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Working alliance and its effects on treatment outcome

Andre Langlois

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WORKING ALLIANCE AND ITS EFFECTS ON TREATMENT OUTCOME

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Psychology: Clinical Counseling

by
Andre Langlois
June 1999
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Approved by:
Faith McClure, Ph.D., Chair, Psychology
Edward Teyber, Ph.D.
Joanna Worthley, Ph.D.

Date 6/15/99
ABSTRACT

The purpose of this study was to evaluate changes in symptoms of psychological distress and psychological well being as a function of the strength of the therapist-client working alliance. It was hypothesized that when therapists and clients rate their working alliance as strong (as measured by the Working Alliance Inventory), treatment outcomes would be positive. That is, strong alliance scores would be associated with lower symptoms of psychological distress (as measured by the Symptoms Checklist-90 Revised) and higher levels of psychological well being (as measured by the Scales of Psychological Well Being), after an average of six weeks of therapy. It was also hypothesized that clients' perception of the alliance would be more strongly associated with treatment outcome compared to therapists' perception of the alliance. Finally, it was anticipated that clients' initial alliance ratings would be more strongly associated with treatment outcome than their end of therapy alliance ratings.
ACKNOWLEDGMENTS

I would like to thank my thesis committee members: Faith McClure, Ph.D.; Edward Teyber, Ph.D.; and Joanna Worthley, Ph.D.
DEDICATION

To Armando,
for helping me
find my path
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INTRODUCTION

A number of studies have assessed the relationship between working alliance and therapy outcome (Mallinckrodt, 1993; Gaston, 1990; Hartley & Strupp, 1983; Krupnick, Elkin, Collins, Simmens, Sotsky, Pilkonis, & Watkins, 1994; Klee, Abeles, & Muller, 1990; Piper, Boroto, Joyce, McCallum, & Azim, 1995). The working alliance has been defined as a collaborative process (Bordin, 1979; Satterfield & Lyddon, 1995) whereby both client and therapist: a) agree on therapeutic goals, b) collaborate on tasks designed to bring about successful outcomes, and c) establish a relationship based on trust, acceptance and confidence. The working alliance has been viewed as a "fundamental moderator" (Gaston, 1990; Wolfe & Goldfield, 1988) of treatment outcome within the psychotherapy process itself and across different forms of treatment approaches (Raue, Goldfried, & Barkham, 1997).

Many studies suggest that a good or positive working alliance facilitates favorable treatment outcome for clients (Gaston, 1990; Raue, Goldfried, & Barkham, 1997; Hovarth & Symonds, 1991; Raue & Goldfried, 1994). In contrast, weak working alliances tend to negatively impact the treatment process, e.g., result in premature terminations. Weak working alliances are, for example, probably partly responsible for the high dropout rates of minority clients seeking therapy (Sue & Sue, 1990). It has
been suggested that positive alliances facilitate the effectiveness of a variety of therapeutic interventions (Mallinckrodt, 1993). That is, therapists are able to broach client resistance and make interpretations more effectively. Likewise, clients feel safer and can therefore process strong affects and other issues more fully (Teyber, 1997; Gaston, 1990; Mallinckrodt, 1993).

In recent years, managed care has forced clinicians to be more accountable to their clients and their health-care insurance providers. This has meant that clinicians have a greater mandate to document the effectiveness of their therapeutic approaches, i.e., show that there is indeed a reduction in client symptomatology and an increase in the clients well being and overall functioning.

**Theoretical Assumptions**

The notion of alliance, originally constructed by psychoanalytic theorists (Raue, Goldfried, & Barkham, 1997; Greenson, 1965; Sterba, 1934), is depicted in Freuds' early theoretical papers on transference (Gaston, 1990; Gaston, Goldfried, Greenberg, Hovarth, Raue, & Watson, 1995), and recognizes the patients as able to engage in trusting and affective relationships with their therapists (Gaston, 1990), which forms the basis of the alliance. Freud used the term alliance to characterize the special relationship (Gaston et al., 1995) between client and therapist. Other psychodynamic theorists discussed the moderating role of
the "working alliance", which included the patient's ability to form a bond with the therapist, as significant to the process and outcome of therapy (Gaston et al., 1995; Greenson, 1967; Raue, Goldfried, & Barkham, 1997).

Greenson (1965) expanded this construct to include the patient's willful participation in treatment which enhanced their ability to work in therapy (Gaston, 1990).

In addition to the client's contribution to the alliance (Gaston, 1990), authors such as Freud (1913/1958) discussed the importance of the therapists' contribution to the alliance, noting the therapists' attitude as an important component in the psychotherapy process. In other words, therapists' personal attitudes and professional therapeutic behavior also contribute greatly to the alliance (Hartley & Strupp, 1983).

Carl Rogers (1957), in developing the client-centered psychotherapy approach, further advanced the importance of therapists' participation in the therapeutic alliance (Gaston, 1990). Rogers emphasized the core conditions of empathy, genuineness, and warmth, as core conditions that therapists must provide to clients in overcoming their difficulties.

Hence, establishing a working alliance requires that client and therapist develop a collaborative approach to therapy that is based on mutual respect, trust, and the commitment to accomplish mutually agreed upon treatment
goals (Klee, Abeles & Muller, 1990; Foreman & Marmar, 1985).

**Empirical Dimensions**

Hovarth & Greenberg (1989) developed the Working Alliance Inventory to measure Bordins’ (1979) theory of the therapeutic alliance. According to Gaston (1990), the three components associated with the therapeutic alliance include: a) the goals for treatment, b) agreement on tasks to arrive at these agreed upon goals, and c) the bond between client and therapist. The Working Alliance Inventory is a 36-item measure designed to evaluate these three components (WAI; Bordin, 1979). The empirical research supports the Working Alliance Inventory as a reliable and valid measure of this construct and these therapeutic dimensions (WAI; Hovarth & Greenberg, 1989). The inventory has been identified as useful in the evaluation of the therapy process across a variety of therapeutic approaches (Hovarth & Greenberg, 1989; Goldfried & Barkham, 1997).

