THE THERAPEUTIC RELATIONSHIP AND ITS ASSOCIATION WITH OUTCOME

by

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We accept this thesis as conforming
to the required standard

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Abstract

This study investigated the association between general relationship factors and outcome in short term counselling. Twenty five clients who were seeking counselling at various settings in the lower mainland of British Columbia completed instruments that were designed to quantify aspects of their relationship with the therapist. Three models of the therapeutic relationship were examined: Strong's social influence theory; Roger's core conditions; and Bordin's working alliance. It was hypothesized that the three dimensions of Bordin's Working Alliance (bond, task, and goal) would correlate significantly with four outcome measures. Two of the outcome measures utilized did not correlate with any of the relationship variables. Task and Bond correlated significantly (p<.01 and p<.05 respectively) with two indices of outcome and Goal had a significant relationship (p<.05) with one of the outcome measures. Of the other four relationship variables that were included in this study, only the social influence variable of client perceived counsellor attractiveness correlated with outcome measures beyond chance levels.
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Chapter I
Introduction and Rationale

BACKGROUND OF THE PROBLEM

Psychotherapy is a very complex phenomena and there are many unanswered questions concerning the process of client change. Some theorists believe that therapeutic effects are mainly the result of specific techniques employed by the therapist. Another group of theorists believe that the effects of therapy can be traced to certain general process factors that are effective between client and therapist over the course of treatment.

'Specific factor' approaches look for particular therapeutic techniques that can best account for therapeutic outcome. A large body of research in psychotherapy has been generated by proponents of various 'schools' of therapy each attempting to demonstrate that the techniques generated from their philosophy are best able to effect therapeutic success. This approach has been complicated by the fact that similar beneficial therapeutic gains have been associated with a great variety of therapeutic strategies each with its own set of techniques. Furthermore, in real life counselling therapists will often eclectically mix and modify a variety of therapeutic strategies to best suit their client. It is acknowledged that specific factor research can contribute a great deal to an understanding of psychotherapy but the fact remains that researchers have not successfully isolated these factors.
Psychotherapeutic change can also be conceptualized from a more global point of view where the focus is on key factors that are common to therapeutic situations in general. These factors are thought to be inherent to all helping relationships. Whereas the specific factor approach tends to compare one form of therapy with another, the general factor approach focuses on the qualities of the psychotherapeutic relationship, in order to discover the means through which constructive therapeutic change occurs. The main problem in general factor research is developing a systematic theory that adequately describes the process of helping. In the past two decades, several investigators have developed theoretical frameworks that emphasize general factors in the process of psychotherapy and this study will focus on three prevailing formulations.

One of the best known counselling models was presented by Rogers (1957, 1967). He postulated that three conditions - empathy, genuineness, and unconditional positive regard - were necessary and sufficient to produce therapeutic effects. In other words, therapeutic change will occur to the degree that the client experiences these qualities in the therapist. Rogers work has stimulated a great deal of research in the last three decades. In an extensive review of the literature, Gurman (1977) concluded that there is a relationship between client perceived therapeutic conditions and outcome in therapy.

Strong's (1968) Social Influence model of psychotherapy has also stimulated a large body of research. This model stems from
attitude change research in social psychology and essentially views psychotherapy as an interpersonal attitude change process. The therapist is likened to a communicator who has a discrepant message to convey to an audience. Extrapolating from the work of Hovland, Janis, and Kelly (1953), Strong postulated that the extent to which counsellors are perceived as attractive, expert, and trustworthy, the less likely the client will be able to discredit the counsellor's message. More specifically, Strong stated that clients who perceive high levels of counsellor expertness, attractiveness and trustworthiness will be more likely to react to counsellor influence attempts and thus to experience successful therapeutic outcomes.

Another general factor theorist, Bordin (1979), has reformulated the concept of the Therapeutic Working Alliance, which focuses on specific components of the relationship between therapist and client. He suggests that any therapeutic relationship can be viewed in terms of three essential components: the personal bond between client and therapist; a common understanding regarding the relevance of the tasks undertaken in therapy; and an agreement on therapeutic goals. Each psychotherapeutic relationship will differ somewhat in composition of bonds, tasks and goals but all successful therapies will have a strong alliance and thus outcome can be associated with these three dimensions.

Each of the aforementioned models of therapy focus on the relationship between client and therapist as the basis for
therapeutic change. Bordin's Working Alliance conceptualization appears to offer a more comprehensive view of the psychotherapeutic relationship than those of Rogers or Strong. His model encompasses an interactional component between client and therapist whereas Rogers and Strong focus only on the qualities of the therapist. Furthermore, it seems logically evident that any productive relationship will devote some consideration to the delineation of goals and the formulation of tasks which will facilitate accomplishment of those goals.

STATEMENT OF THE PROBLEM

The aim of this study is to examine the relationship between the so-called general factors and therapeutic outcome. More specifically, are the variables generated by the theories of Rogers, Strong, and Bordin correlated with outcome and if so, which ones are most useful in predicting outcome variance? Can the variables from the Working Alliance model (Bond, Task, and Goal), which incorporate reciprocal aspects between therapist and client, better account for outcome variance than the variables generated from the models of Rogers and Strong (Empathy, Attractiveness, Expertness, and Trustworthiness)?

Part of this study will attempt to replicate some of the findings reported by Horvath, 1981. As part of his study, Horvath examined the relationship of the seven aforementioned process variables to outcome. He reported that the Task dimension of the Working Alliance was correlated with the composite score of the outcome measure beyond chance levels at
the p<.05 level of significance. In order to more fully explore the relationship between the general factors and outcome, he computed a multiple stepwise regression equation with the composite outcome measure as the dependent variable and general process measures as independent (predictor) variables. He suggested that the Task component of the working alliance might be the most efficient predictor of client reported outcome in short term therapy. Goal and Attractiveness also entered the regression equation at the p<.05 level of significance after the effects due to Task had been removed.

Whereas Horvath's study used a client perceived retrospective survey, the Strupp Posttherapy Questionnaire (Strupp, Wallach, & Wogan, 1964) to measure outcome, the present study will more thoroughly explore the relationship between outcome and the general variables by utilizing three additional measures of outcome: Target Complaints (Battle et. al., 1966); State Trait Anxiety Inventory (Spielberger et. al., 1970); and the Tennessee Self Concept Scale (Fitt, 1965). The Target Complaints (TC) was used to get the client's rating of improvement on concerns that he or she presented at the beginning of treatment. The Tennessee Self Concept Scale (TSC) and State Trait Anxiety Inventory (STAI) were administered twice in an attempt to measure change of 'state' anxiety and self concept over the course of therapeutic treatment.
HYPOTHESES

In the hypotheses that follow, subheadings marked 'a' will be replications of procedures in Horvath's study and 'b','c', and 'd' will be extensions of his research. Statements of statistical significance will assume the p<.05 level unless qualified.

1. The first set of hypotheses is concerned with the relationship between the variable of Task, as measured by the Working Alliance Inventory (Horvath, 1981) and therapeutic outcome:
   
a. Task will correlate significantly with therapeutic outcome as measured by the Strupp Posttherapy Questionnaire (SPQ) composite score.
   
b. Task will correlate significantly with therapeutic outcome as measured by the Target Complaints (TC).
   
c. Task will correlate significantly with therapeutic outcome as measured by the residual change in state anxiety between posttest and pretest on the STAI.
   
d. Task will correlate significantly with therapeutic outcome as measured by the residual change in self concept between posttest and pretest on the TSC.
2. The next set of hypotheses is concerned with the relationship between the variable of Goal, as measured by the WAI, and therapeutic outcome:
   a. Goal will correlate significantly with therapeutic outcome as measured by the SPQ composite score.
   b. Goal will correlate significantly with therapeutic outcome as measured by the TC.
   c. Goal will correlate significantly with therapeutic outcome as measured by the residual change in state anxiety between posttest and pretest on the STAI.
   d. Goal will correlate significantly with therapeutic outcome as measured by the residual change in self concept between posttest and pretest on the TSC.

