlation (Cronbach's alpha ~ .90) and normality in the data, yet the analysis also revealed that a few scale items lacked variance. These items were revised with less equivocal language to possibly generate more variance and help account for socially desirable responding.

Expert Review of the Humility in Counseling Scale

Expert review of scale items was considered an important step in assuring content validity of the instrument (DeVellis, 2017). An expert review of the HICS was conducted by five counseling and psychology scholars from four different educational institutions (see Appendix I). The scale development team made several grammar and content revisions to individual scale items based upon the feedback from the expert reviewers (see Appendix J), which helped support the content validity of the HICS. Based upon the proposed factors of clinical humility for this study, the following is a brief description of the four subscales in the HICS.

Subscales of the Humility in Counseling Scale

Flexibility. Having psychological flexibility is believed to be key to helping a counselor regulate self-appraisal (Wei et al., 2014) and protect against biased decision making (Zmigrod et

al., 2019). Example scale items from the flexibility subscale: “I carefully consider context before assigning meaning to a counseling interaction” and “I can readily adjust my thinking as I learn new information from my clients.”

Self-Awareness. In counseling, self-awareness is developed through the exploration and reflection of personal experiences and may help counselors understand how their biases and attitudes impact the therapeutic alliance (Leach et al., 2010; Suthakaran, 2011). A deepened understanding of self and self-of-the-therapist were aligned with embodying clinical humility. Example scale items from the self-awareness subscale: “I acknowledge when my values may influence the therapeutic process” and “I know the limits of my understanding of clients’ concerns.”

Openness. Being other-oriented, open to feedback, and having a lack of rigidity were viewed as important aspects of clinical humility which could help counselors accept alternative values and attitudes; consider new ideas and contradictory information; and integrate feedback from supervisors, peers, and clients (Leary et al., 2017; Tangney, 2002; C. Sink, personal communication, January 15, 2020). Example scale items from the openness subscale: “Even when my core values are opposite to those of the client, I consciously strive to understand their point of view” and “I readily embrace supporting clients whose values are different from mine.”

Curiosity. In the context of clinical humility, two types of curiosity were relevant: diversive curiosity (i.e., understanding a well-rounded picture of the human experience; Hardy et al., 2017) and empathic curiosity (i.e., engaging in the felt meanings the client is experiencing and linking curious questions to the client’s non-verbal experience; McEvoy et al., 2012). Example scale items from the curiosity subscale: “I really enjoy the search for knowledge related

to the counseling profession" and "I regularly pursue new ways for clients to work through their concerns."

Data Analysis

Data Screening and Cleaning

Following data collection via Qualtrics, the resulting dataset from administration of the HICS for this study was exported to IBM SPSS (version 27). The data was analyzed for multivariate normality, missing data, and outliers. The dataset was screened for extreme outliers, which were removed. Missing Likert scale items were assigned the item mean. Cases that had 5% or more of missing data were deleted.

Inspection of the Parametric Properties of the Scale

Descriptive statistics of item responses were assessed including mean, range, and standard deviation. Several plots were visually analyzed for normality including box, PP, and QQ plots with histograms and box plots. The skew and kurtosis of the items were analyzed, with ideal skew between -1 and 1; ideal kurtosis between -2 and 2 (Field, 2013).

Exploratory Factor Analysis

Exploratory factor analysis (EFA) was identified by this researcher as the analysis method to answer Research Questions 2 and 3. Exploratory factor analysis was performed on this data set to help this researcher understand the latent factors that accounted for the shared variance amongst the items (R. L. Worthington & Whittaker, 2006).

Initial Reliability and Correlational Analysis

To address Research Question 1, a correlation matrix was generated to determine inter-item correlations and the statistical significance was analyzed for an ideal *p*-value of > .5. Once

the correlation matrix was generated, the factorability of the data set was analyzed. Cronbach's alpha was computed looking for low-moderate correlations (r = .30) to strong correlations ($r \geq$ .80) indicating internal reliability consistency (Mvududu & Sink, 2013; R. L. Worthington & Whittaker, 2006).

Verifying Assumptions

Due to the possibility of error when determining factorability, this researcher verified two assumptions prior to factor extraction. The Kaiser-Meyer-Olkin (KMO) test of sampling adequacy was computed to affirm an adequate sample size had been obtained for factorability. This researcher looked for a KMO of .60 to .90 to indicate there was a factor identity matrix (Mvududu & Sink, 2013). Then, the Bartlett's test of sphericity was computed looking for significance of p = < .5 which helped to ascertain the factorability of the dataset by comparing the correlation matrix to the identity matrix and checking for redundancy that could be explained with fewer factors (Mvududu & Sink).

Factor Extraction

The factor extraction method utilized for this study was principal axis extraction in which all the variables belong to the first group and factors were extracted until enough of the shared variance in the correlation matrix was explained (Yong & Pearce, 2013). Principal axis extraction was preferred when exploring underlying factors theorized by the researcher, as was the case with this study (Mvududu & Sink, 2013).

Factor Retention

This researcher examined scale items for high and low factor loadings. Items that had factor loadings of > .35 were considered for retention (Mvududu & Sink, 2013). A few other methods of retention were also employed including the Kaiser criterion, scree plot, and total

variance explained chart. The Kaiser criterion removed factors with eigenvalues less than 1. The total variance chart was examined for meaningful variance, and this researcher also considered removing factors with eigenvalues that explained less than 10% of the total variance. Additionally, this researcher examined the scree plot for visual representation of the number of factors to retain.

Factor Rotation

Mvududu and Sink (2013) suggested using an oblique rotation with EFA in counseling research due to the high likelihood of correlation between the factors. Thus, this researcher used the SPSS oblique rotation of direct oblimin (delta = 0) for this study. This researcher examined the factor correlation matrix and pattern matrix of factor loadings to interpret the shared variance of each variable separate from the unique variance and error variance of each variable. This helped to identify the underlying factor structure and simple factor structure.

Communalities were also examined, and a minimum of 60% of the shared variance was considered acceptable for determining factors. Items which had significant cross-loadings on two or more factors were deleted. This researcher repeated the analysis without the deleted items to obtain a simple factor structure. Additionally, a reliability analysis on the overall scale and the derived factors was also conducted, seeking ideal alpha values of > .70.

Naming the Factors

The names of the factors were confirmed. The possibility of re-naming and/or eliminating the factors was considered if a four-factor structure did not emerge which represented the conceptual meaning of the variables based in the theoretical and research literature supporting this study (Mvududu & Sink, 2013).

Correlation Analysis

To answer Research Question 4, correlations were computed between the demographic variables and the derived factor scores. Pearson's correlation coefficient was examined to determine the effect size of the correlation. The effect size of the correlation ($\geq$ .10-.29 represented a small effect, $\geq$ .30-.49 represented a medium effect, and $\geq$ .50 represented a large effect) was examined to interpret the possible interacting effect of demographic variables on the derived factors (Field, 2013).

Summary

This chapter explored the methodology and statistical procedures essential to administering the HICS and examining its factor structure and reliability. Hill et al. (2017) discussed the need for empirical research on the subdomains of humility. Empirical research has required instruments that have valid and reliable scores from their intended population. Determining the underlying factor structure of the HICS helped to strengthen the theoretical conceptualization of clinical humility. The EFA and correlation analysis of demographic variables helped to determine the viability of the HICS as a reliable measurement of clinical humility.

CHAPTER IV

RESULTS

This chapter presents the results of the data collection and analysis. First, the research questions and hypotheses are restated followed by an overview of the dataset and participant demographic statistics. Second, assumption checking procedures and normality of the data are reviewed. Third, the results of the scale item analysis and Exploratory factor analysis (EFA) are presented with a description of how the latent factors were named. Finally, the findings of the reliability and correlational analysis are presented.

Research Questions and Hypotheses

The main intent of this study was to address a gap in the research literature regarding the lack of a psychometric scale that measures clinical humility. Thus, one purpose of this study was to create and assess the reliability of the Humility in Counseling Scale (HICS). The second purpose was to determine whether a four-factor structure would be supported when the instrument was administered to a broad sample of CITs and practicing counselors. The third purpose was to assess counselors-in-training (CIT) and practicing counselor's perceived clinical humility. The research questions and hypotheses for this study are as follows:

Q1 Do the subscales from the Humility in Counseling Scale demonstrate adequate internal consistency when administered to counselors/CITs?

H01 The Humility in Counseling Scale has a Cronbach's coefficient alpha of $< .80$ across the four subdomains of flexibility, openness, curiosity, and self-awareness.

Ha1 The Humility in Counseling Scale has a Cronbach's coefficient alpha of > .80 across the four subdomains of flexibility, openness, curiosity, and self-awareness.

Q2 Do the items from the Humility in Counseling Scale demonstrate interpretable factorial validity?

H02 Following EFA rotation, the items comprising the factors will have factor loadings of < .35.

Ha2 Following EFA rotation, the items comprising the factors will have factor loadings of > .35.

Q3 What is the strength of association between demographic variables of age and CIT/practicing counselor and derived factor scores?

H03 The potential interaction effects of the demographic variables of age and CIT/practicing counselor will be nonsignificant ($p > .05$).

Ha3 The potential interaction effects of demographic variables of age and CIT/practicing counselor will be significant ($p < .05$).

Dataset and Descriptive Statistics

Data were analyzed with 386 practicing counselors and CITs, ages within the range of 18-79, with the mean age range of 30-39 ($n = 139$). Participants reported their geographical location from 48 of the United States with the highest representation in the data set located in Colorado ($n = 39$), Texas ($n = 38$), Pennsylvania ($n = 28$), Ohio ($n = 20$), New York ($n = 19$), and in Arizona, Massachusetts, Michigan, Illinois, Virginia, and California (n between 10-16). Additionally, six participants reported international locations (Canada, England, and Ireland). There was a higher number of participants who identified their race/ethnicity as White in comparison to non-White participants, and a higher number of participants who identified as Cis woman in comparison to non-Cis gender identities. There was more proportionality in the data between practicing counselors/CITs as well as moderate proportionality across work settings (mental health clinic, schools, private

practice, hospitals, etc.). Additionally, the majority of participants indicated their training program was accredited or in-progress by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Detailed descriptive statistics (see Table 1) were analyzed for age, gender, race/ethnicity, practicing counselor/CIT, practice/training setting, and Council for the Accreditation of Counseling and Related Programs (CACREP)/non-CACREP accreditation status of the participants' training program.

Data Cleaning and Screening

This researcher examined 433 responses to the survey and removed responses that had more than 5% missing data. This resulted in an SPSS (version 27) dataset of 386 participant responses. An additional visual scan of the non-demographic items was conducted which revealed four missing values. The missing values were replaced with the item mean, and alphanumeric participant responses were recoded to numerical responses (Field, 2013). Next, the data were analyzed for normality.

Several plots (PP plots, QQ plots with histograms, box plots) were generated to determine normality in the data. These plots revealed that most scale items were negatively skewed, which was also indicated by the scale item means (i.e., all but four scale items had means $\geq$ 4.0 on the 5-point Likert Scale). The descriptive statistics were reviewed, and the skew and kurtosis of each item was analyzed for extremes (see Table 2). Most items had the desired skew between -1 and 1, and the desired kurtosis between -2 and 2. However, two items were removed for having both extreme skew and kurtosis (i.e., item 1, "I regularly pursue new ways for clients to work through their concerns," had a kurtosis of 4.228 and a skew of -1.447 and item 23, "I always seek to understand my clients' unique perspectives," had a kurtosis of 3.2 and a skew of -1.04). Therefore, subsequent analysis was conducted on the 29 remaining scale items.

Table 1

Frequency Distributions for Demographic Variables

Variable	*n*	%	Valid Percent	Cumulative Percent
Age				
18 - 29	100	25.9	25.9	25.9
30 - 39	139	36.0	36.0	61.9
40 - 49	71	18.4	18.4	80.3
50 - 59	58	15.0	15.0	95.3
60 - 69	15	3.9	3.9	99.2
70 - 79	5	0.8	0.8	100.0
Gender				
Non-Binary	10	2.6	2.6	2.6
Cis Woman	296	76.7	77.1	79.7
Trans Woman	2	0.5	0.5	80.2
Cis Man	33	8.5	8.6	88.8
Genderqueer	2	0.5	0.5	89.3
Agender	1	0.3	0.3	89.6
Genderfluid	3	0.8	0.8	90.4
Different Identity from Above Options	37	9.6	9.6	100.0
Missing	2	0.5		

Table 1 (continued)

Variable	*n*	%	Valid Percent	Cumulative Percent
Race/Ethnicity				
American Indian	5	1.3	1.3	1.3
Asian	9	2.3	2.3	3.6
Asian Indian	6	1.6	1.6	5.2
Black/African American	15	3.9	3.9	9.1
Hispanic/Latinx	20	5.2	5.2	14.3
Middle Eastern or North African	2	0.5	0.5	14.8
Multi-Racial/Bi-Racial	12	3.1	3.1	17.9
Pacific Islander	1	0.3	0.3	18.2
White/Caucasian	309	80.1	80.3	98.4
Different Identity from Above Options	6	1.6	1.6	100.0
Missing	1	0.3		
Licensed/Certified Counselor				
Yes	232	60.1	60.3	60.3
No	44	11.4	11.4	71.7
In-Progress	109	28.2	28.3	100.0
Missing	1	0.3		
Practice/Training Status				
In-Practice (Earned Master's)	206	53.4	53.4	53.4
In-Practice (Earned Ph.D.)	21	5.4	5.4	58.8
In-Training (Master's)	115	29.8	29.8	88.6
In-Training (Ph.D.)	9	2.3	2.3	90.9
Both In-Practice (Earned Master's & In-Training Ph.D.)	35	9.1	9.1	100.0