Raue, Goldfried & Barkham (1997) compared therapist-client alliance relationships in a sample of 57 clients diagnosed with major depression. Although three different theoretical approaches (psychodynamic, interpersonal and cognitive-behavioral) were used by the therapists in this study, these researchers found that after 16 sessions of therapy, the alliance differences across these theoretical
orientations was statistically non-significant. They also found that the alliance was strongly associated with improvement across all theoretical approaches. Hence, Raue et al. (1997) reason that a good client-therapist alliance will predict improvement despite the theoretical orientation of the therapist, and within a relatively short amount of time.

Mallinckrodt (1993) also examined the associations between working alliance, session evaluations (i.e., the depth, smoothness, positivity and arousal experienced during the session) and counseling outcome during brief counseling. At a training facility, 41 client-student counselor dyads were evaluated over a 12-session period. Both alliance and session evaluations were statistically significant predictors of the client-rated outcome. That is, strong positive alliances and session evaluations were associated with clients' rating of their improvement. In contrast, counselor rated outcome was associated with the alliance but not with session evaluations.

In another study, Klee, Abeles, & Muller (1990) also examined several aspects of the therapeutic alliance. Using a sample of 32 adult outpatients seen at a psychology-training clinic, these researchers evaluated whether the quality of the therapeutic alliance, established during the initial therapy session, was related to treatment outcome. Their results confirmed their
hypothesis that early establishment of a strong working alliance was associated with more positive treatment outcomes, while those who had weak alliances had more variable outcomes.

Based on these studies, it appears that establishing a working alliance in therapy requires the clients' participation and interest. It also appears that the strength of the therapeutic alliance does not rely exclusively on the clients' attitude and willingness, but also the therapists' attitude and professional behavior. Thus, it is the therapist-client collaboration, including mutually set goals, agreed upon tasks, and mutual respect and trust that facilitates the alliance and positive treatment outcome (Klee et al., 1990; Rogers, 1957; & Gaston, 1990).

Most of the previous studies focusing on the working alliance have assessed either the clients' perception of the alliance or the therapists' perception of the alliance. When both have been assessed in the same study, it has been unclear which of the two has been more closely associated with treatment outcome. In addition, much of the research has focused on symptom-reduction but rarely on well being. This study thus differs from previous studies in: 1) simultaneously evaluating both client and therapist perceptions of the Working Alliance, 2) evaluating whether one or the other correlates more strongly with treatment
outcome, and 3) evaluating treatment outcome in terms of both symptom change and change in well being, and 4) evaluating whether initial client Working Alliance ratings or end of therapy Working Alliance ratings are more strongly associated with treatment outcome.

The present study will focus on changes in symptoms of psychological distress and psychological well being in clients, seen at a University-based training clinic, as a function of the working alliance, as perceived by both clients and therapists. In addition, we will assess which of the three Working Alliance scores (clients’ pre-test Working Alliance score, clients’ post-test Working Alliance score, therapists’ post-test Working Alliance score) is most predictive of treatment outcome (increases in well being and decrease in symptoms).
HYPOTHESES

The data suggests that a strong working alliance is associated with positive treatment outcome (Gaston, 1990; Gaston et al., 1995). Based on this, it was hypothesized that: 1.A) Clients who rated their working alliance (based on the Working Alliance Inventory) as strong (using the median to divide the group into strong and weak) would show greater decreases in psychological distress (based on changes on the SCL-90-R) and greater increases in psychological well being (based on changes on the Scales of Psychological Well Being) than those who rated their working alliance as weak; B) Therapists who rated their working alliance (based on the Working Alliance Inventory) as strong (using the median to divide the group into strong and weak) would have clients who showed greater decreases in psychological distress (based on changes on the SCL-90-R) and greater increases in psychological well being (based on changes on the Scales of Psychological Well Being).

It was unclear whether client or therapist Working Alliance Inventory ratings would be strongly associated with treatment outcome. It seemed, however, that clients' views of how strong the alliance was, would be more likely to facilitate their willingness to implement therapist interventions and experience change, regardless of the therapists' perception. Thus, it was hypothesized that: 2) The association between clients overall working alliance
(using raw Working Alliance Inventory scores) and changes in psychological distress and psychological well being would be stronger than the association between therapists overall working alliance (using raw Working Alliance Inventory scores) and changes in clients psychological distress and psychological well being.

Klee et al. (1990) suggest that the initial treatment alliance formed has great implications for the outcome of treatment. Based on this, it was hypothesized that: 3) Clients initial Working Alliance scores would be more strongly associated with treatment outcome than their end of therapy Working Alliance scores.
METHOD

Participants

The study included: a) Seventeen volunteer clients, five males and twelve females, who sought treatment at California State University San Bernardino’s psychology Department Training Clinic and b) thirteen volunteer M.S. Counseling Psychology therapists. Only clients and therapists who agreed to participate in the study were included. The client participants were receiving therapy from those of the first-year MS clinical/Counseling students who agreed to participate. All participants were treated in accordance with APA guidelines.

Materials

Three different scales were used in this study: 1) the Working Alliance Inventory (WAI; Hovarth & Greenberg, 1986, 1989) was used with both clients and therapists to assess their perceptions of the therapeutic working alliance (see Appendix A), 2) the Scales of Psychological Well Being (Ryff, 1989) was used to assess the clients’ level psychological well being (see Appendix B), 3) the Symptom Checklist (SCL-90-R; Derogatis, 1983) was used to assess clients’ level of psychological distress (see Appendix C). In addition, a demographic questionnaire was used to identify pertinent demographic information (e.g., race, gender) for participating clients and therapists (see Appendix D). Clients and therapists were also asked to
complete an informed consent form (see Appendix E) and were given a debriefing statement (see Appendix F).