3. The last set of hypotheses is concerned with the relationship between the variable of Bond, as measured by the WAI, and therapeutic outcome:
   a. Bond will correlate significantly with therapeutic outcome as measured by the SPQ composite score.
   b. Bond will correlate significantly with therapeutic outcome as measured by the TC.
   c. Bond will correlate significantly with therapeutic outcome as measured by the residual change in state anxiety between posttest and pretest on the STAI.
   d. Bond will correlate significantly with therapeutic outcome as measured by the residual change in self concept between posttest and pretest on the TSC.
In addition to these hypotheses this study will explore several research questions. What are the relationships between the predictor variables? How do the social influence and core condition variables relate to outcome? How does pretherapy trait anxiety relate with outcome? Which relationship variable is the most efficient predictor of outcome variance for each outcome measure and can any of the other predictors account for outcome variance after the effects due to the primary predictor have been removed?

DEFINITION OF TERMS

Therapist: An individual who is skilled in a method of treatment that is designed to alleviate a client's psychological stress. Therapists in this study were either: doctoral level Psychologists; advanced Masters level students; or employed counsellors.

Client: A nonpsychotic person over the age of 18 who is undergoing treatment with a therapist to relieve psychological stress.

Working Alliance: A close association between client and therapist that is formed to relieve the client's psychological distress. Bordin's working alliance consists of three functional components: personal bonds between client and therapist; shared agreement on therapeutic goals; and shared understanding that the tasks demanded of each of them are reasonable and relevant to the client's difficulties.
Empathy: Empathy is defined as:

'The extent to which one person is conscious of the immediate awareness of another ... It is an active process of desiring to know the full present and changing awareness of another person, of reaching out to receive his communication and meaning that at least those aspects of his awareness that are most important to him at the moment. It is an experiencing of the consciousness "behind" another's outward communication (Rogers et al., 1967, p.103).

Perceived Expertness: Perceived expertness has been defined as the "client's belief that the counsellor possesses information and means of interpreting information which allows the client to obtain valid conclusions about and to deal effectively with his or her problems" (Strong and Dixon, 1971, p.562).

Perceived Attractiveness: A counsellor is perceived as attractive when the client experiences liking, admiration and compatibility for him or her; desire for approval from him or her and desire to be more similar to him or her (Schmidt and Strong, 1971).

Perceived Trustworthiness: A client perceives a counsellor as trustworthy if he believes him to be sincere, open and without motive for personal gain (Barak and Lacrosse, 1975).

SIGNIFICANCE OF THE STUDY

The general factor approach in psychotherapeutic research warrants closer examination. Recent studies have indicated that the interaction between client and therapist in early treatment sessions may have predictive value for therapeutic outcome (Morgan et. al., 1982; Heppner and Heesacker, 1983). Bordin's Working Alliance model provides a framework for studying this
interaction and offers variables that can be quantified. This study attempted to empirically examine Bordin's conceptualization.

If a simple, empirical measure of the Working Alliance can be proven to be valid, the implications are wide ranging. Most importantly, the process of psychotherapy would be better understood and outcome for any given therapeutic relationship could be predicted at an early stage of therapy regardless of the therapist's particular theoretical orientation. The Working Alliance model offers a more comprehensive view of the process of therapy; it offers a way of conceptualizing the client's input into the therapy whereas other general factor models focus on the therapist's contribution.

If the findings from Horvath's study are supported, and the variables generated by the Working Alliance (bond, task, and goal) are important therapy prognosticators, therapists would be able to have early, easily obtained, information about the types of approaches that would increase of probability of therapeutic gain for the client. Programs for counsellor training could also use this information to facilitate instruction of individuals who are planning to enter the helping profession.
Chapter II
Review of the Literature

GENERAL VERSUS SPECIFIC FACTORS IN PSYCHOTHERAPY

Eysenck's (1952) often quoted challenge that psychotherapy may not be more effective than chance remission has stimulated a large body of research on therapeutic outcomes. If one could draw a generalized finding from the therapeutic research that has been done, the most that one could say would be that all forms of psychotherapy are somewhat more effective than no planned help (Frank, 1979; Smith and Glass, 1977). Assuming that this reasonably established generalization is true, the question arises as to which elements of therapy can most account for positive outcomes.

One way to approach the question therapeutic effectiveness is to examine specific therapist behaviors or therapy situations and attempt to discover factors that are vital to successful outcomes. Studies of this nature attempt to control for all the variables in the design except for the ones being examined. Often specific techniques from one therapeutic approach will be compared to the techniques from other approaches.

The major difficulty with the single factor approach is that psychotherapy is a complex phenomena and the task of isolating and measuring specific, independent variables in any given therapeutic approach can be an extremely difficult, if not impossible, task. In order to prove the efficacy of a specific
psychotherapeutic technique, control procedures would have to be developed that would rule out nonspecific treatment effects such as expectancy for improvement or faith in the efficacy of psychotherapy (Kazdin and Wilcoxin, 1976). Even if a specific factor was determined, it would not help to explain the findings that similar gains have resulted from a wide variety of therapeutic approaches (Luborsky, Singer, & Luborsky, 1975; Smith and Glass, 1977). It may be that research methods and instruments currently being employed in outcome research are not yet refined enough, but the fact remains that there is no conclusive evidence that specific therapeutic ingredients can be causally linked to therapeutic change (Kazdin and Wilcoxin, 1976; Strupp and Hadley, 1979).

A number of theorists have been working for a number of years on an alternative approach to psychotherapeutic research (Bordin, 1979; Frank, 1972; Rogers, 1951, 1957; Strupp, 1978). Their aim is to delineate common elements in therapeutic behaviors or situations and then attempt to link these factors with therapeutic outcomes. Using this approach, researchers must first formulate a conceptual framework for psychotherapy that will enable them to define the general variables that are expected to influence outcome. Once these variables have been defined and ways have been found to quantify them in the context of a variety of therapeutic settings, an attempt can be made to relate them to variability in therapeutic success. A description of three such conceptualizations will be presented in the next sections.
THERAPIST-OFFERED FACILITATIVE CONDITIONS

Rogers (1951, 1957) was one of the first theoreticians to present a conceptual framework for psychotherapy that incorporated general process variables which could be defined in functional terms. He stated that three conditions—empathy, genuineness, and unconditional positive regard—were necessary and sufficient to produce constructive personality change. In this model, the therapist's primary task is to provide an atmosphere where the client can experience these core conditions. It is assumed that each individual has the inherent capacity to move towards a state of psychological health and the primary responsibility for the direction of therapy is placed on the client.

In the present study, empathy was chosen for examination because it appeared to be the most studied and best understood of the core conditions. It has been shown that empathy is strongly correlated with the other core conditions which suggests that a therapist who conveys empathy is also expressing the other two conditions (Gurman, 1977; Mitchell, Bozarth, and Krauft, 1977). In a review of 23 studies using client perceived empathy as a process variable, Gurman (1977) reported that there was substantial evidence supporting the relationship between client perceived core conditions and outcome. Rogers defined empathy as:

"The ability of the therapist (to) accurately and sensitively understand experiences and feelings and their meaning to the client during the moment to moment encounter of psychotherapy...The ability and sensitivity required to communicate these inner meanings back to the client in a
way that allows these experiences to be 'his'... (Rogers et. al., 1967, pp. 104-105).

Empathy can be measured from three points of view: the therapist's; the client's; and from that of an independent observer. Logically, it seems evident that the client is ultimately the most competent judge of whether or not he or she experienced the empathy of the therapist. It follows from this that the client's experience of the therapeutic relationship will be most crucially related to outcome.

The Relationship Inventory (RI), developed by Barrett-Lennard (1962), has been used to measure the client's perception of the core conditions (Gurman, 1977). It consists of 64 items, 16 of which reflect the client's experience of therapist empathy. The psychometric properties have been summarized by Gurman (1977) and found to be satisfactory.

SOCIAL INFLUENCE MODEL OF PSYCHOTHERAPY

Jerome Frank (1961) was one of the first theoreticians to focus on the social influence elements in the realm of psychotherapy when he wrote about the role of persuasion in widely divergent approaches to helping. He suggested that psychotherapy is a process wherein the therapist exerts his socially derived influence or power to help the client move towards psychological health. Goldstein (1966) elaborated on this theme by extrapolating research findings from social psychology to counselling psychology. These findings suggested that a communicator's ability to induce attitude change depended
on his capacity to convey credibility (expertness and trustworthiness) and attractiveness (Hovland, Janis & Kelly, 1953).

