ENGLERT, MICHAEL KEITH. Evaluating Quality of Life, General Health, and Client Satisfaction from Counseling Services Provided at a Community-Based Counselor Education Program-Operated Counselor Center. (Under the direction of Dr. Marc A. Grimmett.)

Counselor education and supervision community-based counselor training centers play a unique role in providing counseling services to marginalized and underinsured members of the community. The purpose of the quantitative study was to evaluate the effectiveness of services provided in a community-based university counseling training center. Participants included 27 individuals receiving counseling from master’s level students. An electronic packet that included a demographic questionnaire called the Counseling Client Information Form (CCIF), the World Health Organization Quality of Life-BREF (WHOQOL-BREF), and the Counseling Client Questionnaire (CCQ) was given to participants on average three times during a sixteen-week period. Participants showed significant change in overall quality of life and within the physical health and psychological domains as measured by the WHOQOL-BREF. Results also indicated high levels of satisfaction as measured by the locally generated CCQ. Although results indicated a high level client satisfaction, the level of satisfaction did not change significantly over time. Overall, the counseling center was found to be providing valuable and effective counseling services to the community. Given the need for mental health services, it is recommended that university funding for the community-based counseling center be maintained.
Evaluating Quality of Life, General Health and Client Satisfaction from Counseling Services at a Community-Based Counselor Education Program-Operated Counseling Center

by
Michael Keith Englert

A dissertation submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Counseling and Counselor Education

Raleigh, North Carolina
2019

APPROVED BY:

Dr. Marc A. Grimmett
Committee Chair

Dr. Stanley B. Baker

Dr. Helen Lupton-Smith

Dr. DeLeon Gray
DEDICATION

To Stacy, thank you for always being there, especially during this long process. I will be forever grateful for the sacrifice and time you gave to this endeavor. I love you!

Also, my parents Mike & Becky, for your unconditional love, encouragement and support. I miss you every day.

And, to Jerry, who never stopped believing.
BIOGRAPHY

Michael Keith Englert was born in Texas and raised in Charleston, West Virginia. He earned his bachelor of arts in psychology from The University of South Florida. He subsequently graduated with a master’s degree in clinical mental health counseling from The University of South Florida. Upon graduating, Michael worked extensively as a substance abuse counselor in both agency and private settings. As a doctoral student he was active in the development and implementation of the North Carolina State University Community Counseling, Education, and Research Center, held the position of president of the Nu Sigma Chi chapter of Chi Sigma Iota, and co-founded the North Carolina Statewide Chi Sigma Iota Advocacy Summit. He is a licensed Clinical Mental Health Counselor, National Certified Counselor, and master’s level Certified Addiction Professional. He is also a member of the North American Society of Adlerian Psychology (NASAP).
ACKNOWLEDGMENTS

I would like to acknowledge all of those who have greatly influenced me on this journey. Thank you, Stacy! Your unwavering support, love, and patience brought calm when it was needed most. I would like to express my gratitude to Dr. Grimmett; you provided me the courage to see the world in a way that is rewarding and meaningful. Your enthusiasm will forever inspire me. Dr. Baker gave me mentorship; your sharing of wisdom and guidance brought a new meaning to CSI. I will be forever touched by the time we spent together. Dr. Lupton-Smith, provided friendship; your sense of calm and compassion will forever be with me. Dr. Gray provided me encouragement; thank you for your inspiration and patience. I will be forever grateful. Pauline; you are the best—my guiding light; thank you for being in it with me! To my friend and colleague Dr. Alyx Beckwith; thank you for your kindness and humor! I will forever cherish the great times we shared as CCERC coordinators.

To all who carry on the CCERC experience, enjoy! I want to thank everyone who participated, planned, and believed in CCERC. I am so grateful to have been around such wonderful people, those who took a dream and made it a reality: an incredible experience indeed. I will always be there to watch CCERC grow.
# TABLE OF CONTENTS

LIST OF TABLES ................................................................................................................... vii

LIST OF FIGURES .................................................................................................................. viii

Chapter 1: INTRODUCTION ...................................................................................................... 1

Background of Study .............................................................................................................. 2
  Program Evaluation .............................................................................................................. 2
  Counseling Training Center ............................................................................................... 3
  Statement of the Problem .................................................................................................... 5

Research Design and Purpose of the Study ......................................................................... 7
  Research Questions ........................................................................................................... 10
  Significance of the Study .................................................................................................. 10
  Theoretical Framework ...................................................................................................... 12
  Summary ............................................................................................................................ 13

Chapter 2: LITERATURE REVIEW ......................................................................................... 14
  History of Program Evaluation ......................................................................................... 15
  Perceptions of Counseling Program Evaluation ............................................................. 18
    Challenges to Counseling Program Evaluation .............................................................. 21
    Program Evaluation and Accountability ....................................................................... 21
  Accountability Practices for Counseling Programs .......................................................... 22
    Formative Evaluation ...................................................................................................... 23
    Summative Evaluation .................................................................................................... 24
  Program Evaluation Models .............................................................................................. 24
    Improvement-And-Accountability-Oriented Approaches ................................................ 24
    The Context, Input, Process, and Product Model (CIPP) ............................................... 26
    Business-Oriented Evaluation Model ........................................................................... 28
    The Accountability Bridge Model for Counselors .......................................................... 28
      Counseling Program Evaluation Cycle ....................................................................... 30
      Accountability Bridge ................................................................................................. 30
      Counseling Context Evaluation Cycle ....................................................................... 31
  Summary ............................................................................................................................ 32

Chapter 3: METHOD ................................................................................................................. 34
  Purpose of the Study .......................................................................................................... 35
  Research Design ................................................................................................................. 35
  Research Questions ........................................................................................................... 37
  Community Counseling Education, and Research Center (CCERC) ................................ 38
  Population and Sample Selection ...................................................................................... 40
  Instruments ........................................................................................................................ 42
    Client Demographic Questionnaire (CCIF) .................................................................... 42
    The World Health Organization Quality of Life (WHOQOL)-BREF ............................... 43
    Development of the CCERC Counseling Client Questionnaire (CCQ) ......................... 44
    Client Satisfaction Questionnaire ................................................................................... 46
    CCERC Client Questionnaire ......................................................................................... 47
  Data Collection .................................................................................................................. 50
Data Analysis 51
Summary 52

**Chapter 4: RESULTS** 54
Research Question 1 58
Research Question 2 61
Research Question 3 65
Summary 67

**Chapter 5: DISCUSSION** 68
Summary of Study 68
Discussion of Findings 69
Quality of life 69
WHOQOL-BREF 70
Research Question Three 72
Implications for Practice 74
Implications for Counseling and Counselor Education 76
Recommendations for Future Research 77
Limitations 79
Conclusion 80

**REFERENCES** 83

**APPENDICES** 99
APPENDIX A: Counseling Client Information Form 100
APPENDIX B: WHOQOL-BREF 105
APPENDIX C: Counseling Client Questionnaire 108
APPENDIX D: Informed Consent Form 109
LIST OF TABLES

| Table 4.1 | Basic Demographics | 55 |
| Table 4.2 | Occupational and Educational Demographics | 56 |
| Table 4.3 | Counseling Demographics | 57 |
| Table 4.4 | WHOQOL-BREF Raw Quality of Life Measures | 60 |
| Table 4.5 | WHOQOL-BREF Domain Scores | 64 |
| Table 4.6 | CCERC Satisfaction Questionnaire Scores | 66 |
LIST OF FIGURES

Figure 1  CCERC Counseling Client Questionnaire ......................................................... 49
Figure 2  Quality of Life Boxplot and Histogram ............................................................. 59
Figure 3  Satisfaction with Health Boxplot and Histogram ............................................... 59
Figure 4  Quality of Life and Satisfaction of Health Results ............................................. 60
Figure 5  Physical Domain Boxplot and Histogram ......................................................... 62
Figure 6  Psychological Domain Boxplot and Histogram ............................................... 62
Figure 7  Social Relationship Domain Boxplot and Histogram ....................................... 62
Figure 8  Environment Boxplot and Histogram .............................................................. 63
Figure 9  Total Quality of Life Boxplot and Histogram .................................................... 63
Figure 10 All Domains Results ...................................................................................... 64
Figure 11 Total Quality of Life Results ........................................................................... 65
CHAPTER 1: Introduction

A growing number of counselor education programs operate community counseling centers to serve the needs of the counseling students and the community alike. However, those that cannot document their services as satisfactory may lose university funding, community funding, and an effective training environment for counselors in the program (Erford, 2014; Ernest & Hiebert, 2002). In this chapter, contextual factors motivating centers to focus on client quality of life, client satisfaction, and program success are explained.

The accountability and reform movements in education and in the human services profession have been calling for counseling administrators and the counseling profession to evaluate and demonstrate outcomes of counseling programs and services to maximize efficiency and effectiveness (Astramovich & Coker, 2007; Lloyd-Hazlett, 2018; Loesch, 2001; Maust, Oslin, & Marcus, 2013; Nielson, 2015). As counselor education programs accredited by the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) develop community counseling centers, the centers should be able to demonstrate that a perceived measurable change is being achieved and clients are satisfied with the services they receive (Berk & Rossi, 1999).

These evaluation changes are situated within the broader context of the evaluation field’s movement toward the objective of meeting the requirements of a sound theory (Smith, 1993). A proposed framework for empirically evaluating how theories perform in practice may yield the necessary contribution needed to reach the higher standard for determining what constitutes an empirically sound theory of program evaluation (Miller, 2010). Although theory informs practice in useful ways (Lewin, 1952), Stufflebeam and Coryn (2014) note that “feedback from practice
is needed to validate and strengthen theories” (p. 47). This study will provide feedback from practice.

This study will extend the literature on counselor education program-operated counseling training center program evaluation and accountability. The degree to which clients perceive quality of life and satisfaction are explored to further distinguish the effectiveness of the North Carolina State University counselor education program-operated counseling training centers. To exhibit counseling training center effectiveness, a larger foundation for program evaluation is needed; the accountability bridge model for counselors (Astramovich & Coker, 2007) will serve as the theoretical foundation for program evaluation of a counseling education program-operated counseling training center. The goals of this study are to describe client perceptions relating to quality of life, perceptions relating to satisfaction, and the degree to which program objectives are being met.

Background of Study

Program evaluation. Program evaluation roots can be traced back to the early days of education (Stufflebeam & Coryn, 2014). Educators have been assessing student learning through formal assessments since the 1840s, but systematic evaluation was not recognized until Ralph W. Tyler brought recognition to systematic evaluation with his seminal work in 1930 (Stufflebeam & Coryn, 2014). Since then, he has become known as the father of educational evaluation. Since 1930, education evaluation has progressed through numerous developmental periods (Stufflebeam & Coryn, 2014). The most current is our period of global and multidisciplinary expansion spanning from 2005 to present, a period known for the return to evidence-based evaluation models patterned after the evidence-based practice model of medicine (Stufflebeam & Coryn, 2014).
Evaluation theory was subject to a difficult development period during the 1960s and 1970s, and many theorists developed alternative conceptualizations to challenge the traditions in evaluation theory that restricted the creative theorists of the time (Stufflebeam & Coryn, 2014). Even though this period was challenging for theorists who opposed overwhelming interest in the rigorous scientific method, many creative theorists emerged. Michael Scriven (1973) advocated for goal-free evaluation. Robert Stake (1976) urged for responsive rather than preordinate evaluations. Egon Guba (1978), initially, and then Guba and Lincoln (1989) proposed a naturalistic evaluation against the overly established experimental design approach. Finally, Lee Cronbach (1982) called for contingency-based evaluation, emphasizing generalizability (Stufflebeam & Coryn, 2014).

For a relatively young profession, program evaluation has advanced significantly in the conceptualization of program evaluation (Stufflebeam & Coryn, 2014). Although more development in evaluation theory work is needed, significant progress in the field of evaluation in the last four decades has yielded a rich foundation of literature regarding concepts, standards, guiding principles, practical guidelines, and approaches setting a strong infrastructure for program evaluation theoretical development and practical application (Birckmayer & Weiss, 2000; Christie, 2003; Cullen, Coryn, & Rugh, 2011).

**Counseling Training Center**

A counseling training center embedded in a counselor education program brings great benefit to the practicum and intern counseling experience (Grimmett, Beckwith, Lupton-Smith, Agronin, & Englert, 2017). With an onsite clinical staff, immediate feedback, and faculty involvement, the community counseling model naturally provides accountability to the counseling interns, clients served, counselor education program, and the university (Grimmett et
There is limited information on the number of active counselor education counselor training clinics in the community (Mobley & Myers, 2010), but it is known that counselor education training clinics bring a distinct advantage to counseling student’s professional development (Sweeney, 2010) and to the community as providers of counseling services to marginalized, underinsured, and uninsured members of the community (Luka & McCarthy, 2013).

Counselors in training at counselor education training clinics are closely supervised, and supervisors often provide immediate feedback through live observation; however, it is also important to examine the effectiveness of training centers situated within the community. Effective evaluation may answer numerous questions relating to program effectiveness and accountability. It is important that counselor education programs and students developing training centers recognize the importance of program evaluation and accountability as an evolving standard of practice in counseling (Astramovich & Coker, 2007).

The community-based counselor training centers that served as the research sites for this study are operated by the department of counselor education and supervision located at North Carolina State University (NCSU). The Community Counseling, Education, and Research Center (CCERC) was originally developed as an on-campus counselor training clinic, but it transitioned to one site in the community rather than on the university campus after numerous conversations between a post-doctorate student, a community nonprofit organization, and NCSU faculty during the fall of 2015.

CCERC provides the following services to the surrounding community: individual and couples counseling for community members and students and workshops regarding mental health as well as multicultural and social justice issues for both high school students and
teachers. With a focus on providing counseling services to the underserved and underinsured members of the community, CCERC mostly serves an adult client population matching the demographic profile of the county in which the center is situated (Grimmett et al., 2018). Recently CCERC has experienced considerable growth and has garnered both positive feedback and financial support from university administration; to continue thriving, it needs a systematic process for assessing the effectiveness and impact of the program.

Statement of the Problem

Studying counseling outcomes may provide a comprehensive approach to understanding student counselors’ effectiveness. Measuring the effectiveness of counseling can be traced to the days of comparing symptomology of those receiving and those not receiving therapy in the early 1950’s (Scheurmann, Borsuk, Wong, & Somody, 2018). Outcomes measurement is now a part of health treatment around the globe (Wolpert, Cheng, & Deighton, 2015). However, limited research examining practicing counselors program evaluation is available (Astramovich, 2016; Carr, 2010; Nielson, 2015). Erford, Miller, Duncan, and Erford (2010) found minimal practitioner authors in Measurement and Evaluation in Counseling and Development; likewise, Crockett, Byrd, Erford, and Hayes (2010) found limited practitioner authors in Counselor Education and Supervision. A majority of the conducted research focuses on school counselors rather than student counselors working in community settings (Lloyd-Hazlett, 2018).

The few studies of counselor education training center evaluations are limited in scope; they have focused on specific populations, for example, where the majority of clients identify as Hispanic (Schuermann et al., 2018) and children (Tsai & Ray, 2011). More studies are needed of counselor education program-operated counseling training centers, especially how they are
evaluating their program outcomes and whether those outcomes demonstrate that the counseling is effective.

Program evaluation outcome results can produce sound information that can be provided to prospective clients, administrators, and colleagues (Whiston, 1996). Outcome measures provide evidence of client satisfaction and treatment progress or regression (Hafkenscheid, Duncan, & Miller, 2010; Reese, Norsworthy, & Rowlands, 2009). Outcome measures may also assist counselors-in-training in improving their counseling self-efficacy and increasing their awareness of their impact on clients. With the availability of outcome measures, student counselors may be better prepared to recognize clients who decline early in counseling. Research has indicated that clients who progress early often continue to progress while those clients who decline early may continue to decline (Bell, Hagedorn, & Robinson, 2016; Lutz, Lambert, Harmon, Tschitsaz, Schurch, & Stulz, 2006).