**Working Alliance Inventory**

The working Alliance Inventory (WAI; Appendix A) developed by Hovarth and Greenberg (1986), is a 36 item questionnaire which taps three primary dimensions, these include: a) the clients' perception of an emotional bond of trust and attachment, b) the clients' feelings concerning the overall goals of treatment, and c) the clients' feeling concerning the tasks relevant for achieving these goals. These same dimensions can also be evaluated from the therapists' perspective. There are 12 items for each subscale. The subjects (clients and therapists in the current study) rate each item, on a 7-point Likert scale ranging from 1(never) to 7(always), the extent to which that item applies to them. The dimensions are based on Bordin's working alliance theory. The range of scores for the entire scale is from 36 (Low Alliance) to 252 (Hi Alliance), and the range of scores for each subscale is 12 to 84. According to the four conditions of validity specified by Campbell and Fiske (1959), the WAI presented with good construct validity, multitrait and multimethod analyses (Hovarth and Greenberg, 1989). Hovarth and Greenberg (1991) also analyzed 18 studies for reliability. There were 34 reliability indices reported which resulted in an estimated average reliability of .86. As noted earlier, this scale
can be framed in terms of clients’ perceptions of the working alliance or in terms of therapists’ perception of the working alliance. For this study, the total score, which combines all three of the relevant important alliance dimensions was used to judge the strength of the alliance. Strong and weak were determined by calculating the median for the sample for the sample with those whose scores fell above the median, considered strong, and those whose scores fell below the median, considered weak.

The therapists’, as well as the clients’, WAI scores, which could range from 36 (weak) to 252 (strong), were used. For clients’, both initial and end (pre and post) therapy scores were used to assess whether the alliance at the beginning or at the end was more closely associated with change in clients. Here, the absolute score attained was used. The end of therapy scores for therapists and for clients, using a mean split for strong and weak, were used to evaluate the impact of strong versus weak alliances on treatment outcome.

**Scales of Psychological Well Being**

The scale of Psychological Well Being (SPWB) (Appendix B), developed by Ryff (1989), is an 84-item questionnaire. It consists of six subscales, which will be described below. Each item on the questionnaire is rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The range of scores for the overall
questionnaire is 84 (Low Psychological Well Being) to 504 (Hi Psychological Well Being). Each subscale is described below:

a) Autonomy: This subscale consists of 14 items and yields scores from 14 (low) to 84 (high). High scores indicate that the rater is self-determining and independent while low scores indicate he/she is concerned about the expectations and evaluations of others. The internal consistency (coefficient alpha) of this scale is .83 and its correlation with the parent scale is .97.

b) Environmental Mastery: This subscale has 14 items and yields scores from 14 (low) to 84 (high). High scores indicate that the rater has a sense of mastery and competency in managing the environment while low scores indicate he/she has difficulty managing everyday affairs. The internal consistency (coefficient alpha) of this subscale is .86 and its correlation with the parent scale is .98.

c) Personal Growth: This subscale has 14 items and yields scores from 14 (low) to 84 (high). High scores indicate that the rater has feelings of continued development while low scorers indicate that he/she has a sense of personal stagnation. The internal consistency (coefficient alpha) of
this scale is .85 and its correlation with the parent scale is .97.
d) Positive Relations With others: This subscale has 14 items and yields scores from 14 (low) to 84 (high). High scores indicate that the rater has warm, satisfying, and trusting relations with others. Low scores indicate that he/she has few close and trusting relationships with others. The internal consistency (coefficient alpha) of this subscale is .88 and its correlation with the parent scale is .98.
e) Purpose In Life: This subscale has 14 items and yields scores from 14 (low) to 84 (high). High scores indicate that the rater has goals in life and a sense of directedness while low scores indicate that he/she lacks a sense of meaning in life. The internal consistency (coefficient alpha) of this subscale is .88 and its correlation with the parent scale is .98.
f) Self-Acceptance: This subscale has 14 items and yields scores from 14 (low) to 84 (high). High scores indicate that the rater possesses a positive attitude toward self while low scores indicate that he/she feels dissatisfied with self. The internal consistency (coefficient alpha) of this subscale is
.91 and its correlation with the parent scale is .99.

Each clients' overall PWB change from Pre-test (initial therapy) to Post-test (end of therapy) was used (Psychological Well Being score at administration 2 minus Psychological Well Being score at administration 1).

Symptom Checklist

The SCL-90-R (Appendix C) is a self-report inventory designed to reflect the current psychological symptom status of participants (Derogatis, 1983). It is a 90-item questionnaire. Participants rate each item on a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely often) to indicate the degree to which the symptoms are present or are being experienced by the participant. For this study, respondents were instructed to rate each item based on their experience of each symptom at the beginning of therapy (pre-test) and at the end of therapy (post-test). The SCL-90-R yields scores for depression (e.g., appetite and mood changes), paranoia (e.g., distrust and suspiciousness), somatization (e.g., chest and back pain), irritable anxiety (e.g., pounding heart and feeling lightheaded), and anxiety with agoraphobia (e.g., presence of unexpected panic attacks), as well as an overall distress score. For the purpose of this study, the overall distress score, which can range from 90 (Low report of Psychological Symptoms) to 450 (High report of Psychological Symptoms) to 450 (High report of Psychological Symptoms).
Psychological Symptoms) was used. Specifically, each clients' overall symptom checklist change score from Pre-test to Post-test was used (Symptom Checklist score at administration 1 minus Symptoms Checklist score at administration 2). The coefficient alpha and test-retest reliability for this scale has been calculated at .84 (Derogatis, 1983; Derogatis, Rickels, & Rock, 1976).