Expanding on Goldstein's idea, Strong (1968) has developed a model of psychotherapy which hypothesizes that the therapist can be likened to an opinion changer and that his influence is related to the client's perception of his or her attractiveness, expertness, and trustworthiness. He suggested that this interpersonal influence process occurs in two phases. In the first phase the therapist establishes a power base with client and in the second phase the counsellor draws on this power base to help the client change toward more constructive ways of thinking and acting. Once a client has become involved in therapy, the probability of therapeutic change will be maximized when the therapist is perceived as attractive, expert, and trustworthy.

In order to measure the social influence variables suggested by Strong, Barak and LaCrosse (1975) have developed the Counselor Rating Form (CRF) which yields scores on each of the aforementioned three dimensions as perceived by the client. Three therapists (each representing different therapeutic viewpoints) were rated on 36 bipolar scales and the subsequent factor analysis supported the hypothesis that the three dimensions could be measured. The reliability of the CRF has been supported in analog counselling studies (see Corrigan et. al., 1980 for a comprehensive review).

LaCrosse (1980) used the CRF to test the effect of the
social influence variables on psychotherapeutic outcome in a field setting with clients at a drug abuse clinic. In this study, the CRF and Goal Attainment Scaling (GAS) was used to obtain pre and postcounselling scores for 36 clients who were seeking help with drug abuse problems. A regression analysis was done and it was found the CRF variables accounted for 35% of the outcome variance as measured by GAS. Of the variables studied, initial perceived expertness was the most powerful outcome predictor (accounting for 31% of the total outcome variance).

Heppner and Heesacker (1983) examined the relationship between the social influence variables and client satisfaction within real life counselling. In this study, 72 clients at a university counselling centre completed the Counseling Evaluation Inventory (CEI) and the CRF after several weeks in therapy. The results indicated that client perceptions of attractiveness, expertness, and trustworthiness were correlated with client satisfaction. In the subsequent regression analysis, expertness was the best predictor of the CEI scores.

WORKING ALLIANCE MODEL

Although the concept of the therapeutic working alliance stems back to (Freud, 1913), it has only been in recent years that researchers have attempted to utilize the concept to generate general process variables. Greenson (1965) was one of the first authors to suggest that the working alliance was a quality that was crafted by the therapist, as opposed to an
accidental byproduct of the therapeutic relationship. He suggested that a mutually positive regard between client and therapist is an important component of the alliance but is not sufficient, in itself, to achieve the aims of therapy. The therapist must also be constantly attuned to the dyadic processes that are occurring with the client and endeavor to ensure that he and the client are working together in constructive ways to reach psychotherapeutic goals. In the last few years, several investigators have attempted to relate the working alliance to psychotherapeutic outcome (Luborsky, 1976; Strupp, 1974). These early investigations were limited by the lack of clarity in the definition of working alliance and the subsequent difficulty in quantifying it.

A major effort to relate components of the therapeutic alliance to outcome has been undertaken by members of the Penn Psychotherapy Project. In recent years this group has been developing measures which utilize independent raters to quantify the helping alliance concept. Two types of scales, based on clients' statements, have been developed: Type 1 refers to indications that the client is receiving help or experiencing a helpful attitude from the therapist and Type 2 refers to indications that the client and therapist are working in a joint effort to help the client.

In a recent study (Morgan, Luborsky, Crits-Christoph, Curtis & Solomon, 1982), ten most improved and ten least improved clients (of 73 in an outpatient clinic) who experienced at least 25 psychoanalytically oriented therapy sessions were
rated over four 20 minute intervals during sessions at the beginning and at the end of therapy. It was reported that significant correlations (ranging from .44 to .58) were found between alliance ratings and the outcome measures.

Bordin (1976, 1979) has also offered a promising definition of the working alliance. He postulated that the alliance in psychotherapy has three functional components: the personal bonds between client and therapist; therapeutic goals that are formed by mutual agreement; and the development of tasks that are perceived by the client to be relevant to his (her) difficulties.

Bordin suggested that all successful therapies will have strong alliances although the emphasis on the three factors will vary depending on the particular therapeutic approach that is being employed. If Bordin's view of the working alliance is valid, it should be possible to demonstrate a strong relationship between the three dimensions and psychotherapeutic outcome.

Horvath (1981) has recently developed an instrument to measure the working alliance as defined by Bordin. The Working Alliance Inventory (WAI) was developed on the basis of results from an analogue pilot study and a field study with real clients. It consists of 36 bipolar items which give scores for each of the client perceived dimensions of Bordin's working alliance. Early indications were that the WAI appeared to have acceptable psychometric properties.

Horvath also examined the relationship of the Working
Alliance to outcome. In that study, the WAI along with the CRF (LaCrosse, 1977) and the RI (Barrett-Lennard, 1962) were administered in the third session to real life clients who were participating in a variety of therapies in the lower mainland of British Columbia. A retrospective outcome measure was completed after ten sessions and it was reported that the Task dimension of the Working Alliance correlated significantly with most of the outcome scales while Bond and Goal correlated with some of the outcome indicators.

Horvath also did a multiple regression analysis using the general process variables of Empathy, Trustworthiness, Expertness, Attractiveness, Bond, Task, and Goal to predict therapeutic outcome. The results of his analysis suggested that the Task variable of Bordin's model may be the most efficient therapy outcome prognosticator.

COMPARISON AND CONTRAST BETWEEN THE CONCEPTS OF THE WORKING ALLIANCE, THERAPIST-OFFERED FACILITATIVE CONDITIONS, AND SOCIAL INFLUENCE THEORY

The aforementioned conceptualizations all agree that there are general factors in psychotherapy and that the qualities of the relationship between client and therapist are related to outcomes.

The Rogerian approach assumes that client change is initiated by being exposed to a therapist with the qualities of empathy, genuineness, and unconditional positive regard. Strong's conceptualization assumes that clients change because of the therapist's influence or power - the power base being
established by the client's perception of the therapist's trustworthiness, attractiveness, and expertness. Bordin suggests that potential client change is maximized when there is a good 'fit' between the client, therapist, and the nature of the tasks that both client and counsellor believe to be appropriate to the goals that are decided upon in therapy.

Rogers and Strong focus on qualities offered by the therapist whereas Bordin's working alliance emphasizes the interaction between client and therapist. The salient qualities offered by the therapists are different in Rogers' and Strong's models. In Roger's model the therapist's role is to be without roles; he is nonjudgemental and demonstrates unconditional acceptance. He functions, essentially, to provide an environment wherein the client is able to explore aspects of his personal world that are now either denied or distorted.

In Strong's model, the therapist establishes a definite role in order to create an influence base to help the client change maladaptive attitudes and actions. Outcome depends on how well the therapist is able to convey trustworthiness, expertness and attractiveness.

Bordin's model does not specify the necessity of any particular role for the therapist. It is assumed that different therapeutic situations will place different demands on client and therapist. Regardless of these differences, however, the common elements of bond, task, and goal must exist if therapy is to be effective.
Chapter III
Methodology

SAMPLE

The sample for this study was drawn from a population of clients, eighteen years or older, who were seeking individual, verbally oriented, short term psychotherapeutic help in the lower mainland of British Columbia. Clients who were currently using prescribed psychoactive medications were excluded from the study.

The researcher approached agencies and individual counsellors in the Lower Mainland of British Columbia to ask for their cooperation with the study. Therapists were given general information about the study and its requirements but did not receive particulars about the hypotheses. Those therapists who were willing to cooperate were asked to approach new clients in the first session and solicit their participation in the study. If the client agreed to participate, he or she was asked by the therapist to fill out the first battery of instruments immediately after the first session. Participants were assured of anonymity and advised of their right to withdraw at any time without jeopardizing treatment. They were told that the purpose of the study was to examine the therapeutic relationship but no information was given about the process variables that were be measured. A participant's data was not included in the analysis if they discontinued therapy before the seventh session. If the
client was still in treatment after fourteen sessions, the posttest was administered after that session. Samples of the instructions to the therapist and information given to the client are included in Appendix A.

