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Enhancing Clinical Competencies in Counselor Education: The Deliberate Practice Coaching Framework

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Enhancing Clinical Competencies in Counselor Education: The Deliberate Practice Coaching Framework

Abstract

In the counselor education (CE) literature, there remains a paucity of available research on systematic methods to enhance counselors-in-training (CIT) clinical competencies. Currently, CIT report feeling not only ill-equipped in essential counseling competencies upon graduating, but they also indicate diminished self-efficacy before engaging in clinical work. Therefore, we propose the Deliberate Practice Coaching Framework (DPCF) to address these issues. This systematic framework integrates deliberate practice components and coaching, with a peer mentoring relationship, to help enhance CIT clinical competencies and skill development, as well as promote overall self-efficacy. We provide a case illustrating the application of the DPCF. We also discuss implications for the field and directions for future research.

Keywords

deliberate practice, coaching, mentoring, clinical competencies, counselor education

Counselor education (CE) programs prepare trainees to enter the profession by instilling the necessary clinical competencies and skills to become effective and competent professional counselors. This preparation entails numerous academic courses and the successful completion of practicum and internship hours. Despite these extensive education and training requirements, researchers have found that counselors-in-training (CIT) often exhibit diminished self-efficacy and clinical competence before engaging in counseling work (Flasch et al., 2016). Specifically, the current research indicates that CIT struggle to implement essential counseling competencies, such as working with ethnically diverse clients (Wing Sue et al., 2019) as well as other multicultural and sexuality counseling competencies (Bidell, 2012; Flasch et al., 2016), including working with lesbian, gay, bisexual, and transgender (LGBT) clients (Graham et al., 2012) and treating persons with disabilities (Rivas & Hill, 2018). External measures have further shown that CIT possess cultural biases that they have limited awareness and skills to overcome (Wing Sue et al., 2019). Additionally, trainees who enter practicum or internship face internal (performance) and external (evaluation) pressures, contributing to their reluctance to disclose relevant information during supervision. This intentional nondisclosure may create a missed opportunity for counselor development and growth (Cook & Welfare, 2018), thereby impeding CIT clinical competency development.

Developing Trainee Clinical Competency: Coaching and Deliberate Practice

There is no single systematic method to enhance CIT clinical competencies (Chow et al., 2015). Supervision has long been considered one of the most effective ways to increase student self-efficacy and professional skills (Bakalım et al., 2018). However, the evaluative nature of supervision poses particular challenges, namely CIT anxiety, which may interfere with clinical skills development. Executive coaching is a method that has demonstrated utility in the corporate

sphere as a helpful intervention for enhancing job skills and expertise (Gan et al., 2020; Sperry, 2008). Sperry (2008) defined executive coaching as:

> a form of executive consultation in which a trained professional, mindful of organizational dynamics, functions as a facilitator who forms a collaborative relationship with an executive to improve his or her skills and effectiveness in communicating the corporate vision and goals, and to foster better team performance, organizational productivity, and professional–personal development (p. 36).

Executive coaching carries direct applications for the CE field (Sperry, 2008). For instance, Sperry (2004) indicated that, in executive coaching, CIT collaborate with the doctoral coach to identify specific goals and objectives involving their productivity and well-being to improve their overall skill level and performance. This coaching method is future-oriented and strengths-based, contributing to enhanced self-efficacy of clinical competencies among CIT and augmented leadership development for doctoral coaches (Sperry, 2004).

More recently, deliberate practice has emerged as another mechanism to enhance skill development, promoting expertise in a given domain (Chow, 2015). According to Ericsson and Lehmann (1996), deliberate practice is defined as "tailored training activities designed by a coach or teacher to improve specific aspects of an individual's performance through repetition and successive refinement" (pp. 278-279). Deliberate practice is a unique form of targeted practice; it uses a systematic and intentional focus to hone a specific skill or area (Sperry & Sperry, 2020) and is widely implemented across other fields, such as music and sports (Macnamara et al., 2018). In the realm of CE, studies have shown deliberate practice to significantly enhance CIT clinical competencies and professional development (Chow et al., 2015; Lipp, 2019). For instance, deliberate practice has demonstrated efficacy in understanding and successfully conducting case

conceptualizations (Lipp, 2019). In a study by Chow et al. (2015), the amount of time spent engaged in deliberate practice significantly influenced therapy effectiveness and client outcomes at a greater rate than did therapist characteristics (e.g., theoretical approach). This same study revealed that the most effective therapists engaged in roughly 8 hours of deliberate practice per week, an approximate rate of three times more than less effective therapists (Chow et al., 2015). This finding highlights the essentiality of moving beyond standard didactic skill training, particularly given the profession's move toward feedback-informed treatment.