Table 1 (continued)

Variable	*n*	%	Valid Percent	Cumulative Percent
CACREP Training Program				
Yes	296	76.3	76.3	76.3
No	68	17.5	17.5	93.8
In-Progress	24	6.2	6.2	100.0
Practicing Counselor / Work Setting				
Private Practice	83	21.5	26.9	26.9
Mental Health Clinic	54	14.0	17.5	44.5
Home-Based	4	1.0	1.3	45.8
Pre K-12 School	97	25.1	31.5	77.3
College/University Counseling Center	7	1.8	2.3	79.5
College/University (Faculty)	11	2.8	3.6	83.1
Hospital Setting	11	2.8	3.6	86.7
Other Setting	41	10.6	13.3	100.0
Counselor in Training / Practicum Setting				
Private Practice	33	8.5	21.6	21.6
Mental Health Clinic	27	7.0	17.6	39.2
Home-Based	5	1.3	3.3	42.5
Pre K-12 School	62	16.0	40.5	83.0
College/University Counseling Center	8	2.1	5.2	88.2
Hospital Setting	3	0.8	2.0	90.2
Other Setting	15	3.9	9.8	100.0

Table 2

Item Frequency and Normality Statistics

		Min	Max	*M*	*SD*	Skew	Kurtosis
*Q1	I regularly pursue new ways for clients to work through their concerns.	1	5	4.19	0.759	-1.447	4.228
*Q2	I am honest with myself about all my counseling deficiencies.	1	5	4.270	.589	-0.527	2.002
*Q3	My clients' concerns have a much higher priority than my own within the session.	1	5	4.33	0.716	-1.013	1.367
*Q4	My attitude towards clients is largely malleable.	1	5	3.58	0.831	-0.566	0.055
Q5	When clients challenge me with a different perspective, I am genuinely receptive to new ways of thinking.	1	5	4.25	0.596	-0.597	2.257
Q6	I am fully aware that my behaviors serve as an example to clients.	1	5	4.55	0.580	-0.944	0.340
*Q7	I believe that ongoing personal counseling is essential to enhance my professional development.	1	5	4.09	0.934	-0.835	0.003
Q8	Every client teaches me something about myself.	1	5	3.95	0.881	-0.631	-0.097

Table 2 (continued)

		Min	Max	*M*	*SD*	Skew	Kurtosis
Q9	I earnestly try to understand clients' solutions to their issues even if they conflict with my values.	1	5	4.44	0.556	-0.381	-0.294
Q10	I carefully consider context before assigning meaning to a counseling interaction.	1	5	4.20	0.635	-0.434	0.472
Q11	I am able to restructure sessions in order to adapt to the needs of my clients.	1	5	4.22	0.674	-0.747	1.452
Q12	I am very conscious of how my beliefs affect the counseling process.	1	5	4.32	0.617	-0.672	1.583
Q13	I readily embrace supporting clients whose values are different from mine.	1	5	4.25	0.676	-0.551	0.080
Q14	I really want to learn from clients who don't share my world view.	1	5	4.18	0.788	-1.630	1.630
Q15	When making decisions about counseling, I consider my clients' needs first.	1	5	4.47	0.572	-0.578	-0.152
Q16	I regularly acknowledge my biases when I face ethical dilemmas in counseling.	1	5	4.30	0.623	-0.838	2.460
Q17	I work with my clients to incorporate counseling interventions which challenge my world view.	1	5	3.63	0.790	-0.258	-0.308
Q18	I really enjoy the search for knowledge related to the counseling profession.	1	5	4.44	0.670	-1.098	1.570

Table 2 (continued)

		Min	Max	*M*	*SD*	Skew	Kurtosis
*Q19	I have no difficulty putting my own agenda on hold in the counseling session, allowing clients to lead the session.	1	5	4.22	0.577	-0.134	0.053
Q20	I can readily adjust my thinking as I learn new information from my clients.	1	5	4.22	.577	-0.134	0.053
Q21	I try to advance my skillset in all of my interactions with clients.	1	5	4.18	0.690	-0.636	0.625
*Q22	I wouldn't ask my clients to do something that I, myself, would not try in my personal life.	1	5	3.85	1.034	-0.57	-0.672
*Q23	I always seek to understand my clients' unique perspectives.	1	5	4.52	0.559	-1.047	3.243
Q24	I consistently seek new ways to understand all of my clients.	1	5	4.30	0.608	-0.744	2.435
Q25	I acknowledge when my values may influence the therapeutic process.	1	5	4.26	0.583	-0.287	1.001
Q26	I know the limits of my understanding of client's concerns.	1	5	4.10	0.663	-0.752	1.932
Q27	I find it very hard to explore new client concerns when I lack confidence in my abilities.	1	5	3.31	1.046	-0.217	-0.822

Table 2 (continued)

		Min	Max	*M*	*SD*	Skew	Kurtosis
Q28	In the counseling relationship, I actively put aside my biases to put my clients' concerns before my own.	1	5	4.18	0.603	-0.675	2.684
Q29	I consistently seek professional consultation when my values are perhaps impeding the therapeutic process.	1	5	4.32	0.683	0.741	0.387
Q30	Even when my core values are opposite to those of my client, I consciously strive to understand their point of view.	1	5	4.33	0.546	-0.383	2.353
Q31	I actively seek as much information as I can when facing clients' concerns with which I am unfamiliar.	1	5	4.43	0.564	-0.410	-0.258

Note. *N* = 386; *SE* for Skew = .124; *SE* for Kurtosis = .248; * = items removed prior to EFA; No missing data.

Exploratory Factor Analysis

Inter-item Correlation and Initial Reliability Analysis

Prior to the factor extraction and rotation, items were analyzed for correlations and reliability to have the most viable dataset for exploratory factor analysis. This researcher examined the inter-item correlations to further assess the parametric properties of each item for factorability. Items that minimally correlated with at least half of the other items in the data set ($r \geq .20$) were retained as factors (Field, 2013). The following items were lacking minimal correlations with at least half of the items and, thus, were removed from further analysis: item 2, "I am honest with myself about all my counseling deficiencies;" item 3, "My clients' concerns have a much higher priority than my own within the session;" item 4, "My attitude towards clients is largely malleable:' item 7, "I believe that ongoing personal counseling is essential to enhance my professional development;" item 19, "I have no difficulty putting my own agenda on hold in the counseling session, allowing clients to lead the session;" and item 22, "I wouldn't as my clients to do something that I, myself, would not try in my personal life." Further reliability analysis revealed a Cronbach's Alpha of .880 on the standardized items and, after removing the items for skew/kurtosis extremes and low inter-item correlations, the Cronbach's Alpha was .851 for the factor analysis dataset consisting of 23 scale items.

Exploratory Factor Analysis

Two assumptions were checked prior to conducting the initial EFA. The first, Bartlett's Test of Sphericity, had a result of $\chi_2 (253) = 2220.874$ ($p < .001$) indicating factorability of the dataset. The second, Kaiser-Meyer-Olkin (KMO) Test of Sampling Adequacy, had a result of .889, further demonstrating an intercorrelation matrix favorable for factor analysis (Mvududu & Sink, 2013). The first EFA conducted was with 23 items using Principal Axis factor analysis in

SPSS using the default settings of a 5-factor solution and an oblique factor rotation (direct oblimin, delta = 0). In addition, the Kaiser criterion was utilized to exclude factors with eigenvalues less than 1. This initial EFA revealed a 5-factor solution explaining 35.953% of total variance in the intercorrelation matrix. However, 24.620% of that total variance was explained with the first factor, and the other four factors had less than 4% each. Typically, factors with less than 10% of the shared variance were not retained. Additionally, 21 of the variables loaded on the first factor with a loading of > .350 in the factor matrix with 1 variable loading on the third factor > .350 and another variable loading on the fourth factor > .350. Figure 1 depicts the rotated factor plot.

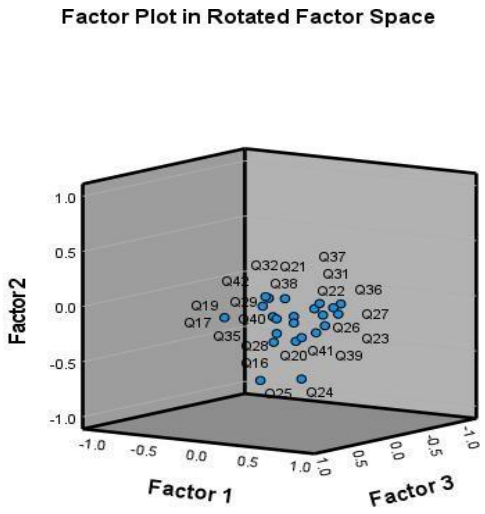

Figure 1. *Rotated factor plot.*

Post-Rotation Analysis

Factor retention was determined by factor loadings > .350, minimal cross loadings on two or more factors, and communalities > .23. Thus, two items were removed post-rotation. These items included: item 17, “I work with my clients to incorporate counseling interventions which challenge my worldview” (communality = .212) and item 29, “I consistently seek professional consultation when my values are perhaps impeding the therapeutic process” (communality = .197). Based upon the results of the post-rotation analysis, this researcher decided to try a two-factor EFA to determine if the variables would have significant factor loadings for a two-factor solution.

Two-Factor Analysis

The second EFA conducted was with 21 items using Principal Axis factor analysis in SPSS indicating a two-factor solution with oblique (direct oblimin, delta = 0) rotation. The Kaiser criterion was again utilized to exclude factors with eigenvalues less than 1. This EFA revealed a two-factor solution explaining 28.432% of the total variance in the intercorrelation matrix. Figure 2 is the scree plot from the two-factor EFA, which provided a visual representation of the two-factor solution. The bend in the line depicts the ideal number of factors to retain (Mvududu & Sink, 2013).

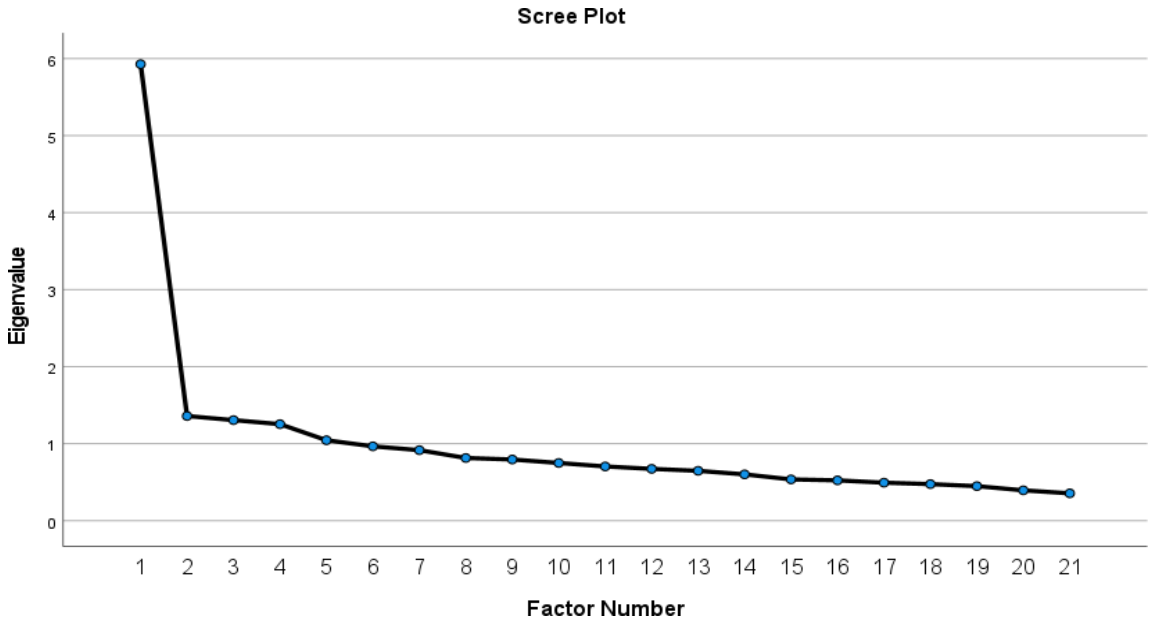

Figure 2. Scree plot.

However, similar to the initial EFA, most of the total variance was explained by the first factor, which accounted for 25.012% of the total variance, and the second factor only accounted for 3.420% of the total variance. Further, 19 of the variables loaded on the first factor with a factor loading > .350. Two of the variables did not load significantly on either factor with loadings < .350.

Post-Rotation Analysis

Consistent with the initial EFA, factor retention was determined by factor loadings > .350, minimal cross loadings on two or more factors, and communalities > .23. After examining the communalities of the variables, three items were removed: item 6, “I am fully aware that my behaviors serve as an example to clients” (communality = .014); item 8, “Every client teaches me something about myself” (communality = .132); and item 27, “I find it very hard to explore new client concerns when I lack confidence in my abilities” (communality =

.065). Based upon the post rotation analysis, this researcher decided to try a third EFA with a one factor solution.

One-Factor Analysis

The third EFA conducted was with 18 items using Principal Axis factor analysis in SPSS indicating a one-factor solution. The Kaiser criterion was again utilized to exclude factors with eigenvalues less than 1. This EFA revealed a one-factor solution explaining 27.478% of the total variance in the intercorrelation matrix. Every variable loaded with factors scores > .350 in the factor matrix (see Table 3). After examining the communalities from the one-factor analysis, it was decided to remove three more items based upon low communalities: item 14, “I really want to learn from clients who don’t share my worldview (communality = .180); item 18, “I really enjoy the search for knowledge related to the counseling profession” (communality = .166); and item 21. “I try to advance my skillset in all of my interactions from my clients (communality = .203).