**Demographic Questionnaire**

A demographic questionnaire (Appendix D) was used to obtain pertinent information on participants in this study. The following dimensions were included: a) gender, b) age, c) education, d) income, e) type of work, f) living arrangements, g) ethnicity, and h) reason for therapy (clients only). In addition, an informed consent form, which describes the purpose of the study, the voluntary nature of participation, and confidentiality, was administered. A debriefing statement, which restated the purpose of the study, the usefulness of the obtained data, and thanked the subjects for their participation, was also given to participants.

**Procedure**

**Clients**

One set of participants were clients seeking therapy at the Community Counseling Center. At their initial intake, all clients were asked if they would be willing to participate in a study assessing the therapy relationship
and its impact on treatment outcome. They were informed that participation is strictly voluntary and in no way a requirement for receiving treatment at the Center. They were told that the process involved being asked to complete a paper and pencil questionnaire at two times during their therapy process (pre-test and post-test). They were told that the questionnaires focused on psychological symptoms, psychological well being, the therapist-client relationship and basic demographic information such as race, gender, and age. Before the first administration, they were contacted by the investigator (a M.S. Clinical Counseling Psychology graduate student) and asked to complete the questionnaire within the first three therapy sessions (pre-test). When contacted by the investigator at pre-test, the study was again described and the "Informed Consent" form was administered (Appendix E). Client participants were then given the WAI, SCL-90-R, SPWB (Scale of Psychological Well Being), and Demographic Questionnaires. Participants were allowed to complete the questionnaires on their own time and asked to return it within seven (7) days. The investigator made arrangements to collect the completed forms from the participants (upon their next therapy appointment). The Post-Test was administered to client participants during sessions 8-10. Once again, the WAI, SCL-90-R, and SPWB were administered. However, demographic data was not collected in the second (post-test)
administration. Client participants were again asked to return the questionnaires within 7 days. The investigator once again collected these questionnaires at the clients' next therapy appointment. At this time, a "Debriefing Statement", restating the purpose of the study and the usefulness of the data collected (Appendix F) was given to them. They were also thanked for their participation.

The completed forms and questionnaires were kept on file in a secured area (locked cabinet). In order to maintain client confidentiality, there was no personal identification on the questionnaires. A participant identification number was assigned, to link participants to their pre-test and post-test data, as well, to match each client participant to their respective therapist. The numbers assigned to each client volunteer was written on the corresponding questionnaires and was used as the only identifier. Each client participant had a data card, which contained the name of the participant and his or her corresponding number. The data cards were kept in a separate locked file cabinet to be used for reference only. This was the only way of identifying a subjects' name and number for future administrations of the questionnaires. Project staff were the only ones to have access to the locked cabinet where the collected data was stored.
Therapists

The other set of participants were the 1st year M.S. Clinical Counseling students who serve as therapists to the clients who were seen in the Community Counseling Center (i.e., client participants). These participants were asked if they would be willing to participate in a study assessing the therapy relationship and its impact on treatment outcome. They were informed that participation was strictly voluntary and in no way a requirement for continuation in the M.S. Counseling Psychology program. Therapist participants were asked to complete a paper and pencil questionnaire on one occasion, during the time they were providing therapy. This questionnaire included the Working Alliance Inventory (WAI) and was administered when their respective client participant was administered the post-test questionnaire. Therapists agreeing to participate were asked to sign the informed consent form, which described the study, voluntary nature of participation, and confidentiality. During their client(s) 8th to 10th session, the investigator contacted the therapist participants and asked them to complete the WAI and demographic information and to return the questionnaires within seven days. Subsequently, the completed forms and questionnaires were kept on file in a secured area (locked cabinet). In order to maintain therapist confidentiality, there was no personal identification on the questionnaires.
A therapist participant identification number was assigned in order to link therapist participants to their respective client participants. The number was used as the only identifier. Each therapist participant had a data card, which contained his or her name and corresponding number. The data cards were kept in a separate locked file cabinet to be used for reference only. This was the only way of identifying the therapist participants' name in order to link it to their client. Again, project staff were the only ones to have access to the locked cabinet where the collected data was stored.

**Design**

A quasi-experimental, between-subjects Pre-test Post-test multivariate factorial design was used to test the proposed hypotheses. The independent variable was Working Alliance, with 2 levels, weak and strong. This independent variable was analyzed from 1) the clients' perspective, and 2) the therapists' perspective. The strength of the working alliance was determined by the scores of the Working Alliance Inventory (WAI; Appendix A; Hovarth & Greenberg, 1986, 1989). The working alliance scores ranged from 36 to 252. For the analyses evaluating treatment outcome based on the working alliance, client and therapist scores were divided into Strong and Weak levels. For each group (client, therapist), their own group median was used to determine the split, with those whose scores fell below
the median identified as "weak" and those above the median identified as "strong". For the analysis evaluating whether the strength of the alliance at the beginning versus at the end is more closely associated with change scores for clients, the absolute score for each client at pre-test and post-test was used. The other independent variable, participant, included 2 levels, therapist or client, which was based on their roles or identity in the study. There were two dependent variables: 1) Psychological Well Being, and 2) Psychological Distress (SCL-90-R). These were assessed at the beginning (pre) and end (post) of therapy. The change (overall post-test minus pre-test scores) on each dependent variable was analyzed. The first dependent variable was determined by changes for the clients on well being (the Scales of Psychological Well Being (Appendix B; Ryff, 1989). The second dependent variable, psychological distress, was determined by the amount of change in psychological symptoms for the clients based on their responses to the Symptom CheckList (SCL-90-R; Appendix C; Derogatis, 1983).
RESULTS

Seventeen clients (5 male, 12 female) participated in the study. The clients ranged in age from 22 to 60. Fourteen were Caucasian, two were Hispanic, and one was Afghan. In addition to the seventeen clients, there were thirteen student therapists who also participated in the study. These student therapists were all first year M.S. Clinical Counseling Psychology students, ranging in age from 24 to 49. Nine of the therapists were female and four were male.

