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The Counseling Relationship Assessment Measure (CRAM): Initial Validation and Psychometric Properties

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A B S T R A C T

Objective: A new measure of the counseling relationship is presented, which is needed given advances in concepts related to the counseling relationship.

Methods and Materials: The research team developed 100 items to assess these three factors from the perspectives of the counselor (50 items) and the client (50 items), then had 12 professional counselors serve as content validity judges; based on their feedback, several items were deleted or modified. The modified measures were sent to 168 counselors and to 252 clients, and Exploratory Structural Equation Modeling (ESEM) and then Confirmatory Factor Analysis (CFA) were used to examine their factor structure.

Findings: Analyses yielded two 6-item versions of the measure (i.e., client and counselor forms), incorporating frame, motivation, and action assessments, demonstrating strong psychometric properties.

Conclusion: The new measure can be used as a complement to or as an alternative to existing measures of the counseling relationship in research or practice.

Keywords: *Relationship Assessment, Framework Consensus, Collaborative Motivation, Collaborative Action*

1. Introduction

There are measures in the literature with which to assess the process and outcome of counseling, including measures of the relationship that develops between the client and counselor (Mercadal et al., 2025; Opland & Torrico, 2024). Operationalized in several ways over the course of many decades (Gelso, 2019), the relationship has been shown to be the most consistent and robust predictor of outcome (Doukani et al., 2024; Wampold & Imel, 2015). Three primary components of the relationship have been defined over many decades: First, a transference/countertransference configuration that dates back to the earlies days of counseling and, second and most recently, a real relationship that involves genuine and realistic perceptions between the participants (Gelso, 2011). However, it is the third component, the working alliance, or the "working part" of the relationship (Gelso, 2019) that has received the most empirical attention (Flückiger et al., 2018).

While several conceptualizations of the alliance have been published over the years, it is the working alliance operationalized by Bordin (1979) that has received the greatest amount of empirical attention (Bordin, 1979). Bordin's operationalization of the alliance in terms of goals, tasks, and bond has proved so useful that some readers see it as the very definition of the relationship in counseling. However, in the past couple of decades there has been discussion about the importance of re-visiting the nature of the working relationship in a way that goes beyond Bordin's operationalization on agreement on goals, tasks, and bond (Gelso, 2006, 2019; Hatcher & Barends, 2006). There are several reasons for the call to revisit how we define the alliance/working relationship. First, in many counseling approaches, goals and tasks are not overtly outlined or discussed, and yet in these same counseling approaches, broad aims and targets *are* part of the work, giving counseling a sense of purpose and direction. Gelso and Hayes (1998) pointed to the importance of thinking about the alliance as a process where the counselor and client collaborate in counseling, often without overtly discussing or setting of goals or tasks to guide the work (Gelso & Hayes, 1998). Second, Gelso (2011; 2019) has also advanced the concept of the real relationship in counseling, which emphasizes a deeper person-to person partnership and collaboration between counselor and client (Gelso, 2011, 2019). The real relationship advances a two-person conceptualization where both client and counselor experience and express genuine perceptions of one another, and contribute collaboratively to the process and outcome of counseling. Numerous studies have now shown that the real relationship is related to and distinct from the alliance, and that the real relationship plays a significant role in shaping process and outcome (Mallinckrodt, 2022). Therefore, it seems important to include in a measure of the working relationship items that account for aspects of the real relationship in counseling.

Third, the vast empirical evidence that has been generated by studies of the Transtheoretical Model (Prochaska & Norcross, 2018) of change supports the development of a new measure. The TTM postulates that there are varying levels of motivation and action on the part of the client, which are correlated with the client's stage of change, and which demand a tailoring of interventions by the counselor to enhance client motivation and action. Motivation is key to undertaking the rigors of counseling, and all forms of counseling recognize that client change/growth is difficult, even painful (Oliveira et al., 2022); clients are often times ambivalent about making difficult decisions, such as adapting new lifestyles, creating boundaries with others in their lives, trusting others including their counselor, and accepting help. As informed by the TTM, rather than seeing motivation as a separate factor outside of the relationship, the new measure being proposed in the current study envisions *both* counselors and clients experiencing varying levels of motivation at different points in counseling, and therefore both experience varying levels of strength in their counseling relationship.

Fourth, all forms of counseling tend to recognize that client change, whether emotional, cognitive, behavioral, or interpersonal, involves action, often tiny steps that accrue in the right direction toward more perceptible outcomes. The new measure being created in the current study envisions the relationship as marked by a series of actions that clients (and their counselors) engage in in counseling. The measure accounts for the client feeling like their counselor is with them every step of the way. A collaborative, joint venture toward change explains the strong link between clients' and counselors' ratings of their relationship with their ratings of outcome (Wampold & Imel, 2015).

1.1. Beyond Bordin

The current study attempts to integrate into a new measure of the counseling relationship aspects of counseling that have not been accounted for in existing measures of the

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working relationship. The new measure will not be limited to the assessment of the relationship solely on agreement on goals and tasks, as originally proposed by Bordin (1979), since many forms of counseling do not overtly set goals and tasks as part of the work (Bordin, 1979). The new measure will assess aspects of the *person-to-person* connection between participants, which goes beyond the traditional, and narrow, characterization of the working relationship as being one between a *counselor and a client*. Third, the new measure will account for the all-important factor of motivation, and sees motivation as interpersonal dimension that is contributed to by both client and counselor. And lastly, the new measure accounts for action: since clients inevitably start thinking and exploring in new ways, sharing previously undisclosed feelings and experiences, and start trying out new behaviors, even small steps, toward growth/change. By accounting for these four components, the new measure of the relationship integrates crucial yet common phenomena that underlie the counseling process.

