The Use of Feedback in Group Counseling in a State Vocational Rehabilitation Setting: A Pilot Study

Saara Grizzell

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THE USE OF FEEDBACK IN GROUP COUNSELING IN A STATE VOCATIONAL REHABILITATION SETTING: A PILOT STUDY

by

Saara Grizzell

A dissertation submitted in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY in

Disability Disciplines

Approved:

Julie Smart, PhD
Major Professor

Jared Schultz, PhD
Committee Member

Robert Morgan, PhD
Committee Member

Terry Peak, PhD
Committee Member

Kathleen Oertle, PhD
Committee Member

Michael Lambert, PhD
Committee Member

Mark R. McLellan, PhD
Vice President for Research and
Dean of the School of Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah
2015
ABSTRACT

The Use of Feedback in Group Counseling in a State Vocational Rehabilitation Setting: A Pilot Study

by

Saara Grizzell, Doctor of Philosophy

Utah State University, 2015

Major Professor: Dr. Julie F. Smart
Department: Special Education and Rehabilitation

The primary objective of this study was to examine the impact of providing feedback with group counseling upon the employment, symptom distress, interpersonal relationships, social role, and mental health functioning of 30 individuals with disabilities receiving services at a state vocational rehabilitation agency. Utilizing a repeated measures randomized wait-list control trial design, participants were randomly assigned to one of two conditions: treatment (feedback plus group counseling) or treatment-as-usual (group counseling only). Each participant completed the Outcome Questionnaire-45, a measure of mental health, on a weekly basis and attended a group counseling program, 1.5 hours each week, for 10 weeks at one of five different offices within a vocational rehabilitation state agency. Analyses of improved mental health functioning between the experimental and control groups failed to reach statistical significance. Analyses found three statistically significant three-way interactions between time, condition, and public benefits when interpersonal relationships ($p=.025$); social role
performance ($p=.021$), and mental health functioning ($p=.028$) were the dependent variables. Participant ratings in the feedback condition for progress made toward employment were significantly higher than those of participants in the treatment-as-usual. Similarly, the proportion of participants employed at the end of the group counseling program was statistically significant and favored the treatment condition. Taken as a whole, results raise the possible importance of public benefits and the use of feedback and group counseling for improving employment outcomes and functioning in the areas of interpersonal relationships, social roles, and overall mental health.

(182 pages)
PUBLIC ABSTRACT

The Use of Feedback in Group Counseling in a State Vocational Rehabilitation Setting: A Pilot Study

by

Saara Grizzell, Doctor of Philosophy

Thirty individuals with disabilities receiving services at a vocational rehabilitation state agency attended a ten week skills based group counseling program. Participants were randomly assigned to one of two conditions: feedback or the treatment-as-usual. Prior to each session, participants filled out the Outcome Questionnaire-45, a questionnaire that provides measures of four different aspects of counseling outcomes: level of symptom distress, problems with interpersonal relationships, social role performance, and mental health functioning. Reports were then generated showing each participant’s scores and progress over time. Group counselors and participants in the feedback condition received these weekly reports. At the end of the study, participants also rated progress toward employment. The social role performance and mental health functioning scores of participants in both conditions showed significant improvement. Participants in the feedback condition rated progress toward employment as significantly higher than did participants in the treatment-as-usual condition ($t(251) = 2.77, p = .006$, two tailed). Interestingly, participants in the feedback condition who received social security or subsistence benefits made the most steady and consistent progress with interpersonal relationships ($p = .025$), social role performance ($p = .021$), and mental health
functioning ($p=.028$). Taken as a whole, results raise the possible importance of public benefits and the use of feedback with group counseling for improving outcomes.
ACKNOWLEDGMENTS

I would like to thank my major professor, Dr. Julie Smart, whose countless hours of mentoring, quiet strength, brilliant mind, and enduring perseverance are a beacon of light. I am also very grateful to Dr. Michael Lambert, whose generosity and understanding gave me faith that I would one day finish this dissertation. I have tremendous respect for Dr. Lambert’s compassion and commitment to making the world a better place. In addition, I owe a great debt to Dr. Jamison Fargo, who patiently guided me through the statistical complexities of this dissertation. Not only is he an amazing scientist, but he is also a devoted seeker of truth. I would also like to thank Anne Hunt for helping with the research design for this project. She has tremendous patience and went out of her way to be of assistance. I am likewise grateful to Kyle Walker, Aaron Thomson, and Russ Thelin for generously providing the necessary agency support for this project. Kyle, Aaron, and Russ are committed to serving people with disabilities in a way that commands respect. In addition, the rehabilitation counselors who facilitated the group counseling sessions for this dissertation are pioneers committed to making a difference. Of course, my loving husband and children have been my cheerleaders through the many, many years of my education. But of all the angels I have mentioned here, I owe the deepest thanks to my Aunt Jerree, who believed in me when no one else did, spent years advocating on my behalf, and sacrificed completing her master’s degree to help me through the early years of my special education classes and raise me as one of her children. My dearest Aunt Mom, I hope you know you made a difference. Your sacrifice was not in vain.

Saara T. Grizzell
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CHAPTER I
INTRODUCTION

This dissertation seeks to study and assess group counseling and an empirically proven successful treatment modality, progress monitoring, with a rarely-studied group of participants, individuals with disabilities (IWDs) in a state/federal vocational rehabilitation agency. Progress monitoring and group counseling have been found efficacious in assisting individuals with a wide variety of concerns; however, what has yet to be evaluated is the provision of progress feedback with group counseling in a vocational rehabilitation context.

Importance of the Problem

Progress Monitoring

Consistently providing information to the client about the impact of his or her progress (or lack of progress) has long been a standard in both mental health settings and vocational rehabilitation agencies. However, the practice of providing counselors and clients with formal feedback about client-specific response to treatment is a more recent trend (Lambert & Shimokawa, 2011). Counselors have traditionally relied on subjective clinical judgment to determine a client’s outcome trajectory (Lambert, 2005). However, mounting evidence suggests that the accuracy of clinical judgment is suspect (Hannan et al., 2005; Sapyta, Riemer, & Bickman, 2005; Walfish, McAlister, O’Donnell, & Lambert, 2012). On the other hand, clinical predictions informed by statistical or actuarial data have demonstrated greater accuracy (Grove, 2005; Shimokawa, Lambert, & Smart, 2010).
As a problem solving method, progress monitoring provides clinicians with feedback about a variety of factors deemed important in the therapeutic trajectories of clients at risk for poor outcomes in mental health settings. The progress monitoring to be used in this dissertation is the provision of client self-assessed mental health functioning to counselors, also described as client-focused outcomes research. Monitoring client progress and providing feedback to therapists and clients during the course of mental health service has empirically demonstrated success in both individual and group interventions (Byrne, Hooke, Newnham, & Page, 2012; Lambert, Hansen, & Finch, 2001a; Whipple et al., 2003).

Unlike traditional approaches that focus on treatment outcomes utilizing aggregated scores, this study employs a patient-focused research approach. Howard, Moras, Brill, Martinovich, and Lutz (1996) introduced the patient-focused approach by utilizing a methodology in which a client’s progress is monitored in clinical settings throughout treatment. Such monitoring involves frequently asking clients to rate relevant factors considered germane to therapeutic outcomes. Providing relevant feedback during the course of treatment alerts the clinician to clients at risk for negative outcomes, making it possible to intervene, to decrease deterioration rates and increase positive treatment outcomes (Howard et al., 1996). This approach has been found particularly helpful in decreasing the deterioration rates of clients identified as not responding to therapeutic interventions (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert et al., 2001a; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005).

**Group Counseling and Job Placement**

Just as receiving feedback during treatment has been found efficacious, group
interventions have been found equally efficacious in assisting individuals with disabilities in adaptive coping (Anson & Ponsford, 2006), learning social skills (Braden et al., 2010), regulating emotions (Walker et al., 2010), and decreasing depression and anxiety (Forman, Vesey, & Lincoln, 2006). Furthermore, coping skills, social skills and capacity to regulate emotions have been empirically linked to job readiness, placement, and long-term success (Kendall, 2003; Mateer & Sira, 2006). Thus, it is reasonable to assume that providing a group intervention and feedback within a vocational state agency would produce positive outcomes for individuals with disabilities.

**Tools to Identify and Guide At Risk Cases**

Although progress monitoring and group counseling are increasingly used in other private and public social service sectors, these interventions have yet to gain ground in the state/federal VR system. Nonetheless, interventions that identify and guide at risk cases are needed. For example, according to the Office of Special Education and Rehabilitative Services (OSERS), in 2011 almost (46.44%) of individuals served by state federal VR agencies were closed without achieving employment outcomes (OSERS, 2013). Furthermore, the 2011 national employment outcome for Supplemental Security Income (SSI) recipients receiving services from general and combined VR state federal agencies was 38.54%, whereas the employment outcome rates of Social Security Disability Insurance (SSDI) beneficiaries receiving state federal VR services was 44.32% (OSERS, 2013). In addition to low employment outcomes, caseloads in state federal VR agencies continue to increase while budget cuts loom large. Thus, exploring cost effective ways of providing empirically validated vocational rehabilitation services seems clearly warranted.
Providing relevant feedback during the course of treatment not only assists the clinician, but also assists the client. For example, in a large landmark Norwegian study, Anker, Duncan, and Sparks (2009) found that providing couples with routine feedback during counseling sessions produced better outcomes, regardless of the counselor’s therapeutic orientation, or use of specific techniques. Duncan, Miller, and Sparks (2004) suggest that providing continuous feedback about client progress throughout a course of treatment could be a beneficial means for empowering clients.

**Progress Monitoring in State/Federal Vocational Rehabilitation Agencies**

Client response to treatment has been empirically investigated in medical settings since the 1980s, but the use of progress monitoring in mental health settings has only been investigated in the last two decades. According to Lambert (2005), “The extent and richness of this effect [effective psychotherapy outcomes] extend over decades of research, thousands of treated individuals, hundreds of settings, and multiple cultures” (p. 141). However, aside from studies conducted in mental health and/or university settings, a review of the literature found no patient-focused research about the effectiveness of progress monitoring on the outcomes of adults with disabilities. In addition, no studies were found that utilized patient-focused progress monitoring in vocational rehabilitation settings. State/federal vocational rehabilitation (VR) agencies differ from mental health agencies due to the fact that in order to be declared eligible for VR services, the clients must have physical, cognitive, or psychiatric disabilities. Therefore, it is reasonable to assume that results of this study could be used to inform practice, increase employment
outcomes in state federal VR agencies, and increase program efficiency in a cost-effective manner.

**Research Questions**

This is an exploratory study that seeks to understand the impact of formal progress monitoring in group counseling upon the outcomes of individuals receiving services in a vocational rehabilitation setting. Therefore, as with most patient-focused outcomes studies, this study will be conducted in an environment that is as similar as possible to routine vocational rehabilitation practice.

**Primary Research Questions**

RQ1 Will the Outcome Questionnaire-45 symptom distress (SD) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than those of participants in the treatment-as-usual condition (GnoFb) over time?

RQ2 Will the OQ-45 interpersonal relationship (IR) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

RQ3 Will the OQ-45 social role performance scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

RQ4 Will the OQ-45 scores on Mental Health Functioning of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?
Secondary Research Questions

If the intervention proves successful, the potential impact of subgroup
demographic and level of pretreatment differences upon intervention outcomes will be
examined. Thus, the secondary research questions will be as follows:

RQ5 Which demographic subgroups (age, gender, ethnicity, disability category, mental
health functioning, work status, socioeconomic status, receiving SSA benefits,
subsistence benefits) does this intervention benefit the most?

RQ6 What impact do various levels of pretest performance (functioning in normal
range, making expected progress, some chance of negative outcome, high chance
of negative outcome) have upon intervention outcomes?

RQ7 What impact does various levels of pretest OQ-45 subscale scores (symptom
distress, problems with interpersonal relationships, social role performance) have
upon intervention outcomes?

RQ8 What impact do various levels of pretest OQ-45 total scores (mental health
functioning) have upon intervention outcomes?

RQ 9: Will the employment status of participants in the treatment-as-usual (GnoFb) and
the treatment (G+Fb) conditions change differently over time?

Hypotheses

Primary Null Hypotheses

HO1: There will be no difference between participants in the treatment condition
(G+Fb) and participants in the treatment-as-usual condition (GnoFb) in symptom
distress.
HO2: There will be no difference between participants in the treatment condition (G+Fb) and participants in the treatment-as-usual condition (GnoFb) in problems with interpersonal relationships.

HO3: There will be no difference between participants in the treatment condition (G+Fb) and participants in the treatment-as-usual condition (GnoFb) in problems with social role performance.

HO4: There will be no difference between the participants in G+Fb condition and participants in the GnoFb condition on scores of Mental Health Functioning.

Primary Alternate Hypotheses

H1: Participants in the treatment condition (G+Fb) will experience a significant decrease in symptom distress as compared to participants in the treatment-as-usual condition (GnoFb).

H2: Participants in the treatment condition (G+Fb) will experience a significant decrease in problems with interpersonal relationships as compared to participants in the treatment-as-usual condition (GnoFb).

H3: Participants in the treatment condition (G+Fb) will experience a significant decrease in problems with social role performance as compared to participants in the treatment-as-usual condition (GnoFb).

H4: Participants in the treatment condition (G+Fb) will experience a significant increase in mental health functioning as evidenced by lower total OQ-45 scores (lower total scores indicate higher mental health functioning) as compared to participants in the treatment-as-usual group (GnoFb).
Secondary Null Hypotheses

If the intervention proves successful, the secondary null hypotheses are as follows:

HO5: There will be no difference between demographic subgroups (age, gender, ethnicity, disability category, mental health functioning, work status, socioeconomic status, receiving SSA benefits, subsistence benefits) in terms of intervention benefit.

HO6: There will be no difference between levels of pretest OQ-45 trajectories (functioning in normal range, making expected progress, some chance of negative outcome, high chance of negative outcome) and impact upon study outcomes.

HO7: There will be no difference between levels of pretest OQ-45 subscale scores (symptom distress, problems with interpersonal relationships, social role performance) and impact upon study outcomes.

HO8: There will be no difference between levels of pretest OQ-45 total scores (mental health functioning) and impact upon study outcomes.

H09: There will be no difference in the employment status of participants in the treatment-as-usual (GnoFb) and treatment conditions (G+Fb) over time.

Secondary Alternate Hypotheses

If the intervention proves successful, the secondary alternate hypotheses are as follows:

H5: Some demographic subgroups (age, gender, ethnicity, disability category, mental health functioning, work status, socioeconomic status, receiving SSA benefits, subsistence benefits) will benefit from the intervention more than others.
H6: Some levels of pretest OQ-45 trajectories (functioning in normal range, making expected progress, some chance of negative outcome, high chance of negative outcome) will have a greater impact upon study outcomes than others.

H7: Some levels of pretest OQ-45 subscale scores (symptom distress, problems with interpersonal relationships, social role performance) will have a greater impact upon study outcomes than others.

H8: Some levels of pretest OQ45 total scores (mental health functioning) will have a greater impact upon study outcomes than others.

H9: The employment status of participants in the treatment-as-usual (GnoFb) and treatment conditions (G+Fb) will change differently over time such that participants in the treatment condition will become employed during the group counseling program at a statistically significant rate when compared to participants in the treatment-as-usual condition.

 Definitions of Key Terms

Progress-Monitoring: The act of repeatedly assessing the client’s mental health functioning and providing feedback to the clinician and the client about the client’s functioning. In this study, the OQ-45 will be used on a weekly basis to assess client response to a skills based group intervention. The OQ-45 will also be used to evaluate client outcomes to treatment.

Algorithms: Estimates of the expected progress of the typical client, allowing comparisons with the actual progress of the clients in this study (Lambert, 1998). Thus, the individual’s week-by-week progress is measured and then compared to expected outcomes.
Clinical Support Tools: Are a specific set of guidelines typically offered to the clinician when a client’s weekly progress results indicate that he/she is at risk for treatment failure. Clinical support tools (CSTs) represent “…an empirically based problem-solving strategy…” (Whipple et al., 2003; p. 60) and are arranged in a step wise fashion to guide the clinician in helping the client get back on track for a positive outcome. CSTs offer systematic stepwise suggestions for problems in any of the following areas: therapeutic alliance, motivation toward treatment, social supports, and stressful life events.

Therapist Feedback: Feedback to counselors will be provided weekly in this study and will include a progress graph showing the client’s progress to date, a brief written message based on the client’s progress, and a visual color alert (white, green, yellow, red) corresponding to the client’s current functioning/progress compared to expected progress. In addition to the graph, written message, and color alert indicator, feedback to the counselor will includes the client’s most recent responses on critical OQ-45 items, a one-word descriptor indicating the significance of changes in the client’s total score over the course of treatment, current level of distress, and a comparison of client subscale scores to score norms.

Client Feedback: Feedback to clients will be provided weekly and will be similar to that of counselor feedback. For example, client feedback reports will include a graph of progress to date. However, unlike the written messages provided to counselors, clients will receive a written narrative that includes a mix of positive and negative feedback, with particular care taken to avoid any messages that could be perceived as detrimental to
client motivation or self-esteem. A progress report will be e-mailed on a weekly basis to clients in the feedback condition.

**State/federal Vocational Rehabilitation Agencies:** Agencies that offer services to assist people with disabilities in obtaining and maintaining meaningful employment in integrated community-based settings consistent with the individual’s strengths, interests, and informed choice.

**Vocational Rehabilitation (VR) Services:** To be eligible for VR, a person must have a physical or mental condition, which acts as a substantial impediment to employment. In addition, there must be a reasonable expectation that VR services will increase the individual’s likelihood of obtaining and maintaining meaningful employment consistent with the individual’s strengths, interests, and informed choice.

**Training of Group Leaders:** Ten masters prepared rehabilitation counselors will act as group facilitators in the present study. Facilitators will be vocational rehabilitation counselors employed fulltime with a vocational rehabilitation state agency in the Intermountain Region of the United States. Prior to commencement of this study, counselors will participate in a 15-week skills based group counseling training. This training course will be conducted by a doctoral candidate with advanced group counseling training, experience teaching masters level group counseling courses, and several years’ experience conducting group interventions with appropriate supervision. The syllabus for this training can be found in Appendix A.

**Limitations**

The present study is small in scope and limited in resources and must be
considered only the beginning of a systematic line of research. In all empirical research, the strength of the independent variable is critical in order to find conclusive results. Many of the studies reviewed in Chapter II report both large numbers of clients and many psychotherapists and, certainly, both the number of these psychotherapists and their qualifications in these studies reviewed in Chapter II strengthen the independent variable. Another small group of studies was conducted in inpatient hospital settings, thus allowing more control of extraneous variables, such as other interventions being offered, and a more in-depth understanding of family and other available social supports.

Another limitation in the present study is the current study design. For example, data will be collected at five different offices within the same vocational rehabilitation state agency. Because the client bases of each office may have participants with different demographics, the current study will compare treatment changes utilizing a within site treatment-as-usual condition with matching design. Therefore, each office will consist of its own counseling group being conducted by a facilitator and co-facilitator who are employed in that particular office. While this within site design may be the most effective and efficient way to address pretreatment group differences, it also limits the generalizability of study results.

In addition to limited generalizability, there is an unavoidable threat to internal validity due to the within site design and the current study’s two treatment conditions. Within each site, participants will be randomly assigned to one of two conditions (e.g. group counseling plus feedback or group counseling without feedback). Each of the counseling groups will consist of participants in the treatment-as-usual condition and participants receiving feedback (treatment condition). In the treatment group, both the
group counselor and the participant will receive the feedback about the client’s progress on a weekly basis. Thus, prior to each group counseling session the counselor will receive feedback (progress reports) on half of the participants within the same counseling group. In other words, group counselors conducting weekly groups will know which participants are in the treatment-as-usual condition and which participants are in the treatment condition. This awareness could account for some of the observed differences. Similarly, participants in the treatment-as-usual condition could perceive the lack of feedback as an indication of receiving lesser services.

Finally, it should be remembered that statistical significance does not always mean clinical significance. Because the methodology of patient-focused research requires clients to be assessed repeatedly throughout the course of treatment, in a federally and state funded eligibility agency, many VR clients often feel “processed” through a bureaucratic maze in which they are viewed by the administration and counselors as a statistic, rather than an individual. Systematic use of “patient-focused research” may lead to greater client engagement in his or her rehabilitation process, result in clients attending a greater number of group sessions, and prevent drop-outs. The use of progress monitoring may allow clients to feel that their opinions are important. This raises questions about what is effective as increases in client engagement cannot be separated from other mechanisms of change that may be associated with feedback.

VR counselors may also benefit because they are recipients of client assessments of their services and can use these assessments to increase their clinical skills. In this way, VR counselors have the opportunity to become “scientists/practitioners.” The state-federal VR system, as the name implies, is a national service provider serving
hundreds of thousands of clients each year and employing master’s level counselors,
creating the possibility of large numbers of clients and counselors and a national database of rich information.
CHAPTER II
LITERATURE REVIEW

Consistently providing feedback to the client about the impact of his/her behavior has long been a standard in mental health settings. Conversely, the practice of providing counselors with formal feedback about client mental health functioning is a more recent trend (Lambert & Shimokawa, 2011). Counselors have traditionally depended on clinical judgment to determine a client’s outcome trajectory (Lambert, 2005). However, mounting evidence suggests that the accuracy of clinical judgment is suspect (Hannan et al., 2005; Sapyta et al., 2005; Walfish et al., 2012). On the other hand, clinical predictions informed by statistical or actuarial data have demonstrated greater accuracy (Grove, 2005; Shimokawa et al., 2010).

For this reason, monitoring client response to intervention has been suggested as a means for increasing positive client outcomes in mental health settings (Lambert et al., 2001a; Lueger et al., 2001; Whipple et al., 2003). Known as patient-focused research, the aim of this approach is to provide feedback to clinicians about client progress early in the treatment process, thus allowing clinicians to reevaluate and modify the treatment approach for clients identified as at risk for poor outcomes (Lambert et al., 2005).

Indeed, research suggests that giving therapists’ feedback about client specific response to treatment improves treatment outcomes (Lambert et al., 2001b; Whipple et al., 2003).

In addition to progress monitoring, research on the use of group counseling has demonstrated positive treatment outcomes. Indeed, group counseling interventions have been successfully used to address a variety of disability related issues (Judd & Wilson, 2005; Tiersky et al., 2005). For example, group counseling has been effective in helping
persons with acquired brain injury explore feelings of loss, find meaning, and set realistic
goals (Fleming & Ownsworth, 2006; Judd & Wilson, 2005). Group counseling has been
deemed efficacious in meeting client vocational counseling needs of individuals living
with HIV (Kohlenberg & Watts, 2003). Furthermore, monitoring progress and giving
feedback to clinicians and clients receiving group psychotherapy has been shown to
decrease depressive symptoms and reduce readmissions to psychiatric inpatient treatment
(Byrne et al., 2012; Newnham, Hooke, & Page, 2010b).

Although group counseling has been found efficacious in assisting individuals
with disabilities in addressing a wide variety of impairment related and return to work
issues, what has yet to be evaluated is the effect of progress monitoring upon the
outcomes of individuals with disabilities in a group counseling context at a state
vocational rehabilitation agency.

To provide a strong conceptual foundation for the ensuing study, it is necessary to
examine the possible factors that influence the effectiveness of feedback to counselors
and clients about client progress. To this end, this review will first define the nature and
scope of feedback interventions (FIs). Next, the factors that affect FIs and relevant FI
theories will be discussed. This will be followed by a review of studies focusing on
feedback as a formalized component of treatment, namely, patient-focused research.
Finally, because this study involves feedback in the context of group work, studies that
have specifically utilized formal feedback in group interventions will be discussed.

**Feedback Intervention Scope and Definition**

The field of psychology defines the term ‘feedback intervention’ as information
provided by an external source to a person about the person’s behavior or the behavior’s
effects (Claiborn, Goodyear, & Horner, 2001). Stated another way, feedback
interventions (FIs) involve providing information about some aspect of another’s
performance on a particular task or a series of tasks (Kluger & DeNisi, 1996). As the
definition implies, FIs not only involve knowledge of results, but include information that
has been deliberately provided about the effectiveness of one’s performance on a wide
variety of tasks. Although there are many types of deliberate feedback and associated
interventions, patient-focused research encompasses interventions that describe another’s
behavior and evaluate that behavior in relation to performance criteria. For example,
Claiborn and Goodyear (2005) described feedback provided to therapists about the
client’s response to treatment as a form of evaluative feedback because such feedback
“lets therapists know how well their clients are doing with respect to criteria of
improvement” (p. 211).

