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THE RELATIONSHIP BETWEEN NONVERBAL IMMEDIACY AND
THERAPEUTIC ALLIANCE IN HIGHER EDUCATION CLIENT-COUNSELOR
INTERACTIONS

BY
VALERIE KLEINJAN

A thesis submitted in partial fulfillment of the requirements for the
Master of Science
Major in Communication Studies and Journalism
Specialization in Communication Studies
South Dakota State University

2014

THE RELATIONSHIP BETWEEN NONVERBAL IMMEDIACY AND
THERAPEUTIC ALLIANCE IN HIGHER EDUCATION CLIENT-COUNSELOR
INTERACTIONS

This thesis is approved as a credible and independent investigation by a candidate for a Master of Science in Communication Studies and Journalism and is acceptable for meeting the thesis requirements for this degree. Acceptance of the thesis does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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ABSTRACT

THE RELATIONSHIP BETWEEN NONVERBAL IMMEDIACY AND
THERAPEUTIC ALLIANCE IN HIGHER EDUCATION CLIENT-COUNSELOR
INTERACTIONS

Valerie A. Kleinjan

2014

Communication is essential to a successful patient-provider interaction. Within health communication literature, a substantial body of research has focused on verbal communication; however, few studies have fully dedicated to nonverbal communication research. The study examined the relationship between perceptions of client nonverbal immediacy and ratings of the therapeutic alliance. Additionally, the study provided an analysis comparing counselor and client ratings of both client nonverbal immediacy and the therapeutic alliance. Results indicated a significant relationship between counselor ratings of client nonverbal immediacy and counselor ratings of the therapeutic alliance. Counselors and clients also rated client nonverbal immediacy similarly, indicating that the counselors are aware of their client's behavior. Counselors and clients also rated the therapeutic alliance similarly.

Chapter 1

Introduction

Communication between patients and medical practitioners frames and structures the patient's perceptions of the physician, the amount of trust the patient places in the relationship, and the likelihood that the patient will follow the physician's recommendations (Bush, 1985; Cant & Aroni, 2008; Sharpley, Jeffrey, & McMahan, 2006). Utilizing the biopsychosocial health care model, health care providers seek to treat not only physical ailments but also the psychological and social conditions of the whole person (Ho & Bylund, 2008). Within this model the focus centers on the patient rather than the illness. Emphasis on the patient forms the foundation for patient-provider communication.

Patient-provider interactions include both verbal and nonverbal communication, each contributing to patient perceptions of rapport with medical practitioners (Wanzer, Booth-Butterfield, & Gruber, 2004). Physicians who engaged in greater empathy and listening skills were rated higher by patients (Wanzer et al., 2004). Nonverbal communication also plays an essential role within patient-provider interpersonal relationships because it conveys approximately 55% of the communicator's meaning, as compared with just 7% of meaning arising from verbal communication (Mehrabian, 1972). Yet, many medical practitioners lack the proper training in evaluating the nonverbal cues of their patients (Coran, Arnold, & Arnold, 2010; Gilbert, 1997). On the other hand, counselors trained in nonverbal attending and responding skills form better relationships with their clients (Grace, Kivlighan, & Kuncze, 1995). This practice highlights a fundamental communication principle between mental health counselors and their clients as "the counselor's nonverbal behavior is a powerful means of projecting a

message of caring to the client and may either strengthen or weaken rapport between counselor and client” (Sharpley et al., 2006, p. 344).

Specifically, this study analyzed the counselor’s perceptions of the client’s nonverbal immediacy as well as the client’s perceptions of his or her own nonverbal cues. Many studies have analyzed either only the patient’s or only the provider’s use of verbal and nonverbal communication in patient-provider interactions (Cant & Aroni, 2008; Coran et al., 2010; Duggan, Bradshaw, & Altman, 2010; Wanzer et al., 2004). However, few studies evaluated patient and physician perceptions of the working alliance (Langhoff, Baer, Zubraegel, & Linden, 2008). Through self-report surveys used in this study, counselors and clients rated their perceptions of the client nonverbal immediacy. Also, each counselor and client assessed the therapeutic alliance. As a result, this study evaluated the relationship between nonverbal immediacy and therapeutic alliance. Additionally, few studies have assessed both the counselor and the client (Langhoff, et al., 2008); this study compared counselor and client assessment of client nonverbal immediacy as well as sought to discover which variable was a greater predictor of the working alliance.

Statement of the Problem

Physical and mental health concerns may produce many complex issues for both the patient and physician. Patients seek health care provider services with questions about their well-being and expectations of expert medical care. For some individuals, past health care experiences may have been negative. Often these negative experiences are a result of poor communication between the physician and patient (Cousins, 1985). Unfortunately, medical schools may not properly train medical students to communicate

with patients who have physical and mental disabilities (Duggan et al., 2010).

Counselors, on the other hand, undergo listening and attending-skills training in masters and doctoral programs, yet the literature analyzing the relationship between counselor nonverbal sensitivity and the counseling process is inconclusive (Grace et al., 1995).

Even though well trained physicians and counselors who have earned collegiate and post-collegiate degrees should be effective communicators and recognize nonverbal cues more readily than the average person, research shows that this may not be the case (Sweeny & Cottle, 1976). However, by incorporating extensive instruction and practice to develop communication competencies, these skills may enable physical and mental health providers to be nonverbally sensitive to their patient's needs (Grace et al., 1995), and thereby improve the health care experience for the patient and professional alike.

Within the patient-provider interaction, researchers recognized four main communication competencies: interpersonal communication skill (ex. listening reinforcement, partnership, etc.), nonverbal communication (ex. personal presentation, responsiveness, anxiety reduction, etc.), professional values (trustworthy, respectful, high integrity, etc.), and counseling skill (collaboration, expert communicator, motivating, therapeutic listening, etc.) (Cant & Aroni, 2008). Due to physical or mental ailments, patients may be unable to verbally express themselves; therefore, the physician's duty to recognize and address the nonverbal cues relayed by the patient becomes increasingly crucial to the relationship (Street & Haidet, 2011). If the provider can appropriately distinguish and react to verbal and nonverbal communication cues, the patient will more likely trust the health care provider (Fiscella et al., 2004). This trust is also based on the physician's or counselor's ability to communicate effectively. Physicians who

demonstrate good listening skills (i.e., facing the patient, making eye contact, utilizing head nods, etc.) create higher satisfaction within their patients (Ishikawa et al., 2006). Similarly, counselors who utilize more facial expressions of interest (Sharpley et al., 2006) and affective body posture (Sharpley et al., 2001) create a greater rapport with the client. Consequently, upon review of the literature regarding patient-provider communication, the central focus revolves around either the patient's or provider's perceptions of rapport and away from nonverbal communication (Coran et al., 2010; Roter & Hall, 2011). The current study evaluated the alliance between counselor and client by asking both the counselor and client to report on client nonverbal immediacy behavior and rate working alliance. By asking both the counselor and client to report, this study provided additional analysis within the current patient-provider literature.

Background of the Problem

Health communication research broadly includes studies on communication with disabled and sick individuals, health promotion and information campaigns, physician-patient communication, and social support groups (Rubin, Rubin, Haridakis, & Piele, 2010). However, the study of interpersonal interactions between the patient and health provider produces important research to the discipline (Duggan & Thompson, 2011). These interactions include verbal and nonverbal communication in which the provider attempts to convey scientific information yet address the patient in a personal manner. On the other hand, the patient must also effectively describe symptoms and concerns to the physician. The biomedical approach, based on the assumption that physical ailments may be treated by physical resources (duPré, 2014), emphasizes science to achieve goals,

yet the communication component within the medical practice directly involves interpersonal interaction (Roter & Hall, 2011).

In spite of a lack of emphasis on the importance of communication within the health profession in the early 20th century, recent reports indicate an increase in attention toward patient-centered communication within the medical field (Roter & Hall, 2011). Health communication literature gravitates around the patients' perceptions and the influence of those perceptions on provider communication and decision making (Bohnert, Zivin, Welsh, & Kilbourne, 2011). Research reveals that physicians often misinterpret or misjudge the viewpoints of the client and, as a result, do not communicate effectively (Street & Haidet, 2011). Poor communication often leads to dissatisfaction with the physician, causing the client to consider an alternative physician (Cousins, 1985).

Communication behaviors intended to help the patient/client feel safe and welcome may enhance the relationship between the patient/patient's family and the provider (Wanzer et al., 2004). Additionally, Wanzer et al. (2004) stated that nonverbal immediacy (smiling, eye contact, and gestures) and listening were two crucial predictors of patient satisfaction. While nonverbal behavior supplements verbal expression, nonverbal communication also provides unspoken feedback to either the patient or provider when words will not suffice (Dolin & Booth-Butterfield, 1993). Interestingly, as the physician makes judgments based on patient nonverbal communication, the patient also critiques and draws conclusions about the physician's relational intentions and credibility (Roter & Hall, 2011). In the current study both the counselor and client rated their perceptions of the client's nonverbal communication. Also, both parties assessed the counselor-client relationship.

Definitions

This study included the use of these key terms: immediacy, nonverbal immediacy, therapeutic alliance, patient-provider communication, and client-counselor communication. Immediacy refers to the physical or psychological distance created between communicators via verbal and nonverbal cues (Weiner & Mehrabian, 1968). Additionally, nonverbal immediacy requires the use of nonverbal behaviors to increase the physical or psychological closeness between interactants (Richmond & McCroskey, 2000a). These behaviors include physical appearance, gestures and body movements, posture (i.e. facing each other), facial expression (i.e. smiling), and eye contact (Richmond & McCroskey, 2000a).

Nonverbal immediacy may factor into the level of communication between the patient and provider and the establishment of rapport. This rapport between a counselor and client often indicates a strong therapeutic alliance. The terms therapeutic alliance and working alliance are used interchangeably in the current study. Alliance indicates a relationship between a patient and provider or client and counselor in which each party works to achieve goals while forming an emotional bond (Bordin, 1979; Duff & Bedi, 2010). This definition is based on Bordin's (1979) working alliance model established on three main components: goals, tasks, and bond. Goals indicate the direction of the therapy process established by the client and counselor in the initial meetings. Tasks refer to the means by which the client will strive to reach his/her goals. Finally, the bond between the counselor and client marks the level of trust and attachment developed throughout the relationship (Bordin, 1979).

Value of the Study

Despite the centrality of nonverbal communication in health care interactions, previous research has largely focused on the role of verbal (Bohnert et al., 2011), rather than nonverbal (Duggan et al., 2010) communication. The present study focused on identifying the relationship between counselors' recognition of nonverbal cues and the clients' perceptions of their therapeutic alliance with the counselor. Given the importance of nonverbal communication, this relationship between nonverbal immediacy and the therapeutic alliance was predicted to be positive. This study reviewed literature on patient-provider communication, client-counselor communication, and nonverbal immediacy.

Understanding communication within the health care system is vital to communication literature and applied practice because many clients and physicians have ineffective communication styles when speaking about the patients' health, and health-related issues are often misunderstood (Duggan et al., 2010). Contrary to previous literature, this study applied specifically to nonverbal communication in the client-counselor relationship. Previous studies indicate a stronger correlation between nonverbal communication and patient satisfaction than between verbal communication skills and satisfaction (Roter & Hall, 2011). Therefore, further analysis of nonverbal communication is necessary to connect the counseling and communication disciplines. In order to accurately depict the therapeutic relationship, this study elaborated beyond previous research by gaining perceptions of nonverbal immediacy from both the counselor and the client.