1.2. Framework Consensus, Collaborative Motivation and Collaborative Action

Fuertes et al. (2020), informed by the literature calling for a revision of the alliance in counseling, particularly the need to go beyond the establishment of goals and tasks as a core component of the alliance, as well as statements and empirical support behind the concept of the real relationship and the empirical evidence on motivation and the TTM, conceptualized the counseling relationship as comprised of three interrelated counselor-client factors (Fuertes et al., 2020): they called these three factors framework consensus, collaborative motivation, and collaborative action. In this new tripartite conceptualization of the counseling relationship, described in more detail below, it is not just the counselor who sets the frame for counseling, but the client as well, and it is not just the client who wrestles with motivation and engages in action, but the counselor as well. Both participants are seen as influencing one another and working together in every facet of counseling.

Framework consensus is conceived of as the extent to which the counselor *and* client see "eye-to-eye" and believe that they are on "the same page" about the focus of the work. Consensus is not limited to an agreement on goals and tasks, but is seen as more of a general agreement on how the client's needs are being discussed and the direction that the therapy is taking. Framework consensus is also characterized by trust, liking, and a growing confidence on the part of the client for the therapist (Gelso, 2011, 2019), the client opens up more and shares more deeply, and the therapist may choose to disclose, judiciously and a clinically-appropriate manner. The frame of counseling, usually thought of as established and maintained by the counselor, is seen as inevitably influenced and shaped by the client's input (Flückiger et al., 2018). The client's input may be effortlessly incorporated by the counselor into the frame of counseling, or it may be negotiated between them, as noted by Safran and Muran (2006). Fuertes et al. (2020) propose that framework consensus begets collaboration between client and therapist (Fuertes et al., 2020; Safran & Muran, 2006).

Rather than seeing motivation as a quality that the client brings to counseling, collaborative motivation refers more to the motivation that is established and developed jointly between the client and counselor (Oliveira et al., 2022; Prochaska & Norcross, 2018). Clients bring varying levels of motivation to counseling depending on the stage of change in which they find themselves in counseling (Prochaska et al., 1995). The *process of change* is centered on the counselor adapting the therapeutic stance and associated interventions that optimally meet the client where the client is at in the process of change (e.g., precontemplation, contemplation, etc.); the *progress of change* is facilitated by the client and counselor developing an increasingly collaborative stance, fueled by collaborative motivation, working together with a sense that they are allies on a common mission- a mission that benefits the client (Hatcher & Barends, 2006; Westermann et al., 2019).

Consensus and collaboration facilitate action. While varying significantly depending on the type counseling provided, collaborative action is in place when clients sense that they are not venturing forth alone, but that their counselors are with them along the way. The client senses that the counselor is working strategically and empathically as an ally of the client: exploring, evaluating, preparing, and supporting whatever work or steps the client chooses to take (Prochaska & Norcross, 2018). When action is collaborative, counselors are involved as partners in devising or revising a plan with the client; counselors provide encouragement and motivation, and are often crucial supports to the client in taking steps toward change. In other words, counselors are more than just "experts dispensing advice" as Clara Hill noted (2014, p. 334); counselors are not distant to the action or disinvested in the process of client change (Hill, 2014).

In the new measure being developed, framework consensus, collaborative motivation and collaborative action are seen as interrelated and synergistic; they shape and

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influence one another, and their combined effect in a dyad represent the level of strength of the relationship.

1.3. Hypotheses

In order to examine the validity of the new measure, we included in the analysis other existing measures of the relationship in the literature, which are described below. It was hypothesized that there would be significant overlap between the new measure, the CRAM, with other measures of the relationship. It was also hypothesized that there would be a moderately strong, positive and significant relationship between the CRAM and a measure of counseling outcome. Finally, in order to establish discriminant validity, it was hypothesized that the CRAM would not correlate at all with a measure of *private* self-consciousness (PSCS; since the latter is more an indication of private and hidden intrapsychic aspects of the self, and not *interpersonal* self-consciousness (Nystedt & Ljungberg, 2002).

2. Method

The Institutional Review Board at Adelphi University reviewed and approved the study (#121520). There were three phases. First, based on the literature cited, the team worked individually to brainstorm items to assess each of the three constructs: framework consensus (FC), collaborative motivation (CM) and collaborative action (CA). During this time period the team met weekly to review the items, and reworded, refined, and added/deleted items until a list of 100 items was obtained; 50 of these items pertained to a counselor form and 50 to a client form.

The second phase involved a content analysis. The research team asked 20 professional counseling contacts in the New York Metropolitan area to participate, and 12 agreed. They were asked to review, rate, and comment on the 50-item CRAM measures (both counselor and client forms). In terms of self-reported gender, the sample included three men, 8 women, and one who responded as "non-conforming". Their age was M=41.76, SD=5.23 with an average of 12 years of counseling experience. The participant pool was predominantly white (n = 6) but included participants who identified as African-American (n = 1), Hispanic or Latino/a (n = 2), and Middle Eastern (n =1). Two reported working primarily in hospital settings, two in university academic departments, and eight in counseling centers or private practices. Ten reported their highest earned degree as Ph.D. or Psy.D., 2 held master's degrees or licensures as mental health counselors. The respondents rated on a scale from 1 (low) to 5 (high) the extent to which they believed in and adhered to the theory and techniques of psychoanalytic/psychodynamic counseling approaches (M=4.2, SD=.63), humanist-existential counseling approaches (M=3.5, SD=1.08) and cognitive-behavioral counseling approaches (M=3.1, SD=1.44).

The respondents were provided a brief explanation of the project and written definitions of each of the three constructs (i.e., FC, CM, and CA), and were asked to rate the extent to which each item was representative of the construct, using the following scale: 1 = "*Unrepresentative*", 2 = "*Somewhat Unrepresentative*", 3 = "*Slightly Unrepresentative*", 4 = "*Not Sure*", 5 = "*Slightly Representative*", 6 = "*Somewhat Representative*", and 7 = "*Representative*". They were also invited to make suggestions for deletions, changes, or additions to all items.

The team evaluated the reviewers' ratings, comments, and suggestions, and made changes to the wording of some items and deleted others based on the feedback. The research team also deleted any items that had a reviewer mean score lower than 5 (i.e., "*Slightly Representative*") on the scale of 1 to 7. The results of the content analysis paired down both forms of the CRAM to 40 items each, with the counselor form then being comprised of 12 CM items, 15 FC items, and 13 CA items. The client form was then comprised of 12 CM items, 14 FC items, and 14 CA items.