Although deliberate practice is a necessary component of attaining expert performance, it remains insufficient on its own (Campitelli & Gobet, 2011). For example, Lipp (2019) discovered that CIT, who actively engaged in deliberate practice, exhibited increased effectiveness in the clinical competency of case conceptualization in conjunction with coaching. This study utilized a systematic, instructional method which drew upon "the five components of deliberate practice which includes self-assessment, skill repetition, formative feedback, stretch goals [beyond the trainees' current ability], and progress monitoring" (Ericsson, 2006; Rousmaniere, 2017, as cited in Lipp, 2019, p. 19). Findings from Lipp's (2019) study also demonstrated stability over time, with trainees maintaining improvements for approximately four weeks. For instance, this study provided evidence that CIT who were trained to use deliberate practice significantly developed their ability to produce competently written case conceptualizations over time (Lipp, 2019).

We contribute to this research body by proposing a theoretical framework that combines the elements of deliberate practice, coaching, and a peer mentoring relationship as a foundation to enhance CIT clinical competencies during their programs. This article describes our Deliberate Practice Coaching Framework (DPCF) and provides a case example to illustrate how to apply this approach with master's-level trainees and doctoral-level coaches. We hope that CE programs can

utilize this framework to help bolster both beginning counselor trainees' and doctoral coaches' essential clinical competencies and self-efficacy over time. Finally, we outline implications for the field and directions for future research.

The Deliberate Practice Coaching Framework (DPCF)

The Deliberate Practice Coaching Framework (DPCF) integrates deliberate practice, coaching, and mentoring to facilitate CIT clinical competencies and self-efficacy (see Figure 1). As previously discussed, deliberate practice is a formal method of targeted instruction used to improve CIT performance. At the same time, coaching is how individuals gain the skills, abilities, and knowledge they need to develop professionally and become more effective in their jobs (Chow et al., 2015; Gan et al., 2020; Sperry, 2008). Coaching aims to support and reinforce the effectiveness of deliberate practice by helping students achieve goals beyond their current abilities while monitoring outcomes and ensuring practice over extended periods (Chow et al., 2015). In addition, coaches provide expert, immediate feedback and performance evaluation, which are necessary to facilitate clinical expertise development (Lipp, 2019). For this article, we use Orlinsky et al.'s (1999) interpretation of clinical skills expertise; it is defined as "mastery . . . of the techniques and strategies involved in practicing therapy, understanding of what happens moment-by-moment during therapy sessions, precision, subtlety, and finesse in therapeutic work, and ability to guide the development of other psychotherapists" (p. 211).

According to Sperry (2010), there are five clinical competencies that competent counselors possess; they are a) presenting a conceptual foundation, b) building and maintaining an appropriate relationship, c) intervention planning, d) implementing the intervention(s), and e) evaluation. Within these competencies includes expertise in formulating case conceptualizations. In this regard, deliberate practice coaches can help facilitate CITs' clinical competencies, having already

demonstrated efficacy in improving CIT case conceptualization writing (Lipp, 2019). The literature reveals that the more time spent targeted at enhancing a therapeutic skill, the better the client outcome (Chow et al., 2015; Clements-Hickman & Reese, 2020). Like supervision practices, deliberate practice coaching directly facilitates this intentional practice by encouraging accountability and engagement for learning to occur with a coach's assistance (Eriksen et al., 2020; Parker et al., 2018). The application of deliberate practice in CE training programs requires a structured framework to guide proper implementation.