Evaluation as a process confirms reliability, effectiveness, efficiency, worth, value, and accountability (Stufflebeam & Coryn, 2014). Evaluative inquiry is large in scope given the wide range of disciplines, activities, and endeavors to which evaluation applies; however, a major focus of evaluative inquiry remains centered on program evaluation (Stufflebeam & Coryn, 2014). Program evaluation is a research discipline centered on the systematic process of collecting and analyzing information about the efficiency, effectiveness, and impact of a program and its services (Boulmetis & Dutwin, 2000). Program evaluation is utilized across disciplines and often described as a process for judging the worth of a program relative to other alternatives based on defensible, previously defined criteria (Scriven, 1980). Program evaluation can provide a nonarbitrary, credible, and defensible basis for terminating bad programs or, conversely, expanding good programs (Stufflebeam & Coryn, 2014). Factors such as environment,
population, political climate, needs of the community, community of the population, and cultural beliefs must be included as program evaluation become more culturally responsive (Heppner, Wampold, Owen, Thompson, & Wang, 2016).

There is increased interest in accountability in education and human services, and program evaluation may benefit the larger social system as a mechanism to promote prevention of behavioral health issues within the community (Ametrano & Stickel, 1999; Lloyd-Hazlett, 2018). Prevention may include an emphasis on risk reduction, social justice, and wellness, which aligns well with the prominence placed on social justice, multiculturalism, and human development in the counseling profession (Albee, 2000; Hage et al., 2007; Kiselica, 2001). Program evaluation is a concern for all counseling practitioners and stakeholders in institutional settings as well (Astramovich & Coker, 2007). Stakeholder feedback helps the evaluator develop program goals and adjust programs and interventions to align with the program goals (Ernst & Hiebert, 2002).

Counselor education program-operated counseling training centers offer a unique approach to addressing affordable community mental health issues by providing counseling from a wellness perspective (Grimmett et al., 2017). While extant models address the training needs of the counselor education program, a focus on client quality of life and satisfaction with community counseling services have often been overshadowed due to the time-consuming complex nature of counseling program evaluation (Loesch, 2001; Wheeler & Loesch, 1981).

Research Design and Purpose of the Study

The purpose of this study is to assess: (a) quality of life and (b) satisfaction of community members receiving counseling services provided by master’s level counseling students at a counselor education program-operated counseling training center. This study will assess overall
quality of life and general health, change within the quality of life domains of physical health, psychological functioning, social relationships, and environment along with client satisfaction at three specific time points during the duration of individual counseling.

It is not known to what degree the perception of quality of life and client satisfaction will change among clients who receive counseling services at a counselor education program-operated counseling center. Therefore, research is important to develop a better understanding of client’s perceptions of quality of life and satisfaction in order to (a) measure the degree to which clients are being helped and (b) distinguish between effective and ineffective approaches for the populations being served (Isaacs, 2003).

A multidimensional approach to program evaluation of a counselor education community counseling training center is used for this study. Demographic data was collected utilizing a modified version of the CCERC Client Information Form (CCIF). Two instruments were utilized to collect quantitative data: The World Health Organization Quality of Life-BREF (WHOQOL-BREF; The WHOQOL Group, 1998) and the CCERC Counseling Client Questionnaire (CCQ; Grimmett, Lupton-Smith, Beckwith, & Englert, 2016). The participants consisted of community members seeking counseling services at CCERC.

Demographic data were gathered utilizing a modified version of the CCIF. The demographic data included gender, sexual orientation, relationship status, education, occupation, alcohol and other drug use, self-harm, intimate partner relationships, and interpersonal violence. The questionnaire also included questions regarding utilization of counseling or therapy (e.g. participation in counseling or therapy, diagnosis or diagnoses, medication). This information was compiled to provide both a background and descriptive picture of the participant and utilization of mental health services.
The WHOQOL-BREF (The WHOQOL Group, 1998) centers on quality of life and provides the foundation for assessing individual’s perceived quality of life. The WHOQOL-BREF (WHOQOL Group, 1998) examines overall quality of life along four specific domains: physical health, psychological health, social relationships, and environment. In 1994 the World Health Organization (WHO) defined quality of life as “an individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns” (WHOQOL Group, 1995, p. 1405).

The WHOQOL-BREF response options range from 1 (very dissatisfied) to 5 (very satisfied) emphasizing the subjective responses rather than the objective life conditions. Field trials examining the WHOQOL-BREF performance as an integrated instrument found good to excellent psychometric properties of reliability and has performed well in tests of validity (Skevington, Lofty, & O’Connel, 2004). As a cross-cultural measurement tool, the WHOQOL-BREF has been tested extensively around the world (Skevington et al., 2004). The WHOQOL-BREF continues to be widely used with a variety of population groups including adults (Fleck et al., 2000), young adults (Li et al., 2009), medical students (Zhang et al., 2012), bipolar disorders (Chand et al., 2004), depression (Berlim et al., 2005), alcohol abuse (Da Silva Lima et al., 2005), and more recently military veterans (Guay, Fortin, Fiketoglu, Poundja, & Brunet, 2015; Lindsay et al., 2017).

The CCQ (Grimmett et al., 2016), a modified version of the Client Satisfaction Questionnaire-8 (CSQ-8), was developed to act as a brief instrument to evaluate client experience and satisfaction. Larsen, Attkisson, Hargreaves, & Nguyen (1979) developed the CSQ-8 to measure and assess consumer satisfaction with health and human services. The CSQ-8 is a brief instrument with documented validity and reliability in diverse client samples. With its
usefulness in a wide range of services, the CSQ-8 provided the appropriate structure and strength for the development of the 10 question CCQ for measuring client experience and satisfaction.

The design of this study is structured to answer the research questions presented in the following section. The purpose of this research study is to determine if—and to what extent—(a) quality of life and general health (b) satisfaction with counseling services changed following counseling services provided by counseling practicum and intern students at CCERC, a CACREP accredited counselor education program-operated community counseling center.

**Research Questions**

The following research questions guided this quantitative study:

**RQ1:** To what extent, if any, do counseling quality of life and general health change following counseling services at a counselor education program-operated community counseling center?

**RQ2:** To what extent, if any, do counseling client WHOQOL domains change following counseling services at a counselor education program-operated community counseling center?

**RQ3:** To what extent, if any, does client satisfaction with counseling services change during counseling services at a counselor education program-operated community counseling center?

**Significance of the Study**

Counselor education program-operated counseling centers allow for professional development for counselors-in-training, introduction to nonclinical activities, opportunities to participate in engagement scholarship, and most importantly counseling program evaluation and research. While there is a need for agreed-upon set of guidelines for counselor education program-operated counseling training centers, the concept of providing accountability for quality
services to those served deserves consideration (Astramovich & Coker, 2007; Luka & McCarthy, 2013).

Due to an established need for counseling accountability, the CCERC model provided an ideal framework for study. The model design is intended to address the systemic needs of the community which often remain unmet due to the nature of the traditional health-care and human services systems (Grimmett et al., 2017). Both counseling students and the general public seeking services at community-based counselor training centers may benefit from the low-cost services provided by counselor education program-operated counseling training centers. This study will seek to move beyond the complexities of counseling to provide a measure of client quality of life and satisfaction of clients seeking services while addressing the call for outcomes research and accountability relating to counselor education program-operated counseling training centers (Astramovich & Coker, 2007; Luka & McCarthy, 2013, Grimmett et al., 2017; Grimmett et al., 2018; Schuermann et al., 2018).

With 67 CACREP (CACREP, 2019) accredited counselor education doctoral programs across the country and a reported 39 active counselor education training clinics providing counseling services to both students and the community (Aces CDPC Interest Network Counseling Clinic Directory, 2015), it is likely many of the remaining counselor education doctoral programs will engage in the development of their own community counseling center to address the mental health needs of the communities in which they are located. Interestingly, only 3 of the 39 active counselor training clinics are located off-campus in the community. According to Lauka and McCarthy (2013), counselor education program-operated counseling training centers “are in a unique position to promote social justice within the community” because they
fill the gap in the provision of counseling services to marginalized, underinsured, or uninsured clients” (p. 111).

In order for counselor education program-operated counseling training centers to grow and flourish, evaluation of the community-based program model is necessary; evaluation will allow stakeholders to understand the quality, efficiency, and equity in the delivery of services, especially for those clinics located within the community. Grimmett et al. (2017) argue that the community counseling model needs to be evaluated to accomplish the following aims: (a) to understand the quality of services provided by the model, (b) to measure and follow client progress, and (c) to assess, plan, and improve the model and services for ongoing improvement and continuous development (p. 166). This study has the potential to inform program evaluation models for future counselor education program-operated counseling training centers.

**Theoretical Framework**

Although the demand for program and accountability is on the rise, counseling program evaluation literature has illuminated the lack of counselor ability to systematically evaluate counseling services and interest in doing so (Fairchild, 1993; Whiston, 1996). A significant contributor to relative counselor disinterest in evaluation is the lack of practical program evaluation models (Astramovich & Coker, 2007).

To address the limited research interest of counselors and complex nature of counseling evaluation, Astramovich and Coker (2007) developed the accountability bridge model to provide a useful framework for counselors and counseling programs to assess program effectiveness, accountability, and impact. The model foundation rests on the business evaluation model proposed by Ernst and Hiebert (2002) and the Context, Input, process, Product Model by Stufflebeam (2000a), which will be discussed in detail in the proceeding chapter.
The accountability bridge model provides a counselor specific process for providing outcome data and program results to stakeholders. The counseling evaluation process is completed through two reoccurring cycles that represent a continual refinement of services based on outcomes, stakeholder feedback, and the needs of the population served (Astramovich & Coker, 2007). The accountability bridge lies between the counseling program evaluation cycle and the counseling context evaluation cycle connecting the two evaluation cycles bridging the communication process of outcome data and program results to stakeholders (clients, counselors, faculty, and administration). While the accountability bridge model for counselors brings a comprehensive approach to counseling program evaluation, this study will focus in particular on evaluating CCERC outcomes, utilizing the accountability bridge model (Astramovich & Coker, 2007) components of program monitoring and refinement and outcomes assessment of the counseling program evaluation cycle.

Summary

In this chapter, the need for counselor education program-operated counseling training center evaluation, the rationale for the study, and an explanation of the study’s purpose were provided. The significance of the study and research questions were also discussed. The literature review follows in the next chapter.
CHAPTER 2: Literature Review

Community counseling centers for education, research, and training can provide significant counseling skill building and supervision opportunities, especially for counselors-in-training who seek to gain knowledge in counseling (Schuermann et al., 2018). Counseling offered within counselor education program-operated counseling training centers can provide great value to the underserved populations within a community; it is affordable, and centers can be strategically located within the community for ease of access (Grimmett et al., 2017). To provide the highest quality of care to the community being served, counseling center faculty administrators will need to know how well the counseling training center approach meets the needs of counselors-in-training and people in the community (Watson & Flamez, 2015). In addition to understanding the need for counseling services within the community, faculty administrators will also need to assess the counselor education program-operated counseling training center’s overall effectiveness, efficiency, and impact of services provided (Erford, 2015).

Studying accountability in counselor training programs entails understanding counselor evaluation, counselor training program evaluation, and evaluation practices in general; thus, this chapter will contain a discussion of the extant literature on those topics. This review will show the rationale for examining counseling training program evaluation in general and counseling training program outcomes in particular, especially relating to both the degree of client change in their perceived quality of life and to their satisfaction with counseling services at community counseling centers sponsored by counseling programs for education, research, and training. In addition, the accountability bridge model for counselors will also be explored. The accountability bridge model provides a framework for the study to which service objectives and program
implementation of counseling services along with results from counseling practices can be assessed (Astramovich & Coker, 2007). The accountability bridge model provides specific components designed to help assess counseling programs and provide accountability to stakeholders involved. Specifically, I will organize the chapter into four sections: (a) history of program evaluation, (b) counseling program evaluation, (c) introduction to the Accountability Bridge Model for Counselors, and (d) Accountability Bridge Model for Counselors.

**History of Program Evaluation**

Evaluation as a field of study began in 1930 with the seminal work of Ralph W. Tyler; Tyler is often referred to as the father of educational evaluation even though program evaluation can be traced back to the Pre-Tylerian period before the 1930s (Stufflebeam & Coryn, 2014). Through the next sixty years, evaluation progressed through several stages of growth (Stufflebeam & Coryn, 2014). During the 1940s and 1950s, as America was recovering from the war and depression, educational infrastructure expanded and participation in educational evaluation increased (Stufflebeam & Coryn, 2014). Community colleges emerged, enrollment in teacher education programs soared, and college enrollment increased significantly (Stufflebeam & Coryn, 2014). Although education expanded significantly, inequities and issues remained as leaders in the field of education failed to address the educational needs of the underprivileged or solve problems in the education system (Stufflebeam & Coryn, 2014). Educational inequities remained because school administrators were not being pressured to evaluate educational programs (Stufflebeam & Coryn, 2014). This failure to evaluate was more than likely due to the limited oversight of federal and state agencies (Stufflebeam & Coryn, 2014).

From the 1960s to the early 1970s, federal funds began to flow into evaluation and large scale curriculum development projects began moving the field towards profound change.
Administrators pushed educators to evaluate more and to do so rigorously; to that end, administrators encouraged educators to further develop existing methodologies grounded in accountability, usability, and relevance (Shadish, Cook, & Leviton, 1991). Due to the rapid growth of federal funding and reports of fraud, abuse, and mismanagement of federal funds, social programs were tasked to provide accountability to congress on the use of federal funds that were being used and how desirable results were being achieved. Even though the large thrust for evaluation diminished educators’ autonomy to evaluate, this movement illuminated the insensitive nature of the evaluation and evaluation’s inability diagnose needs of social programs (Shadish, Cook, & Leviton, 1991; Stufflebeam & Coryn, 2014). According to Stufflebeam, Foley, Gephart, Guba, Hammond, Merriman, and Provus (1971), a growing concern regarding evaluation efforts and reoccurring negative findings led to the establishment of the National Study Committee on Evaluation, signaling a call for new evaluation theories. Consequently, many new theories of evaluation began to emerge (Shadish et al., 1991). Departing from prior approaches, the new conceptualizations of evaluation recognized the need to evaluate goals, look for inputs, examine implementation and delivery of services, and measure intended and unintended program outcomes (Stufflebeam & Coryn, 2014). A large, much needed shift in evaluation had occurred, the “age of professionalism 1973-2004” was set to emerge (Stufflebeam & Coryn, 2014).

The 1960’s were filled with concerns of how evaluation should emerge. As a result of these shifting perceptions the field of evaluation was set to move beyond the current identity crisis of the time into a distinct organized profession. Beginning in the 1970s the focus of the evaluation community and related organizations began to move beyond the uncertainty of the late 60s. Evaluation began to emerge as a distinct profession beginning in 1981 with the
development of standards for judging evaluations of educational programs which led to The Program Evaluation Standards in 1994 (Stufflebeam & Coryn, 2014). This was a robust time for the evaluation field, courses in evaluation methodology began to appear in many universities, and graduate programs in evaluation were established (LaVelle & Donaldson, 2010). Emerging from an era where little literature and no professional organizations dedicated to evaluation existed, the so-called age of professionalism brought many new standards that provided the methods for reviewing and revising the field of evaluation as an independent profession (Stufflebeam & Coryn, 2014). That shift ushered the field into a developmental period that began in 2005 and continues today known as the age of global and multidisciplinary expansion (Stufflebeam & Shinkfield, 2007). By 2005 professional societies were growing and a global presence for the field of evaluation had been established (Stufflebeam & Coryn, 2014). Program evaluation as a profession began to unify as a multidisciplinary evaluation profession (Stufflebeam & Shinkfield, 2007). An interdisciplinary PhD in evaluation located at Western Michigan University was growing with a diverse and robust student and faculty population (Coryn, Stufflebeam, Davidson, & Scriven, 2010). As a consequence of educational programs, professional societies and the development of a multidisciplinary perspective evidence-based evaluation models gained prominence similar to requirements advocated by evaluators during the 1960s (Stufflebeam & Coryn, 2014).