This study includes a review of literature in chapter two. The literature reviewed research on immediacy, nonverbal communication, communication accommodation

theory, the therapeutic alliance, patient-provider communication, client-counselor communication, and client-counselor nonverbal communication. Additionally, the hypothesis and research questions are proposed. Chapter three includes a review of the study's methodology. Research participants, sampling procedures, instrumentation, data analysis, and rationale for this approach are explored in chapter three. Chapter four describes the results of the study. Chapter five provides analysis of the hypotheses and research questions, as well as a discussion of the study's implications, limitations, and future directions.

Chapter 2

Literature Review

Interpersonal interactions occur every day in many different contexts. Through these interactions, individuals engage in both verbal and nonverbal behaviors. In order to effectively analyze the client-counselor relationship, this literature review encompasses the theoretical framework of nonverbal immediacy, communication accommodation theory, and the therapeutic alliance between the client and the counselor. The following review of literature illustrates the usefulness of this previous research.

Immediacy

Research on the construct of immediacy evolved from social psychologist Albert Mehrabian. Early work focused primarily on verbal immediacy (Wiener & Mehrabian, 1968). Immediacy refers to the psychological or physical distance between the communicator and the receiver, the object of communication, or the addressee (Wiener & Mehrabian, 1968). In the case of verbal immediacy, this indicates that language or word choice may influence the reciprocal relationship toward the communicator. For example, using phrases such as “*you and I*” as opposed to “*we*” demonstrates non-immediacy (Wiener & Mehrabian, 1968). Conversely, nonverbal communication indicates actions distinct from verbal messages (i.e. facial expressions, hand and arm gestures, postures, and other various body movements) (Mehrabian, 1972). Research on the literal interpretation of words and their connotative meanings led Mehrabian to develop the immediacy principle. Mehrabian (1971) stated, “People are drawn toward persons and things they like, evaluate highly, and prefer; they avoid or move away from things they dislike, evaluate negatively, or do not prefer” (p. 22). Thus, liking, or favorability,

produces immediacy between the communicator and receiver of communication (Richmond, McCroskey, & Johnson, 2003).

Expanding on Mehrabian's early findings, other researchers (Andersen, 1979) further widened the immediacy principle by applying the concept to instructional communication within the classroom. "The more immediate a person is, the more likely he/she is to communicate at a close distance, smile, engage in eye contact, use direct body orientation, use overall body movement and gestures, touch others, relax, and be vocally expressive" (Andersen, 1979, p. 548). Research supports immediacy in the classroom, observing positive correlations between teacher immediacy and interest toward the teacher and/or course (Andersen, 1979; Gorham, 1988). In addition to positive affect toward the instructor, positive immediacy behaviors also predict a more rewarding classroom environment, less student behavioral challenges, and greater affective learning (Goodboy & Myers, 2009; Gorham, 1988). Teacher communicators who engage in verbal and nonverbal immediacy demonstrate liking toward their students, who then, in turn, may reciprocate that liking (Gorham, 1988).

While Mehrabian's immediacy principle (1971) concentrated on why a communicator uses immediate messages, Richmond and McCroskey (2000a) focused on the impact of immediacy on others. The principle of immediate communication explains "the more communicators employ immediate behaviors, the more others will like, evaluate highly, and prefer such communicators; and the less communicators employ immediate behaviors, the more others will dislike, evaluate negatively, and reject such communicators" (Richmond & McCroskey, 2000a, p. 212). Therefore, this principle suggests that immediacy causes liking. Utilizing effective immediate verbal messages

demonstrate openness, friendship, or empathy. Examples of verbal immediacy include the use of the pronouns “us” or “we” rather than “you” or “you and I” (Richmond & McCroskey, 2000a; Wiener & Mehrabian, 1968).

Using instructor-student communication research as a basis, immediate communication decreases anxiety, decreases status differences, increases perceptions of communication competence, and decreases uncertainty in communication situations (Richmond & McCroskey, 2000a). “Immediacy and liking are two sides of the same coin. That is, liking encourages greater immediacy, and immediacy produced more liking” (Mehrabian, 1971, p. 77). In a study on the relationship between the supervisor and subordinate, Richmond and McCroskey (2000b) found a positive association between the amount of immediacy from the supervisor and positive attitudes toward the supervisor and communication with the supervisor. Consequently, non-immediate communicators are perceived to be less friendly, responsive, outgoing, and likeable as well as cold, aloof, and hostile in comparison to individuals displaying verbal immediacy and nonverbal immediacy (Richmond & McCroskey, 2000a). Essentially, communication is a holistic process in which both verbal and nonverbal immediacy messages are encoded and decoded simultaneously (Gorham, 1988; Richmond & McCroskey, 2000b). This study proposed that the more the client likes the counselor, the more nonverbal immediacy the client will use throughout the counseling session. Also, the more the client uses nonverbal immediacy, the higher the counselor will rate the counselor-client relationship. The following review delineates the body of literature focused on nonverbal communication and behavior.

Nonverbal communication.

While verbal communication allows individuals to use words and meaning as an expression of their thoughts, nonverbal communication displays a person's intention behind word meaning and true expression of emotions (Knudson, 1996; Richmond & McCroskey, 2000a). Based on repression in psychoanalytic theory, the exploration of nonverbal behaviors is a means of inferring a client's internal feelings (Deutsch & Murphy, 1955). Since nonverbal behavior is the language for relationships (Sharpley et al., 2001), nonverbal communication contributes to approximately 65% of meaning in interpersonal connections (Putnis & Petelin, 1996). Nonverbal communication is expressed through smiles, head nods, and other immediacy cues (Gable, 1997). The use of physical appearance, eye contact, touch, facial expressions, gestures, and body posture are all factors contributing to nonverbal immediacy which demonstrate a level of commitment, caring, and genuineness to the interpersonal relationship (Remland, 2000; Richmond & McCroskey, 2000a). Communication-centered nonverbal immediacy generates a positive effect in others as well as promoting the function of the relationship (Richmond & McCroskey, 2000b). Consequently, a provider must recognize these nonverbal cues and interpret the appropriate meaning behind the expression.

Ishikawa et al. (2006) stated that standardized patients gave statistically significant higher ratings to medical students when students faced them directly, used facilitative nodding when listening, and spoke to them at a similar speech and voice volume. The study concluded that eye contact, body posture and facial expressions significantly enhance the client-counselor relationship and communication. Since human expressions communicate behavioral motivations as well as social cues, these signals

may influence how an observer will react in certain situations (Ribeiro & Fearon, 2010; Sommer, Döhnel, Meihhardt & Hajak, 2008). Also, nonverbal cues have been noted to be more important in affective messages than verbal cues (Dolin & Booth-Butterfield, 1993). Additionally, eye contact and other immediacy behaviors (touch, body posture, closeness, etc.) increase patient rapport as well as communicate feelings of affection (Dolin & Booth-Butterfield, 1993). Therefore, the use and interpretation of nonverbal immediacy may improve patient-provider and client-counselor interactions. The following sections provide specific examples of nonverbal immediacy behaviors.

Eye contact.

The eyes are one of the most expressive parts of the body—“Our eyes can speak volumes” (Richmond & McCroskey, 2000a, p. 92). When a person smiles, the eyes indicate whether or not the smile was genuine or false (Frank, Ekman, & Friesen, 1993). A true smile involves the movement of the orbicularis oculi muscles (the muscles surrounding the eyes) in conjunction with the zygomatic major muscles (muscles used to raise the mouth and cheeks) (Frank et al., 1993). Interestingly, the mouth receives the most attention for happy expressions while the eyes are the focus of sad expressions (Eisenbarth & Alpers, 2011). As this research notes, observing the communicator’s eyes will provide the best method of accurately interpreting the intended emotion behind the smile (Eisenbarth & Alpers, 2011). Without the focus on the eyes, humans display many errors in their reasoning and deciphering of facial expressions (Richmond & McCroskey, 2000a).

While eye contact is a central form of nonverbal immediacy, eye contact may have both positive and negative connotations (Remland, 2000). Norman’s (1982) review

of nonverbal communication and behavioral cues states that during normal conversation the person talking spends the majority of the time looking away from the listener while the audience member directly looks at the speaker. In addition, too much eye contact may be considered rude, threatening, or insulting in everyday interpersonal interactions (Norman, 1982). However, in a counseling session, the counselor must also be aware of the client's comfort level and what duration of eye contact gives the client a feeling of security and safety (Grace et al., 1995). Therefore, the present study also assessed the use of eye contact and other nonverbal immediacy behaviors (i.e. body posture and facial expressions) in the counseling relationship.

Paralanguage.

Nonverbal communication includes not only body behavior but also voice and speech fluctuation. Paralanguage refers to the how words are spoken rather than what words are spoken (Remland, 2000). Particular vocal qualities may even increase immediacy between individuals (Richmond & McCroskey, 2000a). These behaviors include short pauses, few silences, positive vocal inflections, vocal variety, animated tone, friendly vocal cues, etc. (Remland, 2000; Richmond & McCroskey, 2000a). On the other hand, lengthy pauses, sarcasm, monotonous tones, and bored or unfriendly tones may be considered non-immediacy behaviors (Richmond & McCroskey, 2000a). Individuals who engage in more immediate paralanguage are often perceived in a more positive regard. Students who engaged their teachers with more nonverbal immediacy were thought to be better students, more motivated, more competent, and teachers, in turn, were more motivated to teach them (Baringer & McCroskey, 2000). This concept may be applied to the counselor-client relationship as well. If the client uses more

immediate paralanguage, the counselor may perceive the relationship more positively as well as be more willing to collaborate on specific goals and tasks.

Body posture.

The use of gestures and body posture enhances the nonverbal message of the speaker and, in turn, affects the listener's perceptions (Ishikawa et al., 2006; Norman, 1982; Richmond & McCroskey, 2000a). Standard posture includes direct eye contact, a slight forward trunk lean, gestures, facing the client in open position (ex. arms and legs uncrossed), and relaxed muscles (Ivey & Simek-Downing, 1980). Just as a speaker sends a nonverbal message to the audience through the speaker's chosen attire (Richmond & McCroskey, 2000a), the counselor or medical care provider may establish rapport with the client through natural gestures and relaxed, professional posture (Morreale, Rubin, & Jones, 1998). The client views the counselor or physician as a role model in a collaborative effort to make changes (Cant & Aroni, 2008). If the client perceives that the counselor, nurse, dietician, or physician does not present themselves in the same manner as they expect from the patient, then the patient cannot and will not trust the provider (Cant & Aroni, 2008). Gestures and body posture have the ability to complement, substitute, or repeat verbal communication (Norman, 1982). Therefore, the counselor's nonverbal immediacy may reinforce the verbal messages to the client, while the client's nonverbal messages enhance the individual testimony.

Facial expressions.

Similar to body posture, facial expressions are also easily observed gestures (Ju & Lee, 2008; Norman, 1982). Facial expressions provide adequate feedback on the emotional states of others and reflect internal attitudes that may not be shared verbally

(Richmond & McCroskey, 2000a). Correctly interpreting these nonverbal and emotion-driven cues builds vital communication within the patient-provider relationship (Gentry, Harris, & Norwicki, 2007). When not displaying any emotion, each individual has a “default” face (Hunter & Tucker, 2008). The default or non-expressive face can often cause confusion or uncertainty to the health care observer (Ekman, 2009). Therefore, understanding a client’s default face will help to better analyze future facial expressions during counseling sessions.

