AN ABSTRACT OF THE DISSERTATION OF

Dominique L. Sotelo for the degree of Doctor of Philosophy in Counseling presented on August 5, 2015.

Title: Clinical Development for Paraprofessional Counselors: A 12 Session Protocol

Abstract approved:____

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Paraprofessional counselors comprise a significant sector of the mental health workforce (Buchbinder, 2003; Golden, 1991; Nieuwsma et al., 2014; Norcross, 2000). Professional counselors have offered both praise (Durlak, 1979) and criticism (Nietzel & Fisher, 1981) for paraprofessional counselors and the services that they provide. Paraprofessional counselors work under the guidance and supervision of trained mental health professionals, yet the extant literature has little to offer in terms of effective methods to foster clinical development.

This current study examined the impact of the PACE-12 clinical development protocol on paraprofessional counselor self-efficacy and counseling skills competence over a course of six weeks. Three groups of paraprofessional counselors received the PACE-12 protocol following a non-concurrent multiple baseline study design. Study participants supplied data at regular intervals during a baseline and an intervention phase. The data analysis confirmed that a functional relationship was present between the PACE-12 protocol and significant increase in counselor self-efficacy scores. The counseling skills competence scores only showed improvement for one of the study participant groups. The implications for researchers included a call for analogous replication studies and improving the methodology for collecting and analyzing counselor

skills competence data. The implications for professional counselors that supervise paraprofessional counselors included: (a) a call to structure ongoing clinical development with a protocol designed specifically for paraprofessional counselors; (b) being intentional about providing support and assurance to paraprofessional counselors when they are asked to improve their counseling skills, particularly in situations where client clinical presentations are acute.

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Clinical Development for Paraprofessional Counselors: A 12 Session Protocol

by
Dominique L. Sotelo

A DISSERTATION

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Doctor of Philosophy

Presented August 5, 2015
Commencement June 2016

Doctor of Philosophy dissertation of Dominique L. Sotelo presented on
August 5, 2015.

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Dominique L. Sotelo, Author

ACKNOWLEDGEMENTS

Non nobis solum nati sumus is a Latin phrase that impacted me during my education at Willamette University. While there were times when I felt alone, divine blessing ensured me that, indeed, I was in grand company. I am truly blessed and grateful for those around me who encouraged me, invested in me, and exhorted me.

To Dr. Lorie Blackman:

Your ability to encourage and insist has made me a better person, which translates into my being able to do the same for all those who lean on me for guidance, support, and instruction.

In Memory of Robert Otto Piehl, Ph.D.:

With your help, I found the person that I was meant to be. Now, I do the same for others. Your life, your dreams, and your purpose were cut short, but nonetheless, they all carry on. See you again, my friend, when the time is right. I, too, am a beggar of the spiritual, a spiritual beggar.

To my wife, Angela:

I am truly and entirely indebted to you because of your patience, tolerance, and—above all—love.

To my two sons:

In so many ways, I hope one day you'll recognize that these steps I took—some right and some wrong—were all to carve a path that you may choose to follow. Jaebin and Conrad, always remember: non nobis solum nati sumus.

CONTRIBUTIONS OF AUTHORS

Lance Schnaker assisted in the analysis and interpretation of the data. Dr. Lorie Blackman assisted in the formatting and editing of the dissertation final copy.

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Clinical Development for Paraprofessional Counselors: A 12 Session Protocol

CHAPTER 1

GENERAL INTRODUCTION

Overview

The purpose of this dissertation is to demonstrate scholarly work by using the manuscript document dissertation format as outlined by the Oregon State University Graduate School. In this format, Chapter one illustrates the purpose of thematically binding the two journal-formatted manuscripts found in Chapters two and three and supports their contributions to the research conclusions pertaining to the provision of group clinical development, specifically by assessing the impact of a predetermined clinical group development protocol for paraprofessional counselors. Chapter two is a literature review titled "A Review of the Literature on Clinical Supervision with Paraprofessional Counselors," and Chapter three presents quantitative research in a manuscript titled "Clinical Development for Paraprofessional Counselors: A 12 Session Protocol." The purpose of the study in Chapter three is to examine the impact that a 12-session group clinical development protocol has on paraprofessional counselors in the domains of counselor self-efficacy and counseling skill competence. Chapter four will present general conclusions and implications that result from this research, and it will also link all of the chapters together.

Paraprofessional Counselors

The incorporation of the paraprofessional counselor into the mental health workforce has been and continues to be viewed as advantageous for multiple reasons. Paraprofessional counselors allow more people to benefit from mental health services by

providing such services at a lower cost (Easton, Platt, & van House, 1985; Golden, 1991; Holland, 1998; Jain, 2010; Sobey, 1970; Walfish & Gesten, 2008) as compared to the cost of services that professionals provide. Training for paraprofessional counselors can occur on a shorter timeline and with a specific treatment focus, which allows them to be recruited, hired, and put to work sooner than is possible for professionally trained counselors (Brown, 1974; Faust & Zlotnick, 1995; Walfish & Gesten, 2008). Paraprofessional counselors can also be directly selected from the social demographic that stands to be the primary recipient of the mental health services. This helps minimize the barriers to accessing mental health services that exist when the professional counselor does not resemble the social demographic of the client (Barlow et al., 2013; Gardner & Shelton, 1977; Gould, 2000; Musser-Granski & Carrillo, 1997).

Clinical Supervision

Clinical supervision for those involved in the helping professions is regarded as a requisite activity (Bernard & Goodyear, 2009; Campbell, 2005; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001; Watkins, 1997). Clinical supervision can be defined as a senior helper providing guidance and mentorship to a junior helper (Bernard, 2010). Substantial literature exists that informs the process for providing clinical supervision to formally educated or technically trained counselors (Goodyear & Bernard, 1998). However, very little literature exists that informs the process for providing clinical supervision to paraprofessional counselors who do not possess formal education or a professional certificate in the field of counseling. This void in the literature is problematic because despite the significant presence of paraprofessional counselors in the mental health workforce, there remains much to be understood about how to support their

development as counselors. Supporting the development of paraprofessional counselors is imperative to ensure that the recipients of their services are treated ethically and competently.

The first research question will set out to determine the impact that a 12-session group clinical development protocol provided to paraprofessional counselors will have on counselor self-efficacy. The second research question will assess the change in counseling competence in paraprofessional counselors as a result of receiving a 12-session group clinical development protocol.

The manuscripts included in this dissertation thematically converge on the process of supporting the clinical development of the paraprofessional counselor through the provision of clinical group supervision. The results of these research questions have implications for the clinical supervisors who are charged with supporting the paraprofessional counselor, the paraprofessional counselors themselves in their ability to be effective, and the consumers of the services that paraprofessional counselors provide.

Importance in the Profession of Counseling

While the exact numbers are difficult to know for certain, estimates suggest that paraprofessional counselors make up as much as 40% of the mental health workforce in the United States (Buchbinder, 2003). Paraprofessional counselors are given different labels and duties, depending on their setting, which is part of the reason that it is difficult to know exactly how many paraprofessional counselors are present in the mental health workforce (Delworth, 1974; Walter & Petr, 2006). Literature references that recognized the identity, role, and purpose of paraprofessional counselors first emerged in the late 1960s (Blau, 1969) and continued through the 1970s (Alley & Blanton, 1976; Brown,

1974; Durlak, 1973; Sobey, 1970). Descriptions of the paraprofessional counselor also widely vary in the extant literature. For the purposes of this dissertation, a paraprofessional counselor is defined as a person who has not received any graduate-level training in a helping profession and who is providing mental health services to a consumer population (Delworth, 1974; Huckshorn, 2007). The era of deinstitutionalization in the late 1960s created a demand for mental health services that overwhelmed the workforce of professional mental health service providers (Hopkinson & Hurley, 1976; Sobey, 1970). The professional response to the presence of paraprofessional counselors has been polarized between sentiments of support and value (Barlow et al., 2013; Brown, 1974; Dubus, 2009; Durlak, 1979; Golden, 1991) to poignant concerns about the paraprofessionals' ability to ethically and competently provide services (Armstrong, 2010; Faust & Zlotnick, 1995; Hopkinson & Hurley, 1976; Schmidt, 1968).

Concerns Regarding Paraprofessional Counselors

Despite the advantages that are attributed to paraprofessional counselors, concerns have been raised about them as group that center on ethics and competence. Professional practitioners have raised ethical concerns about the paraprofessional counselor's ability to understand confidentiality and its limits, professional boundaries, and not supporting client autonomy (Armstrong, 2010; Fagan & Ax, 2002; Holland, 1998; Hopkinson & Hurley, 1976; Jain, 2010; Musser-Granski & Carrillo, 1997). Huckshorn (2007) described paraprofessional counselors' questionable ability to competently deliver counseling services due to their lack of formal education and training.

The concerns about paraprofessional counselors' ability to conduct themselves ethically and to deliver competent mental health services can be addressed through the provision of clinical group supervision (Musser-Granski & Carrillo, 1997; Tan, 1997; Walfish & Gesten, 2008; Walter & Petr, 2006). Bernard and Goodyear (2009) defined clinical supervision as "an intervention provided by a more senior member of a profession to a more junior member or group of members of the same profession" (p. 7). In an effort to elicit efficacious treatment outcomes, clinical group supervision is thought to assist counselors in the process of continuing to develop their core counseling skills and problem-solving strategies that benefit the counseling recipient by increasing the likelihood that the services they receive are both ethical and optimal (Campbell, 2005; Cashwell & Dooley, 2001).

To support the professional development of paraprofessional counselors and to address the concerns about their ability to practice ethically and competently, clinical supervision should be in place (Azar, 2000; Newton, 2000; Walfish & Gesten, 2008). However, it is reported that paraprofessionals often do not receive regular clinical supervision (Durlak, 1979; Sobey, 1970; Walfish & Gesten, 2008). In settings where paraprofessional counselors do receive clinical supervisions, the supervisor may not have a concept of needs specific to paraprofessional counselors (Nittoli & Giloth, 1997). Clinical supervision for the paraprofessional counselor may not always be the priority for the clinical supervisor who is also expected to carry a caseload (Walfish & Gesten, 2008). Due to the varied and infrequent provision of clinical supervision for the paraprofessional counselor, much still remains to be understood about its constitution and provision. Newton (2000) asserted that clinical supervision is more critical for the paraprofessional

counselor than it is for a professional counselor. Thus, a systematic investigation of clinical supervision and its impact on the paraprofessional counselor is warranted, according to Armstrong (2003) and McLeod (2013).

Research Questions

This study investigates the impact that clinical development has on paraprofessional counselors by focusing on the relevant constructs of counselor self-efficacy (Larson & Daniels, 1998; Lent et al., 2009) and counseling skills competency (Gazda et al., 1995). While clinical supervision is considered an essential activity pertaining to formally educated or technically trained counselors (Azar, 2000; Bernard, 2010; Bernard & Goodyear, 2009; Campbell, 2005; Stoltenberg & McNeill, 2009; Watkins, 1997), equivalent claims regarding clinical supervision being essential for supporting the paraprofessional counselor have been few in number and limited in scope. That clinical supervision is essential to the paraprofessional counselor seems to be a logical presumption; however, the empirical basis for such a claim has yet to be established. Studies, such as the one presented in Chapter 3, will serve to establish the foundation for the practice of providing clinical supervision to paraprofessional counselors.

The first research question is, “Do paraprofessional counselors experience an increase in counselor self-efficacy after receiving group clinical development?” The second research question is, “Do paraprofessional counselors demonstrate more advanced counseling skills after receiving group development?”

These research questions address, in part, the unknown impact of clinical development on the paraprofessional counselor. Acquiring this knowledge is critical to

inform the workforce of professional counselors how to best support the development of the paraprofessional counselor and to ensure that consumers of paraprofessional counseling services receive ethical and competent care.

Hypotheses

The hypotheses are as follows:

H_o: A 12-session group clinical development protocol will not improve scores on the Counselor Activity Self-Efficacy Scale Helping Skills subdomain (CASES-HS).

H_1: A 12-session group clinical development protocol will improve scores on the Counselor Activity Self-Efficacy Scale Helping Skills subdomain (CASES-HS).

H_o: A 12-session group clinical development protocol will not improve scores on the Global Scale for Rating Helper Responses (GSRR).

H_1: A 12-session group clinical development protocol will improve scores on the Global Scale for Rating Helper Responses (GSRR).

Glossary of Terms

Paraprofessional counselor: A person who provides mental health counseling services without having a graduate degree in a helping profession and is not enrolled in a helping profession graduate program.

Professional counselor: A person who provides mental health counseling services after completing at least a master's degree in a field of study related to the helping professions.

Clinical development: The process of developing clinical skills and professional identity through the provisions of continuing education, ongoing training, and clinical development.

*Clinical supervision: "*An intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative; extends over time; and has the simultaneous purposes of enhancing the professional services offered to the client she, he, or they see(s) and serving as a gatekeeper for those who are to enter the particular profession" (Bernard & Goodyear, 2009).

Clinical supervisor: A person qualified to provide clinical supervision.

Counselor self-efficacy: A counselor's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future (Larson & Daniels, 1998).

Organization

The organization of the dissertation follows a topical review of the literature in Chapter 2, where the literature is examined for the purpose of illuminating the identity, purpose, and prevalence pertaining to paraprofessional counselors. A particular focus is also given to the provisions of clinical development to the paraprofessional counselor. Chapter 3 is a quantitative research study that assesses the impact of a clinical development protocol on paraprofessional counselors using the constructs of counselor self-efficacy (CASES-HS) and counselor competence (GSRR) as the dependent variables. Chapter 4 contains general conclusions and binds all of the chapters together.