Since 2005 many alternative evaluation approaches from earlier periods of evaluation have gained prominence. Even though the experimental design is often required, the field is moving slowly into more alternative methods such as participatory, theory-driven, and self-evaluation; the latter methods are thought to better evaluate ongoing humanitarian efforts such as health and educational programs internationally (Stufflebeam & Coryn, 2014). The field of
evaluation is evolving, and continues to evolve at a rapid pace as a multidisciplinary field. As evaluation continues to gain prominence as a profession, a consensus is growing that the following topics need to be explored as part of the professional identity and reputation of evaluation: professionalism (Donaldson, 2019), research and evaluation (Coryn et al., 2017), logic of evaluation (Ozeki, Coryn, & Schroter, 2019), and evaluator education (Gullickson, King, LaVelle, & Clinton, 2019). The focus of this study is the evaluation of a newly established community-based counselor training center with a goal to determine the outcomes of interventions and program. Determining program outcomes require counselor participation for the implementation of program evaluation, as an approach to fill the gaps regarding program accountability and effectiveness.

**Perceptions of Counseling Program Evaluation**

Counselors today are in an age of accountability (Erford, 2015; Hays, 2010). Professional counselors are faced with numerous professional demands, including demands to demonstrate effectiveness. In private practice, counselors may only be accountable to third-party payers and licensing boards; however, in agency and program settings, counselors may also be accountable to the people or organizations issuing grants, donations, or other types of funding. Essentially, accountability entails providing specific information to stakeholders and other supervising authorities about the efficacy and efficiency of counseling services (Studer & Sommers, 2000).

Counseling program evaluation in general provides support for concrete, practical information regarding the efficacy and efficiency of the program’s interventions to improve outcomes, specific sectors, and specific client populations (Astramovich & Coker, 2007; Boulmetis & Dutwin, 2000; Watson & Flamez, 2015). With the growing need for accountability, counseling programs will find it necessary to move beyond the assumption that because
counseling services are intended to be good it follows that clients are therefore being helped and the program’s intentions are being achieved. The assumption that the inherent worth of counseling services is self-evident does a great injustice to the counseling profession, the programs in which some counselors are working, and the stakeholders of counseling services (Loesch, 2001).

To meet the needs of the people being served, the primary stakeholders of counseling services, it is important that counseling programs evaluate, assess, and change so that the best possible services are always available. Currently, counseling program evaluation receives minimal attention. There is little information regarding the outcomes of counselor practitioner program evaluation, and literature regarding program evaluation of counselor education program-operated community-based counseling training centers is mainly limited to non-published dissertations, focusing mainly on client satisfaction. Most importantly, according to the Directory of Counselor Education Training Clinics, (ACES CDPC Interest Network, 2015), there are 39 active counselor education counselor training centers in operation; of the 39 programs, limited published literature exists regarding counseling training clinic or center program evaluation and accountability, which may be a result of existing counselor-in-training centers using some form of evaluation such as client satisfaction questionnaires but not publishing outcomes due to limited time, or experience with counseling program evaluation methods. That gap in the literature suggests that the program evaluation approach of this study is needed to bring more attention to counseling program evaluation, to spark a fundamental change in the counseling profession, and to explore ways to evaluate counselor education program-operated counselor training centers effectively.
Lack of clarity about program evaluation and lack of training in its methods may disincline counselors or counseling programs from evaluating (Astramovich, Coker, & Hoskins, 2005; Loesch, 2001). Loesch suggested counseling program evaluation may receive diminished recognition due to the counseling community’s tendency to conflate research and program evaluation. Often counselors see little connection between skills improvement and research or may have not been trained in methods for evaluating counseling (Whiston, 1996). Astramovich et al. (2005), also found that many participants in a program evaluation workshop understood the rationale for program evaluation, yet many were unfamiliar with the methods and skills for implementing program evaluation. Participants reported that they lacked practical models specific to their counseling programs, echoing the need for counselor-specific evaluation methods (Astramovich et al., 2005). A growing community of scholars view the combining of science and practice as a priority (Erford, 2015; Lenz, 2018; Loesch, 2001; Lusky & Hayes, 2001). When counselors begin to evaluate more, they may enhance the counselor identity and the counseling profession as a whole, perhaps helping the profession gain some of the prestige currently afforded to the professions of psychology, psychiatry, and social work (Erford, 2015).

For all stakeholders to benefit from counseling program evaluation as a standard practice, counselors need to be able to evaluate their effectiveness and the impact of counseling interventions (Erford, 2015). Counseling programs intervening with community members should be able to demonstrate that positive outcomes have been achieved (Astramovich & Coker, 2007). Furthermore, counseling programs operating counselor training centers should also be able to demonstrate that the counseling services provided have not harmed the individuals served (Ametrano & Stickel, 1999; Grimmett et al., 2017). Neither of these effects can be assumed, and counselor training programs cannot be confident of positive or negative effects unless some form
of evaluation is conducted. Counseling program evaluations can yield information demonstrating the degree to which clientele are being helped (Astramovich & Coker, 2007) and may provide feedback about clients’ satisfaction; that information can be used to help determine if a meaningful therapeutic alliance is being achieved with the clients which is one of the common factors associated with positive outcomes (Isaacs, 2003; Duncan, Miller, Wampold, & Hubble, 2010). For new programs such as the program of interest in this current study, counseling program evaluation provides the necessary information needed to report the program outcomes to stakeholders and to promote innovative program change.

**Challenges to counseling program evaluation.** Even though conducting program evaluations yields significant benefits, professional counselors have traditionally avoided evaluation and research activities for a variety of reasons, such as lack of training in evaluation methods, the complexity of understanding the influence counseling has on clients, and not seeing the connection between evaluation and the advancement of their clinical skills (Astramovich & Coker, 2007; Erford, 2015; Loesch, 2001; Whiston, 1996). Counseling professionals have been criticized for not exploring research activities, rarely reading research, and generally avoiding the call for conducting evaluations and research (Sexton, Whiston, Bleuer, & Waltz, 1997). To compound the negative view of counseling evaluation, many practitioners will shy away from gathering accountability information because they lack the skills needed to analyze the accumulated data (Whiston, 2013). A final reason for counselor avoidance of evaluation is the limited number of practical evaluation models available for professional counselors. According to Erford (2015), existing models of program evaluation need to be adapted to the counseling profession.
**Program evaluation and accountability.** Counselor avoidance of program evaluation and research can be addressed. Existing counselor education programs can strengthen their curriculum in the area of evaluation. Open discussions can take place between faculty and both master and doctoral level students. Programs could develop master’s level research groups that consist of mental health, college, and school counselors in training who work together on a semester long project relating to their program. Ongoing training can be offered on program evaluation models and data analysis, and such trainings can take place both online and in person (Maras, Coleman, Gysbers, Herman, & Stanley, 2013).

As the field of counseling expands, counselors will be called upon to provide accountability for counselor programs (Granello & Hill, 2003; Krousel-Wood, 2000; Sexton, 1996). Program evaluation precedes accountability (Astramovich & Coker, 2007). As explained by Loesch (2001), to “maximize the efficiency and effectiveness” of how counseling programs accomplish their aims, counselors must “carefully and systematically examine program components, methodologies, and outcomes” (p. 513). The counselors can then provide stakeholders, program administrators, and other supervising authorities with specific information about the effectiveness and efficiency of the counseling services, information that they can use to hold the program accountable (Studer & Sommers, 2000).

**Accountability Practices for Counseling Programs**

The community counseling center in this study was developed under the framework of a conceptual model detailing the three main foundations of identity, community, and structure. With the development of an organized and comprehensive counselor education training model, accountability is an endorsed concept employed to validate the viability and effectiveness of the training model (Loesch, 2001). Program evaluation as stated in Erford (2015) is a practical tool
used to assess the effectiveness and impact of services that provide critical accountability information to stakeholders. The concept of accountability, therefore, continues to gain increased consideration in the counseling profession and is a growing component within counseling programs in general (Astramovich & Coker, 2007). If an evaluation is to address accountability, formative and summative evaluation provide two different alternatives to the evaluation approach. Formative evaluation addresses how the process could be improved while summative evaluation is effective for assessing program worth and merit. It is necessary to discuss both formative and summative evaluation as the intent of the program evaluation of study is to improve counseling program services (formative evaluation) and provide information to stakeholders or decision-makers who provide funding (summative evaluation) for continued operation of the counseling program.

**Formative evaluation.** Formative evaluations generally serve to provide feedback on how to improve the program; conducted during the development of a program and/or on an ongoing basis, formative evaluations offer guidance and ensure program improvement (Stufflebeam & Zhang, 2017). In general formative evaluations assess the process through which a program is being administered (Watson & Flamez, 2015). Typically directed at improving operations, formative evaluations allow program administrators to attend to the nature and needs of the program as it unfolds, allowing adjustments to approaches that may be producing undesirable results (Shandish, Cook, & Leviton, 1991; Watson & Flamez, 2015). Formative evaluation should be proactive, flexible, and responsive; such qualities help facilitate feedback and improvement, which is the spirit of formative evaluations (Stufflebeam & Zhang, 2017). Restrictive or tightly controlled programs, by contrast, will limit the ongoing feedback needed for improvement (Stufflebeam & Zhang, 2017). Formative evaluations are important to
improvement-and-accountability-oriented evaluation approaches that informed this study because they provide alternative courses of action.

**Summative evaluation.** Summative evaluations, which are typically a cumulative record for the sponsor and consumers of what was done and accomplished, complement the formative evaluation (Stufflebeam & Coryn, 2014). Whereas formative evaluations focus on how individual program activities are continuing, being modified, terminating, or being adopted, summative evaluations provide an understanding of how well the program achieved its intended goals (Stufflebeam & Coryn, 2014). According to Scriven (1967), the culmination of a summative evaluation is a summative report, which is normally produced at the completion of a program or the end of a service cycle. Summative evaluations are useful in determining accountability for successes and failures, informing consumers about the quality and safety of services, and creating a better understanding of the assessed program (Stufflebeam & Zhang, 2017). Summative evaluations are important to improvement-and-accountability-oriented evaluation approaches, summative evaluations allow stakeholders to judge a program’s overall value comprehensively in order to make informed decisions relation to program funding or termination (Shadish et al., 1991).

**Program Evaluation Models**

**Improvement-and-accountability-oriented evaluation approaches.** The improvement-and-accountability-oriented evaluation approaches illuminate the criteria needed to assess a program: merit, worth, importance, feasibility, cost, safety, and equity (Stufflebeam & Zhang, 2017). Improvement-and-accountability-oriented approaches fully assess a programs value with focuses evaluative feedback to stakeholders which directly relates to the identity of CCERC which focuses on research relating to outcome measures so to understand quality of services,
client progress and improvement of the CCERC model (Grimmett et al., 2017). Within the improvement-and-accountability-oriented evaluation approaches, there are three distinctive approaches for assessing a program’s value: (a) the decision-and-accountability-oriented approach, (b) the consumer-oriented approach, and (c) the accreditation and certification approach. This review will focus on the decision-and-accountability-oriented approach which focuses on improvement and accountability to improve a program while effectively judging the program’s value. This approach is best represented by the context, input, process, and product model for evaluation (Stufflebeam & Zhang, 2017). Traditionally, the consumer-oriented approach focuses on assisting consumers to make informed choices regarding products and services that are of great quality and use to the consumers. While this approach is grounded in the view of ethics and common good, the approach lacks the accountability component necessary for evaluating the CCERC model, continuously and systematically in order to identify whether the objectives of the CCERC model are being achieved. The accreditation and certification approach typically function as a mechanism to determine if institution, institutional programs, or personnel should be approved to deliver public services (Stufflebeam & Coryn, 2014). The accreditation and certification approach does provide an element of improvement, although, the service of this approach is beyond the scope of the program evaluation needs of CCERC. Counselor education and supervision programs are often required to meet the requirements of accreditation and certification (CACREP, 2016).

The decision-and-accountability-oriented approach is based on the understanding that evaluation should help administrators improve the program and judge its value (Stufflebeam & Coryn, 2014). Stufflebeam and Coryn (2014) explain the philosophical underpinnings of the decision-and-accountability-oriented approach as “an objectivist orientation to finding the best
answers to context-limited questions and subscription to the principles of a well-functioning democratic society, especially human rights, an enlightened citizenry, equity, excellence, conservation, probity, and accountability” (p. 175). Many of the descriptions noted by Stufflebeam & Coryn (2014) mirror the context of the CCERC model, which focuses on providing a counseling center based on equality for all who seek and provide services at the counseling center. Additionally, CCERC provides a structure and atmosphere for counseling excellence for all clients served, and accountability to all stakeholders involved in the development and improvement of the CCERC model (Grimmett et al., 2017).

The shared strengths of improvement-and accountability-oriented approaches are their ability to empower evaluators to fully assess a program’s value, report the program’s accomplishments to right-to-know audiences, and provide timely, focused feedback to all stakeholders on how to build and strengthen programs (Astramovich & Coker, 2007; Stufflebeam & Zhang, 2017).

Three models within the framework of improvement- and accountability-oriented evaluation will be discussed in the rest of this section; the models are CIPP evaluation model (Stufflebeam, 1983), program evaluation business model (Ernst & Hiebert, 2002), and accountability bridge model for counselors (Astramovich & Coker, 2007). The CIPP evaluation model (Stufflebeam, 1983) and program evaluation business model (Ernst & Hiebert, 2002) provide the foundation for the accountability bridge model for counselors. The accountability bridge model for counselors provides the theoretical framework for this study.

The context, input, process, and product model (CIPP). Within the evaluation literature, the decision-and accountability-oriented approach is represented most frequently by the CIPP model for evaluation (Stufflebeam, 1967, 2003a, 2004b, 2005). The CIPP evaluation
model is one of the most widely used evaluation approaches in the evaluation profession with over 500 CIPP related evaluation studies. (Stufflebeam & Zhang, 2017). With over 50 years of updates and applications, the CIPP model provides a robust level of generalizability and utility (Stufflebeam & Zhang, 2017). The CIPP employs a full range of questions to assess a program; many questions relate to the central theme of stakeholders’ needs. CIPP provides assessment of relevant outcomes, uses multiple qualitative and quantitative assessment methods, and is grounded in the principles of democracy.

The CIPP Evaluation Model (Stufflebeam & Zhang, 2017) consists of four core concepts: context, input, process, and product. Context evaluation is utilized in order to “assess needs, assets, and opportunities, as well as relevant contextual conditions and dynamics” (Stufflebeam & Zhang, 2017, p. 23). Input evaluation “assess a programs strategy, action plan, staffing arrangements, and budget for feasibility and potential cost-effectiveness to meet targeted needs and achieve goals” (Stufflebeam & Zhang, 2017, p. 23). Process evaluations “monitor, document, assess, and report on the implementation plans” (Stufflebeam & Zhang, 2017, p. 23). Product evaluations “identify and assess costs and outcomes–intended and unintended, short term and long term” (Stufflebeam & Zhang, 2017, p. 23). A main contributor to the CIPP model is the role of formative and summative evaluation. Formative evaluation proactively assesses a program from beginning to end in order to provides feedback to individuals seeking to improve the program. Summative evaluation provides a comprehensive summation of the program to decision-makers after it has been completed (Shadish et al., 1991). The CIPP model provides multiple aspects of a program and good utility for educators and administrators on a smaller scale (Lippe & Carter, 2018). Given the extensive application of the CIPP model it is
understandable that the CIPP model provides a primary foundation for the accountability bridge model for counselors.

**Business-oriented evaluation model.** The business-oriented evaluation model proposed by Ernst and Hiebert (2002), focuses on results-based programming for accountability so to sustain or increase funding for school-based counseling programs. Both CIPP and the business-oriented models identify measures relating to accountability, the business evaluation model introduces feedback loops to influence strategic planning and service design (Ernst & Hiebert, 2002). The model describes a proposed cyclical evaluation process that links both service delivery evaluation and business operations of a counseling agency into a quality improvement loop (Ernst & Hiebert, 2002). The development of the improvement loop provides a second foundation for the accountability bridge model which details two continuous loops joined by an accountability bridge which represents the communication of outcomes to stakeholders.

