Assessment of Microskills Training for Lay Counselors in Rural Christian Congregations

By

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ABSTRACT

Lay counselors and other informal supports have been demonstrated to be effective forms of alternative support; however, most models for training lay counselors have limited usefulness for rural communities. The purpose of this study was to measure the change in observable microskill usage following a brief (< 10 hours) lay counseling microskills workshop designed for rural, Christian congregations. Researchers evaluated pre/post-intervention transcripts from 12 participants utilizing Hill's (2014) Helping Skills System. Researchers also calculated proportions of words spoken by participants during mock lay counseling interactions with an actor to measure increases in active listening skills. Results of the study indicated a greater level of success with reducing the less-helpful counseling microskills (e.g., direct guidance, self-disclosure) than either increasing positive counseling microskills (e.g., open questions, reflections of feeling) or reducing the amount of time speaking in this sample of Christian lay counselors following the described microskill workshop. The project identified several factors that impacted results, which were not measured by the categorization of verbal responses, including individual learner differences, religious evangelistic efforts, and the use of prayer during lay counseling interactions. This project also attempted to explore the role of rural practitioners in the collaboration with religious congregations in building healthier, supportive communities.

Keywords: rural, Christian, lay counselors, microskills

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Table of Contents

Page

Operational Definitions

Many of the terms utilized in this document may not have widely established definitions. Therefore, in order to assist with readability and clarity, the following represent the operational definitions of key terms:

- *Lay Counselors* are individuals who may lack the training, education, experience, or credentials to be professional counselors, but who nevertheless are actively involved in helping people cope with personal and relational problems (Collins, 2007).
- *Microskills* are the behavioral foundations of intentional counseling and psychotherapy, particularly specific communication skills (Ivey et al., 2018).

Microskill Definitions

- *Approval and Reassurance Statements* are statements that provide emotional support, reassurance, encouragement, and reinforcement. These indicate that the lay counselor empathizes with or understands the client (Hill, 2014). Ivey et al. (2018) refer to these statements as "Encouragers."
- *Open-ended Questions* ask the client to clarify or to explore thoughts or feelings; typically these questions cannot be answered in a few words (Hill, 2014; Ivey et al., 2018).
- *Restatements* are a simple repeating or rephrasing of the content or meaning of the client's statements that typically contain fewer but similar words. Restatements are usually more concrete and clearer than the client's statement (Hill, 2014). Ivey et al. (2018) refer to these as either "Paraphrases" or "Summarizations."
- *Reflections of Feelings* are a repeating or rephrasing of the client's statements, including an explicit identification of the client's feelings (Hill, 2014; Ivey et al., 2018).

- *Closed-ended Questions* are questions requesting limited or specific information or data, usually one- or two-word answers. These questions can be used to gain information, ask a client to repeat, or to ask if the helper's intervention was accurate (Hill, 2014; Ivey et al., 2018).
- *Direct Guidance* is an intervention that provides suggestions, directives, instructions, or advice about what the client should do to change (Hill, 2014). Ivey et al. (2018) also refer to these statements as "Directives," "Instruction," or "Psychoeducation."
- *Self-Disclosures* are statements that revel something personal about the helper's experience or feelings. These statements typically start with an "I" (Hill, 2014; Ivey et al., 2018).

Chapter I

Summary of the Issues

With 19.3% of the U.S. population living in rural areas (U.S. Census Bureau, 2015) and engaging in fewer mental health services (Fischer et al., 2016), while rating their mental health as poorer than urban populations (Hauenstein et al., 2007), the need to better understand the pattern of rural mental health service utilization is inescapable. There are many characteristics of rural communities associated with mental health disparities, including greater rates of poverty (Walker, Tomlinson, & Williams, 2010), stigma toward mental health treatment (Bischoff et al., 2014), and lack of affordable health care options (Shi et al., 2013). Studies suggest that a strong sense of self-reliance and the lack of anonymity can deter help-seeking behaviors for rural residents (Fitzpatrick, Perkins, Luland, Brown, & Corvan, 2017). Unless persuaded to seek treatment by someone they trust (Pillay, Gibson, Lu, & Fulton, 2018), rural individuals are less likely to utilize specialized mental health providers compared to general medical providers (Fischer et al., 2016). For outreach efforts to be successful, rural communities must be convinced that treatment is warranted and possibly beneficial (Fifield & Oliver, 2016).

Due to these differences (e.g., access, perception of need, stigma), many rural residents develop a greater reliance on informal networks of family, friends, churches, and other familiar forms of support compared to residents in urban areas (Caxaj, 2016). Many individuals often initially seek help from those in their social networks prior to, or in place of, seeking professional counseling services (Lampropoulos & Spengler, 2005). Religious congregations are often an influential and accessible form of support in rural communities. Therefore, being able to employ congregations of faith as sources of community support can provide great benefit to members of those communities.

Nationally, nearly 36% of Americans reported attending a religious service on a weekly basis and 77% reported religion/spirituality to be very or somewhat important in their lives (Pew Research, 2017). Furthermore, rural populations report attending religious services more frequently than suburban or urban individuals, with 41.8% of rural residents reporting attending religious services at least 2-3 times each month (Smith, Marsden, Hout, & Kim; General Social Survey [GSS], 2012-2016). Religious involvement has been related to lower rates of mental health concerns (Chen & VanderWeele, 2018) and religious coping (e.g., prayer, hope, and faith) has been associated with better outcomes for mental health treatment (Agorastos, Demiralay, & Huber, 2014). Researchers also assert that the social support provided by religious congregations can be healthy, protective, and healing (Whitehead, 2018).

One method of accessing this social support is the use of non-clergy "helpers" (Terry et al., 2015). The titles given to these individuals vary greatly between religious denominations and settings. Lay counselors, paraprofessionals, natural helpers, care team members, and peer counselors are terms that have all been used to describe those individuals who provide caring relationships and basic interventions for individuals, families, and groups attempting to deal more effectively with the stresses of life (Collins, 2007). Religious leaders are often sought for guidance on both spiritual and non-spiritual matters (Kitchen Andren & McKibbin, 2018). However, faith leaders are often overwhelmed by the responsibilities of administration, evangelism, and educational programming for congregations (Abernethy, Grannum, Gordon, Williamson, & Currier, 2016). Therefore, lay counselors are uniquely positioned to fill this growing need in many communities.

For the purposes of this article, lay counselors is the preferred term to refer to individuals who have no or very limited formal training, education, or credentials in the helping professions.

Help-seekers may not seek out or have access to professional services, but instead interact with lay counselors, who may be perceived as more trustworthy or who are already familiar to the individual through a religious organization (Tan & Scalise, 2016). They may also report seeking less-intensive services due to not believing their condition to be of the severity warranting professional services (Garzon, Tan, Worthington, & Worthington, 2009).

Lay counselors are frequently described as naturally being compassionate, helpful, friendly, and caring. They are also likely to have an inherent empathy, skilled listening ability, and non-judgmental approach (Rek & Dinger, 2016; Tan & Scalise, 2016). Research completed to assess the utility of lay counselors in the provision of support services has revealed mixed results, with evidence both for, and against, lay counseling outcomes being analogous to outcomes for professionally trained clinicians (Dan Boer, Wiersma, Russo, & Van den Bosch, 2005; Freshour et al., 2016).

The use of lay counselors has become a small, but growing practice due to its relevance in areas where access to professional mental health services is inadequate. Two exciting examples include the Feather Carriers of the First Nations (Danard, 2016; Feather Carriers) and Dr. Dixon Chibanda's Friendship Benches of Zimbabwe (Chibanda et al., 2016). Both approaches utilize local sources of support from empathic, invested individuals with minimal, but specific training to serve those in need. The First Nation Feather Carriers is a "life promotion program for First Nations, Métis, and Inuit individuals and families who are at risk for premature death, as well as supporting loss survivors" (Feather Carriers). This program, initiated by Dr. Ed Conners, John Rice, and Dr. Debby Wilson Danard, utilizes "community mobilization to focus on promoting life at the community level through training frontline workers, individuals with lived experience as peer mentors, manager, directors, and support staff" (Feather Carriers).

Similarly, the Friendship Benches of Zimbabwe is a program developed by one of the country's only psychiatrists, Dr. Dixon Chibanda, to combat the extreme lack of social support services in the smaller communities. He utilizes trained local compassionate "grandmothers" to sit on benches in the town center to provide an empathetic ear to those struggling with mental health issues.

Lay Counselor Training

One concern of training lay counselors is to strike a balance of giving individuals an appropriate amount of skills to provide meaningful interactions with others, without requiring the individuals to pursue lengthy training (e.g., a graduate degree) in a mental health profession. Tan and Scalise (2016, p. 116) described effective lay counseling training programs to be "of much shorter duration, significantly less clinical, and are more focused on a simpler set of helping skills, crisis management, and referral services than professional training programs." Therefore, for the purposes of this review and study, training methods for lay counselors are limited to active listening approaches to accomplish the goal put forth by Tan and Scalise (2016).

The process of learning the art and science of counseling has long incorporated the practice of learning to listen and attend effectively (Hill, 2014; Ivey et al., 2018). Many times, these approaches have focused on the application of "microskills," which are defined as "specific communication skills that provide ways for [one] to reach many types of clients" (Ivey et al., 2018, p. 11). From the Ivey et al. (2018) model of microskill training, the portion of skills termed the "basic listening sequence" includes attending and empathy skills, questioning, observation, encouraging, paraphrasing, summarizing, and reflecting feelings. Hill (2014) described the action of orienting oneself toward the client in an effort to listen intently, observe carefully, and then react to what happens during the interaction with the client. Hill (2014) believes that these skills

are so important that she has developed a Helping Skills System (HSS) to evaluate the verbal responses of counselors into categories.

Some of the initial Christian lay counseling trainings were developed in the 1970s. One of the more wide-ranging choices, entitled Stephen Ministries (Haugk, 2000a), emphasizes empathy, positive regard, and basic listening skills. This formal program requires a substantial membership fee for the church, 50 hours of training, participation in continued weekly individual supervision, and monthly peer supervision groups. Lukens (1983), Crabb, and Allender (1984) and Sweeten (1987) have also developed programs designed to train individuals and whole congregations in building better relationships. However, these workshops continue to be extensive, time-consuming, and expensive—not to mention designed for large, urban congregations. If smaller, rural churches (i.e., <150 members) were interested in expanding members' ability to engage in informal support roles more effectively, these existing models would impose several barriers. Many rural Christian congregations would not be able to financially afford to sponsor the training for so few members. Most rural Christian congregations are isolated or lack relationships with mental health professionals qualified to provide trainings fashioned after similar models. Most rural Christian congregations are more likely to employ an informal, spontaneous model of lay counseling ministry, which is much less supported by the previously proposed lay counseling training models. Finally, many rural congregations may find the overly academic and lengthy training process of learning lay counseling skills unappealing.

Tan and Scalise (2016, p. 173) called for further research in the area of lay counselor training programs, especially concerning how well lay counselors can be trained in basic skills. Based on this review of the literature, it is evident that there is very little information on the use or success of lay counseling training models in smaller, rural Christian congregations. Therefore,

this project attempts to determine if a brief (≤10 hours) Christian lay counseling training designed for smaller, rural congregations would produce effective change in the usage of microskills. Hypothesis one suggested that helpful active listening skills would improve. Specifically, approval and reassurance statements, open-ended questions, restatements, and reflections of feeling would all be skills that increased following the training received. Hypothesis two predicted that less-helpful skills such as closed-ended questions, direct guidance, and self-disclosures would decrease as a result of training. Finally, hypothesis three anticipated that the proportion of a lay counselor's words to the total words spoken would decrease as participants were listening more and talking less.

Method

Participants

Participants were recruited from rural, local congregations based on the following criteria: They did not identify as a religious leader or clergy member in a local congregation, they had no previous formal training in any helping profession (e.g., social work, counseling, psychology) or seminary (e.g., theology, ministry), and they acted as part of, or were interested in joining, their congregation's congregational care team and took part in the *UpLift: Lessons in Skilled Visiting* workshop.

The author recruited 19 attendees for two workshops and 12 participants agreed to engage in the study and completed both the pre- and post-assessments. Participants represented three Christian denominations: Church of Christ (41.67%), Maronite Catholic (16.67%), and United Methodist Church (41.67%). The participants were all in middle to late adulthood (M = 58.67; SD = 7.29). Participants were primarily homogenous with regards to self-identified identity: White (83.34%) and non-White (16.67%).

Measures

Helping Skills System. Lay counselors' microskill usage was coded using the Helping Skills System (HSS; Hill, 2014), a revision of the Hill Counselor Verbal Response Category System (Hill, 1986). The HSS consists of 12 categories for evaluating therapist verbal responses. Lay counselors' responses are divided into grammatical sentences that are assigned to mutually exclusive helping skill categories of verbal behavior by trained judges. The helping skill categories are designated as follows: (1) approval and reassurance, (2) closed question, (3) open question, (4) restatement, (5) reflections of feelings, (6) challenge, (7) interpretation, (8) disclosure, (9) immediacy, (10) information, (11) direct guidance, and finally (12) other, which would include any sentence that does not fall into a previous category. Concurrent validity for the HSS was established through significant positive correlations between similar categories in other response mode systems (Elliott et al., 1987). For the HSS, Hess, Knox, and Hill (2006) reported an average kappa between pairs of judges of .91.

Helper words. Researchers calculated the proportion of lay counselor words by dividing the number of lay counselor words by the total words spoken by both lay counselor and mock client in each assessment. This measure has been used by Hill et al. (2008) to evaluate higher levels of active listening skills.

Procedure

Registered attendees of the UpLift: Lessons in Skilled Visiting workshop were invited by phone to participate in the skills evaluation research project by researchers. Informed consent was obtained from participants who were asked to engage in two short (15 minutes) standardized interactions with a mock client, at pre-workshop and post-workshop assessments. The participant interactions were recorded using audio/visual equipment to complete the HSS analysis.

Two female volunteers acted as mock clients. This process was utilized because it contributes to a more authentic learning experience (Esposito, 2009) compared to engaging in a similar activity with another research participant. The directions given to the actors included following one of two prepared scenarios or client backstories and maintaining consistency across mock session interactions. Half of the participants were presented with scenario number one at the pre-assessment and scenario number two at the post-assessment and the other half received the scenarios in reverse order. Scenario #1 for the mock client is to act as a "lonely, bereaved, and anxious middle-aged female and conducted at the client's home." Scenario #2 is for the mock client to act as a "depressed, fearful, late middle-aged female with health concerns and conducted at the client's home."

Intervention. Two separate 10-hour workshops designed to increase microskills in lay counselors were administered over 2 days to obtain the indicated sample. Participants attended the workshop in a local church building or on the campus of a local university. The UpLift: Lessons in Skilled Visiting workshop is designed to help members from Christian congregations develop active listening skills and foster a sense of community, in which members and leadership can support those in mild distress within the congregation and the local community. The goal of the topics discussed in the training was to foster the helper's effectiveness in helping parishioners to meet challenges they are facing in their lives by providing clinically proven active listening skills. The program is prepared to instruct empathic individuals with a strong desire to help others to do so more effectively. The workshop covered various topics, including a biopsychosocial-spiritual model of distress, models of effective lay counseling, traits of skilled helpers, ethical considerations for trainees, and modules detailing the exploring and facilitating skills (Hill, 2014) and the basic listening sequence (Ivey et al., 2018). The workshop

incorporated lecture, experiential exercises, demonstrations (live and recorded), role plays, feedback for others, and self-reflection activities. This material utilized faith-based examples and scenarios that Christian lay counselors are likely to encounter.

Analysis

The analysis and expected findings are drawn from research supporting a developmental perspective on training in microskills (Ivey et al., 2018). The first category of skills was hypothesized to increase in frequency and proportion of overall skill usage following the workshop, as these skills were emphasized throughout the training intervention (e.g., approval and reassurance statements, open-ended questions, restatements, and reflections of feeling), while the second category of skills, which are more likely to be utilized by untrained individuals engaging in interpersonal interactions, were anticipated to reduce in frequency (e.g., closed-ended questions, direct guidance, and self-disclosures). This second category of skills is also not as likely to promote further exploration or expression on the part of the client (Hill, 2014), the main objective of basic lay counseling interventions (Tan & Scalise, 2016).

Lay counselors' videotaped interactions were transcribed to determine the grammatical structure of the lay counselor's verbal responses. According to Hill's (2014) HSS, the judges determined the placement of each grammatical sentence into one of the 12 categories. Three judges (doctoral counseling psychology students) and a fourth auditor (Ph.D. level counseling psychologist) were trained in determining grammatical sentences of participants during the mock counseling session according to Hill's HSS (see Hill, 2014).

Cohen's kappas were calculated to determine the amount of agreement between pairs of judges. Practice transcripts were used in increasing complexity to the development of coding skills and judges were able to reach an average kappa between .60-.85, the acceptable ranges

presented by Hill (2014). The .61-.80 range signifies substantial agreement according to Landis and Koch (1977). In the present study, using a 12 x 12 categorization system decreases the thresholds for kappas to demonstrate considerable agreement existed between judges. A composite kappa was calculated for the project as a whole, M = .64, *SD* = .09.

Helping skills categories of each participant from the pre-assessment and post-assessment evaluations were calculated as proportions to the total skill usage to determine whether microskill usage changed following the workshop. Researchers utilized paired-samples *T*-tests to evaluate in the degree to which the mean for pre-assessment and post-assessment proportions was significantly different. Lay counselors' proportions of words to total words spoken were then calculated from the pre- and post-assessment evaluations to assess for changes in active listening.

Results

The analysis consisted of 24 unique transcripts and 2,558 separate participant grammatical sentence units, not including actor units. Participants' units for each transcript were relatively consistent (*M* = 106.58 units, *SD* = 29.15). There do not appear to be any differences between the number of pre-assessment units (*M* = 102.17, *SD* = 30.64) and post-assessment units (*M* = 111.00 units, *SD* = 28.20); *t* (11) = -.795, *p* = .443; *d* = .30. There did appear to be wide variations among participants as to the total number of words spoken during the transcripts (*M* = 1786.83, *SD* = 499.72), ranging from 771 words to 3,161 words. There was also some variation between the total number of words spoken during the pre-assessment (*M* = 1672.17, *SD* = 409.09) when compared with the total number of words spoken during the post-assessments (*M* = 1901.50, *SD* = 571.04); *t* (11) = -1.384, *p* = .194; *d* = .46.

The author first evaluated the impact of the workshop on four verbal response skills that have been shown to be beneficial in therapeutic interactions: approval and reassurance statements, open-ended questions, restatements, and reflections of feeling. The study's first hypothesis was that these four specific skills would increase following the training, as the workshop focused on these skills. There did not appear to be any differences between pre-assessment use of approval and reassurance statements (M = .226, SD = .082) and post-assessment use (M = .228, SD = .087); t (11) = -.099, p = .923; d = .02. The use of approval and reassurance statements was a skill that seven of the 12 participants improved upon from pre-test to post-test, but the differences do not appear to be clinically or statistically significant. The use of open-ended questions *decreased* between pre-assessment use (M = .072, SD = .044) and post-assessment use (M = .043, SD = .026); t (11) = 2.485, p = .030; d = .63; only one participant showed increased usage between pre-test and post-test. There appeared to be a similar finding with the use of restatements between pre-assessment (M = .038, SD = .023) and post-assessment (M = .028, SD = .015); t (11) = 1.887, p = .086; d = .54; this was a skill for which three participants showed improvements from pre-test to post-test. Lastly, there was a small, non-significant, increase from pre-assessment use of reflections of feelings (M = .007, SD = .012) to post-assessment use (M = .011, SD = .010); t (11) = -.894, p = .391; d = .35; eight participants showed improvements from pre-test to post-test on this skill. Therefore, there does not appear to be substantial support for hypothesis one.

A second area that the author evaluated was the impact of the workshop upon three verbal response types that have been shown to be less helpful during therapeutic interactions: closed-ended questions, direct guidance, and self-disclosures. The study's second hypothesis was that these verbal response styles would decrease in participants at post-assessment. There was a

slight decrease from pre-assessment use of closed-ended questions (M = .120, SD = .044) to post-assessment use (M = .093, SD = .048); t (11) = 1.688, p = .120; d = .58; this decrease existed for eight participants from pre-test to post-test. The use of direct guidance also decreased between pre-assessment use (M = .069, SD = .058) and post-assessment use (M = .041, SD = .028); t (11) = 1.664, p = .124; d = .62; this was true for seven participants from pre-test to post-test. Lastly, there appeared to be a slight *increase* with the use of self-disclosures between pre-assessment (M = .072, SD = .050) and post-assessment (M = .083, SD = .086); t (11) = -.390, p = .704; d = .15. However, one participant's proportion appears to have skewed this data (Participant #12, Pre-test = .070; Post-test = .319). This participant engaged in an appropriate but lengthy personal example about the utilization of congregational members in acquiring social support. When this participant's data is excluded from the analysis on this variable, the results show a decrease between pre-assessment use (M = .072, SD = .052) and post-assessment (M = .061, SD = .046); t (10) = .652, p = .529; d = .23. These findings are consistent with supporting hypothesis two.

A final area that the author evaluated was the impact of the workshop upon the total number of words spoken by the participants. The training workshop was intended to expand active listening skills and therefore reduce the amount of time that the lay counselors spoke during an interaction. These data suggest that participants spoke a greater proportion of the time during post-assessments (M = .716, SD = .094) than during pre-assessments (M = .659, SD = .113); t (11) = -2.094, p = .060; d = .55. There does not appear to be support for hypothesis three.

Discussion

The author hypothesized that the brief intervention for lay counselors in rural Christian congregations would increase the proportion of participants' positive counseling microskills,

decrease less-helpful counseling microskills, and reduce the amount of time spoken by participants. Results of the study indicate a greater level of success with reducing the less-helpful counseling microskills (e.g., direct guidance, self-disclosure) than either increasing positive counseling microskills (e.g., open questions, reflections of feeling) or reducing the amount of time speaking in this sample of Christian lay counselors following the described microskill workshop.

While there was some support for the increase of approval and reassurance statements and reflections of feelings, and the decrease of closed-ended questions and direct guidance, nothing reached the required level of statistical significance. However, when one considers differences between pre- and post-assessments for individual participants, there is evidence for increases in approvals and reassurances for seven participants, increases in reflections of feelings for eight participants, decreases in closed-ended questions for eight participants, decreases in direct guidance for seven participants, and in self-disclosures for five participants (see Tables 1-8 in Supplemental Material).

These differences may indicate that a short training workshop may be effective for learning basic listening and responding skills for some individuals, whereas others may need more training than the 10-hour Uplift workshop provided. The study's results, for example, show that five individuals (e.g., participants #2, #4, #6, #7, and #9) demonstrated consistent growth across multiple categories. These findings suggest that more research is needed to determine what variables influence the effectiveness of short teaching interventions for various lay helpers.

Reflections of feelings was one of the skills taught in the UpLift: Lessons in Skilled Visiting workshop. One of the more unique ways in which participants demonstrated reflections of feeling in the post-assessment was by ending their visitation session in prayer, lifting up

emotional concerns for the actor (e.g., "Heavenly Father, we thank you for today and for your blessings and we are thankful for Jane [actor assigned name for scenario #1]. *She has some concerns and some grief and she's worried*. Be with her, Father, bless her." Participant #5, Post-test). While prayer was not a specific skill discussed in the workshop, it is a natural extension of the skill sets utilized by Christian lay counselors. Prayer has been supported as a powerful tool used in religious/spiritually integrative counseling (Post & Wade, 2009; Young & Young, 2014). In our study, prayer for another appeared as a less direct form of reflecting feelings that allowed the visitor to support and encourage the one being visited. Additionally, this act of reflecting feelings to a third party (e.g., God, a higher power) is a unique function of reflection that is uncommon in individual therapy settings, even more so in lay counseling research.

The response pattern of using self-disclosure in lay counseling invites an interesting question about personal "testimony" or "witnessing" as an evangelistic effort for Christian lay counseling specifically. Indeed, the scenarios in the current study described a recent visitor to the participant's local congregation. The scenario was designed to explain the lack of on-going personal relationship between actor and participant. However, many participants took this as an opportunity to encourage the actor to join their congregation or provide evidence for the benefits of identifying with a local body of worship.

Anecdotally, the actors and volunteer research assistant reported an increase in this behavior at the post-test sessions with most participants. One individual reported that participants appeared to be engaging in "sales pitches" designed to encourage the actor to attend their congregation again soon. For example, Participant #2 arrived at the post-test session under the impression that this would be a second visitation with the same individual as the pre-test. Therefore, she arrived with a pamphlet containing a 2-month schedule of inspirational Biblical

passages, prepared scriptures for their discussion, and a church bulletin from the previous Sunday worship. This participant continued to utilize these materials despite learning that the second interaction was a separate scenario and "individual."

Many other participants followed this pattern of providing a higher proportion of information in their post-test session. Category 10 from the HSS is entitled "Information" and can include information about the process of helping, facts, data, or opinions, or feedback about the client. In fact, we observed a change in Information from pre-test assessment proportions (M = .310; SD = .144) to post-test assessment (M = .385; SD = .130) with a moderate effect size (d = .55). Another example of this finding would be Participant #11's post-assessment transcript. This participant provided substantially more Information during the post-test assessment (Participant #11, Pre-test = .385, 37 actual units; Post-test = .682, 116 actual units). Much of this Information was directly related to the participant's local congregation and what the actor could expect from future worship services or congregational social gatherings.

Whereas participants in this study may or may not identify with the use of phrases like providing "religious testimony" or "personal witnessing" regarding their observed behavior, the author believes these terms help to give greater context to these evangelistic behaviors. Personal evangelism is a highly valued trait in many religious congregations (American Baptist Churches, 2018; Matthew 28:19-20, NASB; United Methodist Church, 2016), and the giving of personal testimony/witnessing has been studied in only a small number of studies (Kline, 2011). The participants in this study all reported highly valuing their faith and involvement in local congregations. Therefore, it also makes sense that they would affirm these factors as being important to holistic well-being and feel compelled to share this with the actors. The religious outreach of this finding was an unexpected, confounding variable that may have interfered with

participants' use of the helping skills by pre-empting the skills they learned in the workshop. The participants appear to have already acquired a strong model for the types of goals and activities that visitation covered; giving information and using evangelistic interventions seemed prominent in their model.

The current study found that only three participants spoke a lower proportion of words at post-test assessment. Additionally, seven participants had a proportion of greater than .700 of words spoken. This finding is likely linked to the previous discussion of providing more Information to someone who appears interested in a congregation. Another explanation could be linked to an increased comfort level with the process of being videotaped during a simulated social interaction at post-test assessment. Several of the participants reported feeling uncomfortable with being on camera and with "pretending to visit" with someone they had never met. One participant reported that she usually engaged in phone visitation and rarely visited in-person. She seemed especially reserved and uncertain during the initial assessment, but much more relaxed during the follow-up assessment. A third explanation could be the timing of pre-test assessments (Friday evenings 5:00-7:00 p.m. during initial workshop hours) and post-test assessments (Saturday morning 9:00 a.m.-12:00 p.m. the following week). Participants could have been experiencing a greater level of cognitive energy on a Saturday morning when compared to a Friday evening, resulting in more energetic responses during the post-test assessment.

Limitations and Directions for Future Research

As with all research, there are limitations associated with both the study's design and execution. This study's research design was confirmatory in nature and its support is drawn from research identifying a developmental perspective on training in microskills for beginning

counselors (Hill, 2014; Ivey et al., 2018). The purpose of this study was to evaluate a system often used with counselors in training to evaluate lay counselors from rural, Christian congregations on microskill usage following a brief training workshop.

Due to the resources available and the method chosen to evaluate these microskills, the sample size was kept intentionally small and designed to meet the needs of the current project. As with all small, geographically limited studies, the findings are not intended to be generalizable, but to provide a greater depth of knowledge to a relatively unstudied topic. This principle is especially true when considering the diversity of rural America (Hamilton et al., 2008) and Christian congregations (Yancey & Kim, 2008). While diversity of Christian congregations, race/ethnicity, gender, and age were pursued, the sample for this project was mostly homogeneous. This homogeneity, however, remains representative of the geographical area.

Another limitation of the current study was that data were gathered from two samples and during two workshops. The need for a second workshop arose from being unable to secure enough participants from the initial workshop alone. Therefore, the workshop presenter made every effort to conform the workshops to the prescribed material; however, examples of material and participant discussion varied during each of the workshops.

A similar limitation was the use of two different actors between workshop one and workshop two. Both actors were given similar training and the identical scenario information. However, each actor's personality and background knowledge may have had unmeasured effects on the individual's interactions with each of the participants and therefore on the study.

A final limitation observed in this study was the use of two separate scenarios in which the participants engaged with actors as the "initial meeting" with this pretend visitor to their

church. It is likely that sessions and microskill usage would have looked quite different when interacting with (a) someone they know on an acquaintance level, (b) a friendship level, and (c) on an unknown individual level. As relationships deepen, the need for information seeking (e.g., closed-ended questions) and providing information likely declines across sessions.

To better understand the relationship between counselor training and lay counselor training, researchers should also evaluate approximate preferred proportions of certain microskills for various session types and for various counselor and/or lay counselor skill levels. For example, perhaps it is logical or more acceptable for lay counselors to engage in self-disclosure to establish rapport and to demonstrate similarity (e.g., disclosure of sobriety/struggles with addiction in AA/NA groups). In rural, Christian congregations, it may be more acceptable for lay counselors to express concerns toward religious teachings or wavering of faith compared to priests, clergy, ministers, or other religious leaders. Therefore, more literature is needed to evaluate the usage of microskills regarding skill level and role of individuals providing support.