Four analyses were run. This included two ANOVAs to test for group differences in treatment outcome based on the strength of the therapist-client working alliance and two multiple regressions to evaluate which of the three therapist-client working alliance scores best predicted treatment outcome.

Group Differences in Treatment Outcome

Group Differences Based on Client Ratings of the Working Alliance

A median split of client working alliance ratings at the initiation of therapy was used to divide the groups into weak and strong alliances. An ANOVA comparing the groups (weak, strong) on changes in symptoms of psychological distress and on psychological well-being yielded a trend for changes in symptoms, $F(1,15) = 3.89$, $p < .07$, and a trend for changes in well-being, $F(1,15) =$
3.48, p<.08. As can be seen in Table 1, weak alliance clients showed improvement (their mean symptom scores decreased by 27.44 points), while the strong alliance clients worsened (their mean symptom scores increased by 20.13 points). Table 1 also shows that weak alliance clients showed an improvement in their sense of well-being (their mean well-being scores increased by 33.11 points) while the strong alliance clients showed a decrease in well-being (their mean alliance scores decreased by 8.38 points).

Group Differences Based on Therapist Ratings of the Working Alliance

A median split of therapist working alliance ratings at the end of therapy was used to divide the clients into groups denoting weak and strong alliances. An ANOVA comparing the groups (weak, strong) on changes in symptoms of psychological distress and on psychological well-being yielded no significant changes in symptoms, F(1,15) = 2.63, p<.13, and or in well-being, F(1,15) = 3.48, p<.10. However, as can be seen in Table 1, weak alliance clients showed a decreased in symptoms (their mean symptom scores decreased by 26.50 points), while the strong alliance clients worsened (their mean symptom scores increased by 14.00 points). Table 1 also shows that weak alliance clients showed an improvement in their sense of well-being (their mean well-being scores increased by 34.63 points).
while the strong alliance clients showed a decrease in well-being (their mean alliance scores decreased by 5.11 points).

**Table 1**

<table>
<thead>
<tr>
<th></th>
<th>Changes in Symptoms</th>
<th>Changes in Well Being</th>
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<tbody>
<tr>
<td><strong>Client Rated</strong></td>
<td></td>
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<tr>
<td>Weak Alliance</td>
<td>M = 27.44 (decrease) M = 33.11 (increase)</td>
<td></td>
</tr>
<tr>
<td>SD = 49.25</td>
<td>SD = 51.62</td>
<td></td>
</tr>
<tr>
<td>Strong Alliance</td>
<td>M = 20.13 (increase) M = 8.38 (decrease)</td>
<td></td>
</tr>
<tr>
<td>SD = 50.10</td>
<td>SD = 38.03</td>
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<tr>
<td><strong>Therapist Rated</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weak Alliance</td>
<td>M = 26.50 (decrease) M = 34.63 (increase)</td>
<td></td>
</tr>
<tr>
<td>SD = 52.67</td>
<td>SD = 63.25</td>
<td></td>
</tr>
<tr>
<td>Strong Alliance</td>
<td>M = 14.00 (increase) M = 5.11 (decrease)</td>
<td></td>
</tr>
<tr>
<td>SD = 50.24</td>
<td>SD = 22.46</td>
<td></td>
</tr>
</tbody>
</table>

**Working Alliance Predictors of Treatment Outcome**

Two stepwise multiple regressions, one for changes in symptoms of distress and one for changes in psychological well-being, were run to see which of three working alliance scores (clients' initial working alliance scores, clients'
end of therapy working alliance scores, and therapists' end of therapy alliance scores) best predicted outcome.

The regression for changes in symptoms indicated that the clients' initial working alliance scores were significantly associated with symptom change ($r (3,13) = .63, p<.05$) and accounted for approximately 39% of the variance in psychological distress change. Similarly, the regression for changes in well-being indicated that clients' initial working alliance scores were significantly associated with well-being change ($r (3,13) = .51, p<.05$) and accounted for approximately 26% of the variance in psychological well-being change. The other alliance scores did not contribute significantly to the changes noted beyond the contribution of the initial client working alliance scores. These results are summarized in Table 2.
<table>
<thead>
<tr>
<th>Step Variables</th>
<th>Overall R</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom Change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Step 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients' Initial Working Alliance Rating</td>
<td>.63</td>
<td>.39</td>
</tr>
<tr>
<td><strong>Well Being Change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Step 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients' Initial Working Alliance Rating</td>
<td>.51</td>
<td>.26</td>
</tr>
</tbody>
</table>
DISCUSSION

The purpose of this study was to evaluate changes in symptoms of distress and psychological well being as a function of the strength of the therapist-client working alliance. In addition, the study evaluated which of three working alliance scores (clients' initial working alliance scores, clients' end of therapy working alliance scores, and therapists' end of therapy alliance scores) best predicted treatment outcome.

