A STUDY OF THE WORKING ALLIANCE IN PSYCHOTHERAPY

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Abstract

Originally identified by Freud (1912, 1913), the therapeutic or working alliance between client and therapist has in the last decade been proposed as the common factor that could account for psychotherapeutic outcome regardless of the theoretical orientations and/or techniques employed by therapists.

Psychotherapy researchers (Allen, Newsom, Gabbard, & Coyne, 1984; Hartley & Strupp, 1983; Horvath, 1981; Luborsky, 1976; Marziali, Marmar, & Krupnick, 1981) have developed various scales for measuring the alliance and have quite consistently demonstrated an alliance-outcome relationship.

The Working Alliance Inventory (Horvath, 1981, 1982) is the first self-report instrument developed to measure the alliance construct. It is based on the theory proposed by Bordin (1975, 1979) that the alliance is the product of the synergistic combination of three highly related components--goal mutuality, agreement regarding relevant tasks and responsibilities, and the development of personal bonds or attachments.

In the present study, the Working Alliance Inventory was administered after each of the first five, the tenth, and the final sessions of 44 psychotherapy cases. It was found to be statistically significantly related to outcome by the third to fifth session on four of the six outcome measures employed.

Another self-report measure, the Helping Alliance Questionnaire (Luborsky, McLellan, Woody, O'Brian, & Auerbach, 1985) was also administered at the third session, as well as

measures of therapist empathy, expertness, attractiveness, and trustworthiness. The Helping Alliance Questionnaire, which is based on a clinically-derived definition of the alliance, was found to be statistically significantly related to outcome on all six of the measures employed. Speculations concerning the differential patterns of results with the two alliance measures are offered.

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I. INTRODUCTION

1. OVERVIEW

The concept of a therapeutic or working alliance between client and therapist represents the most current and promising attempt in psychotherapy process research to explain the relevance of the relationship to therapeutic outcome (Greenberg & Pinsof, 1986; Hartley & Strupp, 1983). It seems to have supplanted Rogers' (1957) "core" or "necessary and sufficient" conditions for change as a fertile source of research and theory (Gelso & Carter, 1985). A number of studies have in recent years begun to reveal the nature and significance of the alliance (Gomes-Schwartz, 1978; Hartley & Strupp, 1983; Horvath, 1981; Luborsky, 1976; Marziali, 1984; O'Malley, Suh, & Strupp, 1983). The present study has subjected some of the findings of these studies to further examination by drawing a sample from a population of real psychotherapy cases conducted in natural settings and implementing an intensive measurement program.

There has long been recognition that the relationship between the person who seeks change, (i.e., the client), and the one who offers to be a change agent, (i.e., the therapist), is an important element of the treatment situation regardless of the therapist's theoretical orientation (Bordin, 1975, 1976, 1979; Frank, 1971; Freud, 1913; Rogers, 1957; Strupp, 1973). Psychotherapy process researchers, after initially focusing on core conditions and producing inconclusive findings there, have only relatively recently begun to refocus away from "specific",

(i.e., technical or orientation), factors and toward "general" or "generic", (i.e., relationship), factors and have begun to empirically demonstrate their importance (Gomes-Schwartz, 1978; Luborsky, Singer, & Luborsky, 1975; Strupp & Hadley, 1979).

Two other approaches to explicating the impact of the client-therapist relationship on therapeutic outcome, Rogers' (1957) core conditions and social influence theory, have also been empirically demonstrated to have some relationship to client change. Rogers hypothesized that the necessary and sufficient conditions for client change were therapist-offered, namely, empathy, unconditional positive regard, and congruence. Strong's (1968) social influence theory related client change to the extent to which the client perceived the therapist as expert, attractive, and trustworthy.

The working alliance is an incorporative and promising approach. Originally proposed by Freud in 1912, the concept of an alliance between client and therapist is emerging as an approach to integrating specific and general factors in an overarching theory of therapeutic change. In particular, Bordin's (1975, 1979) conceptualization of the alliance as the product of the synergistic combination of three highly related components of the alliance--goal mutuality, agreement regarding relevant tasks and responsibilities, and the development of personal bonds or attachments--has prompted investigators to begin to attempt to track and to measure the strength and quality of the alliance in therapeutic engagements.

Gelso and Carter (1985) have described the working

alliance, in pantheoretical terms, as existing when the client's reasonable or "objectively" observing side aligns with the counsellor's working side creating the sense that the participants in the counselling relationship are joined together in a shared enterprise, each making his or her contribution to the work. Drawing on Bordin's (1975, 1979) conceptualization, Gelso and Carter (1985) have suggested that the alliance is an emotional alignment that is both fostered and fed by the emotional bond or positive attachment and by agreement on the appropriateness of goals and tasks. Therapist empathy, genuineness, and respect must be met by client capacity to trust and to form attachments to people. Moreover, the client probably needs to have a world view similar enough to the therapist's theoretical stance that the goals and tasks of the counselling make sense to her or him.

Greenberg (1985) has noted that one of the strengths of Bordin's (1975, 1979) conceptualization is that it helps integrate views on the importance of the relationship and technique in psychotherapy. Specific technical operations that constitute tasks are viewed as requiring particular types of relational bonds, while the completion of certain relationship tasks might involve the use of technical skills. It is the correct combination of goals, tasks, and bonds, or the synthesis of different relational and technical elements, that constitutes a good overall alliance. Docherty (1985) and Hartley (1985) have similarly recognized the integrative potential of the alliance concept.

Recently, researchers (Hartley & Strupp, 1983; Horvath, 1981; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983; Marmar, Marziali, Horowitz, & Weiss, 1986; Pinsof & Catherall, 1984) have demonstrated that the alliance has great potential as a potent predictor of outcome in a fairly wide variety of settings and contexts. Greenberg and Pinsof (1986) have observed that it is particularly impressive that the alliance has been related to outcome when it has been measured in many different ways at different research centres with different types of therapy. These, they say, are unusually robust findings in psychotherapy research.

2. CURRENT PROPOSITIONS ABOUT THE WORKING ALLIANCE

The first three propositions that follow are drawn from Gelso and Carter's (1985) recommendations for research initiatives:

1) Regardless of the duration of counselling, it is important that the alliance be established relatively early if the treatment is to be successful. This proposition is supported by the research of Hartley and Strupp (1983), Luborsky et al. (1983), and Horvath (1981).

2) In terms of Bordin's (1975, 1979) conceptualization, the bonding aspect of the alliance develops most slowly, whereas, if therapy is to proceed effectively, there must be at least general agreement early in the work about the goals appropriate for treatment and the tasks that are necessary to attain those goals.

3) In line with Greenson's (1967) conceptualization, the importance of the working alliance waxes and wanes during the various phases of the psychotherapy intervention. Hartley and Strupp (1983) view their findings as consistent with Langs' (1973, 1974) notion that a strong alliance allows the client to feel trusting enough to experience support during difficult times, and to maintain faith in the therapist's effectiveness and good motives during periods of negative transference. In a similar vein, Bordin (1983) has suggested that in the middle phase of therapy, the process of repairing the alliance when it is weakened or disrupted actually becomes the work of the treatment.

The remaining propositions are drawn from the general literature and reviews of the alliance:

4) Both Hartley and Strupp (1983) and O'Malley, Suh, and Strupp (1983) have observed from their studies that outcome can be related to the occurrence of an increase in alliance strength over the early sessions. In the Hartley and Strupp study, more successful dyads increased their alliances peaking at the first quartile point in the therapy, while less successful dyads troughed at the corresponding point. Suh, O'Malley and Strupp (1986) looked for differential therapist behaviour to account for the changes in client participation across early sessions (which predicted outcome by the third session) and related these changes to patterns of change in therapist warmth and exploration.

5) Based on convergent research from different orientations

(Rice & Kerr, 1986; Sampson & Weiss, 1986), Greenberg and Pinsof (1986) have suggested that involvement may be the most critical client subdimension and indicator of the alliance. Appropriate involvement in therapeutic tasks is evidenced by such general indicators as participation, optimism, perceived task relevance, responsibility, and by orientation-specific indicators such as experiencing in experiential psychotherapy, boldness of exploration in psychoanalytic therapy, inspection of evidence in cognitive therapy, and completion of homework assignments in behavioural therapy. Luborsky (1985) has similarly seen the alliance as only one of a family of positive relationship qualities including positive evaluation of others, involvement in the therapy and feeling understood by the therapist, and others, all of which, he has observed, when taken together have an amazingly consistent predictive record for the outcomes of psychotherapy and imply that these qualities are crucially involved in the curative process of therapy.

3. DEFINITION OF TERMS

Psychotherapy: The treatment of mental or emotional disorders or maladjustments by psychological means, especially involving verbal communication. (Webster's Dictionary, Third Edition)

Outcome: The perceptions of the client and the therapist regarding the success of psychotherapy, particularly as it relates to improvements in target complaints, symptom reduction, increase in self-esteem, resolution of interpersonal problems,

and client's and therapist's posttherapy assessments. Outcome is measured by Target Complaints Improvement, residual gain on the Symptom Checklist-90, the Self-Esteem Index, and the Inventory of Interpersonal Problems, and the Strupp Posttherapy Questionnaire and the Therapist Posttherapy Questionnaire.

Working Alliance: The client's and the therapist's awareness of a set of agreements, understandings, and bonds that were arrived at during a sequence of purposive helping interactions. In particular, the following components according to Bordin (1979) define a viable alliance, regardless of the specific theoretical or technical approach taken by the therapist:

1) The helper and the helpee have a sense of agreement about the goals of the helping process. The helpee has an awareness that these goals are relevant to her/him and feels a degree of identification with the explicit and implicit aims of the particular helping process in which he/she is engaged. The helper has some direct or indirect evidence that the goals established in the therapy relationship are explicitly or implicitly shared and accepted by the helpee.

2) The helper and the helpee have a sense of mutuality (or agreement) that the tasks demanded of each of them in the helping process are reasonable and within their global capabilities (or expertise), and relevant in a direct or indirect way to the goals of the helping process upon which they have mutually agreed.

3) The helper and the helpee experience a sense of a bond

between them. Some of the bases upon which such a therapeutic partnership are built are sense of mutual trusting, liking, understanding, and caring.

Different therapeutic orientations and strategies make different demands on the participants in terms of each of these components. These unique demands create a unique quality for each successful alliance. Bordin has maintained, however, that all helping dyads have to achieve a basic quantitative level in each of the three areas in order to produce the alliance component necessary for a successful helping relationship.

Therapeutic Alliance: The term employed by object relations theorists (Gitelson, 1962; Zetzel, 1956, 1970) for the alliance concept.

Helping Alliance: Luborsky's (1976) term for the alliance concept.

Empathy:

> The ability of the therapist accurately and sensitively to understand experiences and feelings and their meaning to the client during the moment-to-moment encounter of psychotherapy ... . [It] means that the therapist is completely at home in the universe of the patient. ... It is a sensing of the client's inner world ... 'as if' it were the therapist's own ... . The ability and sensitivity required to communicate these inner meanings back to the client in a way that allows these experiences to be 'his' is the other major part ... . The therapist at a high level [of empathy] will indicate not only a sensitive understanding of the apparent feelings but will by his communication clarify and expand the patient's awareness of these feelings and experiences. (Rogers, Gendlin, Kiesler, & Truax, 1967, pp. 104-105)

Perceived Empathy: The extent to which a helpee is aware of the helper's empathy.

Expertness: A counsellor is perceived as an expert or knowledgeable person in his/her field if she/he has the following attributes:

1) objective evidence of specialized training or knowledge such as a diploma or degree;

2) subjective evidence of recognized ability such as reputation, fame, and/or physical signs associated with success, (e.g., affluence); and

3) behavioural evidence of expertise such as rational and knowledgeable arguments and confidence in presentation (Strong, 1968).

Attractiveness: The attractiveness of a helper is a function of the following conditions:

1) physical attractiveness (Cash & Saltzbach, 1978);

2) warmth or friendliness (Goldstein, 1971); and

3) compatability in terms of agreeableness or likeness of opinion (Strong, 1968).

Trustworthiness: A helper is perceived as trustworthy if one or both of the following are present:

1) socially sanctioned role as a helper or legitimate source of influence (Strong, 1968); and

2) steady, deep, and consistent concern for the client's welfare (Frank, 1973).

Specific Factor: A factor or variable that is specific to a technique or procedure and associated with a specific approach to psychotherapy.

General or Generic Factor: A factor or variable that is

common to all of the different approaches to psychotherapy, (eg., the client-therapist relationship).

WAI: The acronym 'WAI' refers to the Working Alliance Inventory (Horvath, 1981, 1982) in both client (WAIc) and therapist (WAIt) forms.

4. RESEARCH QUESTIONS

The present study was intended to answer the following questions:

1) Are client-perceived and therapist-perceived alliance strengths as measured by the Working Alliance Inventory positively related to outcome?

2) Are client-perceived and therapist-perceived changes in alliance strength over the first five sessions as measured by the WAI positively related to outcome?

3) Is client-perceived alliance strength as measured by the WAIc more positively related to outcome than is client-perceived therapist empathy, expertness, attractiveness, or trustworthiness?

4) Is client-perceived alliance strength as measured by the Helping Alliance Questionnaire positively related to outcome?

5) Are client-perceived and therapist-perceived client involvement positively related to outcome?

6) Is congruence of client-perceived alliance strength as measured by the WAIc and therapist-perceived alliance strength as measured by the WAIt positively related to outcome?

II. REVIEW OF LITERATURE

1. THEORETICAL DEVELOPMENT OF THE ALLIANCE CONCEPT

1.1 Psychoanalytic Formulations

The concept of the working alliance emerged initially in the psychoanalytic literature as an aspect of the transference. Freud (1912) distinguished two types of transference--positive affectionate and negative hostile. He further divided the former into a conscious friendly component and an unconscious sexual component.

> If we 'remove' the transference by making it conscious, we are detaching only these two components of the emotional act [i.e., the negative hostile and the unconscious sexual] from the person of the doctor; the other component, which is admissible to consciousness and unobjectionable, persists and is the vehicle of success in psychoanalysis exactly as it is in other methods of treatment. (p. 105)

In fact, Freud (1913) regarded the positive transference as a prerequisite to treatment:

> When are we to begin making our communications to the patient? ... Not until an effective transference has been established in the patient, a proper rapport with him. It remains the first aim of the treatment to attach him to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the imagos of the people by whom he was accustomed to be treated with affection. (pp. 139-40)

Hence, Freud's conceptualization of the bond at this point was largely that of a libidinal attachment of patient to physician.

Sterba (1934) and Bibring (1937) as well as Freud himself

(1937) developed a revised conceptualization in which the conscious rational part of the ego (the autonomous ego functions (Loewenstein, 1954)) was seen as allying itself with the analyst against the unconscious. Successful treatment was related to the kind of relationship with the analyst that the patient was capable of sustaining, or, in other words, the patient and analyst sharing the same purposes (Friedman, 1969).

Object relations theorists beginning with Zetzel (1956) did not distinguish the "therapeutic alliance" from the transference neurosis, instead regarding transference, (i.e., the revival of the early mother-child relationship in the therapeutic relationship culminating in successful introjection of the analyst as a good object), as a basis for the alliance.

> Comparably, the analyst's empathic imbrication with his patient's emotions provides a sustaining grid of 'understanding' (or 'resonance') which leads towards co-operation and identification, to the partial relinquishment of the anaclitic attitude, and in the end to a collaboration which has [been] called 'therapeutic alliance'. (Gitelson, 1962, p. 199)

> In traditional psychoanalysis the transference is interpreted, while the real object relationship is often so secure that it seldom needs explicit reinforcement. ... In most therapy, in contrast, while transference may be obvious to the therapist, it is the reality of the relationship which remains in the forefront. It is the strengthening of the real object relationship which holds the potential for considerably increasing the patient's insight. (Zetzel, 1970, p. 153)

Greenson's (1965, 1967; Greenson & Wexler, 1969) conceptualization of the alliance is similarly broad in scope, encompassing various aspects of the therapeutic relationship

along with the quality of work the client does in the treatment process. His analysis has been the stimulus for the current theoretical and empirical focus on the alliance as the key element in the therapeutic relationship. He identified three contributions to its attainment:

1) the patient's capacity to oscillate between maintaining contact with the reality of the analytic situation and risking regressing into his fantasy world (i.e., developing a transference neurosis);

2) the analyst's humanness consisting of understanding and insight conveyed in an atmosphere of serious work, straightforwardness, compassion and restraint; and

3) the constant scrutiny of how the patient and the analyst seem to be working together, the mutual concern with the working alliance, which in itself serves to enhance it.

1.2 Other Conceptualizations Of The Relationship

Theorists of other schools of therapy have also stressed the importance of the real relationship between therapist and client and their working "contract".

Rogers (1951, 1957) took the most radical relationship-oriented stand when he argued that the therapist-offered conditions of empathy, unconditional positive regard, and congruence were core, (i.e., the necessary and sufficient conditions), for psychotherapeutic benefit. His ideas have stimulated much research which has produced contradictory and ultimately inconclusive findings (Gurman, 1977; Lambert,

DeJulio, & Stein, 1978; Mitchell, Bozarth & Krauft, 1977; Parloff, Waskow & Wolfe, 1978; Watson, 1984).

The most promising instrument developed to measure the core conditions is the Relationship Inventory (Barrett-Lennard, 1962). Barrett-Lennard's assumption in measuring client-perceived conditions was that it is what the client herself/himself experiences that affects him/her directly and thus is the primary locus of therapeutic influence in the relationship.

Gurman (1977) compared client, therapist and observer perceptions of the therapeutic relationship. In twenty of the 26 studies of the relationship between client perception of relationship (as assessed predominantly with the RI) and outcome, positive findings were reported (and in three, mixed, but supportive results were reported). This was a more impressive result than that registered for studies of observer-rated empathy. Equally importantly, however, Gurman noted that like other studies based on the therapist-offered conditions, results tended to 'fall off' when the studies involved subjects from non client-centered therapies. In the present study, the relationship of client-rated empathy to outcome is compared with that of client-rated alliance strength.

Frank (1971) also attempted to define common or nonspecific features of successful therapeutic engagements:

1) an emotionally charged, confiding relationship,

2) a therapeutic rationale accepted by patient and therapist;

3) provision of new information by precept, example, and self-discovery;

4) strengthening of the patient's expectation of help;

5) providing the patient with success experiences; and

6) facilitation of emotional arousal.

The first feature, the patient-therapist relationship, was seen as a necessary but not sufficient condition for all the other common features.

In his book, Frank (1973) viewed the patient-therapist encounter as a system whose properties are determined not only by the characteristics of the protagonists, but also by the context in which the encounter occurs. As the system develops, it, in turn, affects certain features of both members. He concluded that the success of psychotherapy relates not only to a convergence of the therapist's and patient's values, but also to aspects of the patient-therapist interaction that affect the therapist's zeal and the patient's confidence in him/her.

Research on what has become known as the social influence process and was operationalized by Strong (1968) as successful outcome being related to the client perceiving the counsellor as expert, attractive, and trustworthy has also proved inconclusive. On the basis of their review of this research, Corrigan, Dell, Lewis and Schmidt (1980) concluded that:

> Although it is important to understand the relative contribution of perceived counselor attributes to the various stages of a counseling relationship, it may be even more important to understand those events and counselor attributes that facilitate the transition from favourable first impressions to subsequent, presumably more productive, stages of a counseling relationship. (p. 437)

Barak and LaCrosse (1975) developed the Counselor Rating Form to measure the counsellor's expertness, attractiveness, and trustworthiness as perceived by the client. In the present study, the relationships of client-rated therapist expertness, attractiveness, and trustworthiness to outcome are compared with that of client-rated alliance strength.

A distinctly different approach was offered by Bordin (1975, 1979). He attempted to define the working alliance in terms of the demands and agreements between the client and the therapist. More specifically, he postulated that:

1) different therapeutic techniques would place different demands on both therapist and patient;

2) unique strategies would imply different goals and objectives;

3) a good therapeutic alliance would demand an acceptance of, and agreement on 1) and 2) between therapist and client. In other words, these elements would have to 'fit' client and therapist needs and resources and result in mutual agreement between them regarding goals and objectives, and consequently the client would regard the therapy activities as relevant to his/her goals; and

4) a real relationship, a 'bond', would have to develop between client and therapist, involving trust, acceptance, and liking.

The formulation was unique from several points of view (Horvath, 1981):

1) Although it incorporated some of the basic concepts of

the analytic stream of thought, it was operationally independent of therapeutic constructs that were unique to a particular theoretical orientation.

2) It defined a generic process variable that cut across theoretical strategies, (i.e., agreement on goals and tasks plus personal bonds), but at the same time specified that different methods would produce unique topologies within these agreements.

3) The definition of the working alliance could be explicated in terms of discrete therapeutic objectives.

2. EMPIRICAL RESEARCH ON THE ALLIANCE

The previous discussion of the working alliance was based exclusively on clinical observations and logical extrapolations. During the last decade, various North American research groups have developed instruments to measure the alliance and have pursued the relationships between the alliance as a process variable and a variety of outcome variables.

2.1 The Penn Research Group

The earliest empirical work was done by Luborsky and his colleagues at the University of Pennsylvania on the Penn Helping Alliance Scales. Based on his clinical observations, Luborsky (1976) composed a list of seven signs of two types of helping relationships:

Type 1: A therapeutic alliance based on the patient's experiencing the therapist as supportive and helpful with himself/herself as the recipient.

Type 2: A therapeutic alliance based on a sense of working together or collaborating in a joint struggle against what is impeding the patient, with the emphasis on shared responsibility.

Luborsky (1976; Luborsky, Mintz, Auerbach, Crits-Cristoph, Bachrach, Todd, Johnson, Cohen, & O'Brien, 1980) had clinical observers rate the first twenty minutes of two early and two late sessions of the seven most improved and eight least improved patients from a pool of 73 who had had at least 25 sessions of psychoanalytically-oriented psychotherapy. He found that six of seven of the improvers developed helping relationships in the early sessions, whereas none of the eight nonimprovers did so. More precisely, the occurence of Type 1 and 2 alliances correlated .58 with outcome, (i.e., residual gain on a composite of four measures provided by patients and observers).

Luborsky, Crits-Cristoph, Alexander, Margolis, and Cohen (1983) reported that the most frequently observed signs were those in which the patient felt helped or changed by the therapist or the treatment, (i.e., observations about progress toward goals).

The signs were then converted into a more efficient rating scale (14 items) and these were applied to the same data (Morgan, Luborsky, Crits-Cristoph, Curtis, & Solomon, 1982). The rating method was shown to be more reliable than the counting signs method ($\underline{r}$= .75 to .88 for interrater reliability and $\underline{r}$=.95 for internal reliability (coefficient alpha)), and to

have almost equally significant predictive power, accounting for about 25% of the variance of various outcome measures. Only 6 of 57 pretreatment predictors, (i.e., personality correlates), examined achieved correlations that were as high. For example, improvement on the first target complaint, (i.e., the specific symptom for which the client came to treatment (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966)), correlated significantly with the early alliance (r=.44 with the rating method and r=.59 with the counting signs method).

As to the development of the helping alliance, the researchers concluded that it was already present at the third to fifth sessions and showed a modest degree of consistency from the early to the late sessions (r=.57 with the rating method). This finding was more evident for more improved patients (whose scores increased from early to late sessions) than for less improved patients (whose scores decreased). The alliance was also found to correlate moderately highly with the presence of observer-rated therapist facilitating behaviour, (i.e., early helping alliance ratings correlated .55 with early therapist facilitating behaviour ratings), as well as with ten similarities of patient and therapist (r=.53), especially age match and religious activity match.

A self-report, the 11-item Helping Alliance Questionnaire (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985) which roughly parallels the rating scale was administered to male opiate-dependent patients who had received supportive expressive psychotherapy (n=32), drug counselling (n=39), or cognitive-

behavioural psychotherapy (n=39). The self-report was given after the third session to estimate the degree to which the patient experienced the therapist and the therapy as helpful. Therapists completed a parallel form of the questionnaire, the Therapist Facilitating Behaviours Questionnaire (Alexander & Luborsky, 1986). Scores were correlated with seven-month outcomes. The two forms produced similar results--correlations ranged from .51 to .72 with four outcome dimensions.

In the present study, the relationship of alliance strength as measured by the HAQ to outcome is compared with that measured by the WAIc.

Therapists' effectiveness was also examined by Luborsky et al. (1985) by rating their performance against specific techniques defined in manuals prepared for the three types of treatment. Three determinants of therapist success were found to relate to outcome: personal qualities, purity of technique, and helping alliance scores, with the last measure correlating most highly. On the basis of intercorrelations of these determinants (therapists' personal qualities were most highly correlated with the helping alliance measure, r=.74), the researchers concluded that therapists' personal adjustment and interest in helping the patient were critical to the formation of a helping alliance:

> ... the major agent of effective psychotherapy is the personality of the therapist, particularly the ability to form a warm, supportive relationship. (p. 609)

2.2 The Vanderbilt Research Group

The Vanderbilt Psychotherapy Project (Strupp & Hadley, 1979) investigated the relative contributions to outcome of the therapist's technical skills and the qualities inherent in any good human relationship. Sixteen clients seen by experienced therapists were compared with 15 seen by college professors selected for their untutored ability to form warm, understanding, empathic relationships. Patients in both groups showed on average equal improvement.

Using the observer-rated Vanderbilt Psychotherapy Process Scale, Gomes-Schwartz (1978) examined the considerable differences in therapeutic relationships among individual dyads. She was able to contribute provocative evidence that up to 38% of the variance in treatment outcomes could be accounted for by the patient's involvement in the therapeutic process. Patient Involvement was described as an index of a patient's active participation, openness, trust in the therapy, and lack of hostility and negativism in the therapeutic interaction. Given an involved patient, professional therapists were able to maximize therapeutic gains.

Strupp and Hadley (1979) concluded that therapeutic change seemed to occur when there was a conjunction between a patient who was capable of taking advantage of a benign human relationship and a therapist whose interventions were experienced by the patient as expressions of caring and genuine interest. While the "techniques" of professional therapists did not seem to give rise to measurably superior treatment effects,

these skills appeared to potentiate the natural healing processes inherent in a "good human relationship", provided the patient was able to feel comfortable with and resonate to the therapist's general approach to therapy.