Future research should investigate the impact of short, medium, and long lengths of training upon skill level in lay counselors. Whereas short-length trainings are frequently most cost effective and able to produce helpers quickly, medium and longer-term trainings (i.e., Stephen Ministry) may produce more effective and skillful lay counselors. Therefore, it would likely benefit the lay counseling community to better understand the ideal balance between training length and skill level for effective helping.

Additionally, future research should attempt to establish how the lay counselor model of support can continue to be effectively implemented in any number of isolated, underserved settings with succinct, effective, and cost-effective training. The additional examples of the First Nation Feather Carriers (Danard, 2016; Feather Carriers) and Zimbabwe's Friendship Benches

(Chibanda et al., 2016) serve as valuable models from which others can learn as they are evaluated to substantiate their validity and effectiveness.

An additional area of future research would be the use of prayer in Christian lay counseling. Research on this topic could assist in understanding the purpose and effectiveness of this intervention, the motivations of individuals, and the impact of this technique on help-seekers. Because our participants appeared to incorporate the reflections of feelings, studies may investigate the structure, components, and feelings reflected within prayers to better evaluate how prayer is used and whether it is an effective technique in supporting others.

Finally, if similar trainings are to be initiated, the effectiveness of such models and the trainings needed to initiate them should continue to be evaluated according to standard research principles. This study chose to answer the call put forth by Tan and Scalise (2016) regarding the lack of rigorous research toward the field of Christian lay counseling. This study stands as an example in the literature gaps between training graduate-level counselors, training lay counselors, and psychological work with religious congregations. This study also attempts to merge these research gaps with the needs of rural, underserved communities. There continues to be a need for research that evaluates the effects of religion, spirituality, rurality, and lay counseling-type relationships upon communities and individuals.

Conclusions

The existing literature demonstrates that spirituality and religion are important to a large segment of the general population, and particularly so in rural areas. The literature also supports the positive impact that spirituality and religion can have upon mental health, especially concerning the social involvement that many organized religions can provide. The use of lay counselors has also been shown to be an effective means of providing support in situations or

settings where professional assistance is unattainable, underutilized, or culturally ineffective. Therefore, this study demonstrated the need for, and the effectiveness of, a collaboration between mental health professionals and rural, Christian congregations to increase the effectiveness of lay counselors involved in visitation programs through a brief workshop.

In conclusion, the author would like to offer recommendations for application of this research. Initially, there is a cultural necessity to consider the role of lay counselors in many parts of this country and the world. The purpose behind training lay counselors should be to effectively train individuals belonging to a range of cultures and groups, invested in a geographic area, institution (e.g., congregations), or people (e.g., First Nation youth), and by doing so, provide a greater range of individuals with needed support and with a more readily acceptable form of assistance. Mental health professionals should view training community stakeholders in these skills as a professional and community-building responsibility. The author encourages the mental health community to continue to be a proactive force in supporting and evaluating lay counselor efforts as a means of addressing the provider discrepancy, especially in rural areas.

Finally, the author would like to echo continued calls for psychology to collaborate more successfully with religion (Kitchen, Andren, & McKibbin, 2018; Smith, Riding-Malon, Aspelmeier, & Leake, 2018; Tan & Scalise, 2016). This outcome requires participation by both willing partners, but professional mental health clinicians and researchers should continually pursue inclusion and collaboration with clergy and other local religious leaders in efforts to promote healthier communities. This need is especially evident in rural areas where religion and spirituality are frequently important aspects of community life. The author's experiences of collaborating with Christian congregations demonstrate the possibility to "build bridges," through building relationships with gatekeepers (e.g., pastors, elders, minister, clergy). The

existing body of research suggests that as mental health care providers, religious leaders, and religious congregations continue to work together, the yield can be fruitful.

Chapter II

Literature Review

In this chapter the author reviews the literature relevant to the topic of lay counseling in the context of rural culture and religion and spirituality, which lays the framework for the current study. Initially this review will provide a background on rural cultural values and identity. Second, a summary will describe the effects of rural culture on the mental health of those living in rural areas. An exploration of the relationships between religion/spirituality and rural culture will also be provided. The influence of informal support systems will complete foundational information for the topic of lay counseling. Finally, the author will offer a review of lay counseling as a service model and its utilization within religious organizations.

Rural Cultural Values

The origin of the word *rural* is Latin and Indo-European from words meaning "the country" and "space or wide" (Goreham, 2008). Rural is often understood in the context of a rural-urban dichotomy. In definitions, rural areas have been equated with a lack of population density and greater distances to area resources (Hamilton, Hamilton, Duncan, & Colocousis, 2008). However, this narrow definition inadequately categorizes rural individuals or communities, and there continues to be a lack of consensus concerning a definitive definition that satisfies the many uses of the word (Goreham, 2008). The following material attempts to provide some foundational information in understanding rural culture.

While the rural-urban dichotomy continues to exist, the more supported notion is that individuals and communities likely fall along a continuum of rurality and *acculturation* to mainstream culture (Slama, 2004). However, while these differences have been observed, there appear to be fewer differences in values. Wagenfeld (2003) admitted that this shift in cultural

values is likely due to the pervasiveness of popular media and the homogenization of the nation as a result. This is especially true when considering elements such as values, traditions, and customs (Rost, Fortney, Fischer, & Smith, 2002). Therefore, individuals can live in sparsely populated areas of the country, but hold to very mainstream ideals—making them rural in one sense and less so in another. However, Bischoff and colleagues (2014) supported the concept that rural persons often hold to differing values than urban individuals. Specifically, many rural individuals espouse the values of self-reliance, conservatism, a distrust of outsiders, religious beliefs, work orientation, the importance of family, individualism, and fatalism (Ginsberg, 1998; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Others have described the cultural climate of rural areas as relaxed, family-focused, deeply religious, and self-reliant communities that have a higher reliance upon an agricultural economy compared to urbanized areas (Arcury et al., 2005; Farmer et al., 2012; Kellogg, 2002).

One pervasive element of rural culture is the likelihood of having fewer people in the local community. Individuals are more likely to know each other and have few choices in terms of with whom they associate (Harowski, Turner, LeVine, Schank, & Leichter, 2006; Slama, 2004). In many cases, rural areas have fewer options for social interaction. Therefore, the structural social network of rural individuals can look significantly different from the social network of individuals residing in urban areas. Most rural communities focus socially upon family, school, sports, churches, work, and bars (Sullivan, Jackson, & Spritzer, 1996). Some communities may support senior citizen centers or small social clubs, but few have health clubs or youth organizations (i.e., YMCA) (Slama, 2004).

Rural Mental Health

Residents in rural communities continue to receive fewer mental health services of any kind compared to individuals from urban areas, and rural populations consistently rate their subjective mental health as poorer than urban populations (Hauenstein, et al., 2007). The values of individuals can greatly influence how they define a problem and at what severity they will even begin to consider seeking help – whether formal or informal. For instance, a value of self-reliance will lead to attitudes that, "I should be able to manage this without outside help" (Wagenfeld et al., 1994).

Research on rural populations supports the idea that perceived need is important in help-seeking behaviors for mental health treatment. Perceived need is the personal belief that treatment is warranted (Maddux, Brawley, & Boykin, 1995). Because perceived need is a subjective judgment, it does not necessarily correspond with the clinical judgment or evaluation of a health professional (Rost, Smith, & Taylor, 1993). Rural populations have been found to have a lower perceived need for mental health services and are thus less likely to utilize specialized mental health providers compared to general medical providers (Fox, Merwin, & Blank, 1995; Griffiths, Christenson, & Jorm, 2009). People are not likely to seek treatment until they perceive a need, unless they come to be convinced to seek treatment by someone they trust (Gamm, Stone, & Pittman, 2003). For outreach activities targeted to rural populations to be successful, rural communities must first be convinced that treatment is warranted and can be beneficial (Fox et al., 1995; Mojtabai, Olfson, & Mechnic, 2002). Furthermore, research has shown that help-seeking behaviors of rural populations are affected significantly by poverty, access to health care, and ethnicity (Fox, Berman, Blank, & Rovnyak, 1999).

Poverty. One of the most prevalent barriers in rural areas to formal mental health support is poverty (Human & Wasem, 1991; Mohatt, Bradley, Adams, & Morris, 2006). Poverty is often described as the lack of means and resources (Yoshikawa, Aber, & Beardslee, 2012), and some have suggested that it is a means of "social exclusion" (Walker, Tomlinson, & Williams, 2010). The construct of poverty exists beyond a lack of financial stability; it frequently implies limited access to adequate food, shelter, and clothing, resulting in struggles that alone predict much higher levels of stress (Daschiff, DiMicco, Myers, & Sheppard, 2009).

Access to Health Care. A second major barrier to help-seeking in rural areas is the limitation of access to health care. Rural individuals are more likely to be uninsured or have less comprehensive coverage compared to urban populations (Barker et al., 2013). As a result, rural populations receive less preventative care (Brown-Guion et al., 2013; Shi et al., 2013), which may worsen symptomology before a disease is identified (Carney et al., 2012). Individuals in rural areas are more likely to travel 20+ miles to see a general provider and even greater distances to see specialty health-care providers (Buzza et al., 2011).

Ethnicity. Ethnicity has also been shown to be a predictor of help-seeking behavior. Non-White individuals report fewer health care visits (Centers for Disease Control and Prevention, 2004). Indeed, Hispanic families in rural areas were more likely to report needing medical treatment, but not receiving it (Haas et al., 2004). Rural counties not possessing a hospital are more likely to have a higher percentage of African-American residents than counties with a freestanding medical facility (Arcury, et al., 2005). Specific to mental health care, African-Americans are more likely to report hostility and distrust due to the perception that the mental health care system is a representation of the "dominant Caucasian institution" (Fox et al., 1995, p. 442).

Perceived Need. Fox et al. (1999) conducted a study that documented that in rural areas, help-seeking behaviors were affected significantly by poverty, access to health care, and ethnicity. The researchers screened individuals across nine rural counties in Virginia and found that 32.4% of participants screened positive for at least one mental health disorder. The participants were informed of their screening status and given resources to seek mental health assistance; however, at 1-month follow-up only 5.8% of participants had sought professional help since their screening.

The authors of this study suggest that the single greatest barrier to seeking mental health treatment is the lack of perceived need for mental health treatment. The study also showed that 83.2% of participants who screened positive for a mental health disorder reported telling a "friend or family member" about screening positive. Amongst the 83.2% who spoke to a friend or family member, only 13.1% of these informal helpers encouraged the participant to seek professional help. The study concluded that poorer individuals and those in rural communities rely extensively upon friends, family, and other informal supports for health care decision making, thus further complicating rural individuals' help-seeking behaviors by adding third-parties' perceptions of need (Blank, Mahmood, Fox, & Guterbock, 2002). Indeed, previous research has reiterated that rural individuals tend to rely heavily upon family, friends, churches, or other informal forms of help-seeking (Jameson & Blank, 2007; Fox et al., 1995; Schoenberg et al., 2009).

Perception of need for treatment is not the only way in which perception is influencing rural help-seeking behaviors. Several studies have shown that individuals' perceptions of their access to adequate mental health care was more important than the number of providers or clinics in a community. These results suggest that ease of access (Hoyt, Conger, Valde, & Weihs,

1997), convenience (Fortney, Rost, & Warren, 1998), and acceptability (Farmer et al., 2012; Rost, Fortney, Fischer, & Smith, 2002) all play a role in rural help-seeking behaviors.

Stigma. Particularly in rural areas, mental health stigma continues to be a powerful influence on help-seeking behavior (Bischoff et al., 2014; New Freedom Commission, 2003). The stigma derives from principles that are in opposition to some of the strongly held values of rural culture: self-reliance, individualism, privacy, and, at times, religious beliefs (Bachrach, 1983; Gamm et al., 2003; Georges et al., 2013). Coupled with stigma, the lack of anonymity when pursuing treatment in rural areas often serves as a barrier to securing professional treatment (Wrigley, Jackson, Judd, & Komiti, 2005). When these factors are taken in combination with stressful occupations, lack of knowledge of mental health symptoms or treatments (Advancing Suicide Prevention, 2005), and limited availability of adequate mental health services (Eberhardt, Ingram, & Makuc, 2001), one can see the reasons individuals in rural areas may utilize mental health services at lower rates than those in urban areas (Arcury, Preisser, Gesler, & Power, 2005). Indeed, living in urban areas translates into being 47% more likely to seek services than rural residents (Hauenstein et al., 2007).

The perceived cultural competence of the mental health provider is also an influential factor for rural residents in seeking help from a particular service provider. Research has strongly supported the fact that rural residents would prefer to see providers who themselves come from rural areas or who, at the very least, demonstrate an understanding of the cultural nuances associated with rural communities (Beutler, Clarkin, Crago, & Bergan, 1991; Farmer et al. 2012; Fox et al., 1995; Kimpara, Brunet, Beutler, & Alsante, 2016; Schank & Skovholt, 2006).

However, mental health clinicians who practice in rural areas often face sparser clientele bases, isolation from other mental health providers, and the frequent introduction of dual

relationships (Parr, Philo, & Burns, 2004). All these influences can pose problems for clinicians, leading to burnout or increasing the likelihood the clinician will find other settings for employment (Philo, Parr, & Burns, 2003).

Culture: Religion and Spirituality

The cultural competence that rural populations prefer in their health care providers may include an understanding and a respect for religious beliefs. Overall, nearly 36% of Americans reported attending a religious service on a weekly basis and 77% reported religion/spirituality to be very or somewhat important in their lives (Pew Research Center, 2017). Furthermore, data from the General Social Survey indicates that rural populations report attending religious services more frequently than suburban or urban individuals, with 41.8% of rural residents reporting attending religious services at least 2-3 times each month compared to 37.1% of suburban or urban populations. Rural populations also identify as slightly more spiritual (rural, 66.2%; urban, 65.0%) and religious (rural, 59.6%; urban, 54.2%), endorsing either being very spiritual/religious or moderately spiritual/religious (Smith et al.; GSS, 2012-2016).

For many years the study of religion and spirituality (R/S) has largely been neglected by psychologists (Hook et al, 2010). For the purposes of this review, *religion* will be defined as "a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures)" (Koenig, 2008, p. 11). *Spirituality* will be defined as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred" (Hill et al., 2000, p. 66).

Some would argue that the study of R/S should be left to theologians, pastoral counselors, or sociologists. Some report concern that elements of religious beliefs are not easily measurable

(e.g., grace, salvation, faith, hope, charity, afterlife, brotherly love, sacrifice, soul) (Akbar, 1995; Cremins, 2002; Eriksen, Marston, & Korte, 2002; Hook et al., 2010). Schlosser and colleagues (2010) reviewed 1,914 studies from the three major counseling psychology journals (i.e., *Journal of Counseling Psychology*, *The Counseling Psychologist*, and the *Journal of Counseling & Development*) and determined that only 51 projects (.027%) studied R/S. Indeed, the most recent edition of the *Handbook for Counseling Psychology* (Brown & Lent, 2008) makes no mention of "religion" or "spirituality" in the subject index and these words occur only 12 and 3 times, respectively, in the entire text, almost exclusively as a list of demographic variables (i.e., socioeconomic status, gender, race).

However, since the 1940s, some have called for collaboration between the field of psychology and communities of faith (Barbery & Kew, 1949). The Reverend Norman Vincent Peale and Smiley Blanton, MD, collaborated to embody this principle by opening a clinic together. The clinic was located in a large church in New York City. The clinic assisted the underserved and disadvantaged, including refugees following World War II, providing spiritual healing and professional psychiatric treatment. Peale and Blanton each saw the importance provided by both the growing fields of psychiatry/psychology and the healing aspects of R/S.

James Fischer, MD, a psychiatrist who studied under Sigmund Freud, was an influential voice from the early 20th century who expressed support for the powerful influence that R/S could provide to the field of psychology. Upon his retirement from a 50-year mental health career, he was quoted as saying:

> If you were to take the sum total of all authoritative articles ever written by the most qualified of psychologists and psychiatrists on the subject of mental hygiene; and if you were to combine them and refine them and cleave out the excess verbiage; and if you

> were to take the whole of the meat and none of the bones; and if you were to have these unadulterated bits of pure scientific knowledge concisely expressed by the most capable of living poets; you would have an awkward and incomplete summation of the teachings of Christ, particularly the Sermon on the Mount; and it would suffer immeasurably in comparison. (Fischer & Hawley, 1951)

Whereas the notion of blending psychology and R/S has been referenced for over 60 years, the two fields have often seemed at odds. Historically, some believe that the field of psychology has focused little on religion and spirituality because of psychology's exclusive focus on pathology (Seligman & Csikszentmihalyi, 2000). Entwistle (2009) suggested that a holistic perspective of the person should take into account the spiritual component, separate and apart from the psychological one. He encourages adopting a *biopsychosocialspiritual* model for understanding behavior and describing disorder. Entwistle (2009) also urged this consideration when considering treatment (e.g., whether biological therapy, psychotherapy, social intervention, or religiously-based interventions are called for). Furthermore, others have even considered spirituality-based counseling as the "fifth-force" in mental health care (Koenig, 2004).

Lack of R/S Integration in Psychotherapy. Religiously devout individuals are more likely to use mental health services after other services have failed and will often underutilize those services (Griffith & Griffith, 2002). When R/S clients do seek mental health services, they are often underwhelmed by the lack of spiritual topics that most therapists incorporate into their clinical practice (Crosby & Varela, 2014; Knox, Catlin, Casper, & Schlosser, 2005). Religiously committed clients favor therapy that attends to religious themes (Mayers, Leavey, Vallianatou, & Barker, 2007; McCullough & Worthington, 1995; Mitchell & Baker, 2000; Morrow, Worthington, & McCullough, 1993). People of faith are more likely to seek out clinicians who

hold some form of religious beliefs (Gregory, Pomerantz, Pettibone, & Segrist, 2008) or who are of the same religious faith (Post & Wade, 2009). Finally, counselors who utilize religious interventions are perceived more optimistically and as more competent by their religiously committed clients (Guinee & Tracey, 1997; Rose, Westefeld, & Ansley, 2001). Therefore, Richards and Bergin (2000) reported that many religious clients will seek clergy or lay mental health supports to avoid the issues listed above.

Additionally, some religious clients hold traditional or fundamentalist views, including literal translations of scriptures. This population interprets scripture in a literal way as a guide for family and social life that may be quite different from the values and beliefs of mainstream cultures, including most psychologists (Bartkowski & Wilcox, 2000). In one study, Thurston (2000) reported survey results that showed many conservative Christians reported avoiding secular therapists due to fears that their therapist would not understand or appreciate their beliefs or that secular therapy would lead them away from their religious beliefs.

Finally, there is support for a spiritual orientation in therapy as being able to hasten recovery and lessen the severity of distress (King, Speck, & Thomas, 1999). Spiritual orientation in therapy is designed to enhance hope. The spiritual values individuals embrace may determine whether they experience pain or perceive it as suffering, which usually involves a much stronger negative cognitive reaction (Büssing, et al., 2009; Koenig, Larson, & Larson, 2001). Pain is a natural, uncomfortable, and ever-present phenomenon in society; it is not uncommon (Fordyce, 1988). However, suffering is an unnatural deviation from the experience of sadness and pain. Without hope, the result of pain is frequently suffering (Cremins, 2002).

Religious social support. Both theologians (Frazee, 2001) and psychologists (Crabb, 1999) alike have advocated for the enriching benefits that communities of faith can provide

clients dealing with mental health concerns. Congregations provide a fountain of spiritual, familial, and psychological health that simply cannot be replicated in the psychotherapist's office (Dominguez, 2003). There have been many ways in which religious congregations have been called upon and utilized to connect formal and informal systems of care, most often to support the underserved and disenfranchised. For example, religious congregations have been seen to enhance well-being for the benefit of struggling families (Caldwell, Greene, & Billingsley, 1994; Chatters, Taylor, Lincoln, & Schroepfer, 2002; Dollahite & Marks, 2009; Tarakeshwar & Pargament, 2001), community health promotion programs (Campbell et al., 2007; Eng, Hatch, & Callan, 1985; Hatch & Derthick, 1992; Peterson, Atwood, & Yates, 2002), and the support for older adults (Assari, 2013; Rote, Hill, & Ellison, 2013; Taylor, 1986; Yoon & Lee, 2006).

Culturally speaking, this fine-tuned area of religious social support has substantial representation in the African-American community. Numerous studies have shown similar results demonstrating the importance of churches in the social support of African-Americans (Adkison-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Boyd-Franklin, 1989; Dunn & Dawes, 1999; Frame, Williams, & Greene, 1999; Hines & Boyd-Franklin, 1996; Karenga, 1988; Sue & Sue, 1999; Waites, Kaiser, & Martin, 2014). The African-American church is frequently viewed as a source of fellowship and friendship, often resembling psychotherapeutic groups. These settings often encourage their members to "feel, act, and think in ways that are proactive, constructive, and positive" (McRae, Thompson, & Cooper, 1999, p. 207). For instance, evening prayer services often consist of sharing worries and seeking social assistance in the bearing of daily burdens (Eugene, 1995) and are suggested to be beneficial in bringing physical, mental, and emotional relief and spiritual revitalization (Taylor, Chatters, & Brown, 2014; Taylor, Chatters, Lincoln, & Woodward, 2017).

Informal Support Systems

Theorists suggest that the interaction between formal and informal support usage can be described with one of three models (Armi, Guilley, & Lalive d'Epinay, 2008; Davey & Patsios, 1999; Travis, 1995). These models were originally hypothesized to describe help-seeking behaviors of older adults for maintaining independent living, but have since been generalized to encompass other forms of help-seeking.

The *substitution* model theorizes that individuals utilize formal supports in place of informal supports and vice versa, with very little overlap. As an individual pursues access to one form of support (formal or informal), the usage of opposing forms of support decreases. This model is supported by research suggesting that informal supports are often utilized in place of formal mental health services, particularly in certain populations: rural populations (Fox et al., 1995), congregations of faith (Stanley, et al., 2001), older adults in community living (Armi, Guilley, & d'Epinay, 2008), and ethnic minority groups (Sussman, Robins, & Earls, 1987).

A second model, the *complementary* model, hypothesizes that seeking a form of formal support will not necessarily reduce the utilization of informal forms of support. This model suggests that there are areas of overlap between formal and informal supports. Each form of support offers aspects that are unavailable from the alternative form (i.e., informal supports can offer comradery; formal supports can administer evidenced-based psychotherapy) (Deen & Bridges, 2011; Gallo, Marino, & Anthony, 1995; Lampropoulos & Spengler, 2005). This model has probably the most substantial base in the literature. There have been substantial research studies conducted on this model of informal support, particularly in the form of peer support specialists who provide encouragement in collaboration with formal supports (e.g., primary care physicians, psychotherapists) (Chinman, Salzer, & O'Brien-Mazza, 2012; Getrich, Heying,

Willging, & Waitzkin, 2007; O'Brien, Squires, Bixby, & Larson, 2009; Tang, Funnell, Gillard, Nwankwo, & Heisler, 2011; Waitzkin, et al., 2011).

The final model, the *hierarchical compensatory* model, describes the progressive nature of help-seeking behaviors. It is postulated that individuals initially start support-seeking from significant others, then immediate family, followed by extended family and friends, and finally by formal support services in the community (Cantor, 1979; Davey & Patsios 1999; Messeri, Silverstein, & Eugene, 1993; Weller, Berges, Dallo, DiNuzzo, & Lackan, 2006). These three models help to contextualize lay counseling in an understanding of informal support systems.

Lay Counseling Broadly Defined

The word *lay* is derived from the Greek word *laikos*, meaning "of the people"; in other words, *laikos* are common people caring for their peers (Zeph, 2000). Since the mid-1960s, there has been an increasing use of lay approaches to helping services, not limited to a religious context (Boan & Owens, 1985; Garzon & Tilley, 2009; Garzon, Worthington, Tan, & Worthington, 2009; Parent, 2005; Pierce, 1980). Whether these individuals are referred to as paraprofessionals, natural helpers, peer support specialists, or lay counselors, the essence remains the same; these individuals are non-professionals who provide basic helping services (Bartels & Naslund, 2013; Durlak, 1979; Eng, Parker, & Harlan, 1997; Tan, 2011). For the sake of this review, the term *lay counselor* will be used to refer to a person with limited training in counseling who engages in supportive roles with others, usually employing basic nondirective, active listening skills.

Over 40 years ago, Tracy and Gussow (1976) described clients seeking out lay counselors particularly when the "predominant issue [i.e., adjustment, phase of life] was of little interest to professional helpers, when the incidence [rates] were too high for the professionals to be

effective in helping, or when the affected populations had limited access to professionals" (p. 389). The reality is that people seek help and assistance from other people almost every day of their lives, while not necessarily needing the level of support provided in a clinical setting or therapeutic relationship (Lampropoulos & Spengler, 2005). For millennia, people have sought support from shamans, herbalists, acupuncturists, fortune tellers, or clergy for their struggles (Constantine, Lewis, Conner, & Sanchez, 2000; Garrett & Wilber, 1999; Helms & Cook, 1999; Sue, 1994; Sue & Sue, 1999; Utsey, Adams, & Bolden, 2000). When individuals choose not to seek out these groups, they may obtain naturally occurring informal support from bartenders, hairdressers, or beauticians for common problems (Bissonette, 1977a; Hogg & Warne, 2010; McKim & Weissberg, 1981; Roach & Resnick, 1981).

Eng, Rhodes, and Parker (2009) described six categories into which lay counselors can be divided: (1) family and friends, (2) neighbors [geographically located nearby], (3) natural helpers [individuals sought out because of their supportive nature and reputation], (4) role-related helpers [hairstylists, shopkeepers, ministers, etc.], (5) people with the same concerns [AA, NA, care-givers, support groups, etc.], and (6) volunteers [Red Cross volunteer, etc.].

Researchers have previously called for an increase in the amount of research comparing the use of lay counselors to professional therapists (Christensen & Jacobson, 1994) because lay counselors are providing a substantial amount of supportive care that has not been studied (Armstrong & McLeod, 2003; Gardiner, McLeod, Hill & Wigglesworth, 2003; Lampropoulos & Spengler, 2005; Moore, 2006). Examining the effectiveness of lay counseling outcomes is recommended based upon findings consistently reporting that the therapeutic relationship alone can account for nearly 40% of the variance in therapy outcome studies **(**Baldwin, Wampold, & Imel, 2007; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Dinger, Strack,

Leichsenring, Wilmers, & Schauenburg, 2008; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). Studying whether lay counselors can establish compassionate relationships would provide valuable insights.

Additionally, a recent study concluded that no differences existed between patients treated by bachelor-level lay providers and PhD-level expert providers in an older adult sample with Generalized Anxiety Disorder (GAD). Even at 6-month and 12-month follow-ups, the reduction in GAD severity, subjective anxiety, and depression, and improvements in mental health quality of life and sleep were maintained by both groups with no statistical difference. These findings have encouraged new models of care for older adults that may expand the reach of mental health services (Freshour et al., 2016).

A meta-analysis of the use of lay counselors in the treatment of anxiety and depressive disorders was unable to draw any conclusions as to the similarities between qualified therapists and lay counselor outcomes. However, there was sufficient evidence to suggest that the use of lay counselors was superior to control groups or no treatment conditions. The researchers recommended that this, along with previous research, continued to support the development of new programs incorporating lay counselors, and added that one benefit was the cost-effectiveness of using lay counselors, who are usually volunteers (Dan Boer et al., 2005).

Other forms of research have attempted to measure the effectiveness, acceptability, and self-efficacy of lay counselors. One of the earliest studies involving lay counselors was conducted by D'Augelli and Ehrlich (1982), who described 37 trained helpers who completed basic interventions with a total of over 150 different people for an average of 25 minutes per interaction within a week's time. Friends, relatives, co-workers, and neighbors were among the individuals most frequently helped by the participants, and these interactions often took place in

homes, workplaces, or by telephone. These lay counselors were more likely to engage in this helping behavior with individuals they commonly interacted with daily, which differs from the therapeutic model in frequency and accessibility (Taylor, Chatters, Woodward, & Brown, 2013).

Nagel, Newlin, and Cimbloic (1988) evaluated the effectiveness of lay counseling approaches by examining two groups. They assigned older adults and adolescents to one of two training groups: either an *empathetic listening skills* group or a *psychoeducational* group about aging. Nursing home residents seen by both adolescents and older adults trained in either group improved on geriatric depressive measures, further supporting the lay counselors as offering viable treatment alternatives.

There has also been international evidence submitted for the effectiveness of lay counselors, especially in isolated, underserved areas. Gallagher, Tracey, and Milar (2005) reported using volunteer bereavement counselors and 95% of their clients stated that the services rendered were beneficial. Neuner et al. (2008) have shown that minimally trained local lay counselors were able to provide trauma-informed interventions to Ugandan refugees for symptoms of war-related posttraumatic stress disorder (PTSD). Their study found that PTSD symptoms were reduced and physical health outcomes following the lay counselors' interventions were statistically and clinically superior, compared to no treatment. Dewing et al. (2014) also demonstrated the effectiveness of lay counselors working alongside medical professionals to encourage adherence to antiviral medications and safer sexual practices in areas of South Africa where HIV transmission is a serious health concern.