Although humans learn to conceal emotions from appearing on their faces, there are clues, or facial triggers, to detect micromomentary expressions (Haggard & Issacs, 1996), afterward coined micro expressions in later psychological research (Ekman, 2009). Behaviors, gestures or expressions of the face can occur without conscious prompting, which leak or reveal our true feelings or sentiments (Haggard & Issacs, 1996; Matsumoto, Hwang, Skinner, & Frank, 2011). These facial muscle expressions reveal true emotions at such a short duration they are usually not seen by the untrained eye (Ekman, 2009). These muscle responses involve both involuntary and voluntary motion, depending on which parts of the brain are being used. Voluntary smiles are unilateral or asymmetrical, and the muscle movement is not smooth (Ruch, 1995). While revealing micro expressions may escape immediate human detection, they are often caught on film, thus showing facial expressions not necessarily noted by communicators (Ekman, 2009). The imperceptible muscle movement can be more accurately displayed frame by frame, reinforcing the genuineness or falsity of the smile. Additionally, when people lie, the obvious expressions are the ones that draw an observer’s attention; however, the subtle clues reveal true emotions (Ekman, 2009; Ekman, Friesen, & Sullivan, 1988). When a

person is trying to deceive with a false smile, the upper and lower halves of the face are inconsistent because the eyes are not truly engaged in the smile (Anderson, 1999).

Investigating this phenomenon, Ekman's (2009) technique for measuring smiles has revealed over 50 different types of smiles. Felt smiles are authentic when a person shows true happiness, whereas a false smile is meant to mask negative emotions or to convey happiness that is not felt (Ekman et al., 1988).

Further, due to recent terrorist activity within the United States, the Department of Transportation has implemented a training program for airport security staff to identify potential threats by reading the micro expressions of concealed emotions in the faces of passengers (Lipton, 2006 as cited in Porter & ten Brinke, 2008). As this training program indicates, it is possible to distinguish micro expressions in real time. This recognition occurs as passengers walk through airport security checkpoints. With added use in the client-counselor setting, individuals who more accurately read concealed nonverbal cues of emotion were perceived to be less shy and more encouraging, warm, empathetic, and interpersonally sensitive (Knapp & Hall, 2002), all characteristics of effective counselors (Norcross, 2011).

Communication Accommodation Theory

When interacting within the patient-provider or client-counselor setting, each individual is engaged in the process of communicating verbally and nonverbally. Through these interactions, Howard Giles, developer of Communication Accommodation Theory, proposed that individuals adjust or accommodate their speech or behavior to either become closer or distance themselves from the other party (Griffin, 2009). Two main components of Communication Accommodation Theory (CAT) include

convergence and divergence. Convergence is the process of speaking or acting in a way to be more similar to another person, whereas divergence refers to the strategy of displaying the differences between the speaker and receiver (Griffin, 2009). In order to become more similar, a person may adjust his or her speech or behavior. In the client-counselor setting, the counselor engages in postural mirroring to act more like the client and to create a relaxed environment (Sharpley et al., 2001).

Correspondingly, each individual's language and nonverbal actions impact perceptions and reactions from others (Watson & Gallois, 1998). Convergence and divergence encompass two strategies within communication accommodation. Other verbal strategies include interpretability (ability to understand), discourse management (ability to respond to the needs of others), and interpersonal control (role verification in interpersonal relationships) (D'Agostino & Bylund, 2011). Recognizing (or interpreting) and understanding another's needs is vital to health communication and immediacy between and patient and provider (Wanzer et al., 2004). Watson & Gallois (1998) found that when providers treated the patients as individuals and equals, they received higher ratings from the patient. In other words, those providers who accommodated their language and behavior to match the patients were thought to attend to the emotional needs of the patient better than those providers who remained in an authoritative position. Further, the counselor's ability to adapt to the client's words demonstrates high quality listening skills (Bodie & Jones, 2012).

Other forms of accommodation include under-accommodation and over-accommodation (Giles, 2008). Under-accommodation, or maintenance, infers that the individuals persist in their own way of thinking, speaking, and acting regardless of the

other person (Griffin, 2009). In contrast, over-accommodation involves demeaning or patronizing talk or behavior (Giles, 2008; Griffin, 2009). Bohnert et al. (2011) examined the relationship between patients with severe mental illness and perceptions of trust based on provider communication. Results indicated that those individuals with severe mental illness were less likely to rate the provider as a good communicator. These findings may be a result of over- or under-accommodation by the providers when communicating with patients whom they believed to lack the mental capacity for comprehension of health information. According to Duggan et al. (2010), “the danger in over-accommodation is that these behaviors themselves can be interpreted as rapport building; patients with disabilities may perceive this language as inferring what otherwise is normative behavior as exceeding expectations” (p. 347). Physicians and counselors must understand the encoding and decoding process of nonverbal behavior in order to recognize behaviors within their clients that may lead to a better working relationship. Communication accommodation provides an opportunity for the counselor and the client to build rapport. Through accommodation, the client may feel more equal to the counselor and more fully trust the counselor’s intentions for the relationship since both parties are fully invested in the process.

Therapeutic Alliance

Some researchers posit that the therapeutic alliance, or working alliance, encompasses the entire helping process and is necessary for change (Bordin, 1979; Corso et al., 2012). The therapeutic alliance refers to the positive and trusting relationship between the counselor and client in which both parties invest emotionally in the interpersonal connection and goals of therapy (Orlinksy & Howard, 1987). The working

alliance between a counselor and client may equate with the relationship between a teacher and student (Bordin, 1979). Teacher immediacy behaviors positively correlate with student learning and classroom behavior (Goodboy & Meyers, 2009; Gorham, 1988). Similarly, therapeutic alliance is a strong predictor of positive therapy outcomes such as reaching one's goals and overcoming obstacles (Johansson & Jansson, 2010). There are many different counseling and therapeutic techniques used when working with a client, yet the working alliance applies to all. Edward Bordin (1979) proposed three key areas that contribute to the function of the working alliance: agreement on goals, tasks, and bonds. A strong therapeutic working alliance is a collaborative effort of these three areas within the treatment (Hatcher & Gillaspy, 2006).

In a study described by Bordin (1979), "a major contribution is the indication that the therapeutic alliance is not only a prerequisite for therapeutic work, but often may be the main vehicle of change" (p. 255). First, the client and counselor must agree on the goals of the therapy. These goals are often established within the first meeting. Second, the counselor assigns the client tasks in order to accomplish those goals. These tasks will vary depending on the type of therapy utilized (i.e. behavioral v. psychoanalytic therapy). Also, these tasks must be client-centered, meaning the tasks are tailored to the client's needs and strengths. As a result of goal setting and collaboration of tasks, the last factor in a positive working alliance includes the development of bonds. Deeper bonds are formed when both the counselor and client work in collaboration toward a common goal. The patients' or clients' willingness to participate in the goals of therapy is not only influenced by their personalities but also by the environment and support created by the counselor (Bordin, 1979).

The initial onset of therapy establishes a critical base for beginning the foundation of a strong working alliance. Corso et al. (2012) found that primary care patients rated their therapeutic alliance as statistically stronger than ratings reported by a sample of outpatient clients after the first appointment. In order for this relationship to form, counselors and clients must have communication competence (Hannawa, 2011). To establish the goals, tasks, and bonds described in Bordin's (1979) working alliance model, the counselor and client may need to adjust their communication styles to accommodate for the other. Hannawa (2011) examined the role of verbal and nonverbal communication of physicians disclosing medical information to patients. Results indicated physicians exhibiting more positive immediacy behaviors (i.e. positive affect through facial expressions, nonverbal sensitivity and nonverbal attentiveness, touch, etc.) established a stronger rapport with the recipient of the patient care. According to Communication Accommodation Theory (Griffin, 2009), individuals may adjust their behavior in accordance to match others' nonverbal communication (Hannawa, 2011). Therefore, counselors and clients who engage in similar behaviors may relate more easily than those who do not accommodate their communication styles to the other person. Interestingly, Del Re et al. (2012) also concluded therapists' behavior as a greater predictor of therapy outcome than patient variability. Therefore, nonverbal immediacy and communication accommodation may be essential for patient care and therapeutic trust.

Patient and provider communication.

A key component to the patient-provider relationship is trust (Bohnert et al., 2011). Proposed definitions of trust connect medical providers' actions to patients'

confidence levels in the provider (Pearson & Raeke, 2000). Patients' perceived trust of their physicians has a positive correlation with overall satisfaction (Chang, Chen, & Lan, 2013). Cant and Aroni (2008) evaluated the relationship between dietitians and clients and concluded that interpersonal skills and physical appearance by the dietitian accounted for over half of the variation in patient satisfaction. Other studies have linked patient satisfaction to high-quality doctor-patient relationships (Feaser & Thompson as cited in Coran et al., 2010). Also, Bohnert et al. (2011) concluded that building trust and the perception of trust plays a crucial role in patient sensitivity of communication with the provider. Therefore, increased trust is associated with better patient-provider communication (Fiscella et al., 2004).

An evolving theme within the health communication literature emerges from research on the patients' perceptions and the influence of those perceptions on provider communication and decision making (Bohnert et al., 2011). Physicians often underestimate the viewpoints of the client and, as a result, do not communicate thoroughly (Street & Haidet, 2011). Cousins (1985) discovered that 85% of patients considered changing or actually changed physicians due to the poor communication skills of the physician, thus stressing the importance of the physician's ability to communicate effectively. Patients with severe mental illness reported communication and overall care satisfaction as "poor" because the physicians either chose to avoid addressing the illness or did not know how to conduct themselves in those situations (Bohnert et al., 2011; Duggan et al., 2010). Yet, the more frequently patients verbally or nonverbally express their beliefs, values, and questions, the more effectively the providers can interact with the patients (Coran et al., 2010). Although a series of sequenced questions may address

those issues, quite often patients are not physically able or willing to answer personal questions in the early stages of a diagnosis (Bohnert et al., 2011). Therefore, additional research must assess the communication factors that contribute to better understanding of patient beliefs and perceptions.

By recognizing patient communication needs, the physician may further understand and utilize the necessary techniques to provide the most effective and satisfying communication environment for the patient. Wanzer et al. (2004) emphasized patient-centered communication (PCC), which is behavior that may enhance the relationship between the patient, provider, and/or extended family. Furthermore, they stated that nonverbal immediacy (smiling, eye contact, and gestures) and listening were two important factors of patient satisfaction. Quite often patients are unable to verbally express themselves; therefore, the physician's duty to recognize and address the nonverbal cues relayed by the patient increases in importance (Street & Haidet, 2011). Once the provider can accurately recognize and respond to the subtle cues in communication, the patient will more likely trust the health care provider (Fiscella et al., 2004). As a result, the relationship between communication and patient satisfaction will improve (Chang et al., 2013; Lee & Lin, 2011). However, the ability to recognize these nonverbal cues cannot simply be self-taught or learned in a single day at medical school (Coran et al., 2010); it is a continuous process of enhancing one's abilities and perceptions in order to improve the communication between the physician/counselor and the patient/client.

Current literature regarding patient-provider communication tends to focus on either the patient's perceptions or the provider's beliefs about the relationship (Coran et

al., 2010). Communication is a continuous cyclical process that requires feedback from both the sender and the receiver (Morreale et al., 1998). Daily communication within the health care system is of utter importance because many clients and physicians have a difficult time speaking about the patients' health, and health-related issues are often misunderstood (Duggan et al., 2010). The more open the communication between the provider and patient, the more each party will have a firm understanding of the other's wishes, intentions, and goals (Coran et al., 2010; Street & Haidet, 2011). Additionally, this patient focused communication style must filter through all levels of the health field, not only physical ailments. By researching both the patient's and the provider's perceptions of the relationship and studying the training methods utilized, health communication researchers may discover ways to improve overall communication with individuals who have physical and/or mental struggles.

Client and counselor communication.