Moras and Strupp (1982) examined the pretreatment variables, (i.e., personality correlates), in the Vanderbilt database in relation to both the alliances formed and the outcomes achieved. Clinical assessments of interpersonal relations predicted patients' levels of involvement in the therapeutic relationship, accounting for up to 25% of the variance as rated by observers. Since moderately to severely impaired interpersonal relations were less reliable predictors than were basically adequate relations, the researchers concluded that therapist interventions or the particular patient-therapist match play a major role in the development of an alliance, specifically for patients who have difficulty in interpersonal relations.

Hartley and Strupp (1983) constructed the observer-rated Vanderbilt University Therapeutic Alliance Scale (44 items) and applied it to samples of the Vanderbilt project data. Although their analysis of variance indicated no significant association between alliance scores and outcome groups, they compared more and less successful dyads and discovered that the former increased their alliance in the initial phase, peaking at the first quartile point of therapy and then trailing off again in later sessions. The pattern of scores for the less successful group, on the other hand, was a mirror image of that. Their

alliance scores fell from their initial equality with the other group and rose again at the midpoint of therapy. However, they never achieved scores as high as the peak of the more successful group. In the later phases, there were no substantial differences between groups and by the end of therapy, they once more were essentially equal. Hartley and Strupp noted that in the initial phase of therapy, the two groups were significantly divergent on the Responsibility and Anxiety factors of their scale. Like Gomes-Schwartz (1978), they concluded that those patients who went on to achieve better outcomes accepted their own role in bringing about change, and they became more open and less anxious in the sessions.

O'Malley, Suh, and Strupp (1983) measured the relationships in the same data in each of the first three sessions with a revised Vanderbilt Psychotherapy Process Scale. They found a pattern of increased association between process and outcome from which they concluded that Involvement is not necessarily an antecedent quality of the patient, but develops in the course of therapy. Moreover, change in patient participation over the first three sessions correlated more strongly than absolute patient participation in the third session with outcome (r=.63 vs. .46). They (Suh, O'Malley, & Strupp, 1986) accounted for this in terms of the patterns of therapist activity in the early sessions. Increases in Therapist Warmth & Friendliness and in Therapist Exploration resulted in high outcomes for low prognosis patients.

The relationship of change in alliance strength over early

sessions to outcome is further explored in the present study.

2.3 The Langley Porter Research Group

Marziali, Marmar and Krupnick (1981) developed an observer-rated Therapeutic Alliance Scale to measure what they termed the affective, attitudinal aspects of the therapeutic climate. In a pilot study with the five most and five least improved of 25 patients treated in brief dynamic therapy at the Langley Porter Institute, the 21-item Patient Contribution Scale discriminated markedly: patients rated as making a strong positive contribution to the therapeutic alliance had good treatment outcomes. Patients rated as contributing negatively had poor outcomes.

In another study of 52 pathological bereavement cases, patients' positive contributions did not predict outcome, although patients' negative contributions did (r=.34 (p<.05); Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984). However, hierarchical multiple regression analysis revealed that initial patient motivation interacted with the alliance scales in a meaningful way to predict outcome.

Marziali (1984) compared three viewpoints on the alliance--patient, therapist and nonparticipant judge ratings of the same sessions. Patient and therapist-rated scales paralleled the original observer-rated Therapeutic Alliance Scale. The three measurement systems were tested on 42 patients in brief dynamic psychotherapy in sessions 1, 3, 5, 10, 15, and 20. There was significant agreement between them in their estimates of the patients' positive contributions, less for the patients'

negative contributions, and insignificant intercorrelations of ratings of therapist positive and negative contributions.

The patient contributions in each of the three rating systems were the best predictors of outcome, being associated as early as the first and third sessions. Hence, the study concluded that

> Patients' and therapists' ratings of their own and the other's positive contributions to the therapeutic relationship are powerful predictors of therapeutic change ... equal or better ... than the ratings provided by nonparticipant judges. It may be that the therapeutic participants provide the more authentic versions of the quality of the treatment relationship. (p. 422)

In the present study, the relationship of congruence of client and therapist ratings of alliance strength to outcome is explored.

Marmar, Marziali, Horowitz & Weiss (1986) applied the observer-rated scale to 15 cases (segments of the 2nd, 5th, 8th, 11th, and 12th hours of 12-hour treatments) and subjected the results to a factor analysis. Two patient positive factors emerged--satisfaction with therapy and working capacity and commitment. These results were confirmed in a replication with 32 patients.

2.4 The Menninger Research Group

The Menninger Foundation's Psychotherapy Research Project (Horwitz, 1974), a 20-year longitudinal study of 42 cases, identified the therapeutic alliance as not only a prerequisite for therapeutic work, but often as the main vehicle of change. However, the design of the study was naturalistic and loose

(Gelso & Carter, 1985) and, hence, its results could not be taken to be empirically sound.

The current Kansas measures of the therapeutic alliance more narrowly confine the alliance to the patient's collaborative behaviour with the therapist, analogous to Luborsky's (1976) Type 2 helping alliance.

In order to separate the therapeutic alliance from therapist technique, Frieswyk, Colson, & Allen (1984) defined the alliance exclusively in terms of the patient's activity. To also separate it from transference, they restricted the definition to the patient's collaborative work in psychotherapy.

Allen, Newsom, Gabbard, & Coyne (1984) then devised an observer-rated Collaboration Scale to assess the alliance and four scales to assess mediating patient factors--trust in the therapist's commitment, skill and motives; sense of acceptance; optimism about the outcome of therapy; and expression of affect. Collaboration was defined as follows:

> The intent of this scale is to determine the extent to which the patient is making optimal use of the treatment as a resource for constructive change. More specifically, the scale assesses the degree to which the patient actively participates in the work, concretely evidenced in his or her engagement in the requisite treatment tasks, whatever they may be. Raters are to assess the patient's use of the therapy, taking into account the degree to which he or she (a) works actively in the session, (b) brings significant issues and material into the treatment, (c) openly provides information and expresses feelings, (d) makes good use of the therapist's treatment efforts, (e) applies the work done in therapy (e.g., insights and advice) to life outside the therapy, and (f) adopts therapeutic functions (e.g., self-observation) to carry the work forward independently. (p. 386)

Reliability of the scales was demonstrated using the

Vanderbilt project data. The component scales most highly correlated with overall collaborative ratings were: makes good use of therapist's efforts (.96); works actively (.92); shows resistance (-.89); reflects (.88); and is motivated to change (.87). The researchers also found high correlations between the three mediating factors associated with the patient's experience of the relationship. They stressed, however, that their scales were specifically designed to assess the alliance required for psychoanalytic therapy.

Frieswyk, Allen, Colson, Coyne, Gabbard, Horwitz, & Newson (1986) plan to employ their instrument in the intensive study of single cases (in particular with borderline patients) in order to track within-session shifts in the alliance as they relate to various types of therapeutic interventions.

2.5 The British Columbia Research Group

Horvath (1981) employed the Working Alliance Inventory in client and therapist self-report versions to predict outcome after the third session for 29 clients receiving psychotherapy based on a variety of theoretical orientations. The WAI predicted psychotherapy outcome as measured with the Strupp Posttherapy Questionnaire (Strupp, Wallach, & Wogan, 1964) more efficiently than did the Empathy subscale of the Relationship Inventory (Barrett-Lennard, 1962) or the Counselor Rating Form (Barak & LaCrosse, 1975). The Task subscale was the most useful predictor of all aspects of therapy outcome based on client self-report (r=.57). An overview of the results of the correlational data based on therapist report (a modified version

of the Strupp Posttherapy Questionnaire) indicated that the Task domain was also the most effective in predicting therapist-reported client satisfaction and adjustment (r=.68 and .32 respectively). The therapist's perception of client changes, however, most strongly correlated with the therapist-reported Bond component (r=.47).

Relationship and outcome measures were obtained from 36 subjects involved in a program in which the gestalt two-chair method was used to help resolve decisional conflict (Greenberg & Webster, 1982). The Task subscale, the Empathy subscale of the Relationship Inventory and the Counselor Rating Form scales were completed after the second session and a measure of client voice quality (Rice, Koke, Greenberg, & Wagstaff, 1979) was taken in the first session. The Task subscale consistently related to a variety of outcome indices more highly than any of the other prognostic indicators accounting for between 30 to 46% of the outcome variance. It is important to note that all the subjects were engaged in a highly similar, active therapeutic task, (i.e., gestalt two-chair dialogue), so that these results applied to a situation in which a directed therapeutic task was being used.

Noting the high correlation between Task and Empathy in this and in their own study, Horvath and Greenberg (1986) concluded that utilization by the therapist of tasks which were perceived by the client as relevant may lead the client to perceive the therapist as empathic. Task was possibly more highly related to outcome by virtue of it being a more specific

and more interactional measure, indicating that if clients perceive their therapists' in-session suggestions or requests as relevant to their goals, they may perceive the therapist as empathic even if the suggestions or requests are challenging or confronting.

Moseley (1983) employed a revised WAI (Horvath, 1982) with 25 clients in brief therapy from a variety of orientations. Like Horvath (1981), Moseley found a strong correlation between the Goal and Task subscales suggesting that issues pertaining to therapy objectives, (i.e., Goal), and therapy activities, (i.e., Task), are highly overlapped in the early phases of the alliance. Again, the WAI in general and the Task subscale in particular were found to be reliably correlated with therapy outcome as measured by improvement in target complaints (Battle et al., 1966) and the Strupp Posttherapy Questionnaire (Strupp, Wallach, & Wogan, 1964). No significant relationship was found between the alliance measure and either change in state anxiety (State-Trait Anxiety Inventory; Spielberger, Gorsuch, & Lushene, 1970) or change in self-concept (Tennessee Self-Concept Questionnaire; Fitts, 1965). Moseley concluded that these findings on both standardized personality instruments used in the study suggested that the correlation between client reports at the end of the third session and at termination on the Strupp Posttherapy Questionnaire and improvement in target complaints might simply have represented a satisfaction effect rather than a prediction of change. Alternatively, the lack of relationships with the anxiety and self-concept measures might

be explained as a lack of fit between these measures and the actual changes in the treatment, or a function of the brevity of the treatments.

In the present study, the relationship of the WAI to outcome is examined employing a number of outcome measures that reflect the variety currently being utilized in the field of psychotherapy research.

2.6 The Involvement Dimension

One of the most consistent findings of the working alliance research to date has been the significant relationship of client involvement to therapeutic success (Allen et al., 1984; Gomes-Schwartz, 1978; Greenberg & Pinsof, 1986; Luborsky, 1976).

The most recently reported efforts of the various research groups have accordingly been directed at discovering the therapist determinants of client involvement (Allen et al., 1984; Horowitz & Marmar, 1985; Luborsky et al., 1985).

Beutler, Dunbar, & Baer (1980) reported that more effective therapists (as rated by their supervisors) perceived significantly more engagement, (i.e., involvement), in their clients.

Baer, Dunbar, Hamilton II, & Beutler (1980) performed a factor analysis of a 74-item psychotherapeutic process inventory employed by 26 therapists to rate their experience with 99 patients in a psychiatric clinic. Therapeutic Participation, (i.e., the extent to which the patient participates productively in the therapeutic process by demonstrating self-disclosure, self-awareness, insight, or behaviour change), emerged as the

most significant factor accounting for 16.5% of the variance in the therapists' judgments of outcome of treatment. Remarking on the consistency of their findings with those of Gomes-Schwartz (1978), Baer et al. suggested that

> Psychotherapy is characterized by relatively consistent dimensions of process and activity which vary in degree from therapist to therapist. (p. 569)

Using the same clinical sample, Kolb, Beutler, Davis, Crago, and Shanfield (1982) compared the influence of patient's personality, locus of control, perception of the quality of the therapeutic relationship and therapy involvement on the outcome of psychotherapy with 91 patients. Patient's involvement was the best predictor of overall success, being associated with both patient and therapist global ratings of improvement and with decreases in somatic and paranoid symptoms as measured with the Symptom Checklist-90 (Derogatis, Lipman, & Covi, 1973). Therapy dropout was also found to be predictable from involvement.

In the present study, the relationships of exploratory client and therapist-rated involvement measures to outcome are examined.

3. SIGNIFICANCE OF THE PRESENT STUDY

During the past decade, the field of alliance research has been actively generating findings and hypotheses. The British Columbia Research Group has focused on the use of self-report alliance measures based on Bordin's (1975, 1979) conceptualization. Horvath's (1981) exploratory study of the

predictive capacity of the client-rated working alliance has provided some evidence that this more simply administered measure may be at least as effective as the rater-reported measures developed by other research groups. Greenberg and Webster's (1982) and Moseley's (1983) studies have corroborated this evidence. However, small and restricted samples have limited the generalizability of the results of these three studies. Moreover, Horvath related the alliance to outcome as measured with a client report of satisfaction, (i.e., the Strupp Posttherapy Questionnaire). Hence, the question may be posed: Is the correlation simply an artifact of the constancy of client satisfaction through therapy rather than a true measure of change (Glass, 1984)? Moseley's attempt to examine this with two standardized personality measures failed to demonstrate correlations between them and the alliance. Finally, all three studies based their analyses of correlation on only a single administration of the WAI, (i.e., at a single point in therapy).

The present study is intended to more definitively establish the utility of client and therapist-rated measures, both the WAI and the recently developed HAQ which is based on Luborsky's (1976) conceptualization of the alliance. A number of outcome measures currently being employed in the field of psychotherapy research are utilized. The study also subjects some recent hypotheses regarding the relationship of change in alliance strength to outcome (Hartley & Strupp, 1983; Suh et al., 1985) and the significance of client involvement as a subdimension and indicator of the alliance (Greenberg & Pinsof,

1986) to examination.

4. RESEARCH HYPOTHESES

The present study was intended to test the following hypotheses:

Ho-1: There is no statistically significant relationship between perceived alliance strength as measured by the Working Alliance Inventory and outcome. [1]

Ho-1a: There is no statistically significant relationship between client-perceived alliance strength as measured by the WAIc and outcome.

Ho-1b: There is no statistically significant relationship between therapist-perceived alliance strength as measured by the WAIt and outcome.

Ha-1: There is a statistically significant positive relationship or correlation between perceived alliance strength and outcome.

Ho-2: There is no statistically significant relationship between perceived change in alliance strength over the first five sessions as measured by the Working Alliance Inventory and outcome.

Ho-2a: There is no statistically significant relationship between client-perceived change in alliance strength over the first five sessions as measured by the WAIc

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[1] The six instruments used to measure outcome are Target Complaints Improvement, residual gain on the Symptom Checklist-90, the Self-Esteem Index, and the Inventory of Interpersonal Problems, and the Strupp Posttherapy Questionnaire and the Therapist Posttherapy Questionnaire.

and outcome.

Ho-2b: There is no statistically significant relationship between therapist-perceived change in alliance strength over the first five sessions as measured by the WAIt and outcome.

Ha-2: There is a statistically significant positive relationship or correlation between perceived change in alliance strength over the first five sessions and outcome.

Ho-3: There is no statistically significant difference between the relationship of client-perceived alliance strength as measured by the WAIc to outcome and the relationship of client-perceived therapist empathy, attractiveness, expertness, or trustworthiness to outcome.

Ho-3a: There is no statistically significant difference between the relationship of client-perceived alliance strength as measured by the WAIc to outcome and the relationship of client-perceived empathy as measured by the Empathy subscale of the Relationship Inventory to outcome.

Ho-3b: There is no statistically significant difference between the relationship of client-perceived alliance strength as measured by the WAIc to outcome and the relationship of client-perceived therapist attractiveness, expertness, or trustworthiness as measured by the Counselor Rating Form to outcome.

Ha-3: There is a larger statistically significant positive relationship between client-perceived alliance strength and outcome than between client-perceived therapist empathy,

atractiveness, expertness, or trustworthiness and outcome.

Ho-4: There is no statistically significant relationship between client-percieved alliance strength as measured by the Helping Alliance Questionnaire and outcome.

Ha-4: There is a statistically significant positive relationship or correlation between client-perceived alliance strength as measured by the Helping Alliance Questionnaire and outcome.

Ho-5: There is no statistically significant relationship between perceied client involvement as measured by the exploratory Client Involvement Scale and outcome.

Ho-5a: There is no statistically significant relationship between client-perceived client involvement as measured by the CISc and outcome.

Ho-5b: There is no statistically significant relationship between therapist-perceived client involvement as measured by the CISt and outcome.

Ha-5: There is a statistically significant positive relationship or correlation between perceived client involvement and outcome.

Ho-6: There is no statistically significant relationship between congruence of client-perceived alliance strength as measured by the WAIc and therapist-perceived alliance strength as measured by the WAIt and outcome.

Ha-6: There is a statistically significant positive relationship or correlation between congruence of client-perceived and therapist-perceived alliance strength and outcome.

The results of the analyses in the present study have been interpreted using the .05 probability level of statistical significance.

III. METHODS AND PROCEDURES

1. DESIGN OF THE STUDY

In the present study, the development of working alliances has been examined through self-report questionnaires completed by clients and therapists in the course of their actual therapeutic engagements together. The effectiveness of these alliances has been assessed by relating them to a variety of self-report outcome measures.

Forty-four therapies were tracked from first to last session, (i.e., working alliance measures were taken after each of the first five sessions, the tenth session (if there was one), and the final session. In all, seven relationship measures (which encompassed 18 subscales) were employed to assess the therapeutic relationships that were formed, four measures (encompassing 12 subscales) of which were administered as repeated measures, (i.e., the WAIc, the Client Involvement Scale (Client Form), the WAIt, and the Client Involvement Scale (Therapist Form)). All of the relationship measures were correlated with six outcome measures (which encompassed 29 subscales) as well as with one another in order to determine the nature and effectiveness of the 44 working alliances.

The independent variables were:

-client ratings of the strength of WAI Composite, Goals, Tasks, Bonds, and Involvement after each of the first five, tenth, and final therapy sessions.

-therapist ratings of the strength of WAI Composite, Goals,

Tasks, Bonds, and client Involvement after each of the first five, tenth, and final therapy sessions.

-client rating of therapist Empathy after the third session (Relationship Inventory)

-client ratings of therapist Expertness, Attractiveness, and Trustworthiness after the third session (Counselor Rating Form)

-client rating of the helping alliance after the third session (Helping Alliance Questionnaire)

The dependent variables were:

-target complaints improvements

-residual gains in symptom reduction (Symptom Checklist-90), self-esteem (Self-Esteem Index), and interpersonal problem resolution (Inventory of Interpersonal Problems)

-client posttherapy assessment

-therapist posttherapy assessment

2. POPULATION

The population from which the sample was drawn consisted of actual psychotherapies being conducted in Vancouver and Victoria, British Columbia and at the York University Counselling Centre in Toronto, Ontario during February, 1986 through May, 1987. The population was restricted as follows:

1. The clients were in therapy for the first time with the participating therapists.

2. The clients were at least 18 years old.

3. The clients were diagnosed as not psychotic and not

suicidal by the participating therapists.

4. The clients were engaging in individual therapy rather than conjoint or family therapy. Although some of the therapy sessions may have involved their spouses, in the view of the participating therapists, individual therapy was the major service being provided to the clients.

5. The clients were willing and able to give their informed consent to participate in the study.

In British Columbia, about 40 social service agencies employing therapists and about 60 therapists in private practice were approached, first by letter (Appendices 1 and 2) and then by telephone. When invited, the researcher attended agency staff meetings in order to review with the agencies' therapists the nature and scope of the research, the broad outline of the study, the amount of time the procedures would require, and the safeguards that had been designed to protect client and therapist confidentiality and anonymity. These safeguards are detailed below. No information was, of course, given regarding the hypothesized structure of the working alliance. Indeed, the use of the term was avoided, the research being discussed in terms of an exploration of the nature of the therapeutic relationship.

As well, clinic and practica students in the masters and doctoral programs in Counselling Psychology at the University of British Columbia were approached in their clinic and course settings. In Toronto, masters students in Psychology at York University were approached in their clinic setting.

From therapists who agreed to participate in the study, the researchers requested their written consent (Appendix 3), explained the questionnaire administration procedure, and provided them with package(s) of forms and questionnaires. Each package was numerically coded and all forms (except the consent forms) and questionnaires within the package bore the code number so that data could be collected and controlled while preserving client and therapist anonymity. In all, 252 packages were prepared and distributed. Confidentiality was offered to clients by providing them with envelopes attached to each of the questionnaires that they were asked to complete, along with instructions to place their completed questionnaires in these envelopes and to seal them so that the information the client had provided would be available only to the researcher and not to the participating therapist or agency.

3. DATA COLLECTION AND PREPARATION

Therapists signed the Therapist Consent Form attached to an instruction sheet entitled 'Instructions to Therapists in the Psychotherapy Research Project' (Appendix 3). They requested participation from their clients after the first, second, or, in a few cases, the third session offering to pay the client a gratuity of $25.00.

Consenting clients signed the Client Consent Form (Appendix 4) and completed the Target Complaints/Demographic Questionnaire (Appendix 5), the Symptom Checklist-90 (Appendix 6), the Self-Esteem Index (Appendix 7), and the Inventory of Interpersonal Problems (Appendix 8). These measures are described in later

sections of this chapter. This test battery required about 40 minutes of the clients' time.

The demographic data, (i.e., client age, gender, marital status, and education level) collected on the Target Complaints/Demographic Questionnaire were not analyzed statistically, but a summary of them is contained in Appendix 24, Table 24.

After each of the first five therapy sessions as well as after the tenth session (if there was one) and after the final session, both client and therapist completed their respective versions of the WAI (Appendices 9 and 11). This form initially required about five minutes to complete. They also both completed a six-item Client Involvement Scale (Appendices 10 and 12) attached to the WAI. (In many of the cases, the WAI was actually administered after sessions 2 through 6 and, in a few cases, after sessions 3 through 7 since the first and occasionally the second session were considered by the therapist to be assessment session(s) rather than actual therapy session(s), i.e., the client and therapist had not yet contracted to work together.)

After the third session only, clients completed three additional questionnaires, the Relationship Inventory (Appendix 13), the Counselor Rating Form (Appendix 14), and the Helping Alliance Questionnaire (Appendix 15).

Before their 10th sessions, the researcher met with the therapists to collect the forms completed to that point and to provide them with the 10th session questionnaires and with the

termination questionnaire packages as well as with the gratuity cheque and a letter of thanks for the client (Appendix 20). At this time, target complaints were transferred from the form on which the client had recorded them (Appendix 5) to the Target Complaints Improvement Rating Form (Appendix 17).

When therapy concluded, clients again completed the initial battery of four questionnaires as well as the Strupp Posttherapy Questionnaire (Appendix 16). Initial target complaints were rated for improvements (Appendix 17). Therapists completed the Therapist Demographic Data Sheet (Appendix 18) and the Therapist Posttherapy Questionnaire (Appendix 19).

Questionnaires returned from the field were keyed directly into the UBC computer and all input was then visually edited by the researcher. All subsequent data management and analyses were performed at this computing facility.

4. RELATIONSHIP MEASURES

4.1 Working Alliance Inventory

The Working Alliance Inventory (Horvath, 1981, 1982) (Appendices 9 and 11) is a 36-item self-report instrument designed to assess the strength and dimensions of the alliance as conceptualized by Bordin (1975, 1979). Twelve items measure each component--goals, tasks, and bonds.

In order to ensure that the instrument would not be governed by any specific theoretical approach but would apply across orientations, a large number of therapists from different orientations were involved in judging item appropriateness.

Unlike most of the other instruments developed to measure the alliance, the WAI is based on client (WAIc) and therapist (WAIt) perspectives rather than third party evaluation.

> ... such observers, no matter how well trained, can only respond to the behavioural evidence available to them. Important affective and cognitive components of the psychotherapeutic process are entirely unavailable to such raters. (Horvath & Greenberg, 1986, p. 536)

The multitrait-multimethod matrix (Campbell & Fiske, 1959) was used to examine the convergent-discriminant validity of the three dimensions of the WAI--Goal, Task, and Bond--with some support being offered for the convergent validity of the three subscales and for the discriminant validity of the Goal and Task subscales. Acceptable subscale and composite reliabilities (internal consistency and coefficient alpha respectively) were also demonstrated:

Client form:	Goal	.88
	Task	.88
	Bond	.85
	Composite	.93
Therapist form:	Goal	.87
	Task	.82
	Bond	.68
	Composite	.87

The reliabilities derived from the data of the present study, (i.e., internal consistencies and coefficients alpha), of the WAI and of the other relationship measures described in the following sections are presented in Appendix 23, Table 22. The coefficients were found to be similar to those reported by other researchers as reported in this chapter.

The Horvath study provided evidence which is confirmed in the present study that the WAI subscales are highly

interrelated. In the present study, the median Cronbach's (1951) alpha coefficient, (i.e., the degree to which the subscales measured the same thing), was .91 for the WAIc and .94 for the WAIt (Appendix 23, Table 22). These values are similar to Horvath's values of .93 for the WAIc and .87 for the WAIt.

Horvath verified this high degree of agreement among the subscales by intercorrelating them. His findings are presented along with the corresponding findings of the present study in Table 1.

Table 1 - Intercorrelation of the WAI Subscales at Session Three

	BOND:GOAL	BOND:TASK	GOAL:TASK
WAIc	.66	.76	.85
WAIc (Horvath, 1981)	.84	.79	.88
WAIt	.80	.77	.91
WAIt (Horvath, 1981)	.69	.59	.83

These correlation coefficients indicate a strong relationship among the subscales. Horvath concluded that:

> While there was evidence presented that the scales are strongly interrelated, the potential value of utilizing the unique information that may become available through the use of the subscales must weigh heavily in the deliberation. The actual structure of the Working Alliance between helper and helpee is an empirical question which, at this time, is inseparable from the psychometric qualities of the WAI. Much further research is called for to resolve the basic issues underlying the problem. (p. 117)

Hypothesizing on the basic issues underlying the problem to which Horvath has referred above, Greenberg and Pinsof (1986) have suggested that the alliance is a transactional variable

that occurs at a level of abstraction that subsumes a critical client variable which should be the focus of the further research for which Horvath has called.

As reported in Section 2 of Chapter I, Greenberg and Pinsof have noted the consistent finding from alliance-related research that client participation, optimism, perceived task relevance, and responsibility are related to change, and they have hypothesized that Involvement would emerge as the most critical client subdimension and indicator of the alliance. Therefore, they have suggested that further research be directed at this lower level of abstraction toward the development of orientation-specific measures to unravel the issues involved in discriminating the different types of client involvement that are productive in different tasks and treatments.