We present the Deliberate Practice Coaching Framework (DPCF), which integrates deliberate practice, coaching, and peer mentoring (see Figure 1). CIT continue to struggle to apply what is learned in courses, lack confidence and are often apprehensive about disclosing concerns and challenges in supervision for fear of evaluation and perceived incompetence (Cook & Welfare, 2018). To address these concerns, the DPCF relies on doctoral mentors to provide coaching to CIT without the formal evaluation typically delivered by program faculty. Instead, doctoral mentors provide CIT feedback in a supportive manner, with the intent to develop their clinical competencies. Therefore, the mentorship component of the DPCF may prove useful in remedying these concerns while also adding comfort, support, and confidence. Many definitions of mentoring exist in CE research literature. Black et al. (2004) provide an accurate and robust interpretation of mentoring as:

> A nurturing, complex, long-term, developmental process in which a more skilled and experienced person serves as a role model, teacher, sponsor, and coach who encourages counsels, befriends a less skilled person for the purpose of promoting the latter's professional and/or personal development (p. 46).

Mentoring provides support to CIT while also working to bolster their personal and professional growth. For instance, in a qualitative study on co-mentoring, researchers found that mentoring programs strengthened CIT professional identity and enhanced their collegial professional relationships (Murdock et al., 2013). Peer to peer mentoring has added a layer of social support in graduate programs by increasing involvement and easing the student transition to graduate school while also playing a role in the validation process in the transformational tasks of doctoral students as they become counselor educators (Bowman et al., 1990; Dollarhide et al., 2013; Lane, 2020; Perera-Diltz & Sauerheber, 2017). Peer mentoring also has the potential to remove power dynamics that exist in traditional mentoring relationships (Hipolito-Delgado et al., 2021). This mentoring relationship allows for a sense of safety, is less threatening regarding evaluation, permits greater availability, and increases a shared sense of understanding and honest reflection of cultural competency struggles (Allen et al., 2017; Hinkley et al., 2021; Hipolito-Delgado et al., 2021).

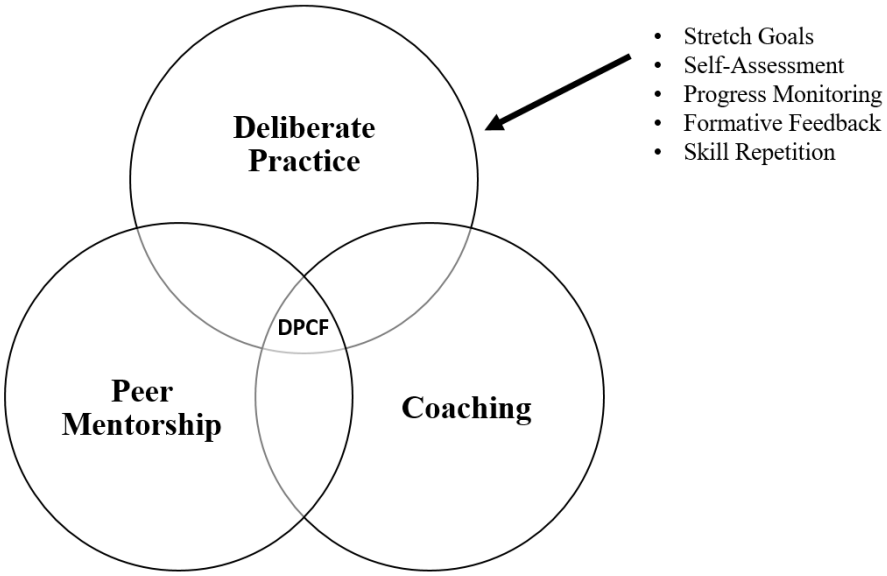
Specific mentor traits, such as personal and professional guidance, support, encouragement, and genuine, nonjudgmental interactions, are essential to effective mentoring (Purgason et al., 2018). The DPCF incorporates these mentor qualities to help meet some of CIT's critical needs, including the use of deliberate practice and coaching by doctoral students to master's-level CIT. Our DPCF comprises the five tasks of deliberate practice: self-assessment, skill repetition, formative feedback, stretch goals, and progress monitoring (Ericsson, 2006; Lipp, 2019; Rousmanire, 2017), with the addition of a sixth task, a peer mentoring relationship. The doctoral coach (or mentor) follows through with the five tasks throughout the mentee's training to enhance CIT clinical competencies and overall self-efficacy (see Figure 1).