The client-counselor relationship may have communication similarities to the provider-patient relationship. Basic counseling skills include attending, questioning, encouraging, reflection of content, reflection of feeling, and summarizing, while advanced counseling skills also include confrontation, self-disclosure, interpretation, immediacy, information, feedback, and directives (Aladağ, 2013). Within the client-counselor interactions, the ability to create a strong therapeutic alliance influences every aspect of therapy (Johansson & Jansson, 2010). Duff and Bedi (2010) define the alliance "as the client and counselor's subjective experience of working together towards psychotherapeutic goals in the counseling context, including the experience of an interpersonal bond that develops while engaged in this endeavor" (p. 91). While there are

many forms of therapy approaches (Cognitive-Behavioral, Person-Centered, Solution-Focused, Gestalt, Adlerian, etc.), each approach stresses the importance of building a strong and trusting relationship with the client (Bordin, 1979; Corey, 2013). Important aspects of this relationship include the counselor's ability to display warmth, empathy, and respect, as well as establishing a bond, developing goals, and assigning strategies to achieve those goals (Sharpley et al., 2006).

As Aladuğ (2013) indicated, the approaches and communication techniques used by counselors are complex. Since clients are often reluctant to receive therapy and do not willingly want to express themselves (Corey, 2013), counseling therapy is dependent on the counselor's ability to recognize and address any and all nonverbal communication signals (Norman, 1982). This aspect of the client-counselor relationship depends not only on the counselor's ability to understand the clients' nonverbal cues but also the message the counselor sends via nonverbal communication.

Furthermore, Sharpley et al. (2006) noted that a counselor's nonverbal behavior positively or negatively impacts rapport with the client. Using a *standardized client*, counselors were perceived to be most effective when their faces expressed interest-excitement and enjoyment-joy (Sharpley et al., 2006). A *standardized client* is a trained research assistant who presents the same problem across multiple counseling sessions, yet also makes minute-by-minute assessments of rapport (Sharpley, Guidara, & Rowley, 1994). The use of a *standardized client* ensures high test-retest reliability and validity across multiple scenarios. Sharpley et al. (2006) indicated a significant relationship between the amount of certain facial expressions and the client's rating of rapport. Additionally, behaviors such as making eye contact, greeting the client with a smile,

sitting without fidgeting, and facing the client all strongly correlate with the therapeutic alliance (Duff & Bedi, 2010).

When nonverbal cues display emotion, signal changes in relationships, or enhance a direct conversation, they may immediately assist the health care provider. Further clues also reveal attempted deception, convey self-perceptions, or expand verbal communication (Grace et al., 1995). Counselors must understand the signals the client transmits as well as the feedback messages they conversely convey to the client (Aladuğ, 2013). Not only does the health care provider need training to understand and decipher patient nonverbal behavior, the provider must analyze, monitor, and practice self-nonverbal conduct so that uncontrolled nonverbal cues do not negatively influence the client-counselor relationship (Ishikawa et al., 2006). Practitioners who engaged in self-touching and non-purposeful movements were rated as less effective than those whose behaviors were purposeful (Ishikawa et al., 2006). Additionally, high quality listening skills may be demonstrated by the counselor's ability to adapt to the client's words (Bodie & Jones, 2012). Yet, when the words and nonverbal cues do not match, the counselor must recognize and adjust to those inconsistencies. By doing so, counselors may help clients further understand themselves.

Client-counselor nonverbal communication

During therapy sessions, the nonverbal message a counselor sends to the client may help or hinder communication. Gaze avoidance, indirect body and facial orientation, leaning away, far distances, and closed body positions (i.e. crossed arms) signify a low involvement in conversation (Remland, 2000). Counselors may also engage in postural mirroring of a client to display synchrony between the client and counselor in an effort to

establish a strong working alliance (collaboration, mutuality, and engagement) (Sharpley et al., 2001). In a study conducted by Sharpley et al. (2001), the counselors engaged in postural mirroring of the torso during high rapport minutes; yet standard posture occurred more frequently during low rapport minutes. Counselor posture opened the flow of communication from counselor to client; yet clients reported a higher rapport with the therapist during those minutes when the counselor's torso mimicked the client's torso. Also noted, mirroring transpires after the initial relationship has occurred, and it is most effective through torso posturing so as to not give the impression of mocking the client (Sharpley et al., 2001). Thus, counselors who engage in postural mirroring may receive a higher rating of rapport/therapeutic alliance than counselors who do not practice this immediacy behavior.

Ultimately, body posture conveys to others how an individual feels toward a person or object, themselves, and the situation (Richmond & McCroskey, 2000a). In the client-counselor relationship, the body posture of the client may or may not indicate to the counselor if the client feels welcome, safe, comfortable, uneasy, stiff, or uninterested. Such behaviors may predict thoughts and perceptions about the client-counselor relationship. Counselors must learn to recognize these signs in order to adapt to the client's needs. Also, clients need to recognize their own behaviors to communicate more effectively with their counselors.

Gentry et al. (2007) evaluated college dorm resident advisors' ability to read facial expressions and their relationships with the hall members. Results indicated that the better the advisors were at accurately distinguishing facial expressions (particularly fear-related), the more effective they functioned as advisors to hall residents. This study

may be generalized to the patient-provider or client-counselor relationship since RA's serve as in-house mentors, counselors, and friends to the members of the hall.

Finally, the effectiveness of the client-counselor relationship may be determined by the client's perception of the counselor's level of commitment to communication. Bush's (1985) study discussed the role of nonverbal communication and gender in patient retention of health information. The more expressive (use of facial expressions, gestures, etc.) the speaker, the more quickly the information was recalled later. The sex of the speaker also influenced the outcome of patient rating. Patients responded more to speakers of the same sex who were highly expressive as opposed to speakers of the opposite sex with low expressiveness (Bush, 1985). As the speaker's expressiveness increased, the patients reported higher opinions of effectiveness, kindness, better explanatory skills, better sense of humor and more understanding. Therefore, the providers' abilities to express themselves with openness both verbally and nonverbally significantly enhanced the communication and positive perception of the interpersonal relationship (Grace et al., 1995; Wanzer et al., 2004). The patient/client reacts to and internalizes the messages and signals the counselor sends, and in a complete collaborative relationship, the feedback loop is cyclical. Thus, communication accommodation may occur between the counselor and the client.

Hypothesis and Research Questions

Ultimately, every individual is intrinsically unique and different. All individuals have their own nonverbal behaviors when communicating; some are better at deceit while others may be read more easily (Richmond & McCrosky, 2000a). Although medical schools and counseling programs provide courses discussing patient care and

communication, few emphasize the significance of nonverbal communication training as a life-long process (Coran et al., 2010; Duggan et al., 2010; Grace et al., 1995). Within these programs, interpreting and practicing effective nonverbal communication must become a key emphasis (Bohnert et al., 2011; Coran et al., 2010; Duggan et al., 2010).

This study analyzed the client-counselor relationship through nonverbal immediacy. While some studies have chosen to identify the perceptions of either the patient or the provider (Coran et al., 2010; Duggan et al., 2010; Street & Haidet, 2011), this study gained insight from both parties. Based on the review of literature and the need to extend understanding of the client-counselor relationship, this study answered the following hypotheses and research questions:

H1: Client perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

H2: Client perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H3: Counselor perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H4: Counselor perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

RQ1: Is there a relationship between the counselors' and clients' perceptions of client nonverbal immediacy?

RQ2: Is there a relationship between the counselors' and clients' perceptions of the therapeutic alliance?

RQ3: Which is a greater predictor of the client ratings of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

RQ4: Which is a greater predictor of the counselor rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

Chapter 3

Methodology

The purpose of this study was to explore the relationship between perceptions of client nonverbal immediacy and perceptions of the therapeutic alliance. By analyzing the following hypothesis and research questions, this study found results that 1) indicated a significant relationship between nonverbal immediacy and therapeutic alliance, 2) identified counselors' abilities to recognize clients' nonverbal behavior and clients' self-assessment of their own nonverbal communication, and 3) assessed the greater predictor of the working alliance, counselor perceptions of client immediacy or client perceptions of client immediacy. Thus the following hypotheses and research questions were answered.

H1: Client perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

H2: Client perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H3: Counselor perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H4: Counselor perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

RQ1: Is there a relationship between the counselors' and clients' perceptions of client nonverbal immediacy?

RQ2: Is there a relationship between the counselors' and clients' perceptions of the therapeutic alliance?

RQ3: Which is a greater predictor of the client rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

RQ4: Which is a greater predictor of the counselor rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

Methodology for the current study included a survey designed to assess the relationship between the nonverbal immediacy of the counselor and the therapeutic alliance. Surveys were administered to both the counselor and the client to gain perceptions of nonverbal communication and the client-counselor relationship. The relationship between variables was assessed via a correlation and regression equation to identify the relationship between nonverbal immediacy and the therapeutic alliance.

Participants

The participants for this study included a purposive sample consisting of counselors and their clients. Participants were male and female with ages ranging 18 years and older. These participants are distinct from random participants because they included actual counselors and individuals currently seeking counseling. Additionally, counselors used a multitude of therapeutic techniques, and the clients had a broad range of mental wellness. Counselors were recruited from a mid-sized Midwestern university counseling service. This university had six counselors willing to participate in the study. The student population was based on each counselor's clientele at the time of data collection. The clients were asked by their counselors to participate in the study.

Counselors asked every client throughout the data collection period to reduce selection bias by the counselors.

For design rationale and replication purposes, actual counselors and clients help further the health communication field and counseling discipline by enabling real-time experiences and judgments. While confederates may be beneficial in an experimental design to help control the use of specific nonverbal communication cues, using actual counselors and clients aids external validity (Ishikawa et al., 2006). Additionally, to assess a therapeutic alliance/rapport, the counseling session and participants should be real. University Counseling Services was chosen because the practicing counselors/therapists/psychologists must be certified by the State in which they serve.

Design

This study used a survey designed to examine the impact of nonverbal immediacy (i.e. eye contact, body posture, and facial expression) on the therapeutic alliance between the counselor and the client. The survey consisted of minor adaptations from previously used surveys as a self-report and others' report measurement. The separate questionnaires were completed by both the counselor and the client immediately following the therapy session. The questionnaire included close-ended questions. Perceptions of the therapeutic alliance and perceptions of nonverbal immediacy (eye contact, gestures, body posture, and facial expressions) were measured. This questionnaire was completed privately to reduce inter-participant bias.

Each survey (one for the client and one for the counselor) was administered immediately following the therapy session. For the convenience of the clients and

counselors and to ensure immediate completion, they were provided a paper copy of the informed consent and survey.

A questionnaire method is the most practical design for this study. Ideally, observing the counseling sessions and physically counting and marking the number of gestures used, the duration of eye contact, and the type of facial expressions used by both the client and the counselor would be the most accurate measurement of the study. However, this option was not feasible considering the counselor-client confidentiality agreement, IRB approval, sampling, and time. While this process may have helped further establish causality between the use of nonverbal immediacy behaviors and the perception of the therapeutic alliance, gaining permission to watch private sessions would have been difficult. However, after the report of findings, the counseling departments may be interested in allowing observation of actual interactions for future research. Other potential methodologies include watching recordings of therapy sessions that are distributed for educational purposes or using confederates to role-play the counseling interaction. While the first option permits observation within a natural setting, there can be no accurate judgment of the counselor or client perceptions of the therapeutic alliance. The second option is an experimental design which allows control over the nonverbal behaviors used by the counselor, then measures the “client’s” perceptions of those interactions. This approach may establish causality, but lacks external validity when generalizing to the actual counselor-client relationship.