Table 3

Factor Matrix from Exploratory Factor Analysis, One-Factor Solution

Item		Loadings
Q5	When clients challenge me with a different perspective, I am genuinely receptive to new ways of thinking.	.499
Q9	I earnestly try to understand clients' solutions to their issues even if they conflict with my values.	.493
Q10	I carefully consider context before assigning meaning to a counseling interaction.	.529
Q11	I am able to restructure sessions in order to adapt to the needs of my clients.	.504
Q12	I am very conscious of how my beliefs affect the counseling process.	.528
Q13	I readily embrace supporting clients whose values are different from mine.	.585
Q14	I really want to learn from clients who don't share my world view.	.424
Q15	When making decisions about counseling, I consider my clients' needs first.	.505
Q16	I regularly acknowledge my biases when I face ethical dilemmas in counseling.	.493
Q18	I really enjoy the search for knowledge related to the counseling profession.	.408
Q20	I can readily adjust my thinking as I learn new information from my clients.	.529
Q21	I try to advance my skillset in all of my interactions with clients.	.450
Q24	I consistently seek new ways to understand all of my clients.	.666

Table 3 (continued)

Item		Loadings
Q25	I acknowledge when my values may influence the therapeutic process.	.532
Q28	In the counseling relationship, I actively put aside my biases to put my clients' concerns before my own.	.570
Q26	I know the limits of my understanding of my clients' concerns.	.462
Q30	Even when my core values are opposite to those of the client, I consciously strive to understand their point of view.	.670
Q31	I actively seek as much information as I can when facing clients' concerns with which I am unfamiliar.	.510

Naming the Factors and Reliability

This researcher created a scale comprised of four proposed factors (self-awareness, openness, curiosity, and flexibility) which measured clinical humility. The scale had a Cronbach's Alpha of .851 for the initial EFA dataset, and the 15-item scale derived from the one-factor EFA had a Cronbach's Alpha of .858. Following three iterations of EFA, conducting a post-rotation analyses, and arriving at a one-factor solution, this researcher reviewed the content of the 15 items which comprised the one-factor solution. There were four items intended to measure self-awareness, five items intended to measure openness, four items intended to measure flexibility, and two items intended to measure curiosity. With only two items remaining which reflected curiosity, this researcher considered statistical and theoretical options for proceeding with and without curiosity as a factor of clinical humility. This researcher decided that further discussion and analysis were needed to determine whether or not curiosity fit as a possible factor of clinical humility. This researcher decided to compare the content of the two curiosity items with other retained items intended to measure flexibility and self-awareness (see

Table 4). It was decided that item 24 related with item 26 and could be coded as self-awareness and item 31 related with item 20 and could be coded as flexibility.

Table 4

Recoding Factors

Item to be Recoded		Related Item	
Q31	I actively seek as much information as I can when facing clients' concerns with which I am unfamiliar.	Q20	I can readily adjust my thinking as I learn new information from my clients.
Q24	I consistently seek new ways to understand all of my clients.	Q26	I know the limits of my understanding of clients' concerns

This researcher then grouped the 15 scale items into 3 potential subscales representing 3 of the proposed factors of clinical humility (i.e., self-awareness, flexibility, and openness; see Table 5). This researcher then conducted a three-factor EFA with the potential subscales to determine if they were statistically three separate factors or theoretically deduced components of the overarching construct of clinical humility.

Table 5

Subscales

Items		Subscale
Q5	When clients challenge me with a different perspective, I am genuinely receptive to new ways of thinking.	Openness
Q13	I really embrace supporting clients whose values are different from mine.	Openness
Q15	When making decisions about counseling, I consider my clients' needs first.	Openness
Q28	In the counseling relationship, I actively put aside my biases to put my clients' concerns before my own.	Openness
Q30	Even when my core values are opposite to those of the client, I consciously strive to understand their point of view.	Openness
Q9	I earnestly try to understand clients' solutions to their issues even if they conflict with my values.	Flexibility
Q10	I carefully consider context before assigning meaning to a counseling interaction.	Flexibility
Q11	I am able to restructure sessions in order to adapt to the needs of my clients.	Flexibility
Q20	I can readily adjust my thinking as I learn new information from my clients.	Flexibility
Q31	I actively seek as much information as I can when facing clients' concerns with which I am unfamiliar.	Flexibility
Q12	I am very conscious of how my beliefs affect the counseling process.	Self-Awareness
Q16	I regularly acknowledge my biases when I face ethical dilemmas in counseling.	Self-Awareness
Q24	I consistently seek new ways to understand all of my clients.	Self-Awareness
Q25	I acknowledge when my values may influence the therapeutic process.	Self-Awareness
Q26	I know the limits of my understanding of my clients' concerns.	Self-Awareness

Note. Numbering from original scale was retained in this table.

Subscale Factor Analysis

The fourth EFA was conducted with 15 items grouped into the 3 subscale variables using Principal Axis factor analysis in SPSS indicating a 3-factor solution with oblique (direct oblimin, delta = 0) rotation. The Kaiser criterion was again utilized to exclude factors with eigenvalues less than 1. This EFA revealed a two-factor solution explaining 65.288% of the total variance in the intercorrelation matrix. However, the first factor accounted for 64.211% of the total variance, and the second factor only accounted for 1.237%. Thus, the analysis did not support the items being grouped and named as three subscales.

Correlational Analysis

This researcher examined the interacting effect of the demographic variables of age and practicing counselor/CIT on the factor scores from the 15 scale items retained from the one-factor EFA, post-rotation, grouped into the 3 variables of self-awareness, flexibility, and openness. First, this researcher examined scatter dot plots generated for a visual representation of the correlations (see Appendix K). The scatter dot plots for the interacting effect of age on the factor scores for flexibility, self-awareness, and openness revealed similarity in the factor scores across all age ranges, with slightly higher scores for the age range of 60-69 in all 3 variables. The scatter dot plots for the interacting effect of practicing counselor/CIT on the factor scores flexibility, self-awareness, and openness revealed similarity in the factor scores across all practicing/training statuses with slightly lower maximum scores for all three variables reported by participants who identified as in-training (Ph.D.).

Next, the Pearson's correlation coefficient was calculated to statistically determine significance of the interacting effect of age and practicing/training status on the variables of flexibility, openness, and self-awareness. The interacting effect was considered significant based

upon the following criteria: ≥ .10-.29 represents a small effect, ≥ .30-.49 represents a medium effect, and ≥ .50 represents a large effect. There were no significant correlations found between the demographic variables and the variables of flexibility, openness, and self-awareness. All of the correlations had $p > .05$. Table 6 displays the correlation results.

Table 6

Pearson's Correlation Coefficient

Demographic Variable	Flexibility	Self-Awareness	Openness
Age	.095	.025	.009
Practicing Counselor/CIT	.028	.010	.038

Note. $N = 386$

Summary

After removing responses with more than 5% of data missing, the results from 386 participants who completed the Counselor Disposition Scale were examined. Prior to the initial EFA, the data were screened, and eight items were removed due to extreme skew and kurtosis and poor inter-item correlations. The initial default SPSS 5-factor EFA was conducted with 23 items followed by a two-factor and one-factor EFA. Each EFA was followed by a post-rotation analysis and items were removed for low communalities. This process resulted in a one-factor solution explaining 27.478% of the total variance. Fifteen items with adequate communalities and factor loadings of > .35 were retained and demonstrated internal reliability (Cronbach's alpha of .858).

The content of the remaining 15 scale items was examined to see how the 4 proposed subscales of humility (flexibility, openness, self-awareness, curiosity) were represented. The

subscale of openness had five items, the subscales of flexibility and self-awareness each had four items, and the subscale of curiosity had two items. Upon further examination, it was decided that the two remaining items describing curiosity were similar to items describing self-awareness and flexibility. Curiosity was removed as a subscale and the items were re-labeled resulting in three potential factors of clinical humility. A final three-factor EFA was conducted with the variables grouped into three subscales which resulted in a one-factor solution explaining 64.211% of the total variance. Statistically, the scale did not contain three distinct subscales. Finally, a correlational analysis was conducted with the demographics variables of age and practicing counselor/CIT and the interacting effects of these variables were insignificant on participants' factor scores. The following chapter will include a discussion and interpretation of these results.

CHAPTER V

DISCUSSION

The purpose of this chapter is to interpret the results of the data analysis in the context of previous research on clinical humility and counselor clinical training. First, a summary of the problem is presented. Second, an interpretation of the results which answer the research questions is discussed. Next, contributions to the field of Counselor Education and Supervision (CES) and limitations of the study are discussed. Finally, implications for future research are presented followed by a conclusion of the current study.

Statement of the Problem

As clients' needs grow in depth and complexity, it would be imperative that counselor educators have a process for training counselors-in-training (CITs) to develop nuanced intrapersonal qualities and further prepare them for the challenges of the therapeutic relationship. Counseling skills have been just one facet of clinical competence. Counselors-in-training must also develop their self-of-the-therapist to gain competence in working with the client's emotional turmoil, life stressors, intersectionality, unique perspectives, and autonomy (Aponte et al., 2009). Branson et al. (2015) discussed the unique demands placed upon CITs to gain academic skills as well as grow in their personal and professional awareness while engaged in their training programs. The authors stated the need for training programs to be proactive in the evaluation of CITs on professional behaviors (i.e., engaged participation, time management, ethical behaviors, assuming responsibility, respect for diverse perspectives) as well as the evaluation of the CIT's commitment to deepening their personal growth. The authors discussed interventions for

developing and remediating observable professional behaviors, however, interventions for developing and remediating intrapersonal development were more elusive. In part, this is because intrapersonal development has been less specifically defined, less tangible to observe, and more difficult to measure.

The purposeful application of clinical humility could be a catalyst to both scaffold and deepen learning experiences to foster intra- and interpersonal development. A self-assessment measure of clinical humility could be an important tool to measure progress with intrapersonal components which strengthen counselor clinical training. Hill et al. (2017) stated that, as of 2017, there had not been any published measures of clinical humility. Further, most instruments measuring humility had not been specifically studied with counselors. The Humility in Counseling Scale (HICS) was designed to begin filling this gap in the research and provide a tool to embed clinical humility into counselor education and supervision (CES) training to help cultivate optimal intrapersonal development (Paine et al., 2015). The following section of this chapter will re-state, answer, and interpret data analyzation results for each of the research questions for this study.

Internal Consistency Reliability

The first research question for this study addressed whether the subscales from the Humility in Counseling Scale (HICS) demonstrated adequate internal consistency and was written as follows:

> Q1 Do the subscales from the Humility in Counseling Scale demonstrate adequate internal consistency when administered to counselors/CITs?

It was anticipated that the null hypothesis for this question would be rejected and the HICS would demonstrate an internal consistency of $\geq$ .80 across all subscales. The null hypothesis was rejected as every Cronbach's alpha that was generated through several iterations of the

exploratory factor analysis (EFA) was ≥ .80. However, the second part of this research question pertaining to subscales made this question somewhat problematic to answer as it was originally stated.

The initial Cronbach's alpha was .860 yet the inter-item correlation matrix revealed that most items were correlated in the low to moderate (.18-.40) range, which could have been due to low variance. These results suggested that the items were correlated enough to measure an overall construct yet may not be divergent enough to create separate subscales (Beavers et al., 2013). Further interpretation of naming factors and subscales occurred with Research Question 2 discussion as subsequent iterations of EFA resulted in a one-factor solution, and a final EFA with the three potential subscales also produced a one-factor solution. The inter-item correlations with the 15 finalized items were again predominantly in the low-moderate range, and when the items were grouped as three subscale variables, they were too closely correlated in the high range (.623, .631, and .654) to be perceived as separate subscales. However, the Cronbach's alpha was .839 when the data was grouped into three subscale variables supporting the rejection of the null hypothesis.

Factorial Validity

The second research question addressed whether the items on the HICS would demonstrate factorial validity and was written as follows:

Q2 Do the items from the Humility in Counseling Scale demonstrate interpretable factorial validity?

This researcher expected that a sufficient number of scale items would be retained from the EFA post-rotation with factor loadings > .35 and the null hypothesis would be rejected. Following the initial EFA and rotation, two factors were removed for loadings < .35; and following the second two-factor EFA and rotation, two more factors were removed for

loadings < .35. Following the third one-factor EFA and rotation, all retained scale items had factor loadings of > .35, and the null hypothesis was rejected. Given that only 4 of the 31 scale items were removed for poor factor loadings, most scale items demonstrated interpretable factorial validity.

This researcher had expected the HICS to produce a four-factor solution representing the four proposed factors of humility (i.e., flexibility, self-awareness, openness, and curiosity). Rather, the results of the EFA produced a one-factor solution without subscales. As reported in Chapter IV, a 5-factor, 2-factor, and 1-factor EFA were conducted resulting in 15 scale items with strong communalities and factor loadings. With only two of the scale items representing curiosity, relabeling the scale items seemed to make statistical sense. This researcher re-examined the content of the scale items to determine if relabeling the two items also made theoretical sense.

Two types of curiosity have been relevant to clinical humility. Hardy et al. (2017) discussed diversity curiosity which was the desire to understand a wide range of information that leads to novel problem solving. This researcher considered that this could be akin to cognitive complexity and perhaps curiosity was a nuanced component of cognitive flexibility. McEvoy et al. (2012) proposed empathic curiosity as the process of being engaged in the felt meanings and emotions a client was experiencing and linking curious questions to that non-verbal process. This researcher considered that increasing a counselor's self-awareness of their internal empathic experiences could lead to effective questions and reflections within the therapeutic process. Thus, curiosity may be a nuanced component of self-awareness. This researcher then compared the content of the two curiosity scale items with scale items representing flexibility and self-awareness and arrived

at the theoretical decision to relabel those items. Item 31, "I actively seek as much information as I can when facing clients' concerns with which I am unfamiliar," was relabeled as flexibility as seeking information about unfamiliar issues required flexibility in thought and practice. Item 24, "I consistently seek new ways to understand all of my clients," was relabeled as self-awareness as gaining new understanding often involves self-awareness.