Two other relevant examples include the Feather Carriers of the First Nations (Danard, 2016; Feather Carriers; Wise Practices) and Dr. Dixon Chibanda's Friendship Benches of Zimbabwe (Chibanda et al., 2016; Chibanda et al., 2017; Nuwer, 2018). Both of these

approaches utilize local sources of support from empathic, invested individuals with minimal, but specific training to serve those in need. The First Nation Feather Carriers is a "life promotion program for First Nations, Métis, and Inuit individuals and families who are at risk for premature death, as well as supporting loss survivors" (Feather Carriers). This program, initiated by Dr. Ed Conners, John Rice, and Dr. Debby Wilson Danard, utilizes "community mobilization to focus on promoting life at the community level through training frontline workers, individuals with lived experience as peer mentors, manager, directors, and support staff" (Feather Carriers). Similarly, the Friendship Benches of Zimbabwe is a program developed by one of the country's only psychiatrists, Dr. Dixon Chibanda, to combat the extreme lack of social support services in the smaller communities. He utilized training local compassionate "grandmothers" to sit on benches in the town center to provide an empathetic ear to those struggling with mental health issues.

Also, the Department of Veteran's Affairs has made efforts to increase the usage of peer specialists in some of its more intensive mental health programs (e.g., inpatient psychiatric, inpatient posttraumatic stress, or inpatient substance abuse units). Chinman and colleagues (2008) described that peer support specialists "draw upon their lived experiences to share 'been there' empathy, insights, and skills...serve as role models, inculcate hope, engaged patients in treatment, and help patients access supports [in the] community" (p. 1315-1316).

This literature review is specific to individual interventions and does not attempt to provide comprehensive evidence for other forms of lay counseling, specifically peer help groups such as Alcoholics Anonymous, Celebrate Recovery, Overeaters Anonymous, Incest Survivors, and Parents with Autistic Children. These peer support groups have been recognized as providing effective nonprofessional help for severe mental health concerns (Alcoholics

Anonymous, 2016; Brown, Whitney, Schneider, & Vega, 2006; Lampropoulos & Spengler, 2005). Such programs have offered enough benefit that the Centers for Medicare & Medicaid Services (2007) consider peer support services evidenced-based services and reimbursable when supervised by licensed mental health professionals.

Lay Counseling in Christian Churches

Lay counseling in church settings is growing to meet the increased demand for accessible, trustworthy, and cost-effective services (Beckner, 2014; Garzon & Tiley, 2009; Garzon et al., 2009; Tan & Scalise, 2016). Lay counseling ministries have been referred to as congregational care teams, visitation teams, pastoral teams, or service ministries, depending upon the function of the ministry (Mack-Tatum, 2013; Perkins, 2007; Scott, 2001). Lay counselors are generally untrained or minimally trained but have a strong desire to help others. These ministries can occur within the congregation for members experiencing personal adjustments or emotional issues, addictions, grief, and even trauma (Clinton & Sibcy, 2012). Lay counseling ministries can also serve as an outreach to prisoners (Kerley, Matthews, & Shoemaker, 2009; Thomas & Zaitzow, 2006), homeless individuals (Sherman, 2004), struggling families (Chatters et al., 2002), older adults (Assari, 2013; Rote et al., 2013), or others in need. The need for lay counseling ministries continues (DeKraai, Bulling, Shank, & Tomkins, 2011), despite a call to educate, train, and utilize lay counselors—which has been reaffirmed for many years and which has remained mostly unanswered (Bergman, 1974; Bissonette, 1977a, 1977b; Brown, 1974; Collins, 1973; Cowen, 1982; D'Augelli & Vallance, 1981; Gordon, 1974, Hunter & Riger, 1986; Johnsson & Berglund, 2003; Kelley & Kelley, 1985; McKim & Weissberg, 1981; Morton & Joseph, 1971; Roach & Resnick, 1981; Zarle, Hartsough, & Ottinger, 1974).

Research on Christian Lay Counseling Programs. There has been little research conducted in recent years on the effectiveness of Christian lay counseling models; studies that have been conducted often neglect actual skill growth or measurement (Tan & Scalise, 2016). As of 2009, there had only been one randomized controlled study conducted, and this study utilized an "eclectic Cognitive Behavioral Therapy" approach to lay counseling, which is poorly defined and unmanualized. Especially when compared to the lay counseling movement, Christian lay counseling is lacking empirical support (Garzon & Tilley, 2009).

Tan and Sarff (1988) concluded that following a lay counseling workshop, the trainees rated themselves as more competent in counseling and Christian counseling knowledge. Additionally, these trained individuals also showed increases in using more understanding and supportive response styles on audiotaped role-plays, while also being less evaluative of their counselees. These trainees were rated as more empathic, respective, and genuine by trained raters based on the same role-plays.

Jernigan, Tan, and Gorsuch (1988) utilized a similar model for training lay counselors, and they included a control group of trainees that only received weekly Bible study classes. Trainees who received the lay counselor training were rated by two independent raters as much more competent, with higher rates of genuineness, than the control group trainees on video-recorded role-play counseling scenarios.

Harris (1985) found that the use of nonpaid, nonprofessional lay helpers in combination with professional pastoral counseling led to increases in client self-esteem that were significantly higher than private professional pastoral counseling alone. The informal support system, along with the formal supports, produced greater results compared to the formal supports alone—further supporting the complementary model of informal support systems.

Toh and Tan (1997) conducted one of the only well-documented studies employing control trials for lay Christian counseling effectiveness. They randomly assigned clients to the lay Christian counseling treatment group (n = 22) or to a wait-listed control group (n = 24) and evaluated pre/post intervention on four outcome measures: target complaints, brief symptom checklist, spiritual well-being scale, and global rating of client's psychological adjustment. The treatment group showed significant improvement at the end of treatment and at 1-month follow-up. To date, no other random control outcome study has been published related to lay Christian counseling. Because of this single controlled outcome study, lay Christian counseling for general psychological problems has been listed as a possibly efficacious treatment (Hook, et al., 2010).

Christian Lay Counselor Training

While there is some evidence for the validity of Christian lay counseling programs, there continues to be a lack of evidence to support many of the training models designed for Christian lay counselors. This is especially difficult in the face of broad definitions, such as Collins (1986) describing counseling as "a caring relationship in which one person tries to help another deal more effectively with the stresses of life" (p. 73). In this next section, this review will focus on the lay counseling models and methods of training individuals in this type of work.

Tan and Scalise (2016) described three major models for lay Christian counseling ministries, the first being an *informal, spontaneous* model. This model is embodied by people naturally caring for one another without any formalized structure or training for the lay counselors. The model is embodied by average congregational members visiting the sick and lonely without a formalized referral process. These lay counselors engage in supporting others in their grief and being companions with the counselees in their pain.

The second model is an *informal, organized* structure. In this model, the lay counselors are selected, trained, and supervised by pastoral counselors or licensed mental health professionals. However, the lay counselors operate within an informal referral network and on location in the community. These visits are likely taking place in a parishioner's home, hospital room, at a restaurant, or a coffee shop.

The final model proposed by Tan and Scalise (2016) is the *formal, organized* form of lay counseling. This model employs a system of appointments held at a central location, usually a church building, where the lay counselors provide counseling services under the supervision of a licensed provider. The lay counselors are trained extensively in formal models of counseling (e.g., Cognitive-Behavioral Therapy, Solution-Focused Brief Therapy) and must undergo ongoing supervision.

Once a lay counseling model has been determined to fit an individual congregation's need for support, individuals must be recruited or selected to pursue training in order to be able to provide lay counseling services. Anderson (2009) proposed several ideal qualities for religious lay counselors that are especially helpful during selection and training processes. These qualities include strong spiritual beliefs, warm and open personality characteristics, demonstrating self-confidence and the ability to build confidence in others, having unconditional positive regard for others, having insight into the strengths of others, and having a willingness to be trained in communication and listening skills in order to work with others.

According to Garzon et al. (2009), lay counseling training approaches can be categorized into active listening, cognitive and solution-focused, inner healing, and mixed approaches. One concern of training lay counselors is to strike a balance between giving individuals an appropriate amount of skill to provide meaningful interactions with others, yet without requiring

the individuals to pursue a master's degree in clinical mental health counseling, marriage and family therapy, social work, or counseling psychology. Tan and Scalise (2016) describe effective lay counseling training programs to be "of much shorter duration, significantly less clinical, and are more focused on a simpler set of helping skills, crisis management, and referral services than professional training programs" (p. 116). Therefore, for the purposes of this review and study, training methods for lay counselors will be limited to active listening approaches, in accordance with the goal put forth by Tan and Scalise (2016).

Microskills. The beginning process of learning the art and science of counseling (Sbanotto et al., 2016) has long centered around the practice of learning to listen and attend effectively (Hill, 2014; Ivey et al., 2018). These approaches have generally focused on "microskills," which are defined as "specific communication skills that provide ways for [one] to reach many types of clients" (Ivey et al., 2018, p. 11). From the Ivey et al. (2018) model of learning microskills, the portion of skills termed the "basic listening sequence" will be the primary focus of the current review and study. This basic listening sequence includes attending and empathy skills, questioning, observation, encouraging, paraphrasing, summarizing, and reflecting feelings. Ivey et al. (2018) also observed that if one does not achieve these skills prior to moving on to other more advanced skills, the result can be meaningless and potentially damaging to those whom counselors attempt to support. From a developmental training perspective, these are skills that can be easily accessed by novice lay counselors with relatively brief forms of training (Hill, 2014; Ivey et al., 2018; Sbanotto et al., 2016).

Hill (2014) identified these basic skills as the process by which counselors build rapport with clients. She described the action of orienting oneself toward the client in an effort to listen intently, observe carefully, and then react to what happens during the interaction with the client.

Hill (2014) believes that these skills are so important that she has developed a Helping Skills System to evaluate the verbal responses of counselors.

Christian Lay Counseling Training Programs. One well-publicized example of the active listening approach is the *Stephen Ministry*. This approach began in 1975 when Kenneth Haugk, PhD, a clinical psychologist and pastor (Haugk, 2000a), developed a program to increase skills for others to demonstrate empathy, positive regard, and basic listening skills. They also incorporated spiritual resources (i.e., prayer, scriptures) in the care of distressed people. However, as a qualified Stephen Minister one must complete 50 hours of training, participate in continuing weekly supervision, and attend monthly peer supervision groups. Not only is the process time consuming and difficult to manage for many individuals interested, but the program can be extremely expensive for small, rural congregations.

Like Haugk's model of training, others have presented formalized training programs. Crabb and Allender (1984) presented a model with three graded levels of intensifying training. Level one training consists of lessons pertaining to increasing interpersonal sensitivity, increasing attentive listening skills, and learning to communicate care to those one wishes to assist. Crabb and Allender believed so strongly in these foundational skills that they recommended that every Christian should have some training in basic listening and caring skills, as provided by their level one training. Level two included moving into a much more structured instructional environment for 40 hours of training on counseling technique and theory. Level three required 6 months to 1 year of weekly classes to become appropriately trained in their specific model of intervention.

Sweeten (1987) presented a model with differing levels of intensity. Similar to the Crabb and Allender model, Sweeten began at the system-level of the congregation. He believed that

adapting a lay helper training strategy to the entire congregation would help to raise a church's general level of personal and interpersonal functioning, thus modeling the congregation as a "therapeutic growth community" (Sweeten, 1987). The foundational level two covered developing empathy, warmth, respect toward counselee, genuineness, confrontation skills, self-disclosure, and immediate feedback. This 8-week course required sessions lasting 2 and a half hours. The final third and fourth courses necessitated another 14 weeks of sessions and were only open to those who successfully progressed through the previous two modules.

Lukens (1983) described a third model for training Christian lay counselors, which consists of six stages. Beginning with stage one, designed for all Christians, this model focused on entering and building relationships, listening skills, and core conditions for therapeutic change (e.g., empathy, respect, concreteness, confrontation, immediacy) (Carkhuff, 1972). Lukens was the first to recommend specific criteria for defining and measuring skills being used in the training of lay counselors. Levels two through four include classroom instruction in Theory and Theology, Personal Awareness, and Body Life Skills II (further interview training). His last levels (five and six) included practicum experience under supervision (40 hours of direct client contact and 10 hours of individual supervision) and further specialization into other areas (e.g., couple and family, financial counseling, vocational).

Tan (1987) proposed a 12-session model that includes beginning sessions teaching basic interviewing skills (e.g., building rapport, listening attentively, watching carefully) and provided an overview of the counseling process. His model for training was eventually expanded to a part-time 1-year program totaling 108 hours. His programs utilized Collins' (1980) *Christian Counseling: A Comprehensive Guide* as the main textbook and resource. Tan (2016) also

described the incorporation of practical skills training, role-playing, discussions of role-plays with feedback for trainees, and trainee case presentations as part of the training curriculum.

Scalise (Tan & Scalise, 2016) described the program he developed in 1986 in collaboration with a congregation in Williamsburg, VA. Scalise's model consists of 15 sessions implemented weekly for 3 hours. His model also specifies lectures and interactive, experiential elements. He described the utility of using small cohorts of five to seven trainees, which facilitates the "relationship-building skills, authentic transparency, and development of trust" (Tan & Scalise, 2016, p. 130). His program also based its foundation on the therapeutic relationship and active listening skills in the beginning sessions, while employing some exploration of the role of Christians in care provision as well.

Conclusion and Research Hypotheses

It is worth noting that many of the preceding models for lay counselor training were initially developed almost 30 years ago and the majority were designed to be implemented in large (500+ members), liberal non-denominational congregations (Crabb & Allender, 1984; Lukens, 1983; Tan, 1987; Tan & Scalise, 2016). Indeed, several of the congregations described in the "Examples of Lay Counseling Ministries in Local Churches" section of Tan and Scalise's (2016) book boasted over 1,000 members. This model of lay counselor training is primarily suited for populated, urban areas where congregations are much larger. If smaller, rural churches (i.e., <150 members) were interested in expanding members' ability to engage in informal support roles, these models would continue to impose several barriers. Many rural Christian congregations would not be able to afford to sponsor the training for so few members. Most rural Christian congregations are isolated or lack relationships with mental health professionals qualified to provide trainings fashioned after similar models. Most rural Christian congregations

are more likely to employ an informal, spontaneous model of lay counseling ministry, which has much less basis in a formalized lay counseling training model. Finally, many rural Christian congregations may find the overly academic and lengthy training process of learning lay counseling skills to be disconcerting.

Tan and Scalise (2016) call for further research in the area of lay counselor training programs, especially concerning how well lay counselors can be trained in basic skills (p. 173). Based on this review of the literature, it is evident that there is very little information on the use or success of lay counseling training models in smaller, rural Christian congregations. Therefore, this is the focus of the current project. The hypotheses are:

H_1: The number of beneficial therapeutic verbal response skills in an interaction with a "visitee" will increase at post-assessment following a Christian lay counseling training method designed for smaller, rural congregations.

H_{1a}: The number of approval and reassurance statements will increase at post-assessment.

H_{1b}: The number of open-ended questions will increase at post-assessment.

H_{1c}: The number of restatements will increase at post-assessment.

H_{1d}: The number of reflections of feelings statements will increase at post-assessment.

H_2: The number of unhelpful therapeutic verbal response skills in an interaction with a "visitee" will decrease at post-assessment following a Christian lay counseling training method designed for smaller, rural congregations.

H_{2a}: The number of closed-ended questions will decrease at post-assessment.

H_{2b}: The number of direct guidance statements will decrease at post-assessment.

H_{2c}: The number of self-disclosures statements will decrease at post-assessment.

H_3: The participants' overall number of words in an interaction with a "visitee" will decrease at post-assessment following a Christian lay counseling training method designed for smaller, rural congregations.

Chapter III

Method

As explained in the previous chapter, the available literature supports the ability of lay counselors to function as effective alternative providers in many settings with limited access to qualified mental health professionals or when there exists underutilization of these services. The current project evaluated the ability of brief (≤10 hours) microskills training to influence helping skill usage in rural, religious lay counselors. This chapter provides a description of the methods employed in the completion of this study, including the selection of participants, the measures for collecting data, the proposed intervention, and the analysis for evaluating collected data.

Participants

Participants were recruited based on specific inclusion criteria. The first criterion was that the participant not identify as a religious leader or clergy member in a local congregation. Because the existing literature mainly focuses on interventions in Christian settings, this project focused on Christian non-clergy participants. Participants were recruited from local congregations. The second inclusion criterion required that the participants would have had no previous formal training in any helping profession (e.g., social work, counseling, psychology) or seminary (e.g., theology, ministry). Third, individuals would act as part of, or be interested in joining, their congregation's congregational care team and take part in the UpLift: Lessons in Skilled Visiting workshop.

The author recruited 19 attendees for two workshops and 12 participants agreed to engage in the study and completed both the pre- and post-assessments. Participants represented three Christian denominations: Church of Christ (41.67%), Maronite Catholic (16.67%), and United Methodist Church (41.67%). The participants were all in middle to late adulthood (*M* age

= 58.67; *SD* = 7.29). Participants were primarily homogenous with regards to self-identified identity: White (83.34%) and non-White (16.67%).

Measures

Helping Skills System. Lay counselors' skills were coded using the Helping Skills System (HSS; Hill, 2004), a revision of the Hill Counselor Verbal Response Category System (Hill, 1978, 1986). The HSS consists of 12 categories for evaluating therapist verbal responses. The analysis system divides lay counselors' responses into grammatical sentences that are designated into mutually exclusive helping skill categories of verbal behavior by trained judges. The helping skill categories are described as follows: (1) approval and reassurance, (2) closed question, (3) open question, (4) restatement, (5) reflections of feelings, (6) challenge, (7) interpretation, (8) disclosure, (9) immediacy, (10) information, (11) direct guidance, and (12) other, which would include any sentence that does not fall into a previous category. Initial concurrent validity for the HSS was established through significant positive correlations between similar categories in other response mode systems (Elliott et al., 1987). For the HSS, Hess, Knox, and Hill (2006) reported an average kappa between pairs of judges of .91.

Helper words. Researchers calculated the proportion of lay counselor words by dividing the number of lay counselor words by the total words spoken by both lay counselor and mock client in each assessed interaction.

Procedure

Registered attendees of the UpLift: Lessons in Skilled Visiting workshop were invited by phone to participate in the skills evaluation research project by researchers from Radford University. Those who agreed to participate met with researchers for an initial assessment of active listening skills. During this initial meeting, researchers obtained informed consent and

collected signatures from participants. The informed consent process explained the nature of the data being gathered and the data's intended purpose. Participants were then asked to engage in two short (15 minutes) standardized interactions with a mock client, once during the initial pre-workshop assessment, and once again in a similar post-workshop assessment. The initial assessments occurred during the first 2 hours of the workshops as each participant was pulled away to complete the assessment individually. The second assessments occurred one week later with each participant given appointment times to return to the site of the training. Mock client/actors were given two scenarios to enact during the assessments, to which each group of participants were randomly assigned to scenario order. These lay counselor/mock client interactions were recorded using audio/visual equipment in order to complete the HSS analysis.

Two female volunteers acted as mock clients. This process was utilized because it contributes to a more authentic learning experience (Esposito, 2009) compared to engaging in a similar activity with another research participant. Other research participants acting as mock clients may intentionally (or unintentionally) attempt to assist lay counselors during assessments, based upon knowledge acquired through the UpLift seminar. The mock clients were given very little instruction on how to respond to lay counselors during "sessions," but were instructed to follow one of two prepared scenarios or client backstories. The only piece of encouragement for the mock client actors was to maintain consistency across mock session interactions. Half of the participants were presented with scenario number one at the pre-assessment and scenario number two at the post-assessment. The second half of participants received the scenarios in the reverse order to minimize any compounding factors of the scenarios themselves. The first scenario (reference Appendix F) for the mock client is to act as a "lonely, bereaved, and anxious middle-aged female conducted at the client's home." The second scenario is for the mock client to act as

a “depressed, fearful late middle-aged female with health concerns conducted at the client’s home.”

Intervention. A 10-hour workshop designed to increase microskills in lay counselors was administered over 2 days. Two workshops were conducted to obtain the indicated sample (August 10-11, 2017 and January 26-27, 2018). The UpLift: Lessons in Skilled Visiting workshop is grounded in a desire to help members from Christian congregations develop active listening skills and foster a sense of community in which members and leadership can support those in mild distress within the congregation and the local community. The topics discussed in the training were meant to grow the helper’s effectiveness in helping people to meet challenges they are facing in their lives by providing clinically proven active listening skills. The program is prepared to instruct empathic individuals with a strong desire to help others do so more effectively. The UpLift workshop covered various topics, including a basic view of distress, models of effective lay counseling, traits of skilled helpers, ethical considerations for trainees, and modules detailing the basic listening sequence. The workshop was presented in a manner that incorporated lecture, experiential exercises, demonstrations (live and recorded), role-plays, feedback for others, and self-reflection activities. The proposed seminar outline was as follows:

1) **Basic View of Distress**
    a) 45-minute lecture describing several of the more prominent theories on distress/mental disorder, allowing time for discussion and questions.
    b) 5-10 minutes also spent allowing lay counselors to reflect upon and articulate a model that fits their perspective.

2) **Models of Effective Lay Counseling**

    a) 30-minute interactive presentation on material from Tan and Scalise (2016) on the various models that lay counseling services have been provided and how their congregation can integrate these into practice locally.

3) **Traits of Skilled Helpers**

    a) 30-minute lecture describing several of the characteristics of lay counselors that make them successful and ways to foster growth in these areas (e.g., psychological health, genuine interest in people, empathy, personal warmth, self-awareness, awareness of values, and tolerance of ambiguity).

    b) 10-minute activity reflecting upon why they want to be involved in lay counseling work (e.g., values clarification exercise).

4) **Ethical Considerations for Lay Counselors**

    a) 50-minute presentation surrounding the issues of understanding competency, role of lay counselors in service provision, referral process for more formal services, consultation with others (clergy or mental health professionals), confidentiality, ethical decision-making models, etc.

    b) 10-15-minute small group (3-4 participants) exercise with case study and employing a basic ethical decision-making model.

5) **Microskill Modules**

    a) **Basics of Empathy**

        i) 30-minute presentation evaluating the basics of demonstrating and understanding empathy. Introductory empathy building skills will be demonstrated and discussed during presentation.

ii) 10-minute small group exercise rating empathic statements on Level 1-3 scale (Ivey et al., 2018) and group discussion following.

b) Attending Behavior

i) 30-minute presentation discussing the components of the lay counselor's behavior that convey active listening and attention.

ii) 10-minute interactive component practicing empathy with case scenarios in groups of 2-3 participants. Hill (Lab 4; 2014) exercise will demonstrate empathy without any verbal communication as the counselor.

c) Observation Skills

i) 30-minute presentation covering the basics of being an attentive observer during lay counseling interactions and what certain behavioral cues from clients may mean.

ii) 20-minute skills will be demonstrated at times by using newly updated Allen Ivey training video clips found online (Basic Attending Skills, 2017).

d) Skilled Use of Questions

i) 30-minute lecture presentation describing the difference between open-ended and closed-ended questions, in which settings each are appropriate, and the goals of each. The purpose is to increase intentional usage of each form of questioning.

ii) 15-minute activity with triads—one counselee and two counselors (one can only ask open questions and one can only ask closed questions, alternating speaking turns).

e) Listening Process – Encouraging, Paraphrasing, and Summarizing

i) 45-minute presentation describing verbal listening process. Will discuss how to use each part and at what points throughout sessions, demonstrating effective and ineffective ways of each.

ii) 15-minute experience where individuals engage in practice paraphrasing video segments from clients (Basic Attending Skills, 2017).

f) Reflecting Feelings

i) 30-minute presentation on the importance of hearing feeling words in client speech and helping clients expand emotional vocabulary. Provide psychoeducational material on feelings.

ii) 15-minute summative activity engaging in microskill practice with partners; scripts will be provided with lines for counselee and prompts for counselors to use various skills (e.g., open question, paraphrase, minimal encourager).

Participants attended the training in a local church building or on the campus of Radford University, receiving approximately 10 hours of education on basic listening and attending skills for lay counselors. The training was conducted by the author, a doctoral-level student in counseling psychology. The seminar incorporated exploring and facilitating skills taught from Hill (2014) and the *basic listening sequence* of Ivey, Ivey, and Zalaquett's (2018) microskills approach, both of which are standard approaches to teaching introductory counselor education courses. This material was presented in a manner that utilizes faith-based examples and scenarios that Christian lay counselors are likely to encounter.

The analysis and expected findings were drawn from research supporting a developmental perspective on training in microskills (Ivey et al., 2018). Some skills were hypothesized to increase in frequency and proportion of overall skill usage as a result of training

due to these skills being emphasized throughout the UpLift seminar (e.g., approval and reassurance statements, open-ended questions, restatements, and reflections of feeling). There were also skills that were anticipated to reduce in frequency and proportion of overall skill usage as a result of participants having more developmentally appropriate skills to utilize as a result of the UpLift seminar (e.g., closed-ended questions, direct guidance, and self-disclosures). These skills (closed-ended questions, direct guidance, and self-disclosures) are also more likely to be utilized by untrained individuals engaging in interpersonal interactions. These skills are also not as likely to promote further exploration or expression on the part of the client, which is the main objective of basic lay counseling interventions (Tan & Scalise, 2016).

Analysis

Lay counselors' videotaped interactions were transcribed in order to determine the grammatical structure of the lay counselors' verbal responses. The judges determined to which of the HSS 12 major categories each grammatical sentence of the lay counselors' pre-/post-assessment interaction belonged. Three judges (doctoral counseling psychology students) and a fourth auditor (PhD-level psychologist) were trained in determining grammatical sentences of participants during the mock counseling session according to the Web Form F HSS (Appendix E) coding procedure (Hill, 2014). This training process included studying and reviewing material presented by Hill (2014). Once the research team began evaluating project transcripts with Appalachian participants, there were several instances where the team felt unprepared by the "textbook, perfect English" of the practice transcripts and accompanying training materials. Therefore, the research developed an accompanying set of rules (Appendix H) that the judges adhered to in conjunction with the HSS.

Judges coded two practice transcripts in order to evaluate agreement level between judges. These practice transcripts, provided by Hill (2014), are accompanied with recommended categorizations to compare judges' answers. Next, several transcripts were completed by the entire team to establish an appropriate Cohen's kappa before beginning to complete the remaining transcripts in pairs. Judges completed coding of transcripts independently, but met regularly to discuss and resolve any discrepancies in coding procedure. The regular meetings prevented drift of judgments and boosted morale of the research team. Finally, the research team met at the conclusion of the project in order to resolve disagreements with consensus on categories used on each unit for all transcripts.

Cohen's kappas were calculated to determine the amount of agreement between pairs of judges. Judgements about helping skills agreement are nominal (yes or no) and the kappa statistic reflects the percentage of agreement corrected for chance agreement (Cohen, 1960; Tinsley & Weis, 1975). Practice transcripts were used in increasing complexity to develop coding skills and judges were able to reach an average kappa between .60-.85, the acceptable ranges presented by Hill (2014). Landis and Koch (1977) reported that the .41-.60 range for kappas demonstrates moderate agreement, the .61-.80 range as substantial agreement, and the .81-1.00 as almost perfect. In the case of this study, Cohen's kappa is being applied to a categorization system that is much larger than the 2 x 2 variables the kappa statistic (and benchmarks) were originally created to measure. Therefore, Gwet (2012) demonstrated that the 95th percentile of Cohen's kappa drops substantially when the number of categories rises (e.g., .60 with two categories, .40 with five categories). In the present study, using a 12 x 12 categorization system decreases the thresholds for kappas to demonstrate considerable agreement existed between judges.

The three judges began working on research transcripts but completed the first four transcripts with all three coders before moving on to paired transcripts. Kappas are calculated for each pair of judges on the transcript and then an average kappa was calculated for the transcript for the three judges. The average kappa for these first four transcripts was $M = .62$, $SD = .03$. Kappas for the rest of the project involved only a pair of judges for each transcript and thus only one kappa statistic. A composite kappa was also calculated for the project as a whole, $M = .64$, $SD = .09$.

Helping skills categories of each participant from the pre-assessment and post-assessment were calculated as proportions to the total skill usage of each interaction to determine whether evidence exists for microskill changes following the workshop. Researchers utilized Paired-Samples T-tests to determine whether differences in means for pre-assessment and post-assessment proportions were statistically different. Lay counselors' proportions of words to total words spoken by both lay counselor and mock client were then calculated from the pre-assessment and post-assessment to demonstrate changes in more active listening on the part of the lay counselor.

The method described in this chapter was followed to study the effect of a brief microskills training upon lay counselors from rural, Christian congregations. While there has been substantial evidence presented for the usefulness and utility of lay counselors in providing alternative services to individuals with support needs, there continues to be a lack of evidence for short-term, inexpensive, accessible, and effective trainings designed for religiously focused lay counselors to develop basic helping skills. Therefore, the current study hopes to add to the current literature in this way.

Chapter IV

Results

In this section the author presents the results of the transcript analysis. The analysis consisted of 24 unique transcripts and 2,558 separate participant grammatical sentence units, not including actor units. The following results were calculated using a paired-samples *T*-test and effect sizes. Participants' units for each transcript were relatively consistent (M = 106.58 units, SD = 29.15). There does not appear to be any differences between pre-assessment units (M = 102.17, SD = 30.64) and post-assessment units (M = 111.00 units, SD = 28.20); t (11) = -.795, p = .443; d = .30. There did appear to be a wide variation between participants for the total number of words spoken during the transcripts (M = 1786.83, SD = 499.72), ranging from 771 words to 3,161 words. There was also some variation between participants for the total number of words spoken during the pre-assessment (M = 1672.17, SD = 409.09) when compared with the total number of words spoken during the post-assessments (M = 1901.50, SD = 571.04); t (11) = -1.384, p = .194; d = .46.