Ultimately, a survey design was the most practical method for assessing both the counselor’s and the client’s perception of the client’s nonverbal immediacy and the

impact on the therapeutic alliance. Contrary to other approaches, this method addressed the perceptions of both the counselor and the client.

Instrumentation

The study included two similar, but essentially different, surveys for both the counselor and the client. Instruments contained the Working Alliance Inventory and Physician Nonverbal Immediacy Measure. Each survey combined basic demographic questions and previously used scales.

Working Alliance Inventory-Short Revised.

The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspay, 2006) is a 12-item self-report instrument designed to assess the strength of the alliance between counselor and client. Both the counselor and client completed this instrument. The WAI-SR addresses three key aspects of the alliance: (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy and (c) development of an affective bond. Working and therapeutic alliance are interchangeable terms for this study. Items are rated on a 5-point Likert scale ranging from 1 = never to 5 = always. Sample questions include the following: Goal) *Counselor Name* and I collaborate on setting goals for my therapy; Task) As a result of these sessions, I am clearer as to how I might be able to change; Bond) I believe *Counselor Name* likes me. Scores range from 12-60 with a higher score indicating a stronger relationship between the counselor and the client. The reliability coefficients are within the expected range ($\alpha > .85$) (Hatcher & Gillaspay, 2006). The reliability of the Counselor WAI-SR used in this study was high ($\alpha = .94$). Also, the reliability of the Client WAI-SR produced a high Cronbach's alpha ($\alpha = .86$). Each survey is internally consistent.

Physician Nonverbal Immediacy Measure.

The Physician Nonverbal Immediacy Measure (PNIM; Richmond, Smith, Heisel, & McCroskey, 2001) is 10-item instrument which assesses patient perceptions of physician nonverbal immediacy behaviors. The scale meets reliability criteria ($\alpha = .81$). This is a 5-point Likert response scale (Never = 0, Rarely = 1, Occasionally = 2, Often = 3, Very Often = 4). Using this rating system, participants responded to statements such as: 1) Uses gestures while talking to me; 2) Looks at me while talking; 3) Smiles at me while talking; 4) Has a very tense body while talking to me, etc. The counselors completed the original scale, but the clients used a modified version to rate perceptions of their own nonverbal immediacy (i.e. "I use gestures while talking to the counselor;" "I have a very tense body while talking to the counselor.") (Richmond et al., 2001). Baringer and McCroskey (2000) made a similar modification in their study. The original scale was used to enable students to report on the nonverbal immediacy of their teachers; however, in this study, the teachers rated the students' nonverbal immediacy ($\alpha = .79$). Similarly, this study will modify the original measure to allow the clients to rate their own nonverbal immediacy. Scores range from 10-50 with higher scores indicating a greater use of nonverbal immediacy behaviors. The PNIM used in the current study produced moderately high Cronbach's alpha (Counselor form $\alpha = .84$; Client form $\alpha = .76$).

By using multiple scales, all variables can be more accurately measured. The WAS is a sufficient measure of the alliance and rapport between the counselor and client. While other measures could be used to assess the relationship, the WAS has been tested and the Cronbach's alpha is high (α range = .85 to .90) (Hatcher & Gillapsy, 2006). The

PNIM is a multi-purpose tool for this study. Although its original design assesses the patient's perceptions of physician nonverbal immediacy, it was modified in this study to allow the counselor to report perceptions of the client nonverbal communication (Baringer & McCroskey, 2000). The PNIM is an updated version of the NIM adapted from the Teacher Nonverbal Immediacy Measure (Richmond et al., 2001).

Procedures

Prior to the initial data collection period, each counselor was briefed on the procedures to use for data collection following a counseling session. The counselors then verbally confirmed their willingness to participate in the study or to withdraw at any time. Since the counselors are essential to the study and to avoid researcher bias and a breach of confidentiality, the counselors administered the surveys to themselves and to the client at the end of the session. Counselors asked the clients if they would like to complete the survey. If the client agreed, then the counselor provided the client with an informed consent and survey to privately complete. After the client exited the room, the counselor completed the counselor version of the survey. The counselor only needed to complete the survey if the client also agreed to participate in the study. Each counselor attempted to complete 20 surveys throughout the course of data collection. This process was followed for every client within the collection period to avoid selection bias toward clients with whom they believe to have a better relationship.

Once the clients agreed to participate, they completed the questionnaire away from the counselors. The questionnaires were keyed with a code to avoid any identification information and also to match the counselor with the client. Upon completion, the client was instructed to submit the survey to the secretary. The secretary

was provided an envelope to store each completed survey. This allowed the client to leave without fear of the counselor reading the survey or creating a temptation for the counselor to do so. The counselors completed the survey in the privacy of their offices. Each counselor was provided an envelope in which to place the completed surveys until collected by the researcher. Also, the researcher was completely removed from data collection, avoiding researcher interference or bias and maintaining the client-counselor confidentiality agreement.

Data Analysis

To determine the influence of perceived nonverbal immediacy on the client-counselor therapeutic alliance, a Pearson product-moment correlation was conducted. A correlation assesses the general association between two variables. A statistical analysis of the relationship between perceived nonverbal immediacy of the client and therapeutic alliance will pair the WAI-SR (Richmond et al., 2001) with the PNIM (Hatcher & Gillaspay, 2006). The correlation coefficient, r , can range from -1.0 to +1.0. Both strength and direction of the relationship will be explained by r . An r of .40 to $> .90$ will be considered a moderate to strong association (Frey et al., 2000). A positive relationship indicates that as one variable increases so does the other. For example, as perceived nonverbal immediacy of the client increases, the level of working alliance will also increase. A significance level of $\alpha < .05$ will be established. This denotes that the researcher can be at least 95% certain that any association between nonverbal immediacy and working alliance is not likely to occur by chance in the population. However, a correlation does not establish causality (Frey et al., 2000). Therefore, this study cannot state that more perceived nonverbal immediacy causes a greater working alliance.

Rather, the results will indicate that the two variables may or may not be related to each other.

A correlation represented the best choice of statistical analysis for the current study. The original hypotheses called for a positive association between counselor and client perceptions, client nonverbal immediacy and the ratings of therapeutic alliance. The correlation coefficient provided the direction and strength of the association. Within the hypothesis testing, the following associations were also tested: client ratings of client nonverbal immediacy and client ratings of therapeutic alliance; client ratings of client nonverbal immediacy and counselor ratings of therapeutic alliance; counselor ratings of client nonverbal immediacy and client ratings of therapeutic alliance; and counselor ratings of client nonverbal immediacy and counselor ratings of therapeutic alliance. Based on the review of literature (Bariger & McCroskey, 2000; Cant & Aroni, 2008; & Richmond et al., 2000; Wanzer et al., 2004), the researcher hypothesized that these associations will also be positive. Through this analysis, a correlation was also conducted to assess the relationship between counselor ratings of client nonverbal immediacy and client ratings of client nonverbal immediacy, and counselor and client ratings of the therapeutic, alliance thus answering research questions one and two.

To analyze research questions three and four regarding client and counselor perceptions of client nonverbal immediacy as a predictor of the therapeutic alliance, a regression analysis was conducted. The results of a regression test explain how much the independent variable (i.e. perceived nonverbal immediacy) can predict scores on the dependent variable (i.e. working alliance) (Frey et al., 2000). While knowing that a significant association exists may be sufficient, it is desired to know whether the

counselor's or client's perceptions of client nonverbal immediacy can explain a significant amount of variance in scores on the Working Alliance Inventory-Short Revised scale. A regression analysis was conducted predict the amount of variance in WAI-SR scores. A statistical package known as SPSS Statistics was used to perform statistical analysis on the data collected in this study (Cronk, 2010).

Chapter 4

Results

This study explored the relationship between perceptions of client nonverbal immediacy and perceptions of the therapeutic alliance. In order to assess the hypotheses and research questions posed in Chapter two, 145 surveys were distributed to counselors and clients at a Midwestern university counseling center. The data collection period began on January 19, 2014 and ended on March 1, 2014. The response rate for data collection was 38%. This chapter reports the analysis of counselor and client perceptions of nonverbal immediacy and the therapeutic alliance based on the results of appropriate demographics, Pearson Product Moment Correlations, and Multiple Regression tests.

Demographic information

Participants included six (one male, five females) counselors. The mean age of the counselors was 41.80 ($SD = 13.25$). Counselors years of experience ranged from 2 to 15 ($M = 6.80$, $SD = 5.36$) years. Half of the counselors are licensed professionals and the others are not. Licensed counselors are master's-degreed mental health service providers who have completed the required number of clinical hours and passed the National Counselor Exam (American Counseling Association, 2011). All of the counselors identified themselves as Caucasian.

All students of the university who utilize the counseling services were invited to participate in the study. Participants included 55 (six males, 49 females) students. Age of the clients ranged from 18 to 56 ($M = 22.60$, $SD = 6.26$). Most of the clients were undergraduates (75.40%) as opposed to graduate students (13.1%). A majority of the clients identified themselves as Caucasian (83.6%), 6.5% indicated either African

American, Native American, Asian, or Hispanic heritage, and 9.80% of participants did not respond to the question. Five (8.2%) of clients indicated that this was their first visit with their particular counselor, whereas 50 (80.3%) of the clients had visited their counselor before the data collection period. Additionally, 24 (39.3%) of the clients have been to a counselor outside of the institution used in this study.

Instrumentation

Each survey administered throughout this study contained demographic questions, the Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006), and the Physician Nonverbal Immediacy Measure (PNIM; Richmond et al., 2001). Both counselors and clients completed the WAI-SR to rate the counseling relationship. Scores range from 12 to 60; low scores indicating a weak relationship and high scores implying a strong relationship between the counselor and client. Counselors completed the PNIM rating the client's nonverbal immediacy while the client conducted a self-report assessment of his or her nonverbal immediacy. Scores on the PNIM range from 10 to 50. Low scores indicate the use of very little nonverbal immediacy behaviors, and higher scores designate that the client engaged in many nonverbal immediacy behaviors.

Table one depicts the counselor and client means and standard deviation of scores on the Working Alliance Inventory-Short Revised and the Physician Nonverbal Immediacy Measure. Overall, clients seemed to rate the working alliance higher than the counselors. Mean scores for the client and the counselor on the Physician Nonverbal Immediacy Scales were similar.

Table 1

Means and Standard Deviations of Measures Employed

Scale	<i>M</i>	<i>SD</i>
Working Alliance Inventory-Short Revised		
Counselor Form	45.33	7.16
Client Form	54.67	5.09
Physician Nonverbal Immediacy Measure		
Counselor Form	40.55	4.72
Client Form	38.38	4.76

The following hypotheses and research questions were proposed for this study.

Significance testing was conducted to determine significant relationships between variables.

H1: Client perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

H2: Client perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H3: Counselor perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H4: Counselor perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

RQ1: Is there a relationship between the counselors' and clients' perceptions of client nonverbal immediacy?

RQ 2: Is there a relationship between the counselors' and clients' perceptions of the therapeutic alliance?

RQ 3: Which is a greater predictor of the client rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

RQ 4: Which is a greater predictor of the counselor rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

Client perceptions of client nonverbal immediacy and ratings of the therapeutic alliance

Hypothesis one stated that “client perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance. A Pearson product moment-correlation was performed. This hypothesis was not supported. A significant relationship between client perceptions of their nonverbal immediacy and client ratings of the therapeutic alliance was not found ($r(37) = .16, p = .33, r^2 = .03$).