In addition to providing feedback about the client’s response to treatment, patient-
focused research includes feedback that falls on a negative-positive continuum, otherwise
known as “valence”. Claiborn and Goodyear (2005) referred to Lambert et al. (2005) to
explain how feedback to therapists functions along this negative-positive continuum. For
example, when the client’s response to treatment falls short of a certain criteria, this is
characterized as negative valence. In this situation, Lambert and colleagues alert the
therapist with use of a yellow or red color alert. On the other hand, when a client’s
response to treatment meets a certain standard, this is known as positive valence. In this
situation, Lambert and colleagues alert the therapist with a white or green colored alert.
As the previous paragraph illustrates, clients may not always respond positively to treatment. In addition, not all feedback interventions have demonstrated improved outcomes. For example, in a seminal meta-analysis on the effectiveness of feedback interventions, Kluger and DeNisi (1996) found that, although feedback interventions improved performance overall ($d=.41$), in some studies feedback appeared to have no effect, and in a third of the studies feedback actually decreased participant performance, suggesting that the efficacy of feedback interventions may be contingent upon certain factors. Thus, this literature review will now turn to factors that affect feedback interventions.

**Factors Affecting Feedback Interventions**

In a review of the literature, there appear to be four factors that influence the effectiveness of a feedback intervention. Claiborn and Goodyear (2005) explored three of these factors, namely: (a) the feedback sender; (b) the feedback itself; and (c) the feedback receiver. The feedback environment is another factor considered relevant in this body of literature (Greller & Herold, 1975).

**The Feedback Sender**

With regard to feedback to therapists, the sources of feedback are the client (indirectly) and the measure used to collect the data (e.g. the OQ-45). Whether the receiver of feedback is a client or a therapist, feedback is more likely to be accepted if the source is viewed as credible (e.g. is seen as trustworthy and as having expertise) and has a level of attractiveness (e.g. is personally relevant and available) to the person receiving the feedback (Strong & Matross, 1973).
According to Claiborn and Goodyear (2005), FIs promote change through interpersonal influence. In individual psychotherapy, it is presumably the therapist’s interpersonal power that influences the client’s change process. However, influential messages may have other sources, such as psychological assessment tests, other group members in group therapy, or through observation of a client’s behavior (Claiborn & Goodyear, 2005). In the case of patient-focused research, systematic feedback about the client’s response to treatment represents the message that in turn potentially influences the therapist receiving the feedback (Claiborn & Goodyear, 2005).

In addition to personal relevance and availability, psychological closeness has been cited as another factor. For example, Greller and Herold (1975) studied five occupational feedback sources (formal organization, supervisor, co-workers, the task, and own self). The feedback in question involved participant job description items, job requirements, and the extent to which job requirements were met. The importance study participants placed on the feedback was found to vary by the source of the feedback and the psychological closeness of the source involved. The closest source was identified as the self, followed by the task, then co-workers. The second most distant source was the supervisor and the most distant source was the company.

In the above study, participants were more receptive to feedback about job description items given by sources that were of increasing psychological closeness. Thus, there was a greater reliance on intrinsic sources (self as the source) than on more external sources. Greller and Herold (1975) posited that study participants were more receptive to intrinsic job description information provided by self because knowledge based on self-appraisal about such information is immediately available. In addition, there is less
distrust and the individual can choose when to consider the information, rather than being asked to consider the information when others are available to provide it. This explanation may add support to Lambert’s (2005) assertion that counselors tend to rely on their own personal views of the client’s progress rather than utilizing outside sources. In addition, there is evidence that counselors (as well as a host of other professionals) see themselves as unusually effective in relation to their peers and more objective data (Hannan et al., 2005; Walfish et al., 2012).

Feedback Characteristics

While source variables of credibility, attractiveness, and psychological closeness are deemed important factors in prompting behavioral change, information processing approaches such as the Elaboration Likelihood Model (ELM; Petty & Cacioppo, 1986) posit that FI influence may have less to do with source characteristics and more to do with the extent to which the feedback is scrutinized. For example, the receiver may superficially accept the message without really scrutinizing the feedback’s validity simply because the message came from a powerful source. Claiborn and Goodyear (2005) believe that the ELM is particularly relevant to feedback interventions in therapy situations and add, “Certainly therapists want to establish a reasonable degree – and a meaningful kind – of social power with clients, but they do not want this to replace clients’ careful consideration of the feedback they receive” (p. 213). Similarly, providing feedback to both clients and counselors about client progress may act as a logical next step for facilitating deeper discussion and exploration.

In addition to potentially being a powerful change strategy in therapy, a number of factors influence the efficacy of feedback interventions. One of those factors has to do
with valence, alternatively referred to as the feedback *sign*. Valence is the degree to which the FI delivers positive or negative information about the receiver and the order or combination of positive and negative information (Claiborn & Goodyear, 2005). Feedback that consists of praise and encourages and supports an observed behavior is deemed positive in valence, whereas feedback about a behavior falling short of a certain criteria is negative in valence (Claiborn et al., 2001).

It may appear at first glance that positive valence FIs naturally facilitate an individual’s meeting of performance standards. However, Baumeister, Hutton, and Cairns (1990) found that the use of obvious praise actually hindered participant performance on demanding cognitive tasks. Research on negative valance FIs have yielded similar findings (Mikulincer, Glaubman, Ben-Artzi, & Grossman, 1991). For example, therapists are more likely to reject negative feedback about the effectiveness of their services (Bickman & Rosof-Williams, 2000). Whether therapist or client, individuals are more likely to accept positive feedback and reject negative feedback (Claiborne & Goodyear, 2005) and to view positive feedback as more accurate. However, negative feedback accompanied by positive feedback has been found more likely to promote feedback acceptance (Davies, 1997). Similarly, feedback accompanied by ideas for how to improve or change negative outcomes has demonstrated greater feedback acceptance (Bickman & Rosof-Williams, 2000).

In addition to the sign of feedback, Wells, Moorman, and Werner (2007) found that participants judged developmental feedback as more acceptable than feedback viewed as a deterrent to future behavior. These researchers found that developmental feedback was associated with higher levels of job satisfaction, organizational
commitment, and felt obligation. They posited that employees would more readily accept performance monitoring when such monitoring was carefully framed in constructive, developmental terms. Similarly, Barone et al. (2005) looked at the accuracy of empathy with psychology graduate students and found that those who received immediate feedback about their empathy judgments had greater accuracy of feelings, but not thoughts, at the end of the course. Given the above findings, it makes sense then that providing immediate feedback to assist the therapist in addressing the client’s impediments to progress would have an increased likelihood of being accepted and utilized.

Just as immediate feedback has empirically demonstrated results, so too has written feedback. For example, Naughton, Feely, and Bennett (2009) used FIs to improve antibiotic prescribing of 50 general practitioners. On one single occasion, these researchers provided participants with written feedback about their individual prescribing practices for the previous 12 months. The second group of practitioners received the same written feedback and a 15 to 30-minute meeting with one of the researchers. Naughton et al. found that the written feedback was associated with improved prescribing. However, the 15 to 30 minute meeting following the written feedback conferred no additional advantage. Thus, giving written feedback to therapists about client response to treatment appears to be supported by findings of the above study.

It also appears that the content and form of the feedback message affects feedback processing. For example, Wilson, Boni, and Hogg (1997) recommended that feedback include new and useful information regarding the individual’s progress, as well as suggestions for improvement. Similarly, velocity or feedback that conveys the amount of
progress since the last provision of feedback appears to augment FI effectiveness (Carver & Scheier, 1990; Hsee & Abelson, 1991). Other researchers have found that the order in which the positive and negative feedback is presented is important. For example, people tend to consider negative feedback more when it is preceded by positive feedback (Kivlghan, 1985; Schaible & Jacobs, 1975). Conversely, when negative feedback precedes positive feedback, then the negative feedback is less likely to be considered (Claiborn & Goodyear, 2005).

**Feedback Receiver Characteristics**

Self-esteem appears to be an important variable in feedback intervention outcomes (Claiborne & Goodyear, 2005). For example, Nease, Mudgett, and Quinones (1999) posited that acceptance of feedback is moderated by self-efficacy (e.g. assessment of one’s capability of achieving success). They found that individuals with high self-efficacy tended to decrease their acceptance of repeated negative feedback, whereas individuals with low self-efficacy did not change their acceptance in the face of repeated negative feedback. Similarly, Baumgardner, Kaufman, and Levy (1989) found that individuals with low self-esteem who were given negative interpersonal feedback in public maintained esteem by being publicly critical of the feedback source. However, in private such individuals behaved differently. On the other hand, individuals with high self-esteem were less critical of negative feedback in public than in private. Furthermore, individuals with high self-esteem viewed positive feedback as more accurate than negative feedback. In addition, Morran and Stockton (1980) found that individuals with high self-esteem tended to be more interested in negative feedback, perhaps because they wanted to hear something about themselves that they previously did not know. Another
explanation is that individuals with high self-esteem are less likely to view the negative feedback as a threat to self.

Similarly, it appears that mood may bias the reception and processing of negative feedback. For example, receivers with low mood tend to be more receptive to negative feedback than receivers without low mood (MacFarland & Morris, 1998). On the other hand, receivers with low mood tend to skew their processing of negative feedback in a negative direction. Likewise, clients who perceive themselves as cared for and as having high social support tend to show better coping with negative life events and better health outcomes (Nezlek & Allen, 2006; Sarason, Sarason, & Gurung, 2001). MacFarland and Morris (1998) found that individuals with low mood skewed ambiguous feedback in a negative direction, regardless of the feedback’s valence.

In addition to self-esteem and mood, it appears that internal locus of control may be an important variable in reception to feedback. For example, Ilgen, Fisher, and Taylor (1979) found that individuals with internal locus of control responded better to feedback directly linked to performance of a specific task (e.g. shooting a basketball). Conversely, individuals with external locus of control performed better when feedback was delivered interpersonally.

Feedback Setting Characteristics

Claiborn and Goodyear (2005) have suggested that the effectiveness of feedback may be limited if the receiver views the situation as an inappropriate forum for the feedback message. However, Greller and Herold (1975) posited that the feedback environment can be enriched. Using an occupational feedback example, Greller and Herold (1975) asserted that satisfying work environments are those in which the
individual determines the requirements and relies less heavily on external sources. On the other hand, Kluger and DeNisi (1996) posited that cues about externally provided goals are a particularly important component and suggest that FIs are augmented by goal-setting interventions to provide the receiver with clear task goals that can be easily compared with the feedback given. By extension then, it seems reasonable to assert that therapeutic FI environments would be better served by facilitating change through feedback to the therapist and the client about the client’s progress.

**Feedback Theories**

Although feedback interventions have long been used to facilitate behavioral change, theories differ on the specific mechanisms that support that behavioral change. Many theories see behavior as goal directed and posit that behavior is regulated by the evaluation of and reaction to a comparison between one’s performance and desired goals/standards (Kluger & DeNisi, 1996), a process which necessarily involves feedback about one’s performance. Theories that see feedback as an important component of this behavioral sequence include: Control (Carver & Scheier, 1982), Goal Setting (Locke & Latham, 1990), Feedback Intervention or FIT (Kluger & DeNisi, 1996), and Contextual Feedback Intervention or CFIT (Sapyta et al., 2005). This review will first briefly discuss control theory and goal-setting theory as a means for providing the context with which to explore the remaining two theories, namely, FIT and CFIT. FIT appears particularly relevant for exploring how and why clients may respond to feedback. On the other hand, CFIT was specifically designed to explain clinician response to feedback.
Since feedback interventions are so heavily conceptually based on FIT and CFIT, this section will focus primarily on these two theories.

**Control Theory**

Control theory (Carver & Scheier, 1982) asserts that when an individual becomes aware of a discrepancy between his/her performance and a desired goal, he or she makes an effort to reduce the discrepancy. This involves two kinds of information-processing systems. The first system facilitates future behavior by managing perceptual input about the behavioral standard. The second system monitors behavior through comparison to the standard. The process by which this occurs is known as a negative-feedback-loop, otherwise represented by the acronym “TOTE” or test-operate-test exit. Thus, the initial test phase includes a comparison between actual performance and a desired goal or standard. If a discrepancy exists and one’s performance falls short of a valued standard, then the individual engages in an operate phase, which involves changing one’s behavior in an effort to reduce the discrepancy. This performance gap is then re-evaluated (test phase). If the discrepancy has been eliminated, then the above feedback loop is exited.

Feedback, even when directed toward a specific task or activity, is often perceived as being aimed at the level of self (Archer, 2010; DeNisi & Kluger, 2000). Carver and Scheier (1982) have argued that there are different levels of self-focus, namely, focus on the “private self” or the “public self.” In addition, evidence suggests that conformity to standards of comparison is heightened by the presence of an audience or mirror (Carver & Scheier, 1982). Thus, different behavioral standards become important based on the level of self-focus. Carver and Scheier suggested that feedback is most effective when the behavioral standards are appropriate to level of self-focus.
**Goal Setting Theory**

Although control and goal setting theories agree that behavior is goal directed, they differ on an individual’s reaction to goals and standards. Goal setting theory (Latham & Locke, 1991) argues that the desire to achieve goals motivates behavior, rather than behavioral discrepancy. In other words, effective feedback necessarily leads an individual to set and commit to goals and thus moderates the effects of goal setting on performance (Latham & Locke, 1991). More specifically, feedback informs the individual about the extent to which his/her performance meets a certain standard. Performance is typically maintained when the standard is met. However, if performance falls short of a certain standard, subsequent improvement is facilitated by the magnitude of the individual’s dissatisfaction with his/her performance and the extent to which he/she expects to be dissatisfied in the future. In addition, Locke and Latham argued that improved performance is a function of the individual’s confidence in his/her ability to improve and whether or not the individual sets a goal to meet the performance standard.

**Feedback Intervention Theory**

As in control theory and goal-setting theory, feedback intervention theory or FIT (Kluger & DeNisi, 1996) assumes that people use feedback as a means for assessing performance in relation to goals or standards. With regard to feedback interventions then, FIT asserts that people may respond to negative feedback by using one of four strategies to eliminate the feedback-standard gap.

Responses to negative feedback. The first strategy for reducing or eliminating the feedback standard gap is to increase one’s efforts or modify one’s strategy so as to meet the goal (Kluger & DeNisi, 1996). In a seminal goal-setting study, Locke and Latham
(1984) demonstrated that it is possible to increase the likelihood of meeting a goal in the face of negative feedback, rather than responding by lowering the standard. For example, when feedback was initially negative but people chose to increase their efforts, Locke and Latham found the following conditions present: the goal was clear, a strong commitment to reach the goal was voiced, and a belief was communicated that the goal would be obtained eventually.

The second strategy (e.g. abandoning the standard) has been empirically researched in seminal studies by Mikulincer (1988) and Bandura (1991). For example, both studies found that individuals were more likely to abandon a goal when the individual perceived a low likelihood that his/her actions would eliminate the feedback-standard discrepancy. In addition, in the face of an extremely and repeated negative FI, individuals not only abandoned the standard, but actually responded with learned helplessness (Mikulincer, 1988). On the other hand, a third strategy proposed by Kluger and DeNisi (1996) involves changing the standard as a means for eliminating the discrepancy. Thus, individuals may lower the standard in the face of negative feedback. The fourth and final strategy is to reject the feedback message all together, and thus effectively deny the existence of a feedback-standard gap.

Three process levels. In addition to asserting four possible strategies for responding to negative feedback, FIT posits that task performance is regulated by three levels of linked processes (meta-task processes, task-motivation processes, and task-learning processes) that involve arranging goals and standards in a hierarchy. Meta-task processes link the focal task with higher order goals of self and are thus at the top of the hierarchy. Such processes have considerable influence upon performance and involve
attention to the self, affect, and possibly framing effects. Conversely, task-learning processes are at the bottom of the hierarchy and involve physical action goals (e.g. open the door) and specific task details. Task-motivation processes are in the middle of the hierarchy and involve motivation toward the task or the interpretation of feedback.

According to FIT, when performing a task, attention is normally directed in the middle of the hierarchy (somewhere between goals of the self and physical action goals). Kluger and DeNisi (1996) added that, although most attention is likely to be at one level, attention “can be present simultaneously, or with quick alternations, at different levels of hierarchy and across several standards within the hierarchy” (p. 262). However, FIs can potentially alter the locus of attention to different levels of the hierarchy. Thus, perceptions associated with FIs are more about what will receive attention rather than if the FI will be perceived at all. Kluger and DeNisi asserted that FIs have differential effects at different levels of the goal/standard hierarchy.

FIs impact upon performance. FIT offers five propositions about the effects FIs have upon performance. The first proposition asserts that FI effectiveness may be mediated by cues that direct one’s attention toward meta-task processes (e.g. toward the self, trustworthiness of the sender). The second proposition asserts that task-motivation and task-learning cues augment performance. The third proposition states that FI effectiveness is influenced by learning cues. The fourth proposition postulates that goal-setting interventions augment the effect of FIs upon performance. Fifth and final proposition is related to characteristics of the receiver and asserts that goals and feedback preferences salient to an individual are dependent upon personality type. Because this literature review has previously explored research associated with many of these
propositions, the remainder of this discussion will focus mostly on FI cues as a mediator upon performance.

The first proposition states that FIs are mediated by cues that direct one’s attention to meta-task processes (e.g. toward the self). For example, normative cues are likely to divert attention away from the task and instead direct attention toward impression management. Other FI relevant meta-task cues include those designed to discourage or praise the receiver and those perceived as a threat to the self. FIT asserts that such cues may direct the person’s locus of attention to personal concerns unrelated to the actual task.

Similarly, some meta-task cues may induce performance-debilitating mood states (e.g. anxiety). Kluger and DeNisi (1996) asserted that attention to the self is likely to elicit affective reactions which may influence the way in which cognitive resources are allocated in a performance situation. According to FIT, such affective reactions are facilitated by “an evaluation of the feedback with respect to salient self goals – which may create several feedback signs” (p. 266). These signs are then summed to create a general interpretation of the feedback as a whole. This general feedback sign is evaluated for its potential to do the self-harm or good and the need to take action. Thus, anxiety represents an evaluation that the feedback given is a threat to self and that one must take action (e.g. lessen or terminate the threat). When attention is directed to a perceived threat to self, Kluger and DeNisi asserted that the gap may be eliminated by avoiding the task that caused the threat to self.

On the other hand, attention to self can improve performance of certain tasks. For example, attention to self has been shown to improve performance of dominant tasks but
debilitate performance of non-dominant tasks (Carver & Scheier, 1982). Meta-task cues have been likewise shown to increase performance on simple two-cue memory tasks but decrease performance on six-cue memory tasks (Mikulincer et al., 1991). In addition, praise has been shown to decrease performance on cognitively demanding tasks but improve performance on simple tasks (Baumeister et al., 1990). Kluger and DeNisi (1996) explained the variable effects of meta-task cues by asserting that the shifting of attention away from the task necessitates a reallocation of cognitive resources. Thus, on a cognitively demanding task, shifting cognitive resources away from the task would indeed decrease performance. However, in the event of automated tasks, fewer cognitive resources are required and thus FI meta-task cues would cause people to put forth more effort.

Kluger and DeNisi (1996) likewise asserted that FIs that include task-motivation and task-learning cues augment performance. For example, velocity (progress) feedback has been shown to increase performance (Carver & Scheier, 1990; Hsee & Abelson, 1991). By focusing on past performance, cues of this type direct attention to task goals and thus activate the task-motivation process level. Furthermore, Kluger and DeNisi proposed that FI cues that offer suggestions or solutions direct attention to task-learning and would likewise improve performance. Similarly, a closely related proposition to this finding is proposition four, namely the assertion that goal-setting interventions augment the effects of FIs upon performance.

Kluger and DeNisi (1996) further proposed that FI effectiveness is influenced by learning cues. For example, when an individual is first learning a task, performance is largely dependent upon cognitive resources (e.g. intelligence). However, once a task is
sufficiently learned, then the role of learning cues in predicting performance diminishes (Hulin, Henry, & Noon, 1990). In the absence of learning cues then, fewer cognitive resources are needed. In this situation FIT asserts that FIs have a more positive effect upon performance. However, research also suggests that, in some instances, providing specific FI information about task performance “may not match the natural way people represent the task cognitively and, therefore, attenuate some benefits of FI for learning” (Kluger & DeNisi, 1996, p. 268). For example, Ganzach (1994) found that providing information about the magnitude of error, rather than just the sign of the error (above or below the target), led to poorer performance.

**Contextualized Feedback Intervention Theory (CFIT)**

As previously discussed, the typical clinical environment does little to facilitate on-going learning for clinicians post-graduation. Sapyta et al. (2005) asserted that this is likely due to a lack of systematic feedback about client outcomes. In an effort to better understand feedback provision to clinicians and maximize the degree to which feedback is received, understood, and incorporated by the clinician, Sapyta et al. (2005) conceptualized a theory, otherwise known as Contextualized Feedback Intervention Theory (CFIT). The assumptions and basic tenants of CFIT are explored in greater detail below.

**Assumptions.** This theory is based on several assumptions. For example, CFIT assumes that clinicians are self-determined learners and that feedback to clinicians enhances the learning self-regulation process. Thus, CFIT asserts that clinicians are goal directed and that a high commitment to achieving clinical goals (e.g. helping clients feel better) is necessary, but not sufficient. In addition to being motivated to accomplish
certain clinical goals, the clinician must be aware of discrepancies between current behavior (e.g. treatment approach) and clinical goals. In other words, an important component of meeting goals is receiving systematic feedback about client response to treatment.

**Goal attainment.** CFIT defines goal commitment as “the amount of interest in accomplishing a goal, even if it requires extra time and effort” (Sapyta et al., 2005, p. 150). Consistent with goal-setting theory, CFIT posits that, in order for clinicians to be motivated toward attaining certain goals (e.g. helping clients feel better), clinicians must view the goal as personally attractive and salient. CFIT asserts that the more a clinician views a particular goal (e.g. helping a troubled client) as instrumental in accomplishing other important goals (e.g. increasing clinical competency, engaging in meaningful work), the more attractive the client-specific goal will become. For example, clinicians voiced much greater motivation to use empirically supported treatment when the treatment was perceived as facilitating improved client mental health outcomes (Torrey, 2001, as quoted in Sapyta et al., 2005).

In addition to goal attractiveness, the clinician must also believe that the goal is likely achievable (Bandura, 1982), otherwise known as goal expectancy. Goal expectancy involves an assessment of internal and external factors germane to goal attainment. Internal factors include one’s own abilities (e.g. self-efficacy) whereas external factors are available supports and barriers to goal attainment. For example, Sapyta and colleagues posited that skills development support from a clinical supervisor (e.g. training on ways to lessen client resistance) can help foster goal commitment and goal attainment (e.g. the development of clinician-client alliance).
**Functions of feedback.** When a feedback-standard discrepancy exists, the clinician needs to be aware that his/her treatment approach falls short of the desired goal. Saptya et al. (2005) asserted that the function of a feedback intervention is to illuminate this discrepancy. Sometimes feedback on a one time basis is enough to initiate clinician change, as is the case with being alerted that a particular client is not making the expected progress. Saptya and colleagues suggested that other types of behavioral change necessitate consistent feedback over a longer period, such as when the clinician is addressing possible approaches for developing and maintaining a solid working relationship with a particular client. Feedback then provides the clinician with a benchmark with which to explore various treatment strategies.

**Cognitive dissonance.** Citing cognitive dissonance theory (Aronson, 1999), Sapyta and colleagues asserted that feedback-standard discrepancies create psychological discomfort (dissonance) and hence motivate the clinician to lessen this discomfort. Saptya et al. (2005) articulated the possible options clinicians have for reducing this dissonance. One option is for the clinician to lessen his/her commitment to the goal and thus effectively make the discrepancy less salient. For example, when the clinician is made aware of a rupture in working alliance, he/she could give less weight to working alliance with the particular client in question. Or the clinician could perceive that the client in question is incapable or unwilling to change. Regardless, such dissonance reducing strategies attribute negative feedback to factors external to self. Conversely, the clinician could accept personal responsibility for the discrepancy and could then make behavior changes to reduce the cognitive dissonance. Hence, in order for a clinician to enact behavioral changes based on discrepant feedback, he/she must maintain a
commitment to the target goal (helping a troubled client) by accepting personal responsibility for the discrepancy. The clinician must likewise believe that he/she has a measure of control over achieving the eventual goal.

**Feedback considerations.** Consistent with previous research, Sapyta and colleagues elaborate on several factors that may influence feedback intervention outcomes (e.g. feedback source, feedback content, feedback sign, and feedback format). Examples of clinically-based feedback sources include the task, the clinician, supervisors, clients, and peers (Ashford, 1993). However, Sapyta and colleagues articulated several limitations about many of the above feedback sources. For example, client feedback is typically “infrequent, unsystematic, and ambiguous” and supervisor/peers must “rely mainly on clinician self-report” (p. 151). Likewise, the clinician as feedback source presents another point of ambiguity. For example, the clinician’s assessment about the relevance of the feedback could lead to dismissing potentially valuable information, while focusing on less pertinent information deemed important only to the clinician.

Similarly, feedback sign is addressed by CFIT. Sapyta and colleagues asserted that clinicians receiving a message that a client’s progress is slower than normal may consider the feedback as negative. On the other hand, empirical research in the context of clinical settings has demonstrated that negative feedback to the clinician seems to have a beneficial effect on behavioral change (Saptya et al., 2005). However, Higgins (1998) cautioned that the feedback sign may motivate clinicians differently based on each clinician’s achievement orientation.