In the present study, the WAI subscales have been examined individually as Horvath has recommended above. As well, a preliminary measure of Involvement (described in the following section) has been employed and compared with the WAI (Ho-5, Section 5 of Chapter IV).

4.2 Client Involvement Scale

Based on the consistent findings of the various research groups regarding the relationship of client involvement to therapeutic success (Section 2.6 of Chapter II), a six-item scale (Appendices 10 and 11) was created to measure Client Involvement. It was administered along with the WAI to both clients (CISc) and therapists (CISt) as an exploratory instrument. It includes two items tapping Participation (#1 and

#4), two tapping Responsibility (#2 and #6), and two tapping Collaboration (#3 and #5).

4.3 Relationship Inventory

The Relationship Inventory (Barrett-Lennard, 1962) (Appendix 13) was designed to measure four dimensions of the interpersonal relationship from the client's perspective--Empathy, Unconditionality, Level of Regard, and Congruence. These dimensions are based on Rogers' (1957) concept of necessary and sufficient conditions for therapeutic change (Section 1.2 of Chapter II).

The instrument has 16 items in each subscale yielding 64 items in total. Because the RI scales tend to be highly correlated (Gurman, 1977), only the most representative of the four, Empathy, was employed in the present study.

Subjects respond to the RI by assigning a value of +3, +2, +1, -1, -2, or -3 to each item. A response of +3 signifies strong agreement, and -3 strong disagreement with the item. In the present study, the scoring adaptation employed by Horvath (1981) was employed, (i.e., after correcting for polarity, values of 1 to 6 were assigned to the responses with higher scores reflecting more positive perceptions of the therapeutic relationship).

Gurman (1977) evaluated 14 studies of the internal consistency of the RI and 10 studies of its test-retest reliability and found that the mean internal reliability coefficient for the Empathy subscale was .84. The mean test-retest coefficient for Empathy was .83. Horvath (1981) reported

a reliability estimate for the RI Empathy subscale of .89.

4.4 Counselor Rating Form

The social influence theory of counselling (Strong, 1968) which this measure reflects was described in Section 1.2 of Chapter II. The Counselor Rating Form (Barak & LaCrosse, 1975; Appendix 14) consists of 36 items referencing therapist qualities that are rated by the client on a seven-point bipolar scale. Each of the three dimensions of social influence, (i.e., expertness, attractiveness, and trustworthiness), is measured by 12 items yielding three subscales. The items are adjective pairs of opposite meaning, (eg., Attractive-Repulsive), with seven spaces separating them. The client marks one of these spaces with an 'X' to indicate his/her perception of the therapist. The closer the mark is made to the left or right adjective, the more the therapist is identified with that descriptor. The CRF is scored by assigning the integers 1 to 7 to the points between the adjectives and summing the scores of the 12 items belonging to each subscale (after correcting for polarity). The range of scores on each subscale varies from 12 to 84 with high scores representing high influence on each dimension.

Reliability coefficients of .75 to .93 for the instrument were reported by LaCrosse (1977) in an analog counselling experiment which involved simulation of different therapeutic approaches. The method of reliability assessment was not reported. Discriminant validity within counsellors (Barak & Dell, 1977) and between counsellors (LaCrosse, 1977) have also

been demonstrated.

4.5 Helping Alliance Questionnaire

As reported in Section 2.1 of Chapter II, Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) have developed an 11-item self-report questionnaire (Appendix 15) which parallels their Helping Alliance Rating Scale. It has eight HA (Helping Alliance) Type 1 items (a therapeutic alliance based on the patient's experiencing the therapist as supportive and helpful with himself/herself as the recipient) and three HA Type 2 items (a therapeutic alliance based on a sense of working together or collaborating in a joint struggle against what is impeding the patient, with the emphasis on shared responsibility).

Subjects respond to the HAQ by assigning a value of +3, +2, +1, -1, -2, or -3 to each item. A response of +3 signifies strong agreement and -3 strong disagreement with the item. Values of 1 to 6 were assigned to the responses in the present study, with higher scores reflecting more positive perceptions of the therapeutic relationship.

Administered after the third session to 110 drug-abuse patients, the total score was correlated significantly ($p<.01$) with the patients' seven-month outcomes on four measures at .51 to .72. Awaiting the results of a "re-pairing" study employing the instrument, Alexander and Luborsky (1986) stated that

> Because of its relative simplicity, if the questionnaire method is comparable to the others predictively, it would become the future method of choice in terms of efficiency and economy of time for measuring helping alliance phenomena. (p. 354)

Nothing further has been reported by the Penn group on this

issue.

5. OUTCOME MEASURES

Six outcome measures were employed in the present study. Three of them were measures employed by Horvath (1981) and Moseley (1983)--Target Complaints Improvement, the Strupp Posttherapy Questionnaire, and the Therapist Posttherapy Questionnaire--and their relationships with the WAI were verified in the present study. The Symptom Checklist-90, the Self-Esteem Index, and the Inventory of Interpersonal Problems were also employed in order to tap the domain of client change in psychotherapy as broadly as possible.

5.1 Target Complaints Improvement

Improvement in target complaints (Appendices 5 and 17) has been employed as an individualized outcome measure in both the Penn (Luborsky et al., 1983; Morgan et al., 1982) and Vanderbilt (Gomes-Schwartz, 1978) studies. Mintz and Kiesler (1982) described the principal advantage of this outcome measure:

> Since they [individualized outcome measures] are tailored to the unique treatment situation of each patient, they are purported to be of much greater relevance and validity as outcome or program evaluation indexes, in contrast to "across the board" or standardized group measures tapping dimensions that may or may not be relevant to a particular patient. (p. 493)

Battle et al. (1966) compared target complaints improvement with other outcome measures, (i.e., patients' and therapists' ratings of overall improvement, a social ineffectiveness scale, and a discomfort scale), in a four-month

psychotherapy study. The researchers found that target complaints correlated significantly with these other measures. Target complaints as an outcome measure seemed to respond differentially to experimental manipulation, were less dependent on the patients' transference situation than global improvement ratings, and were easy for patients to state. Rankings and severity ratings were shown to be highly reliable when reported before and after an intensive psychiatric evaluation interview.

In the present study, clients identified up to three complaints on a questionnaire (Appendix 5) administered at the beginning of therapy. At the conclusion of therapy, clients were presented with these complaints and were instructed to rate their improvement on each on a five-point Likert scale coded 1 ('Worse') to 5 ('A Lot Better'; Appendix 17). The improvement ratings were averaged. Any averaged score over 3.0 ('Slightly Better'), therefore, represented an improvement.

5.2 Symptom Checklist-90

The Symptom Checklist-90 (Derogatis, Lipman, & Covi, 1973; Appendix 6) is comprised of 90 items which reflect nine primary symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Developed with primary emphasis on validity as a criterion measure in clinical drug trials, the instrument has also been shown to be sensitive to a wide variety of nonpharmacologic factors in the treatment setting.

In a study with 209 subjects, Derogatis, Rickels and Rock

(1976) compared the symptom dimensions of the SCL-90 with MMPI scales which reflected very high convergent validity for the SCL-90. Internal consistency coefficients for the nine scales ranged from .77 to .90 and test-retest reliabilities ranged from .78 to .90.

Each item is rated on a five-point scale of distress ranging from 'Not at all' to 'Extremely'. The SCL-90 takes 20 minutes to complete.

Use of this measure as an outcome assessment device is in accord with the recommendations of the National Institute of Mental Health's Outcome Measures Project (Waskow & Parloff, 1975) and it has been utilized by the Langley Porter group in their alliance research (Section 2.3 of Chapter II).

5.3 Self-Esteem Index

Bachman and O'Malley (1977) reported being heavily influenced by Rosenberg (1965) and Coopersmith (1967) in their use of the term self-esteem to refer to "an individual's self-evaluation or judgment of his/her own worth" (p. 366). The Bachman and O'Malley adaptation of the Rosenberg index (Appendix 7) was standardized on a sample of 1608 young men. The SEI is the unweighted mean of the 10 items with the five-point Likert scale of responses coded 1 to 5. It increased by one standard deviation over the eight-year span of Bachman and O'Malley's longitudinal study. Factor analysis revealed a strong first factor explaining up to 69% of the common variance and internal reliability was found to be as high as .81. Construct validity was demonstrated by correlations with other variables such as

negative affective states (r=-.51) and happiness (r=.54).

5.4 Inventory Of Interpersonal Problems

Horowitz, Weckler, and Doren (1983) developed the Inventory of Interpersonal Problems in order to relate interpersonal difficulties to psychiatric complaints. Twenty-eight patients of a psychiatric clinic were interviewed before beginning psychotherapy from which 100 interpersonal problems were identified. These were found to constitute five major clusters of problem behaviours that generally concerned intimacy, aggression, compliance, independence, and socializing (Horowitz, 1979).

One hundred students Q-sorted the items demonstrating internal consistency, (i.e., correlation between problems within a cluster ($p<.01$)). Test-retest reliability of .77 was also demonstrated.

The current version of the IIP (1986, personal correspondence, Appendix 8) consists of 127 items, 118 of which form 12 subscales. These are listed below along with their test-retest reliabilities:

Hard to be Intimate - 11 items - .88
Hard to be Assertive - 17 items - .82
Hard to be Independent - 9 items - .86
Hard to be Sociable - 11 items - .90
Hard to feel Self-Worth - 6 items - .78
Hard to be Supportive - 11 items - .76
Hard to be Aggressive - 5 items - .69
Too Giving - 6 items - .80

Too Aggressive - 13 items - .80

Too Hypersensitive - 10 items - .85

Too Eager to Please - 10 items - .74

Too Dependent - 9 items - .77

5.5 Strupp Posttherapy Questionnaire

The Strupp Posttherapy Questionnnaire (Strupp, Wallach, & Wogan, 1964) (Appendix 16) is a retrospective measure administered at the end of treatment to determine clients' experience of improvement and satisfaction with treatment. The SPQ has shown positive correlation with other sources of outcome measurement in several previous investigations (Cartwright, Kirtner, & Fiske, 1963). Strupp et al. showed that clients' ratings of change correlated with therapists' overall success ratings. Thus, Waskow and Parloff (1975) have concluded, validity appears to be substantial.

Horvath (1981) logically analyzed the 11 therapy-related items to identify three subscales: Satisfaction (3 items), Change (5 items), and Adjustment (3 items). He reported the following reliability estimates for the instrument:

Satisfaction	.87
Change	.88
Adjustment	.77
Composite	.65

Eight other items dealing with pretherapy conditions, the therapist's level of expertise, the time in therapy until change took place, and the decision to terminate the therapy were not analyzed statistically in the present study. A summary of these data is presented in Appendix 22.

5.6 Therapist Posttherapy Questionnaire

The Therapist Posttherapy Questionnaire was adapted by Horvath (1981; Appendix 19) from the Strupp Posttherapy Questionnaire described above in order to provide an outcome indicator based on therapist's judgment. The rationale to include a therapist's evaluation among the outcome measures was based on findings that suggest that the therapist tends to capture a portion of the outcome variance that is quite independent of the client's point of view (Mintz, 1977).

Horvath (1981) dropped one inappropriate item from the client form. He reported the following reliability estimates for the TPQ:

Satisfaction	.37 (2 items)
Change	.75 (5 items)
Adjustment	.81 (3 items)
Composite	.55 (10 items)

Appendix 22 includes a summary of the data from the seven items that were not analyzed statistically in the present study.

5.7 Therapist Demographic Data Sheet

This form (Appendix 18), completed by the therapist at the end of treatment, was designed to gather the following information about the therapist: professional affiliation, highest degree earned, number of years of experience as a therapist/counsellor, and theoretical orientation which most characterized the work with this client. With the exception of theoretical orientation, these data were not employed in the statistical analyses, but a summary of them is contained in

Appendix 24, Table 23.

The reliabilities derived from the data of the present study, (i.e., internal consistencies and coefficients alpha), of all of the outcome measures described in the preceding sections are presented in Appendix 23, Table 22. With one exception, (i.e., the SPQ Satisfaction subscale discussed in Section 1.5.1 of Chapter IV), the coefficients were found to be similar to those reported by other researchers as reported above.

IV. RESULTS

Data were collected from 44 therapy cases initiated and completed during the period February, 1986 to May, 1987. As well, some data were collected from 12 cases that were terminated prematurely by the clients after less than six sessions. The 44 cases have been categorized as to their sources below:

Private practitioners in Greater Vancouver and Victoria.....	22 cases
Therapists employed by social service agencies in Greater Vancouver.....	13 cases
Masters and doctoral students in clinic and practica settings in Toronto, Ontario and Vancouver (including two demonstration cases conducted by a clinic supervisor)	9 cases
	44 cases

In the largest source group, private practitioners, one therapist contributed four cases to the sample, one contributed three, and two others contributed two cases each. The clinic supervisor mentioned above also contributed a case from his private practice. Hence, 35 therapists were represented in the sample of 44 cases. Case dependence resulting from this therapist effect was examined statistically as a post hoc analysis and the results therefrom are reported in Section 7.1. No client was represented in more than one case in the sample.

All of the private practitioners received financial compensation in whole or in part directly from their clients, while the therapists employed by social service agencies received salaries from their agencies, and the student

therapists were not financially compensated.

The 13 cases contributed by therapists employed in agencies represented seven different agencies--five were from an agency specializing in alcohol and drug abuse counselling, four from church-sponsored counselling services, two from community-based non-profit counselling centres, one from a therapist working in a hospital setting, and one from a campus counselling service for women.

The demographic analysis of the sample of clients and therapists is contained in Appendix 24, Tables 23 and 24. In summary, the therapist sample consisted largely of counsellors in private practice having between one and five years of experience and working from a humanistic orientation. However, several therapists, when asked to identify/describe their theoretical orientation in the first part of question #5 on the Demographic Data Sheet (Appendix 18), indicated that they had employed techniques associated with an orientation other than that in which they had categorized themselves. It seems, therefore, that at least some of the therapists in the sample were, in fact, eclectic in orientation.

Such a speculation is consistent with the findings of Watkins, Lopez, Campbell, and Hammill (1986) who surveyed 716 counselling psychologists and found that the majority, (i.e., 40.2%), identifed their primary orientation as eclectic and that the majority of those, (i.e., 36.4%), classified their eclectic orientation as humanistic-existential eclecticism. It seemed that humanistic orientations tended to be absorbed into

synthetic eclecticism, (i.e., integration of a diversity of contemporary approaches), which, the researchers noted, allowed practitioners to use techniques from different theories that seemed appropriate for particular clients.

The client sample consisted largely of females between the ages of 26 and 35 having at least some college education.

The therapeutic dyads were largely same-gender and the therapies would be characterized as brief.

1. RELATIONSHIP OF PERCEIVED ALLIANCE STRENGTH TO OUTCOME

The alliance measure employed in this and subsequent analyses is the average of the third, fourth, and fifth session measures. The selection of this measure is supported by an analysis of the intercorrelations of the WAI scores of each of the first five sessions which is presented in Appendix 25, Table 25.

The results of the analysis of the relationship of perceived alliance strength to outcome are presented by outcome measure.

1.1 Target Complaints Improvement

Target complaints improvement is defined as the average improvement on the three or less complaints identified by the client at the beginning of therapy (Appendix 5) and rated by the client at the end of therapy (Appendix 17). Clients rated their improvement on each complaint on a five-point Likert scale. The mean improvement was 4.07 (4 = 'Somewhat Better' on the questionnaire) with a standard deviation of .59. The findings

for this outcome measure are presented in Table 2 along with the similar results of Moseley (1983).

Table 2 - Relationships between the WAIc and Target Complaints Improvement

		Moseley (1983; n=19)
	r	r
GOAL	.25	.33 [1]
TASK	.34**	.53**
BOND	.40**	.51*
COMPOSITE	.33**	

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

The WAIc COMPOSITE scale as well as its BOND and TASK subscales correlated statistically significantly with target complaints improvement and the WAIc GOAL subscale also approached statistically significant correlation with this outcome measure ($p=.06$).

The magnitude of the correlation between the WAIt and target complaints improvement did not reach statistical significance, ($r=-.08$, Table 8).

[1] Moseley's results were compared with the results of the present study by testing the differences between the correlation coefficients (Glass & Hopkins, 1984, pp. 307-309). The r's were transformed to Fisher Z's, the variances of the Z's computed, and the standard errors of the differences determined. Correlations were found not to differ statistically significantly between the two studies.

1.2 Self-Esteem Index

The Self-Esteem Index, as well as the Symptom Checklist-90 and the Inventory of Interpersonal Problems whose relationships with outcome are discussed in Sections 1.3 and 1.4 respectively, involved pretests and posttests. Residual gains were calculated using the REGRESSION procedure of SPSS:X to perform semi-partial correlations using the pretests as the controls.

The magnitude of change on these outcome measures was examined before the relationships between the process and outcome measures were considered. For the Self-Esteem Index, a t-test comparing the means of the pretest and the posttest, (i.e., 36.09 and 39.36 with standard deviations of 6.72 and 5.51 respectively), produced a t-value of 4.65 ($p<.001$). The standard error of the pair difference, (i.e., the pooled within-groups S.D. divided by the square root of n), was employed in computing the t-value.

Neither the magnitude of the correlation between the WAIc and residual gain on the SEI nor the magnitude of the correlation between the WAIt and residual gain on the SEI reached statistical significance, ($r=.18$ and .17 respectively, Table 8).

1.3 Symptom Checklist-90

The magnitude of change on the Symptom Checklist-90 from pretest to posttest was analyzed by subscale. These results are presented in Appendix 26, Table 26. All of the subscales of the instrument showed statistically significant improvements, (i.e., reductions), in symptoms from the pretests to the posttests.

The F-values ranged from 6.54 ($p \leq .05$) to 46.87 ($p \leq .001$).

Analysis of the SCL-90 at the subscale level was presented up to this point in the present study for the purpose of description only. Since analyses of the relationships between the relationship measures and this outcome measure were considered to be meaningful only at the scale total level and not at the subscale level (since clients would be expected to register change on only some and not all of the subscales), analyses at the subscale level were discontinued at this point.

Neither the magnitude of the correlation between the WAIc and residual gain on the SCL-90 nor the magnitude of the correlation between the WAIt and residual gain on the SCL-90 reached statistical significance, ($r = .05$ and .07 respectively, Table 8).

1.4 Inventory Of Interpersonal Problems

The magnitude of change on the Inventory of Interpersonal Problems from pretest to posttest was analyzed by subscale. These results are presented in Appendix 26, Table 26. All of the subscales of the instrument showed statistically significant improvements, (i.e., reductions), in interpersonal problems from the pretests to the posttests, (i.e., the F-values ranged from 6.39 ($p \leq .05$) to 1148.48 ($p \leq .001$), with the exception of the 'Too Giving' subscale ($F=2.86$, $p=.10$).

Analysis of the IIP at the subscale level was discontinued at this point for the reason stated for the Symptom Checklist-90 in Section 1.3.

The findings for the IIP are presented in Table 3.

Table 3 - Relationships between the WAIc and the Inventory of Interpersonal Problems

	r
GOAL	.44**
TASK	.45**
BOND	.23
COMPOSITE	.40**

** Significant relationship, $p \leq .01$

The WAIc COMPOSITE scale as well as its GOAL and TASK subscales correlated statistically significantly with residual gain on the IIP.

The magnitude of the correlation between the WAIt and residual gain on the IIP did not reach statistical significance

(r=.02, Table 8).

1.5 Strupp Posttherapy Questionnaire

The findings for the SPQ and for the TPQ whose relationship to outcome is discussed in Section 1.6 are presented in Table 4.

Table 4 - Relationships between the WAI and the SPQ and the TPQ

	GOAL	TASK	BOND	COMPOSITE
	WAIc			
Strupp Posttherapy Questionnaire				
Change	.35**	.41**	.35**	.40**
Therapist Posttherapy Questionnaire				
Satisfaction	.33*	.34**	.24	.32*
Change	.27*	.29*	.22	.28*
Adjustment	.13	.14	.10	.13
TPQ Total	.28*	.28*	.22	.28*
	WAIt			
Strupp Posttherapy Questionnaire				
Change	.04	.12	.06	.07
Therapist Posttherapy Questionnaire				
Satisfaction	.24	.33*	.22	.27*
Change	.17	.21	.08	.16
Adjustment	.22	.19	.08	.17
TPQ Total	.24	.28*	.15	.23

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

1.5.1 Satisfaction

Since the reliability of the Satisfaction subscale of the SPQ was found to be extremely low in the present study (Hoyt's (1941) coefficient=.25, Appendix 23, Table 22), correlation of the WAI with it was regarded as invalid. Horvath's (1981) finding of a Hoyt's coefficient of .37 for the TPQ Satisfaction subscale (Section 5.6, Chapter III) seems to corroborate the conclusion that the three items that constitute this scale are poorly constructed.

1.5.2 Change

The WAIc COMPOSITE as well as its GOAL, TASK, and BOND subscales correlated statistically significantly with SPQ Change (r=.40, .35, .41, and .35 respectively).

The magnitude of the correlation between the WAIt and SPQ Change did not reach statistical significance, (r=.07).

1.5.3 Adjustment

The three items that constitute this subscale probe the client's assessment of his/her capacity to cope at the time of test completion rather than her/his assessment of change resulting from therapy, (eg., Item #15: How adequately do you feel you are dealing with any present problem?). Therefore, this subscale was judged invalid and correlation of the WAI with it was also regarded as invalid.

Henceforth in the present study, only correlations with the SPQ Change subscale have been reported.

1.6 Therapist Posttherapy Questionnaire

The magnitude of the correlation between the WAIt and the TPQ did not reach statistical significance, (r=.23). However, the WAIc COMPOSITE as well as its GOAL and TASK subscales did correlate statistically significantly with the TPQ, (r=.28 for the full scale and also r=.28 for each of the two subscales).

1.6.1 Satisfaction

The WAIt COMPOSITE as well as its TASK subscale correlated statistically significantly with TPQ Satisfaction (r=.27 and .33 respectively).

As well, the WAIc COMPOSITE and its GOAL and TASK subscales correlated statistically significantly with TPQ Satisfaction (r =.32, .33, and .34 respectively), and the WAIc BOND subscale also approached statistically significant correlation with it (r =.24).

1.6.2 Change

The magnitude of the correlation between the WAIt and TPQ Change did not reach statistical significance, (r=.16).

The WAIc COMPOSITE as well as its GOAL and TASK subscales correlated statistically significantly with TPQ Change (r=.28, .27, and .29 respectively).

1.6.3 Adjustment

Neither the magnitude of the correlation between the WAIt and TPQ Adjustment nor the magnitude of the correlation between the WAIc and TPQ Adjustment reached statistical significance, (r =.17 and .13 respectively).

2. RELATIONSHIP OF PERCEIVED CHANGE IN ALLIANCE STRENGTH TO OUTCOME

Suh, O'Malley, and Strupp (1986) examined change in therapist behaviour over the first three sessions of therapy on the Vanderbilt Psychotherapy Process Scale. They found that this change score correlated significantly with various outcome measures while the third session score itself did not.

However, Suh et al.'s formula for deriving this change measure involved difference scores which are considered to be unreliable because of the compounded error inherent in their being based on multiple point estimates (Stanley, 1971). Moreover, they summed the difference between Session 3 and Session 1 and the difference between Session 2 and Session 1, thereby doubling the weighting of the latter difference in their total difference without providing a rationale for this weighting.

In the present study, the WAIc COMPOSITE scores for the first five sessions were fitted to a regression line and the slope of this line was then correlated with the various outcome measures. Although an r^2 of .89 was computed for the slope of the regression line, (i.e., the regression line accounted for

most of the variance, and, therefore, the pattern of WAIc development was indeed found to be linear), the magnitude of the correlation between the slope, (i.e., the change in alliance strength over the first five sessions), and none of the outcome measures reached statistically significance.

When a difference score was computed by subtracting the Session 5 WAIc COMPOSITE from the Session 1 WAIc COMPOSITE score and this difference was then correlated with the outcome measures, one statistically significant correlation did occur. Being one of six, this was judged not to be significant evidence of a relationship between change in WAIc strength and outcome. The correlations with the two methods are presented in Table 5.

Table 5 - Relationship of Change in WAIc Strength to Outcome

	Fitted Regression Line	Difference Score Correlation
Target Complaints Improvement	.00	.20
IIP	.15	.33*
SCL-90	-.04	.12
SPQ Change	.02	.08
SEI	.09	.21
TPQ	.05	.04

* Significant difference, $p \leq .05$

Since the WAIt did not correlate statistically significantly with outcome (Ho-1, Section 1), no analysis of the relationship of change in alliance strength as measured by the WAIt to outcome was performed.

3. RELATIONSHIPS OF CLIENT-PERCEIVED THERAPIST EMPATHY, EXPERTNESS, ATTRACTIVENESS, AND TRUSTWORTHINESS TO OUTCOME

The findings relevant to Ho-3 are presented in Table 6 and summarized in Table 8 which concludes Section 5.

Table 6 - Relationships between Other Process Measures and Outcome Measures

	EMPATHY	EXPERT	ATTRACT	TRUST	HA 1	HA 2
Target Complaints	.03	.01	-.13	-.09	.29*	.22
Symptom Checklist-90	.16	.39**	.36**	.42**	.43**	.36**
Self-Esteem Index	.04	.37**	.29*	.27*	.32*	.29*
Inventory of Interpersonal Problems	.26*	.28*	.28*	.28*	.41**	.21
Strupp Posttherapy Questionnaire						
Change	.15	.16	.13	.09	.38**	.17
Therapist Posttherapy Questionnaire						
Satisfaction	.16	.18	-.04	.08	.28*	.31*
Change	.24	.29*	.14	.30*	.28*	.26*
Adjustment	.20	.28*	.16	.16	.21	.35**
TPQ Total	.23	.29*	.10	.20	.30*	.36**

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

3.1 Relationship Inventory

The Empathy subscale of the RI correlated statistically significantly with residual gain on the IIP (r=.26) but not with the other outcome measures.

3.2 Counselor Rating Form

The CRF total score correlated statistically significantly with residual gain on the SCL-90 (r=.42, Table 8), the SEI (r =.33), and the IIP (r=.30).