According to Ernst and Hiebert (2002), quality improvement loops ensure information is circulated properly to stakeholders providing a stimulus for stakeholder recommendations. Once the evaluation of effectiveness has been assessed, program services are assessed for value and redesigned which initiates the continued loop resulting in more effective services. A perusal of the literature revealed no other applications of the model other than the accountability bridge adoption of the models framework. The accountability bridge model benefits from the design of the business-oriented evaluation model as two of the intentions of the model are accountability and quality improvement which align well with the components of the CIPP model and subsequent development of the accountability bridge model for counselors (Astramovich & Coker, 2007).
The accountability bridge model for counselors. Astramovich and Coker (2007) combined the CIPP evaluation model (Stufflebeam, 1967, 2003a, 2004b, 2005) and the business evaluation model by Ernst and Hiebert (2002) to develop an evaluation model specific to counseling called the accountability bridge model for counselors. In so doing, Astramovich and Coker (2007) sought to further address the need for accountability and reform in counseling program evaluation. Like CIPP, the accountability bridge model for counselors employs a full range of questions to assess a program; many questions relate to the central theme of stakeholders’ needs. Also like CIPP, the accountability bridge model for counselors provides assessment of relevant outcomes, use multiple qualitative and quantitative assessment methods, and provides a framework specific to individual counselors for assessing program effectiveness and impact.

In the accountability bridge model for counselors borrows from the business-oriented evaluation model in using ongoing accountability feedback loops, the accountability bridge counseling program evaluation model provides a framework of two cycles of evaluation—the counseling program evaluation cycle first and the counseling context evaluation cycle second—that feed into one another and repeat (Astramovich, & Coker, 2007). In between the two reoccurring cycles there is the accountability bridge during which the program evaluation results are communicated to stakeholders (Astramovich & Coker, 2007). The ongoing accountability feedback loops can help counselors orient themselves to a business-oriented context, according to Ernst and Hiebert (2002).

The accountability bridge model for counselors builds upon CIPP and the business evaluation model. Unlike the latter, which are large-scale evaluation approaches, the accountability bridge model provides a practical model that can guide both novice and
experienced counselors through the evaluation process—from planning to conducting counseling program evaluations. Throughout the evaluation process, counselors may be encouraged to advocate for the comprehensive guidance of counseling services for ongoing quality improvement of services to clients.

**Counseling program evaluation cycle.** According to Astramovich & Coker (2007), the first cycle of evaluation in the accountability bridge model is called the counseling program evaluation cycle; it comprises four stages: (a) planning the program, (b) implementing the program, (c) monitoring and refining the program, and (d) assessing the outcomes of the counseling program. The program evaluation cycle begins with program planning during which evaluators identify counseling methods, activities specific to the populations served, resources, staff, and facilities (Astramovich & Coker, 2007). According to Astramovich and Coker, the actual delivery of services is referred to as the program implementation stage. During that second stage, program administrators or counselors can address any unforeseen differences between the program plan and the reality of services by changing or refining how they deliver the program (Astramovich & Coker, 2007). The third stage, program monitoring and refinement, allows counselors to adjust services based on preliminary results to increase the quality of counseling services and maximize positive outcome assessment results (Astramovich & Coker, 2007). During the final outcomes assessment stage, counselors can determine whether the objectives are being met (Astramovich & Coker, 2007).

**Accountability bridge.** Between the two continuous cycles of counseling program evaluation and counseling context evaluation, Astramovich and Coker (2007) specifically designed a communication bridge to prioritize program “accountability” to stakeholders. The accountability bridge will provide an ongoing flow of information to stakeholders as the two
cycles repeat. This flow of information to stakeholders is important and must be tailored to address the concerns of the specific group.

*Counseling context evaluation cycle.* Outlined by Astramovich and Coker (2007), the counseling context evaluation cycle is the second cycle in the accountability bridge model, and it focuses on the impact the counseling program has on the stakeholders within the larger organizational system. The counseling context evaluation cycle comprises four stages: (a) feedback from stakeholders, (b) strategic planning, (c) assessment, and (d) service objectives. Moving through the four stages, counselors gain the necessary information needed to refine program objectives. During the first stage labeled feedback from stakeholders, counselors ask stakeholders for information that is vital element to the design and delivery of the model (Erford, 2015). Repeated stakeholder feedback maintains the viability of counseling services (Ernst & Hiebert, 2002). During the second stage of the cycle, strategic planning, counselors identify the necessary changes needed in the operation of the organization. Next, the cycle moves to the needs assessment stage where counselors can further explore and identify the needs of the stakeholders (Astramovich & Coker, 2007). During the final stage of the second cycle called service objectives, counselors refine program goals and objectives identifying a sequence of benchmarks that indicate advancements towards program growth and improvement (Astramovich & Coker, 2007). Continual refinement of goals and objectives is paramount because programs without clearly identified goals and objectives cannot be evaluated for impact and effectiveness (Berk & Rossi, 1999).

Recently the accountability bridge model provided a framework for evaluation addictions counseling programs (Astramovich & Hoskins, 2013). Astramovich and Hoskins (2013) suggested applying the accountability bridge model for counselors to addictions counseling
programs to address the call for research and evaluation competencies by addictions counselors as outlined by CACREP (2009) and SAMSHA (2006). Addictions counseling program accountability much like mental health counseling accountability have recognized the need to demonstrate effectiveness. Building upon the sequential and cyclical foundation of the accountability bridge model addictions counselors Astramovich and Hoskins (2013), were able to provide and outline for needs assessment, program development, outcomes assessment, and the sharing of information to stakeholders proactively promote the outcomes and benefits provided to the clients and community. With this in mind, a primary goal of evaluating the CCERC model is to effectively address stakeholders for input regarding continued program funding and improvement. To help promote the use of program evaluation it is suggested that training and supervision of addictions counselors integrate program evaluation skills as a means for advancement of addictions counseling professional practice (Astramovich & Hoskins, 2013).

To demonstrate effectiveness and efficiency of counseling services a major shift has occurred towards examining effectiveness and outcomes in mental health counseling (Astramovich & Coker, 2007). The development of the accountability bridge model for counselors answered the need for a practical program evaluation model specifically designed to guide localized counseling programs in planning and conducting counseling program evaluations for highlighting the benefits of the program and services in the local community (Astramovich & Coker, 2007).

**Summary**

This chapter provided an overview of the empirical and theoretical literature on history and concepts relating to program evaluation, counseling program evaluation, models of evaluation, conceptual framework for this study, and the accountability bridge model for
counselors (Astromovich & Coker, 2007). One other aim of this chapter was to highlight the
gaps in the literature that the current research study intends to fill. Specifically, the results
obtained in this dissertation’s quantitative assessment of quality of life and satisfaction may
assist doctoral-level counselors in determining common areas for further training and preparation
as it relates to counselor education program-operated community-based counselor training
centers.

The purpose of the study was to evaluate the effectiveness of the CCERC model in
achieving the goals of change in quality of life and satisfaction of clients served. The evaluation
was intended for administrators, faculty, students, and all other stakeholders of the counseling
program. Based on these criteria, the accountability bridge model for counselors was best suited
as an evaluation framework for the study. Methodology for gathering information or data for this
type of model may include standardized or counselor-made tests, surveys, questionnaires,
interviews, and self-assessments (Erford, 2015). Questionnaires were used in this study.

Chapter 3 provides more information on the study’s methods.
CHAPTER 3: Method

This purpose of this quantitative study was to examine if any significant differences exist between community counseling client’s perceptions of quality of life and satisfaction of services before and after an intervention in the form of counseling provided by master’s level counselors-in-training. The participants consisted of community members seeking counseling services.

Counselor education training clinics, which provide counseling both on and off site, have an ethical and moral responsibility to assess counseling efficacy (Loesch, 2001). For training clinics with new student counselors to serve the community well, they need to offer effective counseling services, and to ensure that they do that, their services need to be assessed (Schuermann et al., 2018). Meyer (1994)—who was a leading voice in the development of counselor education, program-operated, counselor-in-training clinics—first illuminated the need for quality control. Training clinics come inherent with risk, possibly due to inconsistency in preparation, supervision, and evaluation (Meyer, 1994). According to Ametrano and Stickel (1999), counselors-in-training may not offer the most efficacious treatment; their findings suggested an accountability model be implemented to help meet the demand for quality care to clients when creating or restructuring an existing training clinic. Additionally, Ernst and Hiebert (2002) recommended accountability feedback loops to stakeholders for the enhancement of programs and services. Astramovich and Coker (2007) provide a model that actively addresses the need for counselors to evaluate program outcomes for enhanced counseling practices and accountability, outcomes which may promote the professional identity of counselors.

Chapter 3 will present a review of the purpose of study, research design, and research questions that will guide this study. Instruments utilized to collect the data will be discussed along with the validity and reliability of each instrument. Data collection and analysis will be
discussed in detail as well as the limitations of the study.

**Purpose of Study**

It was not known if or to what extent quality of life and satisfaction among community clients seeking counseling services at a counselor education and supervision training center would change following counseling. In the current study, an evaluation was conducted on a counselor education and supervision training program model that had already been designed and implemented. The focus was on conducting a program evaluation to determine to what extent the model selected and implemented was achieving the program’s objective of improving client’s quality of life and satisfaction.

The purpose of this study is to assess the quality of life and satisfaction of community members receiving counseling services provided by master’s level counselors-in-training at a counselor education program-operated community counseling center. Clients who received counseling services at a counselor education program-operated community counseling counselor training center will be at the center of this study. The goal is to describe and interpret the degree to which counseling affects client quality of life and satisfaction. A one-way repeated-measures design was chosen to address the research questions of this study.

**Research Design**

The research design for this study was non-experimental one-way repeated-measures design consisting of a single group of 27 community counseling clients. The design is considered non-experimental; although the study involved an intervention, the study lacked randomization and random assignment to a control group (Heppner et al., 2016). The design provided data to determine to what extent, if any, quality of life and satisfaction of community counseling clients changed following an intervention of counseling. This design also provided data to determine if
the change was significant. A repeated-measures design was appropriate as data were scheduled to be collected prior to the beginning of counseling services, before the fifth session, and at the completion of counseling services. The WHOQOL-BREF and CCQ were utilized to collect data at all three points. During the initial data collection period, a demographic questionnaire was completed by participants.

A review of the literature on counseling outcome research suggests that the within-subject design provides a powerful and convenient approach to counseling outcome research (Erford, 2015; Verma, 2016). The within-subject design comes with two distinct advantages: (a) the design requires fewer subjects, and (b) by using each participant as his or her own control, the design has the ability to minimize error variance (Verma, 2016). According to Shadish, Cook, and Campbell (2002), the repeated measures design provides an understanding of change over time and is often appropriate to measure psychological phenomena in naturally occurring settings. An independent design was not chosen for this study as an independent design involves two separate groups of participants involving more than one condition (Hayes, 2005). Furthermore, a matched pairs design was not selected as this design requires an experimental and a control group (Hayes, 2005). The study was designed with only one condition, the group of community members who participated in master’s level counseling.

In an effort to adequately answer the questions posed in this study, a non-experimental, repeated-measures design was employed. The repeated measures design was utilized to explore quality of life, general health and satisfaction of clients who received counseling services at a community counseling center. As a pretest measure, the WHOQOL-BREF (The WHOQOL Group, 1998) and the CCERC CCQ (Grimmett et al., 2016) were employed to determine the level of quality of life, general health and satisfaction (i.e., dependent variable). Treatment (i.e.,
master’s intern individual counseling) entailed 50-minute counseling sessions; each participant engaged in a minimum of ten counseling sessions (i.e., independent variable). Both WHOQOL-BREF and CCQ questionnaires were administered before counseling services began (T1), before the fifth session (T2). At the conclusion of counseling services (T3), final assessments were collected measuring quality of life and general health (i.e., WHOQOL-BREF) and client satisfaction (i.e., CCQ).

Research for this study took place at the Community Counseling, Education, and Research Center (CCERC), a counselor education program-operated community-based counseling center located in Raleigh, North Carolina. Understanding client progress and satisfaction related to the selected program model may, in turn, enable the counseling center to demonstrate the correlation between counseling program design and specific outcomes. The current study evaluated client degree of change relating to overall quality of life along with four specific quality of life domains: physical health, psychological health, social relationships, and environment. Secondly, this study assessed the perceived satisfaction and experience of clients utilizing the CCERC model.

**Research Questions**

The following research questions and hypotheses guided this study:

RQ1: To what extent, if any, does counseling client quality of life and general health change following counseling services at a counselor education program-operated community counseling center?

RQ2: To what extent, if any, do counseling client WHOQOL-BREF domains change following counseling services at a counselor education program-operated community-counseling center?
RQ3: To what extent, if any, does counseling client satisfaction change during counseling services at a counselor education program-operated community counseling center?

**Community Counseling, Education, and Research Center**

A counselor education program-operated counseling training center such as the CCERC that was the site of this research provides a closely supervised practicum and internship experience. The CCERC model first described by Grimmett et al. (2017) was developed as a multidimensional, dynamic, and collaborative model with a mission centered on providing both world class community counseling and a structure for the development of counselors and supervisors in a multicultural and social justice practice (Grimmett et al., 2016). The model rests on the three foundations of identity, community, and structure (Grimmett et al., 2017). Within the three foundations lie 14 synergistic and layered components that operationalize the identity and values of the counselor education program in which it is housed as well as reflect the overarching professional values of counseling and counselor education (Grimmett et al., 2017).

In 2018 an expansion of the CCERC model called the model of engagement scholarship was developed to signify the model’s dynamic evolution for responding to contextual and community needs (Grimmett et al., 2018). The CCERC model of engagement scholarship continues to represent the three foundations of identity, community, and structure along with 17 components, thereby furthering the commitment to addressing the societal and structural healthcare problems of the community (Grimmett et al., 2018).

The foundations of identity, community, and structure bring value to counseling and counselor education training as each foundation is essential to the model. Identity represents the core values of CCERC: (a) setting a world class standard for counseling, (b) embodying what bell hooks (2000) called the love ethic, (c) focusing on wellness (Myers & Sweeney, 2008;
Prilleltensky, 2012), (d) offering trauma-informed care (SAMHSA, 2018), (e) promoting multiculturalism and social justice (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015), and (e) advancing research and scholarship (CACREP, 2016; Grimmett et al., 2018). The CCERC model is based on a recognition of the interconnectedness and interdependence between human beings and the environment; the model is community focused Grimmett et al., 2018). The community focus provides a dynamic response for CCERC operation and sustainability, including (a) partners, (b) location, and (c) outreach and engagement (Grimmett et al., 2018). The following components of the CCERC structural design maintain alignment, collaboration, and integration among community and institutional resources: “(a) a public doctoral university, (b) the Carnegie Foundation community engagement classification, (c) a counselor education program, (d) counselor educators, (e) graduate students, and (f) a sliding scale fee” (Grimmett et al., 2018, p. 219).

Graduate students prove essential to the CCERC structure. Master’s and doctoral-level counselor education students enrolled in counseling practicum, internship, and supervision courses provide the counseling services at CCERC. Doctoral program coordinators provide weekly counseling supervision and on-site consultation to both practicum and intern students. Coordinators are on site at all times and provide real-time face-to-face supervision for all counselors-in-training when requested. The level of supervision, feedback, and consultation that occurs at CCERC provides counseling accountability and quality to community clients. Doctoral coordinators provide input on day-to-day operations and research studies conducted at CCERC. Although a relational-collaborative structure is practiced at the center, master’s practicum and intern students are not responsible for any research duties. Research findings and future studies are discussed in weekly staffing for all involved at the center.
Population and Sample

This study was performed at a Counsel for Accreditation of Counseling and Related Educational Programs accredited counselor education, program-operated, community-based, counseling training center located in Raleigh, North Carolina. The training center serves the local community by providing individual, couples, and family counseling. Center counselors are master’s-level students seeking program required counseling practicum and intern experience. Counseling is offered at the center from 9:00am to 6:00pm Monday through Thursday for the duration of the semester. Individual supervision is provided weekly and in real time if required by doctoral students acting as coordinators for the center.