2.1. Inclusion and Exclusion Criteria

Using Prime Panels, recruitment was narrowed to only participants currently receiving mental health counseling, who spoke English fluently, who were at least 18 years of age, and who lived in the United States, Canada, England, or Australia. Prime Panels ensures response quality by only allowing participation from highly rated participants in previous studies.

2.2. Sampling Procedures and Data Collection

For the counselor measure, we relied on listservs of organizations related to the practice of counseling. Participants were offered the chance to enter a raffle to win one of six $50 gift cards. Data collection on the counselor form took almost six-months.

For clients, initial recruitment was conducted through clinicians who had completed the counselor form and were asked to offer the option to participate to their clients. However, we only received a handful of surveys using this method, even after about eight weeks of recruitment. After a

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review of the available literature validating online platforms (Chandler et al., 2019) our study proceeded with collecting client data using CloudResearch's Prime Panels function, which integrates Amazon MTurk recruiting tools into CloudResearch's proprietary recruitment and advertising frameworks to specify demographics and target participants. CloudResearch employs a variety of techniques to identify bots and inattentive, careless, or dishonest responding, ensuring data quality by blocking low-quality participants, duplicate IP addresses, suspicious geocode locations, verifying worker country locations, and blocking any participants who had previously failed any attention checks in other experiments. Using Prime Panels, recruitment was narrowed to only participants currently receiving mental health treatment, while living in the United States, Canada, England, or Australia. Prime Panels were also used to ensure response quality by only allowing responses from highly rated respondents in terms of quality and rate of approval of responses. Additional measures were implemented to prevent low-quality and bot-automated responses from decreasing the quality of the final dataset. To ensure participants progressed through the full study, participants were required to submit a randomly generated code from the survey to get credit for their work. Participants were offered $.75 in MTurk credit in exchange for completion of the survey. Upon agreeing to participate, respondents were redirected by CloudResearch to the survey hosted on Qualtrics XM. Partially and fully incomplete responses were flagged and automatically recorded into Qualtrics after one week of inactivity. On-line data collection was completed over a 6-week period.

2.3. *Participant Characteristics*

Counselors: Collected data were obtained from 168 counselors, but due to incomplete surveys, our demographic and response analyses were performed on a sample size of N = 129. The sample was 64% female (n = 83) and 36% male (n = 46), with an average age of 41.07 (SD = 16.49) and an average of 13.64 years of clinical experience (SD = 14.99). Seventy four percent of the clinicians identified as White (n = 95), 2% as Black or African American (n = 3), 5% as Asian-American (n = 7), 13% as Hispanic or Latino (n = 17), and the remaining 5% (n = 7) identified as "Other" or identified with more than one ethnic background. The sample included Ph.D., Psy.D., or Ed.D. psychologists (n = 65), Master's degree recipients (n = 49), and Master's degree candidates (n = 15), all of whom had clinical experience in either a counseling center (n = 13), private practice (n = 49), mental health center (n = 63), or hospital (n = 4). On a scale from 1 (indicating "Low" adherence) to 5 (indicating "High" adherence), the counselors reported the following as their adherence to three theoretical orientations: psychodynamic/psychoanalytic (M = 3.43, SD = 1.24), humanists/existential (M = 3.11, SD = 1.25), and cognitive-behavioral (M = 3.46, SD = 1.29).

Clients: Collected data were obtained from 252 clients, but due to incomplete surveys, our demographic and response analyses were performed using a sample size, N = 229. Like the counselor sample, the client sample was predominantly female, with 67% of respondents identifying as female (n = 154), and 32% (n = 73) identifying as male. The remaining 1% of participants (n = 2) identified outside of the gender binary. The sample presented with an average age of 38.64 years (SD = 11.92). The results show that 80% of participants identified as White (n = 84), 6% as Black or African-American (n = 14), 3% as Asian American (n = 8), and approximately 7% identified as Hispanic or Latino (n = 16). One participant identified as Native American, while the remaining 2% (n = 6) identified as "Other" or as identified with more than one ethnic background. Participants reported being married or part of a committed, long-term relationship (n = 135), 31 reported as divorced or separated from an intimate partner (n = 31), three identified as widows or widowers, and 60 as single. The median reported income in U.S. dollars ranged from $20,000 to $49,999 ($n$ = 71), 15% of participants reporting earning less than $20,000 ($n$ = 34), approximately 30% reporting income upwards of $80,000 ($n$ = 69), and 24% (n = 55) reporting incomes between $50,000 and $79,999. Almost 83% of respondents (n = 190) held a Bachelor's degree or higher, while only 15% (n = 35) held a high school diploma. Around 2% (n = 4) reported certification or accreditation from a vocational or technical school. The clients' reported average number of sessions with their counselors was 30.70 (SD = 55.82).

2.4. *Measurement of Constructs*

Demographic Questionnaire. We developed a demographic questionnaire to gather information about the participants including age, gender, education, income, and marital status. The data obtained with this questionnaire were presented above.

Counseling Relationship Assessment Measure (CRAM). This is the new measure developed in the current study. As noted above, the CRAM contained 40 items prior

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to factor analysis. All items on both forms are rated on a scale from 1 = "*Never*," 2 = "*Rarely*," 3 = "*Occasionally*," 4 = "*Sometimes*," 5 = "*Often*," 6 = "*Very Often*," 7 = "*Always*." The following are sample items from the client form: "I am motivated to work with my counselor" (CM subscale); "We seem to have a common agenda in counseling" (FC subscale); "We are working very well together" (CA subscale). The counselor form also contained 40 items. The following are sample items from the counselor form: "I am motivated to work with my client" (CM subscale); "We seem to have a common agenda in counseling" (FC subscale); "We are working hard together" (CA subscale). The psychometric properties of the CRAM are described below.