It is essential to note that the relationship between the doctoral coach and master's-level mentee is critical to the DPCF's effective implementation. This relationship requires the support of the organizational culture in which they are embedded (Parker et al., 2018). Therefore, we recommend that counselor educators invest in the DPCF and ensure intentional relational development between the coach and CIT. The design and implementation of the DPCF is a systemic commitment. Developing the DPCF infrastructure necessitates supportive faculty members. Being supportive of this framework consists of the faculty member meeting with the doctoral coaches weekly and requiring them to keep a self-reflective practice journal. Although a faculty member could view this step as time-consuming, it can be managed effectively. We propose that doctoral mentors be concurrently enrolled in their supervision or practicum course at the time of the mentoring relationship. If these courses coincide, the journals can be part of the doctoral course assignments, with the counselor educator meeting with them weekly in class.

Additionally, doctoral coaches can potentially use these hours towards course requirements. In overlapping these courses, doctoral students will simultaneously satisfy their supervision requirements with that of the DPCF, as their mentees will later double as their clinical supervisees. The DPCF is also designed to alleviate issues that commonly arise for master's-level CIT, such as anxiety, uncertainty in counseling skills, gatekeeping issues, confidence, and competence. We propose using this framework to ameliorate some of these concerns that consume faculty time in advising appointments, before and after classes, and within supervision. It will also allow the CIT to feel more comfortable bringing concerns to someone they view as a peer. This structure is best suited for counseling departments that offer both master's and doctoral-level degrees in CE.

Figure 1

The Deliberate Practice Coaching Framework (DPCF)



Deliberate Practice Coaching Framework (DPCF) Application

Doctoral students will enter the coaching and mentoring relationship with their assigned CIT while enrolled in their doctoral-level supervision course. The doctoral coach (or mentor) is versed in the Deliberate Practice Coaching Framework (DPCF) and is supervised by a faculty member throughout the course's duration (see Figure 2). Each doctoral student will be paired with incoming CIT first entering their master's-level CE program. Given the typical imbalance of doctoral students to master's-level students across CE programs, doctoral coaches should be assigned to mentor two to three trainees during one academic semester.

The doctoral mentor and master's-level mentee first build a relationship that assists in orienting the CIT to the program and fostering their comfort level. The doctoral coach mentors the master's-level student in different courses by developing essential counseling competencies and skills while also providing support during direct clinical service. The coach and mentee should

meet at least once a month to discuss expected behaviors and roles while also checking in to maintain the relationship. These check-ins help facilitate the level of support needed to build a trusting relationship, provide a space to exchange interpersonal feedback or possible alliance ruptures, and assist in self-care maintenance. The coach and mentee can discuss any challenges in the CIT coursework during the given semester and other programmatic struggles and triumphs.

For this framework, we recommend that the doctoral coach collaboratively works alongside their CIT to identify targeted goals to enhance clinical competencies and skills while promoting alliance building. Mozdzierz et al. (2014) outlined elements of these deliberate practice targets, including examining case examples, engaging in nonlinear thinking exercises, transcribing examples of master therapists at work, and viewing videos of master therapists providing counseling. The benefits of initially setting these goals include maintaining accountability, establishing boundaries, and fostering continuous professional development (Parker et al., 2018). At the beginning of their work with the doctoral coach, CIT also take the Essential Counseling Competencies: Self-Assessment Inventory (Sperry & Sperry, 2020). This self-assessment helps the CIT review competency areas where they feel they need improvement. Periodically, doctoral coaches can review their mentees' results from this scale so that the CIT can engage in targeted deliberate practice and active self-reflection (see Figure 2).

The DPCF offers a symbiotic relationship between doctoral coaches and master's-level mentees. It allows the doctoral coaches to maximize their teaching, supervision, and leadership skills while still under a supportive faculty member's direct, weekly supervision. This assists in orienting them to various roles that they will assume as a future counselor educator. It also helps the doctoral coach and CIT build a supportive alliance that allows for programmatic connection. In addition to the weekly meetings, the doctoral coaches will need to keep a reflective practice

journal where they can consider methods used in the DPCF and note the ways CIT responded to its use. Reflective journaling helps the doctoral coaches be intentional in their coaching techniques, allowing them to process the most effective methods for their CIT to learn. This also helps the faculty counselor educator assist the coach in their skill development. Finally, the faculty member and doctoral coach's relationship helps to shape the doctoral coaches' professional identity development.