Hypothesis One

The author first evaluated the impact of the workshop upon four verbal response skills that have been shown to be beneficial in therapeutic interactions: approval and reassurance statements, open-ended questions, restatements, and reflections of feeling. Hypothesis one was that participants would increase their use of these four verbal response skills at post-assessment. The following data is presented in Tables 1-4 as proportions of the skills used in relation to the total skills used in each transcript.

Table 1.
Results for H_{1a}: Approval and Reassurance Statements

	Participants											
Assessment	P1	P2*	P3*	P4	P5	P6*	P7*	P8*	P9*	P10*	P11	P12
Pre-Assessment	.124	.221	.168	.314	.405	.178	.179	.230	.192	.305	.250	.140
Post-Assessment	.098	.316	.182	.222	.289	.252	.202	.256	.256	.404	.124	.133

Note. * = Increase in proportion for post-assessment for participants. *N* = 7.

Table 2.
Results for H_{1b}: Open-Ended Questions

	Participants											
Assessment	P1	P2	P3	P4	P5	P6	P7	P8	P9*	P10	P11	P12
Pre-Assessment	.044	.032	.059	.143	.072	.111	.048	.150	.008	.085	.042	.070
Post-Assessment	.008	.018	.020	.074	.024	.052	.032	.060	.081	.079	.029	.035

Note. * = Increase in proportion for post-assessment for participants. *N* = 1.

Table 3.
Results for H_{1c}: Restatements

	Participants											
Assessment	P1	P2*	P3*	P4	P5	P6	P7	P8	P9*	P10	P11	P12
Pre-Assessment	.035	.032	.030	.057	.063	.030	.007	.090	.008	.042	.031	.035
Post-Assessment	.025	.044	.051	.037	.024	.013	.000	0.43	.014	.035	.024	.027

Note. * = Increase in proportion for post-assessment for participants. *N* = 3.

Table 4.
Results for H_{1d}: Reflections of Feelings

	Participants											
Assessment	P1	P2*	P3	P4*	P5*	P6*	P7*	P8	P9	P10*	P11*	P12*
Pre-Assessment	.018	.011	.010	.000	.000	.000	.000	.040	.000	.008	.000	.000
Post-Assessment	.000	.026	.000	.025	.024	.007	.011	.017	.000	.009	.006	.009

Note. * = Increase in proportion for post-assessment for participants. $N = 8$.

There did not appear to be any differences between pre-assessment use of approval and reassurance statements ($M = .226$, $SD = .082$) and post-assessment use ($M = .228$, $SD = .087$); t (11) = -.099, $p = .923$; $d = .02$, and thus, there is no support for H_{1a}. The use of open-ended questions *decreased* between pre-assessment use ($M = .072$, $SD = .044$) and post-assessment use ($M = .043$, $SD = .026$); t (11) = 2.485, $p = .030$; $d = .63$; H_{1b} is not supported. There appeared to be a similar finding with the use of restatements between pre-assessment ($M = .038$, $SD = .023$) and post-assessment ($M = .028$, $SD = .015$); t (11) = 1.887, $p = .086$; $d = .54$, which did not support H_{1c}. Lastly, there was a small increase in the pre-assessment use of reflections of feelings ($M = .007$, $SD = .012$) and post-assessment use ($M = .011$, $SD = .010$); t (11) = -.894, $p = .391$; $d = .35$, which provides modest support for H_{1d}. Therefore, hypothesis one was not supported by the data. The workshop did not lead to observable increases in approval and reassurance statements, open-ended questions, restatements, or reflections of feelings.

Hypothesis Two

The author evaluated the impact of the workshop upon three verbal response types that have been shown to be less helpful during therapeutic interactions: closed-ended questions, direct guidance, and self-disclosures. Hypothesis two stated that these unhelpful verbal response

styles would decrease in participants at post-assessment. The following data is presented in Tables 5-7 as proportions of the skills used in relation to the total skills used in each transcript.

Table 5.
Results for H_{2a}: Closed-Ended Questions

	Participants											
Assessment	P1*	P2*	P3	P4*	P5	P6*	P7*	P8*	P9*	P10	P11*	P12
Pre-Assessment	.080	.063	.149	.200	.099	.119	.186	.140	.117	.085	.135	.070
Post-Assessment	.058	.053	.172	.062	.157	.093	.149	.128	.027	.105	.047	.071

Note. * = Decrease in proportion for post-assessment for participants. $N = 8$.

Table 6.
Results for H_{2b}: Direct Guidance

	Participants											
Assessment	P1	P2*	P3*	P4*	P5	P6	P7*	P8	P9	P10*	P11*	P12*
Pre-Assessment	.080	.232	.099	.086	.036	.044	.069	.020	.017	.042	.073	.035
Post-Assessment	.098	.044	.081	.049	.048	.053	.000	.043	.027	.026	.018	.009

Note. * = Decrease in proportion for post-assessment for participants. $N = 7$.

Table 7.
Results for H_{2c}: Self-Disclosures

	Participants											
Assessment	P1*	P2*	P3*	P4	P5	P6*	P7*	P8	P9	P10	P11	P12
Pre-Assessment	.142	.137	.109	.086	.000	.104	.069	.020	.100	.000	.031	.070
Post-Assessment	.139	.009	.020	.123	.060	.066	.032	.026	.122	.035	.041	.319

Note. * = Decrease in proportion for post-assessment for participants. $N = 5$.

There was a slight decrease between pre-assessment use of closed-ended questions (*M* = .120, *SD* = .044) and post-assessment use (*M* = .093, *SD* = .048); *t* (11) = 1.688, *p* = .120; *d* = .58, which provides support for H_{2a}. The use of direct guidance also decreased between pre-assessment use (*M* = .069, *SD* = .058) and post-assessment use (*M* = .041, *SD* = .028); *t* (11) = 1.664, *p* = .124; *d* = .62, which supports H_{2b}. Lastly, there appeared to be a slight *increase* in the use of self-disclosures between pre-assessment (*M* = .072, *SD* = .050) and post-assessment (*M* = .083, *SD* = .086); *t* (11) = -.390, *p* = .704; *d* = .15. However, one participant's proportion appears to have skewed this data (Participant #12, Pre-test = .070; Post-test = .319). This participant engaged in an appropriate but lengthy personal example about the utilization of congregational members in acquiring social support. When this participant's data is excluded from the analysis on this variable, the results show a decrease between pre-assessment use (*M* = .072, *SD* = .052) and post-assessment (*M* = .061, *SD* = .046); *t* (10) = .652, *p* = .529; *d* = .23; this finding is much more in support of H_{2c}. These findings are consistent with supporting hypothesis two and demonstrate that the workshop did lower the use of closed-ended questions, direct guidance, and self-disclosures.

Hypothesis Three

Finally, the author evaluated the impact of the workshop upon the total number of words spoken by the participants. The training workshop aimed to expand active listening skills, and therefore, likely reduce the amount of time that the lay counselors speak during an interaction. Hypothesis three stated that participants would speak less during the post-assessment. The data suggests that participants spoke a greater proportion of the time during post-assessments (*M* = .716, *SD* = .094) than during pre-assessments (*M* = .659, *SD* = .113); *t* (11) = -2.094, *p* = .060; d

= .55 (see Table 8). H_3 was not supported by the data and the workshop appeared to have little effect on the amount of time the participants spoke during interactions.

Table 8.

Results H_3: Proportion of Words Spoken

	Participants											
Assessment	P1	P2	P3*	P4	P5	P6	P7*	P8	P9*	P10	P11	P12
Pre-Assessment	.692	.643	.734	.384	.634	.739	.742	.517	.769	.608	.755	.692
Post-Assessment	.723	.696	.703	.564	.652	.786	.741	.706	.642	.632	.901	.845

Note. * = Decrease in proportion for post-assessment for participants. $N = 3$.

Additional Analyses

The following information is additional information the author reports in supplement to the above data for the predicted hypotheses. The following chart visualizes the changes in proportions from pre-test to post-test for all participants. Data points above the baseline indicate increases in proportions while those below indicate decreases. The second chart visualizes effect sizes for the 12 categories of the Helping Skills System (HSS).

Chart 1. Differences in Proportions at Post-Test.

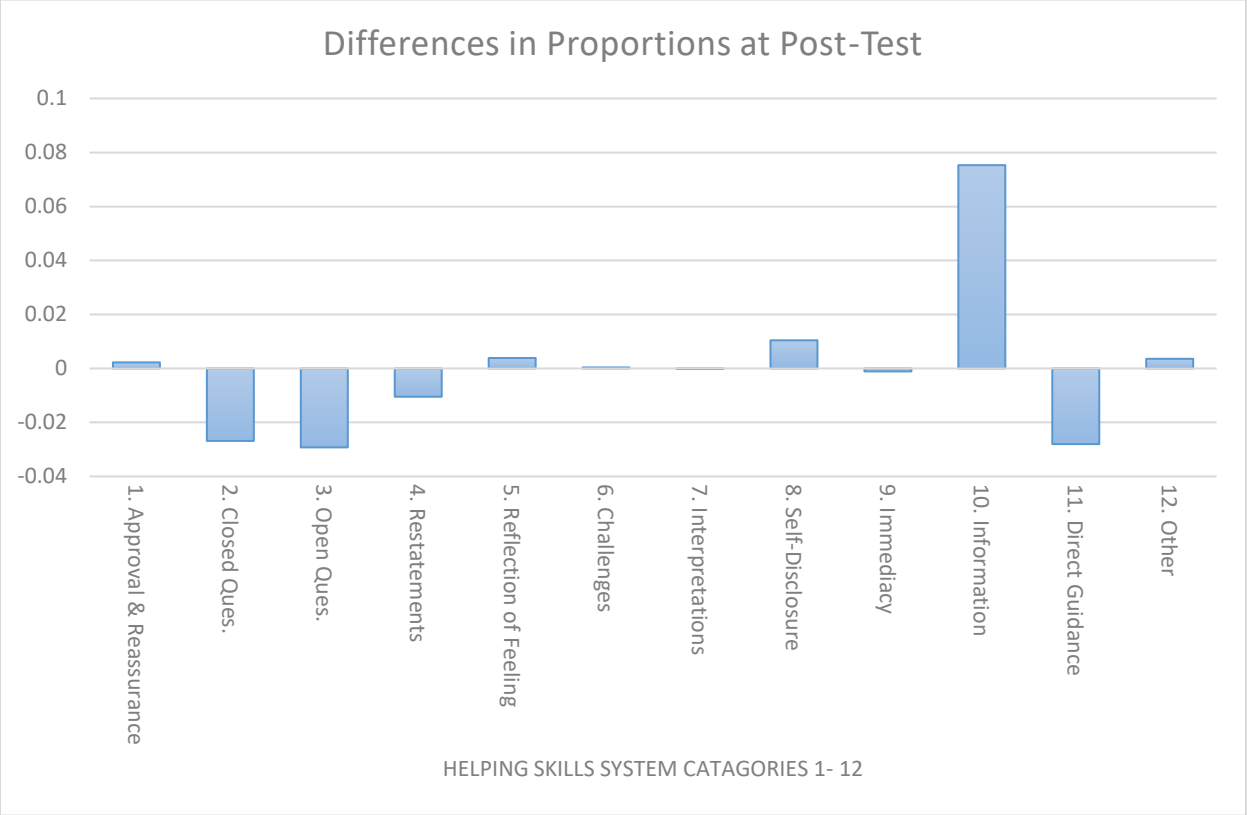
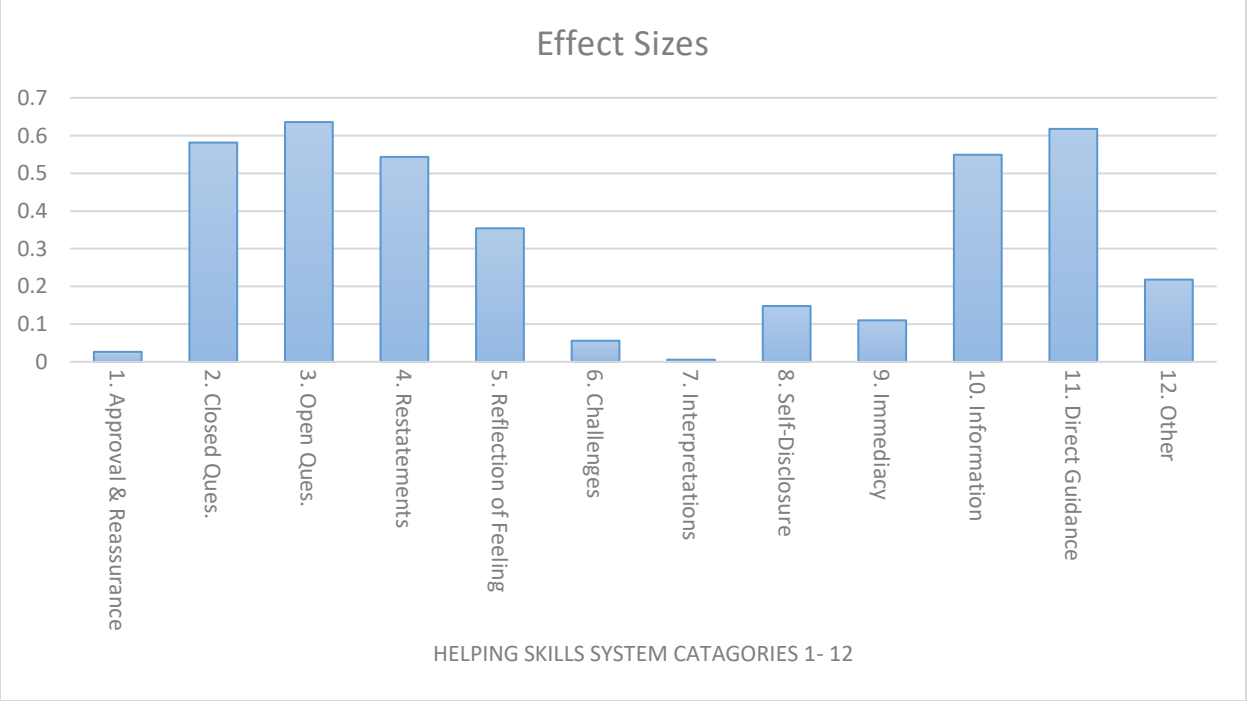


Chart 2. Effect Sizes for Helping Skills System.



Summary

This chapter summarizes the results of the pre-assessment and post-assessment interactions between participants and the actors, as well as the differences between these interactions. Therefore, the chapter outlined the hypotheses and the supporting proportions of verbal response styles or participant proportion of words spoken. Please refer to Appendix I for a full SPSS output for the above data analysis.

The next chapter records the discussion surrounding the implications of the results and places results in a larger context, attempting to combine the existing literature with the current research to answer the original hypotheses. This study's unique contributions to the body of knowledge and its limitations are addressed, as well as directions for future research.

Chapter V

Discussion

In this chapter, the study results are discussed in terms of the original set of research hypotheses. First, the current investigation is revisited, and the findings are evaluated for congruence with the greater body of literature. Next, several themes, which are relevant to the results and the field of psychology in general, will be considered as anecdotal findings from the project. In conclusion, the author discusses the current study's limitations and directions for future research.

Current Study and the Existing Literature

As evidenced by the presented literature, it is clear that rural populations have a lower perceived need for professional mental health services (Fox et al, 1995; Griffiths et al., 2009), often require convincing by someone whom they trust of the need for treatment (Gamm et al., 2003), and that, for many rural individuals, this urging may come from informal networks of family, friends, churches, or other familiar forms of support (Gallo et al., 1995; Richards & Bergin, 2000; Sussman et al., 1987). With nearly 42% of rural residents reporting attending religious services at least 2-3 times a month (Smith et al., 2016), churches can be a significant force in influencing perceived need of mental health treatment and access to recommendations by trusted individuals (e.g., ministers, clergy, lay counselors) (Bartels & Naslund, 2013; Eng et al., 1997; Tan, 2011). Rural individuals may choose to seek support and guidance from lay counselors due to the lack of perceived need for professional help or because these lay helpers may be viewed as trustworthy, of equal status, or familiar to the individual (Garzon et al., 2009; Lampropoulos & Spengler, 2005; Tan & Scalise, 2016). Whereas there have been attempts to train and utilize lay counselors in Christian congregations for many years, very little research has

been conducted with smaller, rural congregations; neither has the efficacy of shorter, more cost-effective trainings been investigated. The current study is an initial exploration into the effectiveness of a brief training workshop for lay counselors in rural Christian congregations.

Answering the Hypotheses

In this section, the results pertinent to each hypothesis are provided. The results and relevant information from procedures are discussed. The author also considers the possibility of generalizing applications from research results.

Hypothesis One (H_1): *The number of beneficial therapeutic verbal response skills in an interaction with a "visitee" will increase at post-assessment following a Christian lay counseling training method designed for smaller, rural congregations.*

H_{1a}: The number of approval and reassurance statements will increase at post-assessment.

H_{1b}: The number of open-ended questions will increase at post-assessment.

H_{1c}: The number of restatements will increase at post-assessment.

H_{1d}: The number of reflections of feeling statements will increase at post-assessment.

These four skills have been traditionally identified as skills that novice counselors learn in beginning training. Therefore, the prediction was that the results of the study would show an increase in these skills as a result of the UpLift: Lessons in Skilled Visiting workshop. Ultimately, these findings demonstrated smaller increases in these skills and for fewer participants than predicted.

The use of approval and reassurance statements was a skill that seven of the 12 participants improved upon from pre-test to post-test, but the differences do not appear to be clinically or statistically significant. Many of these participants' units were verbal encouragers,

"Okay" or "Hmm," showing that the participant was listening and were used to prompt the actors to continue speaking. The UpLift: Lessons in Skilled Visiting workshop teaches this skill as an important method to convey active listening and was practiced during the workshop weekend.

The use of open-ended questions was a skill for which one participant showed increased usage between pre-test and post-test. Open-ended questions are designed to promote speaking by the interlocutor without seeking specific information (e.g., "Was there anything about him [minister] or about his message that you particularly found touching for you?" Participant #10, Post-test). The difference between open-ended questions and closed-ended questions was explained and the appropriate use of these skills was discussed, highlighting the sort of information the questions prompted (e.g., desiring specific information leads to using closed-ended questions). Neither form of question was explicitly stated to be more or less ideal during the workshop. However, the use of open-ended questions was listed as a skill used in encouraging more elaboration by the one being visited. It is possible that the decrease in open-ended questions for most participants can be linked to the discomfort with the skill and not having enough time during the training process to practice or incorporate this new skill into their interaction style. The training of open-ended questions could be an area that deserves more emphasis during the training period due to its complexity and unlikely focus in daily interactions.

The use of restatements was a skill for which three participants showed improvements from pre-test to post-test. The restatement category is a skill that the participant uses to reflect information the actor has spoken back to the actor; it demonstrates active listening and comprehension (e.g., "It sounds like, you're facing some very difficult situations in your life because soon you'll be an empty-nester of sorts, even though your daughter's at [community college]." Participant #2, Post-test). Restatements were demonstrated during the workshop as

paraphrasing and summarizing skills. This skill was reviewed as a means to check that the participant correctly heard the message conveyed during the conversation between visitor and visitee. Generally, restatements utilized by participants were rare. Feedback and questions during the training indicated that several participants saw this process as extremely "therapist-y." One particular participant reported that this skill felt very unnatural with his method of communicating (Participant #7). This sentiment is likely to be held more frequently by participants who are much more direct and problem/solution-focused in their visitation support of others.

The use of reflections of feeling was a skill for which eight participants showed improvements from pre-test to post-test. However, many participants did not utilize this skill in pre-test and only engaged in the skill once or twice during post-test to show this increase. The reflections of feeling category is a skill used to emphasize emotion in the conversation and convey an understanding of the emotional content in a participant's interaction. One of the more unique ways in which this study's participants demonstrated this skill was by ending their visitation session in prayer, lifting up emotional concerns, for the actor (e.g., "Heavenly Father, we thank you for today and for your blessings and we are thankful for Jane [actor assigned name for scenario #1]. *She has some concerns and some grief and she's worried*. Be with her, Father, bless her." Participant #5, Post-test). While prayer was not a specific skill discussed in the workshop, it is a natural extension of the skillsets utilized by lay counselors, specifically in Christian congregations. Prayer has been supported as a powerful tool used in religious/spiritually integrative counseling (Burnett & Panchal, 2008; Post & Wade, 2009; Walker, Gorsuch, & Tan, 2004; Weld & Eriksen, 2007; Young & Young, 2014). Indeed,

participants appear to have incorporated the reflections of feeling category into their practice of prayer.

Prayer by participants posed a particular issue for the research team during the coding process due to its poor fit with the current categorization system. There were often salutations and opening phrases that did not appear to fit neatly into a categorization system designed for individual counseling interactions. Prayer for another may be a less direct form of reflecting feelings that allows the visitor to support and encourage the visitee without engaging in the seemingly repetitive—and, to them, unnatural—act of reflecting feelings back to the individual. Additionally, this act of reflecting feelings to a third party (e.g., God, a higher power) is a unique function of reflection that is very uncommon in individual therapy settings and has not been studied in lay counseling research. Therefore, it does appear that participants integrated new learning with past learning in this particular skill.

The author completed most of the prior analysis using proportions of units within the transcripts to evaluate the usage of the Helping Skills System's (HSS) categories due to the expectation that transcripts would have varying totals of units. However, using proportions could potentially distort an actual increase in the usage of certain HSS categories. When reviewing the average total units for the categories in hypothesis one, the researchers observed the following patterns. Approval and reassurance statements saw a slight increase of actual units from pre-test (M = 22.67; SD = 10.24) to post-test (M = 24.67; SD = 10.49) with a d = .19. There was an actual decrease of open-ended questions from pre-test (M = 6.92; SD = 4.44) to post-test (M = 4.58; SD = 2.64) with a d = .64. There was an observed decrease in restatements from pre-test (M = 3.67; SD = 2.39) to post-test (M = 3.08; SD = 1.62) with a d = .29. Finally, there was slight increase in the usage of reflections of feeling from pre-test (M = 0.75; SD = 1.22) to post-test (M = 1.17; SD

= 0.94) with a d = .38. These findings are consistent with the findings reported in the results section utilizing proportions.

Hypothesis Two (H_2): *The number of unhelpful therapeutic verbal response skills in an interaction with a "visitee" will decrease at post-assessment following a Christian lay counseling training method designed for smaller, rural congregations.*

H_{2a}: The number of closed-ended questions will decrease at post-assessment.

H_{2b}: The number of direct guidance statements will decrease at post-assessment.

H_{2c}: The number of self-disclosures statements will decrease at post-assessment.

These three skills were anticipated to decrease in frequency and proportion of overall skill usage as a result of participants having learned more developmentally appropriate skills to utilize because of the workshop. These skills (closed-ended questions, direct guidance, and self-disclosures) are more likely to be utilized by untrained individuals engaging in interpersonal interactions. These skills are not as likely to promote further exploration or expression on the part of the one being visited, which is the main objective of basic lay counseling interventions (Tan & Scalise, 2016). This hypothesis found some support in that closed-ended questions and direct guidance decreased in proportion, whereas self-disclosure *increased* in proportion at post-test.

The use of closed-ended questions decreased for eight participants from pre-test to post-test with a moderate effect size (d = .58). Closed-ended questions were proposed during the workshop as a means to obtain simplistic and specific information from a visitee. However, participants were warned that when attempting to provide emotional support to someone in a visitation session, seeking specific information should remain a small portion of the interaction. It was often observed that closed-ended questions were asked in an effort to elicit additional

information from the actors, yet still technically fitting the definition of a closed-ended question (e.g., "Do you have hobbies?" or "Are you working?" Participant #6, Post-test). These and other examples indicate possible confusion on the use of closed-ended questions. Another observation is that both forms of questions were utilized less frequently at post-assessment, which could indicate an anxiety about using the "wrong form" of question or having other skills to retrieve the desired responses from the actors.

Another consideration pertaining to the use of questions are the additional research team rules (Appendix H) created to accompany the coding process and Hill's HSS. Rule #5 indicates that the research team should treat units that technically are questions, but better convey a message of restatements, reflections of feeling, and/or direct guidance, etc., as these other categories rather than questions. While the purpose of this rule was to incorporate the likely meaning of the participant, and thus honor the participants' learning rather than limiting the value of utilizing questions, this coding process obviously affected the results of the analysis.

The use of direct guidance decreased for seven participants from pre-test to post-test with a moderate effect size (d = .62). The direct guidance skill was not directly discussed during the workshop, but the primary message of the workshop's empathy module is to "better understand and not provide our opinion" about a given situation or the other's emotions. There appears to be evidence that the forms of direct guidance were also framed differently in post-sessions (e.g., "*One thing you probably should do, and I'm not here to give advice other than to say that you've gotta try to keep faith.* That's the most important part. Whether it's a small thing or a large thing. *We gotta have faith*." Participant #1, Post-test; "*Well, let's talk about that* [anxiety] *some*." Participant #11, Post-test). At post-assessment, participants frequently refrained from "giving

advice" or used direct guidance statements to direct the interpersonal process. The reduction in this skill appears to have been a strength of the designed intervention.

The average proportion of using self-disclosure actually increased with a negligible effect size (d = .15). However, one participant's proportions appear to be skewing this data (Participant #12, Pre-test = .070; Post-test = .319). This participant engaged in a lengthy personal example about the utilization of congregational members in acquiring social support. This lengthy personal disclosure was relevant to the scenario and to the interaction with the actor, therefore, even though it skewed the data, it nonetheless seemed a relevant intervention fitting into the spirit of the training the participant received. When this participant's data is excluded from the analysis, the results show a decrease between pre-assessment use (M = .072, SD = .052) and post-assessment (M = .061, SD = .046); t (10) = .652, p = .529; d = .23. This finding is more consistent with supporting hypothesis two and the instruction during the workshop to place focus on the other person during lay counseling interactions.

This response pattern invites an interesting question about personal "testimony" or "witnessing" as an evangelistic effort. Indeed, the vignettes given to the actors describe a recent visitor to the participant's local congregation. This scenario was designed to explain the lack of on-going personal relationship between actor and participant. However, many participants took this as an opportunity to encourage the actor to join their congregation or they provided evidence for the benefits of identifying with a local body of worship.

Anecdotally, the actors and present research assistant reported an increase in this behavior at the post-test sessions. One individual reported that participants appeared to be engaging in "sales pitches" designed to encourage the actor to attend their congregation again soon. For example, Participant #2 arrived at the post-test session under the impression that this

would be a second visitation with the same individual as the pre-test. Therefore, she arrived with a prepared "presentation" and with a pamphlet containing a 2-month schedule of inspirational Biblical passages, prepared scriptures for their discussion, and a church bulletin from the previous Sunday worship. This participant continued to utilize these materials despite learning that the second interaction was a separate scenario with another "individual."

Many other participants also followed this pattern of providing a higher proportion of information in their post-test session. Category 10 from the HSS is titled "Information" and can include information about the process of helping, facts data, or opinions, or feedback about the client. Many units from each participant's transcripts fell into this category. In fact, also observed was a change in Information pre-test assessment proportions (M = .310; SD = .144) to post-test assessment proportions (M = .385; SD = .130) with a medium effect size (d = .55). Another example of this finding would be Participant #11's post-assessment transcript. This participant provided substantially more Information during the post-test assessment (Participant #11, Pre-test = .385, 37 actual units; Post-test = .682, 116 actual units). Much of this Information was directly related to his local congregation and what the actor could expect from future worship services or congregational social gatherings.

While participants in this study may, or may not, identify with the use of phrases like "providing religious testimony" or "personal witnessing" regarding their observed behavior, the author believes these terms help to give greater context to these evangelistic behaviors. Personal evangelism is a highly valued trait in many religious congregations (e.g., American Baptist Churches, 2018; Jehovah's Witnesses, 2018; Matthew 28:19-20, NASB; United Methodist Church, 2016) and the giving of personal testimony/witnessing has been studied in only a small number of studies (Bennacer, 2008; Kline, 2011; Moon, 2018; Pui Shum Ip, 2013; Trammell,

2015). Furthermore, there does not appear to be any literature related to the use of personal evangelism, testimony, or witnessing and the use of lay counselors. The participants in this study all highly value their faith and involvement in local congregations; therefore, it also makes sense that they would affirm these factors as being important to holistic well-being and feel compelled to share this through Information or self-disclosure as a means of helping to alleviate distress in the actors during the pre-test/post-test assessments. This finding, and possible explanation, was unpredicted and surprising to the author and research team.

Hypothesis Three (H_3): *The participants' overall number of words in an interaction with a "visitee" will decrease at post-assessment following a Christian lay counseling training method designed for smaller, rural congregations.*

Hill and colleagues (2008) discussed the relationship between learning active listening skills and talking less during interactions. Their study found that a sample of undergraduate students in a "helping skills" course had a much lower proportion of words spoken by the participants (Pre-test: M = .280, SD = .11; Post-test: M = .200, SD = .10) compared to participants in the current study. It is unclear whether different characteristics of the participants in Hill and colleagues' study had any bearing on Hill's results. Their participants interacted with other participants from the course, taking turns being actors and participants. Their population was regular college students pursuing undergraduate education in "helping skills," much younger in age (M = 21.64; SD = 2.31), who interacted with each other for several months as part of the course.