With regard to feedback content then, the empirical literature has shown that clinicians are more likely to engage in behavioral change if the feedback received is
about actual clinician behaviors (Saptya et al., 2005). However, Saptya et al. have cautioned that clinician behavior change does not necessarily lead to improved client trajectories, suggesting that: “It may be necessary to supplement the feedback message with a directive intervention, such as providing norms and benchmarks for performance and formative feedback” (p. 151). Offering clinicians’ formative feedback (e.g. concrete suggestions for facilitating positive change) will be explored in greater detail later in this review.

In addition to feedback content, the timing of feedback (immediate or delayed) is likewise important. According to CFIT, feedback should be delivered as quickly as possible post data collection to facilitate the clinician connecting the feedback to his/her behavior. Furthermore, Saptya et al. (2005) suggested that the feedback be cognitively simple to allow for rapid understanding and use. Data should be regularly collected and feedback routinely given to allow the therapist to make changes throughout the course of treatment. It also appears that the desire to improve performance may be heightened by giving the feedback receiver control over the frequency with which he/she receives the feedback (Alder, 2007).

Insomuch as this review has examined factors considered pertinent to FI effectiveness and has provided a conceptual basis with which to understand the mechanisms of behavioral change, attention will now be turned to a review of current trends in patient-focused research.

**Current Trends in Patient-Focused Research**

Since 1996, patient-focused research has sought to determine empirically supported intervention methods by utilizing feedback to therapists about client specific
response (e.g. functioning in key areas) to treatment (Howard et al., 1996). Asserting that feedback could enhance treatment effectiveness and highlight the need for further treatment, many researchers have recommended utilizing repeated client progress assessments and providing feedback to therapists, supervisors, or case managers throughout the treatment course (e.g. Howard et al., 1996; Kordy, Hannover, & Richard 2001; Lambert et al., 2001a; Lueger, 1998). In addition, for clients not making expected treatment gains, Lambert and colleagues (2001a) have suggested that client progress monitoring and therapist feedback provision could be used to facilitate more positive outcomes for such clients.

Although several quality assurance systems have been developed, it appears that only two systems have demonstrated gains in randomized clinical trials (Duncan, 2012). These two systems include the Outcome Questionnaire-45 (OQ-45, Lambert, Kahler, Harmon, Burlingame, & Shimokawa, 2013) and the Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005). The PCOMS consists of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), both scales including four items each. The ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003) is modeled after the four subscales of the OQ-45 and purports to measure the client’s mental health status along four domains: (1) personal or symptomatic distress, (2) relational distress, (3) satisfaction with work/school and relationships outside of the home, and (4) general sense of well-being. On the other hand, the SRS (Miller, Duncan, and Johnson, 2002) assesses therapeutic alliance based on Bordin’s (1979) articulation of alliance, namely the relationship bond and agreement between therapist and client about
goals and tasks for therapy. The ORS and SRS are typically administered in the presence of the therapist, the results of which are discussed during the treatment session.

In the past decade, perhaps the most extensively researched quality assurance system is the Outcome Questionnaire-45 (OQ-45; Lambert et al., 2013), an instrument designed to measure the clients’ weekly progress through repeated administrations during the course of treatment and upon termination. This system is based on three procedural principles: (a) algorithms of expected client progress based on normed averages are used; (b) individual client progress compared to average client progress to identify clients at risk for poor outcomes (Finch, Lambert, & Schaalje, 2001; Lambert et al., 2002a; Spielmans, Masters, & Lambert, 2006); and (c) therapists and case managers provided with feedback about client progress so that adjustments to treatment can be made (Shimokawa et al., 2010). In keeping with these principles, the OQ-45 measures client symptoms of distress, problems with interpersonal relationships, and social role performance, and provides a total score indicating the client’s satisfaction with life. Utilizing the data gathered about the areas above, the OQ-45 generates feedback in the form of progress graphs, warnings for clients not making expected treatment gains (signal alarm cases), and short narratives about progress to date.

Research suggests that monitoring client progress and providing feedback is particularly important in the outcomes of clients who have a poor initial treatment response. For example, in a meta-analytic review of three large-scale studies, Lambert et al. (2003) concluded that, regardless of counselor theoretical orientation, formally monitoring the progress of clients who have a poor initial treatment response can significantly reduce client deterioration and increase positive client outcomes. Lambert
and colleagues caution however, that while progress monitoring may improve outcomes, these improvements may not necessarily represent satisfactory outcomes at termination (Whipple et al., 2003). To this end, Whipple et al. (2003) examined the use of clinical support tools in conjunction with feedback. In this study, Whipple et al. (2003) developed “…an empirically based problem-solving strategy…” (Whipple et al., 2003, p. 60) that consisted of a formalized decision tree arranged in a stepwise fashion to guide the clinician in systematically evaluating factors considered important in successful therapeutic outcomes. These factors included therapeutic relationship, client motivation to change, client social support networks, negative life events, accuracy of the diagnosis, and the appropriateness of medication referral. In addition to evaluating critical factors, these CSTs provided evidence-based solutions to assist the clinician in getting not-on-track clients back on track for positive outcomes. Clients in the feedback plus CST group demonstrated superior outcomes compared to clients in the feedback only condition, thus providing empirical support for the inclusion of CSTs.

Hawkins et al. (2004) also attempted to strengthen the therapist feedback condition by providing clients with ongoing feedback about their progress. Using the OQ-45 to measure progress and outcomes, this study evaluated the impact of providing client progress information throughout the course of treatment to therapists only and to both therapists and clients simultaneously. Utilizing an outpatient sample ($N=201$) at a hospital-based psychotherapy clinic, participants were randomly assigned to 1 of 3 treatment groups: treatment as usual, therapist only feedback, and patient-therapist feedback. Without an increase in number of sessions attended, clients in the two feedback conditions demonstrated significantly better outcomes on average than those in the
therapist only feedback or no-feedback (control) conditions. Thus, providing feedback to clients and therapists may facilitate enhanced outcomes for clients at risk for poor outcomes as well as those on track for positive outcomes.

Lambert et al. (2005) evaluated the results of four large-scale studies about the impact of providing therapists (and sometimes clients) feedback on client progress (Hawkins et al., 2004; Lambert et al., 2001a, 2002a; Whipple et al., 2003). All four studies used the OQ-45 and data were collected for about a year in each of the studies. Three of the studies used participants from the same clinic and were essentially the same. The sample used in the fourth study was treated in a hospital outpatient clinic, was older, and more disturbed. Samples of the four studies were not separated into diagnostic categories. In addition, the therapists used a variety of theoretically guided orientations and were at various levels of training. Each therapist saw a mix of experimental and treatment as usual (no-feedback) clients. Random assignment to the feedback treatment condition was used in all but one of the studies. The length of therapy was not determined by a set research design and sample characteristics such as gender and ethnicity were generally similar across all studies.

Harmon et al. (2007) further examined progress monitoring by combining client/therapist feedback with CST feedback interventions. The treatment sample consisted of 1,374 adult clients seeking services at a large university counseling center. Using a quasi-experimental design, clients were randomly assigned to one of two OQ-45 feedback conditions (therapist only feedback and client/therapist feedback). These two groups were compared to a no-feedback/archival control benchmark. After entering treatment, clients were further divided into on-track or not-on-track for a good outcome
based on OQ-45 results. Clients in the not-on-track conditions of both feedback groups were then randomly assigned to one of two conditions, namely, CST feedback and no CST feedback. Harmon et al. (2007) found statistically significant differences between the feedback and no feedback conditions. For example, deterioration rates decreased from a base rate of 21.3% in the not-on-track archival controls to 17.9% in the feedback only groups and 7.4% for the progress feedback plus CST feedback groups. However, unlike the Hawkins et al. (2004) study, no statistically significant differences were found between therapist only and therapist/client feedback conditions. Harmon et al. (2007) proffered one possible explanation by pointing out that clients in Hawkins et al. (2004) were on average more disturbed than clients in the current study based on intake OQ-45 scores for groups in both studies.

Slade, Lambert, Harmon, Smart, and Bailey (2008) examined the impact upon client outcomes of feedback timing, feedback type, and feedback to clients. The timing variable involved week delayed and immediate electronic feedback and the feedback type variable involved progress feedback and Clinical Support Tool (CST) feedback. In addition, this study sought to replicate previous findings that providing clients with feedback enhances outcomes for clients at risk for poor therapeutic outcome. Using a quasi-experimental design with benchmarking, 1,101 clients seeking mental health services at a large university counseling center were randomly assigned to one of two experimental groups: therapist OQ-45 feedback and client-therapist OQ-45 feedback. Clients in the two experimental groups not on track for positive therapeutic outcomes were further randomly assigned to one of two groups: week delayed CST feedback and no CST feedback. Participant outcomes across experimental groups were then compared
with two archival groups: a week-delayed progress feedback (therapist only and client–therapist) and a 2-week delayed CST feedback group \((n=1374)\) and a no feedback control group \((n=1445)\).

Furthermore, CST feedback was delayed by 2 weeks in the archival group and by one week in the experimental group. Slade et al. (2008) found that progress feedback to therapists significantly improved outcomes, and especially in the case of clients at risk for poor outcomes. However, additional direct feedback to clients did not improve outcomes beyond therapist-only feedback. Although there were no significant differences in outcome between 1-week delayed and 2-week delayed CST feedback provision, clients in the 1-week delayed CST feedback condition attended three fewer sessions on average than did clients in the 2-week delayed CST feedback condition. Overall, Slade et al. interpreted the results as supporting the efficacy of monitoring client progress and providing feedback to clinicians and problem solving methods (CSTs) in cases involving clients at risk for treatment failure.

Lambert and Shimokawa (2011) performed a meta-analysis of two patient feedback systems (e.g. the PCOMS and the OQ System). This meta-analysis included three studies that used the PCOMS (Anker et al., 2009; Reese, Norsworthy, & Rowlands, 2009) and six studies using the OQ-45 (Harmon et al., 2007; Hawkins et al., 2004; Lambert et al., 2001b, 2002b; Slade et al., 2008; Whipple et al., 2003). Results from the three PCOMS studies collectively demonstrated that clients in the feedback condition experienced more improvement than 68% of participants in the treatment-as-usual (no feedback) group. In other words, participants in the feedback group were 3.5 times more
likely to experience reliable improvement and half as likely to experience reliable worsening.

With regard to the OQ system, Lambert and Shimokawa (2011) reanalyzed the combined data set \(N=6,151\) from six OQ feedback studies in terms of three main comparisons (e.g. no feedback, OQ-45 feedback, and OQ-45 plus CST feedback). This reanalyzed data yielded posttreatment OQ-45 mean scores for feedback only, patient/therapist feedback, and CST feedback were -0.28, -0.36, and -0.44, respectively. Collectively, Lambert and Shimokawa (2011) concluded that client deterioration rates can be cut in half by use of the two feedback systems.

**Group Counseling**

One proven method for providing rehabilitation and psychotherapeutic services to individuals with a variety of disabling conditions is the use of groups (Bogart et al., 2007; Burlingame, MacKenzie, & Strauss, 2004; Forman et al., 2006; Lamb et al., 2010; White, Beecham, & Kirkwood, 2008). Research has shown that group psychotherapy is beneficial in the cognitive, behavioral management, and psychosocial outcomes of individuals with a variety of physical, mental health, and disabling conditions (Burlingame et al., 2004; Ownsworth, Fleming, Shum, Kuipers, & Strong, 2008; Ownsworth, McFarland, & Young, 2000; Whitehouse, 1994).

The effectiveness of group interventions may in part be attributed to therapeutic factors such as universality, interpersonal learning, and existential issues (Delmonico, Hanley-Peterson, & Englander, 1998; Yalom, 1995). For example, group participants may have similar functional, cognitive, and psychosocial limitations. Methods of coping
may also be similar. These similarities have a strong influence on group cohesiveness and level of member support (Forssmann-Falck, Christian, & O’Shanick, 1989; Yalom, 1995). More specifically, group therapy is an important forum for acceptance, sharing information, learning and modeling appropriate behavior, learning by observing, developing problem-solving strategies (Dikengil, King, & Monda, 1992; Rivera & Darke, 2012; Yalom, 1995), increasing self-awareness of deficits and ways of accommodating impairments (Klonoff, 1997). Interacting with others who are at different levels of response to disability has been found to assist group members in developing a hopeful outlook (Delmonico et al., 1998).

In connection with therapeutic factors, group work is a natural forum for vicarious learning. For example, group members in one outpatient treatment program, when speaking about the challenges of receiving difficult feedback, often comment on how helpful it is to “…hear other participants receive similar feedback” and how much easier it is “to be open to challenge…when a therapist talks with another group member about a similar challenge” (Rivera & Darke, 2012, p. 514). Indeed, Kaul and Bednar (1994) asserted that receiving feedback from other group members is an important therapeutic component. Interpersonal feedback has likewise been examined in the group therapy literature as an important part of treatment (Davies, Burlingame, Johnson, Gleave, & Barlow, 2008). Similarly, by witnessing the success of group members facing adversity, participants may feel hope or be reminded of personal strengths when helping members who are struggling (Sherman et al., 2004).

In addition to promising research on the overall benefits of group regardless of disability, Colom and colleagues (2003) found that psychoeducation groups resulted in
reduced recurrences and hospitalizations for individuals with bipolar disorder, with gains maintained at 5-year follow up (Colom et al., 2009). Similarly, Simon et al. (2005), evaluated a multicomponent program that included a two-phase psychoeducation group consisting of 212 participants in the treatment condition and 229 in the control condition. The first phase of the group involved five sessions of disease management, followed by a second phase of biweekly maintenance sessions. For more than half who completed both phases, outcomes included fewer manic episodes, less intense symptoms, and more frequent attendance of medication management appointments. These gains were maintained at the 2-year follow-up (Simon, Ludman, Bauer, Unutzer, & Operskalski, 2006). In addition, outpatient dialectical behavior group therapy (DBT) for individuals diagnosed with personality disorders has garnered empirical support. For example, Soler et al. (2009) found a DBT group for individuals with personality disorders to have a positive impact upon retention, managing psychiatric symptoms, and emotional regulation.

Stepakoff et al. (2006) undertook a large uncontrolled study with 4,000 refugees who had experienced trauma. Group leaders were native paraprofessionals trained by trauma professionals. Follow-up outcomes at 1, 3, 6, and 12 months after intake included decreased PTSD symptoms, positive social support, and increased daily functioning. Likewise, Lau and Kristensen (2007) demonstrated positive outcomes for female survivors of sexual abuse participating in one of two groups (e.g. 12-month analytic group or a 5-month solution-focused with psychoeducation group) and found better outcomes for global and social functioning, distress, and quality of life in the briefer, more structured groups.
In addition to producing positive outcomes for mental health issues, group counseling has proven effective in the treatment of pain. For example, cognitive behaviorally based group therapy (CBGT) has demonstrated significant outcomes for reducing pain, managing psychological symptoms, and increasing quality of life in the treatment of participants with irritable bowel syndrome. Similarly, CBGT has proven efficacious in the treatment of chronic pain symptoms and specific pain issues (Bogart et al., 2007; Lamb et al., 2010; White et al., 2008). For example, Lamb et al. (2010) and White et al. (2008) examined the impact of group therapy and found positive outcomes with regard to pain intensity, functional limitations, depression and anxiety of participants with various pain conditions (e.g. low back pain, Lamb et al., 2010; myofascial pain, Bogart et al., 2007).

Group based programs for individuals with other types of chronic conditions have likewise led to greater adherence to treatment protocols. For example, Homer, Nightingale, and Jobanputra (2009) conducted a pilot study and randomly assigned individuals with rheumatoid arthritis or psoriatic arthritis to one of two conditions (group counseling or individual information provision). Participants in the individual information condition missed more monitoring appointments and drug continuation and adherence rates were higher for those in the group counseling condition.

Similarly, in a literature review of group intervention outcomes in the treatment of cancer and HIV disease, Sherman et al. (2004) cited strong support for the use of cognitive-behavioral groups in diminishing sexual risk behaviors among healthy individuals at heightened risk for HIV. On the other hand, individuals in the early stages of cancer or HIV related disease, Sherman et al. (2004) noted that the evidence is
strongest toward the use of “brief, skills-oriented groups for enhancing adjustment.” Overall, these authors conclude that more structured, manualized interventions yield better outcomes for healthy individuals at heightened risk (p. 60).

Conversely, Sherman et al. (2004) concluded that outcomes for individuals with advanced cancer point toward longer-term, existentially oriented, less directive interventions (e.g. supportive-expressive therapy). However, these authors pointed out that patients with advanced cancer have, at least in the short term, benefited from brief, highly structured interventions. However, the evidence is not as strong for these short-term interventions compared with the longer-term, more structured approaches. In sum, these authors concluded that there is considerable evidence to support the use of group interventions in reducing “adverse health behaviors and beliefs among healthy individuals at heightened risk.” In addition, group interventions offer “meaningful benefits” for individuals in the more advanced stages of the disease process (p. 65).

Levels of Group Feedback

In the context of group counseling, feedback interventions are applicable at the following three levels: (a) individual group members, (b) the group leader, and (c) the group-as-a-whole (Kivlighan, 1985). Indeed, feedback interventions targeting the above levels have demonstrated positive group outcomes (Davies et al., 2008). For the purpose of the present study, the remaining sections of this review will focus on feedback interventions at the level of the individual group members and the group leader.

Progress Monitoring and Group Counseling

Newnham et al. (2010b) developed and evaluated a monitoring feedback system
for use in an acute psychiatric setting. The progress monitoring measure used in this study was the World Health Organization’s Wellbeing Index (WHO-5; Bech, Gudex, & Johansen, 1996), a five-item self-report measure previously found to have good reliability and sensitivity in psychiatric settings (Newnham, Hooke, & Page, 2010a). Three outcome measures were used that include the following: Mental Health subscales of the Medical Outcomes Questionnaire Short Form (SF-36; Ware, Snow, Kosinski, & Gandek, 1993); the Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995), and the Nation Outcome Scale (HoNOS; Wing et al., 1998).

Utilizing a historical cohort design, Newnham et al. (2010a) evaluated the efficacy of providing feedback to 1,308 consecutive psychiatric inpatient (60%) and day treatment (40%) participants diagnosed primarily with mood (67.7%) and anxiety (25.9%) disorders, who completed a 10-day CBT group. Consecutive participants were divided into three cohorts. The first cohort (n=461) received treatment-as-usual (no feedback). The second cohort (n=439) completed monitoring measures but did not receive feedback. On the other hand, half way through treatment, third cohort (n=408) participants and their clinicians received patient progress feedback. While participating in the 10-day CBT group, participants routinely completed the WHO-5 (Bech et al., 1996). Newnham et al. (2010a) found feedback effective in reducing depressive symptoms for participants at risk for poor outcomes. Conversely, feedback was not effective in improving wellbeing. The authors posited that improvement in wellbeing may require a longer treatment length and concluded that feedback could be beneficial for improving symptom outcomes.
Using a naturalistic historical design with data from the previous study (e.g. Newnham et al., 2010b), Byrne et al. (2012) evaluated the risk of readmission to a psychiatric hospital of participants in the no feedback and feedback cohorts six months following the completion of a 10-day CBT group intervention. A significant association between feedback to clients and fewer readmissions (n=473) was found for those clients making expected progress during the CBT group counseling program. For example, 90% of the on track patients who received feedback during the CBT group intervention were not readmitted over 6 months. On the other hand, on-track patients who had not received feedback during the CBT group intervention had a readmission rate of 82% post CBT group intervention. The difference in these readmission rates were statistically significant (p<0.05). The authors conclude that feedback could result in lowered risk for psychiatric hospital readmissions for those patients considered on-track during treatment.

Summary and Current Study

This chapter defined feedback and explored how feedback characteristics of the sender, the receiver, the message, and the setting may influence the effectiveness of a feedback intervention. Theories about the specific mechanisms of behavioral change were discussed, as were current trends in patient-focused research. Finally, this chapter explored the value of group counseling interventions and provided empirical support for the provision of feedback in a group counseling context. To this end, the goal of the current study is to investigate the use of group counseling with feedback to counselors and clients about the progress of clients in a state vocational rehabilitation agency.
CHAPTER III

METHODS

This study evaluated the impact of group counseling with formal weekly feedback about the progress of clients receiving services at a state vocational rehabilitation agency. The Outcome Questionnaire-45 (OQ-45, Lambert et al., 2013) was used to examine the following areas of interest: level of symptom distress or SD (e.g. depression and anxiety); problems with interpersonal relationships or IR (e.g. conflict with others, family difficulties, loneliness); social role performance or SR (e.g. problems at paid employment, school, or volunteer work) and mental health functioning (OQ-45 total score). Overall, it was expected that the subscale and total scores of participants in the group counseling plus feedback (G+Fb) treatment condition would reflect significantly better outcomes in the areas stated above than participants in the group counseling with no feedback (GnoFb) treatment-as-usual condition.

Primary Research Questions

RQ1 Will the OQ-45 symptom distress (SD) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

RQ2 Will the OQ-45 interpersonal relationship (IR) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?
RQ3 Will the OQ-45 social role performance scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

RQ4 Will the OQ-45 scores on Mental Health Functioning of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

Secondary Research Questions

If the intervention proves successful, the potential impact of subgroup demographic and level of pretreatment differences upon intervention outcomes will be examined. Thus, the secondary research questions will be as follows:

RQ5 Which demographic subgroups (age, gender, ethnicity, disability category, mental health functioning, work status, socioeconomic status, receiving SSA benefits, subsistence benefits) does this intervention benefit the most?

RQ6 What impact do various levels of pretest performance (functioning in normal range, making expected progress, some chance of negative outcome, high chance of negative outcome) have upon intervention outcomes?

RQ7 What impact does various levels of pretest OQ-45 subscale scores (symptom distress, problems with interpersonal relationships, social role performance) have upon intervention outcomes?

RQ8 What impact do various levels of pretest OQ-45 total scores (mental health functioning) have upon intervention outcomes?

RQ9: Will the employment status of participants in the treatment-as-usual (GnoFb) and the treatment (G+Fb) conditions change differently over time?
Hypotheses

Primary Null Hypotheses

HO1: There will be no difference between participants in the treatment condition (G+Fb) and participants in the treatment-as-usual condition (GnoFb) in symptom distress.

HO2: There will be no difference between participants in the treatment condition (G+Fb) and participants in the treatment-as-usual condition (GnoFb) in problems with interpersonal relationships.

HO3: There will be no difference between participants in the treatment condition (G+Fb) and participants in the treatment-as-usual condition (GnoFb) in problems with social role performance.

HO4: There will be no difference between the participants in G+Fb condition and participants in the GnoFb condition on scores of Mental Health Functioning.

Primary Alternate Hypotheses

H1: Participants in the treatment condition (G+Fb) will experience a significant decrease in symptom distress as compared to participants in the treatment-as-usual condition (GnoFb).

H2: Participants in the treatment condition (G+Fb) will experience a significant decrease in problems with interpersonal relationships as compared to participants in the treatment-as-usual condition (GnoFb).
H3: Participants in the treatment condition (G+Fb) will experience a significant decrease in problems with social role performance as compared to participants in the treatment-as-usual condition (GnoFb).

H4: Participants in the treatment condition (G+Fb) will experience a significant increase in mental health functioning as evidenced by lower total OQ-45 scores (lower total scores indicate higher mental health functioning) as compared to participants in the treatment-as-usual group (GnoFb).

Secondary Null Hypotheses

If the intervention proves successful, the secondary null hypotheses are as follows:

HO5: There will be no difference between demographic subgroups (age, gender, ethnicity, disability category, mental health functioning, work status, socioeconomic status, receiving SSA benefits, subsistence benefits) in terms of intervention benefit.

HO6: There will be no difference between levels of pretest OQ-45 trajectories (functioning in normal range, making expected progress, some chance of negative outcome, high chance of negative outcome) and impact upon study outcomes.

HO7: There will be no difference between levels of pretest OQ-45 subscale scores (symptom distress, problems with interpersonal relationships, social role performance) and impact upon study outcomes.

HO8: There will be no difference between levels of pretest OQ-45 total scores (mental health functioning) and impact upon study outcomes.
H09: There will be no difference in the employment status of participants in the treatment-as-usual (GnoFb) and treatment conditions (G+Fb) over time.

Secondary Alternate Hypotheses

If the intervention proves successful, the secondary alternate hypotheses are as follows:

H5: Some demographic subgroups (age, gender, ethnicity, disability category, mental health functioning, work status, socioeconomic status, receiving SSA benefits, subsistence benefits) will benefit from the intervention more than others.

H6: Some levels of pretest OQ-45 trajectories (functioning in normal range, making expected progress, some chance of negative outcome, high chance of negative outcome) will have a greater impact upon study outcomes than others.

H7: Some levels of pretest OQ-45 subscale scores (symptom distress, problems with interpersonal relationships, social role performance) will have a greater impact upon study outcomes than others.

H8: Some levels of pretest OQ-45 total scores (mental health functioning) will have a greater impact upon study outcomes than others.