Chapter 2

IS CARING ENOUGH? THE WORK OF PARAPROFESSIONALS IN COUNSELING SETTINGS

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Abstract

Paraprofessional counselors constitute a significant portion of today's mental health workforce. Paraprofessional counselors provide a variety of services in a variety of settings. Literature submissions have contained both justifications and cautions about the use of paraprofessionals as counselors. The justifications include achieving equal or better outcomes when compared to professionals, a shorter training period, and cost savings. The cautions identify the lack of training and understanding of professional ethics as potentially harmful to the consumer. Literature submissions have scrutinized the effectiveness of paraprofessional versus professional counseling services, which has resulted in an unsettled acceptance of the paraprofessional counselor as a legitimate service option in the mental health workforce. Much remains unknown about who paraprofessional counselors are, what they do, and how to support their professional development. This literature review will contribute to the body of knowledge working to understanding the role and professional development needs of the paraprofessional counselor.

Keywords: paraprofessional counselor, professional development, clinical supervision

Is Caring Enough? The Work of Paraprofessionals in Counseling Settings

Paraprofessional counselors are a significant group of today's mental health workforce. This literature review will examine the prevalence of paraprofessional counselors, as well as their roles, responsibilities, and professional development needs. Understanding who paraprofessional counselors are and what they do is critical to knowing how to best support their specific needs to ensure that the services that they provide are effective and ethical. Since the late 1960s, the relevant extant literature has contained research and concept articles about the paraprofessional counselor. This present review will highlight just how much remains to be known about paraprofessional counselors, the services that they provide, and how to support their clinical and professional development. Acquiring this knowledge will inform the clinicians who oversee paraprofessional counselors in their efforts to provide effective clinical development, and it will also help ensure that the recipients of paraprofessional counseling services receive the best care possible.

In the helping professions, paraprofessionals, defined as people without formal training or education, do much of the work that is necessary to care for people in need (Delworth, 1974; DeMoss, 1974). Agencies, hospitals, and clinics have been using paraprofessionals to provide mental health counseling services for the past 50 years. Despite their verifiable existence in significant numbers (Buchbinder, 2003; Hoge & Morris, 2002), paraprofessional counselors as a workforce are not well understood. Primary questions particular to paraprofessional counselors center on their identity and specific service contribution (Faust & Zlotnick, 1995). Several factors contribute to the

difficulty that accompanies the process of defining and describing paraprofessional counselors. These factors include the numerous official titles given to them in their work settings, the varied descriptions of the work that they perform, and the lack of a national or regional workforce organization. Paraprofessional counselors are referred to in the extant literature with differing titles, including lay counselors, associate counselors, volunteer counselors, and correctional counselors (Sobey, 1970; Tan, 1997). Paraprofessional counselors belong to several distinct helping professions, including social work, nursing, professional counseling, couples and family therapy, and psychology (Sobey, 1970; Tan, 1997). Paraprofessional counselors perform duties that vary according to the specific setting in which they operate (Buchbinder, 2003; Wallace, 1970).

Articles regarding the presence and role of the paraprofessional counselor emerged in the late 1960s and then sporadically appeared in the 1970s and 1980s. However, since the 1990s, very few such articles have been published. The literature contains distinct themes regarding the paraprofessional counselor workforce. These themes included position papers that support or question the merits of paraprofessional counseling, descriptions of specific settings that incorporate paraprofessional counselors, reviews of the clinical development needs of paraprofessional counselors, and studies and meta-studies that compare the effectiveness of paraprofessional and professional counselors. The literature also contains controversy that focuses on counseling competence and professional ethics and the degree to which a paraprofessional can master either or both. Despite this controversy, paraprofessional counselors are significant providers of services among the helping professions (Buchbinder, 2003;

Golden, 1991; Holland, 1998; Nieuwsma et al., 2014; Norcross, 2000). Furthermore, what is curious about the extant literature about paraprofessional counselors is a lack of clarity regarding how to support them in terms of clinical development.

Purpose Statement

This literature review will detail the utilization of paraprofessional counselors, their roles and duties, and literature based suggestions regarding how to select, train, and support paraprofessional counselors.

Research Questions

This literature review will address three primary questions: 1. Who are paraprofessional counselors? 2. What are the duties specific to paraprofessional counselors? 3. What should be done to support the professional development of the paraprofessional counselor?

Methods

Literature Search

Inclusion and exclusion criteria. We included peer-reviewed journal articles, which were published in full text in the English language. The article content needed to focus on the treatment of mental health disorder via a person who meets the definition of a paraprofessional counselor. A paraprofessional counselor for the purpose of this manuscript is defined as a person who has not completed and is not enrolled in graduate-level training in a helping profession and is regularly tasked with the duty of providing counseling services. We excluded articles when the content focused on a treatment need other than a mental health disorder, such as a medical condition or an education issue.

Search strategy. We searched the Medline, ERIC, EBSCOhost Psychology and Behavioral Science Collection, and Psychinfo electronic databases for relevant articles. We used the terms *paraprofessional counselor*, *lay counselor*, and *volunteer counselor* to search the electronic databases. We also hand-searched the reference lists of the articles acquired from the electronic database search.

Results. The electronic database searches returned 310 articles. We eliminated the duplicate articles, which reduced the total to 283. We added 57 articles after hand-searching the reference lists to bring the total articles for review consideration to 340. We culled the collection of articles based on a review of the article title and abstract. After this process, the article total became 141. We then reviewed the full text of the remaining articles and excluded another 37 articles, leaving 104 articles (Fig 1, p.35).

Included articles. We sorted the 104 articles included in this literature review into four themes:

1. Position papers regarding the use of paraprofessional counselors: 23
2. Descriptions of specific services that paraprofessional counselors provided: 43
3. Identifying clinical needs for paraprofessional counselors: 28
4. Contrasting effectiveness of professional and paraprofessional counselors: 10

Status of the Paraprofessional Counselor

Hoge and Morris (2002) estimated that paraprofessional counselors comprise 40 to 60% of the mental health workforce. The Bureau of Labor Statistics suggests that the number of paraprofessional counselors is approximately 354,800, based on data collected

in May of 2014 (Bureau of Labor and Statistics, 2015). Because there is no official registry for paraprofessional counselors, it is difficult to tally their presence with absolute certainty (Buchbinder, 2003; Nittoli & Giloth, 1997). Despite this difficulty, it is undeniable that paraprofessional counselors are present and providing mental health counseling services (Aiken, LoSciuto, & Ausetts, 1985; Armstrong, 2003; Azar, 2000; Barlow et al., 2013; Blackman, 1981; Buchbinder, 2003; Callagher, 1993; Forrest, 1978; Hatton, 2003; Holland, 1998; Lenihan & Kirk, 1990; LoSciuto, Aiken, Ausetts, & Brown, 1984; Miller & Pylypa, 1995; Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010; Musser-Granski & Carrillo, 1997; Nittoli & Giloth, 1997; Owens, 2011; Pazaratz, 2000; Plouffe, 2007; Riggs & Meyer, 1981; Walfish & Gesten, 2008). Professional counselors and psychologists have varying beliefs about the value and regard of paraprofessional counselors and the services they provide (Brown, 1974; Doukas & Cullen, 2010; Giangreco, 2005; Nietzel & Fisher, 1981; Schmidt, 1968).

Many concerns have been submitted in the literature about paraprofessional counselors. As an example of this expressed concern, Husckshorn (2007) purported that paraprofessional counselors do not have adequate training in the areas of symptoms of mental illness, use of the *Diagnostic and Statistical Manual for Mental Illness* (*DSM*), psychotropic medications and their adverse effects, or evidenced-based treatment interventions (Huckshorn, 2007).

While it is clear that, by definition, a paraprofessional has less formal training than a professional counselor, those who value paraprofessional counselors question the actual impact that extensive training in counseling theory has on counseling outcomes (Atkins & Christensen, 2001; Berman & Norton, 1985; Faust & Zlotnick, 1995). A theme

that was present across much of the literature regarding the paraprofessional counselor is the recommendation that the paraprofessional counselor possesses an innate desire to care for people (Arbuckle, 1968; Carkhuff, 1968; Faust & Zlotnick, 1995; Golden, 1991; Vivien Hunot & Rosenbah, 1997; Kramer, Rappaport, & Seidman, 1979; Pazaratz, 2000; Tan, 1992a; Wilson, 2005). While this sentiment seems well placed, a question that arises is as follows: for the paraprofessional counselor, is caring enough? Additional questions that seem appropriate regarding paraprofessional counselors include the following: how are they recruited? How are they trained? What stages of development do they experience? How are they best supported through the clinical supervision process?

History of Paraprofessional Counselors

Literature references that addressed the presence of paraprofessionals in mental health settings emerged in the late 1960s and through the 1970s (Bayes & Neill, 1978; Blau, 1969; Carkhuff, 1968; Duncan, Korb, & Loesch, 1979; J A Durlak, 1979; Forrest, 1978; Gardner & Shelton, 1977; Gruber, Wehmer, & Cooke, 1979; Hoffman, 1976; Meyerstein, 1977; Moore, 1974; Wallace, 1970). In the late 1960s, paraprofessional counselors began to be recruited by mental health settings to address the shortage of professional counselors (Ivey, Scheffler, & Zazzali, 1998; Walfish & Gesten, 2008). The shortage of professional clinicians was in part attributed to the period of deinstitutionalization. During this period, people who were being treated for mental illness transitioned from receiving services in institutional settings to receiving services in community settings, such as group homes and outpatient clinics (Sobey, 1970). This transition quickly outpaced the availability of the trained professional counseling workforce to adequately address the need for counseling services.

Albee (1968) also recognized the shortage of professional clinicians and attributed the shortage to an allegiance to the disease model of mental illness. Albee (1968) urged the mental health community to formally recognize the behavioral and relational contributions to mental illness and thus allow for the training of bachelor-level clinicians to treat these disorders. Paraprofessional counselors were thus recruited to address the shortage of professional counselors (Golden, 1991). This transition from professional to paraprofessional care became known as the *deprofessionalism* of the mental health service provision (Walter & Petr, 2006). Early on in this transition, paraprofessional counselors were recruited to address the mental health needs of the underserved populations. For example, paraprofessional counselors began to serve ethnic and minority groups (Barlow et al., 2013; Egli, 1987; Musser-Granski & Carrillo, 1997) and rural communities (Azar, 2000; Barlow et al., 2013; Dubus, 2009; Walfish & Gesten, 2008). Paraprofessional counselors would go on to provide counseling services that range from basic to very complex.

Paraprofessional counselors are active in the mental health workforce in many ways. For some, being a paraprofessional counselor is the first step in the process of becoming a professional counselor (Lenihan & Kirk, 1990; Pazaratz, 2000). Others enter the mental health workforce out of a desire to give back to their community (Armstrong & McLeod, 2003; Rath, 2008). Paraprofessional counselors who enter the field due to their demographic proximity to a target population do so with great enthusiasm and gratefulness. For many paraprofessional counselors, the process to become a professional counselor is perceived to be outside of their means in terms of both time commitment and

financial costs required for formal education (Barlow et al., 2013; Golden, 1991; Musser-Granski & Carrillo, 1997; Nagel, Cimbolic, & Newlin, 1988; Rath, 2008).

Paraprofessional Roles and Responsibilities

The roles and responsibilities particular to the paraprofessional counselor vary depending on the setting in which they are operating and the particular client populations they are serving. Paraprofessional counselors are expected to provide counseling services commensurate to the counseling services that trained professional counselors provide, as well as carry out non-clinical duties (Buchbinder, 2003). For example, in the residential setting, paraprofessional counselors, in addition to providing counseling services, can also be responsible for food preparation, supervising clients' showering, and securely escorting clients from one place to another (Buchbinder, 2003; Forrest, 1978). Paraprofessional counselors need to have the ability to switch roles quickly and regularly, depending on the duty they are performing. The divide between clinical and non-clinical duties can put the paraprofessional counselor in a situation in which he or she is accountable to more than one supervisor (Sobey, 1970).

In some settings, paraprofessional counselors are viewed as important members of a clinical team who possess valuable information to contribute to the case management process (Dubus, 2009; Musser-Granski & Carrillo, 1997). In other settings, paraprofessional counselors are left out of the case management process, despite the fact that they often have the most pertinent patient information (Buchbinder, 2003; Dvoskin & Spiers, 2004; Newton, 2000). Excluding paraprofessional counselors from the case management process can result in ill-informed treatment planning and transition planning. Notably, Freshwater (2007) reported that correctional officers who are called

upon to perform counseling duties in prisons have demonstrated 70% accuracy in assessing problematic mental health symptoms in inmates, while the mental health staff members claimed ignorance of any inmate mental health needs.

Settings Using Paraprofessional Counselors

The literature presents a multipart rationale for using paraprofessional counselors. The parts include the cost-savings potential (Easton et al., 1985; Newton, 2000; Walfish & Gesten, 2008), a simpler and quicker training process (Brown, 1974; Faust & Zlotnick, 1995; Walfish & Gesten, 2008), and the advantages associated with matching a paraprofessional counselor who demographically represents the target population (Barlow et al., 2013; Bayes & Neill, 1978; Egli, 1987; Montgomery et al., 2010; Musser-Granski & Carrillo, 1997). Paraprofessional counselors work in both inpatient and outpatient settings, providing a wide range of counseling services. The range of services includes group treatment (Riggs & Meyer, 1981), cognitive behavioral therapy (Montgomery et al., 2010), trauma-based counseling (Walfish & Gesten, 2008), and substance abuse treatment as specific examples (Aiken et al., 1985; Walfish & Gesten, 2008).

Inpatient Settings

Paraprofessionals provide services in the inpatient setting. Examples of inpatient settings include residential drug and alcohol treatment (Aiken et al., 1985; Gruber et al., 1979; LoSciuto et al., 1984), community residential treatment (Pazaratz, 2000), secure psychiatric residential treatment, and secure prison facilities (Dvoskin & Spiers, 2004; Magaletta & Boothby, 2002). In the inpatient setting, paraprofessional counselors work under the supervision of trained counselors. The guidance that the paraprofessional

counselor receives ranges from solely administrative supervision to a blending of clinical and administrative supervision provided by the same person, or receiving administrative and clinical supervision from two different people (Magaletta & Boothby, 2002; Pazaratz, 2000; Sobey, 1970; Tan, 1997).