Hypothesis two predicted a positive relationship between client perceptions of client nonverbal immediacy and counselor ratings of the therapeutic alliance. A significant relationship was not found ($r(33) = .24, p > .17, r^2 = .06$). Client ratings of nonverbal immediacy were not related to counselor ratings of the therapeutic alliance.

Counselor perceptions of client nonverbal immediacy and counselor ratings of the therapeutic alliance

Hypothesis three proposed a positive association between counselor perceptions of client nonverbal immediacy and counselor perceptions of the therapeutic alliance. A moderate positive correlation was found ($r(42) = .37, p = .013, r^2 = .14$), indicating a significant linear relationship between the two variables. The higher the counselor rated client nonverbal immediacy, the higher the rating of counselor's perception of the therapeutic alliance.

Counselor perceptions of client nonverbal immediacy and client ratings of the therapeutic alliance

Hypothesis four projected a positive relationship between counselor perceptions of client nonverbal immediacy and client ratings of the therapeutic alliance. Results indicated that the correlation was not significant ($r(52) = .17, p = .23, r^2 = .03$). The counselors' perception of client nonverbal immediacy was not related to the client ratings of the therapeutic alliance.

Counselor and client perceptions of client nonverbal immediacy

In order to determine the relationship between counselors' and clients' perceptions of client nonverbal immediacy (research question one), a Pearson Product Moment Correlation was conducted. A moderate positive association was found ($r(38) = .43, p = .006, r^2 = .18$), indicating a significant relationship between the two variables. Both the counselors and clients rated the client's nonverbal immediacy in a similar manner.

Counselor and client perceptions of the therapeutic alliance

To evaluate if there is a relationship between the counselors' and clients' perceptions of the therapeutic alliance (research question two), a Pearson Product Moment Correlation was performed. A moderate positive association was found ($r(38) = .39, p = .013, r^2 = .15$), indicating a significant relationship between the two variables. The counselors and clients rated their working relationship similarly. Table 2 depicts the strength of the relationships between the variables as well as the significance of those associations.

Table 2

Correlation Matrix of Continuous Variables

	CLPNIM	CLWAI	COWAI	COPNIM
CLPNIM	1.00			
CLWAI	0.16	1.00		
COWAI	0.24	0.39*	1.00	
COPNIM	0.43**	0.17	0.37*	1.00

Note: CLPNIM = client scores on PNIM; CLWAI = client scores on WAI; COWAI = counselor scores on WAI; COPNIM = counselor scores on PNIM. * $p < .05$ significance level, ** $p < .01$ significance level.

Predicting client rating of therapeutic alliance

The third research question sought to discover if the counselor's perception of client nonverbal immediacy or the client's self-report of nonverbal immediacy is a greater predictor of client therapeutic alliance ratings. In order to assess this research question, a multiple linear regression was calculated. The regression equation was not significant (F

(2, 37) = 1.37, $p = .27$) with an R^2 of .07. Neither counselor nor client ratings of client nonverbal immediacy is a significant predictor of client ratings of therapeutic alliance.

Predicting counselor rating of the therapeutic alliance.

Finally, to predict whether counselor rating of client nonverbal immediacy or client self-report ratings of nonverbal immediacy is a greater predictor of counselor ratings of the therapeutic alliance, a multiple linear regression was performed. The regression equation was not significant ($F(2, 32) = 3.03, p = .06$) with an R^2 of .16. Neither counselor nor client ratings of client nonverbal immediacy is a significant predictor of counselor ratings of therapeutic alliance. Table 3 represents the regression of counselor and client therapeutic alliance rating on counselor and client perceptions of client nonverbal immediacy.

Table 3

Regression of Therapeutic Alliance on Predictor Variables

	Client Working Alliance				Counselor Working Alliance			
	β	t	Sig.	$R^2\Delta$	β	t	Sig.	$R^2\Delta$
Constant		4.91		.07		1.79	.08	.16
COPNIM	-.21	-1.20	.24		.36	1.98	.06	
CLPNIM	.27	1.54	.13		.08	.434	.67	

Note: β = Standardized beta from regression equations. COPNIM = counselor rating of client nonverbal immediacy. CLPNIM = client rating of client nonverbal immediacy.

Summary

This chapter discussed the results of four hypotheses and four research questions using Pearson product moment-correlations and multiple linear regressions. Three of the data analyses conducted produced significant results. Hypothesis three indicated that

“counselor perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.” The correlation was statistically significant.

Although only one hypothesis was statistically significant, two research questions also produced significant results. There is a significant relationship between the counselor’s and client’s perceptions of client nonverbal immediacy. Additionally, the relationship between the counselor’s and client’s perceptions of the therapeutic alliance is significant. However, neither counselor nor client ratings of client nonverbal immediacy are a significant predictor of counselor or client ratings of the therapeutic alliance.

Chapter five discusses the information from the results of this study. Each hypothesis and research question is discussed and recommendations are provided. Proposed limitations and directions for future research are also determined.

Chapter 5

Discussion

This study investigated the association between client nonverbal immediacy and the therapeutic alliance in the client-counselor relationship. Previous studies analyzed patient-provider communication of either the patient or the provider (Coran et al., 2010; Duggan et al., 2010; Street & Haidet, 2011). However, this study evaluated perceptions of the therapeutic alliance from both the counselor and the client. Additionally, both the counselor and the client assessed the client's nonverbal behavior during the counseling session. Through the use of self-report surveys, the researcher examined the following hypotheses and research questions:

H1: Client perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

H2: Client perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H3: Counselor perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance.

H4: Counselor perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.

RQ1: Is there a relationship between the counselors' and clients' perceptions of client nonverbal immediacy?

RQ2: Is there a relationship between the counselors' and clients' perceptions of the therapeutic alliance?

RQ3: Which is a greater predictor of the client ratings of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

RQ4: Which is a greater predictor of the counselor rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?

The researcher recruited participants from a Midwestern university counseling service. Participants included six counselors and their respective clients ($n = 55$). In order for the researcher to remain objective and to respect the confidentiality of the clients, the counselors asked their clients for volunteer participation. If the client agreed to participate, the counselors administered the client form to the client and the counselor form to themselves. At the end of data collection, the researcher gathered the surveys from the counseling office receptionist. Identification of the counselors and the clients remained confidential. Contrary to previous studies (Coran et al., 2010; Wanzer et al., 2004), this study evaluated not only the counselor's perception of client nonverbal immediacy but also the client's perception of his or her own nonverbal behavior and the influence of nonverbal immediacy on the therapeutic alliance. Given the small sample size, analysis of the results is open to interpretation. The data is trending toward significance, and with a larger sample size, more relationships may have been significant.

Client perceptions of client nonverbal immediacy and ratings of the therapeutic alliance

Results indicated that not all hypotheses were supported as initially predicted; however, the study yielded some noteworthy findings to enhance both communication

and counseling research literature. Hypothesis one stated that “client perceptions of client nonverbal immediacy will be positively associated with client ratings of the therapeutic alliance.” This hypothesis was not supported. An increase in client perceptions of client nonverbal immediacy behaviors does not significantly correlate with an increase in their perception of the therapeutic alliance or vice versa. Hypothesis two proposed a positive relationship between client perceptions of client nonverbal immediacy and counselor ratings of the therapeutic alliance. This hypothesis was also not supported. These results seem contrary to previous literature which states that more immediate behaviors lead to liking (Richmond & McCroskey, 2000a). However, Bem’s self-perception theory outlines “the conditions under which we use our own behavior to infer attitudes and beliefs” (Bem, 1967 as cited in Slane & Leak, 1978, p. 241). Through an analysis of self-awareness and immediacy, Slane and Leak (1978) found that “self-perception of liking by way of one’s own immediacy behaviors is a very subtle and even rare process” (p. 246). Bem’s theory offers some explanation as to why client perceptions of their own nonverbal immediacy did not significantly correlate with client and counselor ratings of the therapeutic alliance. Thus, one explanation for the lack of correlation may be explained by the client’s perceived connection with the counselor. If the client believed that the counselor’s relationship was weak, then the client would have used their own nonverbal immediacy to infer his or her degree of liking toward the counselor. However, the clients often rated the therapeutic alliance as high. Therefore, the client most likely relied on the counselor’s nonverbal immediacy to determine their satisfaction with the relationship rather than their own nonverbal immediacy. The

client's self-assessment of their nonverbal behavior has little association with perceptions of the therapeutic alliance.

Nonverbal communication accounts for approximately 65% of communication (Norman, 1982; Putnis & Petelin, 1996). Without nonverbal communication between the counselor and client, the relationship would need to rely solely on verbal communication, which is a minor contributor to overall communication (Mehrabian, 1972). Mehrabian's (1971) immediacy principle proposed that "people are drawn toward persons and things they like, evaluate highly, and prefer" (p. 22). When an individual likes the other person, he or she is more likely to engage in immediate behaviors such as engaged eye contact, natural gestures, and vocal expressiveness (Anderson, 1979). On the other hand, Richmond & McCroskey (2000a) considered the opposite perspective in the principle of immediate communication. The principle of immediate communication implies that immediacy causes liking. The current study argues for both principles. The more the client uses nonverbal immediacy behaviors, the more likely the counselor is to rate the therapeutic alliance as high. Alternatively, clients may also use more nonverbal immediacy because they believe that they have a positive and nonverbally reinforced relationship with the counselor.

Similar to immediacy, accommodation refers to "the constant movement toward or away from others by changing your communicative behavior" (Griffin, 2009, p. 388). In order to create positive immediacy and a stronger relationship between the counselor and the client, both parties may attempt to converge their behaviors to become more similar. The counselor may use postural mirroring of the client (Sharpley et al., 2001); likewise, the client may reciprocate the counselor's eye contact and engage in more eye

contact themselves. As the client feels more comfortable with the counselor, the client's behavior may become more natural. Since client nonverbal immediacy was not significantly correlated to counselor and client ratings of the therapeutic alliance, the clients or counselors may not have felt the desire to accommodate their nonverbal behaviors to become more similar.

Counselor perceptions of client nonverbal immediacy and counselor ratings of the therapeutic alliance

Hypothesis three stated "counselor perceptions of client nonverbal immediacy will be positively associated with counselor ratings of the therapeutic alliance." Results supported this hypothesis. The more nonverbal immediacy the counselor perceived the client to use, the higher the counselor rated the therapeutic alliance. These findings correspond with the principle of immediate communication (Richmond & McCroskey, 2000a). Due to the counselor's perception of client's use of eye contact, gestures, relaxed body position, and vocal expressiveness, the counselor believed the counselor-client relationship to be more effective.

These results are similar to those in Baringer and McCroskey (2000) who examined perceived student nonverbal immediacy behaviors in the classroom and the relationship built from the teacher's level of positive affect toward those students. When students were perceived as more immediate than other students, the teacher reported more positive feelings toward those students and was more motivated to teach them. Baringer and McCroskey's (2000) findings are consistent with the conclusions of the current study. Clients who desire to have a stronger therapeutic alliance with their counselors should engage in positive nonverbal immediacy behaviors. Counselors who

perceive their clients to use more nonverbal immediacy may also be more motivated to work with the client on their tasks and goals.

Additionally, previous research focused on the nonverbal immediacy of the health care provider (Richmond et al., 2001). Through their study, Richmond and researchers concluded that if the patient perceived the physician to use more nonverbal immediacy behaviors, then the patients would be more satisfied with their medical care. Utilizing more immediacy behaviors yields more positive attitudes between communicators (Richmond & McCroskey, 2000b).