Expertness correlated statistically significantly with residual gain on the SCL-90 (r=.39, Table 6), the SEI (r=.37), and the IIP (r=.28). Expertness also correlated statistically significantly with the TPQ (r=.29).

Both Attractiveness and Trustworthiness correlated statistically significantly with residual gain on the SCL-90 (r =.36 and .42), the SEI (r=.29 and .27), and the IIP (r=.28 for both subscales).

4. RELATIONSHIP OF CLIENT-PERCEIVED ALLIANCE STRENGTH AS MEASURED WITH THE HELPING ALLIANCE QUESTIONNAIRE TO OUTCOME

The findings relevant to Ho-4 were presented in Table 6 in Section 3 and are summarized in Table 8 which concludes Section 5.

The HAQ correlated statistically significantly with all six of the outcome measures employed in the present study (r ranged from .29 to .44).

Type 1 Helping Alliance also correlated statistically significantly with all of the outcome measures (r ranged from

.29 to .43), while Type 2 Helping Alliance correlated statistically significantly with residual gain on the SCL-90 (r =.36) and the SEI (r=.29) and with the TPQ (r=.36).

5. RELATIONSHIP OF PERCEIVED CLIENT INVOLVEMENT TO OUTCOME

The findings relevant to Ho-5 are presented in Table 7.

The exploratory six-item Client Involvement Scale was appended to the WAI (both client and therapist forms) in order to examine the relationship of the hypothesized "lower level" Client Involvement variable (Greenberg & Pinsof, 1986) to outcome (Section 2 of Chapter I and Section 4.1 of Chapter III).

Table 7 - Relationships between the Client Involvement Scale and the Outcome Measures

	CISc	CISt
Target Complaints Improvement	.39**	.01 [1]
Symptom Checklist-90	-.02	.06
Self-Esteem Index	.21	.13
Inventory of Interpersonal Problems	.27*	.10
Strupp Posttherapy Questionnaire		
Change	.39**	.12
Therapist Posttherapy Questionnaire		
Satisfaction	.37**	.27*
Change	.29*	.23
Adjustment	.16	.25*
TPQ Total	.32*	.29*

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

[1] The CIS scores were averaged over the third, fourth, and fifth sessions as were the WAI scores (Section 1).

The CISc correlations with outcome were similar to those of the WAIc, (i.e., it correlated statistically significantly with target complaints improvement (r=.39), residual gain on the IIP (r=.27), SPQ Change (r=.39), and the TPQ (r=.32)). Correlation of the CISt with outcome was slightly stronger than that of the WAIt with outcome, (i.e., the CISt correlated statistically significantly with the TPQ, (r=.29)), while the WAIt only approached statistically significant correlation with it, (r =.23, Table 4).

The relationships of the seven relationship measures to the six outcome measures were compared at the scale total level in Table 8.

Table 8 - Summary of Relationship-Outcome Correlations

	Target Complaints	SCL-90	SEI	IIP	SPQ Change	TPQ
WAIc	.33**	.05	.18	.40**	.40**	.28*
CISc	.39**	.02	.21	.27*	.39**	.32*
CRF	-.07	.42**	.33**	.30*	.13	.21
Empathy	.03	.16	.04	.26*	.15	.23
HAQ	.29*	.44**	.33**	.38**	.34**	.34**
WAIt	-.08	.07	.17	.02	.07	.23
CISt	.01	.06	.13	.10	.12	.29*

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

The differences between the WAIc correlation coefficients and the other relationship measure correlation coefficients were

tested using the Z transformation procedure described in Section 1.1. The findings are presented in Table 9.

Table 9 - Z-Ratios of Differences between WAIc-Outcome Correlations and Other Relationship Measures-Outcome Correlations

	Target Complaints	SCL-90	SEI	IIP	SPQ Change	TPQ
CISc	.31	.14	.14	.67	.05	.20
CRF	1.88*	1.81*	.73	.52	1.33	.34
Empathy	1.42	.50	.65	.72	1.62	.25
HAQ	.25	1.96**	.73	.11	.32	.30
WAIt	1.92*	.09	.05	1.84*	1.61	.25
CISt	1.55	.05	.23	.46	1.38	.05

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

The WAIc correlations with outcome were found to differ statistically significantly from the CRF and WAIt correlations with outcome on two measures, and from the HAQ correlation with outcome on one measure.

In order to compare the overall effectiveness of the WAIc and the HAQ, each was included in a multiple regression equation with all of the six outcome measures. The variance (r^2) explained by the WAIc was .31 and that for the HAQ was .32. Hence, on an overall basis, the two alliance measures had equal relationships with outcome.

6. RELATIONSHIP OF CONGRUENCE OF CLIENT-PERCEIVED AND THERAPIST-PERCEIVED ALLIANCE STRENGTH TO OUTCOME

For the purpose of this study, congruence was defined as clients and therapists rating their alliances similarly.

The correlations between the two forms of the WAI are presented in Table 10.

Table 10 - Congruence of the WAIc and the WAIt

	Client Form			
	GOAL	TASK	BOND	COMPOSITE
Therapist Form:				
GOAL	.32*	.32*	.21	.30*
TASK	.37**	.38**	.29*	.37**
BOND	.23	.28*	.21	.25*
COMPOSITE	.32*	.33**	.24	.32*

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

The two forms correlated at low but statistically significant levels on both the COMPOSITE scale and on the GOAL and TASK subscales. They did not correlate consistently statistically significantly on the BOND subscale.

In the analyses presented in Tables 10 and 11, an approximation of Mahalanobis' distance (Bock, 1975, p. 399), (i.e., client's perception minus therapist's perception, squared), was the measure that was correlated with outcome. In order to reduce the skewness of the resulting distribution to produce a more normal distribution, a square root transformation

was performed on the congruence data. Normality was then confirmed with the Kolmogorow-Smirnov goodness of fit test (Hollander & Wolfe, 1971).

Congruence was indeed found to increase somewhat over the seven occasions. The decreasing measures of distance are presented in Table 11.

Table 11 - WAIc-WAIt Congruence at the Seven Occasions

	Mean Distance	S.D.
Session 1	22.00	16.76
Session 2	18.67	17.40
Session 3	18.21	11.37
Session 4	19.12	13.52
Session 5	18.13	15.02
Session 10	16.56	12.68
Final Session	17.05	13.05

The results of the analysis of the correlation of congruence with outcome are presented in Table 12.

Table 12 - Correlation of Outcome with WAIc-WAIt Congruence at the Seven Occasions

	Session						
	#1	#2	#3	#4	#5	#10	Final
Target Complaints	-.20 [1]	-.38**	-.12	-.09	.13	.16	.14
SCL-90	-.04	.23	.23	.09	.09	.08	-.03
SEI	-.04	.18	.13	.26*	.25*	.42**	.20
IIP	-.16	.02	.06	.12	-.03	-.25*	-.25*
Strupp Posttherapy Questionnaire							
Change	-.28*	-.26*	.02	-.10	-.08	.07	-.07
Therapist Posttherapy Questionnaire							
Satisfaction	.15	.18	.14	.00	.13	.06	.07
Change	-.10	.00	-.09	-.11	-.05	-.04	.05
Adjustment	.13	.10	-.01	.01	.09	.43**	.14
TPQ Total	.08	.07	.02	-.03	.07	.22	.11

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

The results of the analysis of the correlation of congruence with outcome were equivocal. Congruence in later sessions correlated statistically significantly with residual gain on the SEI and it approached statistically significant correlation in early sessions with residual gain on the SCL-90. However, congruence correlated negatively with improvement in target complaints and with SPQ Change in early sessions and

[1] Since the congruence measure shrinks as congruence increases, the correlations of this measure with outcome would be expected to be negative. The signs of the correlation coefficients have, therefore, been reversed.

negatively with residual gain on the IIP in later sessions. Congruence was unrelated to outcome on the TPQ.

7. POST HOC ANALYSES

7.1 Analysis Of Therapist Effect

As described at the beginning of this chapter, 35 therapists contributed the 44 cases that constituted the sample. One therapist contributed four cases, two contributed three cases each, and two contributed two cases each. This represented neither a significant therapist effect, (i.e., 30 or 86% of the therapists contributed only one case), nor was it a systematic or balanced effect that would lend itself to statistical control.

Therefore, simple comparisons of the two groups of cases, (i.e., one being the 14 cases from the five therapists contributing multiple cases and the other being the 30 cases from the 30 therapists contributing one case each), were performed to check for significant differences between the groups. Although it was recognized that dependency effects could show in other ways, the standard deviation was used as the "check" indicator. Three "marker variables" of client change were chosen and their standard deviations for each of the two groups were compared and are presented in Table 13.

Table 13 - Analysis of Therapist Effect on Three Marker Outcome Variables

	14 cases from 5 therapists S.D.	30 cases from 30 therapists S.D.
Improvement on Target Complaints	.48	.64
'Change' Subscale of SPQ	.74	.72
Self-Esteem Index--Residual Gain	.89	1.05

7.2 Analysis Of Effect Of Theoretical Orientations Of Therapists

Seven of the cases were characterized by the four therapists involved as other than humanistic in theoretical orientation--four as analytic and three as learning. This represented neither a significant theoretical orientation effect, (i.e., 31 or 89% of the therapists claimed a humanistic orientation, three claimed an analytic orientation, and only one claimed a learning orientation), nor was it a systematic or balanced effect that would lend itself to statistical control. T-tests of the differences between these two groups, (i.e., the seven non-humanistic and the 37 humanistic), were performed on both client and therapist forms of the WAI. No statistically significant differences were revealed in comparisons based on the WAIc. The results of the WAIt comparisons are presented in Table 14.

Table 14 - Analysis of Effect of Theoretical Orientation of Therapist on WAIt

	Humanistic		Non-Humanistic		
	Mean	S.D.	Mean	S.D.	t
GOAL	67.50	1.45	64.67	1.07	1.57
TASK	68.22	1.95	65.06	6.15	2.45*
BOND	74.44	1.95	71.52	6.67	2.16*
COMPOSITE	210.17	6.21	201.25	18.65	2.24*

* Significant difference, $p \leq .05$

The WAIt COMPOSITE as well as its TASK and BOND subscales differed statistically significantly between the humanistic and non-humanistic groups.

7.3 Correlations Of The WAI With The Outcome Measures At The Seven Occasions

The WAI was correlated with outcome at each of the seven occasions at which it was administered in order to examine fluctuations over time.

The mean WAI scores at the seven occasions at which the instrument was administered were examined and are presented in Appendix 23, Table 21 along with the reliability coefficients. The data reveal that the alliances continued to strengthen through the course of therapy.

The correlations of each of the repeated WAIc measures with the outcome measures were examined to determine how the alliances' relationships with outcome changed over the course of therapy. These data are presented in Table 15.

Table 15 - Correlations of the WAIc at Seven Occasions with the Outcome Measures

	Target Complaints	SEI	SCL-90	IIP	SPQ Change	TPQ
			COMPOSITE			
Session 1	.19	-.07	-.02	.05	.30*	.24
Session 2	.24	.06	-.05	.31*	.29*	.17
Session 3	.27*	.12	-.10	.28*	.24*	.25*
Session 4	.29*	.25*	.14	.36**	.40**	.24
Session 5	.40**	.18	.11	.47**	.46**	.31*
Session 10	.38*	.21	.09	.55**	.48**	.41*
Final Session	.21	.17	.06	.30*	.45**	.26*
			GOAL			
Session 1	.04	-.20	-.05	-.03	.11	.12
Session 2	.08	-.09	-.10	.21	.11	.06
Session 3	.16	.07	-.04	.36**	.21	.20
Session 4	.19	.17	.19	.41**	.36**	.32*
Session 5	.31*	.12	.16	.46**	.39**	.27*
Session 10	.22	.11	.21	.65**	.25	.34*
Final Session	.09	.22	.16	.35**	.36**	.30*
			TASK			
Session 1	.24	.02	.03	.12	.36**	.28*
Session 2	.24	.12	.04	.34**	.34**	.17
Session 3	.21	.07	-.06	.30*	.24*	.25*
Session 4	.29*	.26*	.18	.38**	.41**	.21
Session 5	.44**	.17	.16	.56**	.47**	.34*
Session 10	.35*	.21	.14	.54**	.48**	.39*
Final Session	.25*	.27*	.13	.36**	.54**	.27*
			BOND			
Session 1	.25*	.00	-.03	.06	.35**	.26*
Session 2	.36**	.15	-.07	.30*	.36**	.25*
Session 3	.35**	.18	-.16	.11	.22	.22
Session 4	.32*	.25*	.02	.21	.34**	.15
Session 5	.36**	.19	.00	.31*	.40**	.24
Session 10	.42*	.23	-.11	.27	.52**	.35*
Final Session	.22	.00	-.11	.14	.33**	.14

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

Although it has been assumed that the alliance was predictive of outcome by the third session (Greenberg & Pinsof, 1986), the data in the present study indicated that the relationship of the WAI to the outcome measures with which it correlated statistically significantly continued to strengthen through the course of therapy.

The analysis also revealed, however, that the final session WAI's relationship with outcome was usually not as strong as that in earlier sessions.

The relationships of the WAI with residual gain on the SEI and on the SCL-90, both of which were not statistically significant at the third to fifth session (Section 1.2 and 1.3), were not only lower at all seven occasions and sometimes negative, but they did not increase as consistently as did the other WAI-outcome relationships through the course of therapy. In particular, they were unstable over the third, fourth, and fifth sessions, (i.e., lower in the third, rising in the fourth, and dropping in the fifth).

7.4 Relationships Between The WAI And The Other Relationship Measures

The relationships of the WAI with the four other relationship measures included in the present study for the purpose of comparison with it are presented in Table 16.

Table 16 - Relationships between the WAI and the Other Process Measures

	GOAL	TASK	BOND	COMPOSITE
Working Alliance Inventory (Client Form)				
Client Involvement Scale (client-rated)	.70**	.73**	.81**	.81**
Client Involvement Scale (therapist-rated)	.38*	.33*	.38*	.40**
Empathy	.68**	.69**	.57**	.69**
Counselor Rating Form				
Expertness	.37**	.39**	.27*	.36**
Attractiveness	.39**	.39**	.35**	.42**
Trustworthiness	.30*	.27*	.17	.26*
CRF Total	.38**	.39**	.29*	.38**
Helping Alliance Questionnaire				
HA Type 1	.60**	.62**	.40**	.58**
HA Type 2	.56**	.46**	.31*	.47**
HAQ Total	.63**	.62**	.40**	.58**
Working Alliance Inventory (Therapist Form)				
Client Involvement Scale (client-rated)	.37**	.50**	.37**	.43**
Client Involvement Scale (therapist-rated)	.88**	.89**	.84**	.90**
Empathy	.22	.28*	.07	.19
Counselor Rating Form				
Expertness	.24	.28*	.13	.22
Attractiveness	.06	.06	-.03	.06
Trustworthiness	.06	.06	-.08	.03
CRF Total	.13	.13	.01	.11

Table 16 (Cont'd.)

	GOAL	TASK	BOND	COMPOSITE
Helping Alliance Questionnaire				
HA Type 1	.37**	.41**	.20	.34**
HA Type 2	.18	.22	.06	.16
HAQ Total	.33**	.38**	.17	.30*

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

The WAIc correlated statistically significantly with all of the other process measures employed in the study. The WAIt correlated statistically significantly with the client-rated and therapist-rated Client Involvement Scales and with the Helping Alliance Questionnaire, but not with Empathy or with the Counselor Rating Form.

In order to assess the extent to which the five client-rated process measures were tapping related or overlapping constructs, they were correlated with one another at the scale level. These correlations are presented in Table 17.

Table 17 - Intercorrelations of the Client-Rated Process Measures

	WAIc	Empathy	CRF	HAQ	CISc
WAIc	--				
Empathy	.69**	--			
CRF	.38**	.68**	--		
HAQ	.58**	.66**	.51**	--	
CISc	.81**	.46**	.17	.47**	--

** Significant correlation, $p \leq .01$

With the exception of the relationship between the CISc and the CRF, all the relationship measures were statistically significantly related.

7.5 Identification Of Relative Strengths Of Outcome Predictor Variables

In order to investigate which relationship variable or combination of variables were the most useful predictor(s) of the various outcomes, a series of multiple forward stepwise regression equations was developed with the REGRESSION procedure of SPSS:X using the six relationship measures as the independent variables and the six outcome measures as the dependent variables.

There is the possibility of correlated errors when a series of multiple regression analyses are performed with related outcome measures, (i.e., the analyses are not really independent), and, therefore, the probability of a Type I error is higher than that set for each of the analyses. Some of the

intercorrelations of the six outcome measures as presented in Table 18 are statistically significant and, hence, the probabilities set for the multiple regression analyses are, in fact, somewhat understated.

Table 18 - Intercorrelations of the Outcome Measures

	Target Complaints	IIP	SCL-90	SEI	SPQ Change	TPQ
Target Complaints	--					
IIP	.17	--				
SCL-90	.18	.42**	--			
SEI	.40**	.24	.44**	--		
SPQ Change	.51**	.38**	.23	.27*	--	
TPQ	.35**	.12	.24	.31*	.29*	--

* Significant relationship, $p \leq .05$
** Significant relationship, $p \leq .01$

It was noted that these regression equations were unstable, since a ratio of 30 cases per independent variable is desireable to derive a stable equation (Kerlinger & Pedhazur, 1982), a condition that was not met in the present study. Hence, no interpretation was to be applied from these analyses beyond the sample in the study. The explained variances (r^2) were reported only as indications of the contributions of the independent variables to the variances in this study.

For each of the six dependent outcome variables, only one independent relationship variable entered into the equation at the probability level of .05 or less. Intercorrelations of the relationship measures were found to be high as were presented in

Section 7.3, Table 17. Therefore, it seemed that the overlap among the independent relationship variables was such that combining them did not significantly improve upon their predictive efficacy. The results are presented in Table 19. The independent variables which did not enter into the equations were listed with their beta weights after the entering variables in order of their impact.

Table 19 - Relative Strengths of Outcome Predictor Variables

Outcome Variable	Predictor	Beta Weights	R Squared
Target Complaints Improvement	CISc	.39**	.15
	HAQ	.13 [1]	
	WAIc	.04	
	CRF	-.14	
	Empathy	-.19	
IIP	WAIc	.40**	.16
	CISc	.15	
	Empathy	.04	
	CRF	-.17	
	HAQ	-.22	
SCL-90	HAQ	.44**	.19
	WAIc	.31	
	CISc	.29	
	Empathy	.23	
	CRF	-.26	
SEI	HAQ	.33*	.11
	CRF	.22	
	CISc	.07	
	WAIc	.00	
	Empathy	-.22	
SPQ Change	WAIc	.40**	.16 [2]
	CISc	.20	
	HAQ	.17	
	CRF	-.02	
	Empathy	-.25	

[1] Not in equation

[2] The coefficients of determination for SPQ Change and for the TPQ are lower than those reported in Horvath's (1981) study, (i.e., .20 and .29 respectively). It was speculated that the differences might have been due to the smaller n, (i.e., 29), of that study which made for a higher chance of fitting the error, and, hence, for deflation upon replication with a larger sample size.

Table 19 (Cont'd.)

Outcome Variable	Predictor	Beta Weights	R Squared
TPQ	HAQ	.34*	.12
	CISc	.19	
	WAIt	.14	
	WAIc	.11	
	CRF	.06	
	Empathy	.02	

* Significant predictor, $p \leq .05$
** Significant predictor, $p \leq .01$

==========

The two client-rated measures of the alliance, (i.e., the HAQ and the WAIc), and the CISc were consistently better predictors of outcome than were the CRF, Empathy, and the WAIt.

7.6 Comparison Of WAI Scores Of Completed And Prematurely Terminated Cases

Some data were collected on 12 cases that were prematurely terminated by clients.

The WAIc and the WAIt after the first and second sessions were compared and the results are presented in Table 20.

Table 20 - Comparison of WAI Scores of Completed and Prematurely Terminated Cases

	Completed Mean	Completed S.D.	Incomplete Mean	Incomplete S.D.	t	n(c)/n(t) [1]
WAIc						
First Session:						
GOAL	66.59	8.71	59.00 [2]	8.43	2.50*	44/10
TASK	66.14	8.62	60.80	11.25	1.67	
BOND	70.25	8.34	65.20	10.33	1.65	
COMPOSITE	202.98	23.67	185.00	28.07	2.10*	
Second Session:						
GOAL	66.19	7.53	64.67	6.48	.56	43/9
TASK	66.53	7.10	64.44	8.31	.78	
BOND	70.81	6.97	68.78	8.09	.78	
COMPOSITE	203.53	19.71	197.89	20.43	.78	
WAIt						
First Session:						
GOAL	61.49	7.68	62.33	7.04	.34	43/12
TASK	63.49	6.52	65.58	5.87	1.00	
BOND	67.91	7.17	67.58	8.13	.13	
COMPOSITE	192.88	19.59	195.50	19.31	.41	
Second Session:						
GOAL	63.05	7.43	62.20	11.08	.23 [3]	43/10
TASK	64.65	7.31	62.70	8.00	.75	
BOND	70.09	7.62	70.00	6.90	.04	

[1] Based on 44 completed cases and 10 prematurely terminated cases (n(c)=number completed; n(t)=number prematurely terminated).

[2] T-test of the difference between the means of the two groups. F-tests of the differences between the variances of the two groups revealed in all but one case no significant differences and, hence, the t-values were based on pooled variance estimates.

[3] A significant difference between the variances of the two groups was revealed with this F-test and, hence, the t-value based on separate variance estimates was presented.

WAIc COMPOSITE scores as well as WAIc GOAL scores, after the first session were statistically significantly different for those who terminated their therapies than for those who continued to completion. This difference did not hold true after the second session and did not apply to WAIt scores.

V. DISCUSSION

1. INTERPRETATION OF FINDINGS

1.1 Relationship Of Perceived Alliance Strength To Outcome

It was hypothesized that perceived alliance strength was positively related to outcome. This was the case for client-perceived alliance strength, but not for therapist-perceived alliance strength.

The WAIc correlated statistically significantly with target complaints improvement (r=.33, Table 2) as it had as well in the Moseley (1983) study. The BOND subscale correlated particularly strongly (r=.40) with target complaints improvement in the present study.

The WAIc also correlated statistically significantly with residual gain on the IIP (r=.40, Table 3), although this was due to the performance of the GOAL and TASK subscales (r=.44 and .45) rather than to that of the BOND subscale (r=.23). It may be that clients related their changes on this more differentiated outcome instrument to the more technical dimensions of their alliance, (i.e., goals and tasks), than they did their improvements on the more global target complaints that they had themselves identified and described.

The WAIc did not correlate with residual gain on the SCL-90 or the SEI while other relationship measures did so. These findings raise questions about the validity of the WAIc which are addressed in Section 1.4, the interpretation of the findings relevant to the relationship of the HAQ to outcome.

The WAIc did correlate statistically significantly with SPQ Change (r=.40, Table 4). In particular, the TASK subscale correlated statistically significantly (r=.41) with SPQ Change. This was an expected finding since it was consistent with that of Horvath (1981). However, since the SPQ is completed by the client after therapy is concluded, rather than involving pretests and posttests, it is subject to the charge that it is not a true test of outcome, (i.e., therapeutic change), but rather a satisfaction measure.

The WAIc also correlated statistically significantly with the TPQ (r=.28, Table 4). This correlation of the client-rated process measure with the therapist-rated outcome measure counters the claim (Glass, 1984) that the alliance is not an independent predictor of outcome, but rather an in-process assessment of outcome which is later inevitably confirmed in the manner of a self-fulfilling prophecy. Further evidence that the alliance is an independent predictor of outcome is discussed in Section 1.7.3.

The WAIt did not predict outcome as assessed by the client on any of the five measures employed. Correlation with the therapist-rated TPQ was also not statistically significant at the composite level (Table 4).

The failure of the WAIt to predict outcome demonstrated in the present study suggests that the WAIt is not an effective measure of the alliance. The relatively weak correlations of the WAIt with the WAIc (Tables 10 and 16) and the statistically significant differences between the correlations of the WAIc

with target complaints improvement and with the IIP and the WAIt with these two outcome measures (Table 9) indicate that the two instruments are not measuring the same construct, although they both purport to be measures of the alliance. This disparity suggests that the meaning of the alliance construct requires clarification.

It may be argued that stronger correlations of the WAI with outcome would have been achieved had initial WAI values been partialed out of the third to fifth session average measures, thereby lifting the ceiling imposed by the regression effect on initially strong alliances. Since the point spread over the five sessions was only 7.77 out of 252 for the WAIc (Appendix 23, Table 21) and 11.96 out of 252 for the WAIt, inclusion of such a procedure would probably not have effected the study results significantly.

1.2 Relationship Of Perceived Change In Alliance Strength To Outcome

It was hypothesized that perceived change in alliance strength over the first five sessions of therapy was positively related to outcome. This was found not to be the case.

Suh, O'Malley, & Strupp's (1986) research has suggested that increase in therapist behaviours, (i.e., Therapist Warmth and Therapist Exploration), in the early part of therapy might be more critical to successful outcome than the absolute level of such therapist behaviours in the third session.

Although the alliance did increase in the present study (Table 14), when Suh et al.'s procedure was applied to the data,

no relationship between increase in alliance strength over the first five sessions and outcome was found (Table 5). Since the rationale for their method of calculating the increase seems questionable, (Section 2 of Chapter IV), it may be that Suh et al.'s finding was in fact a statistical artifact. In addition, it related to a subgroup of four of their 16 cases, a subgroup which consisted of "low prognosis" patients who achieved "high outcomes" and may not apply across a total sample.

1.3 Relationships Of Client-perceived Therapist Empathy, Expertness, Attractiveness, And Trustworthiness To Outcome

It was hypothesized that client-perceived therapist empathy, expertness, attractiveness, and trustworthiness were less positively related to outcome than was client-perceived alliance strength. This was found to be the case.