The doctoral staff invited all adult clients during the spring 2018 semester to participate in the study. However, the present analysis includes only clients who indicated their option to participate in the study. Typical presenting issues included anxiety, depression, stress, communication, and personal development. Forty clients agreed to participate in the study, of the forty participants who initially entered the study twenty-seven participated in the study full term. Thirteen participants dropped out of the study at different time with a majority or eight participants identifying scheduling issues relating to work as cause for not continuing counseling services.

Clients seeking counseling who completed all the instruments resulted in a sample of 27 clients, who were mostly female (79.0%) and ranged in age from 18-64 with 70% of the participants falling within the 18-34-year range. The percentage of female was slightly higher than the percentage of female clients who sign up for counseling at the center (70.0%). Participant self-identified with all six categories of ethnicity: White American (67.0%), African-American/Black (19.0%), Hispanic/Latino (4.0%), Asian-Caucasian (4.0%), Arab-American...
(4.0%), and Afro-Caribbean (4.0%). Less than half reported involvement in relationships: 26.0% were married, 15.0% were cohabitating, 4.0% were engaged, and 4.0% were divorced; others self-identified as single (52.0%). A large portion of the sample indicated having attended college (62.9%), with nearly half (40.7%) completing a graduate degree. Of the 27 clients who participated 10 (37.0%) were students.

All participants received counseling once a week or once every two weeks, and participants completed at least three data collection points during the five-month data collection period. Recruitment of clients was continuous during the data collection period. Individuals participating in the study sought counseling services for a variety of reasons which will be discussed further in the results section. Participants with previous counseling were not excluded from the study.

In this study, client demographics, quality of life and client satisfaction data were obtained through the use of electronic questionnaires. The method was chosen because of ease of use, the low cost, and ease of analysis (McPeake, Bateson, & O’Neill, 2014). Participants were selected through a recruitment process involving all clients seeking counseling services at CCERC. Once an initial screening of the potential client was completed, the doctoral coordinator and researcher introduced the research study to the individual. The first explanation went over CCERC, the center’s counseling approach, its primary goal of wellness, and the center model. Participants were then introduced to the study, the means of gathering data, the data points, and the duration of the study. Potential participants were then given the opportunity to either opt-in or opt-out with the understanding that taking part in the research study was completely voluntary and the decision to opt-out would in no way affect the individual’s entry to CCERC counseling services. Lastly, confidentiality, and informed consent were discussed in detail and all
participants were offered a copy of the informed consent for their personal records. Proper steps were taken to ensure approval by the Institutional Review Board and to assure anonymity and confidentiality of all participants in the study. Data collection and management was conducted in accordance with university guidelines to assure the protection of all participants, including their rights and wellbeing. Finally, due to the nature of the CCQ, the CCQ included questions that become relevant only once counseling is underway (e.g., “I am treated with respect by the CCERC counselor”), the fifth CCQ was the pretest and the final CCQ that the participants completed served as the posttest. The initial WHOQOL-BREF was the pretest and the final WHOQOL-BREF served as the posttest.

Instruments

The purpose of this section is to describe the instruments used to assess client the demographics, aspects of quality of life, and client satisfaction using the CCERC CCIF (Grimmett, 2015), WHOQOL-BREF (The WHOQOL Group, 1998), and the CCQ (Grimmett et al., 2016) respectively.

Client Demographic Questionnaire. Using a modified version of the CCERC CCIF, demographic data were gathered. Data on the following demographic aspects were gathered: gender, sexual orientation, relationship status, education, occupation, alcohol and other drug use, self-harm, intimate partner relationships, and interpersonal violence. The questionnaire also included questions regarding utilization of counseling or therapy (e.g. participation in counseling or therapy, diagnosis or diagnoses, medication). This information was compiled to provide both a background and descriptive picture of the participant and prior utilization of mental health services. Seven questions from the original CCIF were omitted due to their limited relevance to the study; otherwise, all other demographic questions remained the same (see Appendix A).
The World Health Organization Quality of Life (WHOQOL)-BREF. The WHOQOL-BREF (WHOQOL Group, 1998) examines overall quality of life along four specific domains: physical health, psychological health, social relationships, and environment (see Appendix B). In 1994 the World Health Organization (WHO) defined quality of life as “an individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns” (as cited in WHOQOL Group, 1995, p. 1405). WHO (1996) created an initiative to define quality of life beyond indicators of morbidity and mortality in response to the lack of consensus among researchers about the definition of quality of life. As a result of this initiative, the WHOQOL-100 was developed (Lindsey, Ferrer, Davis, & Nichols, 2017).

The WHOQOL-100 established the importance of the humanistic and multicultural perspectives of health care (Lindsey et al., 2017). Accordingly, the WHOQOL-100 allows for a comprehensive assessment of quality of life. One downside of the instrument’s breadth is the time it can take clients to complete it; since certain settings and populations are better suited to a shorter instrument, an abbreviated version, The WHOQOL-BREF, was developed (WHOQOL Group, 1998). This 26 question version originated from the original WHOQOL-100, which has 100 questions; the brief version has 24 items derived from the 24 facets of the WHQOL-100, and the last two items address the overall quality of life facet and the general health facet, respectively (Lindsay et al., 2017). The WHOQOL-BREF response options range from 1 (very dissatisfied) to 5 (very satisfied) emphasizing the subjective responses rather than the objective life conditions. Scores are transformed into a linear scale between 0 and 100 with 0 being the least favorable and 100 being the most favorable (The WHOQOL Group, 1998). As a cross-
cultural measurement tool, the WHOQOL-BREF has been tested extensively around the world (Skevington, Lofty, & O’Connel, 2004).

Field trials examining the WHOQOL-BREF’s performance as an integrated instrument found good to excellent psychometric properties of reliability and validity in preliminary field tests (Skevington et al., 2004). Cronbach’s alpha for each domain subscale was reported as 0.82 for physical health, 0.81 for psychological health, 0.68 for social relations, and 0.80 for environment (Skevington et al., 2004). With over 10,000 participant responses from 24 centers across the 23 countries included in the development of the instrument, the WHOQOL-BREF has proven a solid psychometric tool for quality of life measures across a wide range of cultures, languages, and countries (Skevington et al., 2004).

The WHOQOL-BREF continues to be widely used with a variety of population groups including adults (Fleck et al., 2000), young adults (Li et al., 2009), medical students (Zhang et al., 2012), bipolar disorders (Chand et al., 2004), depression (Berlim et al., 2005), alcohol abuse (Da Silva Lima et al., 2005), and more recently military veterans (Guay, Fortin, Fiketoglu, Poundja, & Brunet, 2015; Lindsay et al., 2017) with all providing acceptable to good internal consistency relating to the WHOQOL-BREF and its subscales.

**Development of the CCERC Counseling Client Questionnaire (CCQ).** Clients can provide insight and helpful information for improving counseling services. According to Kelly, Kyndgon, Ingram, Deane, Baker, and Osborne (2018), client satisfaction feedback provides valuable information for quality improvement initiatives for the enhancement of client care. With the popularity of addressing accountability in the field of mental health counseling, measurement of client satisfaction may be increasingly useful for identifying practices that clients are responding favorably to and change those aspects that clients feel unhelpful.
Client satisfaction brings a range of definitions to the counseling profession, which are normally based on the particular service. Areas of service may focus on mental health, health, family mediation, child welfare and protection, disabilities, self-help groups, and others. In order to reflect client’s actual experiences, the instrument should align with dimensions of the particular service. In order to properly align instrument and services most client satisfaction instruments are generally developed through three primary sources: clients, professionals, and professional literature (Harris & Poetner, 1998).

Instruments where clients were the primary source of items rely on client’s perspectives and aspects of the services important to them. Instrument development often involves focus groups and interviews. Client focused development allows participants to focus more on the content, wording and possible omissions (McComas, Kosseim, & Macintosh, 1995). Instruments where professionals and clients were the source of items often involved separate focus groups which reflects the combined concerns of both client and professional. Supporting the notion that clients have decision-making power is a noble effort, although, rarely are consumers involved in the development of client satisfaction instruments (McComas, Kosseim, & Macintosh; Young, Nicholson, & Davis, 1995). Instruments where professionals were the primary source of items, while limited, are most likely generated from agency and professional documents (Harris & Poertner, 1998). Consequently, a majority of authors define client satisfaction based on reported finding of other authors (Harris, & Poertner, 1998).

Feedback from clients play an important role in the areas of program monitoring and refinement (Astramovich & Coker, 2007). Therefore, the measurement of client satisfaction can provide the necessary information and feedback needed to alter services in order to meet the needs of clientele served. To better understand client perceptions of services, the CCERC
research team developed the CCQ utilizing the CSQ (Larson, Attkisson, Hargreaves, & Nguyen, 1979) as a structural template. According to Harris and Poertner (1998), many of the client satisfaction instruments used today are derived from the CSQ. Building upon the structural template of the CSQ, the ten question CCQ was developed utilizing the principles of multicultural and social justice (Ratts & Pedersen, 2014) and trauma informed practice (Goodman, Sullivan, Serrata, Perilla, Wilson, Fauci, & DiGiovanni, 2016).

**Client Satisfaction Questionnaire.** The CSQ is a self-report measure to assess consumer satisfaction with mental health services. The Client Satisfaction Questionnaire-8 (CSQ-8) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) is a shortened version of the original CSQ, which provided a foundation for the development of the CCERC CCQ. The CSQ-8 is one of a limited number of standardized self-administered satisfaction measures used in a wide spectrum of settings including clinical and human services, educational and governmental programs, and administrative and research settings (Larsen et al., 1979). The CSQ-8 has been subjected to numerous studies of internal consistency where the coefficient alpha ranged from .83 to .93 with values of .86 and .87 in two of the largest samples. Predictive validity has been hypothesized and demonstrated (Nguyen, Attkisson, & Stegner, 1983). Treatment outcome comparisons are good with CSQ-8 scores at outcome found to be correlated positively with symptom reduction as measured by results on the Client Checklist (Larsen et al., 1979). The central strength of the CSQ-8 is its performance across diverse client samples receiving a wide range of services in both inpatient and outpatient settings norms (Nguyen et al., 1983). Consequently, a majority of authors modify instruments such as the CSQ-8 to fit their purposes and/or augment the instrument with additional items designed to measure specific aspects of the service (Harris & Poertner, 1998).
According to Kelly et al., (2018) the CSQ-8 is a multi-item measure used across the broader healthcare profession seeks to answer the following questions (a) How do you rate the quality of the service you have received? (b) Did you get the kind of service you wanted? (c) To what extent did the program meet your needs? (d) If a friend were in need of similar help, would you recommend the program to him or her? (e) How satisfied are you with the amount of help you received? (f) Have the services you received help you deal more effectively with your problems? (g) In an overall general sense, how satisfied are you with the services you have received? (h) If you were to seek help again, would you come back to the service?

**CCERC Counseling Client Questionnaire.** As a counselor education program-based community counseling center, CCERC provides mental health counseling to the general public. With an increasing focus on program evaluation and accountability within the counseling profession, the CSQ-8 questionnaire provided a good fit as a foundational instrument for the development of a new client satisfaction measure (CCQ), as its initial purpose was to assess mental health services. Building upon the CSQ-8 and the CCERC model (Grimmett et al., 2018), the following dimensions of client satisfaction were identified: (a) humaneness/acceptance, (b) affordability, (c) accessibility, (d) convenience, and (e) quality/competence. These criteria offer an inclusive list based on the appropriateness of each dimension to the particular CCERC setting. Throughout the development of the CCQ, the CCERC research team discussed the appropriateness and value of each individual question and its connection to the CSQ-8 and CCERC model (Grimmett et al, 2017; Grimmett et al., 2018). Each question was thoroughly discussed through a series of weekly meetings; based on content validity, the finalized version was developed.
Overall, the CCQ is a 10-item questionnaire developed by the researcher and CCERC research team to evaluate counseling services. The 10 CCQ items employ a 5-point Likert scale ranging from one to five (1=Strongly Agree, 2=Agree, 3=Neither Agree nor Disagree, 4=Disagree, 5=Strongly Disagree, and N/A) with 1 being the highest possible response and 5 being the lowest possible response (see Appendix C). The additional choice of N/A was added to address five of the 10 questions on the CCQ which may not be applicable for those completing the questionnaire prior to receiving counseling services. The CCQ is presented in Figure 1. The CCQ is a newly developed self-report measure designed to assess client satisfaction with CCERC services. While there has been considerable attention paid to the development of the content validity of the CCQ, this is the first research study toward its reliability statistics.
### Client Questionnaire

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am treated with respect by the CCERC staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>I am treated with respect by the CCERC counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>The counselor helps me with my concerns.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>The fees are affordable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>The appointment times are convenient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>It is easy to schedule my appointment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>The location of the office is convenient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>I am receiving what I need from counseling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>I would recommend CCERC to others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>I am satisfied with the services I am receiving.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Figure 1. CCERC Counseling Client Questionnaire*
Data Collection

Participants were recruited during the initial phone screening for counseling services. Each individual who met the criteria for counseling services was given the chance to either opt in or opt out of the research study. All individuals who elect to participate in the research study met with the counseling center coordinator prior to beginning counseling services. Each participant was informed by the coordinator about the study, informed consent, the process of gathering data for study, and the specific points during the study at which data would be gathered. Each participant completed the questionnaires at least three different times: before counseling services commence, before the fifth session, and when counseling services concluded. Before the first assessment, the counselors-in-training at the center were informed about the purpose of the study and were provided with specific details on the use of the data in future publications and presentations. That was done to prevent conflict of interest due to the role of the researcher as a center doctoral coordinator.

Once the introduction to the study was concluded by the counseling center coordinator, each participant was placed in a secure confidential area and given an encrypted computer with the initial questionnaires preloaded for easy access. Before any questionnaires could be accessed, an informed consent page populated for the participant to sign; once signed, the informed consent became available to be printed for the participant if requested (see Appendix D). Once the signature of participants had been recorded, all other instruments populated. All questionnaires were managed through Qualtrics software for confidentiality with all data managed by the principle investigator. The use of Qualtrics software and all other Qualtrics product or service names are registered trademarks or trademarks of Qualtrics, Provo, UT, USA (http://www.qualtrics.com).
Data Analysis

Data were collected at three different points; then a determination was made regarding the existence of significant differences. After further evaluation of the data, it was determined to eliminate one data point from the WHOQOL-BREF (T2) and CCQ (T1). This omission will be addressed further in the next paragraph. Due to the changes in data points, a Paired-Samples $t$ test was chosen to analyze the data; that approach was appropriate because each question addressed one dependent variable and differences between the means group was needed (Hayes, 2005). Paired $t$-tests were employed to analyze the pre-and post-intervention scores (Hayes, 2005). Data were analyzed to determine if statistically significant differences exist in the following areas and domains of the WHOQOL and CCQ after individual counseling had been received at CCERC: (a) overall quality of life and general health, (b) quality of life as measured by the physical health, psychological health, social relationships, and environment domains, and (c) client satisfaction.

Descriptive statistics were calculated, data were visualized, and assumptions were checked to determine the appropriate analysis. Data were entered in R statistical programming language (R) version 3.5.3. There was also screening for normality, outliers, and missing data. Furthermore, a statistician was utilized to assist with data analysis.

Upon checking the data, corrections were implemented. Those corrections included eliminating one data point from each questionnaire due to the differences of the questionnaires; therefore, paired $t$-tests were employed for both the WHOQOL-BREF and the CCQ. Data points T1 and T3 of the WHOQOL-BREF were utilized, and T2 was eliminated due to inconsistencies, the small sample size, and lack of variability after visualizing the data. The randomness of T2 regarding the WHOQOL-BREF is misleading and would have only taken away power from the
analysis with no increase in information. Data points T2 and T3 of the CCQ were utilized; T1 was eliminated after visualizing the data regarding the CCQ because data point T1 was irrelevant due to the large amount of missing data. It was determined the loss of data was due in fact to the questions on the CCQ. Nearly half the questions on the CCQ were designed to assess client satisfaction once services had begun and not before.