Following the item relabeling, this researcher conducted an EFA with the subscales and the results remained consistent with a strong one-factor solution. Given the strength of the factorial validity of the scale items, it could be interpreted that the HICS was measuring one construct. A plausible interpretation was that the HICS measured clinical humility and flexibility, self-awareness, and openness were facets of that construct. This interpretation was based upon the results of the EFA, the extensive review of prior humility theory and research, and this researcher's collaboration with a scale development team comprised of counseling scholars.

Correlation Between Demographic Variables and Factor Scores

The third research question focused on whether the demographic variable of age and practicing status i.e., practicing counselor/CIT had an interacting effect on factor scores and was written as follows:

> Q3 What is the strength of association between demographic variables of age and CIT/practicing counselor and derived factor scores?

The Pearson's correlation analysis found no significant correlations with either demographic variable. The interaction effects of the demographic variables of age and CIT/practicing counselor were nonsignificant ($p \geq .05$), thus the null hypothesis was accepted. In thinking

about future use of the HICS, this researcher was curious if there was a need to collect demographic information from participants if demographic variables had insignificant interacting effects. To help guide future implementation of the scale, this researcher ran Pearson's correlation analyses with race/ethnicity and gender. Similar to age and practicing status, there were no significant interacting effects from these demographic variables on factor scores. The majority of participants identified White and Cis woman; thus, it is unknown if these demographic variables would have an interacting effect with different race/ethnicity or genders. This is discussed further in the limitations section.

Integrating the Findings

Rejecting the null hypotheses of Research Questions 1 and 2 helped to establish the internal consistency reliability and factorial validity of the Humility in Counseling Scale as a unidimensional scale with potentially viable and reliable scores. Accepting the null hypothesis of Research Question 3 helped to establish that collecting demographic data for interaction effect may be insignificant for future implementation especially if the participant demographics are mostly homogenous. Although prior research review and theoretical inquiry indicated that there may be four factors which comprised clinical humility (flexibility, self-awareness, openness, and curiosity), the statistical results did not support that supposition. Rather, the 15 scale items of the unidimensional measure were grouped by the potential components of clinical humility (i.e., flexibility, self-awareness, and openness) The summative impact of these findings and how they contributed to the field of CES is discussed in the following section.

Contributions to the Field of Counselor Education and Supervision

Although quantitative research may not often be thought of as deeply emotional work, the quote from Aponte and Kissil (2012) about helping CITs work through painful themes in their life bears repeating here:

> Helping therapists acknowledge and understand their struggles, accept their humanity and feel comfortable "going there" emotionally as needed, positions them not only to gain greater mastery of themselves to implement their therapeutic tasks, but also to free and motivate them to indeed work on their personal issues, which of course makes more of their selves available for the work of therapy. (p. 162)

This researcher's contribution of this study was to encourage CES clinical training programs to "go there" with clinical humility in purposeful and impactful ways so that CITs could do the necessary intrapersonal work to accept their own humanity and the humanity of their clients.

Hill et al. (2017) stated that there was much empirical research to be done on the subdomains of humility. Hook et al. (2013) conducted empirical research on cultural humility and created a scale to be used as part of that study. Their research illuminated the importance of cultural humility as part of multicultural training in CES. This current study of clinical humility added to empirical research and illustrated the importance of clinical humility as part of clinical training in CES. Specifically, this study contributed to CES clinical training in the areas of the developing intrapersonal counselor dispositions and the self-of-the-therapist; embracing a humble approach to clinical training; and measuring clinical growth as part of remediation plans.

Intrapersonal Development

The 2016 counseling standards from the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) asserted in standard 2.5.F that the CIT needs to

learn and understand characteristics they embody which could influence the counseling process. Branson et al. (2015) discussed the need for counselor education programs to be proactive in their evaluation of CITs' commitment to personal growth and self-awareness. One contribution of this study and the development of the HICS was to provide both a didactic and evaluative tool for CES programs to frame discussions around intrapersonal growth.

Counselor Dispositions

As discussed previously in this study, clinical training research in CES resulted in a teaching and training focus on facilitative conditions and helping skills. One contribution of this study was a framework from which CITs could expand upon those skills through the inclusion of more nuanced dispositions which may deepen the therapeutic experience. Incorporating clinical humility as one of the taught constructs in practicum training opens the pathway for intrapersonal development. Clinical humility has been, in large part, an intrapersonal experience and the HICS could be utilized as a structure for CITs to develop dispositions of clinical humility.

Homrich et al. (2014) surveyed counselor educators about intrapersonal behaviors they found pertinent to CITs' clinical growth. The intrapersonal behaviors ranked as important by counselor educators included exhibiting awareness of personal beliefs, values, strengths, and limitations; maintaining openness to differences in ideology; participating in self-reflection and exploration; soliciting and respond respectfully to feedback from others; exploring personal reactions; and demonstrating flexible and adaptable thinking. The content of the HICS addressed handling values conflicts, adjusting thinking, setting aside bias, seeking information, considering context, etc. which aligned with the findings of the Homrich et al. (2014) study. By focusing training of intrapersonal behaviors on the areas measured by the scale (i.e., flexibility, openness, and self-awareness), the HICS could be implemented as a way for CITs and faculty to measure

incremental growth as well as offer guidance for areas to be worked on. For example, the HICS could be administered at the beginning, middle, and end of a practicum experience providing the CIT an opportunity to reflect upon areas of strength and areas for growth.

Self-of-the-Therapist

In addition to the dispositions which fostered clinical humility, Paine et al. (2015) stated that clinical humility referenced the sort of person a CIT was becoming. Aponte and Kissil (2012) believed that training CITs to develop their self-of-the-therapist was essential to effective counseling and they acknowledged that there were varying perspectives on the steps needed to train CITs in using their whole self in counseling. Important to developing self-of-the-therapist was self-awareness of the themes in one's life (i.e., painful experiences, cultural experiences, familial experiences, and experiences which shape values/beliefs) which may impact the counseling process. The HICS has scale items which, if reflected upon with authenticity, could be implemented as a tool to facilitate opportunities for those themes to be discussed in relation to the counseling process. For example, one scale item, "I am very conscious of how my beliefs affect the counseling process," could be a prompt for reflection and focused discussion of what beliefs affect the counseling process and what growth may need to happen. Another scale item, "I know the limits of my understanding of clients' concerns," could facilitate learning around what drives the limitations such as a lack of cultural understanding, lack of clinical experience, long held beliefs that are now being questioned etc. The HICS could be both an effective starting point and a growth measure for developing the self-of-the-therapist.

Similar to counselor dispositions, the HICS provided a framework for the CIT to grow in emotional regulation and manage countertransference. The CIT's own life themes naturally impact the therapeutic process and when the CIT notices and regulates emotional reactions

related to their life themes that is part of managing countertransference. Aponte et al. (2009) viewed countertransference not as an obstacle but rather a facilitator of the therapeutic alliance. Aponte et al. believed the collaborative and purposeful work of the CIT and client was not to ignore or suppress countertransference but rather learn therapeutic ways to integrate those experiences into the counseling relationship. The HICS could facilitate purposeful clinical humility as part of managing countertransference. For example, one scale item, "I carefully consider context before assigning meaning to a counseling interaction," could be a springboard for the context of the CIT's emotions that were impacting interpretation of counseling interactions. Another scale item, "When making decisions about counseling, I consider my clients' needs first," could be a prompt to reflect on the emotion regulation needed when countertransference was occurring to truly consider the client's needs first. As articulated by Aponte and Kissil (2012), to not "go there" in clinical training was to deny both the CIT and the client the possibility of a deepened therapeutic relationship free from unnecessary barriers (p. 162).

Humble Approach to Clinical Training

To effectively address the complexities of the therapeutic process, Sandage et al. (2017) articulated the necessity of moving away from the authoritative approach of traditional medical models of clinical training. They proposed that a humble approach may be a more effective training model. They described a humble approach as one which included being cognizant of power dynamics, developing tolerance for ambiguity, and adopting a stance of not knowing. Training CITs to have a humble approach has moved them beyond the certainty of skills compliance to the uncertainty of working with the client's emotional turmoil, life stressors, intersectionality, unique perspectives, and autonomy. The HICS could be utilized as an effective

framework for implementing a humble approach in clinical training. For example, one scale item stated, “I am able to restructure sessions in order to adapt to the needs of my clients.” This item could facilitate discussion around the ambiguity of removing power dynamics and encourage the CIT to reflect upon the intersectionality, life stressors, and autonomy of the client which may necessitate restructuring sessions. Another scale item, “I can readily adjust my thinking as I learn new information from my clients,” supported CITs to embrace not knowing, to step aside from feelings of self-importance, and to engage as a collaborative partner with the client. Embedding clinical humility into CES training via didactic and evaluative processes with the HICS could help to cultivate this humble approach.

Remediation Plans

Although still in the exploratory phase, following further confirmation of the reliability and validity of the HICS, it could be utilized as a component of remediation plans for CITs. Branson et al. (2015) discussed the importance of developing remediation plans which included steps for the CIT to work on their self-awareness and intrapersonal growth as well as their observable professional behaviors. Their suggested performance improvement plans included both tangible and intangible ideas. Tangible ideas included increased supervision and training around safety planning; intangible ideas included increasing cognitive complexity and developing a tolerance for ambiguity. The HICS could be implemented as a tool for facilitating and measuring both concepts. In addition to expanding a CIT’s tolerance for ambiguity as discussed in the previous section, two scale items focused on cognitive complexity. One of the items stated, “When clients challenge me with a new perspective, I am genuinely receptive to new ways of thinking,” and another stated, “I earnestly try to understand clients’ solutions to their issues even if they conflict with my values.” These items supported the CIT to consider

alternate ways of thinking about a client's issues and life choices. The HICS could be used as a purposeful didactic and evaluative tool as part of a CES remediation plan to help CITs narrow, stereotyped, or indifferent thinking.

Clinical Supervision

Watkins and Mosher (2020) described relational, cultural, and intellectual humility as essential tenets of effective clinical supervision. The authors discussed the importance of supervisees developing humility as a buffer between the developmental stress of early clinical training and the need for deep reflective learning. The authors discussed the importance of supervisors developing humility to strengthen the supervision alliance and to help repair ruptures. Further, McMahon (2020) stated that humility, when intentionally cultivated, had the potential to be transformational to clinical supervision. McMahon discussed the potential impact of humility on the developmental, interpersonal, and power dynamics within the supervisory relationship as well as the impact on the supervisor's awareness of their own emotions and life experiences which comprise their self-as-the-supervisor. The HICS could be utilized as a means to measure baseline understanding of clinical humility and the facets which comprise it and as a means to facilitate conversations around cultivating clinical humility as part of the supervisory relationship. These contributions to the field of CES would be most effective with consideration of the limitations of this study.

Limitations of the Current Study

This section discusses limitations to this study including threats to internal and external validity. Obtaining evidence of scale validity is an intricate process which requires comparisons of the data from multiple administrations of the scale. Factor analysis is widely utilized in new scale development as a means for assessing construct validity, yet it is a circular rather than

linear process and making causal attributions from the data is difficult (Wren & Benson, 2004). These limitations are further elucidated in the sections below.

Threat to External Validity: Demographic Variables

External validity is the extent in which the results of the study could be generalized to other populations and settings (Remler & Van Ryzin, 2015). Researchers utilized exploratory factor analysis to facilitate the evolution of a theory about a construct, thus, generalizing the results to other settings was difficult. Obtaining a sample that represented the target population being studied was one factor in decreasing threats to external validity. The sample for this study had adequate representation of both practicing counselors (Professional School Counselors, Licensed Professional Counselors/Candidates, Licensed Mental Health Counselors, and Counselor Educators) and CITs (Ph.D. and Master's) yet there was inadequate representation from non-White, non-Cis woman participants in the variables of race/ethnicity and gender.

Earnest efforts were made to cultivate a sample that was diverse across all demographic variables. This researcher requested permission to join 54 CIT/counseling Facebook groups with transparency about the request having research purposes. The groups represented various geographical locations and professional purposes. Thirty-five of the groups allowed this researcher to participate and post invitations about the study. Additionally, this researcher joined and posted the research invitation on two therapy/school counseling professionals Reddit groups, posted the research invitation on the professional listserv for counselor educators (CESnet) and sent the research invitation to three counselor education faculty who agreed to post it on student and professional listservs they interacted with. However, with 76.7% of the participants identifying as Cis woman and only 19.9% of the participants identifying non-White, the generalizability of the results was decreased. Specific to the variable of race/ethnicity, it would

be important for future research studies involving White-identifying researchers to collaborate with non-White identifying researchers to better understand the contexts which would be appropriate for inviting non-White identifying participants.

Threats to Internal Validity

Internal validity is the extent in which the study demonstrates integrity to the research design allowing the researcher to make causal ascriptions based upon the data (Remler & Van Ryzin, 2015). Social desirability responding and history were two factors which impacted the internal validity of this study.