Working Alliance Inventory-Short Version Counselor and Client Forms (Tracey & Kokotovic, 1989). Participants' emotional bond and level of agreement with

the tasks and goals of counseling were measured with the 12-item short version of the client and counselor forms of the WAI-S. Each item is rated on a 7-point Likert scale (1= "*never*" to 7 = " *always*"). A sample item from the client form is "I am confident in my counselor's ability to help me" (Bond subscale). A sample item from the counselor form is "My client and I have built a mutual trust" (Bond subscale). Individual subscale and overall measure scores were calculated for both forms. Tracey and Kokotovic (1989) found the WAI-S to have excellent internal consistency: counselor scale (Cronbach's α = .95) and client scale (α = .98). With the current sample, the internal consistency of the client form was (α = .90, McDonald's ω = .95). Similarly, high values were obtained for the counselor form (α = .88; ω = .92).

California Psychotherapy Alliance Scale (CALPAS). The CALPAS (Gaston & Marmar, 1994) is a 24-item inventory with separate patient and clinician forms, and each form is comprised of the following four, six-item subscales: Patient Working Capacity (PWC), Patient Commitment (PC), Working Strategy and Consensus (WSC), and Therapist Understanding and Involvement (TU). All items on both forms are rated on a scale from 1 = "*Not at all*," 2 = "*A little bit*," 3 = "*Somewhat*," 4 = "*Moderately*," 5 = "*Quite a bit*," 6 = "*Quite a lot*," 7 = "*Very much so*." A sample item from the client PC subscale is: "Did you find yourself tempted to stop therapy when you were angry or disappointed with therapy?" A sample item from the counselor PWC subscale is: "Client self-disclosed thoughts and feelings." Individual subscale and overall measure scores were calculated for both forms. With the current sample, the internal consistency of the client form ranged from adequate to good for all subscales (total score: α = .94, ω = .94; PWC: α = .69, ω = .74; PC: α = .71, ω = .73; WSC: α = .84, ω = .84; TU: α = .86, ω = .87). Similarly, high values were obtained for the counselor form (total score: α = .94, ω = .96; PWC: α = .88, ω = .89; PC: α = .91, ω = .92; WSC: α = .74, ω = .84; TU: α = .75, ω = .83).

Counseling Outcome Measure (Gelso & Johnson, 1983). The COM is a four-item measure that assesses clients' and counselors' perceptions of client improvement since the start of counseling. Items ask clients to assess perceived improvement in "my feelings," "my behavior," "my self-understanding," and "overall functioning." The counselor form is slightly reworded to assess improvement "in the client's feelings, behavior, self-understanding, and overall functioning since the beginning of treatment." Items on both forms are rated on a 7-point Likert-type scale (1 = "*much worse*" to 7 = "*much improved*") and summed for a total score. Gelso and Johnson (1983) found that three-week test-retest reliability estimates for the four items ranged from *r* = .63 to .81 (Gelso & Johnson, 1983). For the current study, the internal consistency of the client form was excellent (both α and ω = .91). Similarly, high values were obtained for the counselor form (both α and ω = .85).

Private Self-Consciousness Scale (Scheier & Carver, 2013**).** Both counselors and clients completed the nine-item PSCS. Private self-consciousness refers to covert, hidden aspects of the self which are not evident to the evaluation or scrutiny of others, such as private beliefs, attitudes and feelings. The items are rated on a scale from 0 = "*Not like me at all*," 1= "*A little like me*," 2 = "*Somewhat like me*," 3 = "*A lot like me*." A sample item from the scale is "I'm always trying to figure myself out". For the current study, the internal consistency with the client sample was good (α = .83, ω = .84), and slightly lower with the counselor sample (α = .75; ω = .76).

2.5. Analytic Strategy and Data Diagnostics

Exploratory structural equation modeling (ESEM) was utilized as a first step in the identification of the factor structure of the CRAM, followed by confirmatory factor analysis (CFA). ESEM was utilized as it better accounts for cross-loadings than exploratory factor analysis (Asparouhov & Muthén, 2009). Cross-loading was deemed likely given the hypothesized interrelationships among the subscales and similarity in content for items in the CRAM item pool. To ensure that ESEM and CFA samples did not overlap, client

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data was first subdivided equally into two samples (client sample 1 and 2: n = 107). Due to the smaller size of the counselor dataset (n = 93), despite months of attempted data collection, subdivision and use of CFA was not feasible. ESEM and CFA was conducted using MPlus, version 7.2 (Muthén & Muthén, 2017). Robust maximum likelihood (MLR) estimation was utilized for both ESEM and CFA, given that CRAM items deviated from normality for both client samples 1 (mean skew = -.69, mean kurtosis = -.17) and 2 (mean skew = -.77, mean kurtosis = .19) as well as the counselor sample (mean skew = -.93, mean kurtosis = 1.47). MLR was also utilized to accommodate non-normal data because, according to recent scholarship, this estimator is superior to alternative estimators and is robust to outliers (e.g., Li, 2016; (Muthén & Muthén, 2017)).

No meaningful differences in results were found when non-robust maximum likelihood (ML) estimation was used. Geomin rotation was utilized for ESEM. We decided on the number of factors using both empirical (i.e., goodness of fit indices) and theoretical criteria (i.e., if the meaning of the factor is interpretable) and the practical/clinical utility of the factor (e.g., do at least two items load onto all factors, are any of the items redundant). An item was considered to load onto a parent factor if its standardized loading was greater than or equal to .40 and this loading differed from the next highest factor loading by at least .10 (Comrey & Lee, 1992). Good fit was indicated by SRMR values close to .08 or below, RMSEA values close to .06 or below, and CFI values close to .90 or greater (Browne & Cudeck, 1993; Hu & Bentler, 1999). There was no missing data. Bivariate correlations were computed using SPSS, version 25 (IBM Corp., 2017), and internal consistency indices were computed using jamovi, version 1.0.6.0 (The Jamovi Project, 2021).