The WHOQOL-BREF provided the data needed to address RQ1. A Paired Samples $t$-test was conducted to determine if there was a statistically significant change in quality of life and general health among participants following counseling at a counselor education program-operated counseling center.

The WHOQOL-BREF provided the data needed to address RQ2. A Paired Samples $t$-test was conducted to determine if there was a statistically significant change in the WHOQOL-BREF domains of physical health, psychological, social relationships, and environment among participants following counseling at a counselor education program-operated counseling center.

The CCERC CCQ provided the data needed to answer RQ3. A Paired Samples $t$-test was also utilized to determine if there was a statistically significant change in client satisfaction among participants receiving counseling services at a counselor education program-operated counseling center.

In addition, demographic data were collected as this provided a description of the sample of counseling participants in terms of gender, relationship status, religion, age, ethnicity, orientation, education, and occupation. Descriptive statistics included frequency and percentages.

**Summary**

Chapter three provided an overview of the quantitative methods that were utilized to study quality of life and client satisfaction of clients before and after receiving counseling at a
counselor education program-operated community counseling center. The sample for this study comprised clients in the Raleigh North Carolina area who sought counseling. Three instruments were used in this quantitative study. Demographic information was gathered by the CCERC CIFF (Grimmett, 2015); quality of life and general health was evaluated using the WHOQOL-BREF (WHOQOL Group, 1998); and client satisfaction was evaluated using the CCQ (Grimmett et al., 2016). Proper steps were taken to ensure approval by the Institutional Review Board and to assure anonymity and confidentiality of all participants in the study. Data collection and management was conducted within university guidelines to assure the protection of all participants’ rights and wellbeing.

Chapter 4 will provide a summary of the collected data in addition to the analysis and the actual results. Tables and figures will be utilized to present the findings.
CHAPTER 4: RESULTS

This chapter contains the results of the current study designed to measure the impact of counseling services at a counselor education program-operated community-counseling center. The effect on the quality of life of counseling clients was measured using the WHOQOL-BREF. The satisfaction of counseling clients was measured using the CCERC CCQ. The WHO’s definition of quality of life as pertaining to an individual’s “cultural” “context” and community “values” “in relation to their goals, expectations, standards, and concerns” (as cited in WHOQOL Group, 1995, p. 1405) aligns with the principles of the CCERC model of using a holistic approach that attends to the physical, psychological, social, cultural, emotional, relational, and spiritual needs of the client (Grimmett et al., 2018).

Data were collected by administering the following two questionnaires: the WHOQOL-BREF (The WHOQOL Group, 1998) and the CCERC CCQ (Grimmett et al., 2016). These questionnaires were administered prior to receiving counseling services, before the fifth counseling session, and prior to the last counseling session. After collecting data from the 27 participants, the differences in group scores at two time intervals was examined. Paired samples t-tests were used to analyze the data and answer the following questions:

**RQ1:** To what extent, if any, does counseling client quality of life and general health change following counseling services at a counselor education program-operated community counseling center?

**RQ2:** To what extent, if any, do counseling client WHOQOL-BREF domains change following counseling services at a counselor education program-operated community-counseling center?

**RQ3:** To what extent, if any, does counseling client satisfaction change during counseling services at a counselor education program-operated community counseling center?
Table 1

Basic Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Categories</th>
<th>Frequency (n=27)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>21</td>
<td>77.8</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Transgender</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td>Relationship Status</td>
<td>Single</td>
<td>14</td>
<td>51.9</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>7</td>
<td>25.9</td>
</tr>
<tr>
<td></td>
<td>Other (Partnered, Engaged, or Divorced)</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian</td>
<td>13</td>
<td>48.1</td>
</tr>
<tr>
<td></td>
<td>Agnostic</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Other (Buddhist, Catholic, Islam, or Other)</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Atheist</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>Age</td>
<td>18 - 24</td>
<td>9</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>25 - 34</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>35+</td>
<td>8</td>
<td>29.6</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White American</td>
<td>18</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>African-American/Black</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Other (Arab-American, Hispanic/Latino, Afro-Caribbean, Asian-Caucasian)</td>
<td>4</td>
<td>14.8</td>
</tr>
<tr>
<td>Orientation</td>
<td>Heterosexual</td>
<td>23</td>
<td>85.2</td>
</tr>
<tr>
<td></td>
<td>Gay</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>Asexual</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>Bisexual</td>
<td>1</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Basic demographics are shown in Table 1.

Occupational and educational demographics are shown in Table 2. The community counseling center is located in close proximity to a college campus and as such all participants had some college experience, with six college students, eleven college graduates, four graduate or profession school students, and six graduate or professional school graduates. Diverse arrays
of occupations were represented with the greatest single percentage responding with an occupation in Education, Teaching, and Training.

Table 2

*Occupational and Educational Demographics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Categories</th>
<th>Frequency (n=27)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>College Graduate</td>
<td>11</td>
<td>40.7</td>
</tr>
<tr>
<td></td>
<td>College Student</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Graduate or Professional School Graduate</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Graduate or Professional School Student</td>
<td>4</td>
<td>14.8</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td>Education, Teaching, and Training</td>
<td>7</td>
<td>25.9</td>
</tr>
<tr>
<td></td>
<td>Sales</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>Other (Business and Finance, Communication, Computers and Technology, Construct Business Co-owner and Yoga Instructor, Counseling and Psychology, Higher Education, Management, Media Communications and Broadcasting, Office Administration and Managements, Operations Manager, Retail, Server, Social and Life Services, Student or Waitress)</td>
<td>15</td>
<td>55.6</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>3</td>
<td>11.1</td>
</tr>
</tbody>
</table>

Participants presented at the community counseling center with a myriad of issues. The participants were primarily referred to the counseling center from friends. More than half of the participants had counseling prior to their counseling at the center. Of the presenting issues of participants, the most prevalent being Anxiety, Depression, Personal Development, and Stress. Many participants presented with more than one presenting issue. More than half of the participants in the sample had received prior counseling (Table 3).
### Table 3
**Counseling Demographics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Categories</th>
<th>Frequency (n=27)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral Source</strong></td>
<td>Counseling Center</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Counseling Program</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Friend</td>
<td>11</td>
<td>40.7</td>
</tr>
<tr>
<td></td>
<td>Other (Community College Wellness, CCERC Website, Family Member, Wade Edwards Learning Lab, or Other)</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td><strong>Prior Counseling</strong></td>
<td>No</td>
<td>9</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>18</td>
<td>66.7</td>
</tr>
<tr>
<td><strong>Alcohol and/or Drug Use</strong></td>
<td>No</td>
<td>22</td>
<td>81.5</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td><strong>Thought about Self Harm</strong></td>
<td>No</td>
<td>20</td>
<td>74.1</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>7</td>
<td>25.9</td>
</tr>
<tr>
<td><strong>Actually Self Harm</strong></td>
<td>No</td>
<td>22</td>
<td>81.5</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td><strong>Mental Health Hospital</strong></td>
<td>No</td>
<td>24</td>
<td>88.9</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Physical Abuse</strong></td>
<td>No</td>
<td>26</td>
<td>96.3</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Emotional Abuse</strong></td>
<td>No</td>
<td>18</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>9</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Touched w/o Consent</strong></td>
<td>No</td>
<td>20</td>
<td>74.1</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>7</td>
<td>25.9</td>
</tr>
<tr>
<td><strong>Presenting Issue(s)</strong></td>
<td>Anger</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>13</td>
<td>48.1</td>
</tr>
<tr>
<td></td>
<td>Communication Issues</td>
<td>8</td>
<td>29.6</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>6</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Job Loss</td>
<td>1</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>Personal Development</td>
<td>14</td>
<td>51.9</td>
</tr>
<tr>
<td></td>
<td>PTSD</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>Relationship Issues</td>
<td>7</td>
<td>25.9</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
<td>14</td>
<td>51.9</td>
</tr>
<tr>
<td></td>
<td>Substance Use</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td></td>
<td>Trauma</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td>3.7</td>
</tr>
</tbody>
</table>

*Participants may have more than one (1) presenting issue.*
Research Question 1

RQ1. To what extent, if any, does counseling client quality of life change following counseling services at a counselor education program-operated community counseling center?

Participants were administered the WHOQOL-BREF before the first session, after the fifth session, and after the tenth counseling session. The survey contains two raw quality of life measures, Quality of Life and Satisfaction with Health. A paired t-test was used to determine if the change in the participants perceived quality of life and satisfaction with health was significant. The three major assumptions of the paired t-test are that the data are independent, normal, and continuous. Each assumption was evaluated. The assumption of independence is not measurable, but is reasonably met as participants were selected at random and without relationship to one another. The assumption of normality is met as there is only one outlier in the Satisfaction with Health results and the histograms appear to be roughly normal (See Figures 1 and 2). The Quality of Life and Satisfaction with Health measurements are not converted to scores in the WHOQOL-BREF (WHOQOL Group, 1998). Therefore, the measurements are considered to be discrete and not continuous. To address this technicality, a non-parametric Wilcoxon Pairwise Test was used in addition to a parametric paired t-test for comparison. (Wiedermann, & von Eye, 2013). The Wilcoxon Pairwise Test is a non-parametric test used for data that do not meet the assumptions of the paired t-test. In this case, it was used to verify that the results of the paired t-test are not an artifact of the data being discrete and not continuous. Continuous data are not restricted to defined separate values, but can occupy any value over a continuous range (Hayes, 2005).
Figure 2. The Boxplot and Histogram of Quality of Life measurements for the WHOQOL-BREF.

Figure 3. The Boxplot and Histogram of Satisfaction with Health measurements for the WHOQOL-BREF.
Figure 4. Individual results of Overall Quality of Life and Satisfaction with Health scores session 1 and session10.

Scores indicated that counseling at the community counseling center led to a significant improvement in clients’ perceived Quality of Life, but not perceived Satisfaction with Health (See Figure 4 and Table 4). As indicated in Table 4, perceived satisfaction with health appeared to stay constant between session 1 and conclusion of counseling services. This consistency, or lack of significance in perceived satisfaction with health may indicated a number of clients seeking counseling are in need of physicians care due to the underserved nature of underinsured and marginalized population. This may also indicate the need to expand CCERC services to include an exercise and nutritional component for increased health benefits for those seeking counseling services. These services could be addressed during program monitoring and refinement stage during the next program evaluation cycle.

Table 4

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Session 1</th>
<th>Session 5</th>
<th>Final Session</th>
<th>95% CI for Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>4.04</td>
<td>0.81</td>
<td>4.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Satisfaction With Health</td>
<td>3.56</td>
<td>0.8</td>
<td>3.83</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>27</td>
<td>0.02, 0.49</td>
</tr>
</tbody>
</table>

*p<0.05
Research Question 2

RQ2. To what extent, if any, do counseling client WHOQOL-BREF domains change following counseling services at a counselor education program-operated community-counseling center?

Participants were administered the WHOQOL-BREF before the first session, after the fifth session, and after the last counseling session. Comparisons were made between the first measurement and last measurement. The survey measures quality of life scores in four domains: physical health, psychological, social relationship, and environment. Physical health relates to mobility, sleep, daily living activities, and capacity to work. The psychological domain assesses enjoyment, meaning, appearance, self, and diminished negative feelings. Social relationships evaluate areas such as personal relationships, sex, and support of friends. Environment evaluates safety, healthy physical environment, financial security, living space, health services, and transportation. A total quality of life score was also calculated by combining all of the domain scores at each time point. A paired t-test was used to determine the change in the participants’ quality of life domain scores. Raw domain measurements were converted to scores [WHOQOL-BREF Manual Reference, 2005]. The three major assumptions of the paired t-test were evaluated. The assumption of independence is not measurable but is reasonably met as participants were selected at random and without relationship to one another. The assumption of normality is met as there are only a few outliers in the domain results and the histograms appear to be roughly normal (See Figures 4 – 8). The data are continuous.
Figure 5. The Boxplot and Histogram of “Physical” score change measurements for the WHOQOL-BREF.

Figure 6. The Boxplot and Histogram of “Psychological” score change measurements for the WHOQOL-BREF.

Figure 7. The Boxplot and Histogram of Social” score change measurements for the WHOQOL-BREF.
Counseling at the community counseling center led to a significant improvement in clients’ perceived Physical and Psychological domains as well as the Total Quality of Life domain score (See Table 5 and Figures 9-10). An increase was seen in all four domains however; the increase was only significant in the physical and psychological domains as well as the total quality of life domain score. The social and environmental domain did however increase in a positive direction suggesting improvement in both domains. Limited change in the social and environmental domains may indicate a general focus of beginning counselors to seek out issues
relating to psychological and physical needs rather than effects of relationships and environments such as home and work.

Table 5

**WHOQOL-BREF Domain Scores**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Session 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>Mean</td>
<td>Difference</td>
</tr>
<tr>
<td>Physical domain</td>
<td>69.97</td>
<td>19.97</td>
<td>76.98</td>
<td>13.98</td>
<td>79.1</td>
<td>12.28</td>
<td>27</td>
<td>3.95</td>
<td>14.3</td>
</tr>
<tr>
<td>Psychological</td>
<td>57.41</td>
<td>22.8</td>
<td>58.95</td>
<td>21.24</td>
<td>63.73</td>
<td>18.63</td>
<td>27</td>
<td>1.35</td>
<td>11.3</td>
</tr>
<tr>
<td>Social Domain</td>
<td>58.64</td>
<td>24.18</td>
<td>62.65</td>
<td>19.93</td>
<td>67.28</td>
<td>19.87</td>
<td>27</td>
<td>-0.2</td>
<td>17.48</td>
</tr>
<tr>
<td>Environmental</td>
<td>70.72</td>
<td>18.53</td>
<td>73.02</td>
<td>15.91</td>
<td>75.58</td>
<td>16.47</td>
<td>27</td>
<td>-0.08</td>
<td>9.8</td>
</tr>
<tr>
<td>Total</td>
<td>256.74</td>
<td>70.12</td>
<td>271.62</td>
<td>62.57</td>
<td>285.7</td>
<td>55.52</td>
<td>27</td>
<td>13.39</td>
<td>44.52</td>
</tr>
</tbody>
</table>

* p<0.05, ** p<0.01, *** p<0.005, **** p<0.001

*Figure 10.* WHOQOL-BREF physical health, psychological, social relationships, and environment domain scores session 1 and session 10.
Research Question 3

RQ3. To what extent, if any, does counseling client satisfaction change during counseling services at a counselor education program-operated community counseling center?

Participants were administered the CCERC CCQ before the first session, after the fifth session, and after the last session. Comparisons were made between the fifth and the last counseling session as participants would be unable to appropriately evaluate the CCERC services before they received CCERC services. The survey measures satisfaction in several areas as well as a total satisfaction score. A paired t-test was used to determine if there was a significant difference between the satisfaction measurements after the fifth and final sessions. The three major assumptions of the paired t-test: data are independent, normal, and continuous, were evaluated. The assumption of independence is not measurable but is reasonably met as participants were selected at random and without relationship to one another. The assumption of normality is met as there is are only a few outliers in the domain results and the histograms appear to be roughly normal. The data are not however continuous. To address the non-continuous data, a Wilcoxon Pairwise Test was also computed for each satisfaction measurement for comparison to the paired t-test result.
There were no significant differences between the fifth session and final session for any of the satisfaction measurements, although, the total average mean score was 1.4 indicating a high level of satisfaction with CCERC services. [Table 6]. For this reason, no graphs and additional results were included.