The results of the study failed to support the hypotheses that clients, where either the client or the therapist rated the alliance as strong, would show greater improvement in treatment than where the working alliance was rated as weak. Contrary to expectations, clients with strong working alliances (rated by therapists and/or clients as strong) showed an increase in symptoms of distress while those with weak alliances showed the expected decrease in symptoms of distress. In other words, we expected all clients to show a decrease in symptoms but expected strong alliance clients to show a greater decrease. Similarly, the strong alliance group also showed a decrease in psychological well being while the weak alliance group showed the expected increase in psychological well being. Again, we expected an increase in psychological well being for all clients but more so for all strong alliance clients.
These results are surprising since studies typically find that the strength of the alliance facilitates positive treatment outcomes (See Gaston, 1990, for a review). There are several possible explanations for these unexpected findings. One possible explanations is that the “strong” alliance clients, having entered therapy and committing themselves to working diligently on the issues that brought them in, were in the midst of working through the issues when the outcome measures were collected. These clients were thus likely more openly acknowledging their distress, less in denial about the struggles they were facing, and had not yet worked through many of their painful presenting problems. It is also possible that feeling safe and connected to their therapist(s), they were more willing to explore even deeper struggles. In other words, clients may have been expressing more overtly and more clearly their psychological struggles at this point in the therapy process. They may also have more facility (better language) for describing their struggle. Further, the data collection might have occurred after only six sessions for these clients. As a result, long-term prognosis would likely be excellent but they “look worse” in the short-term.

It is important to note that while treatment outcome is generally believed to be facilitated by a strong working alliance, several researchers have noted that the alliance
is not static and varies across the therapy process (Gelso & Carter, 1994; Kivlighan & Shaughnessy, 1995). Indeed, Gelso & Carter (1994) have suggested that "Especially in treatments that abbreviate duration, an initially sound working alliance will subsequently decline, but in successful therapy this decline will be followed by an increase to earlier, high levels" (pp. 301-302). These fluctuations likely impact the clients' therapy experience and the timing of outcome assessments would likely interact with this process.

In addition, a pattern of increasing alliance rather than levels per se is often the more significant predictors of outcome (Hartley & Strupp, 1983; Kivlighan & Shaughnessy, 1995). Hovarth & Greenberg (1989) suggested that "alliance measures taken early in counseling are unable to detect difficulties resulting from technique-specific counseling error occurring in a later session" (p. 228). Thus, counseling "errors" are likely to change the nature of the alliance and the clients' treatment experience. This would be an especially salient feature for therapists in training since they are still novices - and the data suggests that training level impacts alliance ratings and outcomes (Mallinckrodt & Nelson, 1991).

A further issue not frequently addressed in the literature is that working alliance has several dimensions that likely have differing impact on outcome. Thus,
"strong" alliance scores do not mean the same thing for all clients or therapists. For example, Mallinckrodt & Nelson (1991) noted that the "bonding" aspect of the alliance appears similar across training levels but that the goal and task component is higher in those with more experience. Each of these components impact different aspects of the counseling process. In the current study, symptoms of distress and well being were assessed, aspects likely to be affected more by goal-setting than by bonding. Thus, if "bonding" was what accounted for the strong alliance scores, rather than goal setting, assessing interpersonal outcomes rather than symptomatology might have yielded different outcomes. Thus, what outcome measures are used (e.g., symptoms versus interpersonal relationships) would impact findings.

Client severity would also affect outcomes – one possibility is that more disturbed clients might start out with lower alliance scores but show greater improvement over the short term since they have more gains to make. In addition, the type of training/intervention/supervision of the therapist (e.g., behavioral versus interpersonal process) will affect which outcomes will show change over the short term and which will show change over the long-term. Kivlighan and Schmitz (1992) noted for example, that counselor-client dyads who are more focused, deal in the here-and-now, and are more challenging produce more
positive outcomes than those who lack a focus and use more supportive approaches where difficulties are "smoothed over". These factors likely reflect treatment approach, experience and confidence as a therapist, AND interact with the type of outcome measures used, AND with the timing of the outcome assessment.

It would be interesting to follow the clients who participated in the current study over time to see if their alliance ratings fluctuate and if their symptoms and well being eventually change in the expected direction.

The fact that clients with weak working alliances showed greater improvement than those with strong working alliances is interesting. Indeed, these "weak alliance" clients showed decreases in symptoms of distress and increases in psychological well being. While we expect this to occur in therapy for all clients, that fact that it occurred for this group but not the other raises questions about what client and/or therapist characteristics might have contributed. It may be that for these clients, alliance ratings increased over time (thus the pattern of alliance change was what impacted outcome). It is also possible that entering therapy provided them with one of the few positive relationships they have had, especially if their early "weak" alliances were indicative of general difficulty connecting with others. Thus, being in therapy may have reduced their sense of distress and aloneness, and
increased their sense of well being. Follow up over time would be useful in providing information about the enduring quality of the observed improvement and of client and therapist characteristics that contribute to well being and decreased symptomatology.

The hypothesis that clients' initial working alliance scores would be more predictive of treatment outcome than clients' end of therapy alliance scores or than therapists' end of therapy alliance scores was supported. The results indicated that clients' initial working alliance scores accounted for 39% of the variance in symptom change and for 26% of the variance in well being change.

These findings are important and suggest that expectations set at the beginning of therapy may be meaningfully related to the therapy process. Unfortunately, the rather short course of treatment limits our ability to evaluate whether this relationship will hold over longer courses of therapy. In addition, the fact that we do not have therapists' initial therapy working alliance scores limits our ability to assess whether initial impressions by either member of the therapy team is similarly predictive or whether it is the clients' expectations that carry the most weight. Nevertheless, these results suggest that attending to those initial sessions is important.
The generalizability of the findings of this study is limited by a number of factors. The sample size is small, treatment outcome is evaluated rather soon, and the therapists are all at the early stages of their training. It would be useful to assess these same variables with a larger sample, over an extended period of treatment, using therapists with varying levels of training and experience. Since several researchers have suggested that the nature of the alliance varies over the treatment process (Gelso & Carter, 1994; Kivlighan & Shaughnessy, 1995), it would be useful to understand when and why that occurs.