H9: The employment status of participants in the treatment-as-usual (GnoFb) and treatment conditions (G+Fb) will change differently over time such that participants in the treatment condition will become employed during the group counseling program at a statistically significant rate when compared to participants in the treatment-as-usual condition.
Participants

Participants were recruited from five state vocational rehabilitation offices in a state in the intermountain region of the United States. Rehabilitation counselors invited potential participants in person or via written letter to participate in this study. Inclusion criteria included participants who were: at least 18 years of age; receiving vocational rehabilitation services; and able to read, write, comprehend and speak English sufficiently to complete self-report questionnaires and communicate without difficulty. Additional criteria included participants who agreed to complete a paper-pencil self-report questionnaire on a weekly basis, were able to interact with others appropriately; able to attend 80% of the group intervention meetings; had the cognitive capacity to benefit from a cognitive-behavioral approach; and were mentally stable and able to benefit from peer feedback. Participants who had serious emotional dysregulation issues (e.g. angry outbursts, verbal, physical aggression) were excluded from this study.

Because the rehabilitation counselors initially screened and invited potential participants, there was a potential risk of coercion. Whether potential participants were invited in person or by mail, a one page information sheet was provided to potential participants (prior to informed consent) explaining the major points of the study. To minimize the risk of coercion, this one-page information sheet made clear that participation did not in any effect on receiving VR services now or in the future. In addition, the counselor and the written information informed potential participants that the counselor was not part of the research team and that it made no difference to the counselor if the client participated in this study.
Interested clients who met the above criteria were then administered the Group Readiness Questionnaire to assess readiness to participate in group. If a participant’s score did not indicate a readiness to participate in group, then the counselor was alerted, and educated on how to prepare the client for group. Please refer to Table 1 for participant pretreatment demographic information. For information regarding the benefits that participants were receiving prior to intervention, please refer to Table 2.

Counselors

Ten masters-prepared rehabilitation counselors acted as group facilitators in the present study. Facilitators were vocational rehabilitation counselors employed fulltime with a vocational rehabilitation state agency in the Intermountain Region of the United States.

Training Counselors

Prior to commencement of this study, counselors participated in a 15-week skills-based group counseling training from July to November of 2013. This training included discussion on the importance and impact of group development, process, and dynamics and interventions appropriate at each group development stage. Also, this training assisted counselors in developing basic and advanced group counseling skills. In addition, this training provided the tools necessary to select group members and to begin, maintain, and conclude a variety of therapy groups (e.g. support, psychoeducation, and counseling). Similarly, during several weeks of the training counselors separating into smaller groups to generate a tentative curriculum outline for the ensuing 10 week group counseling program used in the present study.
This training course was conducted by the author of this study, a doctoral candidate with advanced group counseling training, experience teaching masters level group counseling courses, and several years’ experience conducting group interventions with appropriate supervision. Please refer to Appendix A for a copy of the training syllabus.

In addition to the 15-week training, counselors participated in a 1.5-hour training that introduced the OQ-45 domains, procedures for the current study, and how to utilize the progress monitoring clinician feedback reports.

This training was important. Although vocational rehabilitation (VR) counselors typically refer consumers to counselors and psychologists outside the VR agency for group counseling, having VR counselors’ conduct counseling groups within a VR state agency has not occurred to any great extent, if at all. As such, this training represents a first step in establishing group counseling as a viable VR state agency intervention.

Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment (n=15)</th>
<th>Treatment-as-usual (n=15)</th>
<th>x² or t</th>
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<tr>
<td>Age (years)</td>
<td>39.13(SD=12.82)</td>
<td>41.67(SD=14.55)</td>
<td>t(28)=-5.08; p=.617</td>
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<td>Gender</td>
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<tr>
<td>M: (n=7); F:(n=8)</td>
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<td></td>
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<td>86.7 n= 13</td>
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<td>6.7 n= 1</td>
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<td>Hispanic or Latino</td>
<td>6.7 n= 1</td>
<td>6.7 n= 1</td>
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<td>Productive Activity Status:</td>
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<td></td>
<td>x²(1) =.24, p=.63</td>
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<td>Employed (part or full time)</td>
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<td>13.3 n= 2</td>
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<td>Volunteer</td>
<td>26.7 n= 4</td>
<td>26.7 n= 4</td>
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<td>Training/School</td>
<td>26.7 n= 4</td>
<td>20 n= 3</td>
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<tr>
<td>Disability Category:</td>
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<td>60 n= 9</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>6.7 n= 1</td>
<td>13.3 n= 2</td>
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Cognitive  6.7  1  0  0  
Psychiatric-Physical  20  3  20  3  
Psychiatric-Cognitive  26.7  4  6.7  1  

Number of Diagnoses:  $x^2(3)=3.43, p=.33$

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<td>3</td>
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</tbody>
</table>

Diagnoses Type:  $x^2(1)=1.03, p=.31$

<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>Count</th>
<th>Frequency</th>
<th>Count</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>46.7</td>
<td>7</td>
<td>53.3</td>
<td>8</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>60</td>
<td>9</td>
<td>53.3</td>
<td>8</td>
</tr>
<tr>
<td>Attention Deficit</td>
<td>20</td>
<td>3</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>20</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Related</td>
<td>13.3</td>
<td>2</td>
<td>13.3</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health Other</td>
<td>13.3</td>
<td>2</td>
<td>26.7</td>
<td>4</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>26.7</td>
<td>4</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Medical Other</td>
<td>26.7</td>
<td>4</td>
<td>20</td>
<td>3</td>
</tr>
</tbody>
</table>

Living Arrangement:  $x^2(7)=3.2, p=.87$

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Count</th>
<th>Frequency</th>
<th>Count</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents with or without siblings</td>
<td>60</td>
<td>9</td>
<td>60</td>
<td>9</td>
</tr>
<tr>
<td>Spouse/Significant other</td>
<td>6.7</td>
<td>1</td>
<td>6.7</td>
<td>1</td>
</tr>
<tr>
<td>Spouse and dependent children</td>
<td>13.3</td>
<td>2</td>
<td>6.7</td>
<td>1</td>
</tr>
<tr>
<td>Roommates</td>
<td>13.3</td>
<td>2</td>
<td>13.3</td>
<td>2</td>
</tr>
<tr>
<td>Live by self</td>
<td>6.7</td>
<td>1</td>
<td>13.3</td>
<td>2</td>
</tr>
</tbody>
</table>

Perceived Economic Status:  $x^2(3)=3.96p=.26$

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Count</th>
<th>Frequency</th>
<th>Count</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Lower</td>
<td>60</td>
<td>9</td>
<td>33.3</td>
<td>5</td>
</tr>
<tr>
<td>Lower-Middle</td>
<td>6.7</td>
<td>1</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Middle</td>
<td>26.7</td>
<td>4</td>
<td>46.7</td>
<td>7</td>
</tr>
<tr>
<td>Upper-Middle</td>
<td>6.7</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Development of the Group Counseling Manual**

During the facilitator training, facilitators met each week to generate possible group session outlines and topics of importance. At the end of the facilitator training, facilitators presented the author of this study with a list of 10 session outlines and possible session handouts. Based on these outlines and handouts, the author of this study designed a manualized curriculum for use during the group counseling program. Please refer to Appendix B for a copy of the manual.
Table 2

*Frequency of Benefits by Condition Pretreatment*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment (n=15)</th>
<th>Treatment-as-usual (n=15)</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Public Benefits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>7</td>
<td>6</td>
<td>$\chi^2(1) = .68, p = .41$</td>
</tr>
<tr>
<td>One</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Four</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Benefits by Type:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Benefits</td>
<td>3</td>
<td>5</td>
<td>$\chi^2(1) = .68, p = .34$</td>
</tr>
<tr>
<td>Medicaid/Medicare</td>
<td>2</td>
<td>4</td>
<td>$\chi^2(1) = .83, p = .36$</td>
</tr>
<tr>
<td>Subsidized Housing</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Food Stamps</td>
<td>4</td>
<td>6</td>
<td>$\chi^2(1) = .60, p = .44$</td>
</tr>
<tr>
<td>Utility Bill Assistance</td>
<td>1</td>
<td>2</td>
<td>$\chi^2(1) = .37, p = .54$</td>
</tr>
</tbody>
</table>

**Group Procedures**

Five manualized, skills-based groups were conducted by a facilitator and co-facilitator one time weekly, 1.5 hours per session, for a total of 10 sessions. Each group consisted of four to eight participants. Each facilitator and co-facilitator were employed at the same office where each group was conducted.

**Session Structure and Content**

The format of each group session consisted of three phases, namely: warm-up, working, and processing. During the warm-up phase, participants participated in an activity designed to introduce the topic and get participants talking and interacting with one another. During the working phase, a specific topic was explored using handouts, exercises, and group discussion. Finally, during the closing or processing phase, facilitators asked participants open ended questions to facilitate participant processing of
the material presented during the working phase. Please refer to Table 3 below for further information about each group session.

Table 3

<table>
<thead>
<tr>
<th>Session #</th>
<th>Topic</th>
<th>Overview of Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introducing the Program</td>
<td>This session oriented participants to the 10 week program, structure of the group, group ground rules, confidentiality expectations and limits, and program goals. In addition, participants introduced one another and reflected on three things that they wished to gain from participating in group.</td>
</tr>
<tr>
<td>2</td>
<td>Giving and Receiving Feedback</td>
<td>This session emphasized giving and receiving feedback. Steps for becoming a better feedback receiver and steps for giving effective feedback were discussed. Participants divided into smaller groups and developed workplace scenarios and written scripts to incorporate feedback skills.</td>
</tr>
<tr>
<td>3</td>
<td>Active Listening</td>
<td>This session focused on the art of listening and asking questions. Participants worked in smaller groups to explore the micro skills associated with active listening (e.g. attending, encouraging, paraphrasing, reflecting, summarizing, and clarifying). Participants examined the guidelines for asking effective questions and applied these skills to workplace situations.</td>
</tr>
<tr>
<td>4</td>
<td>Expressing and Responding to Feelings</td>
<td>This session focused on the skill of expressing feelings and responding to the feelings of others. Participants explored ways of applying these skills to workplace situations.</td>
</tr>
<tr>
<td>5</td>
<td>Having Difficult Conversations</td>
<td>This session introduced the steps and guidelines for effectively communicating when difficulty arises. Participants evaluated and discussed a workplace scenario to incorporate the steps and suggestions outlined above.</td>
</tr>
<tr>
<td>6</td>
<td>Creating Cooperation and Win-Win Solutions</td>
<td>This session introduced the underlying issues associated with conflict and ways of effectively resolving differences. The five steps to negotiating win/win solutions were explored. Ways in which these skills can be applied in obtaining and maintaining employment were discussed.</td>
</tr>
</tbody>
</table>
7 Managing Time Effectively

First, this session explored common barriers to effective time management. Next this session provided concrete suggestions and steps for improving time management skills. Tips for streamlining common tasks were explored. Finally, ways to utilize these time management skills in obtaining and maintaining employment were discussed.

8 Assessing Strengths and Abilities

This session focused on abilities and strengths. First, each participant was asked to rate his/her skills and abilities. Next, participants worked in pairs to explore communicating these abilities and strengths to employers.

9 Managing Disability and Overcoming Obstacles

This session emphasized utilizing strengths to work around or accommodate limitations. Problem solving obstacles and evaluating the need for an accommodation were explored.

10 Reviewing Program and Planning for Success

During this session participants reviewed the group experience and acknowledged member to member growth. Members designed a plan for continued growth.

Measure of Progress and Outcome

The Outcome Questionnaire is used to measure client progress (OQ-45; Lambert et al., 2013). The OQ-45, a self-report instrument, was designed to track client progress before each session throughout the course of treatment and upon termination. It consists of 45 items utilizing a 5-point scale (0=never, 1=rarely, 2=sometimes, 3=frequently, 4=almost always). The OQ assesses three dimensions of functioning in the areas of: (a) symptom distress (SD) (e.g. mainly anxiety and depression), (b) problems with interpersonal relationships (IR) (e.g. loneliness, conflict with others, family difficulties), and (c) social role performance (SR) (e.g. problems with paid employment, school, or volunteer work). In addition to the SD, IR, and SR subscale scores, the OQ-45 yields a total score that reflects mental health functioning. Possible subscale score ranges are as
follows: SD: 0-100; IR: 0-44; and SR: 0-36. Possible total scores range from 0-180. Higher scores indicate greater distress and/or frequency of symptoms and problems.

This instrument has empirically demonstrated strong construct validity. For example, Beckstead et al. (2003) compared the OQ-45 to four other instruments (Symptom Checklist-90-Revised, Social Adjustment Rating Scale-Self Report/and other Report, Inventory of Interpersonal Problems-Short Form, Quality of Life Inventory). Three of the four measures agreed with the OQ-45’s criteria for functional/dysfunctional 85% of the time at pretreatment. At posttreatment, agreement between the OQ-45 and the other instruments was 82%. In addition, at least three measures coincided with the OQ-45 criteria for clinically meaningful change.

The OQ-45 has an internal consistency of 0.93, a 3-week test-retest reliability of .84 (Lambert et al., 2013), and a concurrent validity of positive correlations with the Symptom Checklist 90-Revised ($r = .78$), Beck Depression Inventory ($r = .80$), State-Trait Anxiety Inventory ($r$ State Anxiety $= .64$, $r$ Trait Anxiety $= .80$), Inventory of Interpersonal Problems ($r = .53$) and Social Adjustment Scale ($r = .65$). Norms for the OQ-45 were developed utilizing data collected nationally (Lambert et al., 2013; Umphress, Lambert, Smart, Barlow, & Clouse, 1997).

In addition to research on the validity and reliability of the OQ-45, Lambert et al. (1996) analyzed clinical and normative data and obtained cutoff scores for clinical significance and reliable change following the recommendations of Jacobson and Truax (1991). Lambert et al. (1996) determined 14 points to be the amount by which a client’s total score must increase or decrease in order to show reliable change. Thus, clients whose scores drop at least 14 points are considered “improved” whereas those whose
scores increase by at least 14 points are considered “deteriorated.” Likewise, Lambert et al. (1996) determined a score of 64 as the cutoff for clinically significant change (e.g. the score at which the client is considered “recovered” or to have progressed from dysfunctional to functional). Therefore, scores of 64 and above are in the dysfunctional range whereas scores of 63 and below reflect functional status.

Vermeersch, Lambert, and Burlingame (2000) evaluated the sensitivity to change of each item, each subscale score, and total score of the OQ-45. Using patient data from multiple treatment settings, Vermeersch et al. contrasted changes over time of patients with treatment and those without treatment and found the total score and each subscale to be significantly sensitive to change over time (Total score $t=4.78, df=39$; Subscale scores $SD t=4.26, df=39$; IR $t=3.30, df=39$; SR $t=4.30, df=39$; $P < .001$).

Although the OQ-45 has primarily been used as an individual therapy measure, it has more recently been used to measure progress and outcomes associated with group therapy interventions (Chapman et al., 2010; Davies et al., 2008; Gillaspy, Wright, Campbell, Stokes, & Adinoff, 2002; LoCoco, Gullo, & Kivlighan, 2012). Please refer to Appendix C for a list of OQ-45 questions. A license was purchased for use of this instrument in this study. Please refer to Appendix G for a copy of the invoice.

**Outcome Questionnaire-45 Feedback**

The feedback procedures in the present study are based on procedures used in previous studies (Hawkins et al., 2004; Lambert et al., 2001b, 2002b, 2005).

Feedback delivery. Feedback in the current study was delivered in the feedback condition to participants via a secure, encrypted e-mail service or by US postal mail. The
researcher e-mailed clinician feedback reports to group counselors via a secure, encrypted e-mail system.

Therapist feedback. Feedback to counselors includes a progress graph showing the client’s progress to date, a brief written message based on the client’s progress, and a visual color alert (white, green, yellow, red) corresponding to the client’s current functioning/progress. A white alert indicates that the client is functioning in the normal range, whereas a green alert means that the client is making the expected progress. Conversely, a yellow alert indicates some chance of negative outcome, and a red alert indicates a high chance of negative outcome. The brief messages associated with corresponding colors are as follows:

White: “The patient is functioning in the normal range. Consider termination.”

Green: “The rate of change that the patient is making is in the adequate range. No change in the treatment plan is recommended.”

Yellow: “The rate of change the patient is making is less than adequate. Recommendations: consider altering the treatment plan by intensifying treatment, shifting intervention strategies, and monitoring progress especially carefully. This patient may end up with significant benefit from therapy.”

Red: “The patient is not making the expected level of progress. Chances are he/she may drop out of treatment prematurely or have a negative treatment outcome. Steps should be taken to carefully review this case and decide upon a new course of action such as referral for medication or intensification of treatment. The treatment plan should be reconsidered. Consideration should also be given to presenting this patient at a case conference. The patient’s readiness for change may need to be re-assessed.”
In addition to the graph, written message, and color alert indicator, feedback to the counselor includes the client’s most recent responses on critical OQ-45 items, a one-word descriptor indicating the significance of changes in the client’s total score over the course of treatment, current level of distress, and a comparison of client subscale scores to score norms. To this end, the critical items referenced above include thoughts of suicide, alcohol use habits, the criticism of others about one’s alcohol use, the impact of alcohol/drug use upon school/work functioning, and the ability to manage anger at work/school without resorting to violence. Similarly, therapist feedback includes a one-word descriptor regarding the significance of client score changes (e.g. recovery, reliably improved, no reliable change, or reliably worse/deteriorated). Finally, the client’s current distress level indicates as low, moderate, moderately high, or high.

Client feedback. Client feedback procedures followed in the present study are consistent with client feedback procedures used in previous studies (Hawkins et al., 2004; Lambert et al., 2005). Feedback to clients is similar to that of counselor feedback. For example, client feedback reports include a graph of progress to date. However, unlike the written messages provided to counselors, clients receive a written narrative that includes a mix of positive and negative feedback, with particular care taken to avoid any messages that could be perceived as detrimental to client motivation or self-esteem. A progress report was sent on a weekly basis to clients in the feedback condition.

Assessment of Signal Clients (ASC) Questionnaire

The ASC (Lambert et al., 2007) was developed as a clinical support tool within the OQ Analyst software. This 40-item self-report measure is used to identify obstacles to positive therapeutic outcomes. The ASC measures the following four constructs:
problems with therapeutic alliance, motivation toward treatment, social supports, and stressful life events. A five-point scale from 1 to 5 (strongly disagree to strongly agree), is used to measure each construct with higher scores reflecting more positive results (e.g. stronger alliance, better social support, fewer negative life events). A score for each construct is obtained by summing the responses in each category. The ASC does not include a total score. Each subscale includes 9 or 11 items depending on the construct (e.g. therapeutic alliance and social support, 11 items each; motivation and stressful life events, 9 items each). Scores range from 11 to 55 for the therapeutic alliance and social support subscales and 9 to 45 for the motivation and stressful life events. For example, in the therapeutic alliance subscale a score at or below 42 indicates the need for the counselor to actively address alliance issues.

According to Kimball (2010), the internal consistency coefficients (Cronbach’s alpha) for each subscale is: Therapeutic Alliance (.87); Motivation toward Treatment (.81); Social Support (.88); and Life Events (.81) (as quoted in White, Lambert, Bailey, McLaughlin, & Ogles, 2014). Similarly, Probst, Lambert, Loew, Dahlbender, & Tritt (in press), translated the ASC into German and found similar Cronbach Alpha coefficients for each of the subscales (Therapeutic Alliance: .89; Motivation toward Treatment: 0.78; Social Support 0.76; and Life Events: 0.71).

Participants in the treatment-as-usual (GnoFb) and the treatment (G+FB) conditions were asked to complete the ASC via paper-pencil at the end of session two. Paper-pencil participant responses were entered into the OQ Analyst website for scoring. Paper-pencil questionnaires were kept under lock and key and only the primary investigator and group counselors will have access to participant responses.
ASC results were made available to counselors whose clients were in the feedback condition. The feedback sheet given to each participant’s group counselor provided participant responses to critical items in each of the following areas: therapeutic alliance, motivation toward treatment, social support, and life events. If client responses indicate problems, then a color code of red or yellow will be provided next to the problem area. In addition, the OQ Analyst software provided intervention suggestions. After the study concluded, all identifying participant information on paper-pencil questionnaires was destroyed. Please refer to the Appendix D for the ASC questions and Appendix E for the Clinical Support Tools Decision Tree.

Although the ASC is typically given only to clients who are at risk for poor outcomes, all participants were asked to complete the ASC at the end of session two in the current study. Given the small sample size of this study, administering the ASC to only not-on-track clients could not yield anything in the way of statistically significant results. In addition, the information provided by the ASC could assist group counselors in providing more meaningful services to group participants. A license was purchased for use of this instrument in this study. Please refer to Appendix G for a copy of the purchase invoice.

**Group Readiness Questionnaire (GRQ)**

The Group Readiness Questionnaire (Burlingame et al., 2012) was designed to briefly screen for client expectations about group counseling, perceived ability to communicate in group settings, and tendency toward difficult interactions. This screening tool consists of 19 questions using a Likert-type scale from one to five (Never, Rarely,
Sometimes, Frequently, and Almost Always). The GRQ has demonstrated good predictive, factorial, and convergent validity in a variety of settings (Burlingame, Cox, Davies, Layne, & Gleave, 2011). A license was purchased for use of this instrument in this study. For a copy of the purchase invoice, refer to Appendix G. Please refer to Appendix F for a list of GRQ questions.

**Research Design**

This study is a repeated measures randomized control trial (RCT) design with matching prior to randomization within site based on current distress level, as derived from the total OQ-45 score. Consisting of two conditions over a 10-week period (e.g. the treatment-as-usual and treatment condition), this study included five different counseling groups at five different offices. The no-feedback condition (GnoFb) acted as a control for the treatment condition (G+Fb). In this study, the treatment was the use of group counseling with counselor and client feedback provided. In the treatment-as-usual condition, participants received group counseling but did not receive feedback. In addition, the group counselors did not receive progress feedback about participants in the treatment-as-usual condition. The OQ-45 was administered on a weekly basis during the 10-week group counseling program to participants in the treatment-as-usual and treatment conditions.

Prior to intervention, it was decided that, if a participant in the treatment-as-usual condition were to specifically request feedback about progress based on his or her OQ scores during the 10-week group counseling program, then the participant would be provided with the requested information and would be removed from the treatment-as-
usual condition. However, there were no participants in the treatment-as-usual condition who requested specific feedback during the group counseling program.

Before the first group counseling session, participants in both conditions were administered the OQ-45. The average scores of the first and second administration reflect the baseline/pretreatment for each participant. The use of pretests is recommended for repeated measures studies, especially when the researcher seeks to determine the exact amount of change due to the independent variable. In this study, the independent variable is group counseling with counselor and client progress feedback provided (G+Fb). The dependent variable was measured by scores on the OQ in which lower scores indicate therapeutic success.

In addition to a treatment-as-usual condition, prior to randomization this study matched participants at each site by current distress level (as reflected by each participant’s first pretreatment OQ-45 total score) and disability type (e.g. physical, cognitive, and psychiatric). Furthermore, a bucket randomization procedure was utilized per site to select participants for one of two possible study conditions. Please refer to Figure 1 for further information about the research design.

This study is considered a pilot study, seeking to extend the large body of research which has empirically shown the OQ to be an effective tool to both measure and increase positive client outcomes. This study seeks to extend the use of the OQ and its methodology to a small sample of a population in a setting which has not yet been studied, vocational rehabilitation agency clients, all of whom have disabilities. Nonetheless, the results of the present study will provide vocational rehabilitation state agencies with information about the utility of administering the OQ-45 as well as the
Baseline: OQ-45 administered at time of enrollment.

Originally Enrolled (N=44)

Did not participate due to:
- Transportation issues (n=1)
- Found employment (n=4)
- Declined (n=1)
- Unknown (n=3)

5 counseling groups and matching within site prior to randomization. Participants assigned to one of two conditions: G+Fb or GnoFb

Group 1 (n=7)
- Feedback n=3
- Treatment-as-usual n=4

Group 2 (n=8)
- Feedback n=4
- Treatment-as-usual n=4

Group 3 (n=8)
- Feedback n=4
- Treatment-as-usual n=4

Group 4 (n=5)
- Feedback n=2
- Treatment-as-usual n=3

Group 5 (n=7)
- Feedback n=4
- Treatment-as-usual n=3

OQ-45 administered prior to each group counseling session, 10 sessions 1.5 hours weekly

Dropout rate after first session: n=4; 13.8%

Excluded: 1 outlier

Included in Analysis:
15=Feedback
15=Treatment-as-usual

Figure 1. Research study design diagram.
suitability of group counseling as a viable intervention. A power analysis was not necessary for the present study, because power analyses are typically not undertaken for pilot studies and all available clients were included (Brace, Kemp, & Snelgar, 2013).

**Data Collection**

The OQ-45 was administered on a weekly basis during the 10-week group counseling program to participants in the treatment-as-usual and treatment conditions. Prior to the first group counseling session, participants in both conditions were administered the OQ-45 as part of the informed consent and initial interview process.

The researcher monitored all participant OQ-45 responses on a weekly basis for possible suicidality and a safety risk to others. Prior to data collection, it was decided that, should a participant in the treatment-as-usual indicate that he/she was suicidal or at risk of harming others, the rehabilitation counselor would be notified and appropriate steps to assess participant/other safety, ability to contract for safety and agency protocol would be followed. There were a few participants in the treatment-as-usual who endorsed being suicidal during the group counseling study. The researcher received updates about the program and participants from the group counselors on a weekly basis and determined that the counselors of these participants were already aware of the suicidality issues and were taking appropriate steps to address participant safety.