As seen in Table 6, the mean change scores on all questions decreased 0.3 on average which indicated over time satisfaction with CCERC services continued to increase. A mean score of 1.5 or less would indicate a response of strongly agree. On average all scores fell between 1.09 and 1.56. This would suggest CCERC is attending to the physical, psychological, social, cultural, emotional, relational, and spiritual developmental need of clients seeking CCERC counseling services.

| Table 6 |
| CCERC Satisfaction Survey |

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Session 5</th>
<th>Session 10</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feels Respected by Staff</td>
<td>1.19</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Feels Respected by Counselor</td>
<td>1.19</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Feels Helped with Concerns</td>
<td>1.41</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Finds Fees Affordable</td>
<td>1.09</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Feels times are convenient</td>
<td>1.44</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Feels Appointments are Easy</td>
<td>1.37</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Feels Locations are Convenient</td>
<td>1.48</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Feels Needs are met</td>
<td>1.52</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Would Recommend CCERC</td>
<td>1.22</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Is Satisfied with CCERC</td>
<td>1.37</td>
<td>1.15</td>
<td>(0.89, 0.14)</td>
<td>-0.21</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>14.3</td>
<td>14</td>
<td>(9.3, 19.3)</td>
<td>-0.26</td>
<td>26</td>
</tr>
</tbody>
</table>

In general, the CCERC increased the quality of life of counseling clients. Significant increases were seen in “Overall Quality of Life”, the “Physical Health Domain”, the
Psychological Domain”, and Total Domain Quality of Life. CCERC Satisfaction did not change throughout the duration of the study, possibly due to established high levels of satisfaction recorded during the initial data collection. Consequently, no significant changes were reported.

Summary

Despite the study’s limitations, the statistically significant results suggest that counseling at CCERC is an effective intervention that may prove beneficial for addressing mild to moderate mental health issues in the community population. In addition to the sample including adults with mild to moderate mental health issues, the population was also composed of underserved and underinsured adults. And because entrance into counseling services is not contingent on financial accountability, CCERC may prove to be a practical alternative to traditional counseling services.
CHAPTER 5: DISCUSSION

In the preceding chapter, the presentation and analysis of data have been reported. Chapter 5 consists of seven sections: (a) summary of the study, (b) discussion of the findings, (c) implications for practice, (d) implications for counseling and counselor education, (e) recommendations for future research, (f) limitations of the study, and (g) conclusions. The primary purpose of this dissertation was to evaluate a community-based university counseling training center; in this study, it was the Community Counseling, Education, and Research Center (CCERC). Specifically, the aim of the study was to gain insight into counseling participants’ (a) quality of life and (b) satisfaction with services.

Summary of the Study

The need for counseling program evaluation to systematically evaluate program components, methodologies, and outcomes has been extensively outlined by Whiston (1997), Loesch (2001), and Astramovich & Coker (2007). This quantitative one-way repeated-measures study expands the quantitative program evaluation literature relating to counselor education and training, program-operated, community-based counseling centers. The program evaluation conducted for this study focused on participants’ perceived quality of life and satisfaction with services after being counseled by master’s level counselors-in-training over ten counseling sessions within a counselor education, program-operated, community-based counselor training center. The CCERC CCIF, WHOQOL-BREF, and the CCQ were administered prior to participants beginning counseling and immediately before the fifth and tenth counseling sessions.

There were three main research questions guiding this study:
1. To what extent, if any, does counseling client quality of life change following counseling services at a counselor education program-operated community counseling center?

2. To what extent, if any, do counseling client WHOQOL-BREF domains change following counseling services at a counselor education program-operated community counseling center.

3. To what extent, if any, does counseling client satisfaction change during counseling services at a counselor education program-operated community counseling center.

To answer the first and second questions, participants were administered the WHOQOL-BREF as a measure of quality of life. To answer the third question, participants were administered the CCQ as a measure of the client’s satisfaction.

**Discussion of Findings**

Communicating outcomes data and results to stakeholders provides accountability and acts as a proactive measure to strengthen the professional identity of the counselor education counseling center. According to Erford (2015), counselors should not wait until accountability is demanded by stakeholders to share outcomes data and results.

The data were analyzed based on the three research questions, and this discussion of the findings is organized by research question. Conclusions based upon the data analysis related to each question are also presented in this section.

**Quality of life.** The first research question was as follows: To what extent, if any, does counseling client quality of life change following counseling services at a counselor education program-operated community counseling center? The WHOQOL-BREF has two items that are examined separately when measuring overall quality of life and general health: (a) How would
you rate your quality of life? (b) How satisfied are you with your health? The findings resulting from research question one indicate a positive and significant relationship between counseling and overall quality of life. The results confirmed that there was significant change in overall perception of quality of life between the initial and final counseling sessions. Based upon the mean scores, participants showed a positive change in perceived overall quality of life following completion of counseling. This evidence that counseling services were effective in improving the overall quality of life of the participants responds directly to the call by Loesch (2001) and Erford (2015) for counselor-in-training centers to provide research of program effectiveness and impact.

Analysis regarding overall satisfaction with general health indicated no significant change between initial and final counseling session. Due both to the limited number of counseling sessions and to counselor-in-training students focusing primarily on the client’s psychological wellbeing, it appears fitting that the overall perception of general health remained static. A counseling approach combining the concepts of exercise, diet, and psychological wellbeing may better address client perception of general health.

**WHOQOL-BREF.** The second research question was as follows: To what extent, if any, do counseling client WHOQOL-BREF domains change following counseling services at a counselor education program-operated community-counseling center? As in the findings for research question one, the findings for research question two revealed a significantly positive relationship between the WHOQOL-BREF domains of physical health and psychological health and counseling services. The WHOQOL-BREF was administered before the first counseling session and after both the fifth session and the tenth (i.e., final) counseling session. The WHOQOL-BREF measures quality of life scores in four domains: physical health,
psychological, social relationship, and environment. For this analysis comparisons were made between the first and last counseling session. The results confirmed significant change in the domains of physical health (p<0.01) and psychological (p<0.05). Significant change in physical health and psychological appear to be consistent with recent conducted by Schuermann et al. (2018), which indicated that counseling training centers offer a valuable service to the community where clients are receiving worthwhile services and are experiencing significant change. It should be noted that overall general health and physical health provide different interpretations. Overall general health relates to satisfaction with health. Physical health is related to energy, mobility, sleep, and work. It appears there should be some congruence between the two; however, the differences seem quite possible as an individual could not feel well and yet might perform the physical duties necessary for daily living activities.

Although change scores in the domains of social relationships and environment were not significant, mean scores revealed a positive direction; higher scores were generated at the end of counseling, indicating a slight increase in these two domains. Nonsignificant scores in the domains of social relationships may be related to limited social capital resulting from limited contact with different groups or involvement with local residents (Dong & Bergren, 2016). Many of the participants in the study identified issues relating to anxiety, and high levels of anxiety could possibly limit social engagement. The use of an anxiety scale may prove useful in further exploring counseling clients’ presenting issues.

The domain with the largest change between first and last data points was physical health. The mean increase indicates counseling services positively affected clients’ physical health. This outcome aligns with the holistic wellness component of the CCERC model. A mission of the CCERC model is to provide counseling services that allow individuals to
participate in counseling to benefit their overall physical health (Grimmett et al., 2017). According to Grimmett et al. (2017), a wellness focus “attends to the physical, psychological, social, cultural, emotional, relational, and spiritual developmental needs, rather than focus solely on mental illness” (p. 165). These results may indicate perceived feeling of diminished pain, increased energy, stable sleep patterns, and ability to perform daily tasks. Counseling services are designed to reduce and further client stress by addressing prevention, development, and wellness (Grimmett et al., 2017). These important factors may play an active role in stabilizing presenting issues and in building trust, responsibility, and respect.

Regarding psychological health, the results may also indicate an increased satisfaction with life, concentration, and appearance while reducing negative self-talk regarding one’s own mental health. Clients with high levels of psychological health may have adequate housing, positive social connections, and experience low levels of fear. According to Amerio and Roccato (2005), feelings of lack of safety are related to the most serious problems affecting individuals and communities. CCERC specifically addresses this issue by integrating a trauma-informed approach to counseling and counseling services (SAMHSA, 2018).

**Research question three.** The third research question was as follows: To what extent, if any, does counseling client satisfaction change during counseling services at a counselor education program-operated community counseling center. Scores recorded pre-counseling were found to be inconsistent and incomplete due to the nature of a number of questions on the CCQ that were designed to measure client satisfaction once counseling services had been initiated. During analysis of the data it was noted that the following questions were missing responses or NA was chosen: “I am treated with respect by the CCERC counselor; The counselor helps me with my concerns”; “I am receiving what I need from counseling”; “I would recommend CCERC
to others”; and “I am satisfied with the services I am receiving” (Grimmett et al., 2016). Based on the issues surrounding pre-counseling CCQ data—specifically that participants were unable to appropriately evaluate the counseling services before they had received them, comparisons were made between the fifth and the last counseling session.

The results confirmed there was no significant change between scores recorded between the fifth counseling session and the tenth counseling session. Although there were no significant differences in the CCQ score, it must be noted that the initial scores from the fifth session to the last were on average 1.43. Based on the Likert-type scale utilized for this study, a score of 1.43 falls between strongly agree and agree. The average overall score after the final session was 1.4, which indicates little variation in the participant’s overall perceived satisfaction of counseling services, further indicating services were meeting or exceeding participant expectations. These findings are consistent with the CCERC model’s approach to counseling, which is collaborative, transparent, and accessible (Grimmett et al., 2018).

The eight CCQ (Grimmett et al., 2016) questions that performed better than the overall questionnaire mean score of 1.43 between counseling sessions five and ten were the following: (a) “I am treated with respect by the CCERC staff” (1.19, 1.15); (b) “I am treated with respect by the CCERC counselor” (1.19, 1.15); (c) “The counselor helps me with my concerns” (1.41, 1.41); (d) “The fees are affordable” (1.09, 1.17); (e) “It is easy to schedule my appointment” (1.37, 1.22); (f) “The location of the office is convenient” (1.48, 1.41); (g) “I would recommend CCERC to others” (1.22, 1.3); and (h) “I am satisfied with the services I am receiving” (1.37, 1.33). These findings are consistent with the CCERC model, which focuses on respect, equality, affordability, accessibility, and satisfaction (Grimmett et al., 2017; Grimmett et al., 2018).
Of the eight questions listed above for the CCQ, four of the seven showed a decrease in mean score, indicating an increase in satisfaction. Consequently, the two scores for the following CCQ questions show an increase in the mean score, which may indicate client satisfaction had plateaued or decrease slightly: (a) “The appointment times are convenient” (1.44, 1.56) and (b) “I am receiving what I need from counseling” (1.52, 1.56) (Grimmett et al., 2016).

These outcomes provide valuable information to report to stakeholders for feedback, and stakeholder feedback is vital in the design and delivery of counseling services (Astromovich & Coker, 2007). To provide sustainability, counselor education counseling training centers can no longer leave stakeholders—specifically university administration—to speculate about how the counseling center is meeting the accountability requirements of the CACREP 2016 standards (Lauka & McCarthy, 2013). Adopting the accountability bridge model for counselors (Astromovich & Coker, 2007) may provide the means for creating accountability and sustainability across all counselor education counselor training centers.

**Implications for Practice**

With the call for accountability in the counseling profession, integration of evaluation and research practices is necessary and valuable. Counselor education program-operated, community-based counselor training centers provide the initial experience for many counselors who enter the counseling profession. It is important that the experience of program evaluation become a working component of all counselor education counseling training centers. Despite this increased focus, counselor training has rarely emphasized research and evaluation (Astromovich & Coker, 2007; Heppner et al., 1999; Sexton et al., 1997).

As counselors embrace the call to demonstrate accountability for client outcomes, program evaluation skills are essential to the advancement of the professional counselor. Despite
the calls for research regarding program evaluation, articles are limited (Barrio Minton et al., 2014). Many students are trained to use measures but lack the experience to conduct research (Astramovich & Hoskins, 2013). Counselor training centers such as the one in this study may benefit from developing strategies to inform students on the importance of tracking outcomes and how to use the information for the best interests of the clients.

According to Schuermann et al. (2018) repetitive and required use of outcome measures may help counseling students improve their self-efficacy, increase awareness of their impact on clients, and enhance the therapeutic relationship through discussing results with clients. Understanding and discussing instruments relating to outcome measures during weekly staffing may also be beneficial. The following instruments may help illuminate the importance of outcome research for counselors-in-training: Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996), the Outcome Rating Scale (ORS; Miller & Duncan, 2004), and the WHOQOL-BREF, which is a well established, valid, reliable, person centered instrument designed to interpret patient-reported outcome measures. Traditional doctoral students perform research at counselor training centers mostly to meet requirement of the program (Grimmett, et al., 2017). Developing service learning experiences may also expose students to the challenges often encountered by professional evaluators (Trevisan, 2002). According to Lloyd-Hazlett (2018) a 10-week service-learning project completed by students enrolled in a program evaluation course may positively impact students’ perceived evaluation knowledge and confidence as well as how important they perceive evaluation to be. As community-based, counselor education program-operated counselor training centers continue to develop and expand, service-learning projects may prove beneficial for all students who participate as providers therein.
The CCERC counseling center serves many functions, such as counselor training, research, and scholarship as well as accessible, affordable, high quality counseling services for community members. The approach CCERC provides a high level of accountability to all stakeholders involved. While counselor training is still the primary focus (Hollis, 1997), the CCERC model will benefit by adopting a framework to continually assess counseling effectiveness and impact (Astramovich & Coker, 2007). The accountability bridge model for counselors provides all the necessary components to evaluate the CCERC model. The accountability bridge model (Astramovich & Coker, 2007) appears encouraging as a model to be used in program evaluation. At this point the accountability bridge model appears to be gaining recognition (Astramovich & Hoskins, 2013; Nielson, 2015). As mentioned earlier most evaluation models are considered too complicated for conducting program evaluation in community-based university counseling training centers, especially considering that most are designed for large scale assessment (Astramovich & Coker, 2007). The simplicity and ease of use of the accountability bridge model could increase interest in program evaluation and also fill the need of other community-based, counselor education program-operated counselor training centers to provide and enhance accountability. More counselor education program need to be made aware of the benefits of this model so that more studies can be conducted.

**Implications for Counseling and Counselor Education**

The findings of this study have important implications for many counselor education programs operating or developing counseling training centers. This study identified links between master’s level counseling and clients’ perceived quality of life and satisfaction with services. For counselor education program administrators, this study offers insight into the process of developing a program evaluation model for counselor training centers. It will also
give administrators a good idea of models and strategies needed to positively influence the assessment and development of program evaluation. Research questions one and two demonstrate the functions of a program evaluation model. Research question three demonstrated the effectiveness of a strategic approach to building a comprehensive counselor-in-training model that is uniquely suited to providing excellent mental health services within the community it serves.

**Recommendations for Future Research**

There is a need for further research on community-based, counselor education program-operated counseling training centers. Although practitioners and researchers agree that counseling is effective, in a community setting the mission of the counseling center is to provide replicable, high quality counseling services that sustain the community-based counseling center.

Utilizing program evaluation models such as the accountability bridge model for counselors (Astramovich & Coker, 2007) can help providers such as CCERC examine the outcomes of the specific services they provide to the clients while focusing on the benefits to the local community; doing so may help make program evaluation a meaningful activity for counselors-in-training. Ultimately program evaluation can help bridge the gap between the local community and the university; it can reinforce the importance of mental health counseling services accessible to the community and provide the necessary outcomes data for centers’ sustainability and growth.

As counselor-in-training centers continue to grow and flourish, it will become necessary to explore how they sufficiently enhance student learning. The CCERC model is based on a wellness perspective; with this in mind it may become necessary to further evaluate client symptomology such as anxiety and depression. Demographic data shows that a majority of clients seeking services
at CCERC present with anxiety, depression, or both. Utilization of instruments such as the Generalized Anxiety Disorder 7-item (GAD-7) scale (Spitzer, Kroenke, Williams & Lowe, 2006) and the Patient Health Questionnaire (PHQ-9) (Spitzer, Kroenke, & Williams, 1999) may prove beneficial for professional development as they are both simple to administer and score.

In settings such as CCERC an underserved and underinsured population remains a primary focus. Thus, providing comprehensive evaluation and feedback to the clients served may ultimately enhance the therapeutic relationship. It may provide a deeper and more meaningful experience for both the counselor-in-training and the client.