The Empathy subscale of the RI correlated statistically significantly with only one of the outcome measures, residual gain on the IIP (r=.26, Table 6). This poor result may be attributable to the limitations of the instrument. Such an attribution would be consistent with the conclusions of Gelso and Carter (1985) and of Marks and Tolsma (1986) concerning the contradictory findings of process-outcome studies with respect to empathy (Section 1.2, Chapter II). Gelso and Carter concluded that there is not a simple linear relationship, at least of any magnitude, between therapist-offered conditions and outcome and that the relationship is probably best viewed as highly complex. Marks and Tolsma recommended that since empathy is a complex construct, its investigation requires sophisticated

studies in which the details of the empathic process are closely scrutinized. For example, such variables as variations in the subject population and in the presenting concern and the manner in which it is discussed, (i.e., level of emotional content in the presentation), affect the strength of empathy ratings. Since the present study drew upon a broad population of real cases, no such scrutiny of the empathic process was feasible.

The Counselor Rating Form was more consistently related to outcome than was Empathy, correlating statistically significantly with three of the six outcome measures. It correlated with residual gain on the SCL-90 (r=.42, Table 7), the SEI (r=.33), and the IIP (r=.30), but it did not correlate with target complaints improvement, SPQ Change, and the TPQ. The WAIc did correlate statistically significantly with the latter three.

The CRF's correlation with target complaints improvement and with residual gain on the SCL-90 were statistically significantly different from those of the WAIc with these two outcome measures (Table 9). That the WAIc would outperform the CRF on target complaints improvement and SPQ Change (though not statistically significantly on the latter) is consistent with Horvath's (1981) and Moseley's (1983) results. However, the statistically significant correlations of the CRF and of the HAQ (discussed in Section 1.4) with residual gain on the SCL-90 and the SEI highlight the inadequacy of the WAIc as a comprehensive correlative measure. In particular, both of these relationship measures' correlations with the SCL-90 were statistically

significantly stronger than that of the WAIc with the SCL-90.

1.4 Relationship Of Client-perceived Alliance Strength As Measured With The Helping Alliance Questionnaire To Outcome

It was hypothesized that client-perceived alliance strength as measured with the Helping Alliance Questionnaire was positively related to outcome. This was the case.

The HAQ proved to be a powerful predictor of outcome in the present study, correlating statistically significantly with all six of the outcome measures (Table 8). This 11-item scale is more efficiently administered than the 36-item WAIc and seems to be at least as effective.

The three-item Helping Alliance Type 2 subscale correlated less strongly, though not statistically significantly so, than the eight-item Helping Alliance Type 1 subscale (Table 6), but this seemed to be attributable to one item, (i.e., #11: I feel now that I can understand myself and deal with myself on my own (that is, even if this therapist and I were no longer meeting for treatment appointments).), which consistently elicited responses that were disparate from those to the other items.

In their conceptions, the HAQ is an empirically-driven instrument whereas the WAI is conceptually-driven. Alexander and Luborsky (1986) reported that the HAQ was derived from the Penn Helping Alliance Scale that was in turn developed from Luborsky's study of clinical transcripts. Examination of its items suggests that they reflect a positive or optimism factor, requiring the client to evaluate the extent to which she/he feels good because he/she believes she/he is being or will be

helped by the therapist. The importance of this positive client attitude was affirmed by the finding of Marmar, Marziali, Horowitz, and Weiss (1986) that the patient feeling helped and hopeful was an important factor being tapped by their alliance scale.

The HAQ items may be grouped by content as follows:

Two of the 11 items probe the extent of client-perceived therapeutic progress:

#3-I have obtained some new understanding.

#4-I have been feeling better recently.

Four items probe the extent of client optimism:

#1-I believe that my therapist is helping me.

#2-I believe that the treatment is helping me.

#5-I can already see that I will eventually work out the problems I came to treatment for.

#11-I feel now that I can understand myself and deal with myself on my own (that is, even if this therapist and I were no longer meeting for treatment appointments).

Three items probe the extent of client confidence in the therapist:

#6-I feel I can depend upon the therapist.

#7-I feel the therapist understands me.

#8-I feel the therapist wants me to achieve my goals.

Two items probe the extent of client-perceived client collaboration with the therapist:

#9-I feel I am working together with the therapist in a joint effort.

#10-I believe we have similar ideas about the nature of my problems.

With the exception of items #9 and #10, then, the HAQ is a measure of client attitude. Frieswyk et al. (1986) have criticized such measures of the alliance as having "failed to distinguish underlying and contributing patient attitudes and characteristics from the patient's active collaboration in the therapeutic process" (p. 35). It is this active collaboration which they regard as the within-process variable which may be utilized as a barometer of change which reflects in its variations both the short-term and long-term impact of various classes of therapeutic intervention.

This conceptual basis of the HAQ is different from that of the WAI which is based on Bordin's (1975, 1979) theory concerning the structure of the alliance and which focuses in two-thirds of its items on clarity of goals and task relevance. The WAI demands of the client, therefore, more differentiated, conceptual responses to its items. Such responses may be difficult for less intellectually-adroit clients to make and this difficulty may result in more variation or error in their responses and, hence, in less consistent correlations with outcome.

The WAI items probe a broader range of variables than do the HAQ items. Seven items probe client behaviours and client-perceived therapist behaviours:

#2-_____ and I agree about the things I will need to do in therapy to help improve my situation.

#4-What I am doing in therapy gives me new ways of looking at my problem.

#5-_____ and I understand each other.

#6-_____ perceives accurately what my goals are.

#22-_____ and I are working towards mutually agreed upon goals.

#30-_____ and I collaborate on setting goals for my therapy.

#32-We have established a good understanding of the kinds of changes that would be good for me.

One item probes the extent of client motivation:

#14-The goals of these sessions are important to me.

One item probes the extent of client-perceived therapeutic progress:

#25-As a result of these sessions, I am clearer as to how I might be able to change.

One item probes the extent of client optimism:

#16-I feel that the things I do in therapy will help me to accomplish the changes that I want.

One item probes the extent of client confidence in the therapist:

#21-I am confident in _____'s ability to help me.

One item probes the extent of client confidence in the therapy:

#35-I believe the way we are working with my problem is correct.

Three items probe the extent of client orientation toward collaboration:

#13-I am clear on what my responsibilities are in therapy.

#18-I am clear as to what _____ wants me to do in these sessions.

#24-We agree on what is important for me to work on.

Seven items probe the strength of the interpersonal bond between client and therapist:

#8-I believe _____ likes me.

#17-I believe _____ is genuinely concerned for my welfare.

#19-_____ and I respect each other.

#23-I feel that _____ appreciates me.

#26-_____ and I trust one another.

#28-My relationship with _____ is very important to me.

#36-I feel _____ cares about me even when I do things that he/she does not approve of.

As well, the WAI includes a large number of negatively-stated items, (i.e., 13 of 36), which elicit client doubt rather than client optimism:

#1-I feel uncomfortable with _____.

#3-I am worried about the outcome of these sessions.

#7-I find what I am doing in therapy confusing.

#9-I wish _____ and I could clarify the purpose of our sessions.

#11-I believe the time _____ and I are spending together is not spent efficiently.

#12-_____ does not understand what I am trying to accomplish in therapy.

#15-I find what _____ and I are doing in therapy is unrelated to my concerns.

#20-I feel that _____ is not totally honest about his/her feelings toward me.

#27-_____ and I have different ideas on what my problems are.

#29-I have the feeling that if I say or do the wrong things, _____ will stop working with me.

#31-I am frustrated by the things I am doing in therapy.

#33-The things that _____ is asking me to do don't make sense.

#34-I don't know what to expect as the result of my therapy.

This heterogeneous measure of the alliance which probes client activity, client-perceived therapist activity, client attitudes and characteristics, client doubts, and client feelings about the therapist and the relationship with the therapist is also vulnerable to the charge that it renders the impact of specific classes of therapist interventions on the developing alliance and its subsequent relation to outcome difficult to evaluate (Frieswyk et al., 1986).

The diversity of variables being probed by the WAI is evidenced in the distinctive, though not statistically significantly different, performance of its BOND subscale, both in relation to the other relationship variables and also in its

relationship to outcome. Although the WAIc correlated at .58 with the HAQ (Table 17), the WAIc BOND subscale correlated less strongly at .40. The BOND subscale also correlated less strongly both with the CRF (r=.29, Table 16) than did the WAIc COMPOSITE (r=.38) and with Empathy (r=.57 for the BOND subscale and r=.69 for the WAIc COMPOSITE).

The BOND subscale was more strongly related to target complaints improvement than the WAI and the HAQ (r=.40 vs. .33 (Table 2) and .29 (Table 6) respectively). It was less strongly related to residual gain on the IIP than were the WAIc and the HAQ (r=.23 vs. .40 (Table 3) and .38 (Table 6) respectively). This distinctive performance of the BOND subscale seems consistent with Gelso and Carter's (1985) proposition that the bonding aspect of the alliance develops somewhat independently of the other aspects (Chapter I, Section 2).

The charge that the alliance measure is, in fact, an early evaluation of outcome which is inevitably corroborated as a self-fulfilling prophecy seems to apply to the HAQ, (i.e., this "alliance" measure questions whether the client believes that the therapy is helping; the outcome measures question whether the client believes that the therapy has helped). Unlike the WAI, the HAQ provides little information that would assist the clinician in constructing an alliance with a particular client.

These conceptual differences between the HAQ and the WAI, both of which purport to measure the alliance, seem to support the concern expressed by Greenberg and Pinsof (1986) regarding the construct validity of the various alliance measures.

Although the overall effectiveness of the HAQ and the WAIc in accounting for outcome variance was equal, the HAQ was statistically significantly more strongly related to the SCL-90 than was the WAIc. Various speculations may be offered concerning the comparative weakness of the WAIc in relationship to the SCL-90 and, to a lesser and not statistically significant extent, to the SEI. A clue to that weakness seems to lie in the fact that the CRF as well as the HAQ correlated statistically significantly with the SCL-90 and the SEI (r=.42 and .33 respectively for the CRF and r=.44 and .33 respectively for the HAQ, Table 8). None of the other relationship measures correlated statistically significantly with these two outcome measures. The CRF is a measure of the client's evaluation of the therapist's expertness, attractiveness, and trustworthiness. The HAQ in 6 of its 11 items also measures the client's assessment of the therapist in his/her role as therapist (as distinct from her/his participation in the personal relationship between them).

These two outcome measures are different from the others in that they demand that the client evaluate him/herself, (i.e., pathological symptoms and self-esteem), as opposed to her/his complaints, his/her relationships with others, or her/his experience in therapy. The changes measured with the SCL-90 and the SEI seem to be dependent upon the client's perceiving the therapist as competent.

Such an interpretation seems consistent with the emphasis placed by Butler and Strupp (1986) upon the therapist rather

than the therapy as the change agent:

> ... The purpose of psychotherapy research is to understand how one person (the therapist) influences or fails to influence another person (the patient) within a therapeutic context. Therapeutic context, in turn, can be further defined as a particular interpersonal context in which one person (the patient) seeks some benefit from another (the therapist). Implicit in these statements is the assumption that it is the therapist, not "the therapy", which is the instrument of this beneficial influence. (p. 37)

A further possible explanation of the differential performance of the two alliance measures relates to their different administrations. The WAI was administered at each of the first five sessions whereas the HAQ and the CRF were administered only once at the third session and perhaps, therefore, received more client consideration at this critical point. In fact, the instability of the correlations of the WAIc over the third, fourth, and fifth sessions with the SCL-90 and the SEI (Table 15), (i.e., the lower correlations of the third session WAIc, the rise in the fourth, and the drop in the fifth), suggests the possibility that repeated measures may be intrusive and causing an effect.

Finally, the sample in the present study consisted largely of humanistic/experiential/eclectic cases (Appendix 24, Table 23) in which goals and tasks are not explicitly articulated at the outset of therapy, but are rather identified by the client in the course of her/his becoming aware of his/her process. The humanistic therapist does not conceive of her/his function as being to analyze or resolve a problem or a disorder, but instead

as being to facilitate the client's existential "unfolding" in the context of a dialogic encounter or an "I-Thou" relationship (Buber, 1970). Hence, items in the GOAL and TASK subscales are possibly more likely to receive uncertain and perhaps noncommittal or negative responses from clients in this sample than from clients in a sample which included more learning-oriented cases or certain psychoanalytic cases. There may have been a mismatch with this sample between the assumptions underlying humanistic psychotherapy and the conceptual basis of the WAI.

All of the factors discussed above--the significance of the therapist as expert, the repeated administration effect, and the bias of the sample toward humanistic cases--may have contributed to the weakness of the WAIc relative to the HAQ in its relationship to some of the outcome measures in the present study.

1.5 Relationship Of Perceived Client Involvement To Outcome

It was hypothesized that client-perceived client involvement and therapist-perceived client involvement were positively related to outcome. It was found to be the case that client-perceived client involvement was positively related to outcome, but that therapist-perceived client involvement was not.

The exploratory Client Involvement Scale was included in the present study in order to provide data relevant to Greenberg and Pinsof's (1986) suggestion that Involvement is the critical client variable associated with the formation of the alliance.

The CIS appended to both forms of the WAI performed similarly to the WAIc and the WAIt in relationship to the outcome measures (Table 7). Although Greenberg and Pinsof's suggestion implies that the CIS would correlate more strongly than the WAI, the fact that this six-item scale demonstrated comparable predictive capacity with the WAI suggests that its underlying conceptual basis merits further examination.

1.6 Relationship Of Congruence Of Client-perceived And Therapist-perceived Alliance Strength To Outcome

It was hypothesized that congruence of client-perceived alliance strength and therapist-perceived alliance strength was positively related to outcome. This was found not to be the case.

No research has as yet been published on the congruence of client and therapist perspectives on their working alliance as it relates to outcome. However, Hill, Helms, Tichenor, Spiegel, O'Grady, and Perry (in press) found that client and therapist ratings of therapist interventions were more congruent at higher levels of client experiencing, the measure of therapeutic effectiveness in experiential therapy, than at lower levels of client experiencing.

Congruence of ratings of the alliance by clients and therapists would constitute "objective" evidence of the presence of that alliance. A significant relationship between congruence and outcome would provide strong support for the hypothesized significance of the alliance in psychotherapy (Bordin, 1975,

1979).

In the present study, the two forms of the WAI were found to be weakly but statistically significantly correlated except on the BOND subscales of both (Table 10), and their congruence was found to increase somewhat over the seven occasions at which they were administered (Table 11).

However, the results of the present study are equivocal with respect to the predictive efficacy of congruence of client and therapist ratings of the alliance (Table 12). Congruence in later sessions correlated statistically significantly with residual gain on the SEI and it approached statistically significant correlation in early sessions with residual gain on the SCL-90. However, it correlated negatively with improvement in target complaints and with SPQ Change in early sessions and with residual gain on the IIP in later sessions. Congruence was unrelated to outcome on the TPQ. These findings on the various outcome measures are inconsistent and, hence, no interpretation could be drawn from them.

1.7 Post Hoc Analyses

1.7.1 Analysis Of Therapist Effect

Since the effect of some therapists having contributed multiple cases to the sample was neither significant nor systematic, simple comparisons of the standard deviations of the group of 14 cases contributed by five therapists and the group of 30 cases contributed by 30 therapists were made on three marker outcome variables (Table 13). Since the standard

deviations of the two groups were not extremely different on any of the marker variables, (i.e., one being not more than twice as large as the other), all 44 cases in the sample were treated as independent.

1.7.2 Analysis Of Effect Of Theoretical Orientations Of Therapists

The data were inadequate to analyze a possible effect of theoretical orientation on the alliance. Only four of the 35 therapists categorized themselves as other than humanistic. However, simple comparisons of the WAI scores of the two groups were performed. No differences were revealed in the clients' perceptions of their alliances between the two groups.

However, the therapists' perceptions did differ statistically significantly (Table 14). The non-humanistic cases had weaker alliances than did the humanistic cases. The non-humanistic cases also showed greater variability on the TASK and GOAL components of the alliances.

This analysis was of questionable validity, however, since only four therapists were represented in the non-humanistic group. Moreover, several therapists, when asked to identify/describe their theoretical orientation in the first part of the question (#5 on the Therapist Demographic Data Sheet, Appendix 18), indicated that they had employed techniques associated with an orientation other than that in which they had categorized themselves. This would presumably result in inconsistent application of the theoretical orientation. Hence, it seems likely that this difference actually reflects a

therapist effect on the therapist-rated alliance rather than a true effect of theoretical orientation.

1.7.3 Correlations Of The WAIc With The Outcome Measures At The Seven Occasions

It has been assumed that the alliance "gels" by the third to fifth session (Strupp, 1980) and then remains constant throughout the therapeutic engagement. Saltzman, Luetgert, Roth, Creaser, and Howard (1976) provided empirical evidence that this assumption was a reasonable one in that their 91 subject clients and 19 subject therapists reflected widespread sensitivity to numerous cues that defined the state of their alliances by the third session. Morgan, Luborsky, Crits-Cristoph, Curtis, and Solomon (1982) compared their third and fifth session alliance ratings with the ratings done on the session at which 90% of the treatment (which consisted of at least 25 sessions) had been completed. They found no significant differences between early and late session ratings and concluded that the alliance remains stable over the course of treatment.

However, Bordin (1983) postulated that a "tear-repair" phenomenon occurs which constitutes the critical therapeutic experience. Heppner and Heesacker (1982) have also suggested that the relationship changes over the course of therapy.

The seven repeated measures taken in the present study reveal a trend of increasing strength of the alliance (Table 21) and when correlated with each of the outcome measures also reveal a trend of increasing strength of correlation through the

course of therapy (Table 15). However, this correlation with outcome drops off quite consistently at the final session, presumably because client and therapist have terminated their relationship.

This constitutes further evidence to that presented in Section 1.1 that what is being measured by the WAIc is an independent variable rather than an in-process assessment of outcome.

1.7.4 Relationships Between The WAI And The Other Relationship Measures

Based on their statistically significant relationships with one another, it appears from Tables 16 and 17 that the client-rated relationship measures are indeed tapping overlapping constructs, with the CRF being the most disparate of the five.

Greenberg and Pinsof (1986) have questionned the construct validity of the various alliance measures, (i.e., whether the different research groups are defining the alliance in the same way). The correlation of .58 (Table 17) between the WAIc and the HAQ, although statistically significant, means that one of the measures accounted for 34% of the variance in the other. This is small, considering that the two instruments purport to be measuring the same construct.

1.7.5 Identification Of Relative Strengths Of Outcome Predictor Variables

In the stepwise multiple regression analysis performed for each of the six outcome measures (Table 19), only one of the six relationship measures (either the HAQ, the WAIc, or the CISc) entered into each of the equations that was developed at the .05 probability level or less. This is consistent with the conclusion that most of the relationship measures are tapping overlapping constructs that was drawn in Section 1.7.4.

1.7.6 Comparison Of WAI Scores Of Completed And Prematurely Terminated Cases

The limited process data collected from prematurely terminated therapies revealed a significant difference between client ratings of the alliance after the first session of those who continued to completion versus those who dropped out. Clients who subsequently dropped out rated the Goal subdimension of their alliance significantly lower than clients who continued to completion ($t=2.50$ ($p<.05$), Table 20). Since this difference did not recur on the second session and is based on only ten client ratings, further research seems necessary before any conclusions may be drawn.

2. LIMITATIONS OF THE STUDY

This study has attempted to overcome some of the design limitations of previous studies of the alliance:

1) It is based on more realistic outcome data, (i.e., data were collected in almost all the cases when therapy was

terminated, rather than after an arbitrary ten sessions, as was the case in the Horvath (1981) and Moseley (1983) studies.

2) The problem of confounded sources of alliance and outcome data, (i.e., both being self-reports of client and therapist), is inherent in this study as it was in the Horvath and Moseley studies. In a field study, it is not feasible to introduce third party scrutiny of either process or outcome. However, a variety of outcome measures commonly used in psychotherapy research was employed, all of which reflected some relationship with the alliance measures. Moreover, some cross-correlation between client-rated alliance measures and therapist-rated outcome measures (Section 1.1 of this chapter) was demonstrated as well as a "dropping off" of the alliance-outcome relationship at the final session (Section 1.7.3 of this chapter). These findings seem to counter the claim that the alliance-outcome relationship represents simply a demonstration of the "self-fulfilling prophecy".

However, some factors limit the generalizability of the findings of the present study beyond the sample upon which it is based. That sample consisted of volunteer participants responding to the questionnaires in the course of real therapies in their real settings. Some limitations seem inherent in this selection process:

1) Therapists who volunteered to participate represent a subset who felt confident enough of their therapeutic skills to be willing to have their clients' perceptions of them revealed to researchers through questionnaire responses that were not

seen by the therapists themselves.

2) These therapists selected the clients whom they invited to participate in the study with them--presumably clients with whom they felt confident that they would be able to continue working over the period of time that the study required, (i.e., at least six sessions), and with whom they felt comfortable enough to profer the invitation to participate in it with them.

3) Appropriate clients had to be educated enough to be able to read and complete the questionnaires, sophisticated enough to not find threatening the idea of researchers who were strangers to them examining their responses to the very personal experience of therapy, and motivated enough to complete questionnaires after their sessions. Clients beginning therapy, for example, in crises would not have been suitable participants.

Hence, the sample is biased by all these selection factors toward more successful therapies. The relative homogeneity of the subpopulation reflected in the sample may have been a moderating factor affecting the strength of the process-outcome relationships the study demonstrated. As well, the study findings may not apply to less successful therapies, and to therapies with less educated, sophisticated, and motivated clients, as well as with those in crises.

4) Few of the therapies in the study were actually terminated upon agreement by both participants that the work had been successfully completed. In most cases, external circumstances--geographic relocation of a participant, financial

restrictions, therapist reassignment to other responsibilities, end of university semester, and onset of summer vacation--determined the point of termination of therapy. Although these externally-imposed terminations may accurately reflect the reality of how therapeutic engagements end, they distort the relationship between alliance development and therapeutic change that was being examined in this study, (i.e., these are not ideal cases in which the relationship-outcome relationship can be assumed to have fully developed and, hence, to be reliably demonstrable).

5) Although clients were assured in the preliminary written information provided to them that their responses would be treated confidentially and anonymously, this assurance cannot be assumed to entirely eliminate their inclination in their questionnaire responses usually to want to reflect favourably upon their therapists and upon their own progress and satisfaction with their therapies. Conversely and occasionally, clients may have been expressing residual resentments, either with their therapists or with others in their lives, through their negatively-biased questionnaire responses. It is, in fact, inherently impossible to be wholly objective or unbiased in reporting a subjective experience such as that of being in therapy, particularly when the report must be reduced to the form of quantitatively-scaled responses to questionnaire items.

6) The sample consisted largely of cases conducted by therapists who identified their theoretical orientation as humanistic and, hence, may have yielded different results than a

sample which included more learning and some analytically-oriented cases.

7) The significant alliance-outcome correlation coefficients found in the present study account for only 7 to 25% of outcome variance. In considering whether such coefficients indicate that the theorized significance of the alliance for outcome should be reexamined, the example produced by Rosenthal and Rubin (1979) is relevant. They showed that "small" percentages of variance may be important and that effect size evaluations should be sensitive to the context of the data, in this case the context being the limited empirical efficacy of psychotherapy research and theory at the present time.

3. RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations follow from the findings of the present study:

1) Based on its failure to predict outcome: That the utilization of the WAIt as a research instrument be discouraged.

2) Based on the differential performance of the WAI and the HAQ: that the concern expressed by Greenberg and Pinsof (1986) regarding the construct validity of the various alliance measures be subjected to empirical investigation.

3) Based on the early strength of the BOND subscale measures in this sample of brief psychotherapy cases: That Bordin's (1975, 1979) proposition (Section 2, Chapter I) that the bonding aspect of the alliance develops slowly be modified to exclude brief therapy cases in which the data in the present study suggest the bond must be established promptly if the

therapy is to be successful.

4) Based on the increasing relationship of alliance to outcome up to the tenth session and the drop off in final session alliance-outcome relationship: That the alliance be tracked session by session employing a single-case research design, such that detailed evaluation of fluctuations in the state of the alliance may be associated with treatment interventions (Frieswyk et al., 1986). Such examination would help to clarify the relationships of the hypothesized dimensions of the alliance to the events in therapy.

5) Based on the high intercorrelations of the WAI subscales and the fact that the exploratory Client Involvement Scale correlated as strongly with outcome as did the WAI: That further research be directed at the client subdimension of Involvement that Greenberg and Pinsof (1986) have suggested is subsumed by the transactional alliance variable toward the development of orientation-specific measures to unravel the issues involved in discriminating the different types of client involvement that are predictive in different tasks and treatments.

Such a recommendation is consistent with the conclusion drawn by Stiles, Shapiro, and Elliott (1986) from their review of process-outcome research:

> The alliance construct is really only a conceptual umbrella for uniting a number of client and therapist contributions; the exact operation of these constituent factors remains to be clarified. Although attempting to be inclusive, the alliance concept is vulnerable to criticism also lodged against the general therapist factors: It locates the common core at too high a level of abstraction. (p. 174)

4. SUMMARY AND CONCLUSION

In the present study, the working alliance was measured with a self-report instrument, the Working Alliance Inventory (Horvath, 1981, 1982), based on Bordin's (1975, 1979) conceptualization of the alliance as consisting of relational bonds and the tasks and goals of psychotherapy. This instrument was administered to clients and therapists after each of the first five, the tenth, and the final sessions of 44 therapy cases. For comparative purposes, another alliance measure, as well as measures of therapist empathy, expertness, attractiveness, and trustworthiness, were also administered after the third session.

The WAI and the other five measures were correlated with outcome as measured by six instruments: Target Complaints Improvement, the Symptom Checklist-90, the Self-Esteem Index, the Inventory of Interpersonal Problems, the Strupp Posttherapy Questionnaire, and the Therapist Posttherapy Questionnaire.

The WAIc was found to correlate statistically significantly with four of the six instruments, while the WAIt did not correlate with any of them. Therapist empathy, attractiveness, expertness, and trustworthiness correlated less consistently statistically significantly than did the WAIc with outcome, while the HAQ correlated statistically significantly with all six of the outcome measures.

It was concluded that the two instruments that purport to measure the alliance, the HAQ, which has a phenomenological response set, and the WAI, which has a more behavioural response

set, are actually measuring overlapping but different constructs. Moreover, it was concluded that the alliance construct is located at too high a level of abstraction. An exploratory measure of client involvement, a hypothesized subdimension subsumed by the alliance variable was found to correlate comparably to the WAI with outcome and, therefore, to merit further investigation.