**Study Procedures**

Prior to treatment, IRB approval was obtained. Participants were informed that the current study’s purpose was to explore the impact of providing group counseling with
feedback upon client progress in a vocational rehabilitation setting. They were informed that they would be randomly placed in one of two study conditions (e.g. either the feedback or treatment-as-usual). Participants were fully informed about the nature of the treatment-as-usual (no-feedback) condition and, in the event feedback was found to improve outcomes, participants in the treatment-as-usual condition would be offered the feedback treatment at the end of the study.

As part of the intake process, the researcher conducted a face-to-face interview with each participant and asked the following questions: (a) what is your employment goal and what do you hope to accomplish during the 10-week group counseling intervention?; (b) what economic status best describes your living situation (lower class, lower middle class, middle class, upper middle class, upper class)?; (c) what is your current work status (working part or fulltime, volunteering, training/going to school)?; (d) if receiving benefits, what types of benefits are you receiving (social security, subsidized housing, food stamps, etc.)?; and (e) other demographic information (age, gender, ethnicity).

During the interview, each participant was likewise asked if he/she had access to a computer. Participants with computer access were asked for an e-mail address. The researcher asked each participant which method (e-mail or US mail) he/she preferred for delivering the weekly progress graphs in the event that he/she was randomly selected to be in the feedback group.

Originally, 44 individuals were enrolled into this study. However, prior to the commencement of the group counseling program, 9 enrollees declined participation. Please refer to the study diagram (Figure 1) for further information. Thus, at the start of
the group counseling program, each separate group consisted of 5 to 8 members, for a total of 35 participants. Participants who attended one session and then did not return were deemed as having dropped out of the study. Participants that attended at least two group sessions were included in analysis. One participant’s scores were excluded from analysis as it was determined that this participant did not meet original inclusion criteria. Thirty participants were included in the analysis, 15 participants in each condition.

Participants were asked to arrive to group early to complete the progress and outcome questionnaires by paper-pencil. Paper-pencil questionnaire responses were then entered by the researcher within one to three days after administration into the OQ Analyst web based program. The OQ Analyst then generated a clinician feedback report and a client progress graph for each participant who completed the OQ-45 for the specified week. Feedback was given to treatment participants and their counselors prior to the next session. For those placed into the treatment group, client progress graphs were either e-mailed via a secure, encrypted web based e-mail service, or mailed via US postal service. In addition, clinician feedback reports about the progress of participants in the feedback condition were delivered via secure, encrypted e-mail to specified group counselors.

While counselors were encouraged to utilize the feedback provided to better serve client’s needs, the way in which facilitators used the feedback was not monitored as part of this study. However, counselors were asked each week via e-mail, “Over the past week, how many feedback reports did you review?” Group counselors in the current study indicated viewing clinician progress reports every week 90% to 100% of the time.
In addition to being asked how many feedback reports were viewed each week, each group counselor was asked to rate, on a 1 to 10 scale, the extent to which he/she followed the manual for the previous week’s session (1=Didn’t follow session plan at all to 10=Followed session plan completely). If the counselor did not follow the session, then what he/she did instead was asked. Finally, each counselor was asked on a weekly basis to rate the success of each session (1=Didn’t go at all well to 10=Session went really well). While counselors indicated following the manual closely, departures from the manual typically involved not splitting into smaller groups due to limited attendance. Please refer to Table 4 for information on the means and standard deviations of these ratings by counseling group.

At the end of the study, each participant in the treatment-as-usual condition was given a copy his/her client progress graphs. Although each participant in the feedback condition received his/her progress graphs on a weekly basis, additional copies were provided at the end of the study if the participant requested it. The researcher then interviewed participants by phone (n=23) and asked them to rate the acceptability and

<table>
<thead>
<tr>
<th>Counseling Group</th>
<th>Followed plan</th>
<th>How session went</th>
<th>Number of ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9.8 (.45)</td>
<td>9.88 (.25)</td>
<td>4.5</td>
</tr>
<tr>
<td>2</td>
<td>7.17 (1.27)</td>
<td>8.17 (.79)</td>
<td>9.0</td>
</tr>
<tr>
<td>3</td>
<td>7.60 (.55)</td>
<td>7.40 (.55)</td>
<td>5.0</td>
</tr>
<tr>
<td>4</td>
<td>8.88 (.75)</td>
<td>8.38 (1.09)</td>
<td>4.0</td>
</tr>
<tr>
<td>5</td>
<td>7.67 (1.21)</td>
<td>7.50 (.87)</td>
<td>5.5</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>8.03 (1.35)</td>
<td>8.19 (1.08)</td>
<td>28</td>
</tr>
</tbody>
</table>
helpfulness of the feedback graphs. Participants in the treatment-as-usual group were asked to rate how acceptable and helpful the graphs might have been if they had received them during the group counseling program. Participants in the feedback condition were asked to rate the acceptability and helpfulness of the progress graphs during the group counseling program. Participants in the feedback condition were also asked the number of graphs they viewed during the group counseling study. Participants in both conditions were asked to rate the extent of progress made toward an employment goal during the group counseling program. Finally, each participant was reminded of the group counseling goal he/she set during the first interview prior to the group counseling program. Each participant was then asked to rate the amount of progress he/she made toward his/her group counseling goal.

In addition to participants rating the progress graphs, group counselors were likewise asked to rate, on a 1 to 10 rating scale, the acceptability and helpfulness of the clinician feedback reports received each week during the group counseling program.

Data Analysis

The current study employed random assignment and matching of selected variables in order to minimize potential differences between the treatment and treatment-as-usual conditions at the inception of treatment. In addition, chi square analysis was conducted between conditions to analyze potential differences in categorical demographic variables. Pretreatment differences between groups were controlled for in analysis. Refer to Tables 1 and 2 for the results of these analyses.
The independent variables of time, condition, and office were included in a Linear Mixed Effects Model analysis for each of the dependent variables in RQ 1 through 4. A term for non-linear change over time as well as an interaction between time and condition was included. There were not enough levels for office to be included as a random effect. Both random intercepts and slopes for time were specified in each model. If the interaction between time and condition was not statistically significant, it was dropped from the model.

To address RQ5, a series of models were run, similar to those used for questions 1 through 4. However, a three-way interaction was added between time and condition and the following independent variables: age; gender; ethnicity; number of diagnoses; presence psychiatric, physical, cognitive disability; employment at baseline (yes/no); perceived economic status (low versus middle); subsistence benefits (housing, food stamps, utilities); SSA benefits; any benefits (yes/no); and benefits count.

To address RQ7 and RQ8, the relationship between random intercepts (individual pretest performance) and random slopes (individual change over time) were explored. These random intercepts and slopes were a by-product of mixed effects models conducted for RQ1, RQ2, and RQ3. To address RQ9, the McNemar test for correlated proportions was used by including employment status at baseline and end of the study. This test was conducted overall and then by condition.

Finally, independent samples t-tests were used to analyze the 1 to 10 scale ratings that participants gave about progress toward employment and group counseling goals and helpfulness and acceptability of client feedback graphs.

Analyses were run using SPSS and R.
Limitations

Because the primary aim of this study was to examine the impact of group counseling with feedback in a field setting (e.g. vocational rehabilitation state agency), this study emphasized ecological validity and no attempt was made to limit the types or level of other services that participants received. To this end, counselor theoretical orientation was not monitored and the steps that counselors took as a result of the feedback was not assessed.

There were five threats to the internal validity of this study. First, there is a possibility that the group facilitators may misinterpret client progress information to be an assessment of their skills in group counseling leadership and this negative interpretation may reduce the effectiveness of their skills. A second issue involves each group counselor only receiving feedback (progress reports) on half of the members of the group that he/she facilitates. The group counselor’s awareness of which participants are in the treatment-as-usual condition could affect study results. Similarly, participants in the treatment-as-usual condition could perceive the lack of feedback as an indication of receiving lesser services.

Fourth, attrition, or the loss of clients throughout the 10-week period, could be another threat to validity (Kirk, 1995). For example, if the optimal number of participants in each group is only 6 to 8, a drop-out rate of two or three participants in each group will impact the external validity. Attendance was an issue in this particular study. The average attendance was 5.13 ($SD=2.51$) sessions in the feedback group and 6.13 ($SD=2.28$) sessions in the treatment-as-usual group.
Fifth, there is the possibility of a delayed time impact, which could confound the intervention results. Since there are repeated administrations of the OQ, the dependent variable, spanning a period of 10 weeks, it is possible that the passage of time could have confounded the dependent variable. For example, if several participants began a regimen of psychotropic drugs during this 10-week period, it would be impossible to separate the effects of medication from the effects of the intervention (G+Fb). Many variables, other than the feedback, could differ over 10 weeks and, with such a small sample, we cannot be sure that an unmeasured variable did not cause differences in outcome.

**Human Participants and Ethics Precautions**

**Procedures to Obtain Informed Consent**

Participants were given written information about the purpose of the study, the procedures to be employed, potential risks or discomforts and procedures used to minimize such risks. Participants had an opportunity to ask and have answered any and all questions. Each participant was informed that participation is voluntary and that he/she has the right to withdraw at any time without consequence. It was made clear that participation will not affect the services the individual receives from his/her current vocational rehabilitation agency now or in the future. Participants were informed that any information they provide would be kept confidential. Research team and Institutional Review Board contact information was provided.

Furthermore, because this research study involved individuals with disabilities, special care was taken to obtain written assent from the participant and consent from the legal guardian. Special care was taken to insure that participants understand the risks,
benefits, purpose, and procedures of the study. Every effort was made to insure that participants understand their rights (e.g. voluntary participation, right to withdraw from the study, etc.). Participants and legal guardians were provided with every opportunity to ask questions and receive answers.

**Institutional Review Board of USU**

In accordance with the guidelines of the Utah State University regarding the protection of human participants, a request for a review was submitted to the USU Institutional Review Board (IRB) for approval to provide counseling and client feedback to participants receiving services at a state vocational rehabilitation agency. After receiving IRB approval, participant recruitment and data collection commenced.
CHAPTER IV

RESULTS

RQ 1

Will the OQ-45 symptom distress (SD) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than those of participants in the treatment-as-usual condition (GnoFb) over time?

The SD scores of participants showed no significant differences by condition and no significant interaction between time and condition. Please refer to the Table 5 for a complete listing of results.

Table 5

Random and Fixed Effects for RQ1

<table>
<thead>
<tr>
<th>Name</th>
<th>Variance</th>
<th>SD</th>
<th>Corr</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Intercept)</td>
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<td>18.88</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>3.92</td>
<td>1.98</td>
<td>-0.3</td>
</tr>
<tr>
<td>Residual</td>
<td>36.98</td>
<td>6.08</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimate</th>
<th>SE</th>
<th>df</th>
<th>t-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Intercept)</td>
<td>34.22</td>
<td>9.17</td>
<td>24.47</td>
<td>0.001</td>
</tr>
<tr>
<td>Condition</td>
<td>-1.48</td>
<td>6.82</td>
<td>24.12</td>
<td>0.830</td>
</tr>
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<td>Time</td>
<td>-0.87</td>
<td>0.46</td>
<td>17.32</td>
<td>0.073</td>
</tr>
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<td>Office 1 vs. 2</td>
<td>12.01</td>
<td>10.69</td>
<td>24.13</td>
<td>0.27</td>
</tr>
<tr>
<td>Office 1 vs. 3</td>
<td>8.52</td>
<td>11.19</td>
<td>24.09</td>
<td>0.45</td>
</tr>
<tr>
<td>Office 1 vs. 4</td>
<td>24.18</td>
<td>11.55</td>
<td>24.20</td>
<td>0.047</td>
</tr>
<tr>
<td>Office 1 vs. 5</td>
<td>7.98</td>
<td>10.75</td>
<td>24.13</td>
<td>0.465</td>
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</table>
RQ 2

Will the OQ-45 interpersonal relationship (IR) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

The IR scores of participants showed no significant differences by condition and no significant interaction between time and condition. Please refer to the Table 6 for a complete listing of results.

RQ 3

Will the OQ-45 social role performance (SR) scores of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

Table 6

*Random and Fixed Effects for RQ2*

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<td>(Intercept)</td>
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<tr>
<td>Time</td>
<td>0.108</td>
<td>0.330</td>
<td>-0.32</td>
</tr>
<tr>
<td>Residual</td>
<td>8.702</td>
<td>2.950</td>
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<table>
<thead>
<tr>
<th>Fixed Effects:</th>
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<th>df</th>
<th>t-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Intercept)</td>
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<td>2.99</td>
<td>25.27</td>
<td>2.38</td>
<td>0.025</td>
</tr>
<tr>
<td>Condition</td>
<td>0.12</td>
<td>2.22</td>
<td>24.25</td>
<td>0.06</td>
<td>0.956</td>
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<tr>
<td>Time</td>
<td>-0.13</td>
<td>0.12</td>
<td>19.33</td>
<td>-1.08</td>
<td>0.296</td>
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<td>Office 1 vs. 2</td>
<td>10.10</td>
<td>3.47</td>
<td>24.16</td>
<td>2.91</td>
<td>0.008</td>
</tr>
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<td>Office 1 vs. 3</td>
<td>6.75</td>
<td>3.62</td>
<td>23.58</td>
<td>1.87</td>
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<td>Office 1 vs. 4</td>
<td>15.14</td>
<td>3.76</td>
<td>24.47</td>
<td>4.03</td>
<td>0.001</td>
</tr>
<tr>
<td>Office 1 vs. 5</td>
<td>6.18</td>
<td>3.48</td>
<td>23.90</td>
<td>1.78</td>
<td>0.088</td>
</tr>
</tbody>
</table>
Table 7

**Fixed and Random Effects for RQ3**

<table>
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<th>Name</th>
<th>Variance</th>
<th>SD</th>
<th>Corr</th>
</tr>
</thead>
<tbody>
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<td>(Intercept)</td>
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<tr>
<td>Time</td>
<td>0.48</td>
<td>0.69</td>
<td>-0.63</td>
</tr>
<tr>
<td>Residual</td>
<td>6.74</td>
<td>2.60</td>
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</table>

**Fixed Effects:**

<table>
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<th>df</th>
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<th>p-value</th>
</tr>
</thead>
<tbody>
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<td>(Intercept)</td>
<td>9.45</td>
<td>2.45</td>
<td>27.78</td>
<td>3.86</td>
</tr>
<tr>
<td>Condition</td>
<td>2.14</td>
<td>1.76</td>
<td>25.07</td>
<td>1.22</td>
</tr>
<tr>
<td>Time</td>
<td>-0.40</td>
<td>0.17</td>
<td>15.19</td>
<td>-2.41</td>
</tr>
<tr>
<td>Office 1 vs. 2</td>
<td>-0.53</td>
<td>2.75</td>
<td>24.95</td>
<td>-0.19</td>
</tr>
<tr>
<td>Office 1 vs. 3</td>
<td>2.19</td>
<td>2.85</td>
<td>24.07</td>
<td>0.77</td>
</tr>
<tr>
<td>Office 1 vs. 4</td>
<td>2.09</td>
<td>3.00</td>
<td>25.52</td>
<td>0.70</td>
</tr>
<tr>
<td>Office 1 vs. 5</td>
<td>1.50</td>
<td>2.75</td>
<td>24.41</td>
<td>0.54</td>
</tr>
</tbody>
</table>

The analysis revealed a main effect only for time \( p=0.0294 \) for both conditions. The slope for time was -.40, indicating that, as sessions progressed, SR scores of participants in both conditions decreased by almost a half a point per session. Over the course of the study, SR scores changed by 5 points, representing a 14% change in the scores of this subscale. Please refer to Table 7 for a complete listing of results.

**RQ4**

Will the OQ-45 scores on Mental Health Functioning (MHF) of participants in the group counseling plus feedback condition (G+Fb) reflect significantly better outcomes than participants in the treatment-as-usual condition (GnoFb) over time?

Again, results showed a statistically significant main effect for time only \( p=0.046 \). Specifically, the slope was -1.40, representing an approximate 1.5 point
Table 8

*Random and Fixed Effects for RQ4*

<table>
<thead>
<tr>
<th>Name</th>
<th>Variance</th>
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<tbody>
<tr>
<td>(Intercept)</td>
<td>830.47</td>
<td>28.82</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>7.19</td>
<td>2.68</td>
<td>-0.4</td>
</tr>
<tr>
<td>Residual</td>
<td>94.84</td>
<td>9.74</td>
<td></td>
</tr>
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</table>

<table>
<thead>
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<th>Name</th>
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<th>SE</th>
<th>df</th>
<th>t-value</th>
<th>p-value</th>
</tr>
</thead>
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<td>(Intercept)</td>
<td>51.64</td>
<td>13.63</td>
<td>25.55</td>
<td>3.78</td>
<td>0.001</td>
</tr>
<tr>
<td>Condition</td>
<td>1.70</td>
<td>10.04</td>
<td>24.38</td>
<td>0.17</td>
<td>0.867</td>
</tr>
<tr>
<td>Time</td>
<td>-1.40</td>
<td>0.65</td>
<td>16.91</td>
<td>-2.15</td>
<td>0.0460</td>
</tr>
<tr>
<td>Office 1 vs. 2</td>
<td>20.23</td>
<td>15.74</td>
<td>24.38</td>
<td>1.29</td>
<td>0.211</td>
</tr>
<tr>
<td>Office 1 vs. 3</td>
<td>17.75</td>
<td>16.45</td>
<td>24.15</td>
<td>1.08</td>
<td>0.291</td>
</tr>
<tr>
<td>Office 1 vs. 4</td>
<td>41.47</td>
<td>17.05</td>
<td>24.57</td>
<td>2.43</td>
<td>0.023</td>
</tr>
<tr>
<td>Office 1 vs. 5</td>
<td>14.70</td>
<td>15.81</td>
<td>24.26</td>
<td>0.93</td>
<td>0.362</td>
</tr>
</tbody>
</table>

decrease per session and 14 point decrease (reliable change) over 10 sessions. This represents an 8% decrease in MHF scores for participants in both conditions over the course of the study. This finding suggests that group participant MHF scores improved over the course of receiving group therapy but that this change could not be attributed to progress feedback and the use of clinical support tools. Please refer to Table 8 for a complete listing of results.

**RQ5**

Which demographic subgroups (age, gender, ethnicity, disability category, mental health functioning, work status, socioeconomic status, receiving SSA benefits, subsistence benefits) does this intervention benefit the most?

Three statistically significant 3-way interactions were found between time, condition, and any of the above independent variables. The first interaction included SSA
benefits when IR was the dependent variable ($p=.025$). The second and third 3-way interaction included subsistence benefits when (1) SR was the dependent variable ($p=.021$), and (2) MHF was the dependent variable ($p=.028$).

First interaction: Social security benefits when IR is the dependent variable. In the treatment group, the IR scores of participants not receiving social security benefits demonstrated greater fluctuations with a 9-point decrease between times 1 and 10. The IR scores of participants receiving social security benefits evidenced a more steady 11-point decrease over time. On the other hand, the IR scores of participants receiving social security benefits in the treatment-as-usual condition reflected a 6 point decrease in interpersonal problems whereas treatment-as-usual condition participants not receiving social security benefits plateaued between times 1 and 10. Taken as a whole, this suggests that the presence of both benefits and feedback attenuated interpersonal difficulties. Please refer to Figure 2 for a graph depicting this three way interaction.

It should be noted that the sharp decrease between time 10 and 11 in the treatment-as-usual condition graph with no benefits (Figure 2) was not included in this interpretation as this was based on the scores of only one participant. In addition, the sharp decrease of scores between times 6 to 9 in Figure 2 of the treatment-as-usual condition with social security benefits was not included in this interpretation as these changes reflected of the scores of only one participant.

Second interaction: Subsistence benefits when SR is the dependent variable. In the treatment condition, SR scores of participants receiving subsistence benefits (e.g. food stamps, utility bill assistance, and temporary assistance to needy families) demonstrated a rapid overall decrease of 6 points from times 1 to 6, whereas the SR
scores of participants not receiving subsistence benefits showed a slight overall increase of 3 points from times 1 to 9. This suggests that, for feedback to be effective at decreasing problems with social roles, subsistence benefits are necessary. On the other hand, in the treatment-as-usual condition, the SR scores of participants with subsistence benefits showed notable fluctuations in social role functioning and a slight 3-point increase in scores between times 1 and 7. The SR scores of treatment-as-usual condition participants without subsistence benefits also demonstrated fluctuations in scores, but with an overall decrease of approximately 9 points in problems with social roles over time. This suggests that participants without subsistence benefits may have had a much greater need to resolve problems with social roles (e.g. find employment) than those with subsistence benefits. Taken as a whole, it appears that the most consistent and stable decreases in problems with social role functioning are for those participants in the treatment condition who have subsistence benefits. Please refer to Figure 3 for a graph depicting this three way interaction.

It should be noted that the steep decrease between times 9 and 11 for the no subsistence benefits (both treatment and treatment-as-usual conditions) were not included in this interpretation as this was based on only one participant score per graph. In addition, the steep decrease between times 6 to 9 in Figure 2 were not included in this interpretation as these changes were reflective of only one participant’s scores.

Third interaction: Subsistence benefits with MHF as the dependent variable. In the treatment condition, the MHF scores of participants receiving benefits demonstrated a consistent 40-point decrease between times 1 and 6, whereas the MHF scores of participants not receiving subsistence benefits in the treatment condition evidenced
greater fluctuations with no overall change from time 1 to time 7. This suggests that, for feedback with group counseling to be effective at improving mental health functioning, subsistence benefits are necessary. On the other hand, in the treatment-as-usual condition, the MHF scores of participants with and without subsistence benefits evidenced a 10-point decrease, suggesting that, group counseling in general had a positive impact on mental health function, even without the added benefit of progress feedback. Please refer to Figure 4 for a graph depicting this three way-interaction.

It should be noted that the steep decrease between time 9 and 11 in the no subsistence benefits (both treatment-as-usual and treatment conditions) was not included in this interpretation as this was based on only one participant’s scores. In addition,

---

**Figure 2.** Social security benefits over time with IR as the dependent variable.
Table 9

Social Security Benefits with Number of Participants per Time Period with IR as the Dependent Variable

<table>
<thead>
<tr>
<th>Time</th>
<th>Fb – No Benefits</th>
<th>Fb – Benefits</th>
<th>TAU – No Benefits</th>
<th>TAU – Benefits</th>
</tr>
</thead>
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<tr>
<td>11</td>
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<td>1</td>
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</table>

Figure 3. Subsistence benefits over time with SR as the dependent variable.
the sharp decrease between times 6 to 9 in the treatment-as-usual condition with subsistence benefits (Figure 4) was not included in this interpretation as these changes were reflective of one participant’s scores.

Table 10

*Subsistence Benefits with Number of Participants per Time Period with SR as the Dependent Variable*

<table>
<thead>
<tr>
<th>Time</th>
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*Figure 4. Subsistence benefits over time with MHF as the dependent variable.*
Table 11

Subsistence Benefits with Number of Participants per Time Period with MHF as the Dependent Variable

<table>
<thead>
<tr>
<th>Time</th>
<th>Fb – No Benefits</th>
<th>Fb – Benefits</th>
<th>TAU – No Benefits</th>
<th>TAU – Benefits</th>
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<tr>
<td>1</td>
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<tr>
<td>11</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

RQ6

What impact do various levels of pretest performance (functioning in normal range, making expected progress, some chance of negative outcome, high chance of negative outcome) have upon intervention outcomes?

The 3-way interaction was not significant in any of the four models associated with the analysis of the four dependent variables (SD, IR, SR, MHF). In other words, levels of pretest performance did not have a statistically significant impact upon intervention outcomes.

RQ7

What impact does various levels of pretest OQ-45 subscale scores (symptom distress, problems with interpersonal relationships, social role performance) have upon intervention outcomes?
Levels of pretest OQ-45 subscale scores were not significantly correlated with intervention outcomes. Thus, as determined in analysis of RQ1-3, there was no difference between conditions in outcomes over time. The correlation between random intercepts and slopes for the RQ1 to RQ3 models was SD ($r = -0.30$); SR ($r = -0.32$); and IR ($r = 0.63$), demonstrating that higher starting values on the outcomes were associated with lower or more shallow positive slopes over time. This suggests that participants with higher SD, SR, and IR scores at baseline made less progress overall across time. In addition, the scores of participants with baseline subscale scores in the normal range may have experienced a ceiling effect, thus explaining the lack of change.

**RQ8**

What impact do various levels of pretest OQ-45 total scores (mental health functioning) have upon intervention outcomes?

Levels of pretest OQ-45 mental health functioning scores were not significantly correlated with intervention outcomes. Thus, as determined in analysis of RQ4, there was no difference between conditions in outcomes over time. The correlation between random intercepts and slopes for the RQ4 model was ($r = -0.40$), again suggesting that higher starting values on the outcomes were associated with less progress and more shallow positive outcomes over time. In addition, baseline mental health functioning scores in the normal range may have evidenced a ceiling effect, thus explaining the lack of change.