In particular, it would be useful to understand how those changes impact the treatment process itself and ultimately how they impact the outcome for the clients. Thus, while larger samples would provide much needed information, in-depth assessments of smaller case loads could also provide much needed understanding of the complex interaction between treatment alliance, treatment process, and treatment outcome.

In sum, this study adds to the literature on the importance of evaluating the treatment alliance as a contributor to treatment outcome. However, the results suggest that the treatment alliance, treatment process, and client outcomes may operate in rather complex ways that require in-depth assessments of the therapy process.
### Appendix A

**Working Alliance Inventory (WAI)**

Please respond to the following statements based on how you currently feel about your counselor. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel uncomfortable with my Counselor</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. My counselor &amp; I agree about the things I will need to do in therapy to help improve my situation</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I am worried about the outcome of these sessions</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What I am doing in therapy gives me new ways of looking at my problem</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. My counselor &amp; I understand each other</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My counselor perceives accurately what my goals are</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I find what I am doing in therapy confusing</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I believe my counselor likes me</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I wish my counselor &amp; I could clarify the purpose of our sessions</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I disagree with my about what I ought to get out of therapy</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. I believe the time my counselor & I are spending together is not spent efficiently 1 2 3 4 5 6 7

12. My counselor does not understand what I am trying to accomplish in therapy 1 2 3 4 5 6 7

13. I am clear on what my responsibilities are in therapy 1 2 3 4 5 6 7

14. The goals of these sessions are important to me 1 2 3 4 5 6 7

15. I find what my counselor & I are doing in therapy unrelated to my concerns 1 2 3 4 5 6 7

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

17. I believe my counselor is genuinely concerned for my welfare 1 2 3 4 5 6 7

18. I am clear as to what my counselor wants me to do in these sessions 1 2 3 4 5 6 7

19. My counselor & I respect each other 1 2 3 4 5 6 7

20. I feel that my counselor is not totally honest with me about his/her feelings towards me 1 2 3 4 5 6 7

21. I am confident in my counselor’s ability to help me 1 2 3 4 5 6 7
22. My counselor & I are working towards mutually agreed upon goals 1 2 3 4 5 6 7
22. I feel that my counselor appreciates me 1 2 3 4 5 6 7
23. We agree on what is important for me to work on 1 2 3 4 5 6 7
24. 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
25. My counselor & I trust one another 1 2 3 4 5 6 7
26. My counselor & I have different ideas on what my problems are 1 2 3 4 5 6 7
27. My relationship with my counselor is very important to me 1 2 3 4 5 6 7
28. I have the feeling that if I say or do the wrong things, my counselor will stop working with me 1 2 3 4 5 6 7
29. My counselor & I collaborate on setting goals for my therapy 1 2 3 4 5 6 7
30. I am frustrated by the things I am doing in therapy 1 2 3 4 5 6 7
31. We have established a good understanding of the kind of changes that would be good for me 1 2 3 4 5 6 7
32. The things that my counselor is asking me to do don't make sense! 2 3 4 5 6 7
33. I don’t know what to expect as the result of therapy

34. I believe the way we are working with my problem is correct

35. I feel my counselor cares about me even when I do things that he/she does not approve of
Appendix B

Scales of Psychological Well-Being

Please respond to each of the following items by circling the number that most closely corresponds to what you believe is accurate for you, on a scale ranging from (1) strongly disagree to (6) strongly agree.

1 = strongly disagree  4 = slightly agree
2 = somewhat disagree  5 = somewhat agree
3 = slightly disagree   6 = strongly agree

1. Sometimes I change the way I act or think to be more like those around me
2. In general, I feel I am in charge of the situation in which I live
3. I am not interested in activities that will expand my horizons
4. Most people see me as loving and affectionate
5. I feel good when I think of what I've done in the past & what I hope to do in the future
6. When I look at the story of my life. I am pleased with how things have turned out
7. I am not afraid to voice my opinions, even when they are opposition to the opinions of most people
8. The demands of everyday life often get me down
9. In general, I feel that I continue to learn more about myself as time goes by
10. Maintaining close relationships has been difficult & frustrating for me
11. I live life one day at a time & don’t really think about the future 1 2 3 4 5 6
12. In general, I feel confident & positive about myself 1 2 3 4 5 6
13. My decisions are not usually influenced by what everyone else is doing 1 2 3 4 5 6
14. I do not fit very well with the people & the community around me 1 2 3 4 5 6
15. I am the kind of person who likes to give new things a try 1 2 3 4 5 6
16. I often feel lonely because I have few close friends with whom to share my concerns 1 2 3 4 5 6
17. I tend to focus on the present, because the future nearly always brings me problems 1 2 3 4 5 6
18. I feel like many of the people I know have gotten more out of life than I have 1 2 3 4 5 6
19. I tend to worry about what other people think of me 1 2 3 4 5 6
20. I am quite good at managing the many responsibilities of my daily life 1 2 3 4 5 6
21. I don’t want to try new ways of doing things—my life is fine the way it is 1 2 3 4 5 6
22. I enjoy personal & mutual conversations with family members or close friends 1 2 3 4 5 6
23. I have a sense of direction & purpose in life 1 2 3 4 5 6
24. Given the opportunity, there are many things about myself that I would change 1 2 3 4 5 6
25. Being happy with myself is more important to me than having others approve of me 1 2 3 4 5 6
26. I often feel overwhelmed by my responsibilities 1 2 3 4 5 6
27. I think it is important to have new experiences that challenges how you think about yourself & the world 1 2 3 4 5 6
28. It is important to me to be a good listener when close friends talk to me about their problems 1 2 3 4 5 6
29. My daily activities often seem trivial & unimportant to me 1 2 3 4 5 6
30. I like most aspects of my personality 1 2 3 4 5 6
31. I tend to be influenced by people with strong opinions 1 2 3 4 5 6
32. If I were unhappy with my living situation, I would take effective steps to change it 1 2 3 4 5 6
33. When I think about it, I haven’t really improved much as a person over the years 1 2 3 4 5 6
34. I don’t have many people who want to listen when I need to talk 1 2 3 4 5 6
35. I don’t have a good sense of what it is I’m trying to accomplish in life 1 2 3 4 5 6
36. I made some mistakes in the past, but I feel that all in all everything has worked out for the best 1 2 3 4 5 6
37. People rarely talk to me into doing things I don’t want to do 1 2 3 4 5 6
38. I generally do a good job of taking care of my personal finances & affairs 1 2 3 4 5 6
39. In my view, people of every age are able to continue growing & developing