PROCEDURE

This study had three data collection points. When therapy began the client was asked to complete a battery of pretest questionnaires. This battery consisted of: Spielberger State Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970); Tennessee Self Concept Scale (Fitt, 1965); and Target Complaints (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966). The first two questionnaires were selected on the basis of the assumption that state anxiety and self concept would be expected to change as the client progressed in psychotherapy. The Target Complaints was administered so that a record of the concerns that the client hoped to resolve would be available at the end of therapy.

Immediately after the third session, the clients were asked to complete a second battery of tests which were selected to measure the relationship variables that were included in this study. This battery consisted of: the Relationship Inventory (Barrett-Lennard, 1962); the Counselor Rating Form (Barak and LaCrosse, 1975); and the Working Alliance Inventory (Horvath, 1981).

After termination of therapy or the fourteenth session, whichever came first, the clients were asked to fill out the
same battery of tests given out in the pretest situation plus two additional instruments. The Strupp Posttherapy Questionnaire (Strupp, Wallach, and Wogan, 1964) is a posttherapy evaluation instrument that is designed to measure client perceived change. A scale for the Target Complaints was also included so that clients could rate improvement on concerns that they had presented at the beginning of treatment.

All the materials were completed privately and sealed in individual envelopes for return to the investigator. Clients were advised that their therapists did not have access to their responses on the questionnaires. Following is a summary of tests administered in each session:

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<th>Session 1 Pretest</th>
<th>Session 3 Relationship Measures</th>
<th>Last or Session 14 Posttest</th>
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<td>-Empathy</td>
<td>Tennessee Self Con.</td>
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<td>Target Complaints</td>
<td>Counselor Rating Form</td>
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</table>
DATA ANALYSIS

In this study, two types of therapy outcome measures were utilized. Self concept and state anxiety were measured twice, pre and post therapy. Changes in scores were treated as indices of therapeutic outcome. In order to eliminate the statistical dependence of the raw change scores on the pretest scores for any given client, residual gain scores were calculated for each of these traits (Linn and Slinde, 1977). Residualizing the gain scores has the effect of identifying individuals whose scores changed more than expected. The other type of outcome measures yielded a single score which represented the client's view of treatment effectiveness at posttest.

The general relationship variables that were measured after the third session (empathy, expertness, attractiveness, trustworthiness, bond, task and goal) were correlated with each of the therapeutic outcome measures yielding Pearson's product-moment correlation coefficients.

In addition, stepwise multiple regression equations were calculated using the seven relationship measures as independent (predictor) variables and the outcome measures as dependent variables. In this type of procedure, the independent variable with the highest zero order correlation with the dependent variable is entered into the regression on the first step. If any of the other predictors can account for a 'significant' portion of the variance of the dependent variable after the effects due to the first variable is removed, the next most efficient predictor is entered into the equation. This process
is repeated until none of the remaining predictors can account for significant, unique outcome variance.

INSTRUMENTATION

State-Trait Anxiety Inventory (STAI)

The STAI purports to measure two types of anxiety (Spielberger, Gorsuch, Lushene, 1970). The first twenty items assess 'state' anxiety which is viewed as changing with the immediate condition of perceived tension. The second twenty items measure 'trait' anxiety which is considered to be a more stable condition of anxiety proneness that tends to be characteristic of the individual. Each item has four response options and items were coded so that high scores represent greater levels of anxiety. Scores range from a minimum of 20 to a maximum of 80 on both scales.

In the STAI manual, test-retest reliabilities for state and trait anxiety are reported separately for males and females. Over an one hour interval, reliability coefficients were quoted as .33 (males) and .16 (females) for state, and .84 and .76 respectively for trait. At twenty days, coefficients were .54 and .27 for state verses .86 and .76 for trait. After 104 days reliabilities were .33 and .31 for state and .73 and .77 for trait. Construct validity for trait scores were obtained by correlating trait scores with the IPAT Anxiety Scale, Manifest Anxiety Scale and Affect Adjective Checklist. The coefficients for a group of 125 college women were .75, .80, and .52
respectively (Spielberger et al., 1970).

Tennessee Self Concept Questionnaire (TSC)

The TSC (Fitt, 1965) is a widely used, 100 item test which purports to measure a person's image of self. According to the test's author, the 'Total Positive' scale is the most important single indicator of overall self esteem in the test. This scale is made up of ninety 5-point items. People with low scores have doubts about their self worthiness and tend to be anxious, depressed, and unhappy. High scorers like themselves and are confident of their own value and worth.

In the manual the author reports test-retest reliabilities of .88 and .92 for the 'Total P' scale. In order to demonstrate construct validity of his instrument, Fitt reports that the TSC subscales correlate with MMPI subscales in ways that one would expect. No data is presented in the manual to support this statement.

Target Complaints (TC)

Target Complaints (Battle et al., 1966) was included in the first battery of tests so that the client was able to specify from one to three concerns that he or she hoped to resolve during counselling. In the post test battery, a copy of their original concerns was returned to the client along with a 5-point scale on which the client was asked to rate the amount of change for each concern. Options available were: Worse; No Change; A Little Better; Somewhat Better; and A Lot Better.
(scored 1-5). Scores were summed and then divided by the number of target complaints rated in order to generate an index of outcome.

In order to test the validity of the TC, Battle et al. (1966) compared mean TC improvement scores with outcome scores from four other measures including: the Social Ineffectiveness Scale and Discomfort Scale (Stone, Frank, Nash, and Imber, 1961); the client's overall rating of outcome; and the therapist's rating of the patient's overall improvement. Although specific data was not included, the authors reported that the TC correlated significantly with all four measures.

**Relationship Inventory (RI)**

The RI (Barrett-Lennard, 1962) was designed to measure the client's perception of the core conditions of therapy as formulated by Rogers (1957). This study used a shortened version which consisted of 64, 6-point bipolar items which generated four subscales (Empathy, Genuineness, Unconditional Positive Regard, and Respect). Only the Empathy subscale was used in the analysis. The scoring range for each item on the original test form is -3 to +3 (ranging from most negative to most positive perceptions); in order to eliminate negative scores, the items were recoded from +1 to +6 with higher scores reflecting more positive perceptions of the therapeutic relationship.

Gurman (1977, p.508) evaluated 14 studies of internal consistency reliability and 10 studies of test-retest
reliability and found that the mean internal reliability coefficient for Empathy was .84. The mean test-retest coefficient for Empathy was .83. These findings would seem to indicate that the client's perceptions of the therapist's relationship qualities remain stable over time.

**Counselor Rating Form (CRF)**

The CRF (Barak and LaCrosse, 1975) consists of 36, 7-point items that reflect the three social influence dimensions of counsellor behavior (expertness, attractiveness, and trustworthiness) as perceived by the client. The range of scores on each dimension varies from 12 to 84 with high scores representing high influence on each dimension.

Evidence for the instrument's validity is based on the factor analysis done by the test authors. LaCrosse and Barak (1976) reported split-half reliability coefficients of .87 for Expertness, .85 for attractiveness and .90 for trustworthiness. In that study, intercorrelations among the scales within each counsellor tended to be high but the authors concluded that the dimensions appeared to be unique enough to be of theoretical and practical use.
Working Alliance Inventory (WAI)

The WAI (Horvath, 1981) was designed to measure the client's perception of three functional components of the Working Alliance (bond, task, and goal) as conceptualized by Bordin (1979). The instrument used in this study was a slightly revised version and consisted of 36, 7-point bipolar items. The scores for each scale of WAI could range from 12 to 84 with high scores representing greater emphasis on that component. A composite was also calculated by totaling all three scales.

Validation of this instrument is still in the preliminary stages. The fact that Horvath's study was able to show that there was a relationship between the WAI (Composite and Task scales) and outcome is cited as supporting evidence of construct validity. The results of a multi trait multi method matrix were interpreted as being supportive of the validity of the Goal scale. Horvath analyzed the scales for reliability using Hoyt's ANOVA procedure and reported coefficients of .85 for Bond, .88 for Task, .88 for Goal, and .93 for the Composite score. Intercorrelations between the scales tended to be high which indicated that some of the scales are strongly interrelated.