**RQ 9**

Will the employment status of participants in the treatment-as-usual (GnoFb) and the treatment (G+Fb) conditions change differently over time?
The overall result for the entire sample is statistically significant \(( p = 0.012, \text{ two-tailed})\), meaning that the proportion employed at the beginning \((5/30)\) was significantly different than the proportion employed at the end \((15/30)\). However, when split by group, these proportions were not statistically significantly different \(( p = .063 \text{ for both groups}; \text{ from } 3/15 \text{ to } 8/15 \text{ for feedback}; \text{ from } 2/15 \text{ to } 6/15 \text{ for treatment-as-usual})\). These still might represent important changes in magnitude, but the \(N\) was probably too small to reject the null hypothesis.

**Post Intervention Ratings**

**Graph acceptability and helpfulness.** The average counselor rating of the clinician feedback reports was \(8.7 \text{ (SD: 1.57)}\) for acceptability and \(7.3 \text{ (SD: 1.89)}\) for graph helpfulness on a \(1 \text{ to } 10\) rating scale \((1=\text{Not acceptable/Not helpful to } 10=\text{Very acceptable/helpful})\). Participant graph ratings between the two conditions for graph acceptability and helpfulness were not statistically significant. Overall, participants in both conditions combined gave high ratings for the acceptability and helpfulness of the progress graphs \((\text{acceptability: } M=8.61, SD=1.64; \text{ helpfulness: } M=7.43, SD=2.06)\). Please refer to Table 4 for further information.

Table 12

<table>
<thead>
<tr>
<th>Variable</th>
<th>G+Fb (n=13)</th>
<th>GnoFb (n=10)</th>
<th>(t)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graph acceptability</td>
<td>8.69 (1.70)</td>
<td>8.5 (1.65)</td>
<td>(t(21)=-.272; p=.79)</td>
</tr>
<tr>
<td>Graph helpfulness</td>
<td>7.38 (1.94)</td>
<td>7.5 (2.32)</td>
<td>(t(21)=-.130; p=.90)</td>
</tr>
<tr>
<td>Employment goal progress</td>
<td>5.54 (3.26)</td>
<td>4.45 (3.18)</td>
<td>(t(251)=2.77, p=.006)</td>
</tr>
<tr>
<td>Group counseling goal progress</td>
<td>6.38 (2.69)</td>
<td>5.30 (2.11)</td>
<td>(t(21)=1.05; p=.31)</td>
</tr>
</tbody>
</table>
**Progress toward employment goal.** The average rating was 5.54 ($SD=3.26$) for the treatment condition and 4.42 ($SD=3.18$) for the treatment-as-usual. Participant ratings for progress made toward employment goal was significant by condition, $t(251)=2.77$, $p=.006$, two tailed, meaning that participants in the treatment condition perceived progress toward employment goals as significantly greater than participants in the treatment-as-usual condition.

**Progress toward group counseling goal.** The average rating for the treatment condition was 6.38 ($SD=2.69$). For the treatment-as-usual condition, the average rating was 5.30 ($SD=2.11$). Participant ratings for progress made toward group counseling goal were not significant by condition, $t(21)=1.05$, $p=.31$.

**Post Intervention Comments**

In addition to significant ratings for employment by condition, 18 out of 24 participants shared comments about the group counseling program. Of those 18, 16 participants felt that the group counseling program was a helpful and positive experience.

**Employment related.** More specifically, 10 participants made positive comments about how the group counseling program helped them with employment. For example, five participants stated that the program helped motivate them to apply for jobs, to think about work, and/or to be more “proactive” about seeking employment. Another participant commented on how the group helped him to understand the stresses and demands of supervisors. Others mentioned that it helped to talk about work situations and that the group taught them how to better communicate at work. Two participants mentioned that the group program taught them how to disclose their disability. A few
participants shared that the group help them better understand their skills and what types of employment would best meet their needs.

**Supporting, communicating, and coping.** Eight participants mentioned that it helped to talk to and/or meet others “in the same boat” and that the group gave them a chance to express feelings/frustrations and learn new coping strategies. Others felt that the group helped them to better communicate in general. One participant shared that the group helped her to identify and cope with social anxiety triggers.

**General positive comments.** Several participants stated that they enjoyed the group, that the group members were helpful, the information or skills taught were “good” and that the group counselors “did a great job,” “were really helpful,” or that the group was “well taught.”

**Sessions most helpful and least helpful.** Of the 24 who answered the post intervention questions, 16 participants commented on which sessions were most and least

<table>
<thead>
<tr>
<th>Table 13</th>
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<tbody>
<tr>
<td><strong>Pre Treatment Means (SD) of OQ-45 Subscale and Total Scores</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Treatment</td>
</tr>
<tr>
<td>Treatment-as-usual</td>
</tr>
</tbody>
</table>

*Note: Pretreatment means include OQ-45 administration times 1 and 2. Independent t-tests determined that pretreatment score differences between conditions were non-significant (SD: $t(28)=.199, p=8.44$; IR: $t(28)=.196, p=.846$; SR: $t(28)=.062, p=.951$; MHF: $t(28)=.289, p=.774$)*
Table 14

*Post Treatment Grand Mean (SD) of OQ-45 Subscale and Total Scores*

<table>
<thead>
<tr>
<th></th>
<th>Symptom Distress</th>
<th>Interpersonal Relationships</th>
<th>Social Roles</th>
<th>Mental Health Functioning</th>
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</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>41.2 (19.93)</td>
<td>12.5 (6.49)</td>
<td>9.98 (6.04)</td>
<td>63.53 (29.37)</td>
</tr>
<tr>
<td>Treatment-as-usual</td>
<td>37.8 (20.99)</td>
<td>11.98 (8.41)</td>
<td>8.8 (4.72)</td>
<td>58.6 (31.94)</td>
</tr>
</tbody>
</table>

Possible ranges for each scale are: SD: 0-100; IR: 0-44; SR: 0-36; and MHF: 0 to 180.

helpful. For example, sessions considered the most helpful (number of votes) included:

Listening Skills (9); Resolving Conflicts and Negotiating (8); Giving and Receiving Feedback (7); Expressing and Responding to Feelings (5); Having a Difficult Conversation (5); Managing Time Effectively (3); Assessing Strengths and Abilities (3); and Managing Disability/Overcoming Obstacles (3). On the other hand, the first and last session (Introduction and Program Review) were considered the least helpful. Since the focus of the program was skills-based, it makes sense that the two sessions that were not skills-based would be viewed as less desirable.

**Suggestions for improvement.** Four participants recommended that the group sessions be more focused on specific group needs and that member’s rate, at the end of each session, the helpfulness and applicability of the session content. Several participants commented on group attendance issues and recommended that participant attendance be mandatory. Related to attendance issues, several participants recommended against dividing into smaller groups during sessions. Five participants commented on group selection issues, how another group member tended to dominate the group, and suggested
that group members be selected more carefully. Other suggestions involved having a session about discrimination in the workplace, running the group more as a class, providing a binder to store handouts, and selecting more people at the beginning of the program to accommodate attrition throughout the program.
CHAPTER V  
DISCUSSION

The current study tested the effects of providing progress feedback and group counseling upon the outcomes of treatment and treatment-as-usual participants receiving services at a state vocational rehabilitation agency. The OQ-45 was used to examine the outcomes of symptom distress (SD), problems with interpersonal relationships (IR), problems with social roles (SR), and overall mental health functioning (MHF). Participants completed the OQ-45 prior to each session. Based on participant responses, progress graphs were generated and provided to each participant assigned to the feedback condition and his/her group counselors. In addition, employment outcomes were measured and used to compare treatment-as-usual clients’ employment with that of clients in the treatment condition (e.g. group counseling with progress feedback and clinical support tools).

Results examined mental health functioning as measured by the OQ-45 and indicated that clients, in general, improved over time but that feedback effects did not reach statistical significance. In contrast, ratings for employment progress were statistically significant, \( t(251)=2.77, p=.006 \), two-tailed, meaning that each participant in the treatment condition perceived his/her progress toward his/her employment goal as significantly greater than did participants in the treatment-as-usual condition. This finding of perceived progress by condition is not surprising. According to some researchers (Carver & Scheier, 1990; Hsee & Abelson, 1991), interventions that provide information about progress may alter the direction of the receiver’s attention. By
implication then, it seems plausible that participants in the feedback condition would see themselves as having made greater progress.

In addition, the end of study employment outcome was significant for both conditions ($p=0.012$), and close to significance for the treatment condition ($p=.063$). It must be remembered, however, that this study’s employment outcomes occurred in the context of a group counseling program. Since group counseling has been found efficacious in the cognitive, behavioral, and psychosocial outcomes of individuals with a variety of physical, mental health, and other disabling conditions (Burlingame et al., 2004; Ownsworth et al., 2000, 2008; Whitehouse, 1994), it is impossible to separate the impact of the feedback from the effects of the group counseling program.

The group counseling program in this study heavily emphasized specific skills important to workplace success (e.g. giving and receiving feedback; active listening; expressing and responding to feelings; creating cooperation and win-win solutions; assessing strengths and abilities, managing time effectively, and managing disabilities in the workplace). During group sessions, participants were given opportunities to role play and apply skills to various workplace scenarios. Given that group work is a natural forum for interpersonal feedback and vicarious learning (Davies et al., 2008; Rivera & Darke, 2012), it makes sense that participants in this study would demonstrate a significant overall decrease in problems with social role performance ($p=0.029$).

In addition to facilitating better outcomes in global and social functioning, psychoeducation groups have been found efficacious in addressing symptoms of distress and promoting quality of life (Stepakoff et al., 2006). In the current study, participants evidenced a significant decrease in problems with mental health functioning ($p=0.046$).
However, unlike the findings of Stepakoff and colleagues (2006), the current study did not find a significant decrease in symptom distress (condition, \( p = 0.83 \); time, \( p = 0.073 \)). Issues with session attendance might partially explain this lack of significance. For example, the overall average attendance for both conditions was 5.63 (\( SD=2.48 \)). It may be that participants need to attend a greater number of group sessions and/or attend for a longer period to demonstrate a significant decrease in symptom distress.

In speaking with participants and group counselors, the most commonly cited reason for not attending group was that the participant found employment and was no longer available during group time. Since 9 participants became employed during the program, it stands to reason that attendance would be affected accordingly. Other common reasons for nonattendance included being out of town for extended periods, and feeling discouraged because of missing group sessions. Thus, some caution must be exercised when interpreting low group counseling attendance in the current study, as nonattendance may reflect a positive step for certain participants.

In addition to employment outcomes, study analysis revealed three statistically significant three-way interactions. The first involved IR as the dependent variable with an interaction between time, condition and social security benefits. Although problems with interpersonal relationships decreased for treatment condition participants with and without benefits, participants in the treatment condition with benefits showed the greatest decrease in interpersonal relationship problems, followed by participants in the treatment condition without benefits. In addition, participants in the treatment-as-usual condition with benefits evidenced fewer problems with interpersonal relationships over time. However, the IR scores of participants with no social security benefits in the treatment-
as-usual condition evidenced little change. While social security benefits in general appeared to augment the interpersonal progress of participants over time in the group counseling program, the greatest interpersonal gains occurred for participants receiving social security benefits in the treatment condition.

These results might be best understood by appreciating the processes associated with task performance. Kluger and DeNisi (1996) asserted that task performance is mediated by three hierarchical levels of linked processes (meta-task processes, task-motivation processes, and task-learning processes). When performing a task, individuals typically direct their attention to the middle of the hierarchy, that is, toward task motivation processes. It may be that having social security benefits assisted participants in shifting from task-motivation processes to higher level processes, such as those involved with pursuing more satisfying interpersonal relationships. This would also explain why the IR scores of individuals in the treatment-as-usual group without benefits evidenced little change.

The second three way interaction involved subsistence benefits (e.g. food stamps, utility bill assistance, and temporary assistance for needy families) over time with SR as the dependent variable. Participants receiving subsistence benefits in the treatment condition by far evidenced the most gains in social role performance, followed by participants not receiving benefits in the treatment-as-usual condition. Conversely, participants in the treatment condition with no benefits showed a slight increase in problems with social role performance, as did participants in the treatment-as-usual condition who were not receiving subsistence benefits.
It could be argued that group counseling with feedback raised participant awareness about discrepancies in social role performance, and in turn, may have created psychological discomfort. According to Sapyta et al. (2005), there are different ways that individuals may choose to lessen the discomfort. Participants in the benefits plus feedback group, by virtue of having additional support (e.g. subsistence benefits), may have been in the best position to respond to this cognitive dissonance with a stronger commitment to resolving social role performance issues. Conversely, participants in the treatment-as-usual condition may have experienced less cognitive discomfort from the feedback but, without the support of subsistence benefits, may have also had a greater need to resolve social role performance issues (e.g. obtain employment).

The third three-way interaction involved subsistence benefits over time with MHF as the dependent variable. Participants who received subsistence benefits in the treatment group evidenced the most dramatic decrease in problems with mental health functioning. Participants with and without benefits in the treatment-as-usual group also demonstrated an overall decreasing trend in problems with mental health functioning. However, the mental health functioning scores of participants in the treatment condition without benefits evidenced little, if any substantial change, over time. The progress of the treatment-as-usual group with and without benefits may be reflective of the group counseling program in general. However, it appears that the forum for the most reliable and dramatic growth is brought about when feedback, benefits, and group counseling are part of the equation.

In addition to receiving clinician reports about client progress, counselors also received feedback about participant obstacles to positive therapeutic outcomes (e.g.
problems with therapeutic alliance, motivation toward treatment, social supports, and stressful life events). These obstacles were assessed using the ASC. Due to the small sample size, participants were asked to complete the ASC at the end of session two. Group counselors were then provided with information (e.g. possible obstacles to positive outcomes and tools to address those obstacles) about participants in the feedback condition. Administering the ASC to all participants represents a departure from other studies, as typically a client completes the ASC only when his or her scores show an ongoing risk for treatment failure. Although this study did not evaluate the impact of assessing obstacles and providing clinical support tools, nonetheless, providing these support tools may have played a role in study outcomes.

This study also examined group counselor and client perceptions of the feedback intervention. For example, group counselors, on average, rated the clinician feedback reports as a 7.3 ($SD=1.89$) for helpfulness and the acceptability as an 8.7 ($SD=1.57$; 1=not at all helpful/acceptable to 10=Very helpful/acceptable). Participants also gave high ratings for progress graph acceptability and helpfulness (acceptability: $M=8.61$, $SD=1.64$; helpfulness: $M=7.43$, $SD=2.06$). These high ratings suggest that both counselors and clients viewed the feedback as credible and personally relevant. Furthermore, because the feedback was developmental (e.g. focused on progress made in specific areas), clients and counselors may have given the feedback greater weight. These high ratings lend support to the views of Wells et al. (2007), who found that developmental feedback (nurturing desired behavior) was judged as being fairer than feedback that was perceived as a deterrent to behavior.
Limitations

The purpose of this study was to evaluate the effect of feedback. To this end, the treatment-as-usual (no feedback) condition acted as a control to the treatment (feedback) condition. Stated differently, this study was not about group counseling. Thus, relative to the group counseling condition, there was no control group. This particular study design was chosen to accommodate the reality of conducting research in a service provision environment (a state vocational rehabilitation agency). Given the strong service focus of this study’s research setting, a research project that offered absolutely no benefit to half of all participants (control group) would likely not be approved by the agency. Therefore, offering group counseling to both the feedback and no-feedback condition seemed the best compromise for studying the effects of feedback in a service oriented agency.

Taken as a whole, the results of this study suggest that feedback with group counseling enhanced the employment, social role performance, and mental health outcomes of individuals with disabilities receiving services at a VR state agency. On the other hand, because this study occurred in a field setting and emphasized ecological validity, no attempt was made to limit the types or level of other services that participants received. Thus, it is impossible to separate the impact that other services may have had upon study outcomes. Given the small number of participants, it is also impossible to attribute clinical relevance to the results of this study. In addition, group counselors were aware of which participants were assigned to what condition. Likewise, each participant was apprised of his/her condition assignment (treatment or treatment-as-usual). This may have influenced both participant and counselor behavior.
Attendance was an issue in this particular study. The average attendance was 5.13 ($SD=2.51$) sessions in the feedback group and 6.13 ($SD=2.28$) sessions in the treatment-as-usual group. It appears that these attendance issues may have affected participant attitudes toward the group. For example, during the end of study interview several participants recommended that attendance to group be mandatory as some groups had as few as three participants attending any given week. Given that the optimal number of participants in a group is 6 to 8, there is a distinct possibility that these attendance issues may have weakened the effectiveness of the group intervention.

**Implications for Practice**

This research has several implications for practice. First, given the significant findings for ratings of employment progress and end of study employment rates, vocational rehabilitation counselors in particular and state agencies in general may wish to add consistent feedback about progress as a routine part of each client-counselor session. Similarly, given the significant impact that group counseling made upon participant social role performance and mental health functioning, the field of vocational rehabilitation counseling may wish to implement and consistently offer group counseling as a routine service.

Furthermore, it is interesting to note the key role that social security and subsistence benefits played in mediating the impact of group and feedback in the areas of interpersonal relationships, social role performance, and overall mental health functioning. Given the consistent progress that feedback condition participants who received social security or subsistence benefits made in this study, it may be beneficial
for vocational rehabilitation counselors to place greater emphasis on assisting clients in obtaining needed benefits early in the restoration process.

Finally, the results of this study also suggest that rehabilitation counselors do, in fact, engage in mental health counseling. By extension then, it may be wise for counselors to place greater emphasis upon mental health concerns during client-counselor sessions.

**Directions for Future Research**

The small n’s in the current study may have been a limiting factor in the conclusions that could be drawn, and that have been reported in the individual psychotherapy literature (Shimokawa et al., 2010). Although this study nonetheless supported the feasibility of the group therapy/feedback intervention, replication with a much larger n is called for in future research.

Research that evaluates the role that benefits play in the restoration and employment of people with disabilities is warranted. In addition, research that compares individual and group counseling with and without feedback in a vocational rehabilitation setting is needed. It may likewise be efficacious to compare participant outcomes of vocational rehabilitation treatment as usual (e.g. individual counselor-client sessions without feedback) with enhanced individual counselor-client sessions (with weekly feedback provision).
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APPENDICES
APPENDIX A

Group Counseling Training
Course Syllabus
Group Counseling Training  
Course Syllabus

Instructor: Saara Grizzell, MRC, CRC, LVRC  
E-mail: saara.grizzell@aggiemail.usu.edu  
Office Hours: By appointment

Class Time/Location  
Dates: Wednesday, 7/10/13 to 11/13/13  
Time: 3 to 4:30 PM

Suggested Text  

Purpose and Objectives  
The purpose of this course is to expose experienced rehabilitation counselors to the methods and practices of group counseling. As such, this course will review the importance and impact of group development, process, and dynamics and will explore interventions appropriate at each group development stage. In addition to reviewing basic group counseling skills, this course will emphasize advanced group counseling skills and will provide hands-on training. Special group management issues and disability applications will be explored. Finally, this course will provide the tools necessary to formulate, start, maintain, and conclude a variety of therapy groups such as support, psychoeducation, and counseling.

By the end of this course, students will:
1. Understand group dynamics, group process, and stages of group development  
2. Be exposed to group leadership styles and approaches  
3. Comprehend group counseling theories and how they are demonstrated clinically  
4. Appreciate a range of group types  
5. Discern the facilitator tasks, functions, and roles associated with various groups  
6. Know appropriate group selection criteria and methods  
7. Demonstrate the skills associated with effective group work.  
8. Be exposed to disability applications of group work  
9. Have increased awareness regarding multicultural group work issues  
10. Be able to effectively evaluate therapeutic group work  
11. Recognize ethical and legal ramifications of group work

Course Schedule  
WEEK 1: 7/10/13  
Topic: Group Work in a Vocational Rehabilitation Context
<table>
<thead>
<tr>
<th>WEEK</th>
<th>Date</th>
<th>Topic</th>
<th>Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>7/17/13</td>
<td>Group Stages, Process, and Therapeutic Forces</td>
<td>Chapter 1</td>
</tr>
<tr>
<td>3</td>
<td>7/31/13</td>
<td>Purpose, planning, and group selection</td>
<td>Chapter 3 and 4</td>
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<tr>
<td>4</td>
<td>8/7/13</td>
<td>Beginning stage/phase and the first session</td>
<td>Chapter 5</td>
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<tr>
<td>5</td>
<td>8/21/13</td>
<td>Transition and middle stages; Using Theory</td>
<td>Chapter 12</td>
</tr>
<tr>
<td>6</td>
<td>8/28/13</td>
<td>Basic skills for group leaders</td>
<td>Chapter 6</td>
</tr>
<tr>
<td>7</td>
<td>9/4/13</td>
<td>Establishing, Holding, Shifting, and Deepening Focus</td>
<td>Chapter 7</td>
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<tr>
<td>8</td>
<td>9/18/13</td>
<td>Drawing out and cutting off</td>
<td>Chapter 8</td>
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<td>9/25/13</td>
<td>Rounds, Dyads, and Triads</td>
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<td>Introducing, Conducting, and Processing Exercises</td>
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<td>12</td>
<td>10/16/13</td>
<td>Ethical, Legal, and Multicultural Implications</td>
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<td>11/6/13</td>
<td>Closing Groups and Ending Stage</td>
<td>Chapter 15</td>
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WEEK 15: 11/13/13
Topic: Wrap-up and review

**Student Class Slides:** Sent via e-mail at the beginning of each week

**Curriculum Group Assignment:**
In-class
Class participants will be divided into two groups. Each group will discuss and critique a session-by-session skill based psychoeducation group curriculum outline. Groups will then assist in designing a curriculum. This curriculum will include three sections: Introduction; Session-by-Session Outline; and Handouts. Please refer to sections below for detailed information about each section.

**Introduction:** Contains the following information: an overview of what the curriculum covers; group purpose and goals; facilitator and co-facilitator training; group logistics; for whom this curriculum is intended; the importance and therapeutic value of this curriculum; the group counseling/disability theory upon which this curriculum is based; how progress and group process will be measured; special considerations; and resources/methods used to create the curriculum.

**Session-by-session Outline:** Each session contains an outline of the following: opening, celebrating success/review of homework, topic/skills content, exercises used, process questions, and closing. At least three process questions are included following exercises and homework review. An estimate of time included next to each part of the session (e.g. Opening 10 minutes). At least one handout is used in each session (e.g. information oriented; questionnaire; survey; or homework; etc.).

**Handouts:** Associated with topic of the week

<table>
<thead>
<tr>
<th>Organization of Curriculum</th>
<th>Excellent</th>
<th>Proficient</th>
<th>Inadequate</th>
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<tbody>
<tr>
<td></td>
<td>Includes all three sections. Curriculum is easy to follow and sections are marked. Curriculum pages are numbered. The handouts associated with each session are easily located.</td>
<td>Contains all three sections. Overall organization is good but sections may not be clearly marked. Curriculum pages are numbered. Handouts associated with each session can be located with little effort.</td>
<td>A section is missing or the organization of the curriculum is hard to follow. Pages are not numbered. Handouts associated with each session are hard to locate.</td>
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### Introduction
- Includes all requested information. Clearly written and easy to read. Writing shows careful thought. Utilizes concepts from the class text and/or from class notes. Demonstrates a clear understanding and command of the material.
- Includes all requested information. Generally well written and easy to read. Utilizes concepts from the class text and/or from class notes. Demonstrates a proficient understanding of the material.
- Parts of requested information missing. Difficult to read. Does not include concepts from text, class materials or other professional source. Demonstrates incomplete or vague understanding of material.

### Session-by-session Outline
- Sessions contain all requested parts. Pages numbered. Estimate of time needed to complete each part included. Contains time to process homework/exercises and includes at least 3 process questions that are specific to the homework/exercises. Process questions are open-ended. Each session well thought out. Content shows a firm understanding and grasp of the topic/skills presented.
- Sessions contain all requested parts. Pages numbered. Estimate of time needed to complete each part provided. Includes time to process homework/exercises. Process questions generally connected to homework/exercise focus. Includes at least 3 open-ended process questions. Content shows general understanding and grasp of the topics/skills presented.
- Session parts missing. Pages not numbered. Estimate of time needed to complete each part missing. Does not include time to process homework or exercises. Process questions missing or less than three. Questions are not open-ended. Session content shows vague or inadequate understanding of topic/skills presented.

### Handouts
- Handouts clearly written, easy to follow, contribute to the session content, and are relevant to the overall curriculum goals. Handouts neatly organized and pages numbered.
- Handouts generally well written and easy to follow. Handouts generally relate to the overall curriculum goals. Handout section is generally organized.
- Handouts not well written and difficult to follow. Handouts show little relationship to curriculum goals. Handout section is not well organized.

**Skills Demonstration:**
I will evaluate students for a basic level of group counseling competency via group observations at some point during this course.

**Attendance:**
Attendance is important for several reasons. Besides the obvious reason of learning, continuing education credits for the CRC are being offered for this course. In addition, those individuals who attend class 12 on the ethics of group work and the CRC and ACA codes, will receive CRC ethics credit. In person attendance is required the first Wednesday of every month over the course of this training. The remaining classes during the month may be attended via Visions.