The repeated measures of the alliance revealed that the alliance continued to strengthen in its relationship to outcome beyond the third session, dropping off only at the conclusion of therapy. This finding along with the finding that the client-rated alliance measure, the WAIc, correlated statistically significantly with the therapist-rated outcome measure, the TPQ, suggested that the self-reported alliance measures are tapping a construct that is distinct from an in-process evaluation of same-self-reported outcome.

As one phase of the B.C. Research Group's alliance research program, the present study has contributed important findings with respect to the comparative efficacies of different instruments that purport to measure the alliance, the issue of changes in the alliance over the course of therapy, and the argument regarding whether a client-reported alliance measure is a "true" alliance measure.

REFERENCES

Alexander, L.B. & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford.

Allen, J.G., Newsom, G.E., Gabbard, G.O., & Coyne, L. (1984). Scales to assess the therapeutic alliance from a psychoanalytic perspective. Bulletin of the Menninger Clinic, 48, 383-400.

Bachman, J.G. & O'Malley, P.M. (1977). Self-esteem in young men: A longitudinal analysis of the impact of educational and occupational attainment. Journal of Personality and Social Psychology, 35, 365-380.

Baer, P.E., Dunbar, P.W., Hamilton II, J.E., & Beutler, L.E. (1980). Therapists' perception of the psychotherapeutic process: Development of a psychotherapy process inventory. Psychological Reports, 46, 563-570.

Barak, A. & LaCrosse, M.B. (1975). Multidimensional perception of counselor behaviour. Journal of Counseling Psychology, 16, 202-208.

Barak, A. & Dell, D.M. (1977). Differential perceptions of counselor behaviour: Replication and extension. Journal of Counseling Psychology, 27, 288-292.

Barrett-Lennard, G.T. (1962). Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 76, (Whole No. 562).

Battle, L.C., Imber, S.D., Hoehn-Saric, R., Stone, A.R., Nash, E.H. & Frank, J.D. (1966). Target complaints as criteria of improvement. American Journal of Psychotherapy, 20, 184-192.

Beutler, L.E., Dunbar, P.W., & Baer, P.E. (1980). Individual variations among therapists' perceptions of patients, therapy process, and outcome. Psychiatry, 43, 205-210.

Bibring, E. (1937). On the theory of the results of psychoanalysis. International Journal of Psycho-Analysis, 18, 170-189.

Bock, R.D. (1975). Multivariate statistical methods in behavioural research. New York: McGraw-Hill.

Bordin, E.S. (1975). The generalizability of the psychoanalytic concept of the working alliance. Presented at the annual meeting of the Society for Psychotherapy

Research, Boston.

Bordin, E.S. (1976). The working alliance basis for a general theory of psychotherapy. Presented at the annual meeting of the American Psychological Association, Washington, D.C., September.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research, and Practice, 16, 252-259.

Bordin, E.S. (1983). A working alliance based model of supervision. The Counselling Psychologist, 11, 35-42.

Buber, M. (1970). I and thou (W. Kaufman, Trans.). New York: Scribner's.

Butler, S.F. & Strupp, H.H. (1986). Specific and non-specific factors in psychotherapy: A problematic paradigm for psychotherapy research. Psychotherapy: Theory, Research, and Practice, 23, 30-40.

Campbell, D.T. & Fiske, D.W. (1959). Convergent and discriminant validation by the Multitrait-Multimethod Matrix. Psychological Bulletin, 56, 81-105.

Cartwright, D., Kirtner, W., & Fiske, D. (1963). Method factors in change associated with psychotherapy. Journal of Abnormal and Social Psychology, 66, 169-175.

Cash, T.F. & Saltzbach, R.F. (1978). The beauty of counseling: Effects of counselor physical attractiveness and self-disclosures on perceptions of counselor behaviour. Journal of Counseling Psychology, 25, 283-291.

Coopersmith, S. (1967). The antecedents of self-esteem. San Francisco: Freeman.

Corrigan, J.D., Dell, D.M., Lewis, K.N. & Schmidt, L.D. (1980). Counseling as a social influence process: A review. Journal of Counseling Psychology, 27, 395-441.

Cronbach, L.J. (1951). Coefficient alpha and the internal structure of tests. Psychometrika, 16, 297-334.

Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale: Preliminary report. Psychopharmacological Bulletin, 9, 13-28.

Derogatis, L.R., Rickels, K., & Rock, A.F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. British Journal of Psychiatry, 128, 280-289.

Docherty, J.P. (1985). The therapeutic alliance and treatment

outcome in psychiatry. In R.E. Hales & A.J. Frances (Eds.), Psychiatry update: Annual review, Vol. 4 (pp. 527-531). American Psychiatric Association.

Fitts, W.H. (1965). Tennessee Self-Concept Scale. Nashville, Tenn.: Counselor Recordings and Tests.

Frank, J.D. (1971). Therapeutic factors in psychotherapy. American Journal of Psychotherapy, 25, 350-361.

Frank, J.D. (1973). Persuasion and healing: A comparative study of psychotherapy. Baltimore: Johns Hopkins.

Freud, S. (1912). The dynamics of transference. Standard edition of the complete works of Sigmund Freud, Vol. 12, pp. 97-108. London: Hogarth, 1958.

Freud, S. (1913). On beginning the treatment: Further recommendations on the technique of psychoanalysis. Standard edition of the complete works of Sigmund Freud, Vol. 13, pp. 122-144. London: Hogarth, 1958.

Freud, S. (1937). Analysis terminable and interminable. Standard edition of the complete works of Sigmund Freud, Vol. 23, pp. 209-253. London: Hogarth, 1964.

Friedman, L. (1969). The therapeutic alliance. International Journal of Psycho-Analysis, 50, 139-153.

Frieswyk, S.H., Allen, J.G., Colson, D.B., Coyne, L., Gabbard, G.O., Horwitz, L., & Newsom, G. (1986). Therapeutic alliance: Its place as a process and outcome variable in dynamic psychotherapy research. Journal of Consulting and Clinical Psychology, 54, 32-38.

Frieswyk, S.H., Colson, D.B., & Allen, J.G. (1984). Conceptualizing the therapeutic alliance from a psychoanalytic perspective. Psychotherapy: Theory, Research and Practice, 21, 460-464.

Gelso, C.J. & Carter, J.A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. The Counseling Psychologist, 13, 155-244.

Gitelson, M. (1962). The curative factors in psycho-analsis: I. The first phase of psycho-analysis. International Journal of Psycho-Analysis, 43, 194-205.

Glass, G.V. & Hopkins, K.D. (1984). Statistical methods in education and psychology. Englewood Cliffs, N.J.: Prentice-Hall.

Glass, R.M. (1984). Psychotherapy: Scientific art and Artistic

Science? Archives of General Psychiatry, 41, 525-526.

Goldstein, A.P. (1971). Psychotherapeutic attraction. New York: Pergamon.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. Journal of Consulting and Clinical Psychology, 46, 1023-1035.

Greenberg, L.S. (1985). An integrative approach to the relationship in counseling and psychotherapy. The Counseling Psychologist, 13, 251-259.

Greenberg, L.S. & Pinsof, W.M. (1986). Process research: Current trends and future perspectives. In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford.

Greenberg, L.S. & Webster, M.C. (1982). Resolving decisional conflict by gestalt two-chair dialogue: Relating process to outcome. Journal of Counseling Psychology, 29, 468-477.

Greenson, R.R. (1965). The working alliance and the transference neurosis. The Psychoanalytic Quarterly, 34, 155-181.

Greenson, R.R. (1967). The technique and practice of psychoanalysis. New York: International Universities Press.

Greenson, R.R. & Wexler, M. (1969). The non-transference relationship in the psychoanalytic situation. International Journal of Psycho-Analysis, 50, 27-39.

Gurman, A.S. (1977). The patient's perception of the therapeutic relationship. In A.S. Gurman & A.M. Razin (Eds.), Effective psychotherapy (pp. 503-543). New York: Pergamon.

Hartley, D.E. (1985). Research on the therapeutic alliance in psychotherapy. In R.E. Hales & A.J. Frances (Eds.), Psychiatry update: Annual review, Vol. 4 (pp. 532-549). American Psychiatric Association.

Hartley, D. & Strupp, H.H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), Empirical studies in analytic theories, Vol. 1 (pp. 1-37). Hillsdale, N.J.: Erlbaum.

Heppner, P.P. & Heesacker, M. (1982). Interpersonal influence process in real-life counseling: Investigating client perceptions, counselor experience level, and counselor power over time. Journal of Counseling Psychology , 29,

219-223.

Hill, C.E., Helms, J.E., Tichenor, V., Spiegel, S.B., O'Grady, K.E., & Perry, E. (in press). The effects of therapist response modes in brief psychotherapy. Journal of Counseling Psychology.

Hollander, M. & Wolfe, D.A. (1971). Nonparametric statistical inference. New York: McGraw-Hill.

Horowitz, L.M. (1979). On the cognitive structure of interpersonal problems treated in psychotherapy. Journal of Consulting and Clinical Psychology, 47, 5-15.

Horowitz, L.M., Weckler, D.A., & Doren, R. (1983). Interpersonal problems and symptoms: A cognitive approach. In P.C. Kendall (Ed.), Advances in Cognitive-Behavioural Research, 2, 81-125.

Horowitz, M.J. & Marmar, C. (1985). The therapeutic alliance with difficult patients. In R.E. Hales & A.J. Frances (Eds.), Psychiatry update: Annual review, Vol. 4 (pp. 573-585). American Psychiatric Association.

Horowitz, M.J., Marmar, C., Weiss, D.S., DeWitt, K.N., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. Archives of General Psychiatry, 41, 438-448.

Horvath, A.O. (1981). An exploratory study of the working alliance: Its measurement and relationship to therapy outcome. Unpublished doctoral dissertation, University of British Columbia.

Horvath, A.O. (1982). Working Alliance Inventory. (Revised Edition). Unpublished test.

Horvath, A.O. & Greenberg, L.S. (1986). The development of the Working Alliance Inventory. In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford.

Horwitz, L. (1974). Clinical prediction in psychotherapy. New York: Jason Aronson.

Hotelling, H. (1951). A generalized test and measure of multivariate dispersion. Procedures of the Second Berkeley Symposium on Mathematics, Statistics, & Probabilities, 2, 23-41.

Hoyt, C.L. (1941). Test reliability estimated by analysis of variance. Psychometrika, 6, 153-160.

Kerlinger, F.N. & Pedhazur, E.J. (1982). Foundations of

multiple regression analysis. New York: Holt, Reinhart, & Winston.

Kolb, D.L., Beutler, L.E., Davis, C.S. Crago, M. & Shanfield, S.B. (1982). Patient personality, locus of control, involvement, therapy relationship, dropout and change in psychotherapy. Unpublished manuscript.

LaCrosse, M.C. (1977). Comparative perceptions of counselor behaviour: A replication and extension. Journal of Counseling Psychology, 24, 464-471.

Lambert, M.J., DeJulio, S.S., & Stein, D. (1978). Therapist interpersonal skills: Process, outcome, methodological considerations and recommendations for future research. Psychological Bulletin, 85, 467-489.

Langs, R. (1973). The technique of psychoanalytic psychotherapy, (Vol. 1). New York: Aronson.

Langs, R. (1974). The technique of psychoanalytic psychotherapy, (Vol. 2). New York: Aronson.

Loewenstein, R.M. (1954). Some remarks on defences, autonomous ego, and psycho-analytic techniques. International Journal of Psycho-Analysis, 35, 188-193.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J.L. Claghorn (Ed.), Successful psychotherapy (pp. 92-116). New York: Brunner/Mazel.

Luborsky, L. (1985). Psychotherapy integration is on its way. The Counseling Psychologist, 13, 245-249.

Luborsky, L., Crits-Cristoph, P., Alexander, L., Margolis, M. & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs vs. a global rating method. Journal of Nervous and Mental Disease, 171, 480-491.

Luborsky, L., McLellan, A.T., Woody, G.E., O'Brien, C.P., & Auerbach, A. (1985). Therapist success and its determinants. Archives of General Psychiatry, 42, 602-611.

Luborsky, L., Mintz, J., Auerbach, A., Crits-Cristoph, P., Bachrach, H., Todd, T., Johnson, M., Cohen, M., & O'Brien, C.P. (1980). Predicting the outcomes of psychotherapy: Findings of the Penn Psychotherapy Study. Archives of General Psychiatry, 37, 471-481.

Luborsky, L., Singer, B. & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "Everyone has won and all must have prizes"? Archives of General Psychiatry, 32, 995-1008.

Marks, S.E. & Tolsma, R.J. (1986). Empathy research: Some methodological considerations. Psychotherapy: Theory, Research, and Practice, 23, 4-20.

Marmar, C., Marziali, E., Horowitz, M.J., & Weiss, D.S. (1986). The development of the Therapeutic Alliance Rating System. In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford.

Marziali, E. (1984). Three viewpoints on the therapeutic alliance: Similarities, differences, and associations with psychotherapy outcome. Journal of Nervous and Mental Disease, 172, 417-423.

Marziali, E., Marmar, C. & Krupnick, J. (1981). Therapeutic alliance scales: Development and relationship to psychotherapy outcome. American Journal of Psychiatry, 138 , 361-364.

Mintz, J. (1977). The role of the therapist in assessing psychotherapy outcome. In A.S. Gurman & A.M. Razin (Eds.), Effective Psychotherapy (pp. 590-602). New York: Pergamon.

Mintz, J. & Kiesler, D.J. (1982). Individualized measures of psychotherapy outcome. In P.C. Kendall & J.N. Butcher (Eds.), Handbook of research methods in clinical psychology (pp. 491-534). New York: Wiley.

Mitchell, K.M., Bozarth, J.D. & Krauft, C.C. (1977). A reappraisal of the therapeutic effectiveness of accurate empathy, nonpossessive warmth, and genuineness. In A.S. Gurman & A.M. Razin (Eds.), Effective Psychotherapy (pp. 482-502). New York: Pergamon.

Moras, K. & Strupp, H.H. (1982) Pretherapy interpersonal relations, patients' alliance and outcome in brief therapy. Archives of General Psychiatry, 39, 405-409.

Morgan, R., Luborsky, L., Crits-Cristoph, P., Curtis, H. & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. Archives of General Psychiatry, 39, 397-402.

Moseley, D. (1983). The therapeutic relationship and its association with outcome. Unpublished master's thesis, University of British Columbia.

Nelson, L.R. (1974). Guide to LERTAP use and interpretation. Dunedin, New Zealand: University of Otago.

O'Malley, S.S., Suh, C.S. & Strupp, H.H. (1983). The

Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process outcome study. Journal of Consulting and Clinical Psychology, 51, 581-586.

Parloff, M.B., Waskow, I.E. & Wolfe, B.E. (1978). Research on therapist variables in relation to process and outcome. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behaviour change (pp. 233-282). Toronto: Wiley.

Pinsof, W.M. & Catherall, D.R. (1984). The integrative psychotherapy alliance: Family, couple and individual therapy scales. Center for Family Studies/The Family Institute of Chicago, Northwestern University, Chicago, Ill.

Rice, L.N. & Kerr, G.P. (1986). Measures of client and therapist vocal quality. In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook (pp. 73-106). New York: Guilford.

Rice, L.N., Koke, C., Greenberg, L.S., & Wagstaff, A. (1979). Manual for client vocal quality. York University Counselling & Development Centre, Toronto, Canada.

Rogers, C.R. (1951). Client-centered therapy. Cambridge, Mass.: Riverside.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.

Rogers, C.R., Gendlin, G.T., Kiesler, D.V., & Truax, L.B. (1967). The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics. Madison, Wisconsin: University of Wisconsin Press.

Rosenthal, R. & Rubin, D.B. (1979). A note on percent variance explained as a measure of the importance of effects. Journal of Applied Social Psychology , 9 , 395-396.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, N.J.: Princeton University Press.

Saltzman, C., Luetgert, M.J., Roth, C.H., Creaser, J., & Howard, L. (1976). Formation of a therapeutic relationship: Experiences during the initial phase of psychotherapy as predictors of treatment duration and outcome. Journal of Consulting and Clinical Psychology, 44, 546-555.

Sampson, H. & Weiss, J. (1986). Testing hypotheses: The approach of the Mount Zion Psychotherapy Research Group. In L.S. Greenberg & W.M. Pinsof (Eds.), The

psychotherapeutic process: A research handbook (pp. 591-614). New York: Guilford.

Spielberger, C.D., Gorsuch, R.L., & Lushene, R.E. (1970). Manual for the State-Trait Anxiety Inventory. Palo Alto, Calif.: Consulting Psychologists Press.

Stanley, J.C. (1971). Reliability. In R.L. Thorndike (Ed.), Educational Measurement (pp. 356-442). Washington, D.C.: American Council on Education.

Sterba, R. (1934). The fate of the ego in analytic therapy. International Journal of Psycho-Analysis, 15, 117-126.

Stiles, W.B., Shapiro, D.A., & Elliott, R. (1986). "Are all psychotherapies equivalent?" American Psychologist, 41, 165-180.

Strong, S.R. (1968). Counseling: An interpersonal influence process. Journal of Counseling Psychology, 15, 215-225.

Strupp, H.H. (1973). On the basic ingredients of psychotherapy. Journal of Consulting and Clinical Psychology, 41, 1-8.

Strupp, H.H. (1980). Success and failure in time-limited psychotherapy: A systematic comparison of two cases: Comparison 2. Archives of General Psychiatry, 37, 708-716.

Strupp, H.H. & Hadley, S.W. (1979). Specific vs. nonspecific factors in psychotherapy. Archives of General Psychiatry, 36, 1125-1136.

Strupp, H.H., Wallach, M.S. & Wogan, M. (1964). Psychotherapy experience in retrospect: Questionnaire survey of former patients and their therapists. Psychological Monographs, 78, (Whole No. 588).

Suh, C.S., O'Malley, S.S. & Strupp, H.H. (1986). The Vanderbilt Psychotherapy Process Scale (VPPS) and the Negative Indicators Scale (VNIS). In L.S. Greenberg & W.M. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford.

Waskow, I.E. & Parloff, M.B. (1975). Psychotherapy change measures (Pubication No. 74-120). Rockville, Maryland: National Institute of Mental Health.

Watson, N. (1984). The empirical status of Rogers's hypotheses of the necessary and sufficient conditions for effective psychotherapy. In R.F. Levant & J.M. Shlien (Eds.), Client-centered therapy and the person-centered approach: New directions in theory, research, and practice (pp. 17-40). New York: Praeger.

Watkins, C.E., Lopez, F.G., Campbell, V.L., & Himmell, C.D. (1986). Contemporary counseling psychology: Results of a national survey. Journal of Counseling Psychology, 33, 301-309.

Zetzel, E.R. (1956). Current concepts of transference. International Journal of Psycho-Analysis, 37, 369-376.

Zetzel, E.R. (1970). The capacity for emotional growth. London: Hogarth.

THERAPIST CONSENT FORM

I hereby voluntarily consent to participate in the psychotherapy research study. The nature of this research has been explained to me and I understand that I will be required to complete some questionnaires.

I have been informed that the responses on the questionnaires will be treated anonymously and confidentially and that the researchers will not know my name nor will they have any identifying information about me.

I have explained the nature of the research to my client(s) and I am aware that I am free to withdraw from this study at any time.

Signed .....

Date .....

APPENDIX 4 - CLIENT CONSENT FORM

INFORMATION ABOUT THE PSYCHOTHERAPY RESEARCH PROJECT

This study is designed to generate information about the kinds of interactions that help people solve problems, change, or learn about themselves. The information that is being gathered will enable therapists to develop more effective ways to facilitate change.

There are many different kinds of effective interactions. We would like to know some of your ideas, opinions, and feelings about your interactions with your helper. Your cooperation with the research project is important and we would like to have the benefit of your experience.

Your responses to the questionnaires are completely confidential. The researchers will not know who you are nor will your therapist/counsellor see your questionnaire.

Your part in the research involves the filling out of some questionnaires. The first set of questionnaires will take about 40 minutes to complete. You will be asked to respond to another questionnaire after each of the first five of your therapy sessions (which will take about 5 minutes) as well as after the tenth session (if there is one) and after the final session. Then, at the end of your therapy, we would like you to complete some more questionnaires (which will take another 40 minutes).

Thank-you for your cooperation.

CONSENT FORM

I hereby voluntarily consent to participate in the psychotherapy research study. The nature of this research has been explained to me and I understand that I will be required to complete some questionnaires.

I have been informed that the responses on the questionnaires will be treated anonymously and confidentially and the researchers will not know my name nor will they have any identifying information about me.

If I do not wish to participate in this study, I understand that my decision will in no way affect the standard or the availability of the service I will receive, and that my withdrawal would also in no way affect the standard of service I will receive.

Signed.....

Date.....

Witness (Therapist).....

APPENDIX 5 - TARGET COMPLAINTS/DEMOGRAPHIC QUESTIONNAIRE

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #1A

The enclosed questionnaires are part of a research project to study how clients feel about their therapy/counselling experiences. Please try to answer all questions as completely and accurately as you can. Replace the completed questionnaires in the envelope provided and seal it. Your cooperation in this research is very much appreciated.

Age: ___

Sex (check one): M ___ F ___

Marital Status: Single __ Married __ Divorced __ Widowed __

Education (check highest level and complete question):
__ Elementary school (indicate number of years: ___)
__ High school (indicate number of years: ___)
__ High school graduate
__ College (indicate number of years: ___)
__ College graduate
__ Graduate study or professional training (kind of degree, etc.:
_____)

Please name the three problems or difficulties you most want help with in psychotherapy/counselling:

First Problem: _____

_____

_____

Second Problem: _____

_____

_____

Third Problem: _____

_____

_____

APPENDIX 6 - SYMPTOM CHECKLIST-90

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #2

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please circle the number to the right that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST WEEK INCLUDING TODAY. Mark only one numbered space for each problem and do not skip any items.

Circle the appropriate number:

0 - Not at all
1 - A little bit
2 - Moderately
3 - Quite a bit
4 - Extremely

HOW MUCH WERE YOU BOTHERED BY:

1.	Headaches	0 1 2 3 4
2.	Nervousness or shakiness inside	0 1 2 3 4
3.	Unwanted thoughts, words, or ideas that won't leave your mind	0 1 2 3 4
4.	Faintness or dizziness	0 1 2 3 4
5.	Loss of sexual interest or pleasure	0 1 2 3 4
6.	Feeling critical of others	0 1 2 3 4
7.	The idea that someone else can control your thoughts	0 1 2 3 4
8.	Feeling others are to blame for most of your troubles	0 1 2 3 4
9.	Trouble remembering things	0 1 2 3 4
10.	Worried about sloppiness or carelessness	0 1 2 3 4
11.	Feeling easily annoyed or irritated	0 1 2 3 4
12.	Pains in heart or chest	0 1 2 3 4
13.	Feeling afraid in open spaces or on the streets	0 1 2 3 4
14.	Feeling low in energy or slowed down	0 1 2 3 4
15.	Thoughts of ending your life	0 1 2 3 4

16. Hearing voices that other people do not hear.... 0 1 2 3 4
17. Trembling..... 0 1 2 3 4
18. Feeling that most people cannot be trusted..... 0 1 2 3 4
19. Poor appetite..... 0 1 2 3 4
20. Crying easily..... 0 1 2 3 4
21. Feeling shy or uneasy with the opposite sex..... 0 1 2 3 4
22. Feeling of being trapped or caught..... 0 1 2 3 4
23. Suddenly scared for no reason..... 0 1 2 3 4
24. Temper outbursts that you could not control..... 0 1 2 3 4
25. Feeling afraid to go out of your house alone.... 0 1 2 3 4
26. Blaming yourself for things..... 0 1 2 3 4
27. Pains in lower back..... 0 1 2 3 4
28. Feeling blocked in getting things done..... 0 1 2 3 4
29. Feeling lonely..... 0 1 2 3 4
30. Feeling blue..... 0 1 2 3 4
31. Worrying too much about things..... 0 1 2 3 4
32. Feeling no interest in things..... 0 1 2 3 4
33. Feeling fearful..... 0 1 2 3 4
34. Your feelings being easily hurt..... 0 1 2 3 4
35. Other people being aware of your private thoughts 0 1 2 3 4
36. Feeling others do not understand you or are unsympathetic..... 0 1 2 3 4
37. Feeling that people are unfriendly or dislike you 0 1 2 3 4
38. Having to do things very slowly to insure correctness..... 0 1 2 3 4
39. Heart pounding or racing..... 0 1 2 3 4
40. Nausea or upset stomach..... 0 1 2 3 4
41. Feeling inferior to others..... 0 1 2 3 4

42. Soreness of your muscles..... 0 1 2 3 4

43. Feeling that you are watched or talked about by others..... 0 1 2 3 4

44. Trouble falling asleep..... 0 1 2 3 4

45. Having to check and doublecheck what you do..... 0 1 2 3 4

46. Difficulty making decisions..... 0 1 2 3 4

47. Feeling afraid to travel on buses, subways, or trains..... 0 1 2 3 4

48. Trouble getting your breath..... 0 1 2 3 4

49. Hot or cold spells..... 0 1 2 3 4

50. Having to avoid certain things, places, or activities because they frighten you..... 0 1 2 3 4

51. Your mind goes blank..... 0 1 2 3 4

52. Numbness or tingling in parts of your body..... 0 1 2 3 4

53. A lump in your throat..... 0 1 2 3 4

54. Feeling hopeless about the future..... 0 1 2 3 4

55. Trouble concentrating..... 0 1 2 3 4

56. Feeling weak in parts of your body..... 0 1 2 3 4

57. Feeling tense or keyed up..... 0 1 2 3 4

58. Heavy feelings in your arms or legs..... 0 1 2 3 4

59. Thoughts of death or dying..... 0 1 2 3 4

60. Overeating..... 0 1 2 3 4

61. Feeling uneasy when people are watching or talking about you..... 0 1 2 3 4

62. Having thoughts that are not your own..... 0 1 2 3 4

63. Having urges to beat, injure, or harm someone... 0 1 2 3 4

64. Awakening in the early morning..... 0 1 2 3 4

65. Having to repeat the same actions such as touching, counting, washing..... 0 1 2 3 4

66. Sleep that is restless or disturbed..... 0 1 2 3 4

67. Having urges to break or smash things..... 0 1 2 3 4

68. Having ideas or beliefs that others do not share 0 1 2 3 4

69. Feeling very self-conscious with others..... 0 1 2 3 4

70. Feeling uneasy in crowds, such as shopping or at a movie..... 0 1 2 3 4

71. Feeling everything is an effort..... 0 1 2 3 4

72. Spells of terror or panic..... 0 1 2 3 4

73. Feeling uncomfortable about eating or drinking in public..... 0 1 2 3 4

74. Getting into frequent arguments..... 0 1 2 3 4

75. Feeling nervous when you are left alone..... 0 1 2 3 4

76. Others not giving you proper credit for your achievements..... 0 1 2 3 4

77. Feeling lonely even when you are with people.... 0 1 2 3 4

78. Feeling so restless you couldn't sit still..... 0 1 2 3 4

79. Feelings of worthlessness..... 0 1 2 3 4

80. Feeling that familiar things are strange or unreal..... 0 1 2 3 4

81. Shouting or throwing things..... 0 1 2 3 4

82. Feeling afraid you will faint in public..... 0 1 2 3 4

83. Feeling that people will take advantage of you if you let them..... 0 1 2 3 4

84. Having thoughts about sex that bother you a lot. 0 1 2 3 4

85. The idea that you should be punished for your sins..... 0 1 2 3 4

86. Feeling pushed to get things done..... 0 1 2 3 4

87. The idea that something serious is wrong with your body..... 0 1 2 3 4

88. Never feeling close to another person..... 0 1 2 3 4

89. Feelings of guilt..... 0 1 2 3 4

90. The idea that something is wrong with your mind. 0 1 2 3 4

APPENDIX 7 - SELF-ESTEEM INDEX

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #3

Please indicate how often each of the following statements is true for you by checking the appropriate word:

1. I feel that I am a person of worth, at least on an equal plane with others.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

2. I feel that I have a number of good qualities.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

3. I am able to do things as well as most other people.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

4. I feel I do not have much to be proud of.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

5. I take a positive attitude toward myself.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

6. Sometimes I think I am no good at all.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

7. I am a useful person to have around.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

8. I feel that I can't do anything right.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

9. When I do a job, I do it well.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

10. I feel that my life is not very useful.

Never ___ Seldom ___ Sometimes ___ Often ___ Almost Always ___

APPENDIX 8 - INVENTORY OF INTERPERSONAL PROBLEMS

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #4

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, select the number that describes how distressing that problem has been for you. Then circle that number.