3. Results

3.1. CRAM – Client Form

For the client form, comparison of fit and information indices generated from ESEM suggested the superiority of a one-factor model in client sample 1: CFI = .79, RMSEA = .12, $CI_{90\%}$ = .11 - .12, SRMR = .05. Models with 2 through 6 factors were tested and, while some of these models possessed better fit, all contained at least one factor possessed of two or fewer items, making these models theoretically untenable: three-factor model: CFI = .75, RMSEA = .13, $CI_{90\%}$ = .12 - .14, SRMR = .03; four-factor model: CFI = .82, RMSEA = .12, $CI_{90\%}$ = .11 - .12, SRMR = .03; five-factor: CFI = .85, RMSEA = .11, $CI_{90\%}$ = .10 - .11, SRMR = .03; six-factor model: CFI = .86, RMSEA = .11, $CI_{90\%}$ = .10 - .11, SRMR = .02. Improvements to the one-factor model were made in light of the less than adequate fit of the model, the presence of modification indices suggesting areas of ill-fit, and review of item content. A total of 17 items were removed from the client form to address these concerns and create a more parsimonious measure that would be more useful in applied settings. Items were removed on the grounds of similarity of item content/redundancy. For example, the items "I think that working together I will be able to be successful" and "I believe that with my counselor's help I can achieve my goals" were deemed to be redundant (the latter item was retained, in this case, as it was deemed a better representative of the construct of collaborative motivation). Using this slightly amended and reduced item pool (now 23 items), the unifactorial model was submitted to ESEM using Sample 1. Model fit was substantially improved and now met criteria for good fit: CFI = .95, RMSEA = .06, $CI_{90\%}$ = .05 - .08, SRMR = .04 (see Table 1 for factor loadings). CFA of the client form was conducted in client sample 2 in an attempt to replicate the ESEM results. Results demonstrated a unifactorial model fit the client data adequately from sample 2: CFI = .91, RMSEA = .09, $CI_{90\%}$ = .08 - .11, SRMR = .04 (see Table 1 for factor loadings). This unifactorial model was also found to possess excellent internal consistency in the combined client data (samples 1 and 2: Cronbach's α and McDonald's ω = .98).

Table 1

Standardized factor loadings and expert ratings for unifactorial CRAM – Client Form model.

Item	Judges' Ratings – *M* (*SD*)	ESEM - Sample 1	CFA - Sample 2	CFA of Short Form – Sample 2
1. I am motivated to work with my counselor (CM)	5.45 (1.57)	.82	.74	N/A
2. I feel like we are a team on a mission (CM)	**6.64 (.50)**	**.80**	**.79**	**.82**
5. I believe that my counselor is motivated to help me (CM)	5.18 (1.94)	.82	.83	N/A

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6. My counselor and I are eager to solve my problems (CM)	**6.09 (1.22)**	**.80**	**.87**	**.86**
8. I feel that we have sufficient incentive to get the work done (CM)	5.09 (1.87)	.86	.90	N/A
11. I believe that with my counselor's help I can achieve my goals (CM)	5.91 (1.30)	.84	.84	N/A
13. We are on the same page (FC)	4.82 (2.23)	.85	.87	N/A
15. I feel like I understand what my counselor is telling me (FC)	5.00 (1.67)	.72	.75	N/A
17. We seem to have a common agenda in counseling (FC)	**6.64 (.50)**	**.85**	**.91**	**.91**
18. We agree on the what needs to get done in counseling (FC)	**6.45 (.69)**	**.87**	**.86**	**.89**
19. We have similar beliefs about the work (FC)	6.00 (1.34)	.89	.87	N/A
20. I believe that my counselor understands me (FC)	5.36 (1.75)	.87	.84	N/A
23. My counselor and I agree on the purpose of counseling (FC)	6.45 (.93)	.79	.84	N/A
25. We tend to agree on how hard I should work in counseling (FC)	4.82 (1.47)	.83	.82	N/A
26. We tend to agree about what we discuss in our sessions (FC)	5.45 (1.84)	.82	.84	N/A
27. We are working very well together (CA)	5.45 (1.97)	.88	.91	N/A
28. We are beginning to "get the ball rolling" in making changes in my life (CA)	5.64 (1.21)	.77	.82	N/A
29. We are moving in the right direction (CA)	5.27 (1.68)	.87	.88	N/A
31. I feel that my counselor is with me at every step of the way (CA)	**6.18 (1.25)**	**.88**	**.90**	**.89**
34. We are working hard together (CA)	5.73 (1.74)	.87	.91	N/A
36. We are able to work through obstacles that arise in counseling (CA)	5.27 (1.79)	.89	.87	N/A
38. What my counselor says and does is helpful to me (CA)	4.82 (1.99)	.89	.90	N/A
40. We feel like allies on a joint venture (CA)	**6.27 (1.19)**	**.88**	**.85**	**.90**

Note fot Table 1 and 2 below: Short form items are indicated in **bold**; All loadings significant at $p < .001$; CM = item intended to represent collaborative motivation; FC = item intended to represent framework consensus; CA = item intended to represent collaborative action; Judges' ratings scale: 1 = Unrepresentative, 2 = "Somewhat Unrepresentative", 3 = "Slightly Unrepresentative", 4 = "Not Sure", 5 = "Slightly Representative", 6 = "Somewhat Representative", 7 = Representative. The short versions of the scales are available gratis from the first author upon request.