We suggest implementing the DPCF consistently throughout one academic semester, with a minimum of a once-a-month check-in, to ensure both the acquisition and retention of clinical competencies. In addition, the recommended timeframe enables doctoral students to engage in the process within expected coursework before embarking on their prospective dissertations' rigorous demands. Further, by establishing an agreed-upon timeframe, all parties commit to the relationship without any possible interruptions due to matriculation.

The successful implementation of the DPCF is evidenced by a clear display of trainees' developmental growth from initially identified goals. Regarding a formal assessment for CIT progress, we suggest using Swank and Lambie's (2012) Counseling Competencies Scale-Revised (CCS-R) at the end of each semester by a faculty member familiar with the CIT work (see Figure 2). This scale helps monitor CIT development in the following counseling competencies: "(a) counseling skills; (b) professional dispositions; (c) professional behaviors; (d) the counseling relationship; and (e) assessment and application (Swank & Lambie, 2012, p. 4)." In providing this scale, CIT can compare their self-assessment with the faculty member's assessment in the various areas. Doctoral coaches will also monitor their effectiveness via reflective practice journals and occasionally record a skills-based coaching session.

Cultural Considerations

The mentoring component of the DPCF is crucial to facilitating the attainment of clinical competencies among CIT. For instance, doctoral mentors may be better equipped to prepare CIT to be culturally competent clinicians as research findings have shown that clinicians who have gone through the process of attaining a doctoral degree are more inclined to view themselves as multiculturally competent (Barden et al., 2017). As such, it is imperative that doctoral mentors cultivate an inclusive and collaborative relationship with master's-level mentees. Incorporating mentoring with graduate students becomes essential as it poses implications for minority graduate students' retention, subsequent success, and future diversity of the discipline (Brunsma & Shin, 2017; Hipolito-Delgado et al., 2021). Cultural considerations need to be utilized when applying this framework. First, examining cultural aspects is essential when agreeing upon the objectives of coaching and implementing a culturally appropriate coaching contract. Additionally, the doctoral-level coaches' faculty supervisors may add systemic and cultural components to the DPCF. One systemic model for coaching supervision highlighted elements such as contracting, the relationship itself, teaching, and evaluation within an environmental and organizational context (Gray, 2007). The DPCF addresses these elements while clarifying the importance of social contexts and norms, economic realities and pressures, organizational constraints, and ethical frameworks (Brunsma & Shin, 2017; Gray, 2007). Figure 2 provides a case illustrating the Deliberate Practice Coaching Framework (DPCF) components.

Figure 2

DPCF Components Illustration

COMPONENTS	CASE ILLUSTRATION
Mentoring Relationship	• In their Supervision course, doctoral coaches are versed in the DPCF and assigned to mentor 2-3 incoming master's level CIT as a course assignment.
Stretch Goals	• The doctoral coach meets with their CIT to orient them to the program and collaboratively establish targeted goals and expectations for the coaching sessions.
Self-Assessment	• CIT take the Essential Counseling Competencies: Self- Assessment Inventory (Sperry, 2012) at the beginning of their work with the doctoral coach, and at later periods, to review their self-efficacy in each of the areas. • CIT are also expected to engage in routine self-reflection of targeted goals.
Progress Monitoring	• Coaching sessions occur at least once a month, during which time the doctoral coach engages in informal progress monitoring of the CIT. • The doctoral coach keeps a self-reflective practice journal to monitor coaching methods used with the CIT; this is reviewed weekly by the course faculty member. • At the end of each semester, CIT have a faculty member familiar with their work complete the Counseling Competencies Scale-Revised (Swank & Lambie, 2012) to assess for acquired skills.
Formative Feedback	• Completed CIT scales are processed openly with the doctoral coach so goals can be readjusted as needed. • Throughout this coaching process, doctoral coaches enhance their professional development based on the course faculty member's feedback.
Skill Repetition	• CIT continue to engage in deliberate practice of targeted goals, with the monitoring and support of the doctoral coach.
Coaching Structure	• A triadic process embedded within a supervision course is used. • The course instructor provides explicit instruction on the differences between supervision and coaching (DPCF). • Coaches offer short-term, immediate improvement of performance, narrow focus, specific feedback.