Outpatient

Paraprofessional counselors have a presence in a variety of outpatient settings, as well. These settings include day treatment centers, vocational rehabilitation centers, drug and alcohol treatment centers (Aiken et al., 1985; LoSciuto et al., 1984; Velleman, 1992), and college campuses (Allen, 1974; Lenihan & Kirk, 1990; Teevan & Gabel, 1978; Winston & Ender, 1988). Paraprofessional counselors also provide crisis counseling services through live online forums for people in distress (Barak & Bloch, 2006; Fukkink, 2011). Paraprofessional counselors also provide services in the homes of clients in an effort to make the services more accessible (Barlow et al., 2013; Gould, 2000; Miller & Pylypa, 1995). Military chaplains are another example of paraprofessional counselors who provide critical links to professional mental health services for military veterans who are more comfortable seeing a chaplain. Veterans struggling with post-traumatic stress disorder, major depressive disorder, or substance use problems frequently report seeking out a chaplain as their first step toward getting help (Nieuwsma et al., 2014).

Paraprofessional counselors also provide highly specialized services based on the specific needs of a client population or clinical focus of the setting (Lenihan & Kirk, 1990; Magaletta & Boothby, 2002; Rath, 2008; Silver & Stonestreet, 1978). Administrators in rural communities consider the paraprofessional counselors to be

advantageous because they often closely represent the target population that is being served (Musser-Granski & Carrillo, 1997). Hatton (2003) and Gallagher, Tracey, and Millar (2005) described the use of paraprofessional counselors to provide bereavement counseling to individuals and families struggling with the loss of a loved one. Ahmed (2006) detailed the use of paraprofessional counselors who assisted in an earthquake disaster situation by using art therapy with children. The specific setting in which the paraprofessional is active shapes his or her identity, role, and responsibilities. The examples provided illustrate the variety of settings that incorporate paraprofessional counselors and how the characteristics of their work are unique to the specific setting.

Paraprofessional Counselor Efficacy

The initial discussion within the early literature revolved around the efficacy of services that paraprofessional counselors provide. In addition, researchers have compared the services that paraprofessional counselors and professional counselors provide (Brown, 1974; Durlak, 1979; Gruber et al., 1979; Nietzel & Fisher, 1981). This comparison, in many cases, allowed paraprofessional counselors to be seen as effective as professional counselors (Carkhuff, 1966; Durlak, 1979; Gruber et al., 1979; Hoffman, 1976). For example, Durlak (1979) explained that “the clinical outcomes paraprofessionals achieve are equal to or significantly better than those obtained by professionals” (p. 89). More recently, researchers have upheld the assertion that paraprofessional counselors are as effective as professional counselors (Barlow et al., 2013; Dubus, 2009; Jain, 2010; Plouffe, 2007; Walfish & Gesten, 2008).

Another example of the positive regard shown to paraprofessional counselors comes from Plouffe (2007), who concluded that the paraprofessional counselor “can

administer an approach such as CBT in a brief amount of time with long-term gains" (p. 359). However, professionals who have distilled the efficacy literature through meta-analyses still regularly question claims like these. The literature contains meta-analytical studies that have attempted to settle the debate regarding whether counselors need to receive formal training. Durlak (1979) provided the first meta-analysis that indicated that paraprofessionals were more effective than professional counselors. In response, Nietzel and Fisher (1981) reviewed the research that Durlak (1979) conducted and concluded that it contained analysis flaws and should not be relied upon to compare the counseling effectiveness of paraprofessionals and professionals. Hattie, Sharpley, and Jane (1984) continued the scrutiny of Durlak (1979) by including studies that had not previously been reviewed. The findings of Hattie et al. (1984) overall upheld Durlak's (1979) conclusions. Berman and Nortan (1985) also reviewed Durlak (1979) and concluded that there was no significant difference between professional and paraprofessional counselors.

In a commendable effort to make sense of the aforementioned reviews, Faust and Zoltnick (1995) analyzed the methods that researchers used to determine the effectiveness of paraprofessional counselors compared to professional counselors. These comparison studies typically examined paraprofessional counselors who work within a mental health service clinic or agency. These comparison studies are not suggesting that paraprofessionals are effective on their own with no formal training or formal oversight, whether it is administrative or clinical. Rather, their findings suggest that, in general, there is no difference between paraprofessional counselor outcomes and professional counselor outcomes.

Faust and Zoltnick's (1995) review is helpful because it highlights two driving factors behind the controversy directed at the paraprofessional counselor. The first factor is the tension that arises when observations are counterintuitive. Specifically, it is logical to believe that a person who undergoes intense formal training in the techniques and application of counseling services ought to yield significantly better outcomes over a person who has only received minimal training at best. The assumption that positive outcomes are directly linked to education and academic performance seems logical. However, the outcome studies have, to date, not supported this assumption. Thus, these observations are counterintuitive and evoke resistance (Lampropoulos & Spengler, 2005; Norcross, 2000). In contrast, Faust and Zoltnick (1995) suggested that positive counseling outcomes are predictable based on a person's ability to establish a positive helping relationship. Furthermore, they speculated that paraprofessional counselors may have an advantage specific to establishing a helping relationship because they are not encumbered by a preoccupation to adhere to a specific counseling theory or technique (Faust & Zlotnick, 1995).

Paraprofessional Counselor Recruitment

Paraprofessional counselors across various settings are recruited based on their consistent demonstration of particular personal characteristics. The literature identifies several qualities that make the paraprofessional counselor initially attractive for recruitment. These qualities include warmth, the sense of being capable of conveying empathy, an expressed desire to help other people, and a belief that people can change (Buchbinder, 2003; Pazaratz, 2000). Accordingly, Jain (2010) detailed that paraprofessional counselors at the onset of service should be English literate, be native

language proficient when working with immigrants or minorities, have an innate ability to show empathy, and have a strong motivation to be effective. Recruitment methods described in the literature include distributing flyers in public places, such as grocery stores, community centers, and libraries, as well as using the radio to advertise their services (Golden, 1991). Mental health agencies and clinics also recruit paraprofessional counselors from populations that have at one time been the consumer of a mental health service. Examples include individuals who have successfully completed residential treatment for a substance use disorder or sexual offense (Gruber et al., 1979; Hossack & Robinson, 2005; LoSciuto et al., 1984; Snowden & Cotler, 1974). Regardless of the methods used to recruit paraprofessional counselors, there is a reason to believe that training has a greater impact on competence (Hart & King, 1979).

Paraprofessional Counselor Training

Paraprofessional counselors undergo initial training after being hired and prior to providing counseling services to the target population. Buchbinder (2003) referred to paraprofessional counselors as belonging to an invisible workforce because they can be asked to provide counseling services without ever receiving training or clarity about their role and expectations for their performance. Training for paraprofessional counselors is usually brief and concentrated on a narrow band of subject matter that directly relates to the needs of a specific target population (Collingwood, 1969; Dooley, 1975; Flowers & Goldman, 1976; Gallagher, 1993; Libow & Doty, 1976; Quartaro & Rennie, 1983; Szendre & Jose, 1996; Walfish & Gesten, 2008).

Callagher (1993) was critical of the brief training that the paraprofessional typically receives. A more comprehensive training should cover in detail the role of the

therapeutic relationship and the intricacies of the counseling process with particular emphasis on problem solving and problem-management strategies from the common factors approach to counseling. The investigation Callagher (1993) conducted linked training for the paraprofessional counselor with having an enhanced understanding of their personal qualities and attitudes, thereby increasing reports of client counseling satisfaction. Gould (2000) echoed this observation and recommended the regular use of role playing for the purpose of teaching counseling skills and processing the paraprofessional trainees' response to the content that the client presented. The findings from Collingwood (1971) suggested that initial training for paraprofessional counselors can be effective but that the gains can quickly fade away. Doyle, Foreman, and Wales (1977) were critical of relying only on the pre-service training common for paraprofessional counselors. Their recommendation is to provide pre-service training and immediately follow up with clinical supervision.

In contrast to the concern regarding the narrowness and brevity of training that appears to be commonly offered to the paraprofessional counselor, several articles in the extant literature outline thorough and specific training protocols (Callagher, 1993; Duncan et al., 1979; Freshwater, 2007; Golden, 1991; Gould, 2000; Jain, 2010; Pazaratz, 2000; Wilson, 2005). These training protocols vary from training in basic counseling skills for settings that serve the general mental health needs of clients. Other training protocols are much more specific in terms of addressing specific mental health needs often through the application of very specific interventions. For example, Wilson (2005) detailed paraprofessional training protocol for meeting the needs of clients who are likely not to engage in mental health counseling services due to the lack of available

professional counseling services. The training protocol in this example prepares the paraprofessional counselor to help a wide range of clients' presenting problems. Magaletta and Boothby (2002) recommended that paraprofessional counselors in correctional prison settings receive specific training in basic interpersonal communication skills, group dynamics, dealing with resistance, and managing the special needs of inmates. Lenihan and Kirk (1990) detailed a program named Paraprofessional and Companion Therapists (PACT) that assists college students who struggle with eating disorders. This program follows training protocol that focuses on equipping paraprofessional counselors in the areas of health and nutrition, behavior management contracting, client self-monitoring, journaling and relaxation training (Lenihan & Kirk, 1990).

As demonstrated, the literature contains examples of the training that the paraprofessional counselor should receive or does receive upon being recruited and hired. What remains missing from the literature is an analysis of what these training efforts accomplish in terms of counselor competence, self-efficacy, and counseling outcomes. As long as this knowledge gap exists, confidence in paraprofessional efficacy will remain uncertain.

Paraprofessional Counselor Development

Continuing Education and Training

Paraprofessional counselors receive formal opportunities to develop their skill sets in the form of ongoing training and continuing education. Settings that are in need of a licensure or certification to operate are more likely to ensure that paraprofessional counselors will receive regular continuing education and training opportunities. Wilson

(2005) indicated that paraprofessional counselors who are part of the Volunteer Counseling Service (VCS) in Rockland County, New York, are required to attend weekly seminars that cover critical counseling topics, such as how to counsel depressed clients, how to manage countertransference, and how to manage difficult moments in the counseling session. Golden (1991) also wrote an article about the VCS program and indicated that the paraprofessional counselor develops counseling competency at a slower rate compared to graduate-trained counselors, thus emphasizing the need for organized efforts to ensure clinical development. Romi and Teichman (1998) analyzed a clinical development protocol focused on bolstering the self-efficacy of paraprofessional counselors to manage difficult moments with clients and maintain motivation to therapeutically engage the client. Their results demonstrated a non-effect on both fronts.

Dubus (2009) cited the advantage of using mentors alongside the paraprofessional counselor for the purpose of gaining understating of how the paraprofessional counseling filters information received from the client. Professionals can glean from these mentorship experiences the specific needs for training and support.

Clinical Supervision

The methods and purpose for providing clinical supervision to the professional counselors are well established and understood (Bernard & Goodyear, 2009). The same claim cannot be made when considering the supervision needs of the paraprofessional counselor (Walfish & Gesten, 2008). Kruger, Cherniss, Maher, and Leichtman (1988) conducted a qualitative case study that focused on providing group supervision to paraprofessional counselors in an inpatient psychiatric setting. How paraprofessionals viewed and valued the supervision was the primary focus of their research. The major

conclusion from this instance of research was that paraprofessional counselors appreciated the group supervision experience. This qualitative study represents the single example of published research found in this literature review that is specific to the provision of clinical supervision to paraprofessional counselors.

The provision of clinical supervision to the paraprofessional counselor seems appropriate, and it is generally regarded as a practice that should be prevalent (Azar, 2000; Doyle et al., 1977; Easton et al., 1985; Gould, 2000; Jain, 2010; Tan, 1997; Wilson, 2005). However, paraprofessional counselors have reported that they seldom receive clinical supervision (Durlak, 1979; Sobey, 1970; Walfish & Gesten, 2008). In agency settings, a trained professional coworker is the typical choice for providing clinical supervision to the paraprofessional counselor (Brown, 1974; Tan, 1997). Clinical supervision has also been known to come from volunteer clinicians who are willing to donate their time and expertise (Wilson, 2005). Gould (2000) explained that one of the advantages of providing clinical supervision to the paraprofessional counselor is that it provides the opportunity to evaluate the services that clients receive in a more integrated manner. Without clinical supervision, the evaluation process will tend to occur at a time interval that is distant from the point of the actual service delivery. The literature identifies several factors have impeded the supervision process for the paraprofessional counselor. Despite a will, or recognized need to provide clinical supervision to the paraprofessional counselor, the person charged with this duty often is required to provide direct services to a demanding caseload (Sobey, 1970). When faced with the choice regarding where to focus time and attention, the caseload becomes the priority. Often, a trained professional counselor is elevated to the status of clinical supervisor without the

necessary training, experience, or desire to function in that capacity (Sobey, 1970). In a situation like this, the unequipped clinical supervisor may be hesitant to engage in the process with the paraprofessional counselor (Azar, 2000; Duncan et al., 1979).

Issues Raised About Paraprofessional Counselors

Competence

The question of competence became indelibly marked upon the arrival of the research that Durlak (1970) published, which indicated that paraprofessional counselors are not only competent but also more effective than professional counselors. The studies that Durlak (1970) included examined paraprofessional counselors who were providing services under the guidance of trained professionals. It is important to emphasize that effective paraprofessional counseling services occur in settings where professional counseling services also occur. Subsequent research has replicated the findings that Durlak (1970) submitted by demonstrating the competence of paraprofessional counselors (Atkins & Christensen, 2001; Berman & Norton, 1985; Durlak, 1979; Faust & Zlotnick, 1995; Hattie et al., 1984). Nietzel and Fisher (1981) reported that professional counselors hold an edge over paraprofessional counselors in terms of competence. As a whole, the present literature body supports the notion that paraprofessional counselors are at least as competent as their professionally trained counterparts (Montgomery et al., 2010). Hattie et al. (1984) stated, “There appears to be evidence demonstrating that paraprofessionals must be considered as effective additions to the helping services, and in many cases they are more effective than professional counselors” (p. 540).