Strupp Posttherapy Questionnaire (SPQ)

The SPQ (Strupp et al., 1964) is a retrospective measure of the client's perception of therapy. It consists of 23 items, 11 of which solicit the client's reaction to therapy (questions 5, 7, 8, 16, 17a, 17b, 17c, 18, 19, 20, and 22). The other 12 items were not included in the analysis. Items had 5 to 7 response
alternatives and were coded so that high scores reflected greater change and satisfaction with therapy. The Composite index of psychotherapeutic outcome was arrived at by totaling the scores on the 11 items.

The SPQ was included in the outcome battery for the following reasons:

1. One of the major aims of this study was to replicate the findings of Horvath (1981) and this instrument was the main measure of outcome in that study.

2. The client's retrospective views of therapy should be included in an outcome research battery (Waskow and Parloff, 1975).

3. The validity of the SPQ has been supported by its high correlation with other recognized outcome measurements (Cartwright et al., 1963).
Chapter IV

Results

CLIENT DEMOGRAPHIC CHARACTERISTICS

Process and outcome data were returned from a total of 26 clients. One subject-client was excluded from the study when the experimenter was advised by the subject's therapist that the client had been coming to therapy as part of a requirement for receiving other aid. It was decided that this subject did not meet the definition of 'client' outlined in Chapter I. Of the remaining 25 subjects, the Target Complaints outcome measure was not completed by six clients and three of these six submitted Strupp Posttherapy Questionnaires that were incomplete.

The 25 subjects ranged from 23 to 53 years with mean age of 33.1. Females outnumbered males 19 to 6. Of the 24 clients who responded to the question of marital status, eight were single; six were married; five were divorced; and five were separated. The majority of respondents were college graduates (13) or had one to three years of college experience (8); three categorized themselves as high school graduates.
THERAPIST DEMOGRAPHIC CHARACTERISTICS

When more than one protocol was returned from a particular agency, there was no provision to determine the exact number of therapists involved. In this situation, a therapist may have contributed more than one client and thus it is possible that the therapist's demographic data includes some duplications. Therapists came from a variety of settings in British Columbia representing the following agencies:

Govt. Mental Health Centres 4
Drug and Alcohol Clinics 4
University Counseling Clinic 2
University Psychiatric Clinic 3
Private Counseling Agencies 5
Private Practitioners 7

Educational level and experience of therapists was not collected. Therapists were asked to categorize the predominant therapeutic orientation used with the client in this study and were given seven choices: Client Centred; Psychodynamic; Behavioral; Cognitive Behavioral; Gestalt; Rational Emotive; and Other. Those who checked only one orientation classified themselves as Gestalt (3), Client Centered (2), Cognitive Behavioral (2), Psychodynamic (1), and Rational Emotive (1). The remaining therapists (11) who responded checked two or more categories and a summary of their responses follows:

Client Centered 8
Cognitive Behavioral 5
Rational Emotive 4
Behavioral 3
Psychodynamic 3
Transactional Analysis 1
RELIABILITIES OF MEASURING INSTRUMENTS

Test reliability can be estimated by examining the internal consistency of the items. Internal consistency is an estimate of item homogeneity. In this study, internal consistency estimates of test subscales were calculated by using Hoyt's ANOVA procedure (Hoyt, 1941). An ideally consistent scale, where every item is accurately measuring the same desired construct, would have a Hoyt's value of 1.00. Estimates of the item homogeneity for the total instrument were obtained by calculating Cronbach's Alpha (Cronbach, 1951). The correlation coefficients between subscales and summaries of the raw data will be reported where pertinent. The outcome instruments will be listed first followed by the predictor variable inventories.

State Trait Anxiety Inventory (STAI)

The reliability coefficients listed in Table 4.1 indicate

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Items</th>
<th>Mean Pre</th>
<th>Mean Post</th>
<th>S.D. Pre</th>
<th>S.D. Post</th>
<th>Hoyt Pre</th>
<th>Hoyt Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>20</td>
<td>44.2</td>
<td>39.2</td>
<td>13.2</td>
<td>11.0</td>
<td>.95</td>
<td>.94</td>
</tr>
<tr>
<td>Trait</td>
<td>20</td>
<td>47.5</td>
<td>45.1</td>
<td>10.1</td>
<td>9.7</td>
<td>.91</td>
<td>.91</td>
</tr>
</tbody>
</table>

that the subscales of 'state' and 'trait' anxiety were internally consistent. The manual for this test (Spielberger et al., 1970), reports test retest reliabilities ranging from .73
The magnitude of the State anxiety raw scores did, on the average, diminish over the course of therapy although the change was less than one half standard deviation. As expected, the Trait scores changed less, on the average, than the State scores.

**Tennessee Self Concept Scale (TSC)**

Only the 'Total P' was score used in this study. The reliability coefficients for this scale were consistently high at pre and post test. In the manual for this instrument, test retest reliabilities ranging from .88 to .92 are reported (Fitt, 1965). The reliabilities listed in Table 4.2 indicate that the scale functioned as expected.

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean Pre</th>
<th>Mean Post</th>
<th>S.D. Pre</th>
<th>S.D. Post</th>
<th>Hoyt Pre</th>
<th>Hoyt Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 'P'</td>
<td>90</td>
<td>320.2</td>
<td>332.4</td>
<td>39.2</td>
<td>35.3</td>
<td>.95</td>
</tr>
</tbody>
</table>

The self concept raw score did on the average, increase moderately over the course of therapy. The change of means between pretest and posttest was approximately one third of a standard deviation.
Strupp Posttherapy Questionnaire (SPQ)

As discussed in Chapter 3, a composite index of outcome was derived from the SPQ and the data is listed in Table 4.3.

Table 4.3
Mean, Standard Deviation & Reliability of Strupp Composite Score
N=22

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>S.D</th>
<th>Hoyt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strupp Composite Score</td>
<td>11</td>
<td>43.5</td>
<td>5.9</td>
</tr>
</tbody>
</table>

The Hoyt's ANOVA was .85 which suggests that the SPQ items tended toward homogeneity.

The Target Complaints was also administered in the post test battery but due to the individualized nature of the items, reliability coefficients were not calculated.

Relationship Inventory (RI)

Table 4.4 summarizes the raw score data for the RI and lists a Hoyt's value of .87. It appears the items measuring Empathy were internally consistent. The reliability compares favorably with the test retest reliability of .83 for Empathy reported by Gurman (1977) after an analysis of ten studies using the RI.
Table 4.4
Mean, Standard Deviation & Reliability of the Empathy Scale
N=25

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>S.D.</th>
<th>Hoyt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>16</td>
<td>77.3</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Table 4.5
Means, Standard Deviations, & Reliabilities of the Counselor Rating Form
N=25

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Items</th>
<th>Mean</th>
<th>S.D.</th>
<th>Hoyt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attractiveness</td>
<td>12</td>
<td>73.6</td>
<td>6.9</td>
<td>.87</td>
</tr>
<tr>
<td>Expertness</td>
<td>12</td>
<td>76.7</td>
<td>5.4</td>
<td>.88</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>12</td>
<td>78.2</td>
<td>5.4</td>
<td>.85</td>
</tr>
</tbody>
</table>

Table 4.6
Intercorrelation Coefficients of the CRF Dimensions
N=25

<table>
<thead>
<tr>
<th>Attract</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert</td>
<td>.71</td>
</tr>
<tr>
<td>Trust</td>
<td>.77</td>
</tr>
</tbody>
</table>


Counselor Rating Form (CRF)

Table 4.5 presents the reliability coefficients for the three dimensions of the CRF and Table 4.6 contains the intercorrelation coefficients of the subscales. The Hoyt values obtained suggest that items measuring the subscales are internally consistent and are comparable with the split half reliabilities ranging from .85 to .90 reported by LaCrosse and Barak (1976). The correlation coefficients between the subscales suggest that the constructs of Attractiveness, Expertness, and Trustworthiness are interrelated.