Potential Benefits of the DPCF for Masters-Level CIT

The use of training assistance models for CIT, such as the DPCF, may decrease stress and increase overall wellness (Allen et al., 2017). For example, in a study conducted by Chui et al. (2014), peer relationships demonstrated a more balanced distribution of power, as participants reported that they were more open and honest with peers than supervisors. In addition, Skovholt and Rønnestad (2003) found that CIT's most substantial challenges were acute performance anxiety and feeling scrutinized by gatekeepers. This finding further supports the notion that having

a mentor who is not in a gatekeeping role could be more beneficial and reduce anxiety. Thus, an advantage of the DPCF is the support CIT receive without the looming threat of performance evaluation from program faculty.

The DPCF may also allow CIT to build upon their self-efficacy before engaging in clinical work. Often, beginning counselors enter a practicum setting with minimal clinical competencies and support (Ikonomopoulos et al., 2016). As a result, CIT have difficulty with "attending to clients, being authentically present…[and] establishing rapport," which ultimately leads to client dropout (Kurtyilmaz, 2015, p. 157). One study showed that this anxiety and self-criticism stems from CIT lack of experience (Kurtyilmaz, 2015). The DPCF can help beginning counselors alleviate this anxiety and overly critical self-evaluation. CIT can approach practicum and internship with confidence, knowing that they have the support and mentorship of their doctoral-level coach. When they find themselves challenged with new experiences, the coaches can support CIT engagement in deliberate self-practice, thereby enhancing their self-efficacy and helping them to overcome obstacles and challenges.

Potential Benefits of the DPCF for Doctoral-Level Coaches

The DPCF also poses several benefits for doctoral coaches. Experts have shown that when trained in giving peer feedback, the experience can enhance academic performance (Double et al., 2020). This peer feedback approach helps doctoral students apply skills and develop their professional identity (Dollarhide et al., 2013). To date, there is limited research on formal methods to enhance leadership development among doctoral students (Meany-Walen et al., 2013). The DPCF can promote this competency, which is vital to advancing their professional development opportunities. Specifically, this framework embodies executive coaching's critical components, which promote leadership growth. As such, the role of an executive coach, or in this case, the

doctoral-level coach, is to advocate for the trainees' goals, strengths, and future professional development. Doctoral-level coaches foster their personal leadership development as they work alongside the CIT, guiding them in developing their professional identity and overall clinical skills. Paramount to being an effective leader are excellent communication skills, the ability to provide transparent and honest feedback, the continuous development of knowledge and skills, and serving as a role model (Peters et al., 2020; Sperry, 2004); these components are all achieved using the DPCF. Further, per the Association for Counselor Education and Supervision (ACES), the mentoring component is essential to applying the DPCF and can be used to further leadership competencies.

The DPCF can also help modulate attrition rates by building relationships with faculty and peers. Attrition rates have long been a concern for doctoral programs, with about half of all postgraduate students dropping out, regardless of their discipline (Lovitts, 2001). In a qualitative study of 33 counselor education doctoral students, the mentoring relationship was a significant factor for preventing students' dropout due to the lack of connection with faculty and peers (Golde, 2005). In addition, doctoral students' perceived self-efficacy, self-confidence, and overall wellness demonstrate improvement through mentoring experiences (Liu et al., 2019). The dual-layer of mentorship experiences built into the DPCF can further promote and enhance these doctoral coach qualities. Miller and Stone (2011) found that doctoral students from minority backgrounds identified mentoring as a critical component to their wellness and self-confidence.

The DPCF also gives the doctoral coaches greater responsibility and adds a more profound, personal connection to the program through the mentorship component. This feature could help doctoral students to feel more confident in their role as future educators and to feel more connected to their department and program, with the potential to decrease attrition rates. Therefore, this

framework can support doctoral students' learning, skill development, and competency, which can promote these students' retention rates in online and face-to-face CE programs. Researchers have found that positive factors, such as linking students with faculty, contribute to success in doctoral-level CE students; therefore, faculty should supervise supervision (Neale-McFall & Ward, 2015; Protivnak & Foss, 2009).