While the argument supporting the efficacy of mental health counseling services that paraprofessional counselors provide seems to be well established, researchers have

raised specific concerns regarding their use. Golden (1991) recounted general concerns from the professional community in the 1970s, urging the mental health workforce to not use paraprofessional counselors due to the high potential for clients to be poorly served or even endangered. Brown (1974) presented concerns about the effectiveness of the paraprofessional counselor when clients present with marital issues, sexual dysfunction, and severe pathology. Montgomery et al. (2010) suggested that the paraprofessional counselor may not be suited to provide counseling services to clients who are highly distressed and require a brief course of intervention. The overall view of paraprofessional counselors found in the literature, while mixed in some regards, certainly suggests that they can provide effective services. Additionally, the cautions expressed about paraprofessional counselors should be heeded and systematically addressed.

Ethical Conduct

Professional ethics has been identified as one of the major concerns about the use of paraprofessional counselors. Early in the emergence of the paraprofessional counselor evolution, Gruver (1971) warned that clients could be put at risk of being harmed psychologically. The concerns Gruver (1971) raised included the possibility that paraprofessional counselors may unintentionally cause harm to the client because of the potential for projecting personal difficulties onto the client, burdening the client with their own problems, experimenting with psychotherapeutic techniques, and exploiting clients for personal gain. More recently, questions have been raised about the ability of paraprofessional counselors to understand the intricacies of client confidentiality (Armstrong, 2010; Fagan & Ax, 2002; Musser-Granski & Carrillo, 1997; Wilson, 2005), dual relationships (Jain, 2010; Wilson, 2005) , and supporting client autonomy (Golden,

1991; Jain, 2010). Huckshorn (2007) identified that because paraprofessional counselors lack a unifying code of ethics, their regard as being a legitimate mental health service provider suffers in the view of other professionals.

Retention

Paraprofessional counselors are susceptible to employee turnover and burnout. Jain (2010) identified factors that may lead to the burnout experience for the paraprofessional counselor, which include over-identification with clients, emotional depletion, and maladaptive detachment. Azar (2000) similarly indicated that inexperienced practitioners are susceptible to burnout due to not being prepared mentally and emotionally for working with clients presenting with acute clinical needs, such as trauma. Huxley, Evans, Webber, and Gately (2005) offered specific reasons given for why paraprofessional counselors leave the field, including because they were seeking higher wages, their caseload was too demanding, and they felt an overt sense of not being valued by professional coworkers. Bakker, Van der Zee, Lewig, and Dollard (2006) carried out research to determine if paraprofessional counselors may be more or less prone to burnout based on their personality type. Their research indicated that paraprofessional counselors who scored high on extraversion and low in neuroticism were less prone to burnout. Ortlepp (2002) also studied the factors that contribute to secondary trauma in lay counselors. This study links recruitment with retention by suggesting that lay counselors with a history of using positive coping skills to overcome trauma in their lives tended to be less impacted by the secondary trauma phenomenon.

Paraprofessional counselors who receive a competitive salary, are offered tuition reimbursement for pursuing higher education, and see a clearly identified track for career

advancement and promotion are more likely to report job satisfaction (Musser-Granski & Carrillo, 1997). Settings that provide quality supervision to paraprofessional counselors foster a sense of support and care, which can result in increased service efficacy and can decrease employee turnover (Azar, 2000; Doyle et al., 1977; VivienRosenbach Alan Hunot, 1998).

Summary

As the demand for mental health treatment services increase, it is reasonable to expect that the paraprofessional counselor will continue to provide mental health counseling services as part of a comprehensive mental health service strategy. The mental health workforce will likely continue integrating paraprofessional counselors to provide mental health counseling services. The available literature supports their utility by demonstrating effectiveness on par with professional counselors when paraprofessional counselors are part of a multidisciplinary team and supported by the structure that a clinic or agency provides. Paraprofessional counselors also provide a cost-savings factor, which makes them appealing when funding is limited.

The presence of paraprofessional counselors in the mental health workforce and the professional literature spans over 40 years. Despite this considerable length of time, paraprofessional counselors are still not well understood in terms of their identity, role, and function. There is a categorical difference between professional and paraprofessional counseling, mainly regarding formal training and academic achievement. This literature review showed that the literature lacks research that guides the process for supporting the clinical development of paraprofessional counselors. A need exists for additional research that can provide recommendations for best practices regarding the provision of clinical

supervision and clinical development to paraprofessional counselors. This future research needs to provide details that will inform the process, content, and outcome evaluation methods that will best support the clinical growth of paraprofessional counselors.

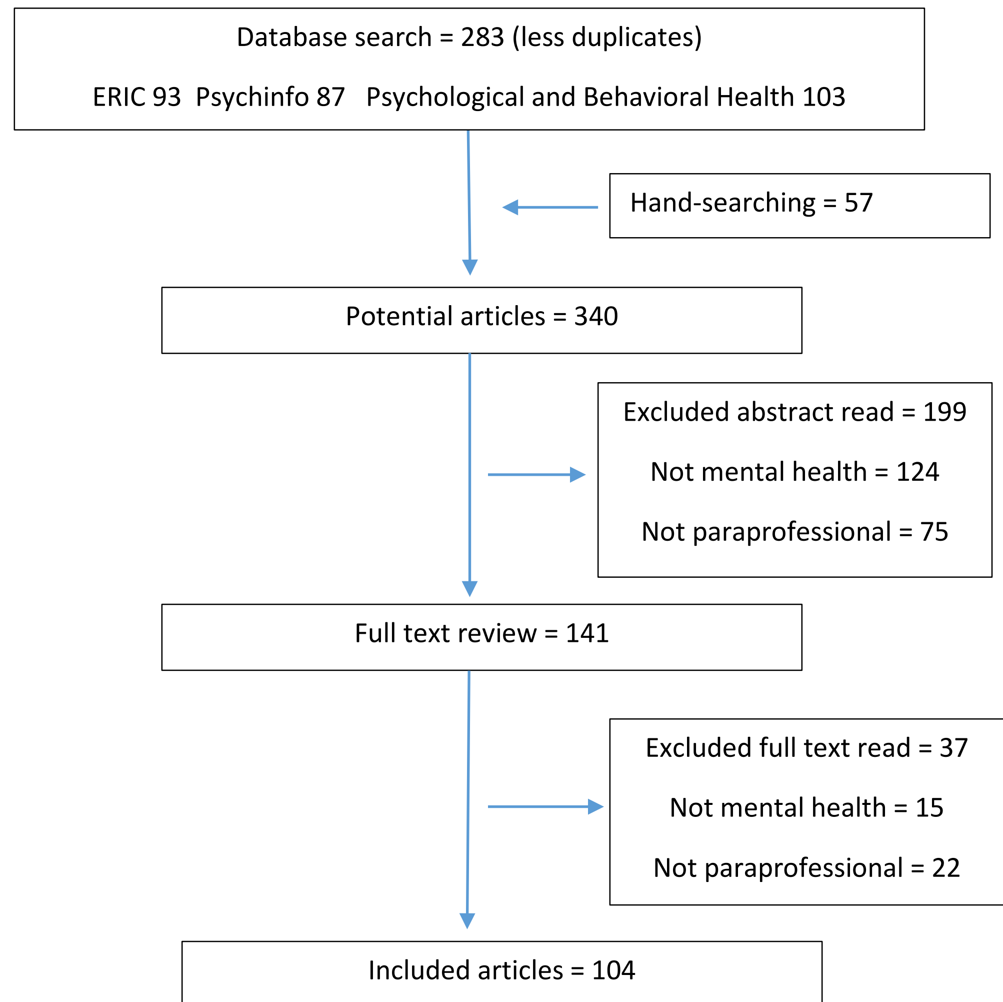

Figure 1. Literature review article collection process.

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Chapter 3

Clinical Development for Paraprofessional Counselors: A Multiple-Baseline Design Analysis of a 12-Session Group Clinical Development Protocol

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Abstract

Paraprofessionals are widely used to provide mental health counseling services to clients in various settings and across multiple professional disciplines. The current literature lacks a protocol that supports the process of clinical development for paraprofessional counselors. We conducted this study to examine the impact that a 12-session clinical development protocol for use with paraprofessional counselors would have on the constructs of counselor self-efficacy and counseling skills competence. We recruited participants for this study who met the definition of a paraprofessional counselor from two separate youth correctional facilities and one residential program for homeless adults. Using a multi-probe, non-concurrent, multiple-baseline design, we determined that counselor self-efficacy was positively impacted post completion of the clinical development protocol. Our analysis of the impact on counseling skill competence did not show any significant results. This study adds to the knowledge regarding how to support the clinical development of paraprofessional counselors. We indicate the need for replication studies to add confidence to our study results.

Keywords: clinical development, paraprofessional counselor, counselor self-efficacy, counselor competence

Clinical Development for Paraprofessional Counselors: A Multi-Probe Non-Concurrent Multiple Baseline Design Analysis of a 12 Session Group Clinical Development Protocol

The use of paraprofessionals to provide mental health counseling services is well established in the literature (Buchbinder, 2003; Gould, 2000; Ivey et al., 1998; Jain, 2010; Montgomery et al., 2010; Tan, 1992b, 1997; Wallace, 1970; Wilson, 2005). Paraprofessional counselors deliver a variety of clinically oriented services, including family counseling, trauma counseling, eating disorders, and drug and alcohol counseling (Gordon & Arbuthnot, 1988; Ivey et al., 1998; Lenihan & Kirk, 1990; Montgomery et al., 2010). Paraprofessional counselors have been ascribed several labels in efforts to define and categorize their identity and role. Some examples in the relevant literature include volunteer counselor, lay counselor, associate counselor, and non-professional counselor. Armstrong and McLeod (2003) defined a paraprofessional counselor as a person who is tasked with providing professional counseling to a target population without having formal training in the field of counseling. This definition will apply through the remainder of this document and will be further operationalized to demark specific criteria used to recruit study participants.

Paraprofessional Identity and Role

The rationale for paraprofessional counseling began to emerge in the 1970s as the demand for mental health counseling grew rapidly (Durlak, 1979; Sobey, 1970). The demand for mental health counseling was particularly recognized in specific populations, such as the elderly and minority groups, which served to further legitimize the use of paraprofessional counselors (Ivey et al., 1998; Sobey, 1970). Montgomery et al. (2010)

indicated that paraprofessional counselors who provide mental health services can do so effectively and at a reduced cost, which makes their services appealing in situations where funding is limited.

Paraprofessional Recruitment Considerations

Paraprofessional counselors are recruited into paid or volunteer positions. In either case, paraprofessional counselors do not have formal training at the graduate level in a helping profession (Dubus, 2009; J A Durlak, 1979; Forrest, 1978; Gardner & Shelton, 1977; Golden, 1991; Wilson, 2005). Recruitment efforts at times have included the canvassing of flyers that expressly state that no experience or education is necessary to apply to paraprofessional counseling positions (Golden, 1991; Wilson, 2005). Knowing that potential paraprofessional counselors will possibly present to their setting on the first day without any education, training, and varied experience in the helping professions, what, then, makes them attractive candidates for hiring? Paraprofessional counselors are often selected based on their observed expressions of warmth, and empathy (Atkins & Christensen, 2001; Faust & Zlotnick, 1995; Gould, 2000; Pazaratz, 2000; Walter & Petr, 2006). Other factors that foster the recruitment of the paraprofessional counselor include a general willingness and interest in helping people (Golden, 1991; Pazaratz, 2000; Wilson, 2005), as well as being a person representing the intended target population for the counseling services (Barlow et al., 2013; Bayes & Neill, 1978; Egli, 1987; Montgomery et al., 2010; Musser-Granski & Carrillo, 1997). Overall, paraprofessionals are recruited based on an expressed desire to care for others and offer help. Professionals over time have questioned whether the desire to care is a

dependable prerequisite to recruit a paraprofessional into a helping profession (Aiken et al., 1985; Faust & Zlotnick, 1995, 1995).

Professionals from the human services disciplines have levied a variety of concerns about the ability of paraprofessional counselors to provide counseling services. The concerns include the effectiveness of the paraprofessional counselor in terms of counseling patient outcomes (Gruver, 1971; Huckshorn, 2007), awareness of the dual-relationship quandary (Fagan & Ax, 2002; Musser-Granski & Carrillo, 1997), the ability to ensure patient confidentiality, and the ability to avoid counseling practice that is overly dependent on advice giving or that becomes ensnared by countertransference (Gould, 2000; Huckshorn, 2007; Jain, 2010). Systematic examinations of these concerns regarding the abilities of the paraprofessional counselor are not present in the extant literature.

Paraprofessional Counselor Clinical Development

Clinical Supervision Overview

Clinical supervision is known to support the development of trained counselors in the areas of self-efficacy and competence (Bernard & Goodyear, 2009). As a practice, clinical supervision is defined as “an intervention provided by a more senior member of a profession to a more junior member or group of members of the same profession” (Bernard & Goodyear, 2009, p. 7). The purpose of clinical supervision is to assist counselors in the process of continuing to develop their core counseling skills and problem-solving strategies that benefit the counseling recipient by increasing the likelihood that the services being delivered to them are ethical and effective (Campbell, 2005; Cashwell & Dooley, 2001). Clinical supervision may appear to operate in much the

same way that other clinically oriented relationships do; however, the clinical supervisor is also charged with evaluating the clinical work of the supervisee. The role as an evaluator is the primary distinguishing factor when comparing the relationship that exists between the counselor and the patient versus the supervisor and the supervisee (Campbell, 2005). McBride (2010) indicated that an additional purpose of clinical supervision is to equip counselors with the skills necessary to keep their service approach up to date. Campbell (2005) claimed that counselors of all education and experience levels can benefit from clinical supervision. Specifically, how the paraprofessional counselor profits from clinical supervision is not detailed in the current literature.

Paraprofessional Counselor Clinical Supervision Needs

Paraprofessional counselors have a need for and the opportunity to benefit from receiving clinical supervision (Walter & Petr, 2006). While multiple models for supervision exist to guide clinical supervision for professional counselors (Campbell, 2005; Watkins, 1997), the same is not true for paraprofessional counselors. Providing clinical supervision to paraprofessional counselors is critical, perhaps even more critical than providing clinical supervision to professional counselors (Newton, 2000). Paraprofessionals likely require a unique emphasis regarding the content of supervision when compared to professional counselors.