Consequently, results of this study are based on the counselor's perceptions of client nonverbal behavior and not necessarily actual client behavior. The findings did not determine causation but rather correlation. The counselor's perception of client nonverbal immediacy and the counselor's perception of the therapeutic alliance increased at the same rate. Arguably, because the counselor rated the therapeutic alliance high, the counselor may then be more drawn to the client and notice more positive immediate behaviors, thus supporting the immediacy principle (Mehrabian, 1971). Counselors and clients may be able to influence each other through the use of nonverbal immediacy (Roter & Hall, 2011). Communication accommodation theory demonstrates that individuals adjust their speech and body language to accommodate to others (Griffin, 2009). As the counselor demonstrates quality listening skills, the client may begin to replicate those nonverbal messages and gain ease with the counselor. Nonetheless, implications of the current study revealed that clients' perceptions of their own immediacy did not associate with ratings of the therapeutic alliance as much as counselors' perceptions of client nonverbal immediacy. Further research is therefore

necessary to study actual client behavior throughout the counseling session rather than only client or counselor perceptions of nonverbal immediacy.

Counselor perceptions of client nonverbal immediacy and client ratings of the therapeutic alliance

Hypothesis four anticipated a positive relationship between counselor perceptions of client nonverbal immediacy and client ratings of the therapeutic alliance. The hypothesis was not supported. The relationship between counselor perceptions of client nonverbal immediacy and client ratings of the therapeutic alliance was not significant. Overall, the counselors rated client nonverbal immediacy and therapeutic alliance lower than the client rated client nonverbal immediacy and therapeutic alliance. Perhaps this is a result of the counselors examining the relationship in a more definitive manner.

Grace et al. (1995) found that those counselors who were trained in nonverbal attending responded more to client nonverbal behavior which lead to higher client ratings of working alliance than those counselors who did not receive the nonverbal attending training. The counselors in the current study may be perceptive of their clients' nonverbal behaviors, which might have led the clients to rate the therapeutic alliance more highly. Interestingly, counselors may be more critical of the client's nonverbal immediacy and the therapeutic alliance because they are trained in nonverbal attending as well as having certain diagnostic expectations of their clients. In Coran et al. (2010) the researchers asked for the physician's perspective of patient-provider communication. While physicians are often criticized for not listening to their patients, the physicians in this study stated that the patients also needed to listen in order to improve communication. Within the counseling profession, counselors must listen extensively to

their clients, yet the counselor also verbally helps to establish goals and tasks in order to improve the client's well-being (Bordin, 1979). If the client did not demonstrate proper listening skills or heed the counselor's directions, then the counselor may have rated the therapeutic alliance lower than the client, despite any client nonverbal immediacy behaviors.

An interesting limitation and implication of this study is that the results are based on perceptions of behavior not actual client behavior. The participating counselors may have over- or under-accommodated their behavior and perceptions of the client's nonverbal immediacy due to the confines of the study. Through fear of evaluation and scrutinization by the researcher, the counselors may have been more critical of the client's behavior and less critical of their analysis of the therapeutic alliance in order to seem more perceptive of nonverbal behavior. Thus creating the disconnect between the counselor and client reports.

Counselor and client perceptions of client nonverbal immediacy

The current research also posed four research questions. The first two research questions asked about the relationship between the counselor's and the client's perceptions of client nonverbal immediacy: Research question one asked "is there a relationship between the counselors' and clients' perceptions of client nonverbal immediacy?" Results indicated a positive correlation does exist. These findings suggest that when the counselor rated the client's nonverbal immediacy as high, the client also rated his or her own nonverbal immediacy behavior as high. Sweeny and Cottle (1976) found no significant difference between a counselor's ability and an untrained observer's ability to detect nonverbal behavior in another person. However, more recently, Gentry

et al. (2007) discussed the difference between highly effective and less effective resident dorm advisors. Those trained advisors who were rated higher demonstrated a greater ability to identify emotions in facial expressions. Recognizing nonverbal cues is a vital part of the counseling process, and counselors who recognize and respond to nonverbal cues receive higher ratings from clients on working alliance measure (Grace et al., 1995). While this study did not compare the counselor's perceptions of the client's nonverbal immediacy to the ability of an untrained observer, the counselors participating in this study did accurately assess the clients' nonverbal behaviors in relationship to how the clients rated themselves. Future research may seek to analyze the effectiveness of counselor training on recognizing and interpreting nonverbal behavior of clients.

Counselor and client perceptions of the therapeutic alliance

Research question two addressed the issue of therapeutic alliance. "Is there a relationship between the counselors' and clients' perceptions of the therapeutic alliance?" Results indicated a positive relationship between the counselor's perception of the therapeutic alliance and the client's perception of the therapeutic alliance. The therapeutic, or working, alliance encompasses the counselor and client relationship from the goals established by the client, the tasks used to achieve those goals, and the emotional bond formed on respect between the counselor and the client (Bordin, 1979). In order to have a successful therapeutic alliance, both the counselor and the client must fully invest in the process and make an interpersonal connection (Orlinksy & Howard, 1987). Those counselors who form strong alliances with their clients see more significant improvement and achievement of therapy goals than counselor-client relationships with a weak therapeutic alliance (Del Re et al., 2012). In this study, the participating counselors

and clients seemed to have formed strong therapeutic alliances. Interestingly, the client's average scores on the Working Alliance Inventory were higher than the counselor's ratings (Client $m = 54.67$, Counselor $m = 45.33$). These results are similar to Street & Haidet's (2010) which indicated that physicians' perceptions of their patients' health beliefs differed significantly. Physicians in the study underestimated how their patients viewed to the health issue. Similarly, counselors rated the therapeutic alliance lower than the clients. The results may be an indicator of the impact of client nonverbal immediacy on the therapeutic alliance. Counselor perceptions of client nonverbal immediacy were significantly related to counselor perceptions of the therapeutic alliance as previously discussed. Logically, a stronger therapeutic alliance between counselor and client will aide in evaluation, diagnosis and therapy implementation. Continued research is necessary to explore the benefits of this positive correlation in order to more fully comprehend the client-counselor communication process.

Predicting ratings of therapeutic alliance

Research questions three and four sought to discover if client ratings of client nonverbal immediacy or counselor rating of client nonverbal immediacy are a greater predictor of client and counselor ratings of the therapeutic alliance. "Which is a greater predictor of the client ratings of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?" And, "Which is a greater predictor of the counselor rating of therapeutic alliance—counselor perceptions of client nonverbal immediacy or client perceptions of self-report nonverbal immediacy behavior?"

Based on the results of the regression analysis, the findings concluded that neither client rating of client nonverbal immediacy nor counselor rating of client nonverbal immediacy are significant predictors of client ratings of the therapeutic alliance or counselor ratings of the therapeutic alliance. Thus, perceptions of client nonverbal immediacy did not predict therapeutic alliance ratings. Implications of this finding indicate that while there is a relationship between counselor perceptions of client nonverbal immediacy and counselor ratings of the therapeutic alliance, how the client nonverbally behaves in the counseling session has little impact on the overall client-counselor relationship. While counselors need to be able to analyze and interpret client nonverbal communication in order to accommodate their own behavior, the client's nonverbal immediacy or nonimmediacy ultimately does not forecast the direction of working alliance.

On the other hand, counselor nonverbal behavior may serve as a greater indicator of a strong therapeutic alliance. Previous research analyzed the impact of counselor nonverbal immediacy on the counselor-client relationship. Counselors who utilized postural mirroring of the client, eye contact and facilitative facial expressions had a better rapport with their clients than those counselors who avoided eye contact, leaned back in their chairs or sat with arms/legs crossed (Remland, 2000, Sharpley et al., 2001). Also, Duff & Bedi (2010) discovered a strong correlation between counselors who make eye contact, greet the client with a smile, sit without fidgeting, and face the client and forming the therapeutic alliance. Seemingly, counselor nonverbal behaviors predict therapeutic alliance outcomes, yet perceptions of client nonverbal immediacy do not. In addition to further exploration of the predictability of quality therapeutic alliances, future

studies may seek to analyze the impact of the therapeutic alliance on nonverbal immediacy behaviors and the clients' perceptions of such.

Limitations and Future Directions

Limitations

A limitation to this study includes a narrow sample of participants (Counselors $n = 6$; Client $n = 55$). When individuals seek counseling, their reasoning to do so is often private, which may hinder the client's likelihood of participating in the study. Further, there may be a bias for those clients who volunteer to participate in this study; this may refine the potential sample to only patients who have a higher comfort level with the counseling and research process. Finally, the goal of the research was to further the counseling discipline and patient-provider research base. However, limiting the sample to only counselors and their clients may not be generalizable (external validity) to all physicians and their patients or other interpersonal relationships. The use of six college counselors does not accurately assess the entire counseling population (Frey, Botan, & Kreps, 2000). Additionally, using only voluntary college counselors and clients from one institution and within a limited time period did not provide the number of participants needed for a more representative research design. The study was conducted in a rural community in which participants cultural differences do not vary compared to a more urban community sample. Also, majority of participants were female; therefore, gender differences may not be discussed.

In this study, counselors asked every client throughout the data collection period to participate. The researcher anticipated each counselor to complete 20 surveys in the one month period. Unfortunately, some of the counselors were only able to complete five

to fifteen surveys. As a consequence, claims about generalization are limited. Within the surveys submitted, some participants chose to leave certain questions unanswered. This again severely limited the number of completed surveys and decreased the likelihood for significant results. Additionally, this study did not control for counselor nonverbal communication or countertransference. Counselors who engage in postural mirroring may receive a higher rating of therapeutic alliance than those counselors who do not practice this immediacy behavior (Sharpley et al., 2001). Also, the counselors' personal experiences and biases may impact the way the client and counselor interact and behave toward one another. Ultimately, the current study represents the client's and the counselor's perceptions of the relationship and nonverbal behavior, yet those perceptions may not be entirely accurate to actual client-counselor behavior.

Future Directions

While the current study provides additional literature toward patient-provider research, future research may seek to expand on the methodology. First, an additional study should combine the use of verbal and nonverbal communication in conjunction with the working alliance. This study may allow researchers to predict which variable correlates with a stronger variance in the working alliance. As we desire to learn from the current research, nonverbal communication plays a significant role in a positive counselor-client relationship. Second, this current study evaluated counselor and client perceptions of client nonverbal immediacy via a survey design. Research that observes the actual session may provide a greater knowledge of reality versus perception. Observing the client-counselor interaction in its natural setting, in addition to the rating of working alliance, may allow researchers to pinpoint specific nonverbal behaviors (i.e. eye

contact, body posture, facial expressions, gestures, etc.) that contribute to the overall alliance. Third, this study was conducted in a rural community. Future studies may seek to analyze nonverbal immediacy in an urban setting to include a multicultural perspective and gender differences. Finally, this research must be applied. As previous literature has demonstrated, counselors are no better than non-counselors at identifying nonverbal behaviors (Sweeny & Cottle, 1976); however, this study revealed that the counselors and clients rated client nonverbal immediacy similarly. The knowledge gained from the client-counselor and nonverbal communication research may be used for the development of training programs to teach counselors and physicians enhanced awareness of the client's nonverbal behaviors and recognition and control over their own nonverbal cues (Grace et al., 1995; Wanzer et al., 2004). Once effectively trained, the physicians/counselors will build a more trusting relationship with their patients/clients (Bohnert et al., 2011). While this study is limited specifically to the counselor/client relationship, its content may be generalized to the patient-provider interaction.