0 = Not at all
1 = A little
2 = Moderately
3 = Quite a bit
4 = Extremely

Part I. The following are things you find hard to do with other people.

It is hard for me to:

1.	trust other people.....	0	1	2	3	4
2.	say "no" to other people.....	0	1	2	3	4
3.	join in on groups.....	0	1	2	3	4
4.	keep things private from other people.....	0	1	2	3	4
5.	let other people know what I want.....	0	1	2	3	4
6.	tell a person to stop bothering me.....	0	1	2	3	4
7.	introduce myself to new people.....	0	1	2	3	4
8.	confront people with problems that come up..	0	1	2	3	4
9.	be assertive with another person.....	0	1	2	3	4
10.	make friends.....	0	1	2	3	4
11.	express my admiration for another person...	0	1	2	3	4
12.	have someone dependent on me.....	0	1	2	3	4
13.	disagree with other people.....	0	1	2	3	4
14.	let other people know when I am angry.....	0	1	2	3	4
15.	make a long-term commitment to another person.....	0	1	2	3	4
16.	stick to my own point of view and not be swayed by other people.....	0	1	2	3	4
17.	be another person's boss.....	0	1	2	3	4

18.	do what another person wants me to do.....	0	1	2	3	4
19.	get along with people who have authority over me.....	0	1	2	3	4
20.	be aggressive toward other people when the situation calls for it.....	0	1	2	3	4
21.	compete against other people.....	0	1	2	3	4
22.	make reasonable demands of other people....	0	1	2	3	4
23..	socialize with other people.....	0	1	2	3	4
24.	get out of a relationship that I don't want to be in.....	0	1	2	3	4
25.	take charge of my own affairs without help from other people.....	0	1	2	3	4
26.	show affection to other people.....	0	1	2	3	4
27.	feel comfortable around other people.....	0	1	2	3	4
28.	get along with other people.....	0	1	2	3	4
29.	understand another person's point of view..	0	1	2	3	4
30.	tell personal things to other people.....	0	1	2	3	4
31.	believe that I am lovable to other people..	0	1	2	3	4
32.	express my feelings to other people directly.....	0	1	2	3	4
33.	be firm when I need to be.....	0	1	2	3	4
34.	experience a feeling of love for another person.....	0	1	2	3	4
35.	be competitive when the situation calls for it.....	0	1	2	3	4
36.	set limits on other people.....	0	1	2	3	4
37.	be honest with other people.....	0	1	2	3	4
38.	be supportive of another person's goals in life.....	0	1	2	3	4
39.	feel close to other people.....	0	1	2	3	4
40.	really care about other people's problems..	0	1	2	3	4

41. argue with another person..... 0 1 2 3 4

42. relax and enjoy myself when I go out with other people..... 0 1 2 3 4

43. feel superior to another person..... 0 1 2 3 4

44. become sexually aroused toward the person I really care about..... 0 1 2 3 4

45. feel that I deserve another person's affection..... 0 1 2 3 4

46. keep up my side of a friendship..... 0 1 2 3 4

47. spend time alone..... 0 1 2 3 4

48. give a gift to another person..... 0 1 2 3 4

49. have loving and angry feelings towards the same person..... 0 1 2 3 4

50. maintain a working relationship with someone I don't like..... 0 1 2 3 4

51. set goals for myself without other people's advice..... 0 1 2 3 4

52. accept another person's authority over me.. 0 1 2 3 4

53. feel good about winning..... 0 1 2 3 4

54. ignore criticism from other people..... 0 1 2 3 4

55. feel like a separate person when I am in a relationship..... 0 1 2 3 4

56. allow myself to be more successful than other people..... 0 1 2 3 4

57. feel or act competent in my role as parent. 0 1 2 3 4

58. let myself feel angry at somebody I like... 0 1 2 3 4

59. respond sexually to another person..... 0 1 2 3 4

60. accept praise from another person..... 0 1 2 3 4

61. put somebody else's needs before my own.... 0 1 2 3 4

62. give credit to another person for doing something well..... 0 1 2 3 4

63. stay out of other people's business..... 0 1 2 3 4

64. take instructions from people who have authority over me..... 0 1 2 3 4

65. feel good about another person's happiness. 0 1 2 3 4

66. get over the feeling of loss after a relationship has ended..... 0 1 2 3 4

67. ask other people to get together socially with me..... 0 1 2 3 4

68. feel angry at other people..... 0 1 2 3 4

69. give constructive criticism to another person..... 0 1 2 3 4

70. experience sexual satisfaction..... 0 1 2 3 4

71. open up and tell my feelings to another person..... 0 1 2 3 4

72. forgive another person after I've been angry..... 0 1 2 3 4

73. attend to my own welfare when somebody else is needy..... 0 1 2 3 4

74. be assertive without worrying about hurting the other person's feelings..... 0 1 2 3 4

75. be involved with another person without feeling trapped..... 0 1 2 3 4

76. do work for my own sake instead of for someone else's approval..... 0 1 2 3 4

77. be close to somebody without feeling that I'm betraying somebody else..... 0 1 2 3 4

78. be self-confident when I am with other people..... 0 1 2 3 4

Part II. The following are things that you do too much.

79. I fight with other people too much..... 0 1 2 3 4

80. I am too sensitive to criticism..... 0 1 2 3 4

81. I feel too responsible for solving other people's problems..... 0 1 2 3 4

82. I get irritated or annoyed too easily..... 0 1 2 3 4

83. I am too easily persuaded by other people.. 0 1 2 3 4

84.	I want people to admire me too much.....	0	1	2	3	4
85.	I act like a child too much.....	0	1	2	3	4
86.	I am too dependent on other people.....	0	1	2	3	4
87.	I am too sensitive to rejection.....	0	1	2	3	4
88.	I open up to people too much.....	0	1	2	3	4
89.	I am too independent.....	0	1	2	3	4
90.	I am too aggressive toward other people....	0	1	2	3	4
91.	I try to please other people too much.....	0	1	2	3	4
92.	I feel attacked by other people too much...	0	1	2	3	4
93.	I feel too guilty for what I have done.....	0	1	2	3	4
94.	I clown around too much.....	0	1	2	3	4
95.	I want to be noticed too much.....	0	1	2	3	4
96.	I criticize other people too much.....	0	1	2	3	4
97.	I trust other people too much.....	0	1	2	3	4
98.	I try to control other people too much.....	0	1	2	3	4
99.	I avoid other people too much.....	0	1	2	3	4
100.	I am affected by another person's moods too much.....	0	1	2	3	4
101.	I put other people's needs before my own too much.....	0	1	2	3	4
102.	I try to change other people too much.....	0	1	2	3	4
103.	I am too gullible.....	0	1	2	3	4
104.	I am overly generous to other people.....	0	1	2	3	4
105.	I am too afraid of other people.....	0	1	2	3	4
106.	I worry too much about other people's reactions to me.....	0	1	2	3	4
107.	I am too suspicious of other people.....	0	1	2	3	4
108.	I am influenced too much by another person's thoughts and feelings.....	0	1	2	3	4

109. I compliment other people too much..... 0 1 2 3 4

110. I worry too much about disappointing other people..... 0 1 2 3 4

111. I manipulate other people too much to get what I want..... 0 1 2 3 4

112. I lose my temper too easily..... 0 1 2 3 4

113. I tell personal things to other people too much..... 0 1 2 3 4

114. I blame myself too much for causing other people's problems..... 0 1 2 3 4

115. I am too easily bothered by other people making demands of me..... 0 1 2 3 4

116. I argue with other people too much..... 0 1 2 3 4

117. I am too envious and jealous of other people..... 0 1 2 3 4

118. I keep other people at a distance too much..... 0 1 2 3 4

119. I worry too much about my family's reactions to me..... 0 1 2 3 4

120. I let other people take advantage of me too much..... 0 1 2 3 4

121. I too easily lose a sense of myself when I am around a strong-minded person..... 0 1 2 3 4

122. I feel too guilty for what I have failed to do..... 0 1 2 3 4

123. I feel competitive even when the situation does not call for it..... 0 1 2 3 4

124. I feel embarrassed in front of other people too much..... 0 1 2 3 4

125. I feel too anxious when I am involved with another person..... 0 1 2 3 4

126. I am affected by another person's misery too much..... 0 1 2 3 4

127. I want to get revenge against people too much..... 0 1 2 3 4

APPENDIX 9 - WORKING ALLIANCE INVENTORY (CLIENT FORM)

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #I1

INSTRUCTIONS

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counsellor). As you read the sentences, mentally insert the name of your therapist (counsellor) in place of _____ in the text.

Below each statement inside, there is a seven-point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think), circle the number '7'; if it never applies to you, circle the number '1'. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your therapist nor the agency will see your answers.

Work fast; your first impressions are the ones we would like to see. (PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

Thank you for your cooperation.

Session #: _____ Date: _____

1. I feel uncomfortable with _____						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
2. _____ and I agree about the things I will need to do in therapy to help improve my situation.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
3. I am worried about the outcome of these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
4. What I am doing in therapy gives me new ways of looking at my problem.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
5. _____ and I understand each other.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
6. _____ perceives accurately what my goals are.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
7. I find what I am doing in therapy confusing.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
8. I believe _____ likes me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
9. I wish _____ and I could clarify the purpose of our sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. I disagree with _____ about what I ought to get out of therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
11. I believe the time _____ and I are spending together is not spent efficiently.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
12. _____ does not understand what I am trying to accomplish in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
13. I am clear on what my responsibilities are in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
14. The goals of these sessions are important to me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
15. I find what _____ and I are doing in therapy is unrelated to my concerns.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
16. I feel that the things I do in therapy will help me to accomplish the changes that I want.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
17. I believe _____ is genuinely concerned for my welfare.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
18. I am clear as to what _____ wants me to do in these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

19. _____ and I respect each other.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
20. I feel that _____ is not totally honest about his/her feelings toward me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
21. I am confident in _____ 's ability to help me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
22. _____ and I are working towards mutually agreed upon goals.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
23. I feel that _____ appreciates me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
24. We agree on what is important for me to work on.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
25. As a result of these sessions, I am clearer as to how I might be able to change.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
26. _____ and I trust one another.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
27. _____ and I have different ideas on what my problems are.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

28. My relationship with _____ is very important to me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
29. I have the feeling that if I say or do the wrong things, _____ will stop working with me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
30. _____ and I collaborate on setting goals for my therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
31. I am frustrated by the things I am doing in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
32. We have established a good understanding of the kind of changes that would be good for me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
33.The things that _____ is asking me to do don't make sense.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
34. I don't know what to expect as the result of my therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
35. I believe the way we are working with my problem is correct.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
36. I feel _____ cares about me even when I do things that he/she does not approve of.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX 10 - CLIENT INVOLVEMENT SCALE (CLIENT FORM)

1. I feel that I am freely, openly and honestly expressing my thoughts and feelings and offering information about my behaviour in this therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. I feel that I am actively working toward the success of this therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I am working together with my therapist to make changes I need to make.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I am fully involved in the process of this therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I feel that I am making the best use of this therapy in order to help me make changes.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. I feel a good deal of responsibility for making this therapy work.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

PLEASE BE SURE TO PLACE THE COMPLETED QUESTIONNAIRE IN THE ATTACHED ENVELOPE AND SEAL THE ENVELOPE.

APPENDIX 11 - WORKING ALLIANCE INVENTORY (THERAPIST FORM)

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #I1 (THERAPIST FORM)

INSTRUCTIONS

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences, mentally insert the name of your client in place of _____ in the text.

Below each statement inside, there is a seven-point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think), circle the number '7'; if it never applies to you, circle the number '1'. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your client nor the agency will see your answers.

Work fast; your first impressions are the ones we would like to see. (PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

Thank you for your cooperation.

Session #: _____ Date: _____

	1	2	3	4	5	6	7
1. I feel uncomfortable with _____ .	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
2. _____ and I agree about the steps to be taken to improve his/her situation.	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
3. I have some concerns about the outcome of these sessions.	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
4. _____ and I both feel confident about the usefulness of our current activity in therapy.	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
5. _____ and I have a common perception of her/his goals.	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
6. I feel I really understand _____ .	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
7. _____ finds what we are doing in therapy confusing.	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
8. I believe _____ likes me.	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
9. I sense a need to clarify the purpose of our session(s) for _____ .	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. I have some disagreements with _____ about the goals of these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. I believe that the time _____ and I are spending together is not spent efficiently.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I have doubts about what we are trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

13. I am clear and explicit about what _____ 's responsibilities are in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

14. The current goals of these sessions are important for _____ .

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

15. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

17. I am genuinely concerned for _____ 's welfare.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

18. I am clear as to what I expect _____ to do in these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

19. _____ and I respect each other.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
20. I feel that I am not totally honest about my feelings toward _____ .						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
21. I am confident in my ability to help _____ .						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
22. We are working towards mutually agreed upon goals.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
23. I appreciate _____ as a person.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
24. We agree on what is important for _____ to work on.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
25. As a result of these sessions, _____ is clearer as to how she/he might be able to change.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
26. _____ and I have built a mutual trust.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
27. _____ and I have different ideas on what his/her real problems are.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

28. Our relationship is important to _____ .

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

29. _____ has some fears that if she/he says or does the wrong things, I will stop working with him/her.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

30. _____ and I have collaborated in setting goals for these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

31. _____ is frustrated by what I am asking her/him to do in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

32. We have established a good understanding between us of the kind of changes that would be good for _____ .

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

33. The things that we are doing in therapy don't make much sense to _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

34. _____ doesn't know what to expect as the result of therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

35. _____ believes the way we are working with her/his problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

36. I respect _____ even when he/she does things that I do not approve of.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX 12 - CLIENT INVOLVEMENT SCALE (THERAPIST FORM)

1. _____ is freely, openly and honestly expressing his/her thoughts and feelings and offering information about his/her behaviour in this therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. _____ is actively working toward the success of this therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. _____ is working together with me to make changes he/she needs to make.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ is fully involved in the process of this therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. _____ is making the best use of this therapy in order to help him/her make changes.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ seems to feel a good deal of responsibility for making this therapy work.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX 13 - RELATIONSHIP INVENTORY - EMPATHY SUBSCALE

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #I2

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each numbered statement with reference to your present relationship with your counsellor, mentally adding his or her name in the space provided. For example, if the other person's name was John, you would read statement #1, as 'John wants to understand how I see things.'

Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.
+2: Yes, I feel it is true.
+1: Yes, I feel that it is probably true, or more true than untrue.
-1: No, I feel that it is probably untrue, or more untrue than true.
-2: No, I feel it is not true.
-3: No, I strongly feel that it is not true.

---

1. ____ wants to understand how I see things..... ___

2. ____ may understand my words but he/she does not see the way I feel..... ___

3. ____ nearly always knows exactly what I mean..... ___

4. ____ looks at what I do from his/her own point of view..... ___

5. ____ usually senses or realizes what I am feeling.... ___

6. I feel that what ____ says usually expresses exactly what he/she is feeling and thinking at that moment... ___

7. ____'s own attitudes toward some of the things I do or say prevent him/her from understanding me..... ___

8. ____ wants me to think that he/she likes me or understands me more than he/she really does..... ___

9. Sometimes ____ thinks that I feel a certain way, because that's the way he/she feels..... ___

10. ___ usually understands the whole of what I mean.... ___

11. ____ just takes no notice of some things that I think or feel..... ___

12. ____ appreciates exactly how the things I experience feel to me..... ___

13. At times ____ thinks that I feel a lot more strongly about a particular thing than I really do..... ___

14. ____ understands me..... ___

15. ____'s response to me is usually so fixed and automatic that I don't really get through to him/her..... ___

16. When I am hurt or upset ____ can recognize my feelings exactly, without becoming upset too..... ___

APPENDIX 14 - COUNSELOR RATING FORM

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #I3

Listed below are several scales which contain word pairs at either end of the scale and seven spaces between the pairs. Please rate the counselor you just saw on each of the scales.

If you feel that the counselor very closely resembles the word at one end of the scale, place a check mark as follws:

fair __ : __ : __ : __ : __ : __ : X unfair

OR

fair X : __ : __ : __ : __ : __ : __ unfair

If you think that one end of the scale quite closely describes the counselor then make your check mark as follows:

rough __ : X : __ : __ : __ : __ : __ smooth

OR

rough __ : __ : __ : __ : __ : X : __ smooth

If you feel that one end of the scale only slightly describes the counselor, then check the scale as follows:

active __ : __ : X : __ : __ : __ : __ passive

OR

active __ : __ : __ : __ : X : __ : __ passive

If both sides of the scale seem equally associated with your impression of the counselor or if the scale is irrelevant, then place a check mark in the middle space:

hard __ : __ : __ : X : __ : __ : __ soft

Your first impression is the best answer.

PLEASE NOTE: PLACE CHECK MARKS IN THE MIDDLE OF THE SPACES

agreeable __ : __ : __ : __ : __ : __ : __ disagreeable

unalert __ : __ : __ : __ : __ : __ : __ alert

analytic __ : __ : __ : __ : __ : __ : __ diffuse

unappreciative __ : __ : __ : __ : __ : __ : __ appreciative

attractive __ : __ : __ : __ : __ : __ : __ unattractive

casual __ : __ : __ : __ : __ : __ : __ formal

cheerful __ : __ : __ : __ : __ : __ : __ depressed

unclear __ : __ : __ : __ : __ : __ : __ clear

distant __ : __ : __ : __ : __ : __ : __ close

compatible __ : __ : __ : __ : __ : __ : __ incompatible

unsure __ : __ : __ : __ : __ : __ : __ confident

suspicious __ : __ : __ : __ : __ : __ : __ believable

undependable __ : __ : __ : __ : __ : __ : __ dependable

indifferent __ : __ : __ : __ : __ : __ : __ enthusiastic

inexperienced __ : __ : __ : __ : __ : __ : __ experienced

inexpert __ : __ : __ : __ : __ : __ : __ expert

unfriendly __ : __ : __ : __ : __ : __ : __ friendly

honest __ : __ : __ : __ : __ : __ : __ dishonest

informed __ : __ : __ : __ : __ : __ : __ ignorant

insightful __ : __ : __ : __ : __ : __ : __ insightless

stupid __ : __ : __ : __ : __ : __ : __ intelligent

unlikeable __ : __ : __ : __ : __ : __ : __ likeable

logical __ : __ : __ : __ : __ : __ : __ illogical

open __ : __ : __ : __ : __ : __ : __ closed

prepared __ : __ : __ : __ : __ : __ : __ unprepared

unreliable __ : __ : __ : __ : __ : __ : __ reliable

disrespectful __ : __ : __ : __ : __ : __ : __ respectful

irresponsible __ : __ : __ : __ : __ : __ : __ responsible

selfless __ : __ : __ : __ : __ : __ : __ selfish

sincere __ : __ : __ : __ : __ : __ : __ insincere

skillful __ : __ : __ : __ : __ : __ : __ unskillful

sociable __ : __ : __ : __ : __ : __ : __ unsociable

deceitful __ : __ : __ : __ : __ : __ : __ straightforward

trustworthy __ : __ : __ : __ : __ : __ : __ untrustworthy

genuine __ : __ : __ : __ : __ : __ : __ phony

warm __ : __ : __ : __ : __ : __ : __ cold

APPENDIX 15 - HELPING ALLIANCE QUESTIONNAIRE

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #I4

Below are listed a variety of ways that one person may feel or behave in relation to another person. Please consider each statement with reference to your present relationship with your therapist.

Mark each statement according to how strongly you feel that it is true, or not true, in this relationship. Please mark every one. Write in +3, +2, +1 or -1, -2, -3, to stand for the following answers:

+3. Yes, I strongly feel that it is true
+2. Yes, I feel it is true
+1. Yes, I feel that it is probably true, or more true than untrue
-1. No, I feel that it is probably untrue, or more untrue than true
-2. No, I feel it is not true
-3. No, I strongly feel that it is not true

____ 1. I believe that my therapist is helping me.

____ 2. I believe that the treatment is helping me.

____ 3. I have obtained some new understanding.

____ 4. I have been feeling better recently.

____ 5. I can already see that I will eventually work out the problems I came to treatment for.

____ 6. I feel I can depend upon the therapist.

____ 7. I feel the therapist understands me.

____ 8. I feel the therapist wants me to achieve my goals.

____ 9. I feel I am working together with the therapist in a joint effort.

____ 10. I believe we have similar ideas about the nature of my problems.

____ 11. I feel now that I can understand myself and deal with myself on my own (that is, even if this therapist and I were no longer meeting for treatment appointments).

APPENDIX 16 - STRUPP POSTTHERAPY QUESTIONNAIRE

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #5

1. How much in need of further therapy/counselling do you feel now?
   __ No need at all
   __ Slight need
   __ Could use more
   __ Considerable need
   __ Very great need

2. What has led to the termination of your therapy/counselling?
   __ My decision
   __ My therapist's decision
   __ Mutual agreement
   __ External factors

3. How much have you benefitted from your therapy/counselling?
   __ A great deal
   __ A fair amount
   __ To some extent
   __ Very little
   __ Not at all

4. Everything considered, how satisfied are you with your therapy/counselling experience?
   __ Extremely dissatisfied
   __ Moderately dissatisfied
   __ Fairly dissatsifed
   __ Fairly satisfied
   __ Moderately satisfied
   __ Highly satisfied
   __ Extremely satisfied

5. Was your therapist of the same sex as you? ___ Yes ___ No

6. What impression did you have of his/her level of experience as a therapist/counsellor?
   __ Extremely inexperienced
   __ Rather inexperienced
   __ Somewhat inexperienced
   __ Fairly experienced
   __ Highly experienced
   __ Exceptionally experienced

7. At the beginning of therapy, how well did you feel you were getting along?
   __ Very well
   __ Fairly well
   __ Neither well nor poorly
   __ Fairly poorly
   __ Very poorly
   __ Extremely poorly

8. How long before entering therapy did you feel in need of professional help?
__ Less than 1 year
__ 1-2 years
__ 3-4 years
__ 5-10 years
__ 11-15 years
__ 16-20 years
_____ years (specify)

9. How severely disturbed did you consider yourself at the beginning of your therapy/counselling?
__ Extremely disturbed
__ Very much disturbed
__ Moderately disturbed
__ Somewhat disturbed
__ Very slightly disturbed

10. How much anxiety did you feel at the time you started therapy/counselling?
__ A tremendous amount
__ A great deal
__ A fair amount
__ Very little
__ None at all

11. How great was the internal "pressure" to do something about these problems when you entered therapy/counselling?
__ Extremely great
__ Very great
__ Fairly great
__ Relatively small
__ Very small
__ Extremely small

12. How much do you feel you have changed as a result of therapy/counselling?
__ A great deal
__ A fair amount
__ Somewhat
__ Very little
__ Not at all

13. How much of this change do you feel has been apparent to others?
(a) People closest to you (husband, wife, etc.)
__ A great deal __ A fair amount __ Somewhat __ Very little __ Not at all
(b) Close friends
__ A great deal __ A fair amount __ Somewhat __ Very little __ Not at all
(c) Co-workers, acquaintances, etc.
__ A great deal __ A fair amount __ Somewhat __ Very little __ Not at all

14. On the whole, how well do you feel you are getting along now?
__ Extremely well
__ Very well
__ Fairly well
__ Neither well nor poorly
__ Fairly poorly
__ Very poorly
__ Extremely poorly

15. How adequately do you feel you are dealing with any present problem?
__ Very adequately
__ Fairly adequately
__ Neither adequately nor inadequately
__ Somewhat adequately
__ Very inadequately

16. To what extent have your complaints that brought you to therapy/counselling changed as a result of treatment?
__ Completely disappeared
__ Very greatly improved
__ Considerably improved
__ Somewhat improved
__ Not at all improved
__ Got worse

17. How soon after entering therapy/counselling did you feel any marked change?
___ hours of therapy (approximately)

18. How strongly would you recommend therapy/counselling to a close friend with emotional problems?
__ Would strongly recommend it
__ Would mildly recommend it
__ Would not recommend it
__ Would advise against it

19. Please indicate the adequacy of this questionnaire in describing your therapy experience. Give any additional data which you feel are relevant to an understanding of your experience.