Social Desirability Responding

Given that most scale items had means > 4 on a 5-point Likert scale, it was likely that social desirability was a factor in this study, thus, posing a threat to the internal validity of the scale. This has been a common concern amongst psychological researchers and McElroy-Heltzel et al. (2018) discussed that participants' desire for likeability could confound the measurement of other constructs. In the case of counselors as participants, it would be plausible that when reading a scale item such as "I am very conscious of how my beliefs affect the counseling process" that counselors would answer that question with aspirational intent. If that scale item was preceded by the scale item which read, "I readily embrace supporting clients whose values are different than mine," perhaps the participant would be primed to think about clients who have different values when answering the item about how their beliefs affect the counseling process. The social desirability concern could potentially be decreased by re-ordering the scale items or having priming statements like, "Think about a client who challenges you when answering the following questions." Further, utilizing the scale as an other-report measure along with self-report may also reduce this threat to internal validity.

History

The data for this study were collected in January/February. For many people, that was a time of goal setting, resolutions, and aspirational thinking. This could have increased social desirability responding and posed a potential threat to the internal validity of the HICS. Further, the data were collected during a pandemic when loss and grief may have had a high prevalence in people's minds. This could be a threat to internal validity and impacted the way in which counselors responded to scale items such as considering their client's needs first or restructuring sessions to adapt to the needs of clients. It would plausible that during the pandemic, counselors were practicing within a crisis response framework which would require more flexibility and openness.

Exploratory Factor Analysis

Exploratory factor analysis has been a common and effective analysis in the early stages of scale development. However, there have been aspects of this process which posed threats to internal validity. First, EFA was most ideal if there was normality in the data. The descriptive and visual analysis of the data from this study revealed a negative skew and some non-normality, which compromised internal validity. Despite non-normality, continuing with EFA was acceptable as other parametric assumptions were met, yet normality in the data may have strengthened the psychometric properties of the HICS (Mvududu & Sink, 2013). Second, there were important subjective elements to the scale development process which posed a threat to internal validity. These elements included focus groups, think aloud/cognitive interviews, item creation, expert review, factor retention, and naming of factors. With these limitations in mind, implications for future research are discussed in the following section.

Implications for Future Research

Hill et al. (2017) stated the empirical need for self-report instruments that produced valid scores which measured the subdomains of humility. There were potential options for utilizing the scale in future research studies, and several of them are proposed in this section. One future study would be confirmatory factor analysis (CFA) of the HICS that could compare and cross-validate the scores from a similar sample size. A compelling aspect of CFA in relation to the HICS was that CFA is theory driven, thus, the current unidimensional measure of humility driven by three underlying facets was a priori model that could be tested with CFA (Ellis, 2000). For example, the 331 participants who identified as practicing counselors for this study were an adequate sample size to be used as fixed values to compare and cross-validate with the factor structure from a similar sample size of a future study. Based upon the potential for the HICS to be utilized in clinical training programs, the CFA would ideally be conducted with participants who were CITs. Further, goodness of fit indices would help to determine if the unidimensional factor structure generated by the EFA from this study would remain viable with a new sample or if a different factor structure emerged. Following CFA, an additional test/re-test study could be conducted in which a group of participants would complete the HICS two times, allowing time to elapse between the two administrations. Potentially, this could strengthen confidence in the reliability of the scores produced by the HICS.

Modifications could be made to the HICS so that it could be an other-report measure with counselor education faculty and/or clients being other-reporters. For example, item 5 as self-report stated, “When clients challenge me with a different perspective, I am genuinely receptive to new ways of thinking.” As an other-report item for CES faculty, it could state, “When clients challenge the CIT with a different perspective, the CIT is genuinely receptive to new ways of

thinking" and as an other-report item for clients, it could state, "When I challenge my counselor with a different perspective, they are genuinely receptive to new ways of thinking." Acknowledging the exploratory phase of this scale, this researcher is suggesting three aspirational studies which could integrate the scale into clinical training and clinical practice. These studies include a comparative analysis of clinical growth utilizing self/other-report applications of the scale, a comparative analysis of perceived clinical humility utilizing self/other-report administrations of the scale, and a qualitative study of CITs' knowledge of and experiences with clinical humility as part of their clinical training. For clinical training, a comparative analysis study of clinical growth comparing the scores from a CIT's self-report of the HICS and clinical training supervisor's other-report of the HICS could be designed as a test, intervention, re-test study. The scale could be administered at the beginning of a CIT's clinical training, an intervention/discussion could occur, and then a follow-up administration of the scale could happen.

Hook et al. (2013) designed a study with an other-report measure of cultural humility in which clients rated their counselor's cultural humility and also the working alliance with the counselor to determine if increased cultural humility would positively correlate with increased working alliance. A similar study with clients could be implemented with the HICS. Further, a qualitative study could be conducted to understand counselors' or CITs' experiences with implementing purposeful clinical humility into their clinical practice. Likewise, a qualitative study could be conducted to understand counselor educators' experiences with integrating the HICS into clinical training and how that impacted their ability to measure facets of intrapersonal development.

Summary

The purpose of this study was to ascertain the factor structure and test the internal reliability consistency of the HICS. Additionally, this researcher wanted to determine any statistically significant group differences from the demographic variables. The overall results of the EFA proposed a unidimensional factor structure measuring the construct of clinical humility. Within this one-factor solution, there were three proposed facets of clinical humility (openness, self-awareness, and flexibility). A follow-up study utilizing confirmatory factor analysis with participants who were CITs would help to strengthen the HICS as a viable scale for multiple uses within clinical training environments. It was important to know that this study was conceived from an idea, then a conversation, then many conversations. These conversations led to literature reviews, contemplation, focus groups, discussions, and eventually scale items. This researcher's ultimate hope was that the creation and analysis of the Humility in Counseling Scale would lead to more conversations within the field of counselor education and supervision about developing the self-of-the-therapist, deepening intrapersonal skills, and embodying clinical humility.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

Date:	11/18/2020
Principal Investigator:	Jennifer Santopietro
Committee Action:	**IRB EXEMPT DETERMINATION – New Protocol**
Action Date:	11/18/2020
Protocol Number:	2010013812
Protocol Title:	An Exploratory Factor Analysis of the Humility in Counseling Scale
Expiration Date:	

The University of Northern Colorado Institutional Review Board has reviewed your protocol and determined your project to be exempt under 45 CFR 46.104(d)(702) for research involving

Category 2 (2018): EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OR OBSERVATIONS OF PUBLIC BEHAVIOR. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

You may begin conducting your research as outlined in your protocol. Your study does not require further review from the IRB, unless changes need to be made to your approved protocol.

As the Principal Investigator (PI), you are still responsible for contacting the UNC IRB office if and when:

UNIVERSITY OF
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Institutional Review Board

- You wish to deviate from the described protocol and would like to formally submit a modification request. Prior IRB approval must be obtained before any changes can be implemented (except to eliminate an immediate hazard to research participants).
- You make changes to the research personnel working on this study (add or drop research staff on this protocol).
- At the end of the study or before you leave The University of Northern Colorado and are no longer a student or employee, to request your protocol be closed. *You cannot continue to reference UNC on any documents (including the informed consent form) or conduct the study under the auspices of UNC if you are no longer a student/employee of this university.
- You have received or have been made aware of any complaints, problems, or adverse events that are related or possibly related to participation in the research.

If you have any questions, please contact the Research Compliance Manager, Nicole Morse, at 970-351-1910 or via e-mail at nicole.morse@unco.edu. Additional information concerning the requirements for the protection of human subjects may be found at the Office of Human Research Protection website - http://hhs.gov/ohrp/ and https://www.unco.edu/research/research-integrity-and-compliance/institutional-review-board/.

Sincerely,

Nicole Morse
Research Compliance Manager

University of Northern Colorado: FWA00000784

APPENDIX B

VERIFICATION OF RESEARCH SUBJECT COMPLIANCE

Verification of Research Subject or Participant Compliance
(To be filed with dissertation proposals, final dissertations, final theses, and final capstones)

Student Name: Jennifer Santopietro Last 4 numbers of Bear ID: 9154

Student's BearMail: sant5734@bears.unco.edu Date Submitted to Grad School: _____

Degree Program: Counselor Education and Supervision PhD

Department/School: Applied Psychology and Counselor Education

All researchers planning to examine data from human participants or animal subjects for which IRB or IACUC approval is necessary, according to the procedures of these entities, are required by the University of Northern Colorado to obtain approval prior to the initiation of any data collection.

This form must be turned in to the Graduate School at the same time the documents for the Dissertation Proposal, Final Dissertation, Final Master's Thesis, or Final Capstone are being submitted. It is understood that circumstances may arise in which the researcher may need to alter some aspect of the research plan necessitating filing of a Change in Protocol to IRB or IACUC. Failure to maintain the necessary records of research review and approval is a violation of Federal Law and could result in suspension of federal research funds to the University of Northern Colorado. Non-compliance with filing this form will significantly delay graduation for the student by disallowing the inclusion of any dissertation, thesis, or capstone data collected while out of compliance. In addition, non-compliance could result in scientific misconduct for the student's advisor (see section on IRB Non-Compliance and Reported Irregularities during Research in the Procedures for Research Involving Human Participants).

Check **one** of the following:

☑ Institutional Review Board Approval (Please attach IRB approval)
Approval date: 11/18/20 Expiration date: _____ Last date of data collection (if applicable): _____

☐ IACUC Board Approval (Please attach IACUC approval)
Approval date: _____ Expiration date: _____ Last date of data collection (if applicable): _____

☐ No Approval from either IRB or IACUC needed (Please provide an explanation, which will be reviewed by the Graduate School)

If you are submitting a **final dissertation**,

Yes ○ No ◉ Have you amended your IRB since submitting your dissertation proposal to the Graduate School?

Yes ○ No ◉ Have you acquired a continuation since submitting your dissertation proposal to the Graduate School?

If you are submitting a **final doctoral capstone or master's thesis**,

Yes ○ No ○ Did you receive IRB or IACUC approval prior to data collection?

If "no," please explain:

Student Researcher's Signature (Required): Jennifer Santopietro Digitally signed by Jennifer Santopietro Date: 2020.11.18 16:19:18 -07'00' Date: _____

Research Advisor's Signature (Required): Vilma Cardona Digitally signed by Vilma Cardona Date: 2020.11.19 17:33:12 -07'00' Date: _____

APPENDIX C

HUMILITY IN COUNSELING SCALE

Counselor Disposition Scale©

(Sink, Santopietro, Reiter, & Orrison; October, 2020)

This questionnaire is designed to measure important counselor dispositions related to improving counseling effectiveness.

Directions

The following statements are meant to appraise what is important to you as a **counselor**. Please read each statement and decide how much you *agree* or *disagree* with that statement. There are no correct or more acceptable responses, only perspectives. Please respond to all items, and please provide some background information. Thank you!

Demographic Information:

1. Gender _____
2. Ethnicity _____
3. Age _____
4. I am a counselor:

☐ in practice (in-service) highest degree obtained: _____

I practice in the following setting (choose one):

☐ mental health clinic
☐ private practice setting
☐ in home
☐ in hospital
☐ school: pre-K ☐ K-12 ☐ Community College ☐ College/University ☐
☐ other? _____

☐ in training (pre-service) in a counseling program: master's ☐ doctorate ☐

My training is in the following setting (choose one):

☐ mental health clinic
☐ private practice setting
☐ in home
☐ in hospital
☐ school: pre-K ☐ K-12 ☐ Community College ☐ College/University ☐
☐ other? _____

5. I am a licensed or certified counselor: Yes ☐ No ☐ In progress ☐
6. My graduate counseling program training was/is Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited: Yes ☐ No ☐ In progress ☐
7. In what state/country is your training program or place of work? _____

Please continue to the next page.

Counselor Disposition Scale©

(Sink, Santopietro, Reiter, & Orrison; October, 2020)

Counselor Disposition Scale

	Dimensions and Items	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
1	I regularly pursue new ways for clients to work through their concerns. (c)	SD	D	N	A	SA
2	I am honest with myself about all my counseling deficiencies. (sa)	SD	D	N	A	SA
3	My clients' concerns have a much higher priority than my own within the session. (f)	SD	D	N	A	SA
4	My attitude towards clients is largely malleable. (f)	SD	D	N	A	SA
5	When clients challenge me with a different perspective, I am genuinely receptive to new ways of thinking. (o)	SD	D	N	A	SA
6	I am fully aware that my behaviors serve as an example to clients. (sa)	SD	D	N	A	SA
7	I believe that ongoing personal counseling is essential to enhance my professional development. (sa)	SD	D	N	A	SA
8	Every client teaches me something about myself. (o)	SD	D	N	A	SA
9	I earnestly try to understand clients' solutions to their issues even if they conflict with my values. (f)	SD	D	N	A	SA
10	I carefully consider context before assigning meaning to a counseling interaction. (f)	SD	D	N	A	SA
11	I am able to restructure sessions in order to adapt to the needs of my clients. (f)	SD	D	N	A	SA
12	I am very conscious of how my beliefs affect the counseling process. (sa)	SD	D	N	A	SA
13	I readily embrace supporting clients whose values are different from mine. (o)	SD	D	N	A	SA
14	I really want to learn from clients who don't share my worldview. (o)	SD	D	N	A	SA
15	When making decisions about counseling, I consider my clients' needs first. (o)	SD	D	N	A	SA

Counselor Disposition Scale©

(Sink, Santopietro, Reiter, & Orrison; October, 2020)

16	I regularly acknowledge my biases when I face ethical dilemmas in counseling. (sa)	SD	D	N	A	SA
17	I work with my clients to incorporate counseling interventions which challenge my world view. (c)	SD	D	N	A	SA
18	I really enjoy the search for knowledge related to the counseling profession. (c)	SD	D	N	A	SA
19	I have no difficulty putting my own agenda on hold in the counseling session, allowing clients to lead the session. (f)	SD	D	N	A	SA
20	I can readily adjust my thinking as I learn new information from my clients. (f)	SD	D	N	A	SA
21	I try to advance my skillset in all of my interactions with clients. (o)	SD	D	N	A	SA
22	I wouldn't ask my clients to do something that I, myself, would not try in my personal life. (sa)	SD	D	N	A	SA
23	I always seek to understand my clients' unique perspectives. (c)	SD	D	N	A	SA
24	I consistently seek new ways to understand all of my clients. (c)	SD	D	N	A	SA
25	I acknowledge when my values may influence the therapeutic process. (sa)	SD	D	N	A	SA
26	I know the limits of my understanding of clients' concerns. (sa)	SD	D	N	A	SA
27	I find it very hard to explore new client concerns when I lack confidence in my abilities. (c)	SD	D	N	A	SA
28	In the counseling relationship, I actively put aside my biases to put my clients' concerns before my own. (o)	SD	D	N	A	SA
29	I consistently seek professional consultation when my values are perhaps impeding the therapeutic process. (sa)	SD	D	N	A	SA
30	Even when my core values are opposite to those of the client, I consciously strive to understand their point of view. (o)	SD	D	N	A	SA
31	I actively seek as much information as I can when facing clients' concerns with which I am unfamiliar. (c)	SD	D	N	A	SA

Thank you for completing this survey.