CACREP and the DPCF

CE programs accredited by The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) adhere to a specific set of standards, including providing adequate training to produce competent professional counselors. Despite this emphasis, the current literature has suggested that training inconsistencies across masters-level CE programs contribute to decreased student retention and perceived incompetence upon graduating (Bidell, 2012; Foss-Kelly & Protivnak, 2017). Similarly, doctoral students also face related issues and challenges that arise from inconsistent training procedures. For instance, some CE programs may prepare doctoral students in research and leadership, while others may focus on teaching and clinical practice; thus, doctoral students may face role confusion and diminished competency in a given domain (Perera-Diltz & Sauerheber, 2017).

Under the CACREP 2016 Standards, counselor education doctoral students focus on five target areas: "counseling, supervision, teaching, research and scholarship, and leadership and advocacy" (CACREP, 2015, p. 35). In their roles as coach and mentor, doctoral students can engage in practice towards three of the five CACREP standards: supervision, teaching, and leadership and advocacy. These standards complement the DPCF as doctoral students can assist CIT in enhancing their clinical practices through non-directives. Additionally, the CACREP 2016 Standards mandate that CIT clinical competencies and skills progression be systematically

assessed through the following procedure: "(1) identification of key performance indicators of student learning…, (2) measurement of student learning conducted via multiple measures and over multiple points in time, and (3) review or analysis of data" (pp. 17-18). The DPCF incorporates the progress monitoring procedure as outlined by CACREP throughout the intervention. Although programs may feel training doctoral students is an additional time constraint, universities adhering to these standards should view the DPCF as a helpful means of meeting several important target areas required for doctoral students.

Currently, counselors and counseling researchers are in an era that demands accountability and evidence-based programs. Therefore, counselors' training, and the profession itself, have become increasingly competency-based (Sperry, 2015). Graduate programs in CE must produce competent counselors who possess "the knowledge and skills necessary to address a wide variety of circumstances" (CACREP, 2015, p. 23). Under CACREP, students in master's-level CE programs must receive ongoing evaluations of their academic, personal, and professional competencies. Incorporating the DPCF into CIT continuing assessment and evaluation allows doctoral students to satisfy CACREP standards by practicing developmentally appropriate supervision and teaching skills (CACREP, 2015). It is expected that faculty will provide the necessary education, training, and supervision that fosters such competence (CACREP, 2015; Foss-Kelly & Protivnak, 2017). Ultimately, this serves to uphold the profession, maintain quality assurance standards, and, most importantly, protect consumers. As such, we propose the DPCF to help facilitate this professional quality.

Implications and Limitations for Counseling Practice

The DPCF poses several implications for the CE field, including enhanced clinical competencies, skills, and performance within their training programs. Franklin and Franklin

(2012) investigated two structurally identical seven-week coaching programs with findings revealing that participants performed 10% better in academic performance at both 12- and 18-month follow-ups. These results have implications for future practice that low-cost coaching interventions have significant effects on academic achievement, compared to other interventions such as increasing financial aid for students (Bettinger & Baker, 2014). All components of this model allow CIT to improve their skills and make meaningful connections in their training programs, reducing anxiety that often stems from the gatekeeping process in supervision (Skovholt & Rønnestad, 2003). Additionally, about half of all doctoral students drop out before completing their programs, regardless of their discipline (Lovitts, 2001). As such, the supportive nature of the DPCF may lend to higher rates of student retention. Specifically, this framework's peer-to-peer mentoring component adds to doctoral students' transformational task and professional identity development as they become counselor educators (Dollarhide et al., 2013).

Mentoring in graduate programs has been researched heavily due to its positive influence on decreasing stress (Lane, 2020). Early studies examining mentorship in CE reveal higher productivity levels in research, publication, and presentation of conference papers for students with mentors (Reskin, 1979). Findings also show that mentored students are more involved, which CE programs perceived as a valuable component for students who faced transitions (Bowman et al., 1990). Master's-level CIT can also benefit from this process, as it allows for the accountability piece to remain but removes the evaluation component conducted by faculty. Mentoring programs within counseling divisions, such as the Association for Multicultural Counseling and Development (AMCD), were initiated in 1992 and have yielded a positive impact on the organizational level of the division and the personal level of the participants (AMCD, 2020). Since no other frameworks exist that combine mentoring with both coaching and deliberate practice

within the counseling profession, the DPCF has the potential to enhance current training practices among CE programs.