The current study found that only three participants spoke a lower proportion of words at post-test assessment. Additionally, seven participants had a proportion greater than .700 of words spoken during the post-assessment. This finding is likely linked to the previous discussion of

providing more Information. Another explanation could be linked to increased comfort level with the process of being videotaped during a simulated social interaction at the post-test assessment. It was obvious when watching pre-test assessments that several participants were very uncomfortable with the process and/or being on camera. A third explanation could be timing of pre-test assessments (Friday evenings 5:00-7:00 p.m. during initial workshop hours) and post-test assessments (Saturday morning 9:00 a.m.-12:00 p.m. the following week). Participants could have been experiencing greater level of cognitive energy on a Saturday morning when compared to a Friday evening, resulting in more energetic responses during the post-test assessment.

Whereas there was some support for the increase of approval and reassurance statements and reflections of feeling and the decrease of closed-ended questions and direct guidance, nothing reached the required level of statistical significance. However, when one considers differences between pre- and post-assessments for individual participants, there is evidence for increases in approvals and reassurances for seven participants, reflections of feelings for eight participants, and decreases in closed-ended questions for eight participants, direct guidance for seven participants, and self-disclosures for five participants (see Tables 1-8 in Chapter 4).

These differences may show that a short training workshop may be effective for learning basic listening and responding skills for some individuals, whereas others may need more training than the 10-hour Uplift workshop provided. The study's results, for example, show that five individuals (e.g., Participants #2, #4, #6, #7, and #9) demonstrated consistent growth across multiple categories and suggest that more research is needed to determine the effectiveness of short teaching interventions for lay helpers.

General Considerations

One of the major considerations for this research project was the utilization of community volunteers who were invested in learning more visitation skills to use within their respective Christian congregations. All of the participants were in middle to late adulthood (M = 58.67; SD = 7.29). Much of the research on beginning trainees in helping skills is completed on college campuses with traditional-aged (18-25 years old) undergraduate and/or graduate students (Bloom, McNeil, Flasch, & Sanders, 2018; Hill et al., 2008; Hill et al., 2016; Kuntze, van der Molen, & Born, 2009). Therefore, this project hopes to add to the literature based upon the demographic variable of age alone; however, this variable engenders additional considerations. Adult learners in education, including helping skills education, often require different approaches to learning. Chen (2017) described the fact that adult learners frequently enter learning spaces with significantly more lived experience, often accompanied by strong opinions, established perspectives, and interaction styles. Adult learning styles of this study's participants likely impacted the level of integration of microskills following the training due to these factors.

Additionally, participants' backgrounds and lived experience likely impacted how information was integrated. For instance, several participants came from education, health care, or military vocational backgrounds. These vocational backgrounds likely led to participants having foundational knowledge in establishing and maintaining personal relationships that influence how one might engage in the visitation process. Interestingly, several participants who engaged in higher levels of providing Information (Category #10) had educational backgrounds. Therefore, it seems that foundational knowledge from years in a career in education, for example, would greatly influence how significantly a single weekend of training could re-write decades of interactional styles. While it was not a purpose of this research study to evaluate the

impact of career backgrounds upon utilization of microskills, this anecdotal evidence can likely spur on new research.

Finally, the participants of this study demonstrated consistency in personality characteristics. Due to the nature of the recruitment method and targeted population, participants were much more likely to be very religious, actively engaged in a community of faith, share a desire for learning, and be socially oriented. While certainly not measured in the course of this study, because of their interest in the training offered, and their self-selection as participants in this study, participants likely had higher levels of agreeableness, which is a common trait among skilled therapists (Branson & Shafran, 2015).

The goal of this training and research project was to establish the impact of having a short-term training on microskills for lay counselors in Christian congregations. The purpose of this design was to increase access to trainings to provide some increase in skill level, while not requiring 6-month- or 12-month-long trainings that are generally too expensive for smaller, rural congregations. However, there is likely a balance that can exist between a weekend seminar and much longer trainings to find the sufficient increase in learning of skills. While no research has been done using the same evaluation method (Hill's HSS; Hill, 2014), it is likely that participants who engage in 6 months of microskill training are likely to demonstrate higher levels of improvement. Therefore, it is possible that a 4-week-long series of in-person trainings, a 3-month self-studying Bible class curriculum, or a 12-week online video course would also provide viable design options for rural, small Christian congregations to implement visitation skill learning.

Finally, this study was designed to better understand the feasibility of briefly training individuals who identify with rural, underserved areas. There is a need to consider training "locals to care for locals" for the work of building stronger rural communities. Research has

substantiated the value of this claim across several fields of study, including the distrust of "outsider professionals" in Appalachian substance use treatment (Moody, Satterwhite, & Bickel, 2017), medical schools recruiting from rural areas to train those interested in returning to rural areas (Grobler et al., 2009), high quality teacher education programs recruiting pre-service teachers from rural areas who are more likely to provide long-term service to rural schools (Azano & Stewart, 2015), and the nationwide policy recommendation that rural communities be assisted in selecting and training professionals locally, while also providing incentives and adequate infrastructure to maintain clinical practice as a means of improving access to appropriate health care (Ellis, Konrad, Thomas, & Morrissey, 2009; Strasser & Neusy, 2010).

Therefore, this program employed lay counselors similar to programs in other parts of the world. Two relevant examples include the Feather Carriers of the First Nations (Danard, 2016; Feather Carriers; Wise Practices) and Dr. Dixon Chibanda's Friendship Benches of Zimbabwe (Chibanda et al., 2016; Chibanda et al., 2017; Nuwer, 2018). Both approaches utilize local sources of support from empathic, invested, local individuals with minimal, but specific training to serve those in need. The First Nation Feather Carriers is a "life promotion program for First Nations, Métis, and Inuit individuals and families who are at risk for premature death, as well as supporting loss survivors" (Feather Carriers). This program, initiated by Dr. Ed Conners, John Rice, and Dr. Debby Wilson Danard, utilizes "community mobilization to focus on promoting life at the community level through training frontline workers, individuals with lived experience as peer mentors, manager, directors, and support staff" (Feather Carriers). Similarly, the Friendship Benches of Zimbabwe is a program developed by one of the country's only psychiatrists, Dr. Dixon Chibanda, to combat the extreme lack of social support services in the smaller communities. He utilized training local compassionate "grandmothers" to sit on benches

in the town center to provide an empathetic ear to those struggling with mental health issues. The desire for rural communities to be capable of sustaining their own mental health networks is a primary goal for evaluating the acceptability and effectiveness of lay counseling programs. The ability for rural practitioners to enlist the support of lay counselors for their clientele in an extended model of mental health care could be a very valuable resource in many areas.

Limitations and Directions for Future Research

As with all research, there are limitations associated with both the study's design and execution. This study's research design was confirmatory in nature and its support is drawn from research identifying a developmental perspective on training in microskills for beginning counselors (Hill, 2014; Ivey et al., 2018). The purpose of this study was to utilize a system often used with counselors in training to evaluate lay counselors from rural, Christian congregations on microskill usage following a brief workshop.

Due to the resources available and to the method chosen to evaluate these microskills, the sample size was designed to meet the needs of the current project and kept intentionally small. As with all small, geographically limited studies, the findings are not intended to be generalizable, but to provide a greater depth of knowledge to a relatively unstudied topic. This principle is especially true when considering how diverse rural America (Hamilton et al., 2008) and Christian congregations (Dougherty & Huyser, 2008; Yancey & Kim, 2008) can be. While diversity of Christian congregations, race/ethnicity, gender, and age were pursued, the sample for this project remained mostly homogeneous. Participants represented three Christian denominations: Church of Christ (41.67%), Maronite Catholic (16.67%), and United Methodist Church (41.67%). The participants were all in middle to late adulthood (M = 58.67; SD = 7.29). Participants were primarily homogenous with regards to self-identified identity: White (83.34%)

and non-White (16.67%). This limitation, however, remains representative of the geographical area of study.

Another limitation of the current study was the sample being gathered from two separate workshops. The need for a second workshop arose when the initial workshop alone did not secure enough participants for the study. Even though the workshop presenter made every effort to teach the same prescribed material in both workshops, examples of material and participant discussion varied during each of the workshops. A similar limitation was the use of two separate actors between workshop one and workshop two. Both actors were given similar training and the identical scenario information. However, actors' personalities and background knowledge may have had unmeasured effects upon the study.

A final limitation observed in this study was the use of two separate vignettes in which the participants engaged with actors as the "initial meeting" with the pretend visitor to their church. It is likely that sessions and microskill usage would have looked quite different when interacting with (a) someone they knew as an acquaintance, (b) a friend, or (c) a stranger. As relationships deepen, the need for information seeking (e.g., closed-ended questions) and the providing information likely declines across sessions.

To better understand the relationship between counselor training and lay counselor training, future research should seek to evaluate the outcomes of other lay counselor training programs. This study focused exclusively on behavioral counts of participant verbal responses. Future research should include measuring the self-efficacy of lay counselors and the perceived helpfulness of lay counselors by those whom they counsel. These factors could also be evaluated prior to and following a similar training. Self-efficacy has been linked to the comfort with using

trained skills and ability to naturally engage in supportive relationships (Barnes, 2004; Lent, Hill, & Hoffman, 2003; Urbani et al., 2002).

Future researchers should consider evaluating preferred proportions of certain microskills for various session types and for various counselor and/or lay counselor skill levels. For example, perhaps it is natural or more acceptable for lay counselors to engage in self-disclosure to establish rapport and to demonstrate similarity (e.g., disclosure of sobriety/struggles with addition in AA/NA groups). In rural, Christian congregations, it may be more acceptable for lay counselors to express concerns toward religious teachings or wavering of faith compared to priests, clergy, ministers, or other religious leaders. Therefore, more literature is needed to evaluate the usage of microskills regarding skill level and the role of individuals providing support.

Next, future research should attempt to establish how the lay counselor model of support can continue to effectively be implemented in any number of isolated, underserved settings and with succinct, effective, and cost-effective training. The examples of the First Nation Feather Carriers (Danard, 2016; Feather Carriers; Wise Practices) and Zimbabwe's Friendship Benches (Chibanda et al., 2016; Chibanda et al., 2017; Nuwer, 2018) serve as valuable models that can be further evaluated to substantiate their validity and effectiveness.

Finally, it is recommended that, if similar trainings are to be initiated, their effectiveness continues to be evaluated according to standard research principles. This investigation seeks to answer the call put forth by Tan and Scalise (2016) regarding the lack of rigorous research in the field of Christian lay counseling. This study fills gaps in the literature between training graduate-level counselors, training lay counselors, and mental health work with religious congregations, while merging results with the needs of rural and underserved communities. However, there

continues to be a need for research that evaluates the effects of religion, spirituality, rurality, and lay counseling-type relationships upon community and individual functioning.

Recommendations and Conclusion

The existing literature demonstrates that spirituality and religion are important to a large segment of the general population and particularly so in rural areas. The literature supports the positive impact that spirituality and religion can have upon mental health, especially concerning the social involvement that many organized religions can provide. The use of lay counselors has been shown to be an effective means of providing support in situations or settings where professional assistance is unattainable, unwelcome, or culturally ineffective. Therefore, this study hoped to show the need for, and the effectiveness of, a collaboration between mental health practitioners and rural congregations of faith to increase the effectiveness of lay counselors involved in visitation programs through a brief training workshop.

This study evaluated video transcripts from participant and actor interactions prior to, and following, a weekend workshop teaching counseling microskills to non-professional counselors (Hill, 2014; Ivey et al., 2018). The evaluation process involved coding these transcripts according to Hill's (2014) Helping Skills System (HSS) of verbal responses and measuring the changes in HSS categories from pre-test to post-test. The author predicted that the brief intervention would increase the proportion of participants' positive counseling microskills (e.g., approval and encouragement statements, open-ended questions, restatements, reflections of feeling), decrease less-helpful counseling microskills (e.g., closed-ended questions, self-disclosure, direct guidance), and reduce the proportion of sentences spoken between participant and actors. Results of the study indicate a greater level of success with reducing the less-helpful counseling microskills than either increasing positive counseling microskills or reducing the

amount of time speaking in this sample of Christian lay counselors following the described microskill workshop.

In conclusion, the author would like to offer recommendations for the application of this research. Initially, there is a cultural necessity to consider the role of lay counselors in many parts of this country and the world. The author would caution mental health providers against an elitist mentality that says an individual should pursue a graduate degree in a helping profession to provide encouragement and support to individuals in need, particularly when the need is so great. The purpose behind training lay counselors should be to effectively equip individuals already invested in a geographic area, institution (e.g., congregations), or people (e.g., First Nation youth) to provide a greater number of individuals with needed support and often with a more readily culturally acceptable form of assistance. As leaders, mental health professionals should view training community stakeholders in these skills as a professional and community-building responsibility. The author also encourages therapists to become more proactive in supporting and developing ongoing lay counselor efforts.

Finally, the author would like to echo continued calls for mental health providers to collaborate more successfully with religious helpers (Kitchen et al., 2018; Smith et al., 2018; Tan & Scalise, 2016). This outcome requires participation by both willing partners; however, professional mental health clinicians and researchers can pursue inclusion and seek collaboration with clergy and other local religious leaders in efforts to promote healthier communities. This need is especially evident in rural areas where religion and spirituality are frequently important aspects of community life. The author's experiences of collaborating with Christian congregations demonstrate the possibility to "build bridges"; it involves building relationships with gatekeepers (e.g., pastors, elders, ministers, clergy). The existing body of research suggests

that as mental health providers, religious leaders, and religious congregations continue to work together, the yield to individuals and communities can be meaningful and fruitful.

References

Abernethy, A. D., Grannum, G. D., Gordon, C. L., Williamson, R., & Currier, J. M. (2016). The Pastors Empowerment Program: A resilience education intervention to prevent clergy burnout. *Spirituality in Clinical Practice, 3*(3), 175.

Adkison-Bradley, C., Johnson, D., Sanders, J., Duncan, L., & Holcomb-McCoy, C. (2005). Forging a collaborative relationship between the black church and the counseling profession. *Counseling and Values, 49*(1), 147-154.

Advancing Suicide Prevention. (2005). *Suicide the second-leading cause of death in states with primarily rural populations.* [Press release]. Retrieved from http://advancingsp.org/Press_Release_8_11_05.pdf

Agorastos, A., Demiralay, C., & Huber, C. G. (2014). Influence of religious aspects and personal beliefs on psychological behavior: Focus on anxiety disorders. *Psychology Research and Behavior Management, 7*, 93.

Akbar, N. (1995). *The community of self* (Rev. ed.). Tallahassee, FL: Mind Productions & Associates.

Alang, S. M. (2015). Sociodemographic disparities associated with perceived causes of unmet need for mental health care. *Psychiatric Rehabilitation Journal, 38*(4), 293-299.

Alcoholics Anonymous. (2016, April). Estimates of A.A. groups and members as of January 1, 2016. Retrieved from http://www.aa.org/assets/en_US/smf-53_en.pdf

American Baptist Churches USA. (2018). Evangelism. Retrieved from http://www.abc-usa.org/about-us/evangelism/

Anderson, L. (2009). Pastoral care and the spiritual formation of older persons. *Journal of Religion, Spirituality, and Aging*, 21, 104-118.

Arcury, T. A., Preisser, J. S., Gesler, W. M., & Powers, J. M. (2005). Access to transportation and health care utilization in a rural region. *Journal of Rural Health, 21*(1), 31-38.

Arcury, T. A., Gesler, W. M., Preisser, J. S., Sherman, J., Spencer, J., & Perin, J. (2005). The effects of geography and spatial behavior on health care utilization among the residents of a rural region. *Health Services Research, 40*(1), 135-156. doi:10.1111/j.1475-6773.2005.00346.x

Armi, F., Guilley, E., & Lalive d'Epinay, C. J. (2008). The interface between formal and information support in advanced old age: A ten-year study. *International Journal of Aging and Later Life, 3*(1), 5-19.

Armstrong, J., & McLeod, J. (2003). Research into the organization, training, and effectiveness of counsellors who work for free. *Counselling and Psychotherapy Research, 3*(4), 255-259.

Assari, S. (2013). Race and ethnicity, religion involvement, church-based social support and subjective health in United States: A case of moderated mediation. *International Journal of Preventive Medicine, 4*(2).

Auld, F., & White, A. M. (1956). Rules for dividing interviews into sentences. *The Journal of Psychology, 42*(2), 273-281. doi:10.1080/00223980.1956.9713040

Azano, A. P., & Stewart, T. T. (2015). Exploring place and practicing justice: Preparing pre-service teachers for success in rural schools. *Journal of Research in Rural Education (Online), 30*(9), 1.

Baker, S., Scofield, M., Munson, W., & Clayton, L. (1983). Comparative effects of teaching basic counseling competencies through brief microskills practice versus mental practice. *Counselor Education and Supervision, 23*(1), 71-82.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*, 842-852. http://dx.doi.org/10.1037/0022-006X.75.6.842

Barbery, H. L., & Kew, C. E. (1949). The nature and function of a church clinic. *Journal of Pastoral Care, 3*(1), 17-25.

Barker, A. R., Londeree, J. K., McBride, T. D., Kemper, L. M., & Mueller, K. (2013). The uninsured and geography. RUPRI Center for Rural Health Policy Analysis, Rural Health Research & Policy Center. Iowa City, IA. Brief 2013-6.

Bartels, S. J., & Naslund, J. A. (2013). The underside of the silver tsunami—older adults and mental health care. *New England Journal of Medicine*, *368*(6), 493-496.

Bartkowski, J. P., & Wilcox, W. B. (2000). Conservative Protestant child discipline: The case of parental yelling. *Social Forces, 79,* 265-290.

Barnes, K. L. (2004). Applying self-efficacy theory to counselor training and supervision: A comparison of two approaches. *Counselor Education and Supervision, 44*(1), 56-69.

Basic Attending Skills, 5th edition [Video file]. (2017). Microtraining Associates. Retrieved June 16, 2017, from Academic Video Online: Premium.

Beckner, C. E. (2014). *Counseling experiences and counselee satisfaction with church-based lay counseling services* (3645724) (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (3645724)

Bergman, R. L. (1974). Paraprofessionals in Indian mental health programs. *Psychiatric Annals, 4*, 76-84.

Berry, A. A., Katras, M. J., Sano, Y., Lee, J., & Bauer, J. W. (2008). Job volatility of rural, low-income mothers: A mixed methods approach. *Journal of Family and Economic Issues, 29*(1), 5-22.

Beutler, L. E., Clarkin, J., Crago, M., & Bergan, J. (1991). Client-therapist matching. *Pergamon general psychology series, 162*, 699-716.

Bilkins, B., Allen, A., Davey, M. P., & Davey, A. (2016). Black church leaders' attitudes about mental health services: Role of racial discrimination. *Contemporary Family Therapy, 38*(2), 184-197.

Bischoff, R. J., Reisbig, A. M., Springer, P. R., Schultz, S., Robinson, W. D., & Olson, M. (2014). Succeeding in rural mental health practice: Being sensitive to culture by fitting in and collaborating. *Contemporary Family Therapy*, *36*(1), 1-16. doi:10.1007/s10591-013-9287-x

Bissonette, R. (1977a). The bartender as a mental health service gatekeeper: A role analysis. *Community Mental Health Journal, 13*, 92-99.

Bissonette, R. (1977b). The mental health gatekeeper role: A paradigm for conceptual pretest. *International Journal of Social Psychiatry, 23*, 31-34.

Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the Black church in the South. *American Journal of Public Health, 92*(10), 1668-1672. doi:10.2105/ajph.92.10.1668

Bloom, Z. D., McNeil, V. A., Flasch, P., & Sanders, F. (2018). A Comparison of Empathy and Sympathy Between Counselors-in-Training and Their Non-Counseling Academic Peers. *Professional Counselor*, *8*(4).Boan, D. M., & Owens, T. (1985). Peer ratings of lay

counselor skill as related to client satisfaction. *Journal of Psychology and Christianity, 4*(1), 79-81.

Boyd-Franklin, N. (1989). Five key factors in the treatment of Black families. *Journal of Psychotherapy & the Family*, *6*(1-2), 53-69.

Branson, A., & Shafran, R. (2015). Therapist characteristics and their effect on training outcomes: What counts? *Behavioural & Cognitive Psychotherapy*, *43*(3), 374.

Brown, A. E., Whitney, S. N., Schneider, M. A., & Vega, C. P. (2006). Alcohol recovery and spirituality: Strangers, friends, or partners? *Southern Medical Journal*, *99*(6), 654-657.

Brown, S. D., & Lent, R. W. (Eds.). (2008). *Handbook of counseling psychology*. John Wiley & Sons.

Brown, W. F. (1974) Effectiveness of paraprofessionals: The evidence. *Personnel & Guidance Journal, 53,* 257-263.

Brown-Guion, S. Y., Youngerman, S. M., Hernandez-Tejada, M. A., Dismuke, C.E., & Egede L. E. (2013). Racial/ethnic, regional, and rural/urban differences in receipt of diabetes education. *Diabetes Education, 39*(3), 327-334.

Burnett, J. A., & Panchal, K. (2008). Incorporating ideological context in counseling couples experiencing infertility. *The Journal of Humanistic Counseling, Education and Development*, *47*(2), 187-199.

Büssing, A., Michalsen, A., Balzat, H. J., Grünther, R. A., Ostermann, T., Neugebauer, E. A., & Matthiessen, P. F. (2009). Are spirituality and religiosity resources for patients with chronic pain conditions? *Pain Medicine, 10*(2), 327-339.

Buzza, C., Ono, S. S., Turvey, C., Wittrock, S., Noble, M., Reddy, G., … Reisinger, H. S. (2011). Distance is relative: Unpacking a principal barrier in rural healthcare. *Journal of General Internal Medicine, 26*(S2), 648-654. doi:10.1007/s11606-011-1762-1

Caldwell, C. H., Greene, A. D., & Billingsley, A. (1994). Family support programs in Black churches: A new look at old functions. ln S. L. Kagan & B. Weissbourd (Eds.), *Putting families first: America's family support movement and the challenge of change* (pp. 137-160). San Francisco, CA: Jossey-Bass/ Pfeiffer.

Campbell, M. K., Hudson, M. A., Resnicow, K., Blakeney, N., Paxton, A., & Baskin, M. (2007). Church-based health promotion interventions: Evidence and lessons learned. *Annual Review Public Health, 28*, 213-234.

Cantor, M. H. (1979). Neighbours and friends, an overlooked resource in the informal support system. *Research on Aging, 1*(4), 434-463.

Carkhuff, R. R. (1972). The development of systematic human resource development models. *The Counseling Psychologist, 3*(3), 4-11.

Carlson, R. G., Sexton, R., Wang, J., Falck, R., Leukefeld, C. G., & Booth, B. M. (2010). Predictors of substance abuse treatment entry among rural illicit stimulant users in Ohio, Arkansas, and Kentucky. *Substance Abuse, 31*(1), 1.

Carney, P. A., O'Malley, J., Buckley, D. I., Mori, M., Lieberman, D. A., Fagnan, L. J., … Morris, C. (2012). Influence of health insurance coverage on breast, cervical, and colorectal cancer screening in rural primary care settings. *Cancer, 118*(24), 6217-6225. doi:10.1002/cncr.27635

Caxaj, C. S. (2016). A review of mental health approaches for rural communities: Complexities and opportunities in the Canadian context. *Canadian Journal of Community Mental Health*, *35*(1), 29-45.

Centers for Disease Control and Prevention. (2004). Access to health-care and preventive services among Hispanics and non-Hispanics -- United States, 2001-2002. *JAMA*, *292*(19), 2331-2333.

Centers for Medicare & Medicaid Services. (2007). *SMDL #07-011*. Retrieved from Centers for Medicare & Medicaid Services website: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf

Chatters, L. M., Taylor, R. J., Lincoln, K. D., & Schroepfer, T. (2002). Patterns of informal support from family and church members among African Americans. *Journal of Black Studies*, *33*(1), 66-85.

Chen, J. C. (2017). Nontraditional adult learners: The neglected diversity in postsecondary education. *SAGE Open*, *7*(1).

Chen, Y., & VanderWeele, T. J. (2018). Associations of religious upbringing with subsequent health and well-being from adolescence to young adulthood: An outcome-wide analysis. *American Journal of Epidemiology*, *187*(11), 2355-2364.

Chibanda, D., Verhey, R., Munetsi, E., Cowan, F. M., & Lund, C. (2016). Using a theory driven approach to develop and evaluate a complex mental health intervention: the Friendship bench project in Zimbabwe. *International Journal of Mental Health Systems*, *10*(1), 16.

Chibanda, D., Cowan, F., Verhey, R., Machando, D., Abas, M., & Lund, C. (2017). Lay health workers' experience of delivering a problem solving therapy intervention for common

mental disorders among people living with HIV: A qualitative study from Zimbabwe. *Community Mental Health Journal, 53*(2), 143-153.

Chinman, M., Salzer, M., & O'Brien-Mazza, D. (2012). National survey on implementation of peer specialists in the VA: Implications for training and facilitation. *Psychiatric Rehabilitation Journal, 35,* 470-473. http://dx.doi.org/10.1037/h0094582

Christensen, A., & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*(1), 8-14.

Clinton, T., & Sibcy, G. (2012). Christian counseling, interpersonal neurobiology, and the future. *Journal of Psychology and Theology, 40*(2), 141-145.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20*(1), 37-46.

Collins, A. H. (1973). Natural delivery systems: Accessible sources of power for mental health. *American Journal of Orthopsychiatry, 43,* 46-52.

Collins, G. R. (1980). *Christian counseling: A comprehensive guide*. Waco, Texas: Word Books.

Collins, G. R. (1986). *Innovative approaches to counseling* (pp. 73). Waco, Texas: Word Books.

Collins, G. R. (2007). *Christian counseling: A comprehensive guide*. Nelson Reference & Electronic Publishing.

Constantine, M. G., Lewis, E. L., Conner, L. C., & Sanchez, D. (2000). Addressing spiritual and religious issues in counseling African Americans: Implications for counselor training and practice. *Counseling and Values, 45,* 28-38.

Cowen, E. L. (1982). Help is where you find it: Four informal helping groups. *American Psychologist, 37,* 385-395.

Crabb, L. J. (1999). *The safest place on earth.* Nashville, TN: Word Publishing.

Crabb, L. J., & Allender, D. (1984). *Encouragement: The key to caring.* Grand Rapids, MI: Zondervan.

Cremins, J. (2002). The rift between religion and psychotherapy: Can it be healed? *Journal of Pastoral Counseling, 37*(10).

Crosby, J. W., & Varela, J. G. (2014). Preferences for religious help-seeking: Racial and gender differences, interfaith tolerance, and defensive theology. *Mental Health, Religion & Culture, 17(*2), 196-209.

D'Augelli, A. R., & Ehrlich, R. P. (1982). Evaluation of a community-based system for training natural helpers. II. Effects on information helping activities. *American Journal of Community Psychology, 10*(4), 447-456.

dan Boer, P. C., Wiersma, D., Russo, S., & Van den Bosch, R. J. (2005). Paraprofessionals for anxiety and depressive disorders: A meta-analysis. *Cochrane Database of Systematic Reviews*, (2), 47-90. doi:10.1002/14651858.cd004688.pub2

Danard, D. D. (2016). *Medicine wheel surviving suicide-strengthening life bundle* (Doctoral dissertation).

Daschiff, C., DiMicco, W., Myers, B., & Sheppard, K. (2009). Poverty and adolescent mental health. *Journal of Child & Adolescent Psychiatric Nursing, 22*, 23-32.

D'Augelli, A. R., & Vallance, T. R. (1981). The helping community: Promoting mental health in rural areas through informal helping. *Journal of Rural Community Psychology, 2*, 3-16.

Davey, A., & Patsios, D. (1999). Formal and informal community care to older adults: Comparative analysis of the United States and Great Britain. *Journal of Family and Economic Issues, 20*(3), 271-299.

Deen, T. L., & Bridges, A. J. (2011). Depression literacy: Rates and relation to perceived need and mental health service utilization in a rural American sample. *Rural and Remote Health*, *11*, 1-13.

DeKraai, M. B., Bulling, D. J., Shank, N. C., & Tomkins, A. J. (2011). Faith-based organizations in a system of behavioral health care. *Journal of Psychology and Theology*, *39*(3), 255-267.

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*, 642-649.

Dewing, S., Mathews, C., Cloete, A., Schaay, N., Simbayi, L., & Louw, J. (2014). Lay counselors' ability to deliver counseling for behavior change. *Journal of Consulting and Clinical Psychology*, *82*(1), 19-29. doi:10.1037/a0034659

Dinger, U., Strack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology, 64*, 344-354. http://dx.doi.org/10.1002/jclp. 20443

Dollahite, D. C., & Marks, L. D. (2009). A conceptual model of family and religious processes in highly religious families. *Review of Religious Research,* 373-391.

Dominguez, A. W., & McMinn, M. R. (2003). Collaboration through research: The multimethod church-based assessment process. *Journal of Psychology and Christianity, 21*, 333-337.

Dougherty, K. D., & Huyser, K. R. (2008). Racially diverse congregations: Organizational identity and the accommodation of differences. *Journal for the Scientific Study of Religion, 47*(1), 23-44.

Dumas, B. K. (1999). Southern Mountain English: The language of the Ozarks and Southern Appalachia. *The Workings of Language: From Prescriptions to Perspectives, 67*.

Dunn, A. B., & Dawes, S. J. (1999). Spirituality-focused genograms: Keys to uncovering spiritual resources in African American families. *Journal of Multicultural Counseling and Development, 27*(4), 240.