Working Alliance Inventory (WAI)

The reliability estimates and intercorrelation coefficients for the WAI subscales are reported in Tables 4.7 and 4.8.

Table 4.7
Means, Standard Deviations, & Reliabilities of the Working Alliance Inventory
N=25

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Items</th>
<th>Mean</th>
<th>S.D.</th>
<th>Hoyt</th>
<th>Cronbach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond</td>
<td>12</td>
<td>69.6</td>
<td>10.1</td>
<td>.92</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>12</td>
<td>68.6</td>
<td>9.8</td>
<td>.92</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>12</td>
<td>67.3</td>
<td>11.1</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td>Composite</td>
<td>36</td>
<td>205.5</td>
<td>28.9</td>
<td>.93</td>
<td>.93</td>
</tr>
</tbody>
</table>

Table 4.8
Intercorrelation Coefficients of the WAI Dimensions
N=25

<table>
<thead>
<tr>
<th></th>
<th>Task</th>
<th>Bond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>.92</td>
<td>.69</td>
</tr>
</tbody>
</table>
The Hoyt values indicated strong internal consistencies of items within subscales and are comparable to the reliabilities of the RI and CRF. For the client form of the WAI, Horvath (1981) reported Hoyt values ranging from .85 to .88 and Cronbach's Alpha in his study was .93. The high values for Cronbach's Alpha suggest that these scales may be measuring strongly related underlying concepts. There appears to be a particularly strong overlap between the Goal and Task dimensions.

RELATIONSHIP BETWEEN PREDICTOR MEASURES

The correlations between the relationship variables used in this study are shown in Table 4.9. With this number of correlations, the 'significance' of single correlations must be interpreted with caution.

<table>
<thead>
<tr>
<th>Empathy</th>
<th>Attract</th>
<th>Expert</th>
<th>Trust</th>
<th>Bond</th>
<th>Task</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attract</td>
<td>.76</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expert</td>
<td>.63</td>
<td>.71</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>.75</td>
<td>.77</td>
<td>.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bond</td>
<td>.76</td>
<td>.73</td>
<td>.66</td>
<td>.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>.70</td>
<td>.65</td>
<td>.69</td>
<td>.53</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>.70</td>
<td>.59</td>
<td>.69</td>
<td>.41</td>
<td>.69</td>
<td>.92</td>
</tr>
<tr>
<td>Anxiety'</td>
<td>-.35</td>
<td>-.14</td>
<td>-.20</td>
<td>-.20</td>
<td>-.32</td>
<td>-.49</td>
</tr>
</tbody>
</table>

'Trait' Anxiety measured at pretest.
Taken one pair at a time, correlations above .35 would occur by chance alone five times out of a hundred (p<.05). Similarly, correlations above .48 would be 'significant' at the p<.01 level correlations above .59 would be greater than chance expectation at the p<.001 level of significance.

It can be seen that the subscales within the WAI are strongly correlated (ranging from .69 to .92) as is the case with the subscales for the CRF (ranging from .63 to .76). The lowest correlations are between Trustworthiness and Task.

The correlations between Trait anxiety at pretest and the relationship predictors are weaker than the correlations between the relationship variables but trait anxiety might have a nontrivial association with some of the predictors. In particular, trait anxiety seems to have a strong negative correlation with Task, Goal and Empathy.

RELATIONSHIP BETWEEN OUTCOME AMD PREDICTOR MEASURES

The correlations between the relationship variables and outcome measures are shown in Table 4.10. Once again a caveat regarding the interpretability of a large number of correlations from small sample must be made. Given the number of correlations in this matrix, it would be expected that a number of 'significant' correlations would occur by chance alone. There does, however, appear to be a pattern of correlations that might be clinically meaningful to explore and compare with
findings from a similar study previous study (Horvath, 1981).

<table>
<thead>
<tr>
<th></th>
<th>'State' Anxiety Residual Score N=25</th>
<th>Self Concept Residual Score N=25</th>
<th>Target Complaints N=19</th>
<th>Strupp Composite N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>.06</td>
<td>-.15</td>
<td>.23</td>
<td>.27</td>
</tr>
<tr>
<td>Attract</td>
<td>.10</td>
<td>-.03</td>
<td>.39*</td>
<td>.52**</td>
</tr>
<tr>
<td>Expert</td>
<td>.20</td>
<td>-.19</td>
<td>.35</td>
<td>.31</td>
</tr>
<tr>
<td>Trust</td>
<td>.23</td>
<td>-.16</td>
<td>.08</td>
<td>.22</td>
</tr>
<tr>
<td>Bond</td>
<td>-.16</td>
<td>.11</td>
<td>.51*</td>
<td>.46*</td>
</tr>
<tr>
<td>Task</td>
<td>-.13</td>
<td>.21</td>
<td>.53**</td>
<td>.50**</td>
</tr>
<tr>
<td>Goal</td>
<td>-.04</td>
<td>-.02</td>
<td>.33</td>
<td>.37*</td>
</tr>
</tbody>
</table>

* p<.05  
** p<.01

The three sets of hypotheses, listed in Chapter 1, stated that the three Working Alliance dimensions will correlate significantly, at the p<.05 level, with four outcome measures. In each set, subhypotheses 'a' attempted to replicate the findings of a study done by Horvath who used the Strupp Posttherapy Questionnaire (SPQ) to measure outcome. Subhypotheses 'b', 'c', and 'd' extend from 'a' and each pertains to additional indices of outcome included in this study: Target Complaints (TC), state anxiety change, and self concept change (respectively). In Table 4.10, it can be seen that there were no significant correlations between the predictor variables and the residual change scores on self concept or state anxiety. On the basis of this data, the null hypotheses cannot be rejected for each subhypotheses 'c' and 'd'.
The first set of hypotheses stated that Task would correlate significantly at the $p<.05$ level with each of the outcome measures. The null hypotheses for 1(a) and 1(b), $H_0: r(x,y)=0$ were rejected in favour of the alternative hypotheses, $H_1: r(x,y)\neq 0$ on the basis of the obtained correlations of .50 and .53 with the SPQ and the TC respectively. These correlations occurred beyond chance at the $p<.01$ level. The correlation of .50 between Task and the SPQ composite score compares with the correlation of .57 reported by Horvath which was significant at the $p<.05$ level.

The second set of hypotheses stated that Goal would correlate significantly at $p<.05$ with the outcome measures. The null hypothesis was rejected for 2(a) but the data fails to lend support for rejection of the null hypothesis for 2(b). In other words, Goal correlated significantly with the Strupp composite (.37) but not with Target Complaints (.33). Horvath reported a correlation of .30 between Goal and SPQ composite which was not significant.

The third set of hypotheses stated that Bond would correlate significantly at the $p<.05$ level with the measures of outcome. The null hypothesis for 3(a) and 3(b) were rejected in favour of the alternative hypothesis, $H_1: r(x,y)\neq 0$. The correlation of Bond with SPQ was .46 and with TC was .51. Horvath reported a correlation of .31 between Bond and the SPQ composite score which was not significant.

In order to explore the relationship between the relationship factors and outcome, multiple stepwise regression
equations were calculated with the outcome measures as dependent variables. Since the zero order Pearson correlations between the relationship variables and the residualized change scores of anxiety and self concept were not significant, multiple regression equations were not calculated for those two scores. The results for the SPQ and TC as dependent variables are summarized in Tables 4.11 and 4.12.