Discussion regarding the importance of infusing social justice into training, research, and delivery of counseling services have been a focus of the counselor education community for over 10 years (Vera & Speight, 2003; 2007). Expanding on the CCERC component of social justice, the counseling center may even further remove the barriers that restrict access to high quality mental health counseling services for underserved populations. According to Grimmett et al. (2017) 22.9% of Black families and 30.5% of Hispanic families live below the poverty level in North Carolina. To strategically meet the needs of the community, the counseling center may benefit from quantifying the variety of prevention, outreach, and advocacy services. Systematically monitoring these services may provide a best practice approach to assuring an inclusive counseling center where all populations have access to high quality therapeutic services.

Regarding the CCQ (Grimmett et al., 2016), the scores relating to the Likert-type scale on the instrument will need to be reversed; in the current version, it is confusing that the lowest score (1) indicates the highest degree of satisfaction. Secondly, the CCQ will need to be administered after the initial counseling session to meet the criteria of the questions on the instrument.
Limitations

This study is limited by both the design and the data analysis employed. As a program evaluation, this study could have focused on other services provided by a community-based counselor training center, such as outreach, counselor training, and the supervisor-counselor relationship. However, given the relative infancy of the CCERC counselor training center, it was decided to limit this study to an examination of counseling services and the outcome assessment procedures used to evaluate those services. Since all participants’ perceptions were measured in a specific sequence, an order effect may have been generated affecting the performance of the participants. Since this research study involved an assessment of quality of life and satisfaction at a specific counselor-in-training program, participation was limited to clients of the CCERC counseling center. Limiting participation to CCERC counseling clients suggests that the assessment describes quality of life and satisfaction at CCERC only, and the assessment of quality of life and satisfaction at another counselor training center may have different results.

Another limitation of the study is the time allowed to collect and analyze data. Since this study was being performed to fulfill program requirements for dissertation, time was fixed and limited.

Small sample size and attrition may act as a limitation along with the variation in the approaches used by the counselors through the duration of the study. Also, due to time constraints the present study did not employ a true experimental design with random assignment and a control group. It is important to note that this may be a non-representative sample of the population seeking counseling services at a counselor education program-operated counselor training center. Finally, the CCQ (Grimmett et al., 2016) will need further testing for reliability and validity for use in future studies. Due to the lack of psychometric analysis, the CCQ instrument will only be appropriate for CCERC until further analysis can be conducted.
Conclusion

The findings of the study address the paucity of research in the area of counselor education program-operated, community-based counselor training centers. This investigation revealed that persons receiving counseling from master’s level counselors-in-training at CCERC showed improvement in quality of life and an overall satisfaction with counseling services. A further assessment of quality of life domains found significant improvement in both physical and psychological health.

Overall, CCERC—the counselor education program-operated, community-based counselor training center at North Carolina State University—appears to have provided a valuable and effective service to the community participants in this study who were in distress and sought counseling services. As reported by the participants, the counseling provided by the counseling staff was effective in providing an environment where positive change in quality of life could be achieved.

With an overall focus in the counseling profession on accountability and with the growth of counselor education program-operated counseling training centers, it would be beneficial for counseling training centers to generate reports at the completion of each academic calendar year outlining outcomes assessment, feedback from stakeholders, strategic planning, needs assessment, and services objective—all of which are addressed in the accountability bridge model for counselors (Astramovich & Coker, 2007). It would also prove beneficial for the counselor training center to have an organized and usable form outlining program planning for the next calendar year. Such reports can be combined with other university wide outcome figures to better understand the role of the center within the university and surrounding community. An example of this would be to compare the demographic and presenting issues of clients accessing
counseling services to that of existing community counseling providers. In this way the counselor training center could determine if certain community groups are underserved and might benefit from targeted outreach efforts.

According to Rosenberg and Rosenberg (2018) communities will continue to see an increased need in services for populations such as veterans, older adults, individuals who identify as LGBTQ, and individuals with substance use disorders. Counseling training centers are poised to address many of these increasing mental health issues within the communities the centers serve. Counselor training centers can begin to fill the gap in behavioral health services for the underinsured and uninsured populations that are often left behind due to the systemic barriers of the current health care system. Beginning counselors need to understand that for many clients the pathway to behavioral change must first begin by addressing the oppressive social conditions that influence human behavior, an idea promoted by Ratts and Pederson (2014): “counselor advocates realize that individual counseling in not sufficient to address systemic-based problems” (p. 29). Educating counselors-in-training in advocacy is part of the mission of CCERC and other counselor training centers (Grimmett et al., 2018). To address the systemic barriers to service. CCERC performs numerous outreach services through a strategic approach to identify underserved areas and populations who are in need of affordable counseling services (Grimmett et al., 2018); evaluation and assessment may ensure that the aforementioned mission is being met.

The findings from this study provide information regarding clients’ perceptions of their quality of life and their satisfaction with the services they received at CCERC, a counselor training center with master’s level counselors-in-training. Participants in the study were satisfied with the experience and services provided and felt that it contributed to their progress.
The findings support the need for further research regarding program evaluation of community-based university counselor training centers (Astramovich & Coker, 2007; Erford, 2015; Grimmett et al., 2017; Luka & McCarthy, 2012; Schuermann et al., 2018). With the growth of counselor education training centers and the limited information regarding program evaluation therein, the implementation of a universally accepted, counselor centered, program evaluation approach for community-based university counselor training centers is needed.
REFERENCES


doi: 10.1080/2326716X.2017.1347390


counseling, education, and research center handbook. North Carolina State University, Raleigh, NC: CCERC.


doi:10.1017/S0033291798006667


APPENDICES
Appendix A

North Carolina State University
Community Counseling, Education, and Research Center (CCERC)
Counseling Client Information Form

Initial Contact Date:

Number of Attempts to Contact:

Client #:

Counselor #:

Start Date:

Semester:

Number of Sessions:

Fee:

Total Collected to Date:

End Date:

Referral Source:
• Broughton
• CCERC Website
• Community Referral
• Family Member
• Friend
• NCSU Counseling Center
• Wade Edwards Learning Lab
• Other (Please indicate in text box below)

Relationship Status:
• Divorced
• Married
• Single
• Partnered
• Please Indicate Highest Education Level:
  • Elementary/Middle School
  • High School Student
  • High School Graduate
  • College Student
  • College Graduate
  • Graduate or Professional School Student
  • Graduate or Professional School Graduate

• Please indicate your spiritual and/or religious practices:
  • Agnostic
  • Atheist
  • Buddhist
  • Christian
  • Hindu
  • Islam
  • Jewish
  • Please indicate below if not listed

Occupation:
• Business and Finance
• Computers and Technology
• Construction
• Counseling and Psychology
• Education, Teaching, and Training
• Engineering
• Fishing, Farming, Forestry
• Health and Medical
• Hospitality, Travel, and Tourism
• Legal, Criminal Justice, and Law Enforcement
• Management
• Media Communications and Broadcasting
• Military and Armed Forces
• Office Administration and Management
• Production and Manufacturing
• Professional and Service (Please indicate in text box below)
• Installation, Repair, and Maintenance
• Sales
• Social and Life Services
• Transportation
• Other (Please indicate in text box below)
• Not Applicable

Presenting Issue:
• Academic Issues
• Anger
• Anxiety
• Communication Issues
• Depression
• Family
• Job Loss
• Parenting Issues
• Personal Development
• PTSD
• Relationship Issues
• Stress
• Substance Use
• Trauma
• Other (Please indicate in text box below)

Age:

• **Race/Ethnicity:**
  • African-American/Black
  • Alaskan Native
  • Asian
  • Asian-American
  • Hispanic/Latino
  • Multiracial/Multiethnic (Please indicate in text box below)
  • Native American/American Indian
  • Native Hawaiian
  • Pacific Islander
  • White American/Caucasian
  • Self Identify (Please indicate in text box below)

Gender:
• Female
• Male
• Non-Binary
• Transgender
• Self Identify (Please indicate in text box below)

Sexual Orientation:
• Bisexual
• Gay
• Heterosexual
• Lesbian
• Self Identify (Please indicate in text box below)

• Have you ever participated in mental health counseling or therapy?
  a. Yes
  b. No

• Has your use of alcohol and/or other drugs caused problems or affected family, school, work, or social life?
  a. Yes
  b. No
  If yes, when did this last happen? (Please respond in box below)

• Have you ever though seriously about harming yourself or someone else?
  a. Yes
  b. No
  If yes, when were your most recent thoughts? (Please respond in box below)

• Have you ever intentionally hurt yourself or someone else?
  a. Yes
  b. No
  If yes, when did this last happen? (Please respond in box below)

• Have you ever been admitted to the hospital for mental health issues?
  a. Yes
  b. No
  If yes, when were you most recently admitted? (Please respond in box below)

• Has your current or former dating or relationship partner (e.g., boyfriend, girlfriend, partner, wife, husband) ever been physically violent towards you?
  *Physical violence towards you includes, but is not limited to, your body, family, friends, pets, and property.
  a. Yes
  b. No
  If yes, when did this last happen? (Please respond in box below)

• Has your current or former dating or relationship partner (e.g., boyfriend, girlfriend, partner, wife, husband) ever been emotionally/psychologically abusive towards you?
  *Emotional/psychological abuse towards you includes, but is not limited to:
    ➢ Comments such as “you will never find anyone as good as me.”
    ➢ Threatening to hurt themselves if you left the partnership.
    ➢ Trying to control what you do and who you are with.
    ➢ Embarrassing and/or humiliating you in front of others.
    ➢ Blaming you and not accepting responsibility during disagreements.
    ➢ Jealousy and not trusting you.

  A. Yes
B. No

If yes, when did this last happen? (Please respond in box below)

• Has anyone ever touched you without consent?
  * Examples of not consenting or not being able to consent include:
    ➢ Being under the age of 16
    ➢ Being incapacitated due to alcohol and/or other drugs
    ➢ Being threatened (for example, “If you don’t have sex with me, I’ll break up with you.”)
    ➢ Being coerced (for example, “if you love me, you would do this.”)
    ➢ Verbally stating unwillingness (for example, “No, Stop,” “I don’t want to”)
    ➢ Physically demonstrating unwillingness (for example, crying, pushing away, “freezing up,” being “passed out”, asleep, unengaging or completely still)

A. Yes
B. No

If yes, when did this last happen? (Please respond in box below)
Appendix B

ABOUT YOU
Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your gender? Male Female
What is your date of birth? Day / Month / Year

What is the highest education you received? None at all
Primary school
Secondary school
Tertiary

What is your marital status? Single Separated
Married Divorced
Living as married Widowed

Are you currently ill? Yes No
If something is wrong with your health what do you think it is? illness/problem

Instructions
This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks. For example, thinking about the last two weeks, a question might ask:

<table>
<thead>
<tr>
<th>Do you get the kind of support from others that you need?</th>
<th>Not at all 1</th>
<th>Not much 2</th>
<th>Moderately 3</th>
<th>A great deal 4</th>
<th>Completely 5</th>
</tr>
</thead>
</table>

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

<table>
<thead>
<tr>
<th>Do you get the kind of support from others that you need?</th>
<th>Not at all 1</th>
<th>Not much 2</th>
<th>Moderately 3</th>
<th>A great deal 4</th>
<th>Completely 5</th>
</tr>
</thead>
</table>

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.
Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Neither poor nor good</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(G1) How would you rate your quality of life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (G4) How satisfied are you with your health?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The following questions ask about how much you have experienced certain things in the last two weeks.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>A moderate amount</th>
<th>Very much</th>
<th>An extreme amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (F1.4) To what extent do you feel that physical pain prevents you from doing what you need to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4(F11.3) How much do you need any medical treatment to function in your daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5(F4.1) How much do you enjoy life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6(F24.2) To what extent do you feel your life to be meaningful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>A moderate amount</th>
<th>Very much</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>7(F5.3) How well are you able to concentrate?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8(F16.1) How safe do you feel in your daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9(F22.1) How healthy is your physical environment?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Mostly</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 (F2.1) Do you have enough energy for everyday life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11 (F7.1) Are you able to accept your bodily appearance?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12 (F18.1) Have you enough money to meet your needs?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13 (F20.1) How available to you is the information that you need in your day-to-day life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14 (F21.1) To what extent do you have the opportunity for leisure activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

<table>
<thead>
<tr>
<th></th>
<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 (F9.1) How well are you able to get around?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 (F3.3) How satisfied are you with your sleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17 (F10.3) How satisfied are you with your ability to perform your daily living activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18 (F12.4) How satisfied are you with your capacity for work?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19 (F6.3) How satisfied are you with yourself?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20 (F13.3) How satisfied are you with your personal relationships?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21 (F15.3) How satisfied are you with your sex life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22 (F14.4) How satisfied are you with the support you get from your friends?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23 (F17.3) How satisfied are you with the conditions of your living place?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24 (F19.3) How satisfied are you with your access to health services?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25 (F23.3) How satisfied are you with your transport?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Quite often</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 (F8.1) How often do you have negative feelings such as blue mood, despair, anxiety, depression?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Did someone help you to fill out this form?...

How long did it take to fill this form out?...

**Do you have any comments about the assessment?**

**THANK YOU FOR YOUR HELP**
## Appendix C

### Counseling Client Questionnaire

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am treated with respect by the CCERC staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>I am treated with respect by the CCERC counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>The counselor helps me with my concerns.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>The fees are affordable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>The appointment times are convenient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>It is easy to schedule my appointment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>The location of the office is convenient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>I am receiving what I need from counseling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>I would recommend CCERC to others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>I am satisfied with the services I am receiving.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Appendix D

North Carolina State University
INFORMED CONSENT FORM for RESEARCH

Assessing the Impact of the Community Counseling, Education, and Research Center (CCERC) Model.

Principal Investigator: Michael Keith Englert, M. A., LPC, LCAS, NCC
Faculty Sponsor: Marc Anderson Grimmett, Ph. D

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of research studies is to gain a better understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those that participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above.

What is the purpose of this study?
The purpose of this study is to assess the impact of services provided by the Community Counseling, Education, and Research Center (CCERC). CCERC is the community counseling center sponsored by the Counselor Education program at North Carolina State University. In order to best serve CCERC clients and ensure that we are providing high quality services, it is imperative that the services be measured. Understanding how clients experience CCERC will also add to the literature on counselor education training centers.

What will happen if you take part in the study?
If you agree to participate in this study, you will be asked to complete a confidential online survey at specific times throughout the counseling process.

Risks
This study poses an element of risk to participants involved. In order to assess the impact of a counselor education training center as a tool for positive growth, questions related to the counseling experience must be asked, which may cause some emotional discomfort. In order to minimize this risk, you will be immediately brought to the resource page once you have submitted the survey. Resource information is also included at the bottom of this form. You are also encouraged to share any discomfort or concerns with your counselor or your counselor’s supervisor at CCERC.
Benefits

The benefits of participation in this research study include the opportunity to contribute to the literature on wellness, multiculturally competent and inclusive counseling, and counselor education centers. Participants will also help CCERC evaluate the impact of counseling services provided, which will serve to improve services for current and future clients.

Confidentiality

The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely on a server maintained by NC State University. The survey data will be copied daily to a secure password-protected network drive via a personal computer, kept in a locked office. At the end of the data collection process, all electronic data files will be removed from the secure server and stored only on a secure password protected network drive. All analyses of the data will be conducted on the PI’s password-protected personal computer in a locked office. No reference will be made in oral or written reports, which could link you to the study. You will NOT be asked to write your name on any study materials so that no one can match your identity to the answers that you provide.

Compensation

There is no compensation for participating in the study.

What if you are an NCSU student?

Participation in this study is not a course requirement and your participation or lack thereof, will not affect your class standing or grades at NC State University.

What if you are an NCSU employee?

Participation in this study is not a requirement of your employment at NCSU, and your participation or lack thereof, will not affect your job.

What if you have questions about this study?

If you have questions at any time about the study or the procedures, you may contact the researcher, (Marc A. Grimmett, PhD, magrimme@ncsu.edu, 919-515-6358).

What if you have questions about your rights as a research participant?

If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Deb Paxton, Regulatory Compliance Administrator, Box 7514, NCSU Campus (919-515-4514).

Consent to Participate

“I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled.”
□ Yes, I consent to participate in this study. Date ______________

□ No, I do not consent to participate in this study. Date ______________