As a model for clinical supervision specific to paraprofessional counselors emerges, the particular content for the model should consider some specific recommendations put forth in the literature. Walter and Petr (2006) indicated that paraprofessional counselors need clinical supervision that emphasizes role identity, building requisite clinical skills, confidentiality, and professional boundaries. Armstrong

and Mcleod (2003, 2010) suggested that paraprofessional counselors need training and ongoing supervision in the areas of common factors among counseling theories, awareness of how a counselor's attitudes and beliefs can influence the counseling relationship, and the basic requisite counseling skills. Clinical supervisors supervising paraprofessional counselors should be mindful that overall the clinical relationship that is forged ought to be focused on mutual respect to foster feelings of empowerment, confidence, and a sense of value for the services provided (Newton, 2000).

Clinical Development

Paraprofessional counselors require opportunities for clinical development for the purpose of enhancing their skills as counselors and furthering their understanding of the counseling profession (Campbell, 2005; Watkins, 1997). Clinical development occurs in varied ways, such as participation in the clinical supervision process, participating in ongoing education, and pursuing specialized training in a specific clinical area. Clinical development as a concept needs to be distinguished from clinical supervision. Clinical development occurs through the process of receiving clinical supervision. However, an instance of clinical development does not constitute clinical supervision. For example, Campbell (2005) explained that a clinical supervisor can use a topical approach to guide the clinical supervision process. This approach entails teaching and training the supervisee on discrete topics that are identified as relevant and applicable. The relevant and applicable topics to be included for the purpose of clinical development for paraprofessional counselors are unknown, if the goal is to support counselor self-efficacy or counseling skill competence. The literature does, however, contain many cautions and

warnings about the paraprofessional counselor, which should inform the topics to be included in clinical development activities.

Counselor Efficacy

Approximately 15.5 million adults in the United States received mental health treatment in outpatient settings in 2012 (SAMHSA, 2015). Particular attention is given to the efficacy of the mental health services provided. Thus, a demand for evidence-based services is paramount for all counselors who are active in the field (Jacobs, Kissil, Scott, & Davey, 2010; Laska, Smith, Wislocki, Minami, & Wampold, 2013; Nelson, Shanley, Funderburk, & Bard, 2012). The effectiveness of an individual counselor also requires nuance, as the counselor's abilities are considered apart from any particular counseling method or intervention. A counselor's personally held beliefs about his or her abilities, including the ability to effectively use basic counseling skills, forms the foundation for an effective counselor. Two constructs that represent these two factors are counselor self-efficacy and counseling skill competence.

Counselor Self-Efficacy

Bandura (1982) explicated self-efficacy as a construct. Across multiple domains of functioning, self-efficacy can predict the performance outcomes for individuals. Bandura (1982) described self-efficacy as having four major contributors: performance attainment, vicarious experiences, verbal persuasion, and psychological states used to judge capability. Self-efficacy theory posits that merely having the ability to perform a task does not predict that the task will be done or that it will be done exceptionally (Bandura, 1982). Self-efficacy is what links capability to behavioral execution.

Bandura's construct of self-efficacy has been applied to the field of counseling through the development of the Counseling Self Estimate (COSE) inventory by Larson, Suzuki, Gilles, Potenza, Bechtel, and Toulouse (1992). Lent, Hill, and Hoffman (2003) also developed a self-efficacy scale for counselors that is known as the Counselor Activities Self-Efficacy Scale (CASES). The CASES measure was developed to incorporate the counselor's progressive nature as he or she develops counseling skills over time (Lent et al., 2003). Bandura (1982) defined self-efficacy as "a generative capability in which component cognitive, social, and behavioral skills must be organized into integrated courses of action to serve innumerable purposes" (p. 122). Larson and Daniels (1998) adapted Bandura's definition of self-efficacy to mental health counselors as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future" (p. 179). In one instance, Larson and Daniels (1998) described counselor self-efficacy (CSE) as being the "the primary causal determinate of effective counseling action" (p. 180). In support of this claim, Halverson, Miars, and Livneh (2006) linked higher degrees of CSE to higher competence in counseling skills, such as advanced empathy, handling dichotomy with clients, assessment of client needs, understanding of the counseling process, and decision making regarding the use of therapeutic techniques.

Counselor Skill Competence

Counselors have an obligation to reliably and consistently provide counseling services that are effective and ethical. Support for this declaration is found in any applicable ethical code, state and federal mandates for evidence-based practices, and state regulatory boards that certify licensed professionals. Accrediting bodies such as the

Council for Accrediting Counseling and other Related Programs (CACREP) exist in part to ensure that counselor training programs achieve outlined standards of counselor competence. As shown above, paraprofessional counselors are questioned as a whole regarding their counseling skill competence.

Ridely, Mollen, and Kelly (2011) defined counseling competence as the determination, facilitation, evaluation, and sustaining of positive therapeutic outcomes. They also provided a comprehensive model to detail counseling competence. This model posits that therapeutic outcomes are first supported by the counselor's abilities in the areas of sustaining, determining, facilitating, and sequencing the counseling process. Professional counselors could incorporate these aforementioned abilities into a topical approach for providing clinical development to paraprofessional counselors. Adopting a model that comprehensively addresses counseling competence, particularly for paraprofessional counselors, allows a clinical supervisor to not only address specific concerns about paraprofessional counselor competence raised in the literature but to also articulate a vision for how to continue to evaluate and support the process for developing counselor competence.

Professional counselors must consider systematically determining paraprofessional counselor skill competence (Campbell, 2005; Fairburn & Cooper, 2011; Sharpless & Barber, 2009). Clinical supervisors can evaluate competence through knowledge tests, instances of co-therapy, live observation of counseling sessions, therapeutic outcome studies, and consumer feedback (Fairburn & Cooper, 2011). All of these methods apply to the paraprofessional counselor. Fairburn and Cooper (2011) also highlighted the ability to role-play activities to not only teach counseling skills but

evaluate counseling skill competence. They suggested that role-play activities are very effective and are more feasible than the other methods of observing the clinical work of counselors.

Purpose of the Study

We developed a 12-session group clinical development protocol for paraprofessional counselors. The impact of the protocol was assessed using the Helping Skills subdomain of the Counselor Activity Self-Efficacy Scale (CASES-HS) (Lent et al., 2003) and with the Global Scale for Rating Helper Responses (GSRR; Gazda, Asbury, Balzer, Childers, Phelps, & Walters, 1995).

Hypothesis

First question. What is the impact of a 12-session clinical development protocol on counselor self-efficacy?

H_o *A 12-session clinical development protocol will not improve scores on the Counselor Activity Self-Efficacy Scale Helping Skills subdomain (CASES-HS).*

H_1 *A 12-session clinical development protocol will improve scores on the Counselor Activity Self-Efficacy Scale Helping Skills subdomain (CASES-HS).*

Second question. What is the impact of a 12-session clinical development protocol for paraprofessional counselors on counseling skill competence?

H_o *A 12-session clinical development protocol will not improve scores on the Global Scale for Rating Helper Responses (GSRR).*

H_1 *A 12-session clinical development protocol will improve scores on the Global Scale for Rating Helper Responses (GSRR).*

Methods

Research Design

This study used a multi-probe, non-concurrent, multiple-baseline (MB) design across participant groups with follow-up (Horner & Baer, 1978; Watson & Workman, 1981) to evaluate the impact of a 12-session development protocol on counselor self-efficacy as measured by the CASES-HS. We chose this study design because of its ability to provide systemic analysis in a natural setting that minimizes the intrusiveness noted in other forms of research design analysis (Wong, 2010). We randomly assigned the three groups of paraprofessional counselors to predetermined baseline lengths of 3, 4, and 5 weeks. The experimental groups assigned to the 4- and 5-week baseline categories followed a multi-probe protocol for collecting baseline data (Horner & Baer, 1978). We considered baselines to be stable when 80% of the data points occurred between a 20% margin surrounding the median data point (Gast & Spriggs, 2009).

An intervention-only (Wong, 2010) (B) design was used to observe how counselor skill competence changed during the intervention phase of the study. We measured counseling skill competence using the GSRR. The rationale for choosing this approach was primarily based in the inability to access the study groups during the baseline phase for the purpose of video-recording role-play sessions.

Participants

The investigators included prospective participants for this study if they met the following criteria: (a) be employed with the duty of directly providing mental health

treatment services to a target population, (b) highest level of education completed was bachelor's degree, and (c) must not be a graduate student enrolled in a discipline related to the helping professions. Twelve paraprofessional counselors participated in this study. We regarded the participants as three separate groups (n=3) composed of five, three, and four participants.

The investigators recruited participants for this study from two state-level youth correctional facilities in Oregon and from a residential treatment program for homeless adult females also in Oregon. The investigators sent emails to the site directors to determine their interest in participating in the study and to receive permission to contact employees who initially meet the criteria of being a paraprofessional counselor. The investigators then contacted potential study participants, inviting their participation in this study. Participants in the study received a gift card to an online retailer for participation in this study.

Measures

Counselor Activities Self-Efficacy Scale

To assess the impact of the clinical development protocol on the self-efficacy of paraprofessional counselors, the researchers used the Helping Skills sub-domain from the Counselor Activity Self-Efficacy Scale (CASES; Lent et al., 2003). We acquired baseline data using a multi-probe technique. Study participants completed the CASES-HS after each clinical development session and 2 weeks post supervision termination. The Helping Skills subset of the CASES is a self-report instrument that contains 11 items formatted to a 9-point Likert-type scale that is categorized into the following three areas: 1) no

confidence, 2) some confidence, and 3) complete confidence. The CASES is designed to quantify the degree of self-efficacy that a counselor endorses.

The CASES-HS measure includes three categories: insight skills, exploration skills, and action skills. An analogous example of an item contained in the CASES is as follows: "How confident are you that you could use the skill of engaging physical posture effectively with most clients over the next week?"

The possible scores from the Helping Skills subset of the CASES range from 0 to 99, where higher scores represent greater self-efficacy on behalf of the study participant. The test-retest reliability for the Helping Skills subset of the CASES measure was demonstrated to be r=.87. Convergent validity was demonstrated by showing positive correlation with the Tennessee Self-Concept Scale, a criterion measure of self-esteem. Additionally, convergent validity was demonstrated by showing negative correlations with the State Anxiety and the Trait Anxiety Scales (Larson et al., 1992).

Global Scale for Rating Helper Responses

Counseling skill competence was assessed using the Global Scale for Rating Helper Responses (GSRR; Gazda et al., 1995). The GSRR is a non-normed instrument that was specifically developed for providing feedback to helpers about their ability to respond appropriately to a helpee in a counseling-type relationship (Gazda, 1974). The GSSR was developed out of a model for helping called the Systematic Helping Relationship Training (SHRT). This model was influenced by the works of Carl Rogers (1957) and Robert Carkhuff (1969). May, Gazda, Powell, and Hauser, (1985) offered content validity for GSRR by showing a positive association between life skills and higher ratings on the GSRR.

The GSRR uses a 4-point scale, 1.0 to 4.0, to identify if the responses offered by a counselor and received by a counselee are harmful, unhelpful, or helpful. Responses that are helpful receive the scores of 4.0, 3.5, or 3.0. Unhelpful responses receive scores of 2.5 or 2.0, and hurtful responses are given a score of 1.0 or .5. A designation of 4.0 represents the ideal response given from a helper to a counselee. This type of response indicates that the helper is focused on problem solving and that the goal is to help the counselee. A score of 3.0 reflects attempts to build the relationship and to gain the trust of the counselee. A 2.0 response is regarded as ineffective and not helpful and is more focused on making the counselor perceived as important from the view of the counselee. Finally, a 1.0 response is assessed as being harmful and not helpful to the counselee, where the goal for the counselor is to dominate the counselee to derive personal gratification. The GSRR is located in the book *Human Relations Development: A Guide for Educators* written by Gazda et al. (1995).

The following scenario approximates how the GSSR serves to rate counseling skill competence. Consider a scenario that unfolds in the course of a counseling session when a counselee states, “I am not sure anything is going to work. I don’t know what to do.” A counselor could respond to the counselee by saying, “You’re telling me that you really quite stuck right now and even may be experiencing feelings of doubt, and hopelessness.” In this scenario, the counselor’s response would receive a score of 3.0 because it is facilitative in nature and is focused on expressing empathy to the counselee for the purpose of building a relationship and earning the right to help.

Data Collection

The investigators used the online survey tool known as Surveygizmo to collect the data for the CASES Helping Skills (CASES-SH). We entered the 11 items from the CASES-SH into the Surveygizmo software with the requisite 9-point Likert scale to record the participants' responses. The study participants received regular prompts to fill out the online survey after each session. The study participants were forced to answer every item on the CASES-SH using software features built into Surveygizmo.

The investigators collected data for the GSRR by video-recording the clinical development sessions. Ten sessions in the clinical development sessions required the participants to role-play. In the clinical development sessions that required role-plays, each participant played the role of the counselor, while another study participant played the role of the client. The role-play exercises presented an opportunity to apply the concept discussed in that particular session of the clinical development protocol.

Procedures

The participants understood that this research study focused on supporting clinical development for paraprofessional counselors. After agreeing to participate in the study, the participants received instructions to complete the CASES-SH online survey to establish a baseline dataset. After the predetermined baseline periods had elapsed, the participants received the 12-session clinical development protocol. The investigators conducted the protocol on ground over the course of six to eight weeks. We conducted sessions twice per week. After each of these 12 sessions, the participants then completed the CASES-SH. Participants also completed the CASES-SH survey one final time, 2 weeks post termination of clinical supervision.