APPENDIX D

CONSENT FORM

UNIVERSITY OF
NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Development of the Counselor Disposition Scale Department of Applied Psychology and Counselor Education

Researcher: Jennifer Santopietro, MS, LPC
email: jennifer.santopietro@unco.edu

Research Advisor: Betty Cardona, Ph.D.
email: vilma.cardona@unco.edu
Phone Number: (970) 351-2731

I am inviting you to participate in a research survey aimed at developing a valid and reliable measure of counselor dispositions. The purpose of this study is to develop a valid and reliable measure of various counselor dispositions which may contribute to the intrapersonal development of counselors and counselors-in-training (CITs). To date, there is a scarcity of instruments available to measure intrapersonal skills in counseling. Your participation in this survey will contribute to enhancing clinical training in counselor education and supervision in the future.

Once you access the survey via the Qualtrics link, your participation will take approximately 15 - 25 minutes of your time. You will not be asked to provide your name, but demographic information will be collected. Eligibility for participation requires that you: (a) are at least 18 years or older and (b) are a CIT, practicing mental health counselor, practicing school counselor, or counselor educator. As compensation for your participation, at the end of the survey you will be offered the chance to enter a drawing for one of five $50 gift cards. This will be done through a separate survey so your information will not be linked to your original survey. Your participation will be anonymous, and your responses will be kept confidential in this researcher's password protected Qualtrics account.

There are no known risks to participation, outside the time it will take to participate. Qualtrics has specific privacy policies of their own. You should be aware that this web service may be able to link your responses to your ID in ways that are not bound by this consent form and the data confidentiality procedures used in this study. If you have concerns you should consult these services directly.

Questions: If you have any questions about this research project, please feel free to contact Jennifer Santopietro at jennifer.santopietro@unco.edu. If you have any concerns about your selection or treatment as a research participant, please contact Nicole Morse, Research Compliance Manager, University of Northern Colorado at nicole.morse@unco.edu or 970-351-1910.

Please understand that your participation is voluntary. You may decide not to participate in this study and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled.

Please take all the time you need to read through this document and decide whether you would like to participate in this research study.

If you decide to participate, your completion of the research procedures indicates your consent. Please keep this form for your records.

APPENDIX E

INVITATION TO PARTICIPATE

Dear Counselor Educators, Counselors, and Counselors-in-Training,

My name is Jennifer Santopietro, and I am a Licensed Professional Counselor and a fourth-year doctoral student at the University of Northern Colorado in Counselor Education and Supervision, under the supervision of Dr. Betty Cardona.

The purpose of this quantitative dissertation study is to investigate counselor dispositions which contribute to the intrapersonal development of counselors-in-training and practicing counselors.

You are invited to participate in the study if you are over the age of 18 and meet the following criteria:

- You are a counselor educator (with a earned or in-process Ph.D. in Counselor Education and Supervision)
- You are a counselor in training (working towards a degree to become a LPC)
- You are a practicing counselor (with LPC [or pre-LPC licensure] or Professional School Counselor credentials)

If you choose to volunteer in this study, you will be asked to complete a survey instrument on counselor dispositions. Overall, participation in this study should take approximately 15-25 minutes of your time. There is no compensation for your participation, but participants can choose to be entered into a drawing for one of five $50 gift cards.

Participation in this research study is voluntary and will not require any personally identifiable information (IRB_____). All data collected in this study will remain confidential in a password protected electronic database (Qualtrics). Should you wish, you may withdraw your consent and terminate participation at any time.

To expand the reach for participants, if you know any counselor educators, practicing counselors, or counselors-in-training who meet the above criteria and might be interested in participating, please forward this email to them.

Please direct any questions or concerns about this study to me, Jennifer Santopietro, by email at jennifer.santopietro@unco.edu or my advisor, Dr. Betty Cardona, can be contacted at vilma.cardona@unco.edu. The University of Northern Colorado's address is: 501 20th St. Greeley, CO 80639.

If you have any questions or complaints about your rights as a research volunteer, contact University of Northern Colorado's Research Compliance Manager at 970-351-1910.
Click on the following link to participate in this study:

APPENDIX F

SYNOPSIS OF FOCUS GROUPS AND THINK ALOUD/ COGNITIVE INTERVIEWS

Focus Groups

To strengthen this conceptualization of clinical humility, this researcher obtained Institutional Review Board (IRB) (See Appendix L) approval to commence the planning phase of the Humility in Counseling Scale (HICS). One of the steps in the planning phase included conducting focus groups to assist with scale item creation. Although focus groups are not always a part of scale development, Mallinckrodt et al. (2015) considered focus groups essential to a ground up induction of generating an item pool. Fowler (2014) stated that it was valuable to conduct discussions with people who were in the intended group to be studied. For this study, the scale development team believed conducting focus groups could be useful for linking theoretical concepts to scale item creation.

Focus Group Participants

For this study, two focus groups were conducted, one with counselors-in-training (CITs) and one with Licensed Professional Counselors. This researcher recruited four Master's level counseling students from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) university in the Rocky Mountain region for one focus group and six practicing counselors also from the Rocky Mountain region for a second focus group. The counseling students were invited to participate from two Master's level counseling courses. This researcher was given permission to come into the classes to briefly describe the study and invite students to participate. The interested students then reached out to this researcher via email to indicate their willingness to participate in the study. The Licensed Professional Counselors (LPCs) were recruited from one community counseling agency via an email that was disseminated by the director of the agency and invited participation. The director then

corresponded with this researcher to confirm there was interest from six of the counselors and set up a time for the focus group.

The CITs' ages ranged from 22-42 with a mean age of 33. Two of the CIT participants identified Caucasian, one identified African American, and one identified mixed race (Black, Hispanic, and Native American). Four CIT participants identified female, and two of them considered themselves spiritual/religious. The LPC participants ages ranged from 32 to 48 with a mean age of 35. Five LPC participants identified Caucasian and one identified Hispanic. Five of the LPC participants identified female, one identified male, and all identified as spiritual and/or religious. Participation for both groups was voluntary, and a consent form was signed by the participants prior to beginning the focus groups. No compensation was given for participation; however, snacks were provided at both focus groups.

Focus Group Methods

The focus group with CITs was conducted in a study room at the university where the participants attended. The focus group with LPCs was conducted in a conference room at the counseling office where the participants worked. The participants for both groups signed an informed consent, and the discussions were semi-structured, with this researcher prompting conversation with questions about the proposed factors of clinical humility. The transcripts were color-coded for statements referencing the initial five proposed measures of clinical humility (flexibility, self-awareness, respectful openness, openness to feedback, and curiosity). In addition, the transcripts were color-coded for two other possible measures of clinical humility (teachability and mindfulness) to determine if it needed to be included as possible measures of clinical humility. Finally, the transcripts were coded for implicit statements of humility, which

supported the scale development team's belief that counselors and CITs may be talking about humility without directly naming it.

Summary of Participant Input from the Focus Groups

Table 7 includes quantitative and qualitative information from both focus groups. After reviewing the transcripts from the focus groups, the scale development team decided to combine two of the possible factors (openness to feedback and respectful openness) into one factor (openness). The team felt that not disaggregating openness was a more accurate measure of clinical humility and chose to develop scale items that reflected both openness to others and openness to feedback. The scale development team also determined that teachability had a close connection to learning and growth which could blur its connection to the latent variable. Further, the team felt that teachability as it related to clinical humility may be more accurately captured by curiosity and openness. Similarly, mindfulness seemed to be a construct that participants discussed in terms of presence and being grounded, which the scale development team agreed may facilitate clinical humility but may not be the embodiment of clinical humility. Thus, the scale development team decided the measures of clinical humility to be included in the HICS would be openness, flexibility, self-awareness, and curiosity.

Table 7

Integrated Results of Quantitative and Qualitative Information from Focus Groups

Possible Factor	Applications to Humility	Example Quotes
Flexibility "What does a flexible attitude look like?"	27	"Being accommodating." "Rolling with where the client is at." "Respecting they have their own autonomy." "You are more flexible the more self-efficacy you have and heard."
Curiosity "What are your perceptions of how being curious impacts counseling?"	8	"Curiosity . . . fosters authenticity. Being curious makes the client feel alive, valid, and heard." "I think curiosity is really important because you have genuinely build that bridge and care about this person. "General curiosity, like what's going on in here? What is this telling me about the client?"

Table 7 (continued)

Possible Factor	Applications to Humility	Example Quotes
Self-Awareness "How do you think counselors continue to grow self-awareness over time?"	22	"Using your emotions as a guide." "Know where my blind spots are." "It's all about how much work I have done on myself."
Respectful Openness "What comes to mind when I say respectful openness to others?"	31	"I think every single person has a value." "Speaks to being nonjudgmental, compassionate, and empathic." "Really comes down to trusting the client and their perspective." "I have the best intentions for this client."
Open to Feedback LPCs: (Gave a scenario of a client in distress/counselor switches to problem solving mode) "Talking about what comes to mind when you that Scenario CITs: "Tell me what comes to mind when I say openness to feedback . . . from peers, clients, and professors."	25	"Not let my ego or judgment or fear come in and just really take what they say is reality." "Getting that feedback and just working with it." "Have an attitude of growth mindset that this is not really about me" "It's practicing not taking things personally."

Table 7 (continued)

Possible Factor	Applications to Humility	Example Quotes
Teachability ** There was not a specific question asked of either group about teachability. It did not seem to fit the flow of the focus group.	7	"There is still plenty of room for growth." "Like working on how can I be a good, nice person today?" "Doing the work helps give perspective on our outside lives and our outside lives gives us perspective on our work."
Mindfulness	6	"Can I be prepared going into any session and just kind of be really present?" "Keeps me steadily grounded in the moment in the session." "sit in the moment, like outside yourself in a way."
Possible Statements of Humility (Without Naming it)	36	"There might be an inherent thing to some extent, self-acceptance." "When I think of the privilege we hold to sit in these painful places with people . . . helps me stay in the room and not lose sight of that." ". . . humble down . . . and work on this relationship with them." "It's like that recognition that in this moment, this is about them."

Think-Aloud/Cognitive Interviewing

The second part of the planning phase utilized think-aloud techniques (the participant engaged in answering the scale items and stated their thoughts about the scale items out loud) and cognitive interview techniques (the researcher asked probing questions while observing the participant's responses and behaviors such as hesitating and re-reading) with three participants (Beatty & Willis, 2007). Once the proposed measures of clinical humility were agreed upon by the scale development team, an initial set of scale items were created to be utilized with the think-aloud process.

Think-Aloud/Cognitive Interviewing
Participants

This researcher recruited four Master's level counseling students from a CACREP university in the Rocky Mountain region for the think-aloud/cognitive interviewing process. The counseling students were invited to participate from two Master's level counseling courses. This researcher was given permission to come into the classes to briefly describe the study and invite students to participate. The interested students then reached out to this researcher via email to indicate their willingness to participate in the study and sat a time to meet with this researcher. The participants signed a consent form prior to engaging in the process, but no demographic information was collected from the participants.

Think-Aloud and Cognitive Interviewing
Method

The think-aloud/cognitive interviews lasted 15-30 minutes each and were conducted 1:1 with this researcher and the participants. The participants were asked to share their thoughts out loud as they engaged in completing sample scale items. Sample scale items were measured with a 5-point Likert scale 1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly*

agree and included items such as: When my clients' core values are very differ from my own, I still desire to learn from their perspectives and I am honest with myself about my deficits as a counselor.

This researcher also observed the participants as they completed the scale items and took note if they paused while answering a particular item, if their responses were the same for many of the items, or if they appeared to need to re-read scale items. This researcher then asked the participants questions based upon their responses, comprehension, response time, and general concerns or confusion with the items. The think-aloud/cognitive interviews were recorded and transcribed by this researcher.

Summary of Participant Input from the Think-Aloud/Cognitive Interviews

Three of the participants in the think-alouds/cognitive interviews expressed ease with completing the scale items and in comprehending the content. One participant expressed difficulty with reading and completing the scale and revealed that they received support from disability services at their university for reading and test-taking. One participant discussed the use of the word *always* in one of the scale items describing it as "tricky language" stating they had been taught that there are many variables to a situation, thus, the word was rarely applicable in most situations. The scale development team took this suggestion into consideration when creating the expanded item pool.