In the interest of creating the most parsimonious instrument possible, one that could be administered every session in the context of weekly counseling, we attempted to create a short form of the CRAM - Client Form. To accomplish this goal, two items were chosen from the three theoretically-identified components of the scale for a short form that was six items in total. Items were selected on the basis of judges' ratings of representativeness in the content validity phase of the study (i.e., items that received an average rating of least a 6 = "Somewhat Representative") and based on factor loadings. The use of purely empirical criterion (i.e., factor loadings) was deemed inappropriate as it likely would have produced a very narrowly-defined measure (assessing only collaborative motivation). We wanted to maximize the content validity of the CRAM and ensure that it was addressing the critiques of existing measures of the relationship and capturing the facets of framework consensus, collaborative motivation, and collaborative action. In addition, the range of factor loadings is small, and making decisions about inclusion on the basis of small differences in factor loadings seemed likely to capitalize on sampling error. Table 1 presents the factor loadings for all items, inclusive of both the original 23-item and short 6-item versions. We purposely selected items from each of these areas so that future research with other samples can further examine this structure. This shortened scale was found to fit client sample 2 better than its longer, parent form: CFI = 1.00, RMSEA < .001, $CI_{90\%}$ = <.001 - .11, SRMR = .02 (see Table 1 for factor loadings). In addition, this short client form correlated very highly with the parent scale, r (212) = .97, $p < .001$, and was found to possess excellent internal consistency (total score: α and ω, both = .95; collaborative motivation subscale: α and ω, both = .83; framework consensus: α and ω, both = .89; collaborative action: α and ω, both = .89). Despite stemming from the three subscales, an examination of the 6 items that make up the client short form (see Table 1, bolded items) reflects a prominent theme of collaboration and solidarity across the items: i.e., "we are a team on a mission," "we agree," "we have a common agenda," "my counselor and I are eager" "we are allies," and "my counselor is with me every step of the way".

3.2. CRAM – Counselor Form

Similar results were obtained using the counselor form, where one through six-factor models were tested and a unifactorial model, CFI = .52, RMSEA = .20, $CI_{90\%}$ = .19 - .22, SRMR = .08, was found to be superior due to the presence of factors containing two or fewer items - two-factor model: CFI = .55, RMSEA = .20, $CI_{90\%}$ = .19 - .21, SRMR = .07. In addition, likely owing to the reduced sample size in the counselor as compared to the client data, the three-, four-, five-, and six-factor models failed to converge. Item redundancies were again eliminated and an improved model was re-submitted to ESEM, as with the client form. Using

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this slightly amended and reduced item pool (now 21 items), model fit was substantially improved and now met criteria for adequate fit: CFI = .90, RMSEA = .09, $CI_{90\%}$ = .08 - .11, SRMR = .06 (see Table 2 for factor loadings). This unifactorial model was also found to possess excellent internal consistency in the combined counselor data (α and ω, both = .96). A short form was created using methods identical to the client form (i.e., two items from each subscale, identified from the ratings provided by the judges in the content analysis phase of the project regarding representativeness and based on factor loadings). This scale was found to fit the counselor data adequately: CFI = .90, RMSEA = .17, $CI_{90\%}$ = .11 - .24, SRMR = .06 (see Table 2 for factor loadings). In addition, this short client form correlated very highly with the parent scale, r (91) = .95, p < .001, and was found to possess excellent internal consistency (total score: α = .88 and ω = .89; framework consensus: α and ω, both = .82; collaborative action: α and ω, both = .81). The internal consistency of the collaborative motivation subscale for the counselor short form was just below adequate, however (α and ω, both = .68;). As with the client short form, despite stemming from the three subscales, an examination of the 6 items that make up the counselor short form (see Table 2, bolded items) reflected themes of consensus and solidarity across the items: i.e., "we are a team on a mission," "we agree on what needs to get done," " we agree on what is important," "we will be able to be successful," "I am with my client in all he/she/they is trying to do," and "my client knows that I am with him/her/them every step of the way".

Table 2

Standardized factor loadings and expert ratings for unifactorial CRAM – Counselor Form model.

Item	Judges' Ratings – *M* (*SD*)	ESEM	ESEM of Short Form
2. I feel like we are a team on a mission (CM)	**6.81 (.40)**	**.70**	**.65**
3. I feel energized to work with my client (CM)	5.09 (1.64)	.68	N/A
6. My client and I are eager to solve his/her/their problems (CM)	6.18 (1.25)	.68	N/A
9. I feel that we have sufficient incentive to get the work done (CM)	5.00 (1.67)	.77	N/A
10. I feel inspired to help my client achieve his/her/their goals (CM)	5.27 (1.85)	.66	N/A
11. I think that by working collaboratively we will be able to be successful (CM)	**6.45 (.82)**	**.69**	**.66**
14. We are on the same page (FC)	5.27 (1.68)	.68	N/A
15. When we disagree we can discuss the disagreement and process it (FC)	5.18 (2.23)	.66	N/A
17. My client believes that I can see things as he/she/they does (FC)	5.36 (1.75)	.74	N/A
19. We agree on what needs to get done in counseling (FC)	**6.55 (.69)**	**.75**	**.79**
22. We have consensus on what needs to be done (FC)	6.09 (.94)	.83	N/A
23. We agree about what is important to tackle in counseling (FC)	**6.45 (.69)**	**.81**	**.86**
25. We tend to agree on the pace of counseling (FC)	5.91 (1.38)	.83	N/A
30. I feel that I am with my client in all that he/she/they is trying to do (CA)	**6.18 (1.17)**	**.76**	**.67**
31. My client knows that I am with him/her/them every step of the way (CA)	**6.00 (1.41)**	**.81**	**.84**
33. I believe that my client knows I am willing to help (CA)	5.45 (1.21)	.89	N/A
34. We are working hard together (CA)	5.55 (1.69)	.80	N/A
36. We are able to work through obstacles that arise in counseling (CA)	5.45 (1.69)	.75	N/A
38. I believe my client finds my interventions to be helpful (CA)	5.00 (1.79)	.70	N/A
39. My client is working with me (CA)	5.55 (1.69)	.84	N/A
40. We both feel like allies on a joint venture (CA)	5.91 (1.04)	.86	N/A

3.3. Construct Validity – Client Short Form

Correlations between several measures with the CRAM - Client Short Form are reviewed below. Results with the longer version of the CRAM are not presented; given the high degree of correlation between the short and longer form, those results are virtually identical and would be redundant (and are available, upon request from the corresponding author). Correlations among CRAM items thought to tap the three components of the scale (collaborative motivation (CM), framework consensus (FC), and collaborative action (CA)) are very high and support the results of the factor analysis that they tap one, unitary construct in the current sample: $r_{CM\ \&\ FC}$ (212) = .82, p < .001; $r_{CM\ \&\ CA}$ (212) = .82, p < .001; $r_{FC\ \&\ CA}$ (212) = .85, p < .001. In addition, correlations between all three components and the total score of the CRAM - Short Form were high and almost identical: r_{CM} (212) = .93, p < .001; r_{FC} (212) = .94, p < .001; r_{CA} (212) = .95, p < .001. Beyond levels predicted, the CRAM - Client Form correlated very highly with the

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Working Alliance Inventory (see Table 3 for bivariate correlations between the CRAM and all extra-test measures), as predicted it correlated moderately high with all four subscales of the California Psychotherapy Alliance Scale, and modestly with clients' ratings of counseling outcome. Contrary to our hypothesis, the correlation with the Private Self-Consciousness Scale was statistically significant but, consistent with our hypothesis, corresponded to Cohen's convention for a small effect (Cohen, 1992).