PACE-12 Clinical Development Protocol

Participants received the PACE-12 protocol from a clinician holding state and national qualifications pertaining to clinical supervision. Participants received 12 sessions of group clinical development, where each session followed a consistent delivery format. Every PACE-12 session focused on a specific topic relevant to the clinical development of paraprofessional counselors. The full PACE-12 protocol is retrievable from Sotelo (2014). An overview of the group clinical development protocol is as follows:

Session 1: Topic – Common Factors Approach to Counseling

Session 2: Topic – Personal Attitudes, Beliefs, and Biases about Mental Health

Session 3: Topic – Professional Boundaries and Dual Relationships

Session 4: Topic – Cultural Competence: Social Capital

Session 5: Topic – Counseling as a Process

Session 6: Topic – Goal Setting

Session 7: Topic – Crisis Management

Session 8: Topic – Assessing Progress

Session 9: Topic – Counselor Self-Disclosure

Session 10: Topic – Resolving Impasse

Session 11: Topic – Recognizing Competence Limits: Getting Help

Session 12: Topic – Termination

The PACE-12 session content is focused on addressing concerns affixed to paraprofessionals by reformulating the concerns into specific elements of clinical development.

PACE-12 Implementation Fidelity

We developed a session protocol checklist, Sotelo (2014), for the purpose of assessing fidelity to PACE-12 protocol. An independent reviewer was used to review the recorded PACE-12 sessions with the fidelity checklist.

GSRR Measure Fidelity

The GSRR scale is a subjective assessment of counselor competence in providing helpful responses to counseling clients. Two independent raters reviewed the GSRR data to help mitigate bias on the part of the researchers. The recruited independent raters were trained in the use of the GSRR prior to rating the responses of the study participants. The independent raters analyzed the role-play data to determine the GSSR scores. Both of these independent raters held state licensure as a professional counselor as well as national certificates in clinical supervision.

We calculated inter-rater reliability using the Krippendorf's alpha statistic (Hayes & Krippendorff, 2007). The investigators recruited two independent raters to analyze the role-play data to determine the GSSR scores. Both of these independent raters were doctoral-level counselor educators who held a state license as a professional counselor and a national certificate in clinical supervision. The independent raters received approximately 2 hours of training on the GSRR scale. After the training, the two independent raters applied the GSSR scale to a pair of counseling videos that had been uploaded to YouTube. Five time markers were identified in each video where the counselor offered a response to the client. These responses were scored using the GSRR. Two training sessions were required to achieve an inter-rater reliability of α=.91. This

value indicates a high degree of inter-rater reliability (Hayes & Krippendorff, 2007; Kazdin, 2010).

Data Analysis

The data analysis for the collected data used both statistical and visual analysis methods. Visual analysis graphs shown in Figure 2 show the three group scores during the baseline and intervention phases for the CASES-HS scores. The scores are represented as groups of paraprofessional counselors who received the 12-session clinical development protocol. Combining visual analysis with statistical effect-size (ES) analysis is cited in the literature as being advantageous and allowing single-case research to meet the criteria for establishing evidenced-based practice (Brossart, Vannest, Davis, & Patience, 2014; Parker & Vannest, 2012; Parker, Vannest, & Brown, 2009). We included two separate ES calculations for the CASES-HS scores, which Brossart et al. (2014) recommends. Providing two ES results for single-case research addresses concerns about the variability that exists among the established methods for calculating SCR effect size (Brossart et al., 2014; Parker et al., 2005). We chose the Percent of All Non-Overlapping Data and the TAU-U effect size for this study. Both of these ES calculations are well suited for small data sets and are easily calculated. We addressed missing data by employing the multiple imputation methods using the IBM SPSS software (IBM, 2013). Thus, the analysis of the counseling skills competence GSRR data followed an intervention-only design (Wong, 2010). Figure 3 displays the GSRR scores for the three study groups.

Visual Analysis

Visual analysis is regarded as the standard method for analyzing data collected through single-case research designs (Brossart et al., 2014; Gast & Spriggs, 2009; Horner et al., 2005; Lane & Gast, 2013; Parker et al., 2009). Visual analysis allows the researchers to monitor the impact of the intervention as the study unfolds. This ability to closely monitor an intervention allows the researcher to better understand the impact of the intervention on the dependent variable (Gast & Spriggs, 2009; Lane & Gast, 2013; Parker & Vannest, 2012). We followed the protocol for conducting a visual analysis of graphed data that Lane and Gast (2013) outlined. The protocol calls for determining mean-level performance during the baseline and intervention phases, data trends during the intervention phase, and data variability in both phases.

PAND

The percent of all non-overlapping data method (PAND) (Parker, Hagan-Burke, & Vannest, 2007) is a proportion ES statistic that fits the data collected in this study well. The PAND method can be hand-calculated and requires plotting collected data on a graph for the purpose of visual analysis. Data collected prior to the clinical supervision protocol was used to establish a baseline to compare to data collected during and after the clinical supervision protocol. The PAND method then contrasts baseline data with post-baseline data, focusing on the percent of non-overlapping data that exists between the baseline and post-baseline measures. In accordance with the PAND method, we constructed a 2x2 contingency table for the purpose of statistical analysis. This process allowed the calculation of Pearson's phi and phi^2 values, which are analogous to Pearson R and R^2

values. We used the WinPEPI (Abramson, 2011) software to calculate the phi effect size and the corresponding confidence intervals for the PAND method.

TAU-U

The TAU-U calculation (Parker, Vannest, Davis, & Sauber, 2011) is a dominance statistic that provides an effect size while also having the ability to control for trends in the data. The ability to control for trend is regarded as valuable given the sentiment that data trend issues complicate data analysis in single-case research designs (Gast & Spriggs, 2009; Kazdin, 2010). TAU-U can be hand-calculated for smaller data sets, which makes it a good fit for this study. The investigators used an online calculator from the website www.singlecaseresearch.org to calculate the TAU-U effect size and the corresponding confidence intervals.

Results

For each of the participating study groups, the effects of the 12-session clinical development protocol are reported on the following: (a) the fidelity of PACE-12 implementation, (b) change in scores on the CASES-HS, and (c) change in scores on the GSRR.

Clinical Development Protocol Fidelity

The recruited independent reviewers used a checklist (Sotelo, 2014) to assess the implementation fidelity for the 12-session clinical development protocol. The checklist contains 12 items that the reviewers used to determine if the activity was present in the recorded videos of each session. For each group, a total of 144 items were indicated. The fidelity ratings were 95% for Group 1, 92% for Group 2, and 94% for Group 3.

Counselor Self-Efficacy

The CASES-SH scores for all three groups are presented in Figure 2 (p.81). Baseline data for Group 1 showed a mean CASES-SH score of 76 (range=75-78), with a stable and slight accelerating trend. Group 2 baseline showed a CASES-SH mean score of 69 (range=64-72), with a stable and slight decelerating trend. The baseline mean for the CASES-SH score observed for Group 3 was 63 (range=61-64), with a stable and slight decelerating trend.

In the intervention phase where the 12-session clinical development protocol was delivered, the CASES-HS score means for Groups 1, 2, and 3 were 84, 79, and 69, respectively. All three groups showed stable improving trends in the intervention phase. The percent of non-overlapping data for Groups 1, 2, and 3 were 92%, 92%, and 83%, respectively.

Groups 1, 2, and 3 also provided CASES-HS 2 weeks post termination of the 12-session clinical development protocol. The scores for CASES-HS at the 2-week follow-up were 91 for Group 1, 93 for Group 2, and 76 for Group 3.

Two separate ES calculations were calculated for the CASES-SH scores. Using the PAND calculation, the ES was .81 CI [.71, .93] at the 90% level. The TAU-U ES calculation was determined to be .93 CI [.59, 1.3], p=0.000 at the 90% level.

Counselor Competence

The GSRR scores for all three study groups are displayed in Figure 3 (p.82). We conducted an intervention-only (Wong, 2010) visual analysis for all three study groups. Group 1 showed level stability with no discernible data trend. Group 2 showed that the level was variable with an improving data trend. Group 3 showed results-level stability

with no discernible data trend. Effect-size calculations for single-case research designs could not be carried out because of the absence of baseline data. Other methods for determining effect size were not warranted based on the visual analysis of the graphed data.

Discussion

The present study examined the impact of a 12-session clinical development protocol on the constructs of counselor self-efficacy and counselor skill competence in paraprofessional counselors. Three groups of paraprofessional counselors received the clinical development protocol on three separate timelines. The resulting data was analyzed by visual analysis and two different ES calculations.

Hypothesis 1

The results indicate that a functional relationship can be established regarding counselor self-efficacy scores indicated by the CASES-SH measure supplied by the study participants improving in response to receiving the clinical development protocol. The visual analysis for all three groups showed an immediate improvement in the CASES-SH scores after receiving the first two sessions from the clinical development protocol and a stable, improving trend. The ES calculations both indicated a strong effect attributed to the independent variable, which was the delivery of the clinical development protocol. Effect-size interpretation was based on Cohen's d (1988) standard of effect sizes of .2 being regarded as small, .5 representing a medium effect, and .8 suggesting a large effect.

Hypothesis 2

The counselor skill competence scores, as indicated by the GSSR scores, remained mostly unchanged for Groups 1 and 3. Group 2 showed a stable improving

trend as determined by our visual data analysis. We cannot establish a functional relationship between counseling skill competence and the independent variable of receiving the clinical development protocol, because of the lack of baseline data and only group 2 showing a remarkable trend. While only one of the three groups showed an overall improvement in the GSRR scores, the scores for Groups 1 and 3 remained stable throughout the provision of the clinical development. This suggests that their counseling skill competence, as determined by the GSRR scores, did not deteriorate.

All three groups showed a mean GSSR score of 2.5. A score of 2.0 on the GSSR reflects responses that are neither harmful nor helpful. A score of 3.0 indicates a response that is helpful. The mean GSRR score of 2.5 for all three groups indicates that some degree of counseling skill competency was present in the study participants. This point is important, considering the concern in the literature about the potential for paraprofessional counselors to damage clients. The results of this study suggest that these paraprofessional counselors were not hurtful or damaging with their responses.

The visual analysis of the data consistently showed that scores on the CASES-SH and the GSRR peaked around sessions 7 -9. After these sessions, we observed a decline in the GSRR scores in two of the study groups. By design, the content of the clinical development protocol becomes more challenging as the protocol progresses. Early protocol sessions focus on concepts that are skill based, such as learning more about the common factors approach to counseling. Later sessions focus on dealing with problems that occur in the counseling relationship. The role-plays that occurred in these later sessions were more intense than the role-plays that occurred in earlier sessions.

Considerable more time was needed to debrief the role-play activities that occurred toward the end of the PACE-12 protocol as compared to the earlier sessions.

The PACE-12 protocol was designed with two primary objectives. The first objective was to respond to the concerns about the presence of the paraprofessional counselors in the mental health workforce found in the existing literature. The second objective was to improve the efficacy of the paraprofessional counselors as assessed by the CASES-HS measure for counseling self-efficacy and GSSR for counseling skill competence. The content of the PACE-12 protocol could have been focused exclusively on increasing counseling skill competence, which may have demonstrated better results for improving counseling skill competence.

The PACE-12 protocol is the first known effort to incorporate specific concerns expressed in the relevant literature mental health professionals about paraprofessional counselors in a clinical development opportunity that is also focused on improving paraprofessional counselors' clinical aptitude. This study examined the PACE-12 protocol and its impact on two well-established constructs pertinent to counselor efficacy. Analyzing counselor self-efficacy and counselor skill competence in the same study allows for a more comprehensive interpretation of the results. Paraprofessional counselors need to be supplied with clinical development opportunities that focus on counselor self-efficacy and counseling skill competence. While it is clear that counselor self-efficacy is critical to counselor efficacy, counseling skill competence—or what the counselor actually does—is equally important. Study designs that incorporate both counselor self-efficacy measures and counseling skill competence will offer a balanced assessment of overall counselor competence.

Limitations

The merits of single-case research methodology are well established in the literature (Gast & Spriggs, 2009; Horner et al., 2005; Lane & Gast, 2013; Wong, 2010). Horner et al. (2005) argued that single case research can establish evidenced-based practices. This study, however, cannot establish external validity because to do so requires several replications that yield similar results. Aside from external validity, at least two limitations are present with this study. First, only three groups of paraprofessional counselors were included, and we selected them based on convenience. Next, a baseline phase was not established for the GSRR data, and thus, we can make no inference regarding the PACE-12 protocol and any impact on counselor competence.

Implications for Researchers

This study suggests that paraprofessional counselors stand to benefit from receiving ongoing clinical development. Specifically, this study demonstrated that counselor self-efficacy can be positively impacted by the 12-session clinical development protocol that we developed. Replication studies are needed to establish the external validity of the results of this study and the 12-session clinical development protocol. Counseling skill competence remains critical when considering the paraprofessional counselor. Future research with improved methodology for data collection and assessment of counseling skill competence is needed to further the understanding of how to positively impact the counseling skill competence of paraprofessional counselors. The GSRR measure should be critically evaluated for its ability to detect smaller or varying improvements in counseling skill competence. Other measures focused on assessing

counseling skill competence may prove to be better suited for use in study designs similar to the study we conducted.

Implications for Practitioners

Professional counselors who are responsible for the clinical development of paraprofessional counselors now have the PACE-12 protocol available to them, which has demonstrated a positive impact on counselor self-efficacy. While this study did not demonstrate a positive impact on counseling skill competence, it is important to note that competence did not deteriorate, either. Thus, it appears that this 12-session protocol can then be used without concern regarding eroding any initial counseling skill competence. The PACE-12 protocol presents role-play scenarios that the study participants perceived as being quite relevant and equally difficult to manage. Paraprofessional counselors who receive the PACE-12 protocol may need consistent reassurance that while the role-plays are difficult, the opportunity for practice in a controlled setting can help improve their skills and abilities.

Conclusion

Paraprofessional counselors provide mental health services to a wide variety of target populations in diverse settings. Professionals who supervise paraprofessionals need to ensure that the paraprofessionals are supported in their clinical development. Studies like the one presented here are very important for the purpose of developing an empirical base to both inform the specific clinical development needs of paraprofessional counselors and guide the process for supporting those needs. The PACE-12 protocol offers a structure for supporting the clinical development of paraprofessional counselors in the areas of counselor self-efficacy and counselor skill competence.