Some of the feedback from the participants was about their personalization of the scale item content and supported the scale development team's conceptualization of clinical humility. For example, one participant discussed thinking about a scale item from the frame of mind of the client always being first. This aligned with the other-oriented aspect of conceptualizing clinical humility that was discussed in chapter two of this study (Sandage et al., 2017). Another

participant discussed that they valued learning from the client's experiences which the team believed could be indicative of curiosity. The scale development team felt that, overall, the think-aloud/cognitive interview process provided supportive insight into the potential content, wording, and format of the scale item pool.

APPENDIX G

SYNOPSIS OF PILOT STUDY

Administration of the HICS with a Pilot Sample

van Teijlingen and Hundley (2002) discussed the value of testing a newly developed survey with a small pilot sample prior to the wider distribution sample. These authors stated that administering a scale to a small sample of participants would help to increase the likelihood of success of the main study by sorting out logistical concerns with the scale and ascertaining appropriate research protocols. The scale development team received Institutional Review Board (IRB) approval (see Appendix M) to administer the initial Humility in Counseling Scale (HICS) to a small developmental sample of participants and send the HICS to counselor scholars for expert review.

The purpose of administering the HICS with a pilot sample of participants was three-fold. One, the participants were asked to give feedback on the wording, content, and grammar of the scale. Two, the scores from the scale were analyzed for inter-item correlation and descriptive statistics. Three, the scale development team utilized information from the development administration of the HICS to finalize revisions prior to sending the scale to counseling scholars for review.

Pilot Study Participants

The scale development team recruited participants from two states--one in the West and one in the East--for administration of the HICS with a developmental sample of participants. The participants included 15 masters level counseling students and 9 Licensed Professional Counselors. The CITs were recruited from two Council for Accreditation of Counseling and Related Programs (CACREP) universities via email and this researcher visiting several counseling courses to discuss the study and invite participation. Five of the Licensed Professional Counselors (LPCs) were recruited from one community counseling agency via an

email that was disseminated by the director of the agency and invited participation. The director then corresponded with this researcher to confirm there was interest from five of the counselors and set up a time for this researcher to come to the agency and administer the scale. Four of the LPCs were recruited via email.

Collectively, the participants had an age range of 23-61, with a mean age of 37 and a standard deviation of .541. The participants represented various ethnicities (White 72%, *n* = 17, Hispanic *n* = 3, African American *n* = 1, Asian American *n* = 1, Biracial *n* = 1, Turkish *n* = 1) and genders (female *n* = 19, male *n* = 4, transgender *n* = 1). The participants also represented a variety of work settings including private practice (*n* = 6), mental health clinic (*n* = 10), hospital (*n* = 4), home setting (*n* = 1), and school setting *n* = 3.

Pilot Study Procedure

The HICS was administered using both an online survey tool (Qualtrics) and a paper version of the scale. Eighteen participants completed the paper version, and 6 participants completed the Qualtrics version. In addition to completing the scale, the participants were asked to comment (directly next to each scale item on paper version or in the comment section following each item on the Qualtrics version) on whether the scale item made sense, whether the wording was clear, and whether there was anything off-putting about the item. The participants who completed the paper version did so in a quiet space at the participants' university or counseling practice with written directions provided with the scale. The participants who completed the Qualtrics version had written directions provided on Qualtrics. The completed paper versions were given to this researcher and kept in a secure, locked file box and the Qualtrics version was uploaded to a password protected Qualtrics account connected to a member of the scale development team's educational institution. The scale development team

met and collaborated on revisions to the HICS based upon the input from the participants and data analysis of the responses.

Summary of Participant Input from the Pilot Study

There were several suggestions for improving the clarity of the demographic section of the HICS which the scale development team integrated into subsequent revisions of the scale. All feedback from the participants was taken into consideration by the scale development team, particularly when two or more participants gave similar input. Table 8 includes a summary of scale item input from participants in the developmental administration of the HICS and the item revision decisions of the scale development team. In addition to considering the participants' suggestions, the scale development team agreed upon additional minor wording revisions and corrected an item numbering error to ready the HICS for expert review.

Table 8

Summary of Participant Input and Scale Development Team's Revisions

Scale Item	Participant Input	Teams' Decision
"I mostly seek to understand my clients' unique point of view."	Several participants suggested removing the word "mostly."	Scale item was revised. The word "always" replaced "mostly."
"I really enjoy the search for knowledge related to the counseling profession."	A couple participants suggested removing the word "really.	Scale item was not revised.
"I really enjoy new ways of understanding others."	Several participants suggested removing the word "really."	Scale item was revised. The word "thoroughly" replaced "really."
"I often strive to come up with effective therapeutic interventions for my clients that challenge my world view."	Once participant was uncertain that challenging the worldview of the counselor was necessary; One participant was uncertain if the item was referring to the client's or counselor's world view.	Scale item was revised to read: "I work with my clients to incorporate counseling interventions which challenge my world view."
"I actively pursue numerous solutions to clients' counseling concerns."	Several participants expressed confusion with this item.	Scale item was revised to read: "I earnestly try to understand clients' solutions to their issues even if they conflict with my values."
"I can easily let go of controlling the counseling process in order to adapt to the needs of my clients."	Several participants expressed confusion with this item.	Scale item was revised to read: "I am able to restructure sessions to adapt to the needs of my clients."

Table 8 (continued)

Scale Item	Participant Input	Teams' Decision
"Even when I conflict with my clients, I still appreciate their point of view."	Several participants expressed confusion with this item.	Scale item was revised to read: "Even when my core values are opposite to those of the client, I consciously strive to understand their point of view."
"When my clients' core values are different from my own, I still desire to learn from their perspective."	One participant stated this item was similar to other items.	Scale item was revised to read: "I really want to learn from clients who don't share my world view."
"In the counseling relationship, I actively put my clients' preferences before my own."	A couple participants expressed confusion with this item.	Scale item was revised to read: "In the counseling relationship, I actively put aside my biases to put my clients' concerns before my own."
"I know the limits of my understanding of clients' concerns."	A couple participants expressed confusion with this item.	Scale item was not revised.
I wouldn't ask my clients to do something that I, myself, would not try to in my personal life."	A couple participants expressed confusion with this item.	Scale item was not revised.

Data Analysis of the Responses from the Pilot Study

This researcher conducted preliminary psychometric evaluation on the responses from the developmental administration of the HICS using IBM SPSS statistical software (version 27). The statistical outputs from the analysis can be found in Appendix H. The descriptive analyses included running frequencies (i.e., mean, percentage, and standard deviation), normality testing with skew and kurtosis; and running Cronbach's alpha for inter-item correlation. This preliminary analysis revealed a couple of pieces of encouraging information. First, the scale development team's rigorous process of generating an item pool seemed effective in that the Cronbach's alpha was approximately .90 across all items. Although the Cronbach's alpha would likely decrease with a wider administration of the HICS, this initial analysis showed a good starting point for inter-item correlation (DeVellis, 2017). Second, the skew was largely under 1.0 (one item was above 1.0) and the kurtosis was largely under 2.0 (two items were above 2.0) which pointed to normality in the distribution (DeVellis, 2017).

The preliminary analysis also revealed a couple of areas for possible concern. First, the means of the responses were largely 4.0 or higher with relatively low variance. This could be attributed to the small sample size of the developmental study. Once a larger amount of data were collected, the scale development team would ideally like to see a range of 1-5 across most items. However, that range was not common with self-report measures, thus, a range of 2-5 would be good and a range of 3-5 would be acceptable. A range of 4-5 would be unacceptable (C. Sink, personal communication, October 3, 2020).

There were three scale items which produced ranges between 4-5. The scale development team decided to revise these items to attempt to generate more variability. The proposed item revisions were as follows: Scale item 1 read: "I always seek to understand my clients' unique

perspectives.” The revised item reads: “I strive to understand my clients' unique perspectives, even when their perspectives challenge my values or elicit uncomfortable emotions.” Scale item 4 read: “I thoroughly enjoy finding new ways of understanding others.” The revised item reads: “I actively seek to expand the depth of my knowledge and understanding of others.” Scale item 17 read: “I typically grow as a counselor through my interactions with my clients.” The revised item reads: “I often perceive interactions with clients as opportunities for professional growth.”

APPENDIX H

PILOT STUDY DATA ANALYSIS OUTPUT

Table 9

Descriptive and Reliability Data from Pilot Study

Item	Mean	Variance	Range	Skew	Kurtosis	Cronbach's alpha
1	4.6087	0.249	4 - 5	-0.477	-1.951	.889
2	4.5652	0.439	3 - 5	-1.288	0.625	.882
3	43913	0.340	3 - 5	-0.291	-0.665	.884
4	4.1739	0.514	3 - 5	-0.273	-0.893	.887
5	4.6957	0.221	4 - 5	-0.911	-1.291	.887
6	4.0000	0.636	2 - 5	-0.588	0.378	.882
7	4.3043	0.403	3 - 5	-0.340	-0.517	.892
8	3.217	1.087	2 - 5	-0.212	-1.719	.901
9	4.0455	0.617	2 - 5	-0.732	0.862	.893
10	3.7826	0.632	2 - 5	-0.167	-0.241	.885
11	3.6957	0.676	2 - 5	0.110	-0.576	.893
13	4.2174	0.542	3 - 5	-0.376	-0.975	.884
14	4.2174	0.451	3 - 5	-0.280	-0.627	.884
15	3.8696	1.028	2 - 5	-0.578	-0.608	.883
16	4.2609	0.656	3 - 5	-0.534	-1.243	.890
17	4.3043	0.312	3 - 5	0.023	-0.462	.897
18	4.0435	0.498	3 - 5	-0.061	-0.820	.886
19	4.7273	0.208	4 - 5	-0.097	-0.887	.887
20	4.4348	0.621	2 - 5	-1.599	2.902	.892
21	4.2609	0.474	3 - 5	-0.392	-0.717	.882

Table 9 (continued)

Item	Mean	Variance	Range	Skew	Kurtosis	Cronbach's alpha
22	4.3913	0.431	3 - 5	-0.617	-0.484	.883
23	4.3043	0.402	3 - 5	-0.617	-0.484	.883
24	4.2174	0.814	2 - 5	-0.875	-0.114	.891
25	4.2174	0.360	3 - 5	-0.092	-0.202	.887
26	3.8696	0.482	3 - 5	0.179	-0.750	.891
27	4.1739	0.423	3 - 5	-0.177	-0.462	.883
28	4.2609	0.474	3 - 5	-0.392	-0.717	.886
29	4.2174	0.360	3 - 5	-0.092	-0.202	.884
30	4.3478	0.510	3 - 5	-0.639	-0.695	.895
31	3.9091	0.944	1 - 5	-1.176	2.466	.897
32	4.1304	0.300	3 - 5	0.110	0.601	.886
33	4.4348	0.439	3 - 5	-0.767	-0.347	.884

APPENDIX I

EXPERT REVIEW INVITATION

May 1, 2020

Dear_____,

Our research team are reaching out to you as a counseling scholar to invite you to be an expert reviewer for the *Humility in Counseling Scale*. This scale is being developed by Dr. Chris Sink (Retired ODU; currently Research Associate, W. Washington University), Jennifer Santopietro (Doctoral Candidate, University of Northern Colorado), Alyssa Reiter (Doctoral Student, Old Dominion University), and Beth Orrison (Doctoral Student, Old Dominion University). The Humility in Counseling Scale is a self-report measure designed to appraise the respondents' perceptions of humility in the counseling relationship. The targeted sampling frame includes in-service counselors (practitioners), preservice counselors (counselors-in-training), and counselor educators. We have piloted the scale with 25 professional counselors, counselor educators, and counselors-in-training and revised the scale based upon the participants' feedback. Your expertise will be invaluable to help us finalize the revisions prior to a wider distribution of the scale.

The rationale for our study began with our belief that, for counselors, the concept and practice of humility in the clinical context is somewhat elusive and generally not included in the assessment of key counselor dispositions. This led us to wonder about the potential impact of humility on the counseling relationship and if it was explicitly expressed and integrated into the counseling process. A review of the counseling literature revealed a dearth of research on the humility as expressed within the counseling context. The studies that do exist in leadership, positive psychology, multicultural, and spirituality literature define humility as accurately assessing oneself and imperfections, appreciating the value of all people their unique contributions, being other-oriented, teachability, regulating the need for status, and displaying modesty (Exline & Geyer, 2011; Owens et al., 2013; Tangney, 2000; Worthington et al.,2017). We concluded that some of characteristics do not entirely fit within the counseling relationship, so we had to draw on literature outside of the field. Later work by Paine et al., 2015) suggested that humility is a psychotherapeutic virtue separate from a clinical skill stating, "humility is a term in reference to the sort of person the clinician is becoming rather than the skills they are proficient in" (p. 10). They proposed the idea that when clinicians develop humility, they are better able to integrate complex relational dynamics within the psychotherapeutic system. Developing and embodying humility could deepen the therapeutic process, and the ability to measure clinical humility could help to clarify its relevance to the counseling relationship. In short, based on our reading of literature, we propose that humility in counseling relationship encompasses four major intersecting domains: self-awareness, openness, curiosity, and flexibility. Our proposed instrument attempts to validly measure these areas.

Attached to this email is the scale for you to review. In effort to keep the expert review process efficient, organized, and consistent across reviewers, we respectfully request that you make all edits, modifications, and suggestions using the *track changes* feature in Microsoft Word (or equivalent). We are asking you to review the scale regarding the following considerations:

item content validity, appropriateness of items, grammatical and punctuation errors, existence of cultural stereotypes or biases, readability, difficulty level, and overall instrument appearance. If you believe an item should be deleted from the scale, please write a brief rationale for this decision.

When you have completed reviewing the scale, please save all of your changes and return the document via email jennifer.santopietro@unco.edu. Please do not hesitate to contact us with any questions or concerns. If at all possible, could you return your review by May 30, 2020.