Durlak, J. A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin, 86*(1), 80-92. doi:10.1037/0033-2909.86.1.80

Eberhardt, M., Ingram, D., & Makuc, D. (2001). Urban and rural health chartbook. *Health United States, 2001*. Hyattsville, MD: National Center for Health Statistics.

Elliott, R., Hill, C. E., Stiles, W. B., Friedlander, M. L., Mahrer, A. R., & Margison, F. R. (1987). Primary therapist response modes: Comparison of six rating systems. *Journal of Consulting and Clinical Psychology, 55*, 218-223. doi:10.1037/0022-006X.55.2.218

Eng, E., Hatch, J., & Callan, A. C. (1985). Institutionalizing social support through the church and into the community. *Health, Education, & Behavior, 12*, 81-92.

Eng, E., Parker, E., & Harlan, C. (1997). Lay health advisor intervention strategies: A continuum from natural helping to paraprofessional helping. *Health Education & Behavior, 24*(4), 413-417.

Eng, E., Rhodes, S. D., & Parker, E. (2009). Natural helper models to enhance a community's health and competence. In R. J. Di Clemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research* (2nd ed., pp. 303-330). San Francisco, CA: Jossey-Bass.

Entwistle, D. N. (2009). A holistic psychology of persons: Implications for theory and practice. *Journal of Psychology and Christianity, 28*(2), 141-148.

Eriksen, K., Marston, G., & Korte, T. (2002). Working with God: Managing conservative Christian beliefs that may interfere with counseling. *Counseling and Values, 47,* 48-68.

Esposito, J. F. (2009). Student actors as mock-clients: Authentic learning for human services students. *Human Service Education, 29*(1).

Eugene, T. M. (1995). There is a balm in Gilead: Black women and the Black church as agents of a therapeutic community. *Women and Therapy, 16*, 55-71.

Farmer, J., Bourke, L., Taylor, J., Marley, J. V., Reid, J., Bracksley, S., & Johnson, N. (2012). Culture and rural health. *Australian Journal of Rural Health*, *20*(5), 243-247.

Feather Carriers. (n.d.). *Training at a glance.* Retrieved from https://www.feathercarriers.com/training-at-a-glance/

Fifield, A. O., & Oliver, K. J. (2016). Enhancing the perceived competence and training of rural mental health practitioners. *Journal of Rural Mental Health*, *40*(1), 77-83.

Fischer, E. P., McSweeney, J. C., Wright, P., Cheney, A., Curran, G. M., Henderson, K., & Fortney, J. C. (2016). Overcoming barriers to sustained engagement in mental health care: Perspectives of rural veterans and providers. *The Journal of Rural Health*, *32*(4), 429-438.

Fisher, J. T., & Hawley, L. S. (1951). *A few buttons missing: The case book of a psychiatrist*. New York, NY: Lippincott Co.

Fitzpatrick, S. J., Perkins, D., Luland, T., Brown, D., & Corvan, E. (2017). The effect of context in rural mental health care: Understanding integrated services in a small town. *Health & Place*, *45*, 70-76.

Fordyce, W. E. (1988). Pain and suffering: A reappraisal. *American Psychologist*, *43*(4), 276. doi:10.1037//0003-066X.43.4.276

Fortney, J., Rost, K., & Warren, J. (1998). A joint choice model of the decision to seek depression treatment and choice of provider sector. *Medical Care, 36*(3), 307-320.

Fox, J., Berman, J., Blank, M., & Rovnyak, V. (1999). Mental disorders and help seeking in a rural impoverished population. *International Journal Psychiatry in Medicine, 29*(2), 181-195.

Fox, J., Merwin, E., & Blank, M. (1995). De Facto mental health services in the rural South. *Journal of Health Care for the Poor and Underserved, 6*, 434-468.

Frame, M. W., Williams, C. B., & Green, E. L. (1999). Balm in Gilead: Spiritual dimensions in counseling African American women. *Journal of Multicultural Counseling and Development, 27*(4), 182.

Frazee, R. (2001). *The connecting church: Beyond small groups to authentic community.* Grand Rapids, MI: Zondervan.

Freshour, J. S., Amspoker, A. B., Yi, M., Kunik, M. E., Wilson, N., Kraus-Schuman, C., … Stanley, M. (2016). Cognitive behavior therapy for late-life generalized anxiety disorder delivered by lay and expert providers has lasting benefits. *International Journal of Geriatric Psychiatry, 31*(11), 1225-1232. doi:10.1002/gps.4431

Gallagher, M., Tracey, A., & Milar, R. (2005). Ex-clients' evaluation of bereavement counseling in a voluntary sector agency. *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 59-76.

Gallo, J. J., Marino, D. F., & Anthony, J. C. (1995). Filters on the pathway to mental health care, II: Socio-demographic factors. *Psychological Medicine, 25*, 1149-1160.

Gamm, L. D., Stone, S., & Pittman, S. (2003). Mental health and mental disorders—A rural challenge. In L. D. Gamm, L. L. Hutchison, B. J. Dabney, & A. M. Dorsey (Eds.), *Rural*

healthy people 2010: A companion document to healthy people 2010. Volume 1. College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.

Gannon, B. N., & Stacciarini, J. M. R. (2016). Review of the literature: A rural-urban comparison of social networks of older adults living with HIV. *Journal of the Association of Nurses in AIDS Care*, *27*, 419-429.

Gardiner, C., McLeod, J., Hill, I., & Wigglesworth, A. (2003). A feasibility study of the systematic evaluation of client outcomes in a voluntary sector counseling agency. *Counselling and Psychotherapy Research*, *3*(4), 285-289.

Garrett, M. T., & Wilbur, M. P. (1999). Does the worm live in the ground? Reflections on Native American spirituality. *Journal of Multicultural Counseling and Development*, *27*, 193-206.

Garzon, F., & Tilley, K. A. (2009). Do lay Christian counseling approaches work? What we currently know. *Journal of Psychology & Christianity*, *28*(2), 130-140.

Garzon, F., Worthington, E. L., Jr., Tan, S. Y., & Worthington, R. (2009). Lay Christian counseling and client expectations for integration in therapy. *Journal of Psychology & Christianity*, *28*(2), 113-120.

Georges, A., Alterman, T., Gabbard, S., Grzywacz, J. G., Shen, R., Nakamoto, J., … Muntaner, C. (2013). Depression, social factors, and farmworker health care utilization. *The Journal of Rural Health*, *29*(s1), s7-s16. doi:10.1111/jrh.12008

Getrich, C., Heying, S., Willging, C., & Waitzkin, H. (2007). An ethnography of clinic "noise" in a community-based, *promotora*-centered mental health intervention. *Social Science & Medicine, 65,* 319-330. http://dx.doi.org/10.1016/j.socscimed.2007.03.004

Ginsberg, L. H. (1998). Introduction: An overview of rural social work. In L. H. Ginsberg (Ed.), *Social work in rural communities*. Alexandria, VA: Council on Social Work Education.

Gordon, J. E. (1974). The development of paraprofessionals in employment work. *Personnel and Guidance Journal, 53,* 289-293.

Goreham, G. (2008). *Encyclopedia of rural America: The land and people*. Millerton, NY: Grey House Pub.

Gregory, C., II, Pomerantz, A. M., Pettibone, J. C., & Segrist, D. J. (2008). The effect of psychologists' disclosure of personal religious background on prospective clients. *Mental Health, Religion & Culture, 11,* 369-373.

Griffith, J. L., & Griffith, M. E. (2002). Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives. New York, NY: Guilford Press.

Griffiths, K. M., Christensen, H., & Jorm, A. F. (2009). Mental health literacy as a function of remoteness of residence: An Australian national study. *BMC Public Health, 9,* 92.

Grobler, L., Marais, B. J., Mabunda, S. A., Marindi, P. N., Reuter, H., & Volmink, J. (2009). Interventions for increasing the proportion of health professionals practising in rural and other underserved areas. *Cochrane Database Syst Rev, 1*(1).

Guinee, J. P., & Tracey, T. J. G. (1997). Effects of religiosity and problem type on counselor description ratings. *Journal of Counseling and Development, 76,* 65-73.

Gwet, K. L. (2012). *Handbook of inter-rater reliability: The definitive guide to measuring the extent of agreement among multiple raters*. Advanced Analytics, LLC.

Haas, J. S., Phillips, K. A., Sonneborn, D., McCulloch, C. E., Baker, L. C., Kaplan, C. P., … Liang, S. (2004). Variation in access to health care for different racial/ethnic groups by

the racial/ethnic composition of an individual's county of residence. *Medical Care, 42*(7), 707-714. doi:10.1097/01.mlr.0000129906.95881.83

Hamilton, L. C., Hamilton, L. R., Duncan, C. M., & Colocousis, C. R. (2008). *Place matters: Challenges and opportunities in four rural Americas.* Durham, NH: Carsey Institute, University of New Hampshire.

Harowski, K., Turner, A. L., LeVine, E., Schank, J. A., & Leichter, J. (2006). From our community to yours: Rural best perspectives on psychology practice, training, and advocacy. *Professional Psychology: Research and Practice, 37*(2), 158-164.

Harris, J. (1985). Non-professionals as effective helpers for pastoral counselors. *Journal of Pastoral Care, 39*(2), 165-172.

Hasty, J. D. (2012). *This might could help us better understand syntactic variation: The double modal construction in Tennessee English* (Doctoral dissertation). Michigan State University, Linguistics.

Hatch, J., & Derthick, S. (1992). Empowering Black churches for health promotion. *Health Values: The Journal of Health Behavior, Education & Promotion, 16*(5), 3-9.

Hauenstein, E. J., Petterson, S., Rovnyak, V., Merwin, E., Heise, B., & Wagner, D. (2007). Rurality and mental health treatment. *Administration and Policy in Mental Health and Mental Health Services Research, 34*(3), 255-267. doi:10.1007/s10488-006-0105-8

Haugk, K. (2000a). *Stephen Ministry training manual*, Volume 1. St. Louis, MO: Stephen Ministry.

Hays, K., & Lincoln, K. D. (2017). Mental health help-seeking profiles among African Americans: Exploring the influence of religion. *Race and Social Problems, 9*(2), 127-138.

Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process.* Needham Heights, MA: Allyn & Bacon.

Hess, S. A., Knox, S., & Hill, C. E. (2006). Teaching graduate trainees how to manage client anger: A comparison of three types of training. *Psychotherapy Research, 16*(3), 282-292. doi:10.1080/10503300500264838

Hill, C. E. (1978). Development of a counselor verbal response category. *Journal of Counseling Psychology*, *25*(5), 461.

Hill, C. E. (1986). An overview of the Hill counselor and client verbal response modes category system. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook.* (pp. 131-159). New York, NY: Guilford Press.

Hill, C. E. (2014). *Helping skills: Facilitating exploration, insight, and action* (4th ed.). Washington, DC: American Psychological Association.

Hill, C. E., Anderson, T., Kline, K., McClintock, A., Cranston, S., McCarrick, S., ... & Gupta, S. (2016). Helping skills training for undergraduate students: Who should we select and train? *The Counseling Psychologist*, *44*(1), 50-77.

Hill, C. E., Roffman, M., Stahl, J., Friedman, S., Hummel, A., & Wallace, C. (2008). Helping skills training for undergraduates: Outcomes and prediction of outcomes. *Journal of Counseling Psychology*, *55*(3), 359.

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, M. E., Jr., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour*, *30*(1), 51-77.

Hines, P. M., & Boyd-Franklin, N. (1996). African American families. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 66-84). New York, NY: Guildford Press.

Hogg, C., & Warne, T. (2010). Ordinary people, extraordinary voices: The emotional labour of lay people caring for and about people with a mental health problem. *International Journal of Mental Health Nursing*, 19(5), 297-306.

Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D.J., II, Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66*, 46-72.

Hovey, J. D., Hurtado, G., Morales, L. R., & Seligman, L. D. (2014). Religion-based emotional social support mediates the relationship between intrinsic religiosity and mental health. *Archives of Suicide Research, 18*(4), 376-391.

Hoyt, D. R., Conger, R. D., Valde, J. G., & Weihs, K. (1997). Psychological distress and help seeking in rural America. *American Journal of Community Psychology, 25*(4), 449-470.

Human, J., & Wasem, C. (1991). Rural mental health in America. *American Psychologist, 46*(3), 232-239.

Hunter, A., & Riger, S. (1986). The meaning of community in community mental health. *Journal of Community Psychology, 14*, 55-71.

Ivey, A., Ivey, M., & Zalaquett, C. (2018). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (9th ed.). Pacific Grove, CA: Brooks Cole.

Jameson, J. P., & Blank, M. B. (2007). The role of clinical psychology in rural mental health services: Defining problems and developing solutions. *Clinical Psychology: Science and Practice*, *14*(3), 283-298.

Jehovah's Witnesses. (2018). Why Jehovah's Witnesses go from door to door | faq. Retrieved from https://www.jw.org/en/jehovahs-witnesses/faq/door-to-door/

Jernigan, R., Tan, S. Y., & Gorsuch, R. L. (1988, November). *The effectiveness of a local church lay Christian counselor training program: A controlled study*. Paper presented at International Congress on Christian Counseling, Lay Counseling Track, Atlanta, GA.

Johnsson, K. O., & Berglund, M. (2003). Education of key personnel in student pubs leads to a decrease in alcohol consumption among the patrons: A randomized controlled trial. *Addiction, 98*(5), 627-633.

Karenga, M. (1988). Black studies and the problematic of paradigm: The philosophical dimension. *Journal of Black Studies, 18*(4), 395-414.

Kelley, P., & Kelley, V. R. (1985). Supporting natural helpers: A cross-cultural study. *Social Casework,* 66, 358-366.

Kellogg Foundation. (2002). *Perceptions of rural America*. Battle Creek, MI: Kellogg Foundation.

Kerley, K. R., Matthews, T. L., & Shoemaker, J. (2009). A simple plan, a simple faith: Chaplains and lay ministers in Mississippi prisons. *Review of Religious Research*, 87-103.

Kimpara, S., Brunet, H., Beutler, L. E., & Alsante, J. (2016). Client, therapist, and treatment variables: Client-therapist "matching". *The Oxford handbook of treatment processes and outcomes in psychology: A multidisciplinary, biopsychosocial approach*, 157.

King, M., Speck, P., & Thomas, A. (1999). The effect of spiritual beliefs on outcome from illness. *Social Science and Medicine, 48,* 1291-1299.

Kitchen Andren, K. A., & McKibbin, C. L. (2018). Rural clergy and geriatric depression: Predictors of providing counseling versus referring to mental health providers. *Professional Psychology: Research and Practice, 49*(2), 107-115.

Kline, S. L. (2011). Communicating spirituality in healthcare: A case study on the role of identity in religious health testimonies. *Journal of Applied Communication Research, 39*(4), 334-351.

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research, 15*(3), 287-303.

Koenig, H. G, Larson, D. B., & Larson, S. S. (2001). Religion and coping with serious medical illness. *Annals of Pharmacotherapy, 35*(2), 352-359.

Koenig, H. G. (2004). Religion, spirituality, and medicine: Research findings and implications for clinical practice. *Southern Medical Journal, 97*, 1194-1200.

Koenig, H. G. (2008). Concerns about measuring "spirituality" in research. *The Journal of Nervous and Mental Disease, 196*(5), 349-355.

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *The Canadian Journal of Psychiatry, 54*(5), 283-291.

Krause, N. (2015). Trust in God and psychological distress: Exploring variations by religious affiliation. *Mental Health, Religion & Culture, 18*(4), 235-245.

Kuntze, J., van der Molen, H. T., & Born, M. P. (2009). Increase in counselling communication skills after basic and advanced microskills training. *British Journal of Educational Psychology, 79*(1), 175-188.

Lampropoulos, G. K., & Spengler, P. M. (2005). Helping and change without traditional therapy: Commonalities and opportunities. *Counselling Psychology Quarterly*, *18*(1), 47-59. doi:10.1080/09515070500099629

Landis, J. R., & Koch, G. G. (1977). An application of hierarchical kappa-type statistics in the assessment of majority agreement among multiple observers. *Biometrics*, 363-374.

Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the Counselor Activity Self-Efficacy Scales. *Journal of Counseling Psychology*, *50*(1), 97.

Lukens, H. C. (1983). Training paraprofessional Christian counselors: A model proposed. *Journal of Psychology and Christianity*, *2*(3), 61-66.

Mack-Tatum, D. R. (2013). Developing a congregational care model: Mount Olive Baptist Church. (Doctoral Dissertation) Liberty University.

Maddux, J. E., Brawley, L., & Boykin, A. (1995). Self-efficacy and health behavior: Prevention, promotion, and detection. In J. E. Maddux (Ed.), *Self-efficacy, adaption, adjustment, theory, research, and application*. New York, NY: Plenum.

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*, 317-327.

McCullough, M. E., & Worthington, E. L., Jr. (1995). College students' perceptions of a psychotherapist's treatment of a religious issue: Partial replication and extension. *Journal of Counseling & Development*, 73, 626-634.

McKim, B. J., & Weissberg, R. P. (1981). Bartenders as informal, interpersonal help-agents. *American Journal of Community Psychology*, *9*, 715-729.

McRae, M. B., Thompson, S. C., & Cooper, S. (1999). Black churches as therapeutic groups. *Journal of Multicultural Counseling and Development, 27*, 207-211.

Messeri, P., Silverstein, M., & Litwak, E. (1993). Choosing optimal support groups: A review and reformulation. *Journal of Health & Social Behavior*, *34*(2), 122-137.

Mitchell, J. R., & Baker, M. C. (2000). Religious commitment and the construal of sources of help for emotional problems. *British Journal of Medical Psychology, 73*, 289-301.

Mohatt, D. F., Bradley, M. M., Adams, S. J., & Morris, C. D. (2006). Mental health and rural America: 1994-2005. *Washington, DC: United States Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy*.

Mojtabai, R., Olfson, M., & Mechanic, D. (2002). Perceived need and helpseeking in adults with mood, anxiety, or substance use disorders. *Archives of General Psychiatry, 59*(1), 77-84.

Moody, L. N., Satterwhite, E., & Bickel, W. K. (2017). Substance use in rural Central Appalachia: Current status and treatment considerations. *Journal of Rural Mental Health*, *41*(2), 123.

Moore, S. (2006). Voluntary sector counselling: Has inadequate research resulted in a misunderstood and underutilized resource? *Counselling and Psychotherapy Research, 6*(4), 221-226.

Morrow, D., Worthington, E. L., & McCullough, M. E. (1993). Observers' perceptions of a counselor's treatment of a religious issue. *Journal of Counseling and Development, 71*, 452-456.

Morton, B., & Joseph, Z. (1971). The prevention of family violence: Dilemmas of community intervention. *Journal of Marriage and the Family, 33*, 677-682.

Nagel, J., Newlin, M., & Cimbloic, P. (1988). Efficacy of elderly and adolescent volunteer counselors in a nursing home setting. *Journal of Counseling Psychology*, *35*(1), 81-86.

Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *76*(4), 686-694. doi:10.1037/0022-006x.76.4.686

New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America: Final report (DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S Department of Health and Human Services.

Nuwer, R. (2018, October 16). How a bench and a team of grandmothers can tackle depression. Retrieved from http://www.bbc.com/future/story/20181015-how-one-bench-and-a-team-of-grandmothers-can-beat-depression?

O'Brien, M. J., Squires, A. P., Bixby, R. A., & Larson, S. C. (2009). Role development of community health workers: An examination of selection and training processes in the intervention literature. *American Journal of Preventive Medicine, 37,* S262-S269. http://dx.doi.org/10.1016/j.amepre.2009.08.011

Packard, T. (2009). Core values that distinguish counseling psychology: Personal and professional perspectives. *The Counseling Psychologist, 37*(4), 610-624. doi:10.1177/0011000009333986

Parr, H., Philo, C., & Burns, N. (2004). Social geographies of rural mental health: Experiencing inclusions and exclusions. *Transactions of the Institute of British Geographers*, *29*(4), 401-419.

Patsios, D., & Davey, A. (2005). *Formal and informal community care for older adults*. Cambridge University Press.

Perkins, P. R. (2007). Pastoral teams and congregational health in smaller churches.

Peterson, J., Atwood, J. R., & Yates, B. (2002). Key elements for church-based health promotion programs: Outcome-based literature review. *Public Health Nursing, 19*(6), 401-411.

Petterson, S., Williams, I. C., Hauenstein, E. J., Rovnyak, V., & Merwin, E. (2009). Race and ethnicity and rural mental health treatment. *Journal of Health Care for the Poor & Underserved, 20*(3), 662-677.

Pew Research Center. (2017). *Religion in America: Religious Landscape Survey*. Washington, DC. Accessed March 15, 2017. http://www.pewforum.org/religious-landscape-study/

Philo, C., Parr, H., & Burns, N. (2003). Rural madness: A geographical reading and critique of the rural mental health literature. *Journal of Rural Studies*, *19*(3), 259-281.

Pierce, N. F. (1980). *Preference for pastoral counseling roles as perceived by male and female adults.* Paper presented at the annual meeting of the southeastern psychology association, March 26-29, 1980, Washington, DC.

Pillay, Y., Gibson, S., Lu, H. T., & Fulton, B. (2018). The experiences of north-central rural Appalachian clients who utilize mental health services. *Journal of Rural Mental Health*, *42*(3-4), 196-204.

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology*, *65*(2), 131-146.

Potgieter, S. D. (2015). Communities: Development of church-based counselling teams. *HTS Theological Studies*, *71*(2), 1-8.

Rek, I., & Dinger, U. (2016). Who sits behind the telephone? Interpersonal characteristics of volunteer counselors in telephone emergency services. *Journal of Counseling Psychology*, *63*(4), 429.

Richards, P. S., & Bergin, A. E. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.

Roach, A. M., & Resnick, H. (1981). Training bartenders as helpers on a college campus. *Personnel and Guidance Journal, 60,* 119-121.

Rost K., Smith G. R., & Taylor J. L. (1993). Rural-urban differences in stigma and the use of care for depressive disorders. *Journal of Rural Health, 9*(1), 57-62.

Rost, K., Fortney, J., Fischer, E., & Smith, J. (2002). Use, quality, and outcomes of care for mental health: The rural perspective. *Medical Care Research and Review, 59*(3), 231-265.

Rote, S., Hill, T. D., & Ellison, C. G. (2013). Religious attendance and loneliness in later life. *The Gerontologist*, *53*(1), 39-50.

Rushing, N. C., Corsentino, E., Hames, J. L., Sachs-Ericsson, N., & Steffens, D. C. (2013). The relationship of religious involvement indicators and social support to current and past suicidality among depressed older adults. *Aging & Mental Health*, *17*(3), 366-374.

Sbanotto, E. A. N., Gingrich, H. D., & Gingrich, F. C. (2016). *Skills for effective counseling: A faith-based integration*. InterVarsity Press.

Schank, J. A., & Skovholt, T. M. (2006). *Ethical practice in small communities.* Washington, DC: American Psychological Association.

Schlosser, L. Z., Foley, P. F., Stein, E. P., & Holmwood, J. R. (2010). Why does counseling psychology exclude religion? A content analysis and methodological critique. In J. G.

Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (3rd ed., pp. 453-465). Thousand Oaks, CA: Sage Publications, Inc.

Schoenberg, N. E., Hatcher, J., Dignan, M. B., Shelton, B., Wright, S., & Dollarhide, K. F. (2009). Faith moves mountains: An Appalachian cervical cancer prevention program. *American Journal of Health Behavior, 33*(6), 627-638.

Scott, G., & Lovell, R. (2015). The rural pastors initiative: Addressing isolation and burnout in rural ministry. *Pastoral Psychology*, *64*(1), 71-97.

Scott, R. B. (2001). Increasing assimilation and decreasing attrition through the development of a lay ministry and congregational care program. (Doctoral Dissertation) Asbury Seminary.

Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5-14. doi:10.1037/0003-066X.56.1.89

Sherman, A. L. (2004). *Restorers of hope: Reaching the poor in your community with church-based ministries that work*. Wipf and Stock Publishers.

Shi, L., Lebrun-Harris, L. A., Daly, C. A., Sharma, R., Sripipatana, A., Hayashi, A. S., & Ngo-Metzger, Q. (2013). Reducing disparities in access to primary care and patient satisfaction with care: the role of health centers. *Journal of Health Care for the Poor and Underserved, 24*(1), 56-66.

Slama, K. (2004). *Rural culture is a diversity issue*. Retrieved from American Psychological Association website: http://www.apa.org/practice/programs/rural/rural-culture.pdf

Smith, A. E., Riding-Malon, R., Aspelmeier, J. E., & Leake, V. (2018). A qualitative investigation into bridging the gap between religion and the helping professions to improve rural mental health. *Journal of Rural Mental Health*, *42*(1), 32.

Smith, T. W, Marsden, P., Hout, M., & Kim, J. General Social Surveys, 1972-2016. Sponsored by National Science Foundation. -NORC ed.- Chicago: NORC at the University of Chicago. Data accessed from the GSS Data Explorer website at gssdataexplorer.norc.org

Stanley, S. M., Markman, H. J., Prado, L. M., Olmos-Gallo, P. A., Tonelli, L., St. Peters, M. …Whitton, S.W. (2001). Community-based premarital prevention: Clergy and lay leaders on the front lines. *Family Relations, 50*(1), 67-76.

Stone, H. W. (1994). *Brief pastoral counseling: Short-term approaches and strategies.* Minneapolis, MN: Augsburg Fortress.

Strasser, R., & Neusy, A. J. (2010). Context counts: Training health workers in and for rural and remote areas. *Bulletin of the World Health Organization, 88,* 777-782.

Sue, D. W. & Sue, D. (1999). *Counseling the culturally different* (3rd ed.). New York, NY: Wiley.

Sue, S. (1994). "Mental Health." In Zane, N. W. S., Takeuchi, D. T., and Young, K. N. J.. (Eds.), *Confronting Critical Health Issues of Asian and Pacific Islander Americans* (pp. 266–88). Thousand Oaks, Calif.: Sage

Sullivan, G., Jackson, C. A., & Spritzer, K. L. (1996). Characteristics and service use of seriously mentally ill persons living in rural areas. *Psychiatric Services, 47*(1), 57-61.

Sussman, L. K., Robins, L. N., & Earls, F. (1987). Treatment-seeking for depression by Black and White Americans. *Social Science Medicine, 24,* 187-196.

Sweeten, G. R. (1987). Lay helpers and the caring community. *Journal of Psychology and Christianity, 6*(2), 14-20.

Tan, S. Y. (2011). *Counseling and psychotherapy: A Christian perspective*. Grand Rapids, MI: Baker Publishing Group.

Tan, S. T., & Sarff, P. (1988, November). *Comprehensive evaluation of a lay counselor training program in a local church*. Paper presented at International Congress on Christian Counseling, Lay Counseling Track, Atlanta, GA.

Tan, S. Y. (1998). Increasing care through lay counseling. *Enrichment Journal*. Retrieved from http://enrichmentjournal.ag.org/199804/092_counseling.cfm

Tan, S. Y. (2013). Lay counselor training. In R. K. Sanders (Ed.), *Christian counseling ethics: A handbook for psychologists, therapists and pastors* (2nd ed., pp. 382-396). Downers Grove, IL: Inter Varsity Press.

Tan, S. Y., & Scalise, E. T. (2016). *Lay counseling: Equipping Christians for a helping ministry* (Rev.). Grand Rapids, MI: Zondervan.

Tang, T. S., Funnell, M. M., Gillard, M., Nwankwo, R., & Heisler, M. (2011). Training peers to provide ongoing diabetes self-management support (DSMS): Results from a pilot study. *Patient Education and Counseling, 85,* 160-168. http://dx.doi.org/10.1016/j.pec.2010.12.013

Tarakeshwar, N., & Pargament, K. I. (2001). Religious coping in families of children with autism. *Focus on Autism and Other Developmental Disabilities, 16*(4), 247-260.

Taylor, R. J. (1986). Religious participation among elderly Blacks. *Gerontologist, 26,* 630-636.

Taylor, R. J., Chatters, L. M., & Brown, R. K. (2014). African American religious participation. *Review of Religious Research, 56*(4), 513-538.

Taylor, R. J., Chatters, L. M., Lincoln, K. D., & Woodward, A. T. (2017). Church-based exchanges of informal social support among African Americans. *Race and Social Problems, 9*(1), 53-62.

Taylor, R. J., Chatters, L. M., Woodward, A. T., & Brown, E. (2013). Racial and ethnic differences in extended family, friendship, fictive kin, and congregational informal support networks. *Family Relations*, *62*(4), 609-624.

Terry, J. D., Smith, A. R., Warren, P. R., Miller, M. E., McQuillin, S. D., Wolfer, T. A., & Weist, M. D. (2015). Incorporating evidence-based practices into faith-based organization service programs. *Journal of Psychology and Theology*, *43*(3), 212-223.

Thomas, J., & Zaitzow, B. H. (2006). Conning or conversion? The role of religion in prison coping. *The Prison Journal*, *86*(2), 242-259.

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services*, *60*(10), 1323-1328.

Thurston, N. S. (2000). Psychotherapy with evangelical and fundamentalist Protestants. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 131-154). Washington, DC: American Psychological Association.

Tinsley, H. E., & Weiss, D. J. (1975). Interrater reliability and agreement of subjective judgments. *Journal of Counseling Psychology*, *22*(4), 358.

Toh, Y. M., & Tan, S. Y. (1997). The effectiveness of church-based lay counselors: A controlled outcome study. *Journal of Psychology and Christianity*, *16*(3), 260-267.