Figures

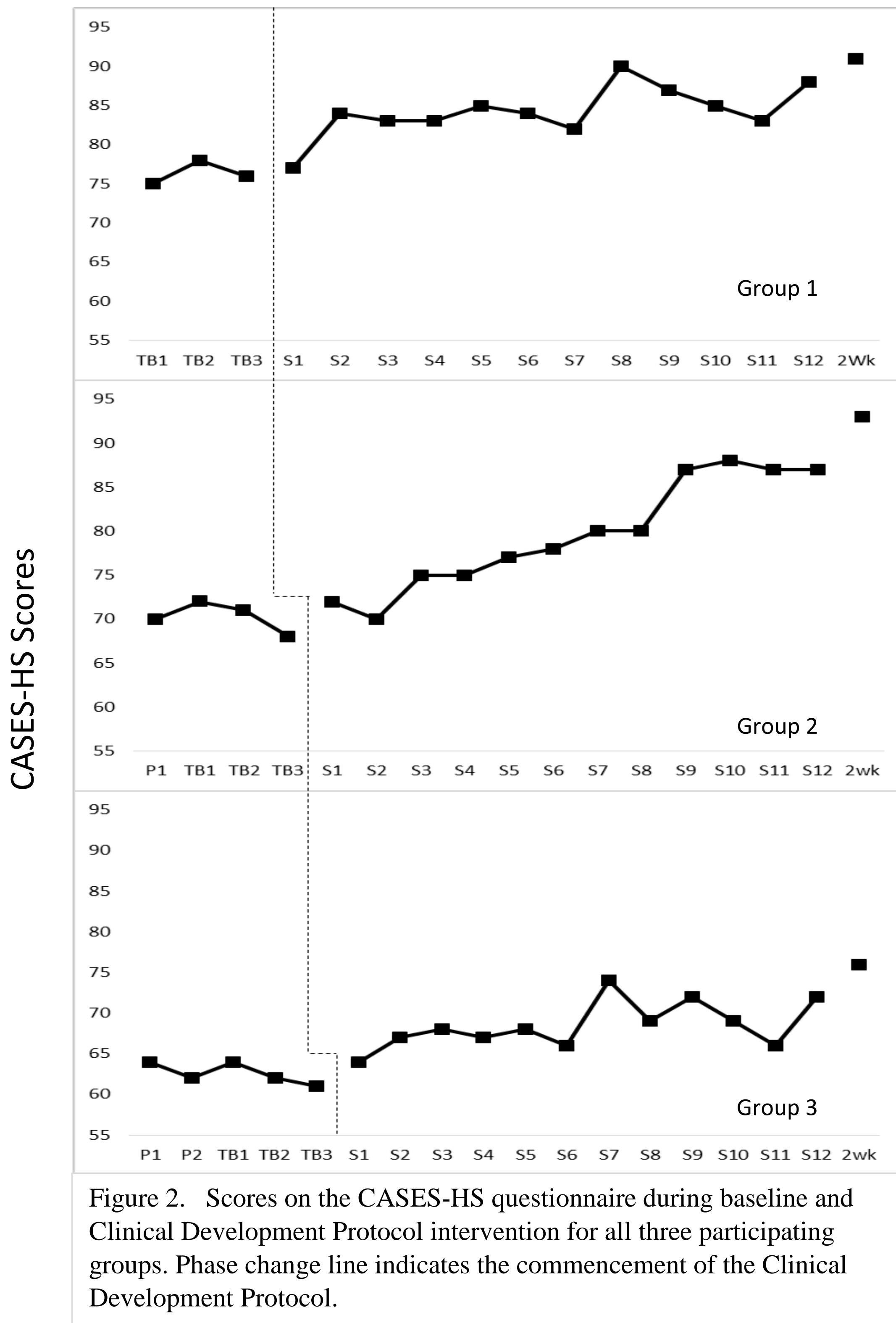

Figure 2. Scores on the CASES-HS questionnaire during baseline and Clinical Development Protocol intervention for all three participating groups. Phase change line indicates the commencement of the Clinical Development Protocol.

Figure 2. CASES-HS Scores for all three study groups.

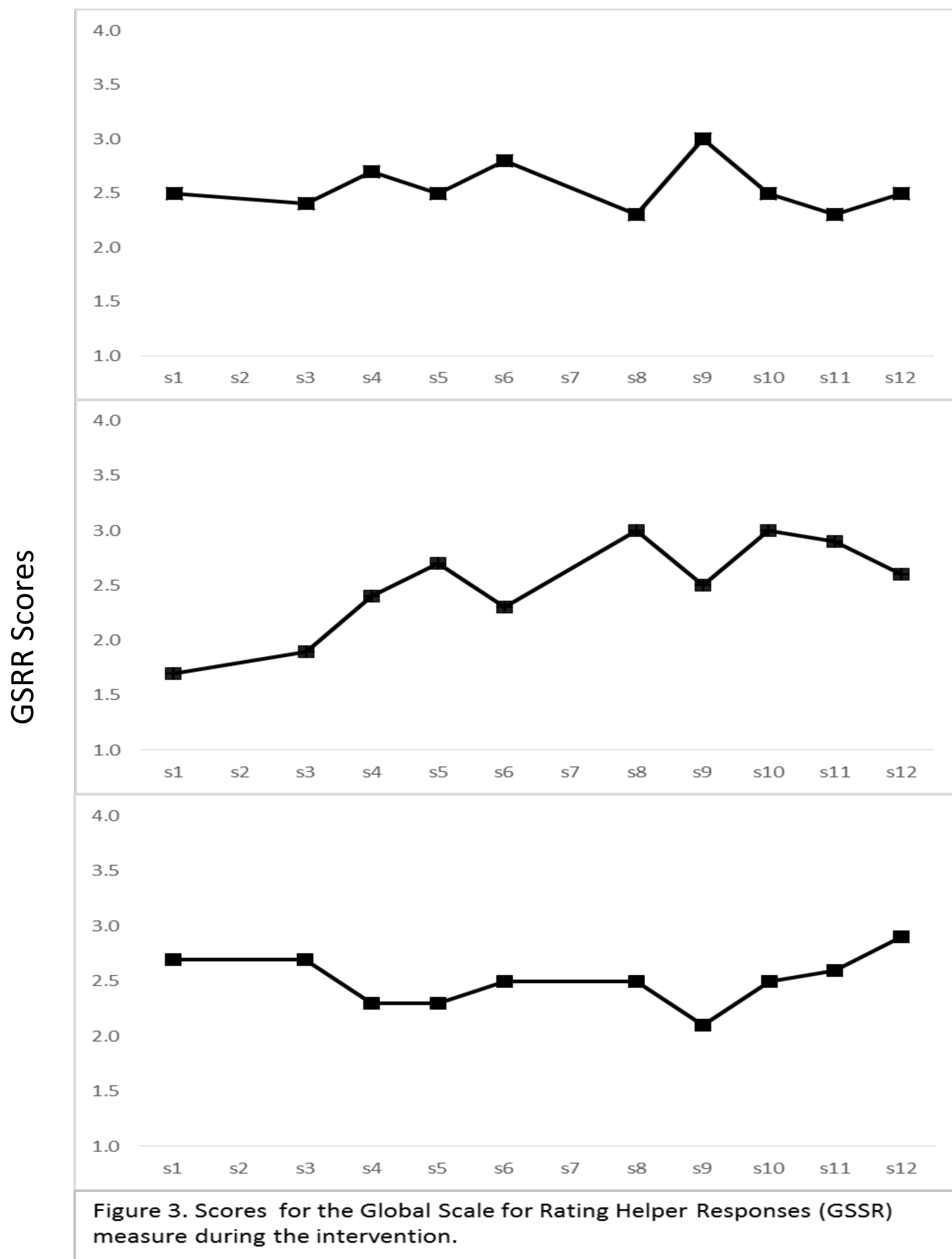

Figure 3. GSSR Scores for all three study groups.

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Chapter 4

CHAPTER 4

GENERAL CONCLUSION

This dissertation includes two thematically linked manuscripts focused on explicating the role, utility, and clinical development needs pertaining to paraprofessional counselors. The following texts provides a summary of the following: (a) a literature review titled, "Is Caring Enough? The Work of Paraprofessionals in Counseling Settings"; (b) a summary of a quantitative study titled "Clinical Development for Paraprofessional Counselors: A Multiple-Baseline Design Analysis of a 12-Session Group Clinical Development Protocol"; (c) a discussion of the how the literature review and the quantitative study are related; and (d) a discussion regarding the need for further investigation to converge the remaining knowledge gaps pertaining to paraprofessional counselors.

A review of the relevant and existing literature provided substantial information about paraprofessional counselors. The fact that no one single term is used to identify paraprofessional counselors made the literature review challenging. This lack of a singular identity also obfuscates the efforts to quantify the number of paraprofessional counselors who are present in the workforce. Hoge and Morris (2002) estimated that the paraprofessional counselors comprise 40 to 60% of the mental health workforce. Despite accounting for a significant portion of the workforce, there is much unknown about who paraprofessional counselors are and the services that they provide. The literature presents both criticism and commendations for the presence of paraprofessional counselors in the workforce. Concerns have been presented in the literature calling into question the ability of paraprofessional counselors to provide services with competence and proper

understanding of professional counseling ethics. Literature also exists that positively supports the work and presence of the paraprofessional counselor. Studies have been published that suggest that paraprofessional counselors are as effective as trained counselors (Atkins & Christensen, 2001; Carkhuff, Kratochvil, & Friel, 1968; Faust & Zlotnick, 1995; Hattie, Sharpley, & Jane, 1984). The professional literature also contains submissions that claim the paraprofessional counselor can be more effective than the trained counselor (Durlak, 1979). Despite the divide that exists for criticizing and commending the paraprofessional counselor, a theme that both sides concede is the need to ensure clinical development. A formally trained counselor still requires ongoing training, education, and supervision to maintain competent and ethical service delivery. The same needs exist for paraprofessional counselors; however, those specific needs are mostly unknown. This literature review discovered just one (Kruger, Cherniss, Maher, & Leichtman, 1988) formal investigation related to supporting the clinical development of paraprofessional counselors in which the findings focused on the subjective rating of the valuation of receiving clinical supervision. Overall, the literature is devoid of any submissions that indicate the clinical needs of paraprofessional counselors and likewise any submission for how to support the clinical development of paraprofessional counselors. What does exist in the literature is a list of reasons why paraprofessional counselors are not fit for the work, along with an opposing idea that what paraprofessionals do have—a desire to care—is what matters the most.

We designed and conducted a research study to broaden the knowledge about methods for furthering the clinical development for paraprofessional counselors. This study followed a non-concurrent, multiple-baseline design. Three groups made up of at

least three paraprofessional counselors received clinical development protocol, PACE-12 (Sotelo, 2014), written specifically for use with paraprofessional counselors. The PACE-12 protocol content incorporates the criticisms and concerns expressed in the literature about paraprofessional counselors. The clinical development sessions were held twice per week over the course of 6 to 8 weeks; each session lasted between 60 and 90 minutes. We tested two hypotheses: (a) that scores on the CASES-HS, which measures counselor self-efficacy, would improve in response to the protocol; and (b) that scores on the GSRR, which measures counselor competence, would improve in response to the protocol. The study participants completed an online survey to supply the data used to investigate the first hypothesis. We collected data for the second hypothesis by video-recording each clinical development session of the PACE-12 protocol. Independent raters viewed the video recordings and scored participants as they participated in role-plays.

Using the visual analysis method that Lane and Gast (2013) outlined, we determined that a functional relationship was present for the PACE-12 protocol and led to improving scores on the CASES-HS. Two ES calculations (PAND=.811, TAU-U=.92) support the findings of our visual analysis and the assertion of a functional relationship. Thus, we rejected the null hypothesis. Our visual analysis of the GSRR data did not show an improvement across all three groups. Thus, a functional relationship could not be established for the PACE-12 protocol and improving counseling skill competence as assessed through the GSRR. Therefore, we accept the null hypothesis for our second research question.

Participant Response

The participants unequivocally expressed appreciation for the clinical development opportunity provided through this research study. As to be expected, the participants started the PACE-12 protocol with some anxiety and hesitancy. Initially, there was some uncertainty observed and expressed based on the time commitment involved and the fact that the sessions involved role-play activities that were video-recorded. The groups of participants seemed to settle into the process by session three, as evidenced by their enthusiastic sharing of the prior session's experiences using a new skill or technique. Initially the role of the PACE-12 facilitator was not specifically focused on providing direct clinical direction to the role-play session. We quickly determined that the PACE-12 facilitator should provide clinical direction to the role-play sessions as an effort to solidify the content of the each PACE-12 session. This alteration in the provision of the delivery of the PACE-12 protocol was minor and is well supported as appropriate when conducting single case research (Lane & Gast, 2013; Parker & Vannest, 2012). Many group participants never expressed having been exposed to the topics covered in the PACE-12 protocol. In instances where a session topic was a review, the group was able to move the discussion to areas of specific application and advanced understanding. Many times, the participants would recall times when the session topic applied to a specific person they were counseling. As predicted by the literature, only four of the participants reported ever receiving any form of clinical supervision. In all four cases, the supervision was provided for the purpose of obtaining an initial certification in drug and alcohol treatment. Once they earned their certification, their clinical supervision ceased. The clinical supervision offered in these scenarios also was narrowly focused on the

realm of addictions counseling as opposed to a broader mental health focus. Multiple study participants expressed an elated dismay at never having had an intensive clinical development opportunity before, despite many years of working; however, after completing the PACE-12 protocol, they reported feeling much more prepared for counseling work. The last session of the PACE-12 protocol allowed the study participants to reflect overall on the experience of participating in the study. Every group consistently expressed a belief of having enhanced clinical abilities because of their participation in the study. One group expressed concern about the fact that their setting did not have a framework for providing ongoing clinical support. This concern was certainly always present with them; however, after experiencing 12 sessions of clinical development, they became convinced of the need for a quality ongoing clinical supervision process.

Observations

Counselor self-efficacy. The quantitative study results showed significant results for improving counselor self-efficacy. Each session of the PACE-12 protocol presented a concept that is regarded as both important to the development of professional counselors and specifically critical to the paraprofessional counselor as identified in the available literature. Many of the topics presented in the PACE-12 protocol were either entirely novel or represented aspects of their training that occurred in the distant past for the study participants. The session format consistently allowed for reviewing progress, introducing a new topic, applying the new topic in the session, and a final review of the information covered in the session. The session consistency combined with the expressed intent of the study to enhance their counseling abilities would explain in part the significant improvement in the collected self-efficacy scores.