We appreciate your assistance.

Sincerely,

Christopher Sink
Jennifer Santopietro
Alyssa Reiter
Beth Orrison

APPENDIX J

SYNOPSIS OF FEEDBACK FROM EXPERT REVIEW

Expert Review of the Humility in Counseling Scale

One of the respected procedures for maximizing validity and reliability of a scale was to have a panel of experts who were knowledgeable in the content area of the item pool review the initial scale items (DeVellis, 2017). The expert reviewers could help to assess the quality of the items by confirming the scale developers' definition of the phenomenon; evaluating the clarity, conciseness, redundancy, grammar, and face validity of the items; and suggesting ways to focus measurement of the phenomenon the developers may have missed (DeVellis, 2017; Worthington & Whittaker, 2006). Insightful comments from expert reviewers may help scale developers gain new perspective on how to decrease possible ambiguity and strengthen scale items. Thus, DeVellis stated that it was important for scale developers to conscientiously consider the feedback from expert reviewers to then make informed decisions about scale revisions.

Expert Review Participants and Procedure

The scale development team incorporated input from the development administration of the scale to revise the Humility in Counseling Scale (HICS) prior to the expert review process. Next, the scale development team sent a letter (Appendix I) and the revised scale following the pilot study via email to six counseling and psychology scholars from four educational institutions in three different areas of the United States. The letter explained the rationale for the study and invited their participation. Five scholars accepted the invitation to provide feedback on the scale. No demographic information about the reviewers was collected. The reviewers were asked to make comments on a Microsoft Word version of the HICS that was emailed to them. Then, the reviewers returned the scale to this researcher via email with their comments. This researcher compiled the comments of the expert reviewers into a color-coded spreadsheet which was shared

with the scale development team. Finally, the team discussed the feedback from the expert reviewers to make collaborative decisions about scale item revisions.

Summary of Input from the Expert Review

The expert reviewers suggested a few grammatical and wording changes, some of which were incorporated into the revised version of the HICS to be used for this study. For example, the reviewers suggested rewriting one item that ended with a preposition and another item that seemed confusing with the word "opposite" in the same sentence as "shared." The scale development team incorporated both suggestions. Additionally, another scale item read, "When clients' challenge me with a different perspective, I am genuinely receptive to new ways of thinking about the concern." The reviewers suggested removing the phrase "about the concern" as it narrowed the prompt. The team agreed with this suggestion and made the revision.

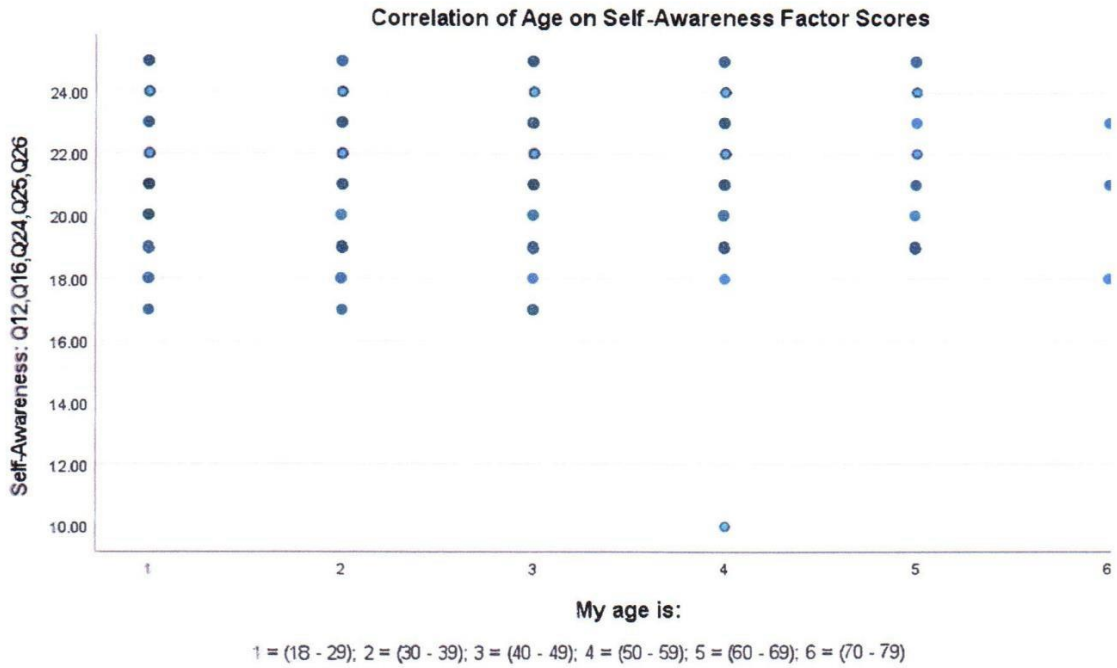
There were a few suggestions by the reviewers that the scale development team did not decide to incorporate. The decisions to not incorporate some of the revisions were influenced by the team's knowledge of humility research, beliefs about variance, and collective perspective based in the literature of how clinical humility may be measured within the counseling relationship. For example, one reviewer stated that the word "restructure" seemed too vague within the scale item that read, "I am able to restructure sessions to adapt to the needs of my clients." The team considered substituting with the word "re-design" or "re-direct" instead of "restructure." Ultimately, the team decided that structure aligned with counseling--structuring sessions, structuring the counseling relationship--and captured the in-the-moment adaptation a counselor with clinical humility may express.

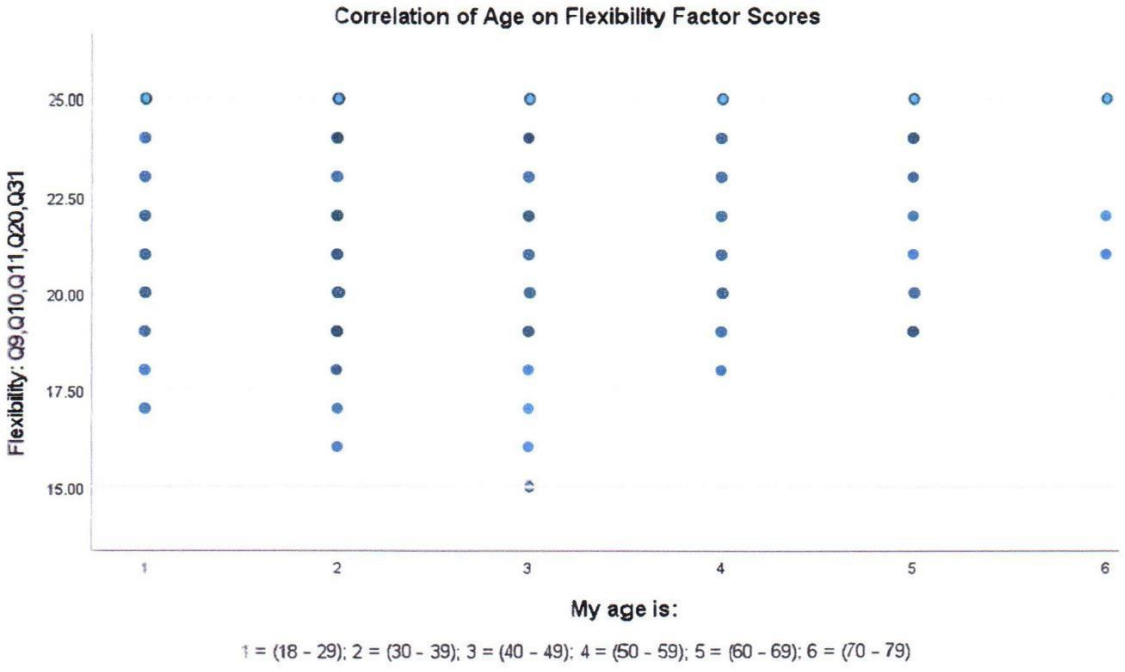
Similarly, a reviewer stated that the word "thinking' was possibly ambiguous in the scale item that read, "I can readily adjust my thinking as I learn new information from my clients."

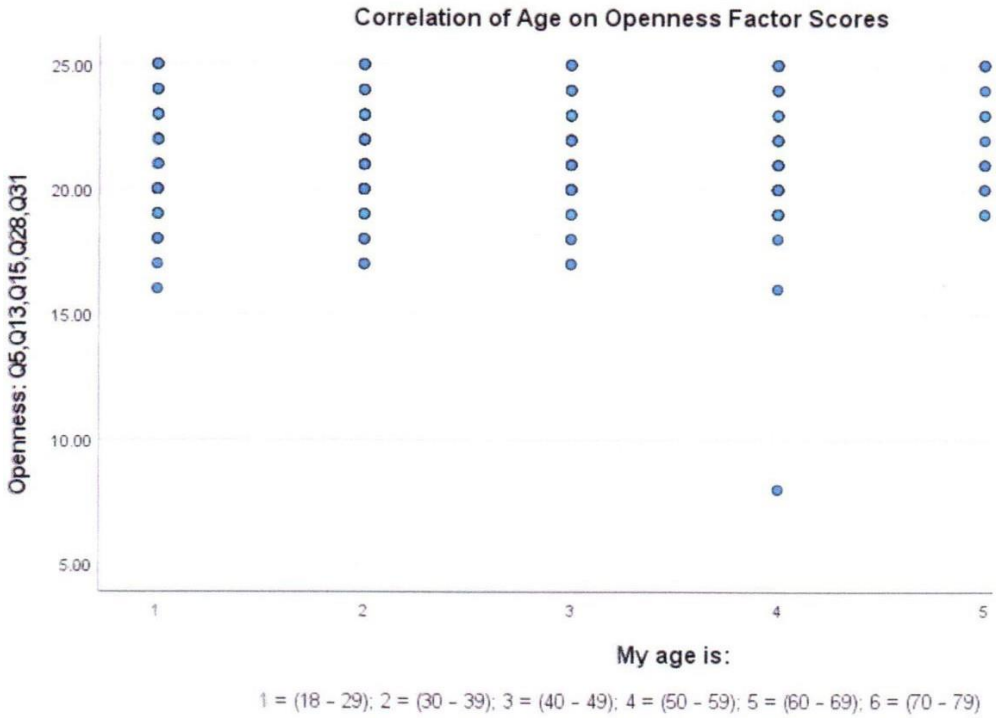
Based upon their review of the literature, the scale development team believed that the measure of flexibility for clinical humility aligned most with cognitive flexibility. Thus, the word "thinking" more succinctly captured the concept of flexibility in clinical humility. Finally, there were a few suggestions to remove words that pushed absolutes and to consider reverse scoring of the some of the items. The team decided to leave the word "all" for one scale item and rejected the suggested word "may" for another scale item to allow for more variance. Additionally, the team decided against reverse scoring as it did not seem to fit well with the construct being measured and was not done with the developmental administration of the HICS.

APPENDIX K

SCATTER DOT PLOTS FOR CORRELATIONAL ANALYSIS


Correlation of Age on Self-Awareness Factor Scores
Self-Awareness: Q12,Q16,Q24,Q25,Q26
24.00
22.00
20.00
18.00
16.00
14.00
12.00
10.00
1
2
3
4
5
6
My age is:
1 = (18 - 29); 2 = (30 - 39); 3 = (40 - 49); 4 = (50 - 59); 5 = (60 - 69); 6 = (70 - 79)


Correlation of Age on Flexibility Factor Scores
Flexibility: Q9,Q10,Q11,Q20,Q31
25.00
22.50
20.00
17.50
15.00
1
2
3
4
5
6
My age is:
1 = (18 - 29); 2 = (30 - 39); 3 = (40 - 49); 4 = (50 - 59); 5 = (60 - 69); 6 = (70 - 79)


Correlation of Age on Openness Factor Scores
Openness: Q5,Q13,Q15,Q28,Q31
25.00
20.00
15.00
10.00
5.00
1
2
3
4
5
My age is:
1 = (18 - 29); 2 = (30 - 39); 3 = (40 - 49); 4 = (50 - 59); 5 = (60 - 69); 6 = (70 - 79)

APPENDIX L

ITEM DEVELOPMENT INSTITUTIONAL REVIEW BOARD APPROVAL

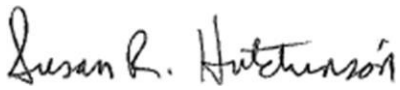
Date: April 4, 2019

TO: Jenni Santopietro
Counselor Education and Supervision

SRM 700

RE: Exempt Review of "Development of a Counseling Attitudes and Behaviors Scale," submitted by Jenni Santopietro, (Research Advisor: Susan Hutchinson, Department of Applied Statistics & Research Methods)

The above referenced prospectus has been reviewed for compliance with HHS guidelines for ethical principles in human subjects research. The decision of the Institutional Review Board is that the project is approved for exempt status as proposed for a period from April 4, 2019 to May 8, 2019.



Susan R. Hutchinson 4/4/2019
Omnibus IRB Reviewer Date

APPENDIX M

PILOT STUDY INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

INSTITUTIONAL REVIEW BOARD

DATE: July 17, 2019

TO: Jennifer Santopietro, MS

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1459798-1] Development of the Counselor Disposition Scale

SUBMISSION TYPE: New Project

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS

DECISION DATE: July 17, 2019

EXPIRATION DATE: July 17, 2023

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Thank you for a well written and thorough application. I am verifying your application as exempt, but have a couple notes for you to address prior to starting your project.

* *Please revise my contact information on the informed consents to list my office as the Office of Research and Sponsored Programs. We do not have an office with the name as it is currently listed.*

* *All non-UNC researchers will need to go through their respective IRB offices for approval before engaging in any research activities.*

Thank you, Nicole Morse

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Nicole Morse at 970-351-1910 or nicole.morse@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.