There are also implications for faculty members wishing to bring this framework to their CE programs. Since differing belief systems, theoretical orientations, and multicultural differences are bound to exist, faculty members implementing the DPCF are significant in the way they pass on clinical skills to their doctoral-level coaches. This embedded flexibility allows for a diversity of thought and inclusion of culturally competent aspects. In addition, when faculty members implement the DPCF into their programs, they can influence the model via their teaching methods, including instruction, self-reflection, modeling, and feedback (Gray, 2007). Overall, the DPCF offers many potential benefits to both master's-level CIT and doctoral students. This framework's primary limitations include an increased time burden placed on students in their training programs and the mental fatigue and concentration necessary to effectively enhance clinical competencies through deliberate practice (Mozdzierz et al., 2014). However, there would be an overall decrease in time spent to remediate students who face skills-based challenges and struggle to make connections to their current program.

Although it would be more beneficial to allow the mentorship to continue throughout the trainee's time in their master's program, it is up to the doctoral coach and CIT to decide if they would like to continue the mentoring experience after the first year. Despite this, allowing doctoral-level students to work as mentors through a project in their supervision class will enable them to be trained and held accountable consistently. Another limitation may be the training necessary for doctoral students to become mentors through the DPCF. The doctoral student may have completed their master's degree through a different school and is unaware of the requirements necessary to succeed in the master's level program compared to their doctoral program. Doctoral-

level coaches must also have sufficient clinical experience to mentor master's level CIT in order to increase the likelihood of effectiveness. Programs would need to determine what training is adequate, the minimal requirements to be a doctoral-level mentor, and who would oversee the training.

These steps may not seem suitable to some university programs, which may be wary of additional time constraints. However, our framework allows for time-saving opportunities in other areas that are typically laborious, such as providing further assistance to students struggling in their practicum and internship. In addition, integrating the DPCF as part of the curriculum in a doctoral-level supervision course can allow doctoral students to become familiar with how to differentiate the roles and expectations between a supervisor (faculty member) and a coach (doctoral mentor).

Future Research

CE programs have long attempted to implement training models and mentoring approaches to enhance CIT clinical competencies and skill development. Despite this, the literature has lacked research on these systematic methods (Chow et al., 2015). As a result, CIT have indicated feeling ill-equipped in essential counseling competencies upon graduating; they also report diminished self-efficacy before engaging in clinical work (Bidell, 2012; Flasch et al., 2016). In an attempt to address these issues, we presented the DPCF. Regarding future research, this framework will need to be manualized so all CE programs that wish to participate in the process can do so. The DPCF will require further research to assess its effectiveness with groups of master's and doctoral-level counseling students. A quasi-experimental study would need to be conducted to examine DPCF pre- and post-clinical training to determine its efficacy and utility with CIT and CE programs. Qualitative data also needs to be collected to learn about the individual experiences of master's and

doctoral students participating in the program. This additional data would allow for the generalizability of the DPCF to be assessed. Finally, further research implementing the framework into CE programs is needed to validate the evidence base of the DPCF.

Conclusion

CE programs are expected to prepare CIT to become effective professional counselors. Despite this, the research raises important questions about the efficacy of programs in developing CIT essential counseling competencies. Deliberate practice is a necessary component of skill development and enhancement; yet, findings suggest it remains inadequate (Campitelli & Gobet, 2011). Therefore, we presented the DPCF, which integrates deliberate practice and coaching with a mentoring relationship, to enhance CIT clinical competencies during their programs. The DPCF may prove useful in increasing master's-level CIT confidence and decreasing apprehension about disclosing concerns by mitigating the fear of evaluation and perceived incompetence seen in typical supervisory relationships. Further, research findings suggest that the mentoring aspect of the DPCF may lower doctoral attrition rates while simultaneously satisfying CACREP 2016 Standards (CACREP, 2015; Golde, 2005;). Thus, the DPCF presents many benefits to both masters-level CIT and doctoral coaches. We suggest that further research of the DPCF, as an integrative coaching and mentorship framework, be conducted to assess its effectiveness in enhancing CIT counseling competencies and professional development.

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