Table 3

Correlations between, and Descriptive Statistics of, the CRAM - Client Short Form and Measures of the Working Alliance, Private Self-Consciousness, and Counseling Outcome.

	M (*SD*) Observed Range	WAI-S	WAI-S-Goals	WAI-S-Tasks	WAI-S-Bond	CPAS-Total	CPAS-PWC	CPAS-PC	CPAS-WSC	CPAS-TU	COM	PSCS
CRAM-SF-C Total	31.89 (7.69) 7-42	.90***	.75***	.90***	.85***	.74***	.65***	.68***	.71***	.71***	.71***	.24***
CRAM-SF-CCM	10.41 (2.68) 3-14	.82***	.67***	.81***	.77***	.66***	.61***	.62***	.61***	.62***	.65***	.26***
CRAM-SF-CFC	10.92 (2.52) 2-14	.87***	.72***	.87***	.80***	.71***	.60***	.65***	.70***	.69***	.64***	.22**
CRAM-SF-CCA	10.56 (2.96) 2-14	.87***	.72***	.87***	.82***	.72***	.62***	.66***	.70***	.69***	.71***	.20**
WAI-S-Total	61.93 (12.78) 26-84	--	.86***	.97***	.95***	.78***	.69***	.72***	.74***	.74***	.73***	.24***
WAI-S-Goals	18.70 (3.18) 10-28		--	.79***	.69***	.61***	.52***	.55***	.59***	.58***	.57***	.17*
WAI-S-Tasks	21.60 (5.12) 6-28			--	.89***	.78***	.69***	.73***	.74***	.72***	.72***	.23**
WAI-S-Bond	21.64 (5.39) 6-28				--	.76***	.69***	.69***	.70***	.73***	.70***	.24**
CPAS-Total	127.71 (26.20) 44-168					--	.91***	.92***	.95***	.95***	.63***	.22**
CPAS-PWC	30.96 (6.24) 12-42						--	.78***	.80***	.81***	.62***	.28***
CPAS-PC	30.64 (6.90) 8-42							--	.82***	.80***	.58***	.17*
CPAS-WSC	32.25 (7.48) 10-42								--	.88***	.56***	.20***
CPAS-TU	33.85 (7.57) 6-42									--	.59***	.22***
COM	22.76 (4.06) 8-28										--	.26***
PSCS	27.60 (5.30) 9-36											--

Notes for Tables 3 and 4: CRAM-SF-T = Counseling Relationship Measure – Client Short Form Total Score; CRAM-SF-CCM = Client Collaborative motivation-Short Form; CRAM-SF-CFC = Client Framework consensus-Short Form; CRAM-SF-CCA = Client Collaborative action-Short Form; WAI-S = Working Alliance Inventory-Short; CALPAS = California Psychotherapy Alliance Scale; PWC = Patient Working Capacity subscale; PC = Patient Commitment subscale; WSC = Working Strategy and Consensus subscale; TU = Therapist Understanding subscale; COM = Counseling Outcome Measure; PSCS = Private Self-Consciousness Scale; ***Significant at the .001 level; **Significant at the .005 level. *Significant at the .05 level.

3.4. Construct Validity – Counselor Short Form

Similar to the Client Short Form, correlations among CRAM - Counselor Form items thought to tap the three components of the scale (collaborative motivation (CM), framework consensus (FC), and collaborative action (CA)) were very high and support the results of the factor analysis that they tap one, unitary construct in the current sample: $r_{CM\ \&\ FC}$ (93) = .54, $p < .001$; $r_{CM\ \&\ CA}$ (93) = .63, $p < .001$; $r_{FC\ \&\ CA}$ (93) = .80, $p < .001$. In addition, correlations between all three components and the total score of the CRAM - Short Form were similarly high: r_{CM} (93) = .83, $p < .001$; r_{FC} (93) = .88, $p < .001$; r_{CA} (93) = .92, $p < .001$. Beyond levels

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predicted, and similar to the Client Form, the CRAM - Counselor Form correlated very highly with the Working Alliance Inventory (see Table 4 for bivariate correlations between the CRAM and all extra-test measures), as anticipated, correlated moderately high with all four subscales of the California Psychotherapy Alliance Scale, and modestly with counselors' ratings of client progress in counseling. As anticipated, the correlation with the Private Self-Consciousness Scale was not significant.

Despite the very high level of correlation between the total scores for the CRAM and the WAI-S, an inspection of the correlations on Tables 3 and 4 between the subscales of the CRAM and the subscales of the WAI-S shows that there is considerably lower overlap between the measure subscales. The two tables also show that counselors, in comparison to clients, distinguished more differences between the CRAM and WAI-S subscales. The differences in overlap between the total scales and the subscales indicate that the subscales measure the distinct constructs underlying each measure (i.e., FC, CM, and CA for the CRAM, and agreement on goals, tasks, and bond, for the WAI-S) more effectively.

Table 4

Correlations between, and Descriptive Statistics of, the CRAM - Counselor Short Form and Measures of the Working Alliance, Private Self-Consciousness, and Outcome.