The Counselor Activities Self-Efficacy Scale (CASES; Lent, Hill, & Hoffman, 2003) was selected to monitor counselor self-efficacy in the study participants. We chose the CASES measure for two primary reasons. The first reason was that the CASES measure contains subdomains that allowed the measure to be tailored to specific needs. The Helping Skills domain of the CASES (CASES-HS) was selected because it contains 11 questions that reduced the burden on the study participants as they were asked to fill out the questionnaire many times throughout the study. Additionally, the Helping Skills domain was developed to assess counselor self-efficacy as it pertains to a set of counseling skills that were deemed necessary for the novice counselor. The Helping Skills domain seemed quite appropriate for use with paraprofessional counselors. However, the PACE-12 protocol was developed independent of the specific questions contained in the CASES-HS domain. The PACE-12 never verbatim represented a question or concept that the study participants would find in the CASES-HS questionnaire. The question of a counselor's ability to appropriately use the skill of the self-disclosure would represent the one area where the PACE-12 protocol would align with a specific question on the CASES-HS measure. Despite the lack of an intentional content link between the PACE-12 protocol and the CASES-HS, the study participants often engaged in a discussion about their ability to counsel based on the language used in the CASES-HS questionnaire.

Counseling skill competence. The study results showed improvement for only one of the participant groups regarding counseling skill competence. The other two groups showed no change. The informal feedback provided by the study participants throughout the PACE-12 protocol would suggest that they believed their counseling skills

competence was improving. The participants stated that although the role-play activities were often the most daunting part of their participation, they experienced how helpful it was to practice a skill in a role-play and then receive helpful and supporting feedback from the group. All three groups stated that they had never seen one another in the role of a counselor in an individual session format. Study participants shared that they benefitted from witnessing how their coworkers respond to client presentations.

Similarly, as discussed above for counselor self-efficacy, the PACE-12 protocol was developed independently of the specific items found in the Global Appraisal for Rating Helper Responses (GSRR; Gazda et al., 1995). Therefore, none of the session content found in the PACE-12 intentionally targeted factors that would represent counseling skill competence as determined by the GSRR. The primary method for improving counseling skill competence in the study participants was the role-play activities required in 10 of the 12 sessions. The GSRR judges the response given by a counselor to a client, designating the response as harmful, unhelpful, helpful, or expansive. As the PACE-12 protocol unfolded, the role-play scenarios increased in difficulty, as they addressed critical topics in counseling, such as counselor self-disclosure (session 9), resolving impasse (session 10), and responding to suicidal ideation (session 11). The role-play scenarios were intense, as determined both by the participant report and by the observation of the PACE-12 facilitator. Study participants were observed first reading and reacting to the role-play scenarios immediately after receiving the handouts for any given PACE-12 session. This observation reinforces the assertion that the study participants gave the role-play activities considerable regard.

Recognizing that the content for the PACE-12 protocol focused on addressed the concerns levied in the literature about paraprofessional counselors, it is plausible that counseling skill competence did not improve across all three groups due to the intense nature of predetermined role-play scenarios. In discussing the results with the independent raters a sentiment was put forth that even the most skilled counselor would potentially find the role-play scenarios found in the PACE-12 protocol challenging. In considering the scenarios of self-disclosure, suicidal ideation, and resolving impasse, the varied ways that these topics impact different clinicians is important to consider. The raters' aptitude and experience with difficult scenarios such as these likely influenced how they rated competence in the study participants.

The literature would suggest that self-efficacy strongly associated to behavioral performance (Bandura, 1982; Larson & Daniels, 1998; Lent et al., 2009). While it may be true that when a counselor possess higher degrees of self-efficacy it is more likely that they will exhibit targeted counseling behaviors, this does not necessarily equate to competence in the delivery of those counseling behaviors. This distinction should be further explored and controlled for in future research that sets out examine counselor self-efficacy and counseling skill competence pertaining to the clinical development of paraprofessional counselors.

In summary, the PACE-12 protocol content was developed to address the concerns in the literature about paraprofessional counselors. Additionally, we used the PACE-12 protocol to determine its impact on counselor self-efficacy (CASES-HS) and counseling skill competence (GSRR). A strategy that we could have employed to specifically target improvement on the CASES-HS and the GSRR measures would have been to explicitly

incorporate the skills being assessed by both measures into the PACE-12 protocol. Counseling self-efficacy is an important construct for both developing counselor identity and improving client outcomes (Daniels & Larson, 2001; Larson et al., 1992; Lent et al., 2003). Counseling skill competence also represents an important construct that is particularly salient to the paraprofessional counselor (Armstrong, 2003; Jain, 2010). The PACE-12 protocol represents an approach to providing clinical development that is twofold. First, we developed the PACE-12 protocol to address the competence and ethical concerns regarding paraprofessional counselors found in the literature. Second, we designed the PACE-12 protocol to positively impact counselor self-efficacy and counseling skill competence. We recognized the need to balance these two objectives in the content of the PACE-12 protocol during the data analysis when considering replication studies.

Conclusion

The manuscripts presented in this dissertation offer a literature review and a quantitative study that provide clinical implications relevant both to the field of counselor education and to other disciplines known to offer counseling services through paraprofessional counselors. Understanding more accurately the needs of the paraprofessional counselor and how to support those needs is necessary because paraprofessional counselors are actively providing services to people requiring counseling and other clinical services. This dissertation provides specific information to the trained counselor who provides clinical supervision to paraprofessional counselors regarding their clinical needs. The study carried out in this dissertation also provides a clinical development protocol can be used to further the clinical development of

paraprofessional counselors. Future research is needed to continue to enhance the understanding of paraprofessionals' identity, role, and responsibilities and how to support their ongoing clinical development. The study presented in this dissertation could be used as a template for replication studies that are needed to build empirical confidence, given the nature of non-concurrent, multiple-baseline-designed methods.

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APPENDICES

Appendix A

PACE-12 Clinical Development Protocol

The PACE-12 Clinical development protocol can be retrieved from the following weblink: https://goo.gl/5ngi2X

Appendix B

Counselor Activity Self-Efficacy Scale – Helping Skills Domain

The Counselor Activity Self-Efficacy Scale was obtained by contacting Robert Lent, PhD, via email at boblent@umd.edu.

Appendix C

Global Scale for Rating Helper Responses (GSSR)

The GSRR measure is located in the following book: Gazda, G., Asbury, F. R., Balzer, F. J., Childers, W. C., & Phelps, R. E. (1995). *Human relations development model: A manual for educators.* Boston: Allyn & Bacon.

Appendix D

Informed Consent Letter

CONSENT FORM

Project Title:	Clinical Development for Paraprofessional Counselors: A Multiple-Baseline Design Analysis of a 12-Session Group Clinical Development Protocol
Principal Investigator:	Lorie Blackman, PhD
Student Researcher:	Dominique Sotelo, MA
Co-Investigator(s):	Wendy Bruton, PhD Ryan Melton, PhD
Version Date:	5-21-2014

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1. WHAT IS THE PURPOSE OF THIS FORM?

This form contains information you will need to help you decide whether to be in this research study or not. Please read the form carefully and ask the study team member(s) questions about anything that is not clear.

2. WHY IS THIS RESEARCH STUDY BEING DONE?

The purpose of this research study is to assess the impact of a 12-session group clinical development protocol designed for paraprofessional counselors.

This study is being conducted for the purpose of completing a doctoral dissertation.

Up to 20 participants may be invited to take part in this study.

3. WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

You are being invited to take part in this study because you are believed to be a paraprofessional counselor that is asked to provide mental health counseling services as part of your regular employment or volunteer duties.

4. WHAT WILL HAPPEN IF I TAKE PART IN THIS RESEARCH STUDY?

The study activities include participating in receiving group clinical development that is designed for paraprofessional counselors. The group clinical development protocol consists of 12 sessions that will be delivered over a maximum of 12 weeks. The group clinical development sessions will last 90 minutes each. Data will be collected from the participants through a series of online surveys and through the video-recording of role-plays that will be conducted during the group clinical development sessions. The data will be collected for the purpose of conducting a quantitative research study.

Study duration: The study duration will be a minimum of 15 weeks and a maximum of 21 weeks. The variation in duration is due to a randomized baseline assignment prior to initiating the 12-session group clinical development protocol. A final data collection event will occur 2 weeks after the final session of the group clinical development protocol is delivered. The clinical development will be delivered by Dominique Sotelo at a setting that is to be determined, but it will be close to your employment or volunteer setting. You will be asked to respond to an online survey a maximum of 15 times. You should be able to fill out the online survey in approximately 20 minutes. You will also be video-recorded performing role-plays in the course of the group clinical development a maximum of 15 times.

Recordings and photographs: This study involves the capturing of video/audio recording of participants conducting role-plays during the provision of group clinical development. If you do not wish to be video-/audio-recorded, then you should indicate that you are not willing to be video-recorded, and thus you will not be eligible to participate in this research study.

______I agree to be video-/audio-recorded.

Initials

______I do not agree to be video-/audio-recorded.

Initials

Randomization: This study involves a process called randomization. Randomization means that you will be assigned to a specific baseline by chance. It is like drawing names out of a hat. Neither you nor the people doing the study will choose what group you will be in. Your group will have a one in three chance of being assigned to the 3-week, 4-week, or 5-week baseline group.

Future use of data: Because it is not possible for us to know what studies may be a part of our future work, we ask that you give permission now for us to use your personal information without being contacted about each future study. Future use of your information will be limited to studies about clinical development and paraprofessional counselors. If you agree now to future use of your personal information but decide in the future that you would like to have your personal information removed from the research database, please contact Lorie Blackman via email at blackmal@onid.oregonstate.edu.

______You may store my information for use in future studies.

Initials

______ You may not store my information for use in future studies.

Initials

Future contact: We may contact you in the future for another similar study. You may ask us to stop contacting you at any time.

Study results: You will receive a copy of the study results when they become available**.**

5. WHAT ARE THE RISKS AND POSSIBLE DISCOMFORTS OF THIS STUDY?

This research study poses minimal risks to those who choose to participate. The research study involves providing group clinical development to you. Because this protocol is being delivered in a group format, you will be participating with other people who have also agreed to be part of this research study. Group clinical development will involve having discussions about the work you do as a paraprofessional counselor. There is a possibility that you could feel uncomfortable engaging in the group discussions. Additionally, the group clinical development will require you to role-play sessions that could again make you feel uncomfortable.

What you choose to talk about in the group clinical sessions will be kept confidential with limitations. Because the protocol will be delivered in the group format, a guarantee cannot be made that the other study participants will not disclose to others things that you have talked about in the group clinical development sessions. The clinical supervisor for this study, Dominique Sotelo, may also be obligated to break confidentiality if there is a reason to believe that you pose a risk to the people that receive clinical services from you. In this situation, your employment or volunteer supervisor will be notified.

6. WHAT HAPPENS IF I AM INJURED?

Oregon State University has no program to pay for research-related injuries. There are minimal, if any, foreseeable risks associated with this research study that would suggest that you could be injured by choosing to participate. If you think that you have been injured as a result of being in this study, please contact Lorie Blackman, PhD at the following email address: blackmal@onid.oregonstate.edu

7. WHAT ARE THE BENEFITS OF THIS STUDY?

We do not know if you will benefit from being in this study. However, you may benefit from receiving this group clinical development protocol that has been designed for paraprofessional counselors.

8. WILL I BE PAID FOR BEING IN THIS STUDY?

You will not be paid for being in this research study. However, you will receive a gift card to Amazon.com in the amount of $100 as a token of appreciation for your participation in this research study.

9. WHO WILL SEE THE INFORMATION I GIVE?

The information you provide during this research study will be kept confidential to the extent permitted by law. Research records will be stored securely, and only researchers

will have access to the records. Federal regulatory agencies and the Oregon State University Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you.

If the results of this project are published, your identity will not be made public.

Video recordings will be kept confidential and shared only with the following people:

- Lorie Blackman, PhD – Principal Investigator
- Dominique Sotelo, MA – Student Researcher
- Wendy Bruton, PhD – Research Assistant
- Ryan Melton, PhD – Research Assistant

The video recordings will be used to provide data that will be analyzed as part of the research study. Wendy Bruton and Ryan Melton, both of whom are legally and ethically bound to ensure confidentiality, will review the videotapes to analyze data and to ensure that Dominique Sotelo provided the clinical development as described in the written group development protocol.

To help ensure confidentiality, we will assign a code number to each of the participants to limit the possibility of your data being linked directly to you. All video equipment and media used to store video recordings will be secured by the double lock method at all times.

Absolute confidentiality of data provided over the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

Under Oregon law, researchers are required to report to the appropriate authorities any information concerning child abuse or neglect. The researchers may also report threats of harm to self or others.

10. WHAT OTHER CHOICES DO I HAVE IF I DO NOT TAKE PART IN THIS STUDY?

Participation in this study is voluntary. If you decide to participate, you are free to withdraw at any time without penalty. You will not be treated differently if you decide to stop taking part in the study. If you choose to withdraw from this project before it ends, the researchers may keep information collected about you, and this information may be included in study reports.

Online survey questions: You will be asked to respond to an online survey at predetermined points throughout this research study. You will be asked to answer each

question every time you take the survey. Failure to answer each question will jeopardize the ability to include your data in the research study.

11. WHO DO I CONTACT IF I HAVE QUESTIONS?

If you have any questions about this research project, please contact Lori Blackman, PhD, at the following email address: blackmal@onid.oregonstate.edu.

If you have questions about your rights or welfare as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office at (541) 737-8008 or by email at IRB@oregonstate.edu.

WHAT DOES MY SIGNATURE ON THIS CONSENT FORM MEAN?

Your signature indicates that this study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Do not sign after the following expiration date: 8-12-2015

Participant's Name (printed):

____

Signature of the Participant:

____

(Date)

Signature of Person Obtaining Consent:

____

(Date)