Tracy, G. S., & Gussow, Z. (1976). Self-help groups: A grassroots response to a need for services. *Journal of Applied Behavioral Science, 12*, 381-396.

Travis, S. S. (1995). Families and formal networks. In R. Blieszner & V. H. Bedford (Eds.), *Handbook of aging and the family* (pp. 459-473). Westport, CT: Greenwood Press.

United Methodist Church. (2016). Your ministry of evangelism. Retrieved from https://www.umcdiscipleship.org/resources/your-ministry-of-evangelism

Urbani, S., Smith, M. R., Maddux, C. D., Smaby, M. H., Torres-Rivera, E., & Crews, J. (2002). Skills-based training and counseling self-efficacy. *Counselor Education and Supervision, 42*(2), 92-106.

U.S. Census Bureau. (2015, April 9). 2010 Census Urban and Rural Classification and Urban Area Criteria. Washington, DC: U.S. Government Printing Office. https://www.census.gov/geo/reference/ua/urban-rural-2010.html

Utsey, S. O., Adams, E. P., & Bolden, M. (2000). Development and initial validation of the Africultural Coping Systems Inventory. *Journal of Black Psychology, 26,* 194-215.

VanderWeele, T. J., Jackson, J. W., & Li, S. (2016). Causal inference and longitudinal data: A case study of religion and mental health. *Social Psychiatry and Psychiatric Epidemiology, 51*(11), 1457-1466.

Wagenfeld, M. O., Murray, J. D., Mohatt, D., & DeBruyn, J. C. (1994). *Mental health and rural America: 1980-1993.* Washington, DC: U.S. Government Printing Office.

Wagenfeld, M. O. (2003). A snapshot of rural and frontier America. In B. H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide* (pp. 33-40). Washington, DC: American Psychological Association. doi:10.1037/10489-002

Waites, C., Kaiser, A., & Martin, F. (2014). Health promotion for African American elders: Church is the likely place. In Vakalahi, H. F. O., Simpson, G. M., & Giunta, N. (Eds.). *The collective Spirit of aging across cultures* (Vol. 9) (pp. 191-205). Netherlands: Springer Science & Business Media.

Waitzkin, H., Getrich, C., Heying, S., Rodríguez, L., Parmar, A., Willging, C., . . . Santos, R. (2011). Promotoras as mental health practitioners in primary care: A multi-method study of an intervention to address contextual sources of depression. *Journal of Community Health, 36,* 316-331. http://dx.doi.org/10.1007/s10900-010-9313-y

Walker, D. F., Gorsuch, R. L., & Tan, S. Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and Values, 49*(1), 69-80.

Walker, R., Tomlinson, M., & Williams, G. (2010). The problem with poverty: Definition, measurement and interpretation. In G. Walford, E. Tucker, & M. Viswanathan (Eds.), *The Sage handbook of measurement: How social scientists generate, modify, and validate indicators and scales* (pp. 353–376). London, England: Sage.

Weld, C., & Eriksen, K. (2007). The ethics of prayer in counseling. *Counseling and Values*, *51*(2), 125-138.

Weller, S. C., Berges, I., Dallo, F., DiNuzzo, A., & Lackan, N. (2006). Social support: A cultural model. *Human Organization*, *65*(4), 420-429.

Whitehead, B. (2018). Religiousness on mental health in older adults: The mediating role of social support and healthy behaviours. *Mental Health, Religion & Culture*, *21*(4), 429-441.

Wise Practices. (n.d.). *Feather Carriers - Leadership for Life Promotion.* Retrieved from https://wisepractices.ca/practices/feather-carriers/

Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry*, *39*(6), 514-521. doi:10.1111/j.1440-1614.2005.01612.x

Yancey, G., & Kim, Y. J. (2008). Racial diversity, gender equality, and SES diversity in Christian congregations: Exploring the connections of racism, sexism, and classism in multiracial and nonmultiracial churches. *Journal for the Scientific Study of Religion*, (1), 103.

Yoon, D. P., & Lee, E. K. O. (2006). The impact of religiousness, spirituality, and social support on psychological well-being among older adults in rural areas. *Journal of Gerontological Social Work*, *48*(3-4), 281-298.

Yoshikawa, H., Aber, J. L., & Beardslee, W. R. (2012). The effects of poverty on the mental, emotional, and behavioral health of children and youth: Implications for prevention. *American Psychologist*, *67*(4), 272.

Young, C. S., & Young, J. S. (2014). *Integrating spirituality and religion into counseling: A guide to competent practice*. John Wiley & Sons.

Zarle, T. H., Hartsough, D. M., & Ottinger, D. R. (1974). Tornado recovery: The development of a professional-paraprofessional response to a disaster. *Journal of Community Psychology*, *2*, 311-320.

Zeph, C. P. (2000). The spiritual dimensions of lay ministry programs. *New Directions for Adult & Continuing Education*, (85), 77.

Zuroff, D. C., Kelly, A. C., Leybman, M. J., Blatt, S. J., & Wampold, B. E. (2010). Between-therapist and within-therapist differences in the quality of the therapeutic relationship: Effects on maladjustment and self-critical perfectionism. *Journal of Clinical Psychology*, *66*, 681-697. http://dx.doi.org/10.1002/jclp.20683

APPENDIX A

Informed Consent Form

Psychology Department

RADFORD UNIVERSITY

CHBS 5108
P.O. Box 6946
Radford, VA 24142

(540) 831-5361
FAX (540) 831-6113

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Consent for Participation in Interview Research

Title of Research: Lay Counselors' Growth Utilizing Video Assessment

Researcher(s): Ruth Riding-Malon, Ph.D., Licensed Psychologist
Jeremiah Burkhart, M.S., Doctoral Student

I volunteer to participate in a research project conducted by Radford University researchers: Dr. Ruth Riding-Malon and her research team. I understand that this project is designed to gather information about non-professionals learning & demonstrating active listening skills.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation in the study at any time without penalty. If I decline to participate or withdraw from the study, no one in my community will be told.

2. I understand that most participants will find the exercise interesting and thought provoking. If, however, I feel uncomfortable in any way during either of the demonstration sessions, I have the right to discontinue the exercise and request my material not be included in the data analysis.

3. Participation involves being filmed by Radford University researchers while providing visitation to a client (an actor) prior to training offered by Dublin United Methodist Church on visitation skills. Following the training, I will be encouraged to attend another session where I will be filmed during a similar interaction. Each interaction will last approximately 20-30 minutes. A video recording of the interactions will be made and coded to measure any differences between videos made before and after training on visitation skills. Video recordings will be used only for research purposes by the investigator and her associates.

   Please sign below if you are willing to allow us to record the interaction using an audio/visual recording.

_____

Participant Signature Date

4. I understand that the researcher will not identify me by name in any reports using information obtained from this interaction and that my confidentiality as a participant in this study will remain secure. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions.

5. There are no known risks to participation in this study, no more risk than in everyday life. The information gathered through this study is anticipated to enhance understanding of non-professionals learning active listening skills for the purpose of engaging in visitation ministries. It is our hope that through the information gathered in this study, psychologists and religious communities can work together to achieve greater collaboration and greater continuity of care in rural communities.

6. I understand that this study was approved by the Radford University Committee for the Review of Human Subjects Research. If I have questions or concerns about my rights as a research subject or have complaints about this study, I should contact Dr. Laura J. Jacobsen, Interim Dean, College of Graduate Studies and Research, Radford University, ljacobsen@radford.edu, (540) 831-5470.

7. I acknowledge that I am 18 years of age or older. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction and I voluntarily agree to participate in this study.

8. I have been given a copy of this consent form for my personal records.

_____

Participant Signature Date

_____ _____

Printed Participant Name Signature of Investigator

For further information about this study, please contact:

Dr. Ruth Riding-Malon, Primary Investigator
(540) 831-6892
rridingmalon@radford.edu

APPENDIX B

Letter of Support from Community Pastor

Dublin United Methodist Church
P.O. Box 577
GPS: 424 East Main Street
Dublin, VA 24084
Ph (540) 674-5128
www.dublinumc.com
email - office@dublinumc.com

Dear Institutional Review Board for Research Involving Human Subjects,

Allow me to introduce myself. I am Rev. Don Hanshew, the pastor of Dublin United Methodist Church. We are going to be offering a training for members of our congregation to learn active listening skills. The training is meant to give these individuals some of the skills needed to be effective visitation team members.

We have agreed to work closely with **Jeremiah Burkhart** who is being supervised by **Dr. Ruth Riding-Malon** on a research project designed to measure the effectiveness of active listening skills trainings. We have agreed to allow the researchers to randomly select 15 individuals to participate in pre- and post-training evaluations of their active listening skills by way of video recordings. **[IRB-462 "Lay Counselors' Growth Utilizing Video Assessment"]**

The researchers have my full support and we are pleased to be working on this project, which we hope to complete during the Summer and early Fall 2017.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Rev. Don Hanshew

Rev. Don Hanshew, Pastor

APPENDIX C

WEB FORM C
SAMPLE TRANSCRIPT

Instructions: Type everything except minimal utterances (e.g., "okay," "you know," "er," "uh"). Use slashes (/) to divide helper statements into response units (i.e., grammatical sentences—every sentence must include a subject and verb; see Web Form F. While watching the videotape of the session, code your intentions using the Intentions List (Web Form D); code helping skills using the Helping Skills System (Web Form E); you and the client rate helpfulness on a 9-point scale (1 = hindering, 5 = neutral, 9 = very helpful); the client codes reactions according to the Client Reactions System (Web Form G).

Helper: "Thank you for coming in./ Our session will hopefully only last about 20 minutes./ You can talk about whatever you'd like to talk about./ Everything will be confidential unless you mention any kind of child abuse or threaten to harm yourself or others./ I'm being supervised today./ Is that okay?/ My supervisor is behind the one-way mirror and is watching me./ And, oh yeah, I'm also taping the session so that I can listen to it later./ Do you have anything to talk about today?"/

Helper Intentions	Helper helping skills	Helper help rating	Client help rating	Client reactions	What would have been a better intervention?
1, 3	12, 10a, 10a, 10a, 10a, 2, 10a, 10a, 2	5	6	21	My name is Bertha./ Everything you say is confidential unless you reveal abuse or an intent to harm self or others./ Also, I'm taping the session and am being supervised from behind the window./ What would you like to talk about today?/ (8, 10a, 10a, 3)

Client: "I'm having a problem with my roommate. We don't seem to be getting along. She's a real slob and never cleans up her part of the room. She leaves dirty dishes all over. It's awful."

Helper: "So she's a slob and never cleans up."

Helper Intentions	Helper helping skills	Helper help rating	Client help rating	Client reactions	What would have been a better intervention?
6, 8	4	7	7	7	You sound angry at her./ (5)

Client: "I am so angry at her. I don't see why I got stuck with such a slob. I indicated on my preference form that I am very neat. We're just totally different people. And I feel like I don't know how to handle the situation when she gets nasty about me wanting to clean the room."

Helper: "Tell me more about how you feel./ Tell me about the last time she got nasty./ What would you like to do about all this?"/

Helper Intentions	Helper helping skills	Helper help rating	Client help rating	Client reactions	What would have been a better intervention?
2, 5	3b, 3a, 3d	5	4	19	Tell me more about what went on in the most recent conflict between the two of you./ (3a)

Client: "I would really like to move out. I want to have a roommate I can get along with."

Helper: "How would it feel to move out?/ Are you allowed to switch roommates?"/

Helper Intentions	Helper helping skills	Helper help rating	Client help rating	Client reactions	What would have been a better intervention?
12,2	3b, 2	5	4	19	You're really fed up with the situation and want out./ (5)

Intentions: 1 = set limits, 2 = get information, 3 = give information, 4 = support, 5 = focus, 6 = clarify, 7 = hope, 8 = catharsis, 9 = cognitions, 10 = behaviors, 11 = self-control, 12 = feelings, 13 = insight, 14 = change, 15 = reinforce change, 16 = resistance, 17 = challenge, 18 = relationship, 19 = helper needs. (See Web Form D)

Helping skills: 1 = approval/reassurance, 2 = closed question, 3a = open question about thoughts, 3b = open question about feelings, 3c = open question for insight, 3d = open question for action, 4 = restatement, 5 = reflections of feelings, 6 = challenge, 7 = interpretation, 8a = disclosure of feelings, 8b = disclosure of insight, 8c = disclosure of strategies, 9 = immediacy, 10a = information about the process of helping, 10b = facts, data, opinions, 10c = feedback about the client, 11a = process advisement, 11b = directives, 12 = other. (See Web Form E)

Helpfulness ratings: 1 = hindering, 5 = neutral, 9 = helpful.

Reactions: 1 = understood, 2 = supported, 3 = hopeful, 4 = relief, 5 = negative thoughts or behaviors, 6 = better self-understanding, 7 = clear, 8 = feelings, 9 = responsibility, 10 = unstuck, 11 = new perspective, 12 = educated, 13 = new ways to behave, 14 = challenged, 15 = scared, 16 = worse, 17 = stuck, 18 = lack of direction, 19 = confused, 20 = misunderstood, 21 = no reaction. (See Web Form G).

APPENDIX D

WEB FORM E
HELPING SKILLS SYSTEM

Introduction: The Helping Skills System (HSS) includes verbal helping skills, which refer to what helpers say during sessions to help clients. One (and only one) skill is judged as occurring in every grammatical sentence (a unit that includes at least a subject and a verb) of the helper's speech (instructions for dividing speech into grammatical sentences can be found in Web Form F). Note that this judgment is a description of the presence or absence of the helping skill, but it is not an indication of the intensity or quality of the helping skill. In this appendix, I present each skill and its definition followed by examples. Web Form F presents guidelines for using the HSS in research.

1. **Approval and Reassurance:** Provides emotional support, reassurance, encouragement, and reinforcement. It might indicate that the helper empathizes with or understands the client. It might suggest that what the client is feeling is normal or to be expected. It might imply sympathy or attempt to alleviate anxiety by minimizing the client's problems. It might imply approval of the client's behavior.

   Helper: "I'm concerned about you."

   Helper: "That's hard."

   Helper: "I understand what you're going through."

   Helper: "I can't believe he said that."

   Helper: "I think you did the right thing."

   Helper: "That's really good that you were able to speak up to him."

   Helper: "You're right."

2. **Closed Question:** Requests limited or specific information or data, usually a one- or two-word answer, a "yes" or "no," or a confirmation. Closed questions can be used to gain information, to ask a client to repeat, or to ask if the helper's intervention was accurate.

   Client: "I went away for the weekend."
   Helper: "Did you like it?"

   Client: "My husband thinks I'm too fat."
   Helper: "Do you think you're too fat?"

   Helper: "What did you say?"

   Helper: "Right?"

   Helper: "Does this fit for you?"

3. **Open Question:** Asks the client to clarify or to explore thoughts or feelings. The helper does not ask for specific information and does not purposely limit the nature of the client's response to a "yes" or "no" or a one- or two-word response, even though the client may respond that way. Note that open

questions can be phrased as directives as long as the intent is to facilitate clarification or exploration. Open question can be divided into four types:

a. *Open question about thoughts (these ask the client to clarify or explore thoughts; includes asking for examples)*

Helper: "What would you like to talk about today?"
Client: "Everything is awful right now."

Helper: "What kind of hassles are you experiencing?"
Client: "I've had a backache for days."

Helper: "Tell me your thoughts about that."
Client: "I just keep waking up tense all the time and not feeling good about life."

Helper: "Tell me about the last time this happened."

b. *Open question about feelings (these ask clients to clarify or explore feelings)*

Client: "I just can't seem to get my schoolwork done."
Helper: "I wonder how you're feeling about that."

Client: "My mother keeps yelling at me about everything."
Helper: "Tell me more about your feelings."

Client: "I get so angry at my boss."
Helper: "Tell me about the last time that happened."

Client: "I don't know how to respond when my boss criticizes me."
Helper: "What is a specific example of what he says, and how you respond?"

Client: "My sister got all the attention in the family."
Helper: "How does that make you feel?"

Client: "What should I talk about?"
Helper: "How are you feeling right now?"

c. *Open question for insight (these invite the client to think about deeper meanings for their thoughts, feelings, or behaviors)*

Client: "I just can't seem to talk to my boyfriend about our racial differences."
Helper: "What do you suppose is going on that makes it hard for you to talk with him?"

Client: "We've been married for 40 years, and it just seems that we don't have much to do with each other any more."
Helper: "What is your understanding about your lack of connection?"

Client: "My boss makes me so angry, and I just don't have time to deal with him now because I have to spend so much time taking care of my mother who's dying."
Helper: "What connection do you make between your anger at your boss and your mother

dying?"

d. *Open questions for action (these are aimed at helping the client explore action)*

Client: "We've been married for 40 years, and it just seems that we don't have much to do with each other any more."
Helper: "What kinds of things have you tried in the past to change this pattern?"

Client: "My boss makes me so angry, and I just don't have time to deal with him now because I have to spend so much time taking care of my mother who's dying."
Helper: "What would you like to do to fix the situation with your boss?"

Client: "Our house just went into foreclosure, and I lost my job, and I have four kids to feed."
Helper: "What resources have you discovered that might help you?"

4. **Restatement:** A simple repeating or rephrasing of the content or meaning of the client's statement(s) that typically contains fewer but similar words and is usually more concrete and clear than the client's statement. The restatement may be phrased either tentatively or as a direct statement. The restatement may be a paraphrase of either immediately preceding material or material from earlier in session or treatment.

Client: "My father thinks I should earn my own money."
Helper: "You're saying your father doesn't want to support you anymore."

Client: "Since I got into trouble, no one will talk to me."
Helper: "Everyone seems to be ignoring you."

Client: "I'm finally getting my life in order. I've been feeling good most of the time. My job is getting easier."
Helper: "Things are going well for you."

Client: (talks for a long time about his reactions to his parents aging)
Helper: "Your parents are not as able to take care of themselves as they get older, and you're wondering whether you should step in and start making some decisions for them."

Helper: "Last session you talked about your problems with anger and you wondered where it came from."

5. **Reflections of Feelings:** A *repeating* or rephrasing of the client's statements, including an explicit identification of the client's feelings. The feelings may have been stated by the client (in either exactly the same words or in similar words) or the helper may infer the feelings from the client's nonverbal behavior, the context, or the content of the client's message. The reflection may be phrased either tentatively or as a statement.

Client: "I did better than I've done before."
Helper: "You're pleased with your performance."

Client: "My best friend went out with my boyfriend."
Helper: "You feel hurt that she did that?"

Client: "I don't know if I could handle this problem by myself. It feels like it's too much for me right now."
Helper: "You feel uncertain of yourself and overwhelmed by this problem."

6. **Challenge:** Points out *discrepancies,* contradictions, defenses, or irrational beliefs the client is unaware of, unable to deal with, or unwilling to change. Challenges can be said with either a tentative or confrontational tone.

Client: "I know Jannelle really likes me."
Helper: "From what you've said, she seems to be hostile to you and maybe even jealous. That doesn't sound to me like she likes you."

Client: "I feel so worthless. Nothing's going right. I'd be better off dropping out of school."
Helper: "You did poorly on one test, so you want to drop out of school?"

Client: "I don't have any problems. Everything in my life is going really well right now."
Helper: "You say everything is going well, but you keep getting sick. I wonder if it's difficult for you to look at your situation?"

Client: "If I don't get into graduate school, I *couldn't* stand it. It would mean the end of everything."
Helper: "I doubt that you *couldn't* stand it. I wonder how you might <u>really</u> react?"

7. **Interpretation:** Goes *beyond* what the client has overtly stated or recognized and gives a new meaning, reason, or explanation for behaviors, thoughts, or feelings so the client can see problems in a new way. Makes connections between seemingly isolated statements or events; points out themes or patterns in the client's behavior or feelings; explicates defenses, resistances, or transferences; gives a new framework to behaviors, thoughts, feelings, or problems.

Client: "I'm doing badly in school. I just can't seem to study. Another problem is that my husband and I have been arguing constantly."
Helper: "Perhaps you're unable to concentrate in school because you're preoccupied with the problems with your husband."

Client: "I can't seem to get close to anyone."
Helper: "Since your father died, you have had a hard time trusting anyone. Maybe you're afraid that if you get close to someone, she or he will die."

Client: "I have just been incredibly mean and nasty to everyone this week."
Helper: "I wonder if you use your anger as a protection to keep you from getting too close to anyone."

Client: "He never does anything around the house, just goes out drinking with the guys. I get stuck taking care of the kids and all the housework."
Helper: "He seems to be saving you from any decision about what you are going to do with your life and your career."

8. **Disclosure:** *Reveals* something personal about the helper's nonimmediate experiences or feelings.

These statements typically start with an "I." However, not all helper statements that start with an "I" are self-disclosures (e.g., "I can understand that" or "I don't know" are not self-disclosures). There are four types of self-disclosures:

a. *Disclosure of feelings (a statement about a feeling that the helper had in a similar situation as the client)*

Client: "I just don't really know how I feel."
Helper: "When I have been in your situation, I felt angry when someone stood me up."

Client: "I've got to meet his mother tomorrow. I've never met any boyfriend's mother."
Helper: "If I were you, I would feel nervous about meeting his mother."

Client: "I get so anxious at parties that I just don't want to go to any."
Helper: "I have a hard time at parties, too. I never know what to say to strangers."

b. *Disclosure of insight (a statement about an experience in which the helper gained insight)*

Client: "I am stuck about why I have so much difficulty speaking in public."
Helper: "I have pondered that for myself and discovered that I am most anxious with public speaking when I am feeling down and unsure of myself in general, which makes me worry about what others think of me."

Client: "I've got to meet his mother tomorrow. I've never met any boyfriend's mother, and I'm feeling almost paralyzed with anxiety."
Helper: "When I was in a similar situation, I realized that I was projecting my negative feelings about my mother onto his mother."

Client: "I get so anxious at parties that I just don't want to go to any."
Helper: "I have a hard time at parties, too. I just never know what to say to strangers."

c. *Disclosure of strategies (a statement about strategies that have worked for the helped in the past)*

Client: "I just don't know how to get a job in the department."
Helper: "One strategy that I tried when I was your age was to go and talk to all the professors about their interests, and then if I liked the professor I asked if she or he had any openings for assistants."

Client: "I have difficulty figuring out how to eat right."
Helper: "One thing that has worked for me was to go to a nutritionist and talk about diets."

9. Immediacy: Discloses helper's immediate feelings about self in relation to the client, about the client, or about the therapeutic relationship.

Client: "Everything has been going great in helping."
Helper: "It's interesting that you say that now because I've been feeling anxious and stressed in our relationship."

Client: "Do you like me?"
Helper: "I feel very close to you."

Client: (cutting helper off) "No, that's not it. You're wrong. I feel fine."
Helper: "I am feeling annoyed that you keep interrupting me."

10. Information: Supplies information in the form of data, facts, opinions, resources, or answers to questions. There are three types of information:

a. *Information about the process of helping*

Client: "Will I be meeting with you weekly?"
Helper: "We will meet twice a week."

Client: "Should I start?"
Helper: "Mmhmm."

b. *Facts, data, or opinions*

Client: "What were the results of the test?"
Helper: "The test indicates that you share interests with people happily employed in forestry."

Client: "I think I want to major in biology."
Helper: "Biology requires several additional laboratory courses."

Client: "I got really upset but I didn't say anything to her."
Helper: "It is my opinion that when people bottle up their anger, they are more prone to blowing up at some point."

Helper: "Students tend to do better on tests after they have gotten a full night of sleep."

c. *Feedback About the Client*

Client: "Am I depressed?"
Helper: "You seem more anxious than depressed."

Helper: "You did a great job asserting yourself in that situation. Your voice tone was firm and appropriate. But you didn't have much eye contact."

11. Direct Guidance: *Provides* suggestions, directives, instructions, or advice about what the client should do to change (goes beyond directing the client to explore thoughts or feelings in session). There are two types of direct guidance:

a. *Process Advisement*

"Play the part of the firefighter in your fantasy."
"Try and relax your muscles right now."
"Rate your level of relaxation now."

b. *Directives*

"I want you to try to talk to your father during the week and tell him about your feelings about his not calling you."
"Take the test tomorrow before you forget the material."
"For homework, I would like you to complete this record of your automatic thoughts."
"You should take charge of your life."

12. Other: Includes helper statements that are unrelated to the client's problems, such as small talk, salutations, and comments about the weather or events.

"Excuse me."
"Goodbye. See you next week."
"The Redskins game was terrific, wasn't it?"
"That's a pretty blouse that you're wearing."

Note: The Helping Skills System (HSS) is a substantially revised version of the Hill Counselor Verbal Response Category System (HCVRCS) and published in the first edition of this book, C. E. Hill & K. M. O'Brien, 1999, *Helping skills: Facilitating exploration, insight, and action.* Washington, D.C.: American Psychological Association. The current version has been modified again for the third edition of this book.

APPENDIX E

WEB FORM F
USING THE HELPING SKILLS SYSTEM FOR RESEARCH

This section presents materials that can be helpful to researchers who would like to use the helping skills system in research. This material is adapted from previous manuals of the Hill Counselor Verbal Response Category System (Hill 1986, 1992; Hill et al., 1981). In this form, I discuss collecting data, unitizing transcripts, training judges, and determining inter-judge agreement. At the end, I provide a practice transcript that judges can use for training. In this form, I do not discuss using the Helper Intentions List, Client Reactions System, or Client Behavior System, nor do I discuss coding attending or nonverbal skills. For more details about coding and process research, see Hill (1986, 1992), and Hill & Lambert (2003). I have been experimenting with judging the quality of interventions in addition to helping skills, and interested researchers can contact me about my work in this area.

METHOD

Collecting Data
I have found that transcripts are necessary for making judgments about helping skills. Although it is possible to code helping skills from listening just to tapes, it is difficult to ensure that judges are responding to the same segment of the session; judges often hear different things, which lowers the agreement levels. Hence, a verbatim transcript must first be created (which typically requires that one person type the transcript and another proofread by listening to the tape).

Unitizing Transcripts
Once a transcript is created, it must be unitized because people do not typically talk in neat sentences. Therefore, to code speech, it is necessary to force what people have said into some kind of unit. This system requires that speech be broken into response units, which are essentially grammatical sentences. The rules that I use have been adapted from Auld and White (1956). A unit is indicated in a transcript by a slash (/). Two judges first code all transcripts independently (without consulting each other). Agreement should be computed for the independent codings. Agreement should be above 90 % because codings are relatively easy if judges follow the rules listed below. Judges should discuss all discrepancies and agree on final judgments. The rules are as follows:

1. A grammatical sentence consists minimally of a subject and a verb. More specifically, the unit consists of an independent or main clause, standing by itself or occurring with one or more dependent or subordinate clauses. A clause is a statement containing a subject and a predicate, with or without complements or modifiers. Judges should be careful not to try to interpret what the sentence means, but should attend carefully to clauses and conjunctions.

   I define an *independent or main clause* as a clause that expresses a completed thought and can stand alone as a sentence. When two independent clauses are joined together by *coordinating conjunctions* (and, or, nor, but), or by *conjunctive adverbs* (accordingly, also, besides, consequently, hence, however, moreover, nevertheless, otherwise, then, therefore, thus, still, yet), they are considered separate units.

   I define a *dependent or subordinate clause* as a clause that does not express a complete thought and cannot stand alone as a sentence. There are several types of dependent clauses: (a) an adjective clause—acts as an adjective; modifies a noun or a pronoun (e.g., The report *that he submitted* was well documented); (b) a relative pronoun clause—begins with relative pronouns (who, whom, what, whose, which, that) that act as either subject or object of the verb

in the clause (e.g., He got *what he wanted*); (c) a noun clause—acts as a noun within the sentence (e.g., *Exercising at night* helped her sleep better); and (d) an adverbial clause acts as an adverb in the sentence (e.g., I was astonished *when I heard the news).*

Independent and dependent clauses are joined together by conjunctions. There are several types of conjunctions: (a) Subordinating conjunctions (after, although, as, as is, as long as, as though, because, before, if, so that, then, unless, when, whenever, where, wherever, while, and whereas) always introduce an adverbial clause, joining it to the rest of the sentence. Subordinating conjunctions generally confer meaning to the subsequent clause, whereas coordinating conjunctions do not. Therefore, subordinating conjunctions can join dependent clauses (usually adverb clauses) or fragments. (b) Coordinating conjunctions (and, or, but, nor) can join independent clauses or fragments. (c) Correlative conjunctions (either–or, neither–nor, both–and, not only but [also], whether–or) precede dependent clauses or fragments and are always used in pairs.