	M (*SD*) Observed Range	WAI-S-Total	WAI-S-Goals	WAI-S-Tasks	WAI-S-Bond	CPAS-Total	CPAS-PWC	CPAS-PC	CPAS-WSC	CPAS-TU	COM	PSCS
CRAM-SF-T Total	34.02 (5.40) 18-42	.90***	.77***	.87***	.77***	.67***	.54***	.60***	.70***	.57***	.50***	.04
CRAM-SF-TCM	11.55 (2.09) 3-14	.68***	.62***	.60***	.62***	.50***	.37***	.43***	.61***	.41***	.37***	-.02
CRAM-SF-TFC	11.17 (1.95) 4-14	.82***	.66***	.86***	.65***	.63***	.54***	.58***	.63***	.50***	.44***	.09
CRAM-SF-TCA	11.30 (2.10) 4-14	.88***	.74***	.83***	.77***	.63***	.51***	.59***	.61***	.59***	.50***	.04
WAI-S-Total	65.09 (8.20) 30-81	--	.84***	.94***	.89***	.67***	.54***	.63***	.68***	.57***	.57***	.05
WAI-S-Goals	19.10 (2.36) 14-26		--	.72***	.60***	.56***	.44***	.53***	.56***	.47***	.43***	.12
WAI-S-Tasks	22.11 (3.67) 8-28			--	.76***	.63***	.51***	.59***	.65***	.51***	.55***	-.01
WAI-S-Bond	23.88 (3.11) 8-28				--	.61***	.49***	.56***	.60***	.56***	.54***	.05
CPAS-Total	129.95 (20.72) 36-163					--	.93***	.93***	.87***	.84***	.51***	.11
CPAS-PWC	32.38 (6.46) 6-42						--	.83***	.74***	.73***	.46***	.15
CPAS-PC	33.21 (6.47) 6-42							--	.75***	.73***	.54***	.10
CPAS-WSC	30.62 (5.48) 12-39								--	.62***	.41***	.03
CPAS-TU	33.74 (4.67) 12-42									--	.45***	.11
COM	23.99 (2.98) 12-28										--	.22*
PSCS	29.37 (3.73) 19-36											--

4. Discussion

The researchers set out to create a new measure of the counseling relationship to assess framework consensus, collaborative motivation, and collaborative action, a new tripartite conceptualization of the counseling relationship. The resulting measure, the CRAM, is presented as six-item measures in both client and counselor forms, each with strong psychometric properties that relate in theoretically

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predicted ways with other measures of the relationship. The fact that the structure of the measure, identified in one sample of clients, was also associated with good model fit in an independent sample provides some measure of assurance that the measure can be used with therapist-client dyads to assess the strength of the therapeutic relationship. This cross-validation of results also provides support that the CRAM assesses three facets of this relationship (FC, CM, and CA). The CRAM assesses framework consensus without limiting the assessment to agreement on goals and tasks between participants; therefore, the CRAM may be a measure of interest to researchers and clinicians who operate clinically without emphasizing the setting of goals and tasks (e.g., humanist, existential, or interpersonally oriented professionals) and/or who practice counseling approaches that allow for longer-term care. The measure can be used to assess levels of consensus and collaboration as well as motivation and action in counseling dyads. Given its very brief length, the CRAM may also be an option for use in research in which observations are routinely made in counseling, including after each session.

4.1. Future Research Directions and Limitations

The results show that while the CRAM is related but distinct from the CALPAS and the subscales of the WAI, it is highly correlated with the total score of the WAI-S. Given the preliminary psychometric properties of the CRAM uncovered in the current study, future research can be directed at further establishing its reliability and validity, particularly with larger and more diverse samples of respondents. One way to do so would be to examine the measure in applied settings involving dyads in on-going counseling. This research could examine how the CRAM relates to other processes in counseling, such as a dyads' consensus, collaboration, and level of motivation, the rate of gain or progress as assessed by dyads, the resolution of ruptures as perceived by counselors and clients, and ratings of counselor and client satisfaction. A limitation of the current study is that the counselors and clients were not working together as dyads, so it seems valuable for future research to examine the level of overlap in CRAM ratings between paired counselors and clients. Relatedly, another limitation of the study is that different modalities were used to collect the data, since counselors participated via emails and requests through listservs and professional contacts, while clients were sampled online via CloudResearch's Prime Panels function. It is possible that clients sampled online may differ in systematic ways from the total population of all clients engaged in psychotherapy. Future research examining active counseling dyads would address this limitation. Another limitation is the fact that a confirmatory factor analysis was not conducted on the counselor form, and this was due to an insufficient number of counselors participating in the study. This type of analysis is necessary and constitutes an important future step in further validating the counselor measure. Finally, future research should attempt to sample both clients and counselors from under-represented groups to determine the generalization of the current study to these groups.

4.2. Practical Implications

The CRAM could be used to monitor the quality of clinical services, as viewed from the perspective of the client, and to assess relational dynamics among dyads. By using the CRAM, interventions can be put in place to increase therapist involvement, client participation, increase the strength or quality of the counseling relationship, and possibly increase client participation and satisfaction. The CRAM also has potential value as a tool to advance therapist training, particularly in programs or therapists focusing on the central role of the client-counselor relationship.

4.3. Conclusion

In conclusion, the CRAM is a new measure of the relationship in counseling that is based on new advanced constructs of framework consensus, collaborative motivation, and collaborative action in counseling. The CRAM displayed excellent preliminary evidence of its reliability and validity with the current sample. As is true with other measures of the relationship, there are opportunities for studying how the CRAM explains process and outcome when there are differences or disparities between counselors and clients on factors such as race, sexual orientation, values, or income. The CRAM could be adapted in research internationally, particularly countries where psychoanalytically/psychodynamically counseling approaches are more prevalent, and where the traditional focus on goals and tasks as lynchpins of the relationship is less emphasized. The CRAM could also be used as an alternative measure to the WAI-S or in conjunction with the WAI-S and/or the CALPAS. Furthermore, the measure is half the length of the WAI-S and may have wider appeal than the WAI-S as a practical tool to assess services in a variety of clinical settings. When used in conjunction with other

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measures of the relationship and of process and outcome in counseling, the brief length of the CRAM can provide additional evidence about the relationship in research or in counseling without burdening participants.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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