Table 4.11
Stepwise Regression Analysis
Dependent variable: Strupp Composite
N=22

<table>
<thead>
<tr>
<th>P. to enter=.05</th>
<th>R²=.27</th>
<th>F probability=.014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables Entered</td>
<td>F ratio</td>
<td></td>
</tr>
<tr>
<td>Attractiveness</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Variables Remaining</td>
<td>Partial Correlation</td>
<td>T-prob</td>
</tr>
<tr>
<td>Empathy</td>
<td>-.22</td>
<td>.35</td>
</tr>
<tr>
<td>Expertness</td>
<td>-.08</td>
<td>.74</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>-.31</td>
<td>.18</td>
</tr>
<tr>
<td>Bond</td>
<td>.10</td>
<td>.65</td>
</tr>
<tr>
<td>Task</td>
<td>.26</td>
<td>.25</td>
</tr>
<tr>
<td>Goal</td>
<td>.11</td>
<td>.62</td>
</tr>
</tbody>
</table>

Table 4.12
Stepwise Regression Analysis
Dependent variable: Target Complaints
N=19

<table>
<thead>
<tr>
<th>P. to enter=.05</th>
<th>R²=.45</th>
<th>F probability=.007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables Entered</td>
<td>F ratio</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>Variables Remaining</td>
<td>Partial Correlation</td>
<td>T-prob</td>
</tr>
<tr>
<td>Empathy</td>
<td>-.14</td>
<td>.59</td>
</tr>
<tr>
<td>Attractiveness</td>
<td>.18</td>
<td>.50</td>
</tr>
<tr>
<td>Expertness</td>
<td>.06</td>
<td>.81</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>-.35</td>
<td>.16</td>
</tr>
<tr>
<td>Bond</td>
<td>.03</td>
<td>.89</td>
</tr>
</tbody>
</table>
With the SPQ as the dependent variable, perceived Attractiveness was the most efficient predictor of outcome and accounted for 27% of the variance. After the variance due to Attractiveness was 'removed' no other relationship variable accounted for a significant portion of the variance at the p<.05 level. Horvath found that Task was the most powerful predictor of outcome as measured by the SPQ. The second factor in that study was Goal. He also reported that Attractiveness contributed significantly to the explanation of SPQ variance after the variance due to Task and Goal had been removed.

The multiple regression analysis for Target Complaints is shown in Table 4.12. In this equation, the Task variable is the most efficient predictor of client reported outcome. The Goal dimension also contributed to prediction of the outcome measure after the variance due to Task had been removed.

The underlying premise of this study has been that aspects of the client and therapist interaction in early treatment are related to and perhaps can be used as a basis for prediction of psychotherapeutic outcome. It is also possible that pretreatment client variables also have some relation to outcome. One of the pretreatment variables, 'trait' anxiety, was correlated with the outcome measures in order to visually compare the magnitude of the correlation coefficients against those of the relationship variables with outcome. These correlations are presented in Table 4.13.
Table 4.13
Relationship of Trait Anxiety to Outcome

<table>
<thead>
<tr>
<th></th>
<th>Residualized 'State' Anxiety Change Score</th>
<th>Residualized Self Concept Change Score</th>
<th>Target Complaints</th>
<th>Strupp Composite</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=25</td>
<td>N=25</td>
<td>N=19</td>
<td>N=22</td>
</tr>
<tr>
<td>Trait Anxiety (at pretest)</td>
<td>.19</td>
<td>-.22</td>
<td>-.31</td>
<td>-.27</td>
</tr>
</tbody>
</table>

Although there is a trend toward an inverse relationship between anxiety and outcome, the magnitudes of the correlations, taking them one pair at a time, were not significant at the p<.05 level.
Chapter V
Discussion

SUMMARY AND CONCLUSIONS

The main purpose of this study was to examine the relationship of Bordin's Working Alliance dimensions to psychotherapeutic outcome. In addition to Bond, Task, and Goal, four other so called general process factors (Empathy, Attraction, Expertness, and Trustworthiness), generated by two different conceptualizations of the therapeutic relationship, were examined with respect to four measures of therapeutic outcome. Hypothesis about the relationship between the Working Alliance dimensions and outcome were formed on the basis of findings reported by Horvath (1981).

Three sets of hypotheses were formulated. The first hypothesis in each set were formulated as attempts to replicate findings from Horvath's study and concerned the relationship of the Working Alliance dimensions to outcome as measured by the Strupp Posttherapy Questionnaire composite score. The remaining hypotheses in each set pertained to the relationship of the Working Alliance dimensions with three additional indices of outcome: the Target Complaints; change on self concept over the course of treatment as measured by the Tennessee Self Concept Scale (TSC) and change of anxiety as measured by the State Trait Anxiety Inventory (STAI). Multiple stepwise regression equations were calculated with the outcome measures as the dependent variables and the seven relationship variables as
predictors.

The major findings of the study were:

1.) The Working Alliance dimensions did seem to relate to two measures of outcome in a way that might have clinical significance.

A) Strupp Posttherapy Questionnaire (SPQ)
Using the SPQ as the outcome measure, it was found that Task correlated significantly (p<.01) with therapeutic outcome as did Bond and Goal (p<.05).

B) Target Complaints (TC)
Using the TC as the outcome measure, Task (p<.01) and Bond (p<.05) correlated significantly with outcome. In the subsequent multiple regression analysis, outcome was best predicted by the Task dimension of the working alliance which accounted for 28% of the variance. The Goal dimension also contributed to the prediction of outcome after the variance due to Task had been removed. Task and Goal together accounted for 46% of outcome variance.

2.) Of the other relationship variables, only perceived Attractiveness correlated with measures of outcome beyond chance levels (p<.01 with SPQ and p<.05 with TC). When a multiple stepwise regression equation was calculated with the SPQ as the dependent variable, Attractiveness entered the equation as the
most efficient predictor of outcome, accounting for 27% of the variance. The correlation coefficient of Attractiveness with SPQ was .52 as compared with .50 with Task and it appears as though these scales might account for an overlapping portion of the outcome variance.

3.) None of the relationship variables correlated significantly with outcome as measured by the residualized change scores on self concept and state anxiety.

In a study that correlated the same relationship variables with outcome, Horvath reported that the Task dimension had the strongest correlation with the SPQ composite score and was the best predictor of outcome variance on this measure. In the present study, the Task dimension was the only relationship variable to correlate with both the the SPQ and TC at the p<.01 level. It was also the most efficient predictor of outcome variance for the TC.

The data in this study, in conjunction with the findings reported by Horvath, provides evidence for the role of Task in therapy. It suggests that clients who report, at an early stage of therapy, that the activities undertaken in therapy are appropriate and relevant to their problems will be more likely to experience positive outcomes. If the client understands clearly what is going on in therapy and has confidence that the tasks will help him (or her) to achieve the therapeutic goals, therapeutic effectiveness will be maximized.

Goal correlated significantly (p<.05) with the SPQ and accounted for a significant portion of the variance for the TC.
after the effects due to Task had been removed. This would seem to indicate that the successful negotiation of goals in the early stage of therapy may also enhance the probability of successful outcome. Horvath had also reported that Goal accounted for a significant portion of the SPQ variance after the effects due to Task were removed.

Task and Goal seem to co-relate with outcome. The correlation between these dimensions is very strong (.93) which suggests that these two scales are tapping into a single underlying component of the alliance and, logically, these concepts are related. Once goals have been established, the next step is to delineate the tasks which must be performed in order to reach the goals. Similarly, it is difficult to formulate tasks without at least implicit reference to the goals of therapy. These two variables do not overlap completely however. In both the regression analysis done by Horvath and the present study, Task and Goal accounted for separate aspects of outcome variance. It may be that these two scales are tapping into two aspects or stages of a common underlying process - literally a 'working' alliance. If the therapies in this study had been primarily problem solving, behaviorally oriented treatments, the importance of the Task and Goal dimensions would have been self evident. However in this study a wide spectrum of therapeutic approaches was represented which indicates that these dimensions are important across approaches.

The Bond dimension of the Working Alliance had significant correlations (p<.05) with both of the outcome measures. This
would seem to indicate that the quality of the personal relationship between client and therapist is also positively related with outcome. Though Bond is highly correlated with Empathy ($r=.76$), the fact that Empathy did not correlate significantly with the outcome measures seems to indicate that Bond was more effective in this study at capturing the 'personal' component of the relationship.

The scales of Bond and perceived Attractiveness are also related conceptually as is evidenced by the correlation of .73 between the two scales. Both scales correlated significantly with two outcome measures but judging from the multiple regression analyses, it appears as though Attractiveness might be better able to account for outcome variance of at least one measure.

It is interesting to speculate about the role of perceived Attractiveness in relation to outcome. Even though Attractiveness had significantly contributed to outcome variance (as measured by the SPQ) in Horvath's study, the emergence of this variable in the present study as the best predictor of the SPQ was unexpected. In the field studies that have used the social influence variables as predictors of outcome (LaCrosse, 1980; Heppner and Heesacker, 1983), perceived expertness has been found to be the best predictor of outcome variability.