**CORE Requirements:**
This course closely adheres to CORE’s standards regarding group counseling curriculum knowledge domains and outcomes. Refer to the standards below for further information.

**Knowledge Domains:**
- Group dynamics and counseling theory
- Interdisciplinary teamwork
- Group leadership styles and techniques
- Group methods, selection criteria, and evaluation strategies
- Group skills development
APPENDIX B

GROUP COUNSELING MANUAL
SESSION ONE: INTRODUCTION
(1.5 hours)

PRIOR TO SESSION

MATERIALS:
Plenty of lined blank paper
Pencils or pens
One Handout: “Overview of Group Counseling Sessions” (Refer to Appendix: Session 1)

PREPARATION:
Review session plan; copy handout; retrieve blank and lined paper; sharpen pencils; arrange chairs into circle (space permitting)

INTRODUCTION (30 minutes)
- Welcome and introduce purpose of group: To teach and facilitate the development skills associated with successfully obtaining and maintaining employment
- Co-leaders introduce themselves briefly and share personal and professional background
- Pair participants and have them introduce themselves BY FIRST NAME ONLY to each other and answer the following questions:
  - What attracted them to the group?
  - Other facts that wish to share about themselves
- Reconvene in large group. Have each participant introduce the other participant BY FIRST NAME ONLY to the entire group
- Acknowledge specific comments and what participants wish to obtain from their participation in this group

ORIENTATION (10 minutes)
- Orient participants to the structure of the group (time, place, frequency, order of sharing)
- Orient participants to how you will interact with group (e.g. that will scan the room, that may be necessary to re-direct discussion and/or cut people off at times; explain why you will do this)
- Orient participants to ground rules and confidentiality
  - Who you see here, what you hear here, when you leave here, let it stay here
  - Limits of confidentiality: abuse or harm of children/vulnerable adults; wanting to harm self or others; committing a crime. Will report to appropriate authorities
  - Ok to share personal reactions outside of group but not ok to share identifying information
  - Respect privacy of each participant
  - Right of participant not to share or participate
  - Regular attendance at sessions
o Being on time and contacting group leader beforehand if going to be late or miss a session
o Completing all homework assignments. Progress in sessions depends on this. Completing homework helps the group as a whole in learning, processing, and exploring new skills
o Will be sharing some sensitive feelings in this group. Ask group how can make this group a safe place to share (e.g. not using shared information against a participant at some later point; avoiding criticism of another; no putdowns; no scapegoating, etc.)

• Ask participants about any other ground rules may wish to add. Write these additional rules on white board or paper. Inform participants that will post these rules every week.

PURPOSE / GOALS / OVERVIEW (10 minutes)
• Emphasize how participant goals shared above are in line with the purpose and goals of the curriculum. Introduce the rational and need for the group:
  o Job readiness and long term job success have been linked to interpersonal skills, coping skills, and the ability to manage emotions.
  o To this end, the 10 week group counseling program focuses on the interpersonal, coping and emotion regulation skills necessary to successfully obtain and maintain employment.

• Goals of group program:
  o Build skills in effective listening, validating feelings, and asking questions
  o Provide skill building opportunities in giving and receiving feedback
  o Increase ability to communicate effectively with co-workers and employers
  o Increase ability to resolve conflict in the context of employment
  o Increase ability to negotiate win/win solutions in work situations
  o Increase ability to effectively manage time and prioritize
  o Build self-esteem through exploration of strength based focus on abilities
  o Increase skill of managing disability in the workplace

• Ask for participant comments about goals and sessions

WORKING PHASE (20 MINUTES)
Exercise: Distribute blank paper and pencils. Ask participants to reflect on what three things they wish to get out of this group program. In connection with this, instruct participants to write or draw at least three goals on the paper provided. Give participants 5 minutes to create this list. Then have participants divide into dyads or
triads and share the list with smaller group. Give participants 10 minutes to discuss in smaller group. While participants are in smaller groups, mill around the room and answer any questions participants may have about the exercise. Reconvene in the larger group and ask participants to share one thing from list. Ask open-ended questions to help facilitate the processing of this exercise (e.g. what was the exercise like for them, challenges with formulating goals, etc.)

**PROCESS/CLOSING PHASE (20 minutes)**
- Briefly summarize the session.
- Ask the following process questions:
  - What did you learn today?
  - What were you thinking/feeling during group today?
  - What observations did you make about yourself, the group leaders, or other group members?
  - Is there anything that was not clear about today’s session, or the group in general?
- Acknowledge the good work participants did during the session. Point out how much you appreciated the support members gave one another. Thank the group for allowing you to share this time with them.
- Invite participants to do the homework. Homework: Ask participants to think about specific ways in which the group can help them achieve their group counseling goals. Ask them to also think of specific ways they can support other group members in meeting their goals.
- Remind participants of next session. Next week will talk about the skill of giving and receiving feedback.
- Remind participants to complete on-line OQ-45.
- REMEMBER:
  WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION TWO: GIVING AND RECEIVING FEEDBACK
(1.5 hours)

PRIOR TO SESSION
MATERIALS:
ASC questionnaire and large manila envelope
Pencils or pens
Three Handouts: “Steps to Becoming a Better Feedback Receiver;” “Steps to Giving Feedback;” and “Providing Feedback Guidelines” (Refer to Appendix: Session 2)
Plenty of blank lined paper

PREPARATION:
Review session plan; post group rules; copy and organize handouts and ASC questionnaire; retrieve lined paper and pencils; obtain large manila envelope for ASC; arrange chairs into circle (space permitting)

WELCOME (15 minutes)
- Welcome participants and do a name round to assist members with names
- Mention that this is session 2 of 10 sessions
- Review last week’s homework (think of ways that group members can support one another in meeting one another’s group counseling goals). Invite participants to share.
- Ask participants to notice the mood or atmosphere of the room. Elicit comments. Point out that it is common for the second session to be much quieter than the first session.
- Do a name round to help participants remember names.
- Today’s session focuses on the skill of giving and receiving feedback

WARM-UP (15 minutes)
Since in most districts participants will be sitting at a large table, ask participants to sit opposite of one another (if space permits, can alternatively have participants form two lines facing one another). Now tell them to look at the person sitting across from them and take in all of the physical details. Now ask that participants face away from one another. Ask participants on one side of the room to change one small thing about his/her appearance (e.g. change watch to different wrist, unzip coat, take off one ear ring, put wedding ring on different hand). The change must be visible to the person on the opposite side of the table or line. Give participants 15 seconds to make this change. Then ask participants to once again face each other. Give participants 1 minute to guess what changed. Participants can ask questions to guess the change. Once time is up, have participants face away from each other and this time have the other side of the room make a small change. Repeat the whole process over again.
Ask open-ended questions to process the activity: How did it feel having someone looking at you? How might this activity relate to giving and receiving feedback? What were your thoughts during this activity?
WORKING PHASE (40 MINUTES)

- Working with other people is vital to success at home, school and in the workplace. Part of fostering a working rapport is having the ability to give and receive feedback. We all need feedback from each other. It’s one of the key ways in which we learn, grow, and improve.
- Feedback is a valuable tool for improving performance, developing skills, solving problems, and opening the door to workplace opportunities.
- Providing feedback is an important workplace skill, whether or not you supervise others. If you work at a place long enough, at some point you will likely need to give a co-worker feedback about how his/her behavior affects you.
- Research indicates that most employees find receiving feedback difficult (Heen & Stone, 2014). The good news is that the skills of receiving feedback can be learned.

Exercise: Have participants divide into two smaller groups (Group A and Group B). The purpose of this activity is to explore options for giving and receiving feedback. Explain that going to distribute three handouts about giving and receiving feedback. Ask participants to review the three handouts in the two smaller groups. Distribute the following: “Steps to Becoming a Better Feedback Receiver”; “Steps to Giving Feedback”; and “Providing Feedback Guidelines.” Ask participants to discuss these handouts and experiences they have had with giving and receiving feedback. Give smaller groups 15 minutes to read and discuss these handouts. Reconvene in larger group and discuss experiences associated with giving and receiving feedback. Then have participants get back into smaller groups. Ask one of the groups to write scripts on giving feedback in different workplace scenarios. Ask the other group to write scripts on receiving feedback in different workplace scenarios. Give groups 15 minutes to write the scripts. Reconvene in a large group. Ask participants to share various scripts for giving and receiving feedback. Ask open-ended questions to process the exercises.

PROCESS/CLOSING PHASE (20 minutes)

- Briefly summarize the session and ask the following process questions: What did you learn today? What were you thinking/feeling during group today? Is there anything that was not clear about today’s session, or the group in general?
- Acknowledge the good work participants did during the session. Point out how much you appreciated the support members gave one another.
- Invite participants to do the homework. Homework: Apply these feedback steps at least once during the week and then come prepared next week to share what happened when implemented these steps.
- Remind participants of next session. Next week will talk about the skill of listening and validating the feelings of others. Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire online during the week.

REMEMBER: WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION THREE: THE ART OF ACTIVE LISTENING  
(1.5 hours)

PRIOR TO SESSION
MATERIALS:
Blank paper (not lined) for paper tear activity  
Lined paper for written activity  
Pencils or pens  
Two Handouts: “Listening Skills” and “The Skill of Asking Questions” (Refer to Appendix: Session 3)
PREPARATION:  
Review session plan; post group rules; copy and organize handouts; retrieve blank and lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)  
• Welcome participants and do a name round to assist members with names  
• Mention that this is session 3 of 10 sessions  
• Ask about feedback homework and invite one or two participants to share  
• Purpose of today’s session is to facilitate the development of listening skills

WARM UP (20 minutes)  
Activity: Explain that now going to do a paper tear activity. The purpose of this activity is to demonstrate the importance of listening skills. Tell everyone that in a minute will ask participants to close eyes and then follow the instructions you give about working with a piece of paper. Now, if participants are comfortable with doing so, tell them to close their eyes. Tell participants to not open their eyes or speak or ask questions or make comments during this exercise. Then hand each participant an 8 x 11.5 paper. Tell them that you are going to read a set of directions asking participants to fold and then tear the piece of paper according to the directions that you give them. Now read and have participants follow the following: 1) fold the piece of paper in half; 2) tear off the upper right hand corner; 3) fold the paper in half again; 4) tear off the lower left corner; 5) fold the paper in half one more time; 6) tear off the upper left corner; and 7) Now, have participants open their eyes and unfold their papers.  
Ask the following process questions:
• What was it like trying to follow the instructions and not being able to ask questions or make comments?  
• What are the differences between the different snowflakes?  
• Even though everyone received the same instructions, all of the snowflakes look different.  
• What would have made this activity easier to understand?
WORKING PHASE (40 minutes)

- Active listening is when a listener tries to understand both the facts and feelings of the speaker. The listener then restates what he/she heard to make sure that he/she understood the speaker correctly.
- Listening is a skill that includes several smaller skills such as: attending, encouraging, paraphrasing, reflecting, summarizing, and clarifying.
  - Attending means showing through body language and verbal prompts that you are interested and really want to understand.
  - Encouraging involves verbal statements that invite the speaker to add more information.
  - Paraphrasing means using your own words to restate the speaker’s message.
  - Reflecting means putting into words the emotions of the speaker.
  - Summarizing involves restating the speaker’s main points.
  - Clarifying includes using questions or statements to elicit more information.
- Avoid questions that ask “Why?” as such questions can put people on the defensive.

Exercise: Have participants break into smaller groups of dyads or triads. The purpose of this activity is to practice listening skills. Distribute the following handouts: “Listening Skills” and “The Skill of Asking Questions.” Distribute several pieces of lined paper and pencils. Ask participants to read the handouts and then think of one employment situation in which these skills would be useful. Then have the smaller groups write a work scenario and a script that incorporates these skills. Give the smaller groups about 15 to 20 minutes to complete the script. Have each participant play a part. Reconvnne in larger group and have each smaller group present their scenario and script (this will take another 20 minutes). Encourage the larger group to pick out one thing that they liked about each smaller group’s presentation. Having the larger group say something specific that is positive gets members use to giving one another feedback. It is important at this beginning group stage to keep feedback positive. Also encourage members to ask questions in such a way that communicates a sincere desire to understand the presentations better.

Processing the exercise:
What was this activity like for you?
What did this exercise teach you about hearing feelings (e.g. sound like you are feeling...)?
What did you learn about validating feelings?

PROCESS/CLOSING PHASE (20 minutes)

- Ask the following questions:
  - How can you integrate these skills over the next week?
  - What stood out to you about today’s session?
- Introduce the homework:
o Distribute paper and pencil to each member. Ask each member to write the name of someone with whom it would be useful to practice the skills learned today.

o Invite participants to then make a commitment to actually practice the skills with the individual whom they listed.

o Let participants know that you will ask them about the homework next week.

• Thank the group for all the hard work they did today.
• For next two weeks will talk about communicating effectively. Remind of next group meeting, time and date.
• Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire on-line during the week.

• REMEMBER:
  WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION FOUR: EXPRESSING AND RESPONDING TO FEELINGS

PRIOR TO SESSION

MATERIALS:
Lined paper
Pencils or pens
Three Handouts: “Communicating feelings;” “Reframing;” and “Reframing Examples.”
(Refer to Appendix: Session 4)

PREPARATION:
Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)
- Welcome participants and do a name round to assist members with names
- Mention that this is session 4 of 10 sessions
- Ask about feedback homework and invite one or two participants to share
- Purpose of today’s session is to facilitate the skill of communicating effectively. In today’s session will specifically discuss how to communicate feelings and how to respond to the feeling statements of others.

WARM UP (20 minutes)
Activity: Divide participants into two smaller groups. Distribute the Word Box Activity, blank paper and pencils. Explain each box gives word or drawing clues about a word or a phrase. Give smaller groups 15 minutes to figure out as many of these words or phrases. Then reconvene in the larger group and have each group read off their best guesses for each box (refer to Appendix for word box answers). Ask open-ended questions to process the exercise: How might this exercise reflect the process of communicating with others? For some of the boxes there were different answers. How might this situation reflect communicating with others?

WORKING PHASE (40 minutes)
- Part of communicating effectively involves expressing your own feelings and expressing or showing that you understand or are trying to understand the feelings of others.
- Introduce the skill of “I” messages e.g. When you __ (a specific behavior), I felt (a specific feeling). “I” messages communicate that you are responsible for your own feelings, rather than blaming someone else for your feelings.
- Introduce the differences between empathy and sympathy. Empathy is expressing or showing that you understand or are trying to understand.
- Empathy is not the same as sympathy. Sympathy is mutual agreement about a feeling. When you empathize the focus is not on agreeing. Rather, the focus is on understanding the feelings of the other person.
- The skill of communicating also involves knowing how to respond to hostile, angry, negative, accusing, or demanding statements in a way that makes the
communication more productive. One way is to “reframe” an angry statement into a statement that is more productive and focuses on the problem rather than the persons involved.

Exercise: Divide into dyads or triads. Ask participants to read the following handouts: “Communicating feelings;” “Reframing;” and “Reframing Examples.” Distribute the handouts and lined paper and pencils. Ask participants to discuss how might apply these skills to workplace situations. Ask both groups to write “I” messages and reframing scripts of various workplace scenarios. Give participants 15 minutes to complete this exercise. Then reconvene in a large group and ask participants to share the “I” message and reframing scripts. Ask open-ended questions to process this exercise (How was it coming up with the scripts? How did your group come up with the scripts?)

PROCESS/CLOSING PHASE (20 minutes)

- Ask the following questions: How can you integrate these skills over the next week? What stood out to you about today’s session?
- Introduce the homework: Invite participants to think of a person or situation in which they can practice “I” messages and reframing.
- Thank the group for all the hard work they did today.
- Next week will talk about communicating effectively. Remind of next group meeting, time and date.
- Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire on-line during the week.

REMEMBER:
WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION FIVE: HOW TO HAVE A DIFFICULT CONVERSATION
(1.5 hours)

PRIOR TO SESSION
MATERIALS:
Lined paper
Pencils or pens
Three Handouts: “Introduction to Difficult Conversations;” “Steps for Having a Difficult Conversation;” and “Difficult Conversation Example” (Refer to Appendix: Session 5)
PREPARATION:
Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)
• Welcome participants. Mention that this is session 5 of 10 sessions. Mention that we are now half way through this group counseling program
• Ask about homework (Practicing “I” messages and reframing) and invite one or two participants to share
• Last week we talked about expressing and understanding feelings, and how to respond to angry, hostile demands. This week we are going to shift the focus from specific statements to whole conversations. Now that we know about “I” messages and reframing another’s angry demands, we will focus on how to effectively engage in difficult conversations

WARM UP (20 minutes)
Activity: Distribute lined paper and pencils. Explain that you are going to read a list of four nouns about animals or common objects. After you read each noun, ask the participants to write or draw a couple of details about the first image that comes to mind (e.g. color, size, type, species). For example, if say the word ice cream, participants would write down the flavor of ice cream, if it is in a cone or a bowl, etc. Read the list of nouns slowly to give participants a chance to write or draw the images that come to mind. List of nouns: Dog; Cat; Ball; Slippery Slide. After reading the list, ask participants to share the details of what they wrote for each noun. Ask open-ended questions to process this warm-up: Why do you think there are so many different descriptions for the same noun? Is anyone’s version of dog, cat, ball, or slippery slide more correct? Why or Why Not?

WORKING PHASE (40 minutes)
• Truth is not about being right or knowing the facts. Rather, truth is about understanding perspective, interpretation, or values
• Communication is all about understanding perspectives, interpretations, and values.
• Stone, Patton, & Heen (1999) say that every difficult conversation is actually three smaller conversations, namely, the: 1) What happened conversation; 2) Feelings conversation; and 3) Identity conversation.
The “what happened conversation” involves the facts about the situation/issue. The “feelings conversation” involves the feelings of self and others about the situation/issue. The “identity conversation” is a conversation that I have with myself about my perceptions of myself and what the issue or situation says about me.

By understanding these three parts, we can shift from having ineffective difficult conversations that simply result in telling our story, to successfully engaging in difficult conversations that result in learning, sharing, and growing together.

**Exercise:** Have participants divide into dyads or triads. Tell them that you will be distributing two handouts about difficult conversations. Instruct them to read the handouts first and then discuss the handouts in their smaller groups. Ask them to reflect a difficult situation they may have experienced involving a boss or a co-worker. Referring to the handouts, ask participants to discuss how might they apply the difficult conversation steps to the past employment situation? Once you have given the instructions, distribute two of the three session handouts (“Introduction to difficult conversations” and “Steps for having a difficult conversation”). During this time mill around the room, clarifying instructions and answering questions. Give participants 10 minutes to read and discuss the two handouts. Then reconvene and discuss as large group. Ask for volunteers to share how would apply the steps and suggestions in past employment situations. Ask additional open ended questions to process the activity (e.g. What did you learn from discussing the handouts in your smaller groups?)

Now divide participants into two groups. Explain that will distribute a two and a half page script of a difficult conversation. Ask participants to read through the script and identify/mark the different sub conversations (what happened conversation; feelings conversation; learning conversation). Also have participants note places in the script where one or more steps are followed (Step 1: Begin from the third story; Step 2: Explore their story and yours; and Step 3: Problem-Solve). Give the two groups 15 minutes to read and mark the scripts as previously indicated. Reconvene as a large group and compare script notes. Ask additional open-ended questions to process the exercise (e.g. What did you notice about the conversation in the script? What was the overall tone of the conversation? What impact do you think the conversation had upon the relationship?)

**PROCESS/CLOSING PHASE (20 minutes)**

- Ask the following questions: How can you integrate these skills over the next week? What stood out to you about today’s session?
- Invite participants to have a difficult conversation with someone. Come prepared to share the results of the conversation next week.
- Thank the group for all the hard work they did today.
- Next week will talk about resolving conflict and negotiating win/win solutions. Remind of next group meeting, time and date.
- Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire on line during the week.
- REMEMBER: WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION SIX: CREATING COOPERATION AND WIN/WIN SOLUTIONS
(1.5 hours)

PRIOR TO SESSION
MATERIALS:
Lined paper
Pencils or pens
White board markers and eraser
Four Handouts: “Nature of conflict;” “Interests, needs, demands and resolving conflict;” “Maslow’s hierarchy of needs;” and “Negotiating win/win solutions.” (Refer to Appendix: Session 5)
PREPARATION:
Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)
• Welcome participants. Mention that this is session 6 of 10 sessions and that we are now exactly half way through the group counseling program
• Ask about homework (having a difficult conversations) and invite participants to share
• This week we are going to shift the focus to resolving conflicts and negotiating win/win solutions

WARM UP (20 minutes)
Activity: Distribute lined paper and pencils. Ask participants: “If you were going to the moon, and could only take 3 items, what 3 items would you take and why?” Give participants a few minutes to list the items they would take. Ask participants to share their lists and reasons in dyads or triads. Reconvene as a large group and ask a couple of participants to share their lists and reasons. Ask open-ended questions to process the activity (e.g. How might this activity relate to negotiating and resolving conflicts? What did you discover about your values? Did your list change after you shared it with others? If yes, in what ways?)

WORKING PHASE (40 minutes)
• Conflict is not good or bad, it is just a natural part of life and presents an opportunity to communicate
• How does your attitude about conflict affect the way you approach interpersonal relationships at work and at home?
• Interests versus demands
  o Demands are bottom lines and are non-negotiable
  o Interests and needs are concerns and values that motivate an individual into action (both positive and negative actions)
• Making demands during a conflict frequently leads to an impasse wherein resolution is impossible. A more productive approach for dealing with demands is to recognize the underlying needs and interests fueling the demand.
• Needs and interests are much more negotiable than demands.
• We have discussed skills in previous sessions that can you use to identify the needs of others. What skills could you use in this situation? (e.g. active listening and reframing)
• There are five principles of negotiating win/win solutions:
  o Focus on the problem and not the person
  o Focus on interests, not demands
  o Invent options for mutual gain (brain storm from different perspectives/no judging!)
  o Use objective criteria
  o Develop your best negotiated options

Exercise: Divide into two smaller groups. Distribute lined paper and pencils. Tell participants that you are going to distribute 3 of the 4 handouts after you give them the instructions. Instruct them to review the handouts in the smaller groups and then generate a one-page list of work related demands and possible underlying interests and needs. Distribute the following handouts: “Nature of conflict;” “Interests, needs, demands, and resolving conflict;” and “Maslow’s hierarchy of needs.” Give participants 15 minutes to review handouts and generate list. Then reconvene in larger group and ask each smaller group to share their list of demands and underlying concerns.

Divide into dyads. Distribute the handout “Negotiating win/win solutions.” Ask each participant to review the handout and then answer the questions on the handout. Give participants 5 minutes to review the handout and then answer the questions. Then ask participants to share and discuss their responses in dyads. Give participants 10 minutes to discuss in dyads. Reconvene in the larger group and invite participants to share their responses.

Ask open-ended questions to process this exercise (e.g. How might having negotiating skills help with obtaining and maintaining employment? How might being skillful at identifying possible underlying needs, interests, and concerns assist with successful co-worker and employer relationships?)

PROCESS/CLOSING PHASE (20 minutes)
• Ask the following questions: How can you integrate these skills over the next week? What stood out to you about today’s session?
• Homework: Invite participants to commit to resolving a conflict and creating win/win solutions this week.
• Thank the group for all the hard work they did today.
• Next week will talk about managing time and prioritizing. Remind of next group meeting, time and date.
• Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire on-line during the week.
• REMEMBER:
  WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION 7: MANAGING TIME EFFECTIVELY
(1.5 hours)

PRIOR TO SESSION

MATERIALS:

Pencils or pens

Four Handouts: “Time management: What’s getting in the way;” “Improving your estimating skills;” “Managing daily tasks: The wade formula;” and “Tips for streamlining common tasks” (Refer to Appendix: Session 7)

PREPARATION:

Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)

• Welcome participants. Mention that this is session 7 of 10 sessions and that we are more than half way through the group counseling program
• Ask about homework (resolving conflict/creating win-win solutions) and invite participants to share
• This week we are going to shift the focus to managing time effectively

WARM UP (20 minutes)

Activity: This activity involves participants getting out of their chairs and walking to a different part of the room. In this activity, ask members to rate extent to which they feel confident about their time management skills. On a scale from 1 to 10, with 1 = “Not at all confident” and 10 = “Very Confident”, designate one side of the room to represent 1 and the opposite side to represent 10. Explain that the middle point between these two opposites represents a 5= “Some confidence in time management skills”. Once you have explained this, ask participants to leave their chairs and walk to the point in the room they think best represents their level of confidence in their own time management skills. Then ask each participant to the reasons for his/her response. Link members, point out commonalities, and ask open-ended questions to deepen understanding of member choices (e.g. What do you believe is getting in the way of feeling confident about your time management skills?) If there are a few people in the “Very confident” category, ask probing questions to discover time management strategies. Figure out ways that the group members can assist each other in time management (e.g. later in the group ask one of the members who is very confident to mentor a member whose skills are not as strong).