Conclusion

In conclusion, this study hoped to find evidence supporting the hypotheses that perceived nonverbal immediacy (i.e. eye contact, body posture, facial expression, etc.) of the client will positively associate with therapeutic alliance between the counselor and the client. Based on the survey design, expected results produced a significant, positive correlation between the counselor's perceptions of client nonverbal immediacy and counselor ratings of the therapeutic alliance. Further, findings included a positive relationship between counselor and client ratings of client nonverbal immediacy, as well as perceptions of the therapeutic alliance. These findings have potential implications for

nonverbal communication and counseling research. By understanding the role of nonverbal communication more thoroughly and recognizing nonverbal immediacy cues, counselors and other health care providers may significantly improve interpersonal relations with clients and patients, thus creating more effective/satisfying therapy results, while also continuing to build the client-counselor and patient-provider bond.

Appendices

Appendix A



South Dakota State University

Office of Research/Human Subjects Committee

SAD Room 124

Box 2201 SDSU

Brookings, SD 57007

To: Valerie Kleinjan, Department of Communication Studies and Theatre

Date: December 10, 2013

Project Title: The Relationship between Nonverbal Immediacy and Therapeutic Alliance in Higher Education Client-Counselor Interactions

Approval #: IRB-1312005-EXM

Thank you for taking such care in completion of the request and research protocol. This project is approved as exempt human subjects' research. The basis for your exempt status from 45 CFR 46.101 (b) is:

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

If there are any unanticipated problems involving risks to subjects or others, or changes in the procedures during the study, contact the SDSU Research Compliance Coordinator. At the end of the project please inform the committee that your project is complete.

If I can be of any further assistance, don't hesitate to let me know.

Sincerely,

Norm

Norman O. Braaten
SDSU Research Compliance Coordinator

Appendix B

Client Cover Letter with Implied Consent

Dear Participant:

I, Valerie Kleinjan am conducting a research project entitled "The Relationship between Nonverbal Immediacy and Therapeutic Alliance in Higher Education Client-Counselor Interactions" as part of a master's thesis at South Dakota State University.

The purpose of the study is to evaluate the relationship between the client and the counselor.

You, as a student, are invited to participate in the study by completing the attached survey. We realize that your time is valuable and have attempted to keep the requested information as brief and concise as possible. It will take you approximately five to ten minutes of your time. Your participation in this project is strictly voluntary. Choosing to participate or not participate in the study will have no effect on the quality of care and advice you receive from the counselor. You may withdraw from the study at any time without consequence.

There are no known risks to you for participating in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn as a result of this study.

Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title or any other identifying item. Your responses will be anonymous to both the researcher and the counseling staff to ensure that they cannot be linked to you.

Please assist us in our research and return the completed survey to the office secretary, and she will file the survey in an envelope. If you decide to stop participating at any time, please return your blank survey to the office secretary. You are also free to not answer specific questions on the survey.

Your consent is implied by the return of the completed questionnaire. Please keep this letter for your information. If you have any questions, now or later, you may contact us at the number below. Thank you very much for your time and assistance. If you have any questions regarding your rights as a research participant in this study, you may

contact the SDSU Research Compliance Coordinator at 605-688-6975,
SDSU.IRB@sdstate.edu.

Sincerely,

Valerie Kleinjan
Communication Studies & Theatre
SDSU Pugsley Continuing Education Center
Box 2218
Brookings, SD 57007
valerie.kleinjan@sdstate.edu
(605) 688-6131

This project has been approved by the SDSU Institutional Review Board, Approval No.:
1312005-EXM

Appendix C

Counselor Cover Letter with Implied Consent

Dear Participant:

I, Valerie Kleinjan am conducting a research project entitled "The Relationship between Nonverbal Immediacy and Therapeutic Alliance in Higher Education Client-Counselor Interactions" as part of a master's thesis at South Dakota State University.

The purpose of the study is to evaluate the relationship between the client and the counselor.

You, as a counselor, are invited to participate in the study by completing the attached survey. We realize that your time is valuable and have attempted to keep the requested information as brief and concise as possible. It will take you approximately five to ten minutes of your time. Your participation in this project is voluntary. You may withdraw from the study at any time without consequence.

There are no known risks to you for participating in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn as a result of this study.

Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title or any other identifying item. Your responses will be anonymous to ensure that they cannot be linked to you.

Please assist us in our research and file the completed survey in the enclosed envelope. If you decide to stop participating at any time, please discard your blank survey in a separate envelope. You are also free to not answer specific questions on the survey.

Your consent is implied by the return of the completed questionnaire. Please keep this letter for your information. If you have any questions, now or later, you may contact us at the number below. Thank you very much for your time and assistance. If you have any questions regarding your rights as a research participant in this study, you may contact the SDSU Research Compliance Coordinator at 605-688-6975, SDSU.IRB@sdstate.edu.

Sincerely,

Valerie Kleinjan
Communication Studies & Theatre
SDSU Pugsley Continuing Education Center
Box 2218
Brookings, SD 57007
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(605) 688-6131

This project has been approved by the SDSU Institutional Review Board, Approval No.:
1312005-EXM

Appendix D

Counselor Information Sheet

Participation in a Research Project
South Dakota State University
Brookings, SD 57007

Department of Communication Studies and Theater

Project Director: Valerie Kleinjan

Phone No. (605) 688-6554

E-mail valerie.kleinjan@sdstate.edu

Date 12-2-13

Please read (listen to) the following information:

1. This is an invitation for you as a counselor to participate in a research project under the direction of the Communication Studies and Theatre Department.
2. The project is entitled "The Relationship between Nonverbal Immediacy and Therapeutic Alliance in Higher Education Client-Counselor Interactions."
3. The purpose of the project is to evaluate the relationship between the client and the counselor.
4. If you consent to participate, you will be involved in the following process, which will take about five to ten minutes of your time: Following an individual session, you will discuss the research study with your client by reviewing the cover letter. If the client agrees to participate, then you may present them with the survey which is to be completed privately in the waiting area. Once the client exits the room, then you as the counselor will complete your version of the survey. Upon completion, file the survey in the enclosed envelope. If the client declines to participate, then you do not need to complete a survey. This process should be followed for every client during the data collection period. If the client has already completed the survey, then they should not complete it again. Clients under the age of 18 will not be allowed to participate without parental consent.
5. Participation in this project is voluntary. You have the right to withdraw at any time without penalty. If you have any questions, you may contact the project director at the number listed above. The quality of care provided to the client should not be influenced by their choosing to participate or not participate in the study.
6. There are no known risks to you for participating in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn

as a result of this study.

7. There is no compensation for your participation in this study.
8. Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title or any other identifying item.
9. As a research participant, I have read the above and have had any questions answered. I will receive a copy of this information sheet to keep.

If you have any questions regarding this study you may contact the Project Director. If you have questions regarding your rights as a participant, you can contact the SDSU Research Compliance Coordinator at (605) 688-6975 or SDSU.IRB@sdstate.edu.

This project has been approved by the SDSU Institutional Review Board, Approval No.: 1312005-EXM

Appendix E

Demographics: Counselor Form

DIRECTIONS: Please respond to the following demographic questions. Circle the answer that applies or fill in the blank with your response.

Survey ID# _____

1. What is your gender? Female Male
2. What is your age? _____
3. What is your ethnicity? African American Asian
 Caucasian Hispanic
 Native American Other _____
4. Are you a licensed professional? Yes No
5. How many years of experience? _____
6. Is this an initial assessment/clinical interview/intake/evaluation of this client?
 Yes No

Appendix F

Demographics: Client Form

DIRECTIONS: Please respond to the following demographic questions. Circle the answer that applies or fill in the blank with your response.

Survey ID# _____

1. What is your gender? Female Male

2. Age: _____

3. What is your ethnicity? African American Asian
 Caucasian Hispanic
 Native American Other _____

4. Is this your first time with this therapist?
 Yes No

5. Have you been to see a counselor somewhere outside of this institution?
 Yes No

6. Are you an undergraduate or a graduate student? _____

Appendix G

Working Alliance Inventory—Short Form: Counselor

DIRECTIONS: As you read the sentences, mentally insert the name of your client in place of _____ in the text. If the statement describes the way you always feel (or think) mark the *Always* space; if it never applies to you mark the *Seldom* category. Use the following ratings to describe the variations between these extremes. Please indicate the rating which mostly closely describes your relationship in the space to the right of the statement.

	Seldom	Sometimes	Fairly Often	Very Often	Always
1. _____ and I are working toward mutually agreed upon goals					
2. We agree on what is important for _____ to work on.					
3. _____ and I collaborate on setting goals for his/her therapy.					
4. We have established a good understanding of the kind of changes that would be good for him/her.					
5. What I am doing in therapy gives _____ new ways of looking at his/her problem.					
6. I feel that the things we do in therapy will help _____ accomplish the changes that he/she wants.					
7. As a result of these sessions, _____ is clearer as to how he/she might be able to change.					
8. I believe the way we are working with _____ problem is correct.					
9. I believe _____ likes me.					
10. _____ and I respect each other.					
11. I feel that _____ appreciates me.					
12. I feel _____ cares about me even when I do things that he/she does not approve of.					

Appendix H

Working Alliance Inventory—Short Form: Client

DIRECTIONS: As you read the sentences, mentally insert the name of your therapist in place of _____ in the text. If the statement describes the way you always feel (or think) mark *Always*; if it never applies to you mark the *Seldom* space. Use the following ratings to describe the variations between these extremes. Please indicate which rating mostly closely describes your relationship in the space to the right of the statement.

	Seldom	Sometimes	Fairly Often	Very Often	Always
1. _____ and I are working toward mutually agreed upon goals					
2. We agree on what is important for me to work on.					
3. _____ and I collaborate on setting goals for my therapy.					
4. We have established a good understanding of the kind of changes that would be good for me.					
5. What I am doing in therapy gives me new ways of looking at my problem.					
6. I feel that the things I do in therapy will help me accomplish the changes that I want.					
7. As a result of these sessions, I am clearer as to how I might be able to change.					
8. I believe the way we are working with my problem is correct.					
9. I believe _____ likes me.					
10. _____ and I respect each other.					
11. I feel that _____ appreciates me.					
12. I feel _____ care about me even when I do things that he/she does not approve of.					

Appendix I

The Physician Nonverbal Immediacy Measure (PNIM): Counselor Form

DIRECTIONS: Please respond to the questions based on the behavior of the client you saw immediately prior to completing this survey. The following statements describe the ways some people behave while talking with or to others. Please indicate in the space at the right of each item the degree to which you believe the statement applies to **(fill in the client's name)**. Please use the following 5-point scale:

The Client...	Never	Rarely	Occasionally	Often	Very Often
1. Uses gestures while talking to me.					
2. Speaks with a monotone or dull voice when talking to me.					
3. Looks at me while talking.					
4. Smiles at me while talking.					
5. Has a very tense body position while talking to me.					
6. Frown while talking to me.					
7. Looks elsewhere while talking to me.					
8. Has a very relaxed body position while talking to me.					
9. Smiles at me as he or she comes in the room.					
10. Uses vocal variety when talking to me.					

Appendix J

The Physician Nonverbal Immediacy Measure (PNIM): Client Form

DIRECTIONS: Please respond to the questions based on your own behavior in the session immediately prior. The following statements describe the ways some people behave while talking with or to others. Please indicate in the space at the right of each item the degree to which you believe the statement applies to you. Please use the following 5-point scale:

I...	Never	Rarely	Occasionally	Often	Very Often
1. Use gestures while talking to the counselor.					
2. Speak with a monotone or dull voice when talking to the counselor.					
3. Look at the counselor while talking.					
4. Smile at the counselor while talking.					
5. Have a very tense body position while talking to the counselor.					
6. Frown while talking to the counselor.					
7. Look elsewhere while talking to the counselor.					
8. Have a very relaxed body position while talking to the counselor.					
9. Smile at the counselor as he or she comes in the room.					
10. Use vocal variety when talking to the counselor.					

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