In order to get a better understanding of the interrelation between Attractiveness and outcome, the items contributing to the Attractiveness score were inspected. Essentially the items can be grouped into three broad categories: warmth and
friendliness; compatibility and closeness; and enthusiasm. In other words, the findings for Attractiveness suggest that the clients are more likely to experience positive outcomes when they report experiences of warmth, closeness, liking and enthusiasm.

The correlations of Task, Goal, Bond, and Attractiveness with outcome suggests that a 'successful' alliance has two major aspects. One component consists of the 'working' alliance where tasks and goals contribute to outcome. The importance of this component was reflected by the data on the interrelated scales of Task and Goal. The other aspect consists of a 'therapeutic' alliance where the personal relationship between the client and therapist is central to effective psychotherapy (which was reflected by the data on perceived Attractiveness and Bond).

The fact that none of the predictors correlated with the outcomes based on change of anxiety and self concept was perplexing. These outcome measures were incorporated into this study in an attempt to navigate around the possible confounding effect that could occur when clients directly rate both process and outcome.

Inspection of the data revealed that anxiety decreased and self concept increased for the majority of clients. Eighteen subjects moved favorably on both these dimensions and three clients either moved on only one scale or showed little change for both. The clients from two therapists (two clients each) however appeared to deteriorate in that they showed a relatively high increase in anxiety (average of 10 points or about one
standard deviation) and a corresponding decrease in self concept (average of 18 points or about one half of a standard deviation). When these four subjects were removed from the data, Task correlated significantly (p<.05) with both residualized change scores (the direction with anxiety was inverse).

Whatever happened with these four clients is unknown. It is possible that these two therapists were ineffective in these situations or it may be that factors outside of therapy precluded therapeutic gain during treatment. In any case it is interesting to note that if the cases where obvious deterioration is evident are eliminated, the Task dimension correlated significantly with all four measures of outcome. It could be that the Working Alliance model is most applicable with clients who, at the start of therapy, are amenable to therapeutic gain.

Some recent research has focused on the role of pretreatment variables in psychotherapeutic treatment (Luborsky et. al., 1980; LaCrosse, 1980) and an auxiliary aim of this study was to explore relationship of pretreatment anxiety to outcome. It was found that the client's initial level of 'trait' anxiety had comparatively low correlations with the outcome measures, although it appears that the direction of the associations was consistently inverse i.e. the clients with higher initial anxiety tended towards lower outcome scores. A visual comparison of the correlations suggests that the relationship variables are more strongly correlated with outcome
than an individual difference variable such as anxiety.

LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

Any conclusions drawn from a data base of n=25 must be considered tentative and statements about statistical significance have been frequently qualified. Ideally, future studies concerning the therapeutic relationship should have a larger sample of clients who are experiencing a wide variety of problems and treatment orientations. In addition, procedures should be available to obtain follow-up scores.

Aside from the size of the N, the major difficulty with this study is the reliance on client ratings for both relationship variables and outcome measures. For example, the client who tends to rate a dimension of the therapeutic relationship highly may also have tendencies to rate outcome in a particular way. Ideal ways to avoid this problem would be to have nonparticipant judges rate the relationship dimensions and then attempt to correlate these scores to outcome or to have outcome rated by an independent observer.

In this study, the intention was to examine the client's perception of the therapeutic relationship in a context of a variety of therapeutic orientations that are commonly available in the community. The only alternative would have been to have an independent observer rate outcome and, outside of the clinic situation, this approach tends to be impractical. Future studies of this nature might focus on ways of getting therapist ratings of outcome.
A number of implicit assumptions were made in this study that might be questioned. It was assumed that the therapeutic relationship would be established by the third session. Strupp (1980) has suggested that the therapeutic relationship is established by the end of the third session and evidence has been presented that the helping alliance is stable over treatment (Morgen et. al., 1982). However, at least one social influence study has suggested that the relationship changes over the course of therapy (Heppner and Heesacker, 1982). This area needs further exploration.

The findings from this study can only be generalizable to short term therapies. It may be that the dynamics of therapeutic change are different in long term therapy. For example, the Working Alliance dimensions could be critical to change in the earlier stages of therapy but other, more affective, components of the relationship might become more dominant in relation to the therapeutic change in later stages.

The use of clients who agree to participate in a study such as this one, might also limit the generalizability of these findings. Clients who agree to donate some time and effort to research may experience therapy differently than clients who would refuse to participate.

The findings of this study in conjunction with the results reported by Horvath (1981) support the usefulness of Bordin's Working Alliance model as a conceptualization of the client change process in short term therapy. It also provided support
for the validity of the Working Alliance Inventory as a research instrument with clinical utility.
List of References


Bordin, E.S. The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research, and Practice, 1979, 16, 252-260.


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


Luborsky, L., Singer, B. & Luborsky, L. Comparative studies of psychotherapies: Is it true that "Everybody Has Won and All Must Have Prizes"? Archives of General Psychiatry, 1975, 32, 995-1008.


Information about the Therapeutic Relationship Project

This study is designed to generate information about the kinds of relationships 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. Your cooperation with the research project is important and we would very much appreciate having the benefit of your experience.

If you agree to participate in the study, you will be asked to fill out three questionnaires. The first instrument will take about 45 minutes to complete. In the next weeks, you will be asked to complete a short form and another questionnaire requiring approximately 45 minutes. Your responses to the questionnaire will be kept strictly confidential. The researchers will not know who you are, neither will your therapist see your questionnaire.

When this study is completed, individual debriefing will be available and overall findings will be accessible to those who are interested.

CONSENT FORM

I hereby voluntarily consent to participate in the helping relationship 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. I understand that I am free to withdraw from this study at any time, and that my withdrawal will in no way affect the standard of service I will receive.

Signed

Date

Witness (Therapist)
INSTRUCTIONS TO PARTICIPANTS IN THE

PSYCHOTHERAPY RELATIONSHIP RESEARCH PROJECT

This project is designed to explore the different kinds of helping relationships that develop in counselling/psychotherapy. Your participation is vitally important to the project and your generosity with your time and energy is much appreciated. The procedure we are using is designed to ensure complete confidentiality. Please follow the steps outlined below:

1. Ask your client to volunteer to participate in the project. Read and explain, if necessary, the consent form. Have your client sign the form and sign it yourself as witness. Place the consent form in the small white envelope marked "consent" and mail it to the researcher.

2. Open packet 'I' and administer questionnaires A, B, & D before the first session (should take about 25 minutes to fill out). If time permits, administer questionnaire C (which takes about 30 minutes) before the first session as well; otherwise, please encourage your client to complete 'C' immediately after the interview. After the client has left, please transfer the data from questionnaire D onto the appropriate lines of questionnaire L and put 'L' into packet III so that it will be available for future reference. Please hold the completed questionnaires A, B, C, and D in the "kit".

3. Make a note on your calendar to remind yourself to administer packet 'II' after the third session.

4. After the third interview, ask the client to complete the questionnaires in packet II (E, F, G which will take about 25 minutes). Please encourage your client to fill them out right after the session. Have your client seal these forms, plus the questionnaires from the first session, into the self addressed envelope (marked packet II) and mail to researcher.

5. Please make another note on your calendar to administer the forms in packet 'III' after the 14th session. If therapy terminates before 14 sessions, administer this packet after the last session.

6. After the 14th or last session, give your client the questionnaires marked 'PC' from packet III to fill out and seal in the packet III envelope (takes about one hour). The therapist should fill out the questionnaire marked 'PT' from packet III. Place all the completed questionnaires in the large manilla envelope and return it to the researcher.

7. Should you have more than one client participating in the project, please follow the complete procedure each time, using a new kit.

8. Each questionnaire in a given kit has the same 3 digit code so that the client's responses can be kept together. To assure confidentiality, there is no record of which client receives which code. If a client wishes to receive detailed debriefing on his or her particular responses, they should be advised to record their code number and call researcher at the number below after termination of therapy.

9. Thankyou for your cooperation! If you have any questions, call Doug Moseley at