• You have the power to make choices and to influence how you spend your time. Time management is about acknowledging what’s important to you and giving those important things a place in your schedule.
• The first step is to take a close look at what is getting in the way of you focusing on the things that are important to you. When you understand what is causing your time management problems, you will be in a better place to address your unique time management issues and accomplish all that you wish to do.
WORKING PHASE (40 minutes)

- During our working phase, we will first explore the obstacles that may be interfering with managing time effectively. Next we will look at improving the skill of estimating the length of time tasks take. Finally, we will cover how to manage large numbers of tasks.

**Distribute the handout “Time Management: What’s getting in the Way?” Introduce and discuss this handout as a group. Have participants identify obstacles they face in managing time effectively. Distribute pencils in case participants want to take notes (5 to 10 minutes)**

**Exercise 1:** In dyads, ask participants to do the following: 1) review the handout “Improving your estimating skills” and 2) If not good at time estimation, then ask participant to discuss how might apply at least one suggestion for improving his/her estimation skills. If good at estimation, what suggestions does participant having for improving time estimation skills? After giving instructions then distribute the handout. Give participants 10 minutes to discuss. Reconvene as a large group and ask open ended questions about what discussed in dyads. In large group discuss for 5 minutes.

**Exercise 2:** Divide into two smaller groups. Ask participants to do the following: 1) review the two handouts: “Managing daily tasks: the wade formula” and “Tips for streamlining common tasks” and 2) How might each participant implement at least one suggestion from the handouts? Once you have given the instructions, then distribute the two handouts. Give participants ten minutes to discuss in smaller groups. Then reconvene as a large group and ask open-ended questions about what discussed in small groups. In large group discuss for 5 minutes.

**Ask:** How might the information from the handouts be useful for obtaining and maintaining employment?

PROCESS/CLOSING PHASE (20 minutes)

- Ask the following questions: How can you integrate these skills over the next week? What stood out to you about today’s session?
- Homework: Invite participants to applying at least one suggestion for managing time more wisely. Be prepared to share with the group next week.
- Next week will focus on assessing strengths and abilities. Remind of next group meeting, time and date.
- Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire on-line during the week.
- **REMEMBER:** WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE
SESSION 8: ASSESSING STRENGTHS AND ABILITIES
(1.5 hours)

PRIOR TO SESSION

MATERIALS:
Pencils or pens
Lined paper (half sheets)
3 Handouts: (“Descriptive words for positive character traits;” “Skills Rating Handout” and “Skills of Success” Refer to Appendix: Session 8)

PREPARATION:
Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)
- Welcome participants. Mention that this is session 8 of 10 sessions and that we only have two more sessions counting today.
- Now is the time to start preparing participants for the last group session. To this end, consider conducting a 1 to 10 scale round. Ask participants, on a scale of 1 to 10, with 10 being very ready and 1 being not at all ready, how ready are they to wrap things up and say goodbye to the group. Explain that you will be spending some time discussing this at each session. Explain what will be doing at each session moving forward. Lay out for participants exactly what you will be doing each week to bring closure to the group. Let the members know that the last session will be about reviewing what have learned and designing a plan for continued growth
- Ask about homework (implementing one time management strategy) and invite participants to share
- This week we are going to focus on assessing abilities and strengths.

WARM UP (20 minutes)
Activity: This activity involves acknowledging and recognizing the strong points of group members. Distribute the “Descriptive words for positive character traits” handout and pencils/pens. Give each participant as many half sheets of paper as there are other participants. At the top of each half sheet, have participants write the other participants names with a different name on each sheet. Ask participants to list one positive character trait for each group member utilizing a separate sheet of paper for each member. Give participants five minutes to make the lists. Then have participants share what they wrote for each participant, briefly explaining why they chose that word for that person. After sharing, have participants give the cards to the participant in question.

After everyone has shared their words, ask the following open-ended questions to process the exercise:
What was it like having others share their words about you?
Did any of the words about you surprise you? Why or why not?
How might you use the information today to apply for jobs? Prepare for interviews? Seek a promotion at work?

WORKING PHASE (40 minutes)

- The working phase of today’s session is about focusing on abilities and strengths. We are interested in what people can do rather than what they cannot.
- To start things off, we are first going to have everyone rate their skills using a rating sheet. Then we will invite each of you to develop a 30 second infomercial highlighting the skills and abilities you have to offer to an employer.

Exercise: Divide into pairs. Distribute the “Skills Rating Handout” Give participants 3 to 5 minutes to quickly rate how skilled they believe they are in a variety of areas. In dyads, have participants discuss the ways in which they have or could utilize their skills in work situations. Then ask the pairs to develop a 30 second Infomercial of what each participant could bring to an employment situation. Give participants 15 minutes to develop these infomercials. Reconvene as a large group and ask participants to share their infomercials with the class. Ask open-ended questions to process the exercise (What did you discover about your skills today? Are there any skills that you didn’t realize you have? What was it like discussing your skills with your partner? What was sharing your infomercial with the class like? How might you apply today’s exercise to applying for jobs, writing resumes, interviewing for positions, and asking for a raise?)

PROCESS/CLOSING PHASE (20 minutes)

- Ask the following questions: How can you integrate what you learned today over the next week? What stood out to you about today’s session?
- Homework: Distribute the “Skills of Success” handout. Invite participants to review the handout and take the one-time assessment of skill strengths and challenges by going to the web address listed on the handout. Tell participants to bring the handout and the assessment results with them next week.
- Thank the group for all the hard work they did today.
- Next week will talk about managing disability and workplace accommodations. Remind of next group meeting, time and date.
- Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire on-line during the week.
- REMEMBER: WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE

One word feedback activity taken from:
SESSION 9: MANAGING DISABILITY AND OVERCOMING OBSTACLES  
(1.5 hours)

PRIOR TO SESSION

MATERIALS:
Colored pencils or colored markers
Six Handouts: “Cross off Marks;” “Fears, Hopes, Considerations” “Overcoming Obstacles Worksheet;” “Sample Reasonable Accommodation Request Form;” and “Skills for Success.” “Skills for Success” handout also used last session. Sixth handout “Visualizing the Future” is a written homework exercise (Refer to Appendix: Session 9)

PREPARATION:
Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (10 minutes)

- Welcome participants. This week we are going to shift the focus to managing disability effectively
- Mention that this is session 9 of 10 sessions and that we only have two more sessions counting today.
- Normally would discuss homework. However, mention that will be discussing the homework handout (“Skills for Success”) during today’s working phase.
- Rather than discussing homework, use this time to continue the process of ending the group. Consider doing a hopes, fears, and considerations round. Distribute the handout “Fears, Hopes, and Considerations.” Ask participants to read the four sentence stems. Ask for volunteers to share the hopes, fears, or considerations they have about other group members.

WARM UP (20 minutes)

Activity: The more you know about how to do something, the more likely you are to be successful. Knowledge is power. The purpose of today’s activity is to demonstrate how important knowledge is to being successful. Have participants divide into pairs.

This activity is called “Cross off marks.” Facilitator and co-facilitator will demonstrate the activity. To demonstrate cross off marks, first make 15 large vertical marks on the whiteboard in three sets of five. Then explain that this game is played by each person taking turns crossing off one, two, or three marks on the page. The last person who is stuck crossing off the very last vertical line looses. Once you and your co-facilitator have demonstrated the game, have participants divide into pairs. Distribute the “Cross off marks Activity” handout to each participant. Then distribute pencils/pens (colored pencils are best). Ask that participants play ten rounds (2 pages). See if they can figure how to win the game. After participants have played the ten rounds, ask them if they noticed any patterns about how to win. Then explain the “secret” to winning the game.

-----
Secret to winning “cross off marks” game: To win the game, you want to try to cross off marks two, six, and ten. If you are able to cross these marks off (and especially mark number 10), then you will always be the winner. It doesn’t matter who goes first.

-----

Ask open-ended questions to process the activity (e.g. how might this activity apply to managing disability in the workplace?)

**WORKING PHASE** (40 minutes)

- Part of managing disability and returning to work involves capitalizing on one’s strengths while working around one’s limitations. Your chances of being successful will increase if you have a clear plan for accommodating your limitations and using your strengths to work through challenges.

**Exercise 1:** Divide into pairs. If participants did not bring the “Skills for Success” Handout with them from last week, then distribute replacement handouts. Remind participants of the homework from last week (e.g. review the handout and take the one-time assessment at web address listed). For participants who took the assessment, ask them to discuss their top three strengths in the 12 skill areas and the top three challenge areas of the “Skills for Success” handout. For participants who did not take the on-line assessment, ask them to mark what they believe their top three strengths and top three challenges to be on the list. Give participants 5 minutes to discuss this in dyads. Then reconvene as a large group and ask for volunteers to share what they discovered about their strength areas and challenges.

**Exercise 2:** Divide into two smaller groups. In addition to pens/pencils, distribute the following: “Overcoming Obstacles Worksheet” and “Sample Reasonable Accommodation Request Form”. On the top of the obstacles worksheet, ask each participant to list his/her employment goal. Then ask participants to reflect upon and write down the top three obstacles/challenges to reaching that employment goal. Also ask participants to reflect on possible ways to address those challenges. Ask them to consider utilizing the skill strengths from above to help generate alternatives to overcoming the challenges or obstacles they face. Finally, ask participants to write a specific action plan for addressing these obstacles and challenges. Invite participants to work in their smaller groups to develop the action plan. Also ask participants to consider asking for accommodations where needed. Give participants 15 minutes to fill out the “Overcoming Obstacles Worksheet”; review the accommodations form and discuss in their action plans in smaller groups. Reconvene as a larger group and ask for volunteers to share their challenges, alternatives, and plans with the group.

**PROCESS/CLOSING PHASE** (20 minutes)

- Ask the following questions: How can you use what you learned today to assist you in seeking and maintaining employment? What stood out to you about today’s session?
- Homework: Distribute “Visualizing the Future” handout. Ask participants to think about what each group member may be doing in six months and again in one
year from now. Ask participants to record their thoughts about each member in the space provided.

- Thank the group for all the hard work they did today. Next week will be our last meeting. Remind of next group meeting, time and date. Remind to check e-mail for link to questionnaire. Follow link and fill out the questionnaire online during the week.

- REMEMBER:
  WHO YOU SEE HERE, WHAT YOU HEAR HERE, WHEN YOU LEAVE HERE, LET IT STAY HERE

Cross-off Marks activity adapted from:
SESSION 10: REVIEW AND PLAN FOR SUCCESS
(1.5 hours)

PRIOR TO SESSION
MATERIALS:
Pens/pencils
Lined paper
3 handouts: ("Then and Now;” “Group Program Summary;” “Visualizing the Future;”)
PREPARATION:
Review session plan; post group rules; copy and organize handouts; retrieve lined paper; sharpen pencils; arrange chairs into circle (space permitting)

WELCOME (5 minutes)
• Welcome participants. Mention that this is the last session. Rather than covering the homework, do a quick 1 to 10 round, with 1 equaling “Not at all ready” and 10 equaling “Completely ready;” Ask participants how ready they are for group to end. Reassure members that will really work on having everyone ready by the end of the session.
• Today we will review and summarize what we have learned over the past nine weeks. We will also focus on formulating a plan for applying that learning. We will assess how group members have grown and changed, finish unfinished business, and talk about feelings that members may have about the group ending.

WARM UP (15 minutes)
Activity: Distribute the “Then and Now” handout and pens/pencils. Ask participants to think about their experience of the group, each member of the group, and the facilitators and then answer the questions on the handout. Give participants 10 minutes to fill out the handout. Then ask participants to share with the group what they have written. Once participants have shared, then ask open-ended questions to process the activity (e.g. What did you discover from this activity? What about the sharing stood out to you?)

WORKING PHASE (30 minutes)
• Distribute the “Group Program Summary” handout. Briefly review major points of previous sessions. This summary should be no longer than 8 minutes.
• Distribute lined paper and pencils. Ask members write about some aspect of the group (e.g. four or five things that have learned in group, most helpful group experience, sessions that were particularly helpful, etc.). In dyads, small group, or whole group, have members share what have written.
• Also ask participants to share what they have learned from other members or memories they have of other participants. Ask participants to acknowledge and celebrate the growth of other participants. Congratulate participants on their growth.
Exercise: Ask participants to think about how they can apply what they have learned. Ask them to write down steps they will take to apply that learning to their everyday lives. Ask participants to divide into dyads or triads and to discuss what have written. When bring the big group back together, ask for volunteers to share what steps they will take to apply what they have learned.

CLOSING/PROCESS PHASE (40 minutes)
• For the closing phase, focus on handling feelings of separation and saying goodbye. One way to do this is through visualization exercises. We will do a writing exercise and a visualization exercise.

  Writing Exercise: Remind participants of the homework wherein you asked them to visualize what each participant would be doing 6 months and 12 months from now and complete the “Visualizing the Future” handout accordingly. For those that did not do the homework or bring the handout with them, redistribute the “Visualizing the Future” handout. Distribute pencils/pens. Give participants 5 to 10 minutes to write any remaining thoughts about each participant’s future. Then ask participants to share with the group what they wrote. Give participants 10 minutes to share and discuss.

  Visualization Exercise: Now that have finished writing what we see others doing, we are going to do a visualization exercise about what we see ourselves doing in five years. Say the following: “Now relax and close your eyes if that is comfortable for you. Imagine five years from now; you have just been invited to a group reunion and have decided to attend. Think about where you are living and with whom. What significant events have occurred in the past five years? What do you most want to share about your life now? In a minute I am going to ask that you walk around the room and share your thoughts with other group members. I want you to act like you are seeing the other group members for the first time in 5 years. OK, open your eyes, start milling around the room and sharing with others.” Give members about 10 minutes to mill and talk with other members. Then ask open-ended questions to process the exercise (e.g. what did they discover about the other group members? What was it like for you to visualize what you would be doing in five years?)

• For most members saying goodbye will be a smooth process. However, some members may experience anxiety. Facilitate members handling separation feelings by validating that such feelings are normal. Allow members to express their feelings of sadness or loss. Point out that the sharing and closeness they experienced in this group need not end with this group. They can develop close connections with other groups/people.

• Re-emphasize the importance of maintaining confidentiality after the group has ended.

• Mention other resources that are available to them. Offer to meet with members separately if necessary.

• Before you close, let participants know that the researcher Saara Grizzell will be contacting them to ask some additional questions, discuss the study, feedback
charts. Let them also know that in approximately 3 months she will send information via e-mail about the results of the study.

- Let them know that will be repeating this group program again and will start in ____ weeks.
- If have decided to do a follow-up, then mention the date, place, time of the follow-up.

*Visualization exercise adapted from:*
APPENDIX C

Outcome Questionnaire (OQ-45.2)
### Outcome Questionnaire (OQ-45.2)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along well with others.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. I tire quickly.</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>O</td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td>O</td>
<td>O</td>
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<tr>
<td>4. I feel stressed at work/school.</td>
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<tr>
<td>5. I blame myself for things.</td>
<td>O</td>
<td>O</td>
<td>O</td>
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</tr>
<tr>
<td>6. I feel irritated.</td>
<td>O</td>
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<td>O</td>
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<td>O</td>
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<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td>O</td>
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</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td>O</td>
<td>O</td>
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</tr>
<tr>
<td>9. I feel weak.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>10. I feel fearful.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark “never”).</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>O</td>
</tr>
<tr>
<td>12. I find my work/school satisfying.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>13. I am a happy person.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>14. I work/school satisfying.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>15. I feel worthless.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>16. I am concerned about family troubles</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>17. I have an unfulfilling sex life.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>18. I feel lonely.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>19. I have frequent arguments.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>OQ-45 (continued)</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Almost Always</td>
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</tr>
<tr>
<td>20. I feel loved and wanted...............</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>21. I enjoy my spare time...............</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>22. I have difficulty concentrating......</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>23. I feel hopeless about the future.....</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>24. I like myself.........................</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>25. Disturbing thoughts come into my mind that I cannot get rid of.......</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>26. I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark “never”).....</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>27. I have an upset stomach.............</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>28. I am not working/studying as well as I use to.........................</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>29. My heart pounds too much............</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>30. I have trouble getting along with friends and close acquaintances....</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>31. I am satisfied with my life..........</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>32. I have trouble at work/school because of drinking or drug use (If not applicable, mark “never”)............</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>33. I feel that something bad is going to happen........................</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>34. I have sore muscles..................</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>36. I feel nervous........................</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
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</tr>
<tr>
<td>37. I feel my love relationships are full and complete…………..</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>38. I feel that I am no doing well at work/school…………………</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>39. I have too many disagreements at work/school…………………..</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>40. I feel something is wrong with my mind…………………….</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>41. I have trouble falling asleep or staying asleep………………..</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>42. I feel blue………………………………</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>43. I am satisfied with my relationships with others…………………</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>44. I feel angry enough at work/school to do something I might regret………</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>45. I have headaches………………………………</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
APPENDIX D

Assessment of Signal Clients (ASC)
Assessment of Signal Clients (ASC)

INSTRUCTIONS: (#1-11): The following statements describe attitudes people might have about their counselor. Please answer the questions below about the group counselor with whom you are also receiving individual VR services. Thinking about the last group session you completed with your counselor:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt cared for and respected as a person.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. I felt my counselor understood me.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. I found the suggestions my counselor made were useful.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. I felt like I could trust my counselor completely.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. I was willing to share my innermost thoughts with my counselor.</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6. I felt there was a breakdown in the relationship with my counselor.</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7. I felt like my counselor disapproved of me.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>8. At times, the tone of my counselor’s voice seemed critical or impatient.</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9. My counselor seemed to be glad to see me.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>10. My counselor and I seemed to work well together to accomplish what I want.</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>11. My counselor and I had a similar understanding of my problems.</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

INSTRUCTIONS (#12-22): The following statements describe the support you felt outside of group counseling during this last week:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. I could count on my friendships when things went wrong.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>13. I could talk about problems with my friends.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>14. I could talk about problems with my family.</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>15. I got the emotional help and support I needed from someone in</td>
<td></td>
<td></td>
<td></td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
my family.  

16. There was a special person who was around when I was in need.  

17. There was a special person with whom I could share my joys and sorrows.  

18. I could get material support if needed (like: money, food, transportation, childcare, tools, repairs, health care, legal advice, etc.)  

19. I had support from social groups (like: church, school, AA, clubs, etc.)  

20. I felt accepted by someone other than my counselor.  

21. I felt connected to a higher power.  

22. Some subjects were so sensitive I couldn’t talk with anyone about them.  

INSTRUCTIONS (#23-31): The following statements describe some current feelings about being in group counseling. Looking back over the past week:

23. I wonder what I am doing in group; actually I find it boring.  

24. Honestly, I really don’t understand what I can get from group.  

25. I am not really sure what to work on in group.  

26. I had thoughts about quitting group; it’s just not for me.  

27. I don’t think group will help me feel any better.  

28. I have no desire to work out my problems.  

29. Although I am currently unhappy with life, there is nothing I can do about it now.  

30. Through group I am taking more responsibility for changing my life.  

31. I am in group because someone is requiring it of me.
INSTRUCTIONS (#32-40): During this past week:

32. I had an interaction with another person that I found upsetting. - O O O O O
33. I felt rejected or betrayed by someone. ~ ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
34. I made a mistake that I can’t undo. ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
35. I received bad news that was difficult for me. ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
36. I lost a person I was close to. ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
37. There was trouble at home, work, or school. ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
38. I had health problems (such as physical pain). ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
39. I shrank from facing a crisis or difficulty. ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ O O O O O
40. I had difficulty adjusting to an occurrence in my life. ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ O O O O O

Selected words of this questionnaire have been modified. Permission given by Michael J. Lambert to slightly modify these words for use in the following study: The use of feedback in group counseling in a vocational rehabilitation setting: A pilot study.
APPENDIX E

Clinical Support Tools Decision Tree
Clinical Support Tools Decision Tree

1. Does the client report Concerns with the Therapeutic Alliance?
   - Yes → See Therapeutic Alliance Intervention handout. Proceed to #2
   - No → 2. Does the client report Problematic Motivation?
     - Yes → See Stages of Change Interventions handout. Proceed to #3
     - No → 3. Does the client report Low Social Support?
       - Yes → See Social Support Interventions handout. Proceed to #4.
       - No → 4. Does the client report an important Stressful Life Event?
         - Yes → See Life Event Handout. Proceed to #5.
         - No → 5. Reassess the diagnostic formulation. Is there an effective treatment option that has not been attempted?
           - Yes → Consult relevant resources and alter the treatment plan. Proceed to #6.
           - No → 6. Is medication an effective treatment option?
             - Yes → Refer for psychiatric consultation.
             - No
APPENDIX F

Group Readiness Questionnaire (GRQ)
### Group Readiness Questionnaire (GRQ)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I am with a group of people who are talking about a topic I feel strong about, how likely am I to express my opinion?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. I like to share my feelings with others...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. I avoid talking in groups...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. I often feel like an outsider in group discussions</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. I typically dominate group discussions</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6. I hardly ever say what I’m thinking when I am with a group of people...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7. If I disagree with what someone is saying, I will interrupt them before they can finish what they are saying...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>8. When I first meet someone, I like to share things about myself...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9. I am very private and hardly ever share how I feel...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>10. I think that working in a group will really help me...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>11. If I participate in a group, I expect to feel quite a bit better when we are finished</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>12. I think that sharing my feelings with others will help me feel better</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>13. I am abrupt with others if I feel strongly about what I am saying....</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>14. I tend to keep to myself in groups...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>15. I often contribute to group discussions</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>16. I am an open person...</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
17. I argue for argument’s sake........ O  O  O  O  O  O
18. I am the life of a party............. O  O  O  O  O  O
19. Others tend to see me as withdrawn O  O  O  O  O  O
APPENDIX G

Purchase of License to Use OQ-45, GRQ, and ASC
# Purchase of License to Use OQ-45, GRQ, and ASC

![OQ Measures LLC Logo]

**OQ Measures LLC**
PO Box 521047
Salt Lake City, UT 84152

(801) 649-4392
Sales@OQMeasures.com
www.OQMeasures.com

---

**Bill To**

Saara Grizzell  
Utah State University  
Dept of Special Education & Rehab Counseling  
2865 Old Main Hill  
Logan, UT 84322-2865 USA

---

**Invoice**

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
<th>Quantity</th>
<th>Price Each</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>102-</td>
<td>OQ Analyst Software - Research Project - OQ 45, OQ GRQ, OQ ASC</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>104-</td>
<td>Technical Support - Fees Waived per Mike</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>401-</td>
<td>Shipping and Handling - Fees Waived Per Mike</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Payment**

| Total       | $           |
| Payment     | $           |
| Balance Due | $0.00       |

---

Phone Number: (801) 649-4392
Fax Number: (801) 747-6900
Website: www.OQMeasures.com
CURRICULUM VITAE

Saara T. Grizzell  648 South 1200 East
saara.grizzell@aggiemail.usu.edu  Salt Lake City, UT 84102
Phone: 801-550-9786

Education
Bachelors, Psychology, Honors, University of Utah, Salt Lake City, Utah, 1994
Masters, Rehabilitation Counseling, Honors, Utah State University, 2007
Doctorate, Disability Disciplines, Rehabilitation Counseling, Utah State University, 2015

Certifications and Licenses
CRC, Commission on Rehabilitation Counselor Certification, Certificate # 00102959
LVRC, Utah Division of Occupational & Professional Licensing, License # 7619255-6101

Other Training
Teacher’s Training, DUI Intervention Groups, Utah Division of Substance Abuse, Prevention Research Institute, Salt Lake City, Utah, 2002.

Background, Skills and Experience
• Acknowledged skill teaching masters level vocational rehabilitation and group counseling courses
• Many years experience facilitating successful neuro-orientation, psychoeducation, and addictions recovery groups
• Many years experience providing counseling and guidance in the field of vocational rehabilitation, public and private settings
• Background in the provision of neuro-rehabilitation services
• Strong supervisory, agency and administration management skill
• Acknowledged expertise in forensic vocational evaluation and rendering court testimony

**Presentations**


**Publications**


**Employment Summary**
2014 – Current   Utah State Office of Rehabilitation, Draper, Utah *(Case Manager)*
2014 – Current   Utah State University, Logan, Utah *(Group Counseling Instructor)*
2008 – 2011   Masters Level Courses, Utah State University, Logan, Utah *(Instructor)*
2002 – 2007   Vocational Consulting Solutions, Inc., SLC, Utah *(Owner)*
2006 – 2007   Utah State Office of Rehabilitation, Taylorsville, Utah *(Rehab Counselor)*
1999 – 2006   Intermountain Substance Abuse, SLC, Utah *(Group Facilitator/Instructor)*
1999 – 2002   CorVel Corporation, SLC, Utah *(Vocational Rehab Specialist)*
1999 – 2000   Utah Brain Injury Association, SLC, Utah *(Employment Specialist)*
1998 – 2000   Rehab Without Walls, SLC, Utah *(Program Case Manager)*
1996 – 1998   Learning Services, West Valley, Utah *(General Manager/Coordinator)*
1994 – 1996   Learning Services, West Valley, Utah *(Employment / Life Skills Trainer)*
1991 – 1994   Psychology Department, Advising Center, University of Utah *(Director/Advisor)*