2. Independent clauses can be distinguished from dependent clauses: (a) when two independent clauses are connected, the second is introduced by a coordinating conjunction or a conjunctive adverb; and (b) dependent clauses are introduced by subordinating conjunctions or by pronouns such as *who, which,* or *that.*
3. Some combinations of words without an expressed subject and predicate can make complete sentences (and therefore units). These are called elliptical sentences. Examples: "Speak"/ (a command), "Good"/ (an exclamatory sentence), "What?"/ (a question), or a response to a question. Helper: "What room did they give you?"/ Client: "The same as before."/
4. False starts do not count as separate units. For example, "And Wednesday night, uh, I more or less ... I didn't high-pressure him"/ counts as one unit. "And Wednesday night, uh, I more or less..." is not scored as a separate unit.
5. Utterances lacking some essential feature of a complete sentence because of an interruption by the other speaker or a lapse into silence are considered separate units whenever the meaning is clear. Example: "And he would ask her to write the..."/ (the meaning in this sentence is clear even though the last word or two is not spoken). However, when the speaker has not said enough to make his or her meaning clear, we consider the utterance a false start rather than a unit (e.g., "The little girl ..." would not be considered a unit).
6. Minimal verbal encouragers (e.g., "um-hmm") and silences are not counted as separate units unless they are responses to direct questions.
7. Phrases such as "you know" and "I guess" are not usually considered separate units. Example: "Some, you know, very serious thing may be, you know, happening."/ (all one unit). Similarly, stutters, uhs, ahs, etc. are not separate units. However, the phrase "right?"/ or "is that right?"/ at the end of a sentence is considered a separate unit because it asks for confirmation and is typically a separate action.
8. If one independent clause is interrupted parenthetically by another independent clause, each is scored as a separate unit. Example: "I decided to go ... well, really what happened was she asked me ... to the concert." In this case, the clause "well, really what happened was she asked me" is a separate unit which interrupts the other unit, "I decided to go to the concert." Hence, in this case there are two units.

Selecting and Training Judges

At least three and preferably four or five judges should be used for coding transcripts into helping skills. The reason for using more judges is that these judgments are difficult to make; having more opinions typically leads to better final judgments. I typically select upper level undergraduates or graduate students who have high grade-point averages, are motivated to learn about helping skills, and are detail oriented, because they are more likely to be able to perform and enjoy the task.

To train, judges should read through this book to get an overview of the skills, reread the helping skills system (Web Form E) to learn the definitions of the skills, and then code the practice transcript and discuss discrepancies in codings. Each response unit should be coded into one and only one helping skill. After they have completed the practice transcript, judges should go through several real transcripts independently and code each helper response unit into one of the 12 helping skills (the transcripts in chapter 18 could be used). After independent coding, judges should come together and discuss their codings and resolve discrepancies. Judges should continue training until they reach high rates of agreement (two of the three judges, three of the four judges, or four of the five judges agree on 80 % of the codings for all the response units within a one-hour transcript). Training (not including reading this book) usually requires about 20 hours.

The judges are now ready to code actual transcripts. The judges should do all codings independently, preferably apart, so they do not influence one another. Judges should meet frequently during the judgment process to discuss and resolve discrepancies. Frequent meetings can build morale and prevent drift of judgments. Judgments that the majority of judges agree on during the independent judgments (two of three, three of four, or four of five) are considered the consensus judgment—those for which there is no consensus must be discussed and resolved. During discussions, make sure that one person does not dominate and persuade others. Every participant should have a chance to talk openly and have her or his opinions heard.

Determining Agreement Levels among Judges

Judgments about the helping skills are nominal (yes or no) and hence the most appropriate statistic for agreement is a kappa statistic because it reflects percentage agreement corrected for chance agreement (Cohen, 1960; Tinsley & Weiss, 1975). Kappas should be calculated for each pair of judges, so you end up with three kappas if you use three judges (report the average kappa). You should compute the kappas on all the data or a large representative sample of the data used for the study. You can determine kappas for the 12 major categories (e.g., 1, 2, 3, 4, 5, etc.), or including all the subcategories within some of the categories (3a, 3b, 3c, 3d, 8a, 8b, 8c, 10a, 10b, 10c, l la, l lb, which would yield 20 categories). Please note, however, that it is harder to obtain adequate kappas (>.60) when using 15 categories. You need kappas to be above .60, so if you obtain above .60 for the 12 categories but not for the 15 categories, report the data using 12 categories. Note that when categories occur infrequently, it is more difficult to obtain high kappas. You can also obtain kappas for individual categories by comparing it to all other categories combined.

To compile the data to calculate kappas, you first need to create a table that summarizes the co-occurrences of categories used by the two judges. To do this, make a table that has the number of columns and rows representing the number of categories that you are using. Then go through the codings and make hash marks (/) in the relevant boxes (e.g., if Judge 1 coded the first response unit as category 1 and Judge Two coded it as category 3, you would put a hash mark in the box formed by column one and row three).

Calculate a percentage for each box by dividing the number of hash marks in the box by the total number of categorizations in the table. Table 1 shows the hypothetical data for two judges who each categorized 100 response units into four categories. The formula for kappa (Tinsley & Weiss, 1975) is $K = P_o - P_c / 1 - P_c$ where P_p = the proportion of ratings in which the two judges agree, and P_c = the proportion of ratings for which agreement is expected by chance. The total proportion of agreement Po is obtained by adding the figures in the diagonal (.18 +.18 +.24 +.10 =.70). The expected change agreement (P_c) is obtained by summing the product of multiplying the rows by their respective columns: (.20 x.30) + (.30 x.20) + (.30 x.40) + (.20 x.10) =.26. Hence, by filling the numbers into the formula, we get (.70 -.26)/(1-.26) or.44/.74 =.59. Kappa can vary from -1.00 to 1.00. A kappa of 0 indicates that the observed agreement is exactly equal to the agreement that could be observed by chance. A negative kappa indicates that the observed agreement is less than the expected chance agreement. A kappa of 1.00 indicates perfect agreement between judges.

Table 1. Hypothetical Proportions of Categorizations by Two Judges to Determine Kappa

	Judge 2 scores		Judge 1 scores		Row total
	Category 1	Category 2	Category 3	Category 4	

Category 1	.18	.00	.02	.00	.20
Category 2	.00	.18	.12	.00	.30
Category 3	.06	.00	.24	.00	.30
Category 4	.06	.02	.02	.10	.20
Column total	.30	.20	.40	.10	

PRACTICE TRANSCRIPT

Instructions for Unitizing

The transcript is presented first with no punctuation so you can practice unitizing. Put a slash (/) after each grammatical sentence (see earlier directions) for the helper's statements. Check your unitizing against the transcript **shown later**. For every slash shown in the transcript, you should mark whether or not you have one. Considering that there are 57 slashes in the transcript, you should agree on at least 51 before you proceed further. For each instance that you disagree with the transcript, go back to the rules and try to understand the discrepancy.

Transcript

1. **Helper:** Thanks for coming today my name is Judy I am beginning to learn helping skills we have 20 minutes to talk today you should talk about whatever is on your mind
   Client: I've been feeling down lately. I'm having a lot of trouble getting motivated. I haven't felt like going to class. Nothing really interests me.

2. **Helper:** Give me an example of what happened the last time you didn't go to class oh but first what is your major?
   Client: I haven't really decided on a major because I haven't found anything that interests me.

3. **Helper:** So you haven't decided yet are you living on campus?
   Client: I'm living at home and I feel a lot of pressure on me. I would like to live in the dorm but my parents won't pay for it and I don't have the money myself. I mean my parents live right near campus and they say why should you live in a dorm when we live so close that you can easily walk. You might as well save money.

4. **Helper:** It seems to you like your parents are forcing you to live at home.
   Client: Yeah, it sure does and I really resent it. I think I would feel so much freer in a dorm. I feel restricted at home, like they're watching every move I make, and I don't feel free to come and go as I please.

5. **Helper:** You feel stifled it sounds like you also feel uncomfortable because your parents are so restrictive.
   Client: Right, but I'm not sure how to deal with it. They do provide me with a place to sleep and help me out a little with school. I feel like I ought to be grateful to them.

6. **Helper:** You started fidgeting a lot just then and your voice got real soft I wonder if you feel a little upset did I get that feeling right?
   Client: Well, I guess I feel bad, like I'm not a good son. I feel like they're giving me so much and all I do is want more.

7. **Helper:** How do you feel about that?

Client: I was really angry last night when they told me that they really didn't want me to leave. They got all upset when I even brought up the topic, especially my mom.

8. **Helper:** I wonder if both you and your parents are having trouble separating because of your changing role as you're growing up maybe they're not quite ready for you to leave home because they're anxious about having an empty nest and I wonder if you have a hard time leaving because you're afraid you'll hurt them I wonder what you think about what is causing the problem between you and your parents
   Client: That could be true. You know, I'm an only child and my parents are older. They built their whole world around me.
9. **Helper:** On the one hand, it's hard to leave them but on the other hand, you want to go out and lead your own life.
   Client: Well I want to move out, but I don't want to hurt them.

10. **Helper:** When I left home my parents were quite upset and I felt terrible and guilty what is it like for you?
    Client: Yeah, well, I don't know. It seems so difficult to figure all this out.

11. **Helper:** How do you feel about the situation?
    Client: I feel guilty about wanting to leave them. But I also feel angry that they don't want to let me grow up. I know they've got problems, but they should work them out on their own. What do you think I should do?

12. **Helper:** You should move out you could have a talk with your parents and tell them how you feel.
    Client: Well I could try it. If I wanted to get into the dorms, do you know how I'd go about it?

13. **Helper:** The housing office on campus would have all that information they're located on the other side of campus.
    Client: I should call them I guess. Do you really think I should move out?

14. **Helper:** I can see that you would like me to tell you what to do but I'm a little anxious about giving you advice because I don't know enough about you and your situation you are the one who has to decide whether to move out.
    Client: I'm afraid of making a mistake, so I'd like to hear what you think.

15. **Helper:** I feel a bit surprised that you want me to tell you what to do I wonder if you also rely on your parents to tell you what to do too and then get angry at them when they do?
    Client: I never thought of that before. You might be right. I do get passive and then they tell me what to do. And I certainly do get angry at them. I guess we have some bad patterns that have been established over the years. I'll think about that. But I would still like to know whether you think I should move out?

16. **Helper:** I can tell you that when I had problems with my parents I talked to them and then I moved out it was important for me to talk to them to keep our relationship good but I felt really scared when I first sat down to talk with them because I was afraid they would get angry in my opinion it will probably be hard on all of you at first but most young people need to leave home and strike out on their own even if it is hard.
    Client: Well, thanks for your help.

17. **Helper:** What do you think you'll do?

Client: Maybe I'll talk with my parents.

18. **Helper:** Let's try it right now the research shows that it is easier to do it outside once you have practiced doing it in a helping session what I'd like you to do is pretend that your parents are right here and tell them that you want to move out.
    Client: Okay. Mom and Dad. I just want to tell you that, well, I guess I would like to move out maybe sometime soon.

19. **Helper:** That was a good start but you hesitated several times and your voice got real soft try to say it louder and state exactly what you want.
    Client: Mom and Dad: I have decided to move out.

20. **Helper:** That sounds real good your voice was loud and clear and you stated exactly what you wanted try doing that when you talk to them you know I want to tell you that I am really enjoying working with you because you are so eager to change how do you feel about the work we did today?
    Client: I feel really good. You gave me a lot to think about. I'm not sure yet what I'll do, but I feel more confident that I'll be able to work it out with my parents.

21. **Helper:** Terrific bye now I hope you enjoy the rest of the day.
    Client: You too. Bye.

Instructions for Judging Helping Skills

Place each response unit (indicated by a slash) in the following practice transcripts into one and only one of the helping skills (use the spaces in front of the helper statements to indicate your judgment). After you have judged every response unit, look at the correct responses at the end. Please note that I am trying to illustrate all the skills here, rather than trying to present a transcript where the helper is particularly effective. Use the following numbers for the helping skills (note that attending skills are not coded in this transcript):

1 = approval and reassurance
2 = closed questions
3a = open questions about thoughts; **3b** = open questions about feelings; **3c** = open questions for insight;
3d = open questions about action
4 = restatement
5 = reflections of feelings
6 = challenge
7 = interpretation
8 = self-disclosure
9 = immediacy
10a = information about the process of helping; **10b =** data, facts, or opinions; **10c =** feedback about client
11a = process advisement; **11b =** directives
12 = other

Scoring

1. /_/_/_/_/ **Helper:** Thanks for coming today./ My name is Judy./ I am beginning to learn helping skills./ We have 20 minutes to talk today./ You should talk today about whatever is on your mind./
Client: I've been feeling down lately. I'm having a lot of trouble getting motivated. I haven't felt like going to class. Nothing really interests me.

2. /_/ **Helper:** Give me an example of what happened the last time you didn't go to class./ Oh, but first, what is your major?/
Client: I haven't really decided on a major because I haven't found anything that interests me.

3. /_/ **Helper:** So you haven't decided yet./ Are you living on campus?/
Client: I'm living at home and I feel a lot of pressure on me. I would like to live in the dorm but my parents won't pay for it and I don't have the money myself. I mean my parents live right near campus and they say why should you live in a dorm when we live so close that you can easily walk. You might as well save money.

4. _/ **Helper:** It seems to you like your parents are forcing you to live at home./
Client: Yeah, it sure does and I really resent it. I think I would feel so much freer in a dorm. I feel restricted at home, like they're watching every move I make, and I don't feel free to come and go as I please.

5. /_/ **Helper:** You feel stifled./ It sounds like you also feel uncomfortable because your parents are so restrictive./
Client: Right, but I'm not sure how to deal with it. They do provide me with a place to sleep and help me out a little with school. I feel like I ought to be grateful to them.

6. /_/_/_/ **Helper:** You started fidgeting a lot just then/ and your voice got real soft./ I wonder if you feel a little upset./ Did I get that feeling right?/
Client: Well, I guess I feel bad, like I'm not a good son. I feel like they're giving me so much and all I do is want more.

7. _/ Helper: How do you feel about that?
Client: I was really angry last night when they told me that they really didn't want me to leave. They got all upset when I even brought up the topic, especially my mom.

8. /_/_/_/ **Helper:** I wonder if both you and your parents are having trouble separating because of your changing role as you're growing up./ Maybe they're not quite ready for you to leave home because they're anxious about having an empty nest./ I wonder if you have a hard time leaving because you're afraid you'll hurt them./ I wonder what you think about what is causing the problem between you and your parents?/
Client: That could be true. You know I'm an only child and my parents are older. They built their whole world around me.

9. /_/ **Helper:** On the one hand, it's hard to leave them,/ but on the other hand, you want to go out and lead your own life./
Client: Well, I want to move out, but I don't want to hurt them.

10. /_/ **Helper:** When I left home, my parents were quite upset and I felt terrible and guilty./ What is it like for you?/
Client: Yeah, well, I don't know. It seems so difficult to figure all this out.

11. _/ **Helper:** How do you feel about the situation?/
Client: I feel guilty about wanting to leave them. But I also feel angry that they don't want to let me grow up. I know they've got problems, but they should work them out on their own. What do you think I should do?

12. /_/ **Helper:** You should move out./ You could have a talk with your parents and tell them how you feel./
Client: Well, I could try it. I if I wanted to get into the dorms, do you know how I'd go about it?

13. /_/ **Helper:** The housing office on campus would have all that information./ They're located on the other side of campus./
Client: I should call them I guess. Do you really think I should move out?

14. /_/_/ **Helper:** I can see that you would like me to tell you what to do,/ but I'm a little anxious about giving you advice because I don't know enough about you and your situation/you are the one who has to decide whether to move out./

Client: I'm afraid of making a mistake, so I'd like to hear what you think.

15. /_/ **Helper:** I feel a bit surprised that you want me to tell you what to do./ I wonder if you also rely on your parents to tell you what to do too and then get angry at them when they do?/
Client: I never thought of that before. You might be right. I do get passive and then they tell me what to do. And I certainly do get angry at them. I guess we have some bad patterns that have been established over the years. I'll think about that. But I would still like to know whether you think I should move out?

16. /_/_/_/_/ **Helper:** I can tell you that when I had problems with my parents, I talked to them and then I moved out./ It was important for me to talk to them to keep our relationship good./ But I felt really scared when I first sat down to talk with them because I was afraid they would get angry./ In my opinion, it will probably be hard on all of you at first./ But most young people need to leave home and strike out on their own even if it is hard./
Client: Well, thanks for your help.

17. _/ **Helper:** What do you think you'll do?/
Client: Maybe I'll talk with my parents.

18. /_/_/ **Helper:** Let's try it right now./ The research shows that it is easier to do it outside once you have practiced doing it in a helping session./ What I'd like you to do is pretend that your parents are right here and tell them that you want to move out./
Client: Okay. Mom and Dad. I just want to tell you that, well, I guess I would like to move out maybe sometime soon.

19. /_/_/_/ **Helper:** That was a good start./ But you hesitated several times./ and your voice got real soft./ Try to say it louder and state exactly what you want./
Client: Mom and Dad: I have decided to move out.

20. /_/_/_/_/_/ **Helper:** That sounds real good./ Your voice was loud and clear,/ and you stated exactly what you wanted./ Try doing that when you talk to them./ You know, I want to tell you that I am really enjoying working with you because you are so eager to change./ How do you feel about the work we did today?/
Client: I feel really good. You gave me a lot to think about. I'm not sure yet what I'll do, but I feel more confident that I'll be able to work it out with my parents.

21. /_/_/ **Helper:** Terrific./ Bye now,/ I hope you enjoy the rest of the day./
Client: You too. Bye.

Answers to Practice Transcript

1 = 12, 10b, 10b, 10a, 11a
2 = 3a, 2
3 = 4, 2
4 = 4
5 = 5, 5
6 = 10c, 10c, 5, 2
7 = 3b
8 = 7, 7, 7, 3c
9 = 4, 6 (Note that although the whole intervention is a challenge, two separate codes are necessary because there are two separate units; by itself, the first unit is a restatement and the second is a challenge.)
10 = 8a, 3a
11 = 3b
12 = l lb, l lb
13 =10b, 10b
14 = 9, 9, 6 (see note for response 9)
15 = 9, 7

16 = 8c, 8c, 8a, l0b, l0b
17 = 3a
18 = 11a, l0b, 11 a
19 = 1, 10c, 10c, l la
20 = 1, 10c, 10c, l lb, 9
21 = 1, 12, 12

Note: Two (if there are three) or three (if there are four) judges should agree with at least 51 of the 57 judgments shown above, and you should understand the reasons for your lack of agreement with every response before you go on to the next stage (judging helping skills in transcripts of real sessions). (I expect higher agreement levels on this practice transcript than I would on transcripts of real sessions because these helper responses were created to be easier to judge.

References

Auld, F., & White, A. M. (1956). Rules for dividing interviews into sentences. *Journal of Psychology, 42,* 273–281.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20,* 37–46.

Hill, C. E. (1986). An overview of the Hill Counselor and Client Verbal Response Modes Category Systems. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook.* New York: Guilford.

Hill, C. E. (1992). An overview of four measures developed to test the Hill process model: Therapist intentions, therapist response modes, client reactions, and client behaviors. *Journal of Counseling and Development, 70,* 729–737.

Hill, C. E., & Lambert, M. J. (2003). Methodological issues in studying psychotherapy process and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84–135). New York: Wiley.

Hill, C. E., Siegelman, L., Gronsky, B., Sturniolo, R., & Fretz, B. R. (1981). Nonverbal communication and counseling outcome. *Journal of Counseling Psychology, 28,* 203–212.

Tinsley, H. E. A., & Weiss, D. J. (1975). Interrater reliability and agreement of subjective judgments. *Journal of Counseling Psychology, 22*, 358–376.

Appendix F

Mock Client Scenarios

Jane (Scenario #1)

Read to research participant: "I'm a lonely, grieving, anxious woman in her 60's, and you came to my home to visit after I visited your congregation a couple of times. We are seated on the front porch."

Actor info (Other suggested points if they come up):

- Widowed 5yrs ago (haven't really dated or thought about remarrying)
- Financially Stable
- Still work as a teller at the local bank
- Close to retirement
- A few close friends in the neighborhood/town
- 1 son + daughter in law (2 grandkids) live in North Carolina
    - Come visit about 1x month
    - Talk to them almost daily
- Worry about daily stressors & safety of grandkids

Barbara (Scenario #2)

Read to research participant: "I'm a depressed, fearful woman in her 40's that is struggling with health concerns, and you came to my home to visit after I visited your congregation a couple of times. We are seated on the front porch."

Actor info (Other suggested points if they come up):

- Married 27 years (stable, but emotionally distant marriage)
    - Husband works with city utility dept.
- You have visited new church, but husband and kids have not come with you
- Not financial or safety concerns
- Has worked as an administrative assistant at an eye doctor's office last 15 years
- Chronic pain and physical health has impacted ability work, motivation, and energy level
- One close friend lives the next town over
- 1 Daughter in local community college
- 1 Son, a senior in high school
- Fearful surrounding possible diagnosis of *Multiple Sclerosis* (MS) – doctors still running tests

Appendix G

UpLift: Lessons in Skilled Visitation

Workshop Outline

1) **Basic View of Distress**
    a) 45-min lecture describing several of the more prominent theories on distress/mental disorder, focusing upon biopsychosocial-spiritual model, allowing time for discussion and questions.
    b) 5-10 min also spent allowing lay counselors to reflect upon and articulate a model that fits their perspective.
2) **Models of Effective Lay Counseling**
    a) 30-minute interactive presentation on material from Tan & Scalise (2016) on the various models that lay counseling services have been provided and how their particular congregation can integrate these into practice locally.
3) **Traits of Skilled Helpers**
    a) 30-min lecture describing several of the characteristics of lay counselors that make them successful and how to foster growth in these areas (e.g., psychological health, genuine interest in people, empathy, personal warmth, self-awareness, awareness of values, and tolerance of ambiguity).
    b) 10-min activity reflecting upon why they want to be involved in lay counseling work (e.g., values clarification exercise).
4) **Ethical Considerations for Lay Counselors**
    a) 50-min presentation surrounding the issues of understanding competency, role of lay counselors in service provision, referral process for more formal services,

consultation with others (clergy or MH professionals), confidentiality, ethical decision making models, etc.

b) 10-15 min small group (3-4 participants) exercise with case study and employing a basic ethical decision making model.

5) Microskill Modules

a) Basics of Empathy

i) 30-min presentation evaluating the basics of demonstrating and understanding empathy. Introductory empathy building skills will be demonstrated and discussed during presentation.

ii) 10-min small group exercise rating empathic statements on Level 1-3 scale (Ivey et al., 2018) and group discussion following.

b) Attending Behavior

i) 30-min presentation discussing the components of the lay counselor's behavior that convey active listening and attention.

ii) 10-min interactive component practicing empathy with case scenarios in groups of 2-3 participants. Hill (Lab 4; 2014) exercise demonstrate empathy without any verbal communication as the counselor.

c) Observation Skills

i) 30-min presentation covering the basics of being an attentive observer during lay counseling interactions and what certain behavioral cues from clients may mean.

ii) 20-min skills will be demonstrated at times by using newly updated Allen Ivey training video clips found online (Basic Attending Skills, 2017).

d) Skilled Use of Questions

i) 30-min lecture presentation describing the difference between open-ended and closed-ended questions, which settings each are appropriate, and the goals of each. The purpose is to increase intentional usage of each form of questioning.

ii) 15-min activity with triads 1 counselee and 2 counselors (1 can only ask open questions and 1 can only ask closed questions, alternating speaking turns).

e) Listening Process – Encouraging, Paraphrasing, & Summarizing

i) 45-min presentation describing verbal listening process. Will discuss how to use each part and at what points throughout sessions, demonstrating effective and ineffective ways of each.

ii) 15-min experience where individuals engage in practice paraphrasing video segments from clients (Basic Attending Skills, 2017).

f) Reflecting Feelings

i) 30-min presentation on the importance of hearing feeling words in client speech and helping clients expand emotional vocabulary. Provide psychoeducational material on feelings.

ii) 15-min summative activity engaging in microskill practice with partners, scripts will be provided with lines for counselee and prompts for counselors to use various skills (e.g., open question, paraphrase, minimal encourager).

Appendix H

Additional Rules for Coding

Burkhart Dissertation "Helping Skills System"

We will include the following rules to better help to make sense of the Helping Skills System:

1. Each minimal encourager (usually found at the beginning of the sentence) should be included as its own unit. Examples include "Okay," "Right," and "Good."

2. Several times during the participant speaking, he/she may trail off, abruptly change subjects, or not complete the thought. This shall be considered a False Start according to Web Form F: Rule 4. On the transcripts simply include the false start in the surrounding units or mark them out, whichever helps you complete the transcript categorization.

3. Similar to the minimal encouragers, participants will be often start their responses with "Fillers" (e.g., "So," "Well"). These responses will be included with surrounding units and not considered separate units by themselves.

4. Appalachian culture and linguistics often avoid confrontation (Dumas, 1999; Hasty, 2012) and recommendations may be phrased as questions in order to preserve politeness. Therefore, these should be coded as direct guidance.

5. The team agreed that if a unit is technically a question, but fits better into another category (e.g., restatement, reflections of feeling, direct guidance), the unit should be coded as those other categories and not as questions.

APPENDIX I

SPSS Output – Paired-Samples T-test

```
GET

FILE='C:\Users\jburkhart\Desktop\Burkhart_Dissertation_LayCounselorHelpingSki
lls.sav'.
DATASET NAME DataSet1 WINDOW=FRONT.
T-TEST PAIRS=PreCat1Prop PreCat3Prop PreCat4Prop PreCat5Prop PreCat2Prop
PreCat11Prop PreCat8Prop
    PreWordProp WITH PostCat1Prop PostCat3Prop PostCat4Prop PostCat5Prop
PostCat2Prop PostCat11Prop
    PostCat8Prop PostWordProp (PAIRED)
  /CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.
```

T-Test

Notes

Output Created		07-JUL-2018 17:11:28
Comments		
Input	Data	C:\Users\jburkhart\Desktop\Burkhart_Dissertation_LayCounselorHelpingSkills.sav
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	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	12
Missing Value Handling	Definition of Missing	User defined missing values are treated as missing.
	Cases Used	Statistics for each analysis are based on the cases with no missing or out-of-range data for any variable in the analysis.

Syntax		T-TEST PAIRS=PreCat1Prop PreCat3Prop PreCat4Prop PreCat5Prop PreCat2Prop PreCat11Prop PreCat8Prop PreWordProp WITH PostCat1Prop PostCat3Prop PostCat4Prop PostCat5Prop PostCat2Prop PostCat11Prop PostCat8Prop PostWordProp (PAIRED) /CRITERIA=CI(.9500) /MISSING=ANALYSIS.
Resources	Processor Time	00:00:00.02
	Elapsed Time	00:00:00.02

Paired Samples Statistics

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	PostCat1Prop	.2278399	12	.08742472	.02523734
Pair 2	PreCat3Prop	.0720398	12	.04358786	.01258273
	PostCat3Prop	.0428063	12	.02556987	.00738139
Pair 3	PreCat4Prop	.0383713	12	.02297149	.00663130
	PostCat4Prop	.0278957	12	.01467043	.00423499
Pair 4	PreCat5Prop	.0072170	12	.01194293	.00344763
	PostCat5Prop	.0110805	12	.00976451	.00281877
Pair 5	PreCat2Prop	.1201788	12	.04397127	.01269341
	PostCat2Prop	.0933403	12	.04823665	.01392472
Pair 6	PreCat11Prop	.0693704	12	.05754663	.01661228
	PostCat11Prop	.0413465	12	.02831802	.00817471
Pair 7	PreCat8Prop	.0722624	12	.04966325	.01433655
	PostCat8Prop	.0826884	12	.08633910	.02492395
Pair 8	PreWordProp	.6590961	12	.11345756	.03275238
	PostWordProp	.7161835	12	.09385583	.02709384

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PreCat1Prop & PostCat1Prop	12	.568	.054

Pair 2	PreCat3Prop & PostCat3Prop	12	.400	.197
Pair 3	PreCat4Prop & PostCat4Prop	12	.553	.062
Pair 4	PreCat5Prop & PostCat5Prop	12	.059	.856
Pair 5	PreCat2Prop & PostCat2Prop	12	.289	.363
Pair 6	PreCat11Prop & PostCat11Prop	12	.218	.495
Pair 7	PreCat8Prop & PostCat8Prop	12	.157	.627
Pair 8	PreWordProp & PostWordProp	12	.599	.039

Paired Samples Test

		Paired Differences			
					95% Confidence Interval of the Difference
		Mean	Std. Deviation	Std. Error Mean	Lower
Pair 1	PreCat1Prop - PostCat1Prop	-.00224453	.07885059	.02276221	-.05234380
Pair 2	PreCat3Prop - PostCat3Prop	.02923353	.04075956	.01176627	.00333614
Pair 3	PreCat4Prop - PostCat4Prop	.01047568	.01923230	.00555189	-.00174394
Pair 4	PreCat5Prop - PostCat5Prop	-.00386349	.01497430	.00432271	-.01337770
Pair 5	PreCat2Prop - PostCat2Prop	.02683841	.05509316	.01590403	-.00816611
Pair 6	PreCat11Prop - PostCat11Prop	.02802384	.05832373	.01683661	-.00903330
Pair 7	PreCat8Prop - PostCat8Prop	-.01042598	.09260787	.02673359	-.06926621
Pair 8	PreWordProp - PostWordProp	-.05708744	.09442951	.02725945	-.11708509

Paired Samples Test

		Paired Differences 95% Confidence Interval of the Difference			
		Upper	t	df	Sig. (2-tailed)
Pair 1	PreCat1Prop - PostCat1Prop	.04785475	-.099	11	.923
Pair 2	PreCat3Prop - PostCat3Prop	.05513092	2.485	11	.030
Pair 3	PreCat4Prop - PostCat4Prop	.02269530	1.887	11	.086
Pair 4	PreCat5Prop - PostCat5Prop	.00565073	-.894	11	.391
Pair 5	PreCat2Prop - PostCat2Prop	.06184294	1.688	11	.120
Pair 6	PreCat11Prop - PostCat11Prop	.06508097	1.664	11	.124
Pair 7	PreCat8Prop - PostCat8Prop	.04841425	-.390	11	.704
Pair 8	PreWordProp - PostWordProp	.00291020	-2.094	11	.060