THANK-YOU FOR YOUR PARTICIPATION IN THIS PROJECT

APPENDIX 17 - TARGET COMPLAINTS IMPROVEMENT RATING FORM

PSYCHOTHERAPY RESEARCH QUESTIONNAIRE #1B

We are interested in how much the following problems or difficulties of yours have changed since the beginning of therapy. Please circle the words that describe your position.

A _____

_____

worse...same...slightly better...somewhat better...a lot better

B _____

_____

worse...same...slightly better...somewhat better...a lot better

C _____

_____

worse...same...slightly better...somewhat better...a lot better

APPENDIX 18 - THERAPIST DEMOGRAPHIC DATA SHEET

THERAPIST DEMOGRAPHIC DATA SHEET

1. Professional affiliation:

Psychologist ___ Social Worker ___ Counsellor ___

Psychiatrist ___ Other (please specify) _____

2. Highest degree completed:

B.A. ___ M.D. ___ PhD. ___

Ed.D. ___ M.Ed. ___ B.S.W. ___ M.S.W. ___

Other (please specify) _____

3. Number of years experience as a therapist/counsellor:

None ___ 1 - 5 ___

6 - 10 ___ 11 - 15 ___ More ___

4. Sex (check one): M __ F __

5. Identify/describe the theoretical orientation which most characterizes your work with this particular client:

_____

_____

If you had to place yourself in one of the following three categories, which would you choose? (check one)

analytic ___ learning ___ humanistic ___

APPENDIX 19 - THERAPIST POSTTHERAPY QUESTIONNAIRE

THERAPIST POSTTHERAPY QUESTIONNAIRE

1. How much more therapy do you feel your client needs now?
   __ No need at all
   __ Slight need
   __ Could use more
   __ Considerable need
   __ Very great need

2. What determined this choice to terminate with your client now?
   __ Client's decision
   __ Therapist's decision
   __ Mutual agreement
   __ External factors

3. How much has your client benefitted from therapy?
   __ A great deal
   __ A fair amount
   __ To some extent
   __ Very little
   __ Not at all

4. Everything considered, how satisfied are you with the results of your client's psychotherapy experience?
   __ Extremely dissatisfied
   __ Moderately dissatisfied
   __ Fairly dissatsifed
   __ Fairly satisfied
   __ Moderately satisfied
   __ Highly satisfied
   __ Extremely satisfied

5. As a therapist/counsellor, how would you describe <u>yourself</u>?
   __ Extremely inexperienced
   __ Rather inexperienced
   __ Somewhat inexperienced
   __ Fairly experienced
   __ Highly experienced
   __ Exceptionally experienced

6. At the beginning of therapy, how well did you feel your client was getting along?
   __ Very well
   __ Fairly well
   __ Neither well nor poorly
   __ Fairly poorly
   __ Very poorly
   __ Extremely poorly

7. How severely disturbed was your client at the beginning of therapy?
__ Extremely disturbed
__ Very much disturbed
__ Moderately disturbed
__ Somewhat disturbed
__ Very slightly disturbed

8. How much anxiety did your client experience at the beginning of therapy?
__ A tremendous amount
__ A great deal
__ A fair amount
__ Very little
__ None at all

9. How much internal "pressure" did your client experience about these problems when he/she entered psychotherapy?
__ Extremely great
__ Very great
__ Fairly great
__ Relatively small
__ Very small
__ Extremely small

10. How much do you feel you client has changed as a result of therapy?
__ A great deal
__ A fair amount
__ Somewhat
__ Very little
__ Not at all

11. How much of this change do you feel has been apparent to others?
(a) People closest to him/her (husband, wife, etc.)
__ A great deal __ A fair amount __ Somewhat __ Very little __ Not at all
(b) Close friends
__ A great deal __ A fair amount __ Somewhat __ Very little __ Not at all
(c) Co-workers, acquaintances, etc.
__ A great deal __ A fair amount __ Somewhat __ Very little __ Not at all

12. On the whole, how well do you feel your client is getting along now?
__ Extremely well
__ Very well
__ Fairly well
__ Neither well nor poorly
__ Fairly poorly
__ Very poorly
__ Extremely poorly

13. How adequately do you feel your client is dealing with any present problem?
__ Very adequately
__ Fairly adequately
__ Neither adequately nor inadequately
__ Somewhat inadequately
__ Very inadequately

14. To what extent has your client's complaint(s) or symptom(s) that brought him/her to therapy changed as a result of treatment?
__ Completely disappeared
__ Very greatly improved
__ Considerably improved
__ Somewhat improved
__ Not at all improved
__ Got worse

15. How soon after entering therapy did you feel that marked changes had taken place in your client?
___ hours of therapy (approximately)

THANK-YOU FOR YOUR PARTICIPATION IN THIS PROJECT

APPENDIX 20 - LETTER OF THANKS TO CLIENTS

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education
Department of Counselling Psychology
5780 Toronto Road
Vancouver, B.C.
V6T 1L2

Dear Participant,

Thank you for helping us with the Psychotherapy Research Project by completing our questionnaires. In appreciation of your participation, we are enclosing a cheque for $25.00.

Sincerely,

Jean Adler
Project Coordinator

APPENDIX 21 - INSTRUMENT SCORING KEYS

Symptom Checklist-90

Somatization-1, 4, 12, 27, 40, 42, 48, 49, 52, 53, 56, 58
Obsessive-Compulsive-3, 9, 10, 28, 38, 45, 46, 51, 55, 65
Interpersonal Sensitivity-6, 21, 34, 36, 37, 41, 61, 69, 73
Depression-5, 14, 15, 20, 22, 26, 29, 30, 31, 32, 54, 71, 79
Anxiety-2, 17, 23, 33, 39, 57, 72, 78, 80, 86
Anger-Hostility-11, 24, 63, 67, 74, 81
Phobic Anxiety-13, 25, 47, 50, 70, 75, 82
Paranoid Ideation-8, 18, 43, 68, 76, 83
Psychoticism-7, 16, 35, 62, 77, 84, 85, 87, 88, 90
Additional Scales-19, 44, 59, 60, 64, 66, 89

Self-Esteem Index

1, 2, 3, 4 , 5, 6 , 7, 8 , 9, 10 [1]

Inventory of Interpersonal Problems

Hard to be Intimate-1, 11, 26, 30, 34, 37, 39, 44, 70, 71, 72
Hard to be Assertive-2, 5, 6, 8, 9, 13, 17, 22, 32, 33, 35, 36, 43, 57, 69, 74, 78
Hard to be Independent-4, 16, 25, 47, 51, 54, 55, 56, 66
Hard to be Sociable-3, 7, 10, 23, 27, 28, 42, 46, 48, 62, 67
Hard to feel Self-Worth-21, 31, 45, 53, 60, 76
Hard to be Supportive-12, 18, 19, 29, 38, 40, 50, 52, 61, 64, 65
Hard to be Aggressive-14, 20, 41, 58, 68
Not Members of H subscales-15, 24, 49, 59, 63, 73, 75, 77
Too Giving-88, 97, 101, 104, 109, 113
Too Aggressive-79, 82, 90, 96, 98, 102, 111, 112, 115, 116, 117, 123, 127
Too Hypersensitive-80, 92, 99, 105, 106, 107, 108, 118, 124, 125
Too Eager to Please-81, 83, 91, 93, 103, 110, 114, 120, 122, 126
Too Dependent-84, 85, 86, 87, 94, 95, 100, 119, 121
Not Member of T subscales-89

Working Alliance Inventory (Client Form)

GOAL: 3 , 6 , 9 , 10 , 12 , 14 , 22 , 25 , 27 , 30 , 32 , 34
TASK: 2 , 4 , 7 , 11 , 13 , 15 , 16 , 18 , 24 , 31 , 33 , 35
BOND: 1 , 5 , 8 , 17 , 19 , 20 , 21 , 23 , 26 , 28 , 29 , 36

---

[1] Reverse-weighted items are underlined.

Working Alliance Inventory (Therapist Form)

GOAL: 3 , 5 , 9 , 10 , 12 , 14 , 22 , 25 , 27 , 30 , 32 , 34
TASK: 2 , 4 , 7 , 11 , 13 , 15 , 16 , 18 , 24 , 31 , 33 , 35
BOND: 1 , 6 , 8 , 17 , 19 , 20 , 21 , 23 , 26 , 28 , 29 , 36

Relationship Inventory (Empathy Subscale)

1, 2 , 3, 4 , 5, 6, 7 , 8 , 9 , 10, 11 , 12, 13 , 14, 15 , 16

Counselor Rating Form

Expertness - 2 , 3 , 8 , 11 , 15 , 16 , 19 , 20 , 21, 23 , 25 , 31
Trustworthiness - 12 , 13 , 18 , 24 , 26 , 27 , 28 , 29 , 30 , 33 , 34 , 35
Attractiveness - 1 , 4 , 5 , 6 , 7 , 9, 10 , 14 , 17 , 22 , 32 , 36

Helping Alliance Questionnaire

HA Type 1 - 1, 2, 3, 4, 5, 6, 7, 8
HA Type 2 - 9, 10, 11

Strupp Posttherapy Questionnaire

Satisfaction - 3 , 4, 18
Change - 12 , 13a , 13b , 13c , 16
Adjustment - 1 , 14 , 15

Therapist Posttherapy Questionnaire

Satisfaction - 3 , 4
Change - 10 , 11a , 11b , 11c , 14
Adjustment - 1 , 12 , 13

APPENDIX 22 - ADDITIONAL INFORMATION COLLECTED ON THE SPQ AND THE TPQ

On the Strupp Posttherapy Questionnaire (Appendix 16), the following questions were not included in the analyses of the present study. The numbers recorded for each item response are the number of respondents.

2. What has led to the termination of your therapy/counselling?

My decision	- 4
My therapist's decision	- 2
Mutual agreement	-15
External factors	-23

6. What impression did you have of [your therapist's] level of experience?

Extremely inexperienced	- 2
Rather inexperienced	- 0
Somewhat inexperienced	- 4
Fairly experienced	-10
Highly experienced	-20
Exceptionally experienced	- 7
No response	- 1

7. At the beginning of therapy, how well did you feel you were getting along?

Very well	-17
Fairly well	-16
Neither well nor poorly	- 5
Fairly poorly	- 1
Very poorly	- 3
Extremely poorly	- 2

8. How long before entering therapy did you feel in need of professional help?

Less than 1 year	-16
1-2 years	- 8
3-4 years	- 5
5-10 years	- 9
11-15 years	- 3
16-20 years	- 1
Over 20 years	- 2

9. How severely disturbed did you consider yourself at the beginning of your therapy/counselling?

Extremely disturbed - 4
Very much disturbed -16
Moderately disturbed -12
Somewhat disturbed - 8
Very slightly disturbed - 4

10. How much anxiety did you feel at the time you started therapy/counselling?

A tremendous amount -15
A great deal -15
A fair amount - 9
Very little - 5
None at all - 0

11. How great was the internal "pressure" to do something about these problems when you entered therapy/counselling?

Extremely great -15
Very great -13
Relatively small -12
Very small - 4
Extremely small - 0

17. How soon after entering therapy/counselling did you feel any marked change?

After less than 5 hours of therapy -19
after 5-10 hours of therapy -16
After more than 10 hours of therapy - 6
No response - 3

On the Therapist Posttherapy Questionnaire (Appendix 19), the following questions were not included in the analyses of the present study.

2. What determined this choice to terminate with your client now?

Client's decision - 8
Therapist's decision - 0
Mutual agreement -17
External factors -19

5. As a therapist/counsellor, how would you describe yourself ?

Extremely inexperienced - 1
Rather inexperienced - 0
Somewhat inexperienced - 5
Fairly experienced -20
Highly experienced -16

Exceptionally experienced - 1
No response - 1

6. At the beginning of therapy, how well did you feel your client was getting along?

Very well - 2
Fairly well -10
Neither well nor poorly - 4
Fairly poorly -15
Very poorly -10
Extremely poorly - 2
No response - 1

7. How severely disturbed was your client at the beginning of therapy?

Extremely disturbed - 5
Very much disturbed - 4
Moderately disturbed -18
Somewhat disturbed -11
Very slightly disturbed - 5
No response - 1

8. How much anxiety did your client experience at the beginning of therapy?

A tremendous amount - 4
A great deal -15
A fair amount -21
Very little - 3
None at all - 0
No response - 1

9. How much internal "pressure" did your client experience about these problems when he/she entered psychotherapy?

Extremely great - 6
Very great -13
Fairly great -20
Relatively small - 3
Very small - 0
Extremely small - 0
No response - 2

15. How soon after entering therapy did you feel that marked changes had taken place in your client?

After less than 5 hours of therapy -13
After 5-10 hours of therapy -23
After more than 10 hours of therapy - 6
No response - 2

APPENDIX 23 - RELIABILITY ESTIMATES OF THE INSTRUMENTS

The computer package LERTAP (Laboratory of Educational Research Test Analysis Package; Nelson, 1974) was used to estimate the reliability of each of the instruments employed in the study. LERTAP uses Hoyt's (1941) analysis of variance algorithm to compute coefficients of internal consistency. Internal consistency is an estimate of the extent to which subscale items all tap the same construct.

LERTAP can be used to calculate Cronbach's (1951) coefficient alpha, a measure of total test reliability, or the degree to which the subscales of the test tend to measure the same thing. When subscales measure quite distinct or unrelated constructs, the total scale reliability is expected to be less than the reliability found in each of the subscales. Cronbach suggested that this coefficient alpha is an index of how much the total scale score reflects "common elements rather than a hodgepodge of elements each specific to one subtest" (Cronbach, quoted by Nelson, 1974, p. 280).

All of the process and outcome measures employed in the study were analyzed with LERTAP and the results are presented in Table 22.

The means and standard deviations of the relationship measures are presented in Table 21. The means and standard deviations of the outcome measures are presented in Sections 1.1 and 1.2 of Chapter IV (target complaints improvement and the SEI), in Appendix 26, Table 26 (SCL-90 and IIP), and in Table 22 (SPQ and TPQ).

Table 21 - Means and Standard Deviations of Relationship Measures

	Session						
	#1	#2	#3	#4	#5	#10	Final
Working Alliance Inventory (Client Form)							
Goal	68.50	69.02	70.43	71.05	70.63	72.65	72.05
	10.62	8.82	8.40	7.88	7.77	7.19	7.45
Task	69.36	70.02	71.05	72.02	72.07	71.92	72.02
	9.86	8.52	7.76	7.48	7.60	7.11	7.35
Bond	70.25	70.81	72.55	72.81	73.07	75.19	73.82
	8.34	6.97	6.93	7.49	8.00	6.09	7.55
Composite	208.11	209.86	214.02	215.88	215.78	219.77	217.89
	26.95	22.47	21.17	21.06	21.21	17.96	20.50
Working Alliance Inventory (Therapist Form)							
Goal	63.53	65.19	66.91	68.23	68.19	66.96	70.17
	8.66	9.03	8.09	7.83	9.37	8.12	7.81
Task	65.58	67.07	67.70	68.95	68.48	67.00	69.57
	7.37	8.20	7.63	6.77	8.77	6.66	8.43
Bond	67.91	70.09	71.63	71.77	72.31	72.12	73.36
	7.17	7.62	5.85	7.25	7.36	5.88	6.25
Composite	197.02	202.35	206.23	208.95	208.98	206.08	213.10
	21.29	23.44	20.35	20.64	24.31	19.28	21.48
Client Involvement (Client Form)							
Participat'n	12.61	12.65	12.41	12.61	12.49	12.69	12.21
	1.78	1.51	1.58	1.50	1.91	1.19	1.62
Responsib'ty	12.89	12.67	12.59	12.86	12.83	12.92	12.61
	1.69	1.48	1.45	1.37	1.45	1.09	1.22
Collaborat'n	12.30	12.19	12.11	12.21	12.05	12.35	12.09
	2.05	1.93	1.60	1.81	2.02	1.41	1.64
Composite	37.73	37.51	37.11	37.67	37.37	37.96	37.91
	5.03	4.51	4.35	4.42	5.10	3.41	4.19
Client Involvement (Therapist Form)							
Participat'n	11.37	11.67	11.84	12.09	11.86	11.88	11.88
	1.81	1.99	1.94	1.53	1.95	1.64	1.69
Responsib'ty	10.91	11.44	11.51	11.70	11.79	11.36	11.76
	1.99	2.11	1.83	1.78	2.08	2.16	2.08
Collaborat'n	10.88	11.40	11.58	11.84	11.57	11.48	11.62
	1.98	1.95	1.65	1.76	1.64	1.83	2.11
Composite	33.16	34.51	34.93	35.63	35.21	34.72	35.24
	5.35	5.89	5.14	4.81	6.11	5.47	5.75

Table 21 (Cont'd.)

	Session						
	#1	#2	#3	#4	#5	#10	Final
Relationship Inventory (Empathy subscale)			75.21 9.30				
Counselor Rating Form							
Expertness			74.91 7.32				
Attractiveness			72.91 7.27				
Trustworthiness			78.05 6.32				
Composite			225.86 19.57				
Helping Alliance Questionnaire							
HA Type 1			41.32 4.68				
HA Type 1			13.83 1.96				
Composite			55.15 6.18				

Table 22 - Reliability Estimates of the Instruments

	Hoyt's Coefficient	Cronbach's Alpha
Relationship Measures		
Working Alliance Inventory (Client Form)		
Goal	.87 (.84 to .89) [1]	.91 (.85 to .92)
Task	.87 (.77 to .90)	
Bond	.81 (.75 to .85)	
Working Alliance Inventory (Therapist Form)		
Goal	.92 (.88 to .95)	.94 (.90 to .94)
Task	.91 (.84 to .93)	
Bond	.82 (.72 to .88)	
Client Involvement (Client Form)		
Participation	.79 (.68 to .85)	.92 (.89 to .93)
Responsibility	.72 (.51 to .84)	
Collaboration	.85 (.73 to .89)	
Client Involvement (Therapist Form)		
Participation	.80 (.74 to .87)	.96 (.92 to .97)
Responsibility	.88 (.83 to .94)	
Collaboration	.92 (.86 to .98)	
Relationship Inventory (Empathy subscale)	.81	N/A
Counselor Rating Form		
Expertness	.84	.88
Attractiveness	.80	
Trustworthiness	.82	
Helping Alliance Questionnaire		
HA Type 1	.84	.61
HA Type 2	.71	

[1] The median figure and the range are reported for the repeated measures.

Table 22 (Cont'd.)

	Hoyt's Coefficient		Cronbach's Alpha	
Outcome Measures				
Target Complaints	N/A		N/A	
Symptom Checklist-90				
Somatization	.81/.84 [2]		.94/.95	
Obsessive-Compulsive	.81/.86			
Interpersonal Sensitivity	.75/.82			
Depression	.85/.86			
Anxiety	.77/.86			
Hostility	.66/.58			
Phobic Anxiety	.64/.84			
Paranoid Ideation	.65/.82			
Psychoticism	.75/.81			
Self-Esteem Index	.90/.87			
Inventory of Interpersonal Problems				
Hard to be Intimate	.78/.83		.87/.87	
Hard to be Assertive	.87/.90			
Hard to be Independent	.75/.75			
Hard to be Sociable	.87/.89			
Hard to feel Self-Worth	.57/.48			
Hard to be Supportive	.70/.60			
Hard to be Aggressive	.67/.74			
Too Giving	.70/.80			
Too Aggressive	.85/.83			
Too Hypersensitive	.81/.91			
Too Eager to Please	.75/.86			
Too Dependent	.88/.83			
Strupp Posttherapy Questionnaire		**S.D.** [3]		**S.D.**
Satisfaction	.25	.69	.70	.58
Change	.62	.72		
Adjustment	.74	.82		
Therapist Posttherapy Questionnaire				
Satisfaction	.66	.89	.77	.74
Change	.85	.78		
Adjustment	.87	.90		

[2] Pretest/posttest coefficients.

[3] Means are not reported for the SPQ and for the TPQ because the number of possible responses per item varied on these instruments and, hence, item scores were standardized before subscale scores were computed.

APPENDIX 24 - DEMOGRAPHIC ANALYSIS OF THE SAMPLE

Therapists: In order to describe the sample, the therapists have been categorized in various ways from the demographic data that they provided at the end of their engagements (Appendix 18). These categorizations are presented in Table 23.

Table 23 - Categorization of Therapists

Professional affiliation	Registered Psychologists	2
	Unregistered Psychologists	1
	Social Workers	9
	Counsellors	23
Highest degree completed	Ph.D.	3
	M.S.W.	5
	B.S.W.	4
	M.A./M.Ed.	17
	B.A.	6
Experience as a therapist	More than 15 years	3
	11-15 years	6
	6-10 years	7
	1-5 years	18
	Less than 1 year	1
Theoretical orientation (with this client)	Analytic [1]	4
	Learning	3
	Humanistic	37
Gender	Female	21
	Male	14

[1] Gelso and Carter (1985) have defined the three orientations as follows:

Analytic: Approaches that place a premium on making the unconscious conscious and that at least use Freudian personality theory as a basic starting point.

Learning: Approaches based on or highly compatible with principles of classical or instrumental conditioning, and, most recently, cognitive mediational process.

Humanistic: The perspective that pays greatest attention to the client's (and the therapist's) "here-and-now" functioning, to the client's inherent trustworthiness and capacity for actualization. (pp. 196-197)

Clients: The clients have also been categorized in various ways as presented in Table 24 from the data they provided at the beginning of their therapies (Appendix 5).

Table 24 - Categorization of Clients

Age	18-25 years	11
	26-35 years	18
	36-45 years	9
	Over 45 years	6
Gender	Female	29
	Male	15
Marital Status	Single	17
	Married	13
	Divorced	14
Education Level	Some high school	4
	High school graduates	5
	Some college	15
	College graduates	10
	Some graduate studies	10

Thirty-three of the therapeutic dyads were same-gender, (i.e., client and therapist both female or both male), and 11 were cross-gender.

Although precise information was not collected on the number of sessions constituting each case, it was estimated that they ranged from 6 to 25 sessions and in duration from six weeks to seven months. The average number of sessions per case was estimated to be 12.

APPENDIX 25 - ESTABLISHMENT OF THE ALLIANCE THROUGH EARLY SESSIONS

It has been hypothesized that the alliance is established by approximately the third to fifth session (Horvath & Greenberg, 1986).

In order to test this hypothesis, the first five repeated measures of the WAIc were correlated with one another. The data presented in Table 25 suggested that the alliance did indeed become more stable from Session 3 on.

Table 25 - Intercorrelations of the WAIc at the First Five Sessions

	Session				
	#1	#2	#3	#4	#5
Session 1	--				
Session 2	.71	--			
Session 3	.55	.78	--		
Session 4	.61	.79	.86	--	
Session 5	.52	.73	.80	.81	--

The present study, therefore, has employed as its measure of the alliance the average of the third, fourth, and fifth session measures.

APPENDIX 26 - MAGNITUDE OF CHANGE ON THE OUTCOME MEASURES

Analyses of the magnitude of change from pretest to posttest on the Symptom Checklist-90 and the Inventory of Interpersonal Problems were performed as repeated measures (i.e., pretest and posttest) MANOVAs using SPSS:X. The results are presented in Table 26.

Table 26 - Magnitude of Change on Symptom Checklist-90 and Inventory of Interpersonal Problems

	N of Items	Mean	S.D.	F [1] [2]
Symptom Checklist-90				
Somatization-pre	12	9.03	8.46	
-post		5.68	6.50	8.39**
Obsessive-Compulsive-pre	10	16.92	7.98	
-post		8.66	6.77	45.54***
Interpersonal Sensitivity-pre	9	13.90	6.95	
-post		8.88	6.42	26.36***
Depression-pre	13	25.53	11.01	
-post		12.78	8.95	46.87***
Anxiety-pre	10	13.53	7.30	
-post		8.43	7.48	19.84***
Hostility-pre	6	6.05	5.45	
-post		3.52	4.29	20.73***
Phobic Anxiety-pre	7	3.45	4.06	
-post		2.15	3.36	6.54*
Paranoid Ideation-pre	6	7.07	4.60	
-post		4.09	4.25	25.13***
Psychoticism-pre	10	8.75	6.99	
-post		4.56	6.12	21.34***
SCL-90 Total-pre	90	114.50	54.26 [3]	
-post		64.82	50.30	4.90***

[1] Univariate F-tests are reported for the subscales. Hotellings (1951) multivariate test of significance is reported for the scale totals.

[2] The standard error of the pair difference, (i.e., the pooled within-groups S.D. divided by the square root of n), was employed in computing the F-value.

[3] The mean total pathology prescore of 1.27 (S.D.=.60) is almost identical to the prescore of 1.25 (S.D.=.39) reported by Derogatis, Rickels, and Rock (1976) in their validation study of the SCL-90.

Table 26 (Cont'd.)

	N of Items	Mean	S.D.	F
Inventory of Interpersonal Problems				
Hard to be Intimate-pre	11	15.28	8.00	
-post		10.61	7.18	25.39***
Hard to be Assertive-pre	17	36.31	11.83	
-post		30.70	13.57	15.18***
Hard to be Independent-pre	9	16.66	6.44	
-post		13.09	5.89	21.31***
Hard to be Sociable-pre	11	40.98	8.12	
-post		12.01	8.39	1148.48***
Hard to feel Self-Worth-pre	6	9.80	4.91	
-post		8.31	3.98	6.39*
Hard to be Supportive-pre	11	13.34	6.60	
-post		9.97	6.58	17.74***
Hard to be Aggressive-pre	5	10.15	4.15	
-post		8.77	4.87	6.49*
Too Giving-pre	6	7.91	4.65	
-post		6.99	4.75	2.86
Too Aggressive-pre	13	14.88	8.84	
-post		11.72	8.55	8.57**
Too Hypersensitive-pre	10	17.56	8.53	
-post		14.19	8.94	13.72***
Too Eager to Please-pre	10	18.16	8.94	
-post		15.03	7.58	10.50**
Too Dependent-pre	9	15.56	6.45	
-post		12.05	6.52	17.36***
Total IIP-pre	127	231.51	67.84	
-post		164.68	72.93	178.37***

* Significant difference, $p \leq .05$
** Significant difference, $p \leq .01$
*** Significant difference, $p \leq .001$