40. I feel like I get a lot out of my friendships

41. I used to set goals for myself, but that now seems like a waste of time

42. In many ways, I feel disappointed about my achievements in life

43. It is more important to me to "fit in" with others than to stand alone on my principles

44. I find it stressful that I can't keep up with all the things I have to do each day

45. With time, I have gained a lot of insight about life that has made me a stronger, more capable person

46. It seems to me that most other people have more friends than I do

47. I enjoy making plans for the future & working to make them a reality

48. For the most part, I am proud of who I am & the life I lead

49. I have confidence in my own opinions, even if they are contrary to the general consensus

50. I am good at juggling my time so that I can fit everything in that needs to get done

51. I have a sense that I have developed a lot as a person over time

52. People would describe me as a giving person, willing to share my time with others

53. I am an active person in carrying out the plans I set for myself
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>54.</td>
<td>I envy many people for the lives they lead</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55.</td>
<td>It's difficult for me to voice my own opinions on controversial matters</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56.</td>
<td>My daily life is busy, but I derive a sense of satisfaction from keeping up with everything</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57.</td>
<td>I do not enjoy being in new situations that require me to change my old familiar ways of doing things</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58.</td>
<td>I have not experienced many warm &amp; trusting relationships with others</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59.</td>
<td>Some people wander aimlessly through life, but I am not one of them</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60.</td>
<td>My attitude about myself is probably not as positive as most people feel about themselves</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61.</td>
<td>I often change my mind about decisions if my friends or family disagree</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62.</td>
<td>I get frustrated when trying to plan my daily activities because I never accomplish the things I set out to do</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63.</td>
<td>For me, life has been a continuous process of learning, changing, &amp; growth</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64.</td>
<td>I often feel like I'm on the outside looking in when it comes to friendships</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65.</td>
<td>I sometimes feel as if I've done all there is to do in life</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66.</td>
<td>Many days I wake up feeling discouraged about how I have lived my life</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
67. My efforts to find the kinds of activities & relationships that I need have been quite successful 1 2 3 4 5 6

68. I enjoy seeing how my views have changed & matured over the years 1 2 3 4 5 6

69. I know that I can trust my friends and they know they can trust me 1 2 3 4 5 6

70. My aims in life have been more a source of satisfaction than frustration 1 2 3 4 5 6

71. The past had its ups and downs, but in general I wouldn't want to change it 1 2 3 4 5 6

72. I'm concerned about how other people evaluate the choices I've made in my life 1 2 3 4 5 6

73. I am not the kind of person who gives in to social pressures to think or act in certain ways 1 2 3 4 5 6

74. I have difficulty arranging my life in a way that is satisfying to me 1 2 3 4 5 6

75. I gave up trying to make big improvements or changes in my life a long time ago 1 2 3 4 5 6

76. I find it difficult to really open up when I talk to others 1 2 3 4 5 6

77. I find it satisfying to think about what I have accomplished in life 1 2 3 4 5 6

78. When I compare myself to friends & acquaintances, it makes me feel good about who I am 1 2 3 4 5 6

79. I judge myself by what I think is important, not by the values of what others think is important 1 2 3 4 5 6
80. I have been able to build a home & lifestyle for myself that is much to my liking

81. There is truth to the saying that you can't teach an old dog new tricks

82. My friends and I sympathize with each others' problems

83. In the final analysis, I'm not so sure that my life adds up to much

84. Everyone has their weaknesses, but I seem to have more than my share
Appendix C

Symptom Checklist (SCL-90-R)

Here is a list of things people sometimes report experiencing. Please circle how often you have experienced each of the following in the last four (4) weeks.

<table>
<thead>
<tr>
<th>HOW OFTEN DID YOU FEEL OR EXPERIENCE:</th>
<th>Not At All</th>
<th>Extremely Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Headaches</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Nervousness or shakiness inside</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Repeated unpleasant thoughts that won’t leave your mind</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Faintness or dizziness</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Loss of sexual interest or pleasure</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. Feeling critical of others</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. The idea that someone else can control your thoughts</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. Feeling others are to blame for most of your troubles</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. Trouble remembering things</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. Worried about sloppiness or carelessness</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. Feeling easily annoyed or irritable</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. Pains in heart or chest</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>13. Feeling afraid in open spaces or streets</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>14. Feeling low in energy or slowed down</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>15. Thoughts of ending your life</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>16. Hearing voices that other people do not hear</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>17. Trembling</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
18. Feeling that most people cannot be trusted 1 2 3 4 5
19. Poor appetite 1 2 3 4 5
20. Crying easily 1 2 3 4 5
21. Feeling of being trapped or caught 1 2 3 4 5
22. Feeling shy & uneasy with the opposite sex 1 2 3 4 5
23. Suddenly scared for no reason 1 2 3 4 5
24. Temper outbursts you could not control 1 2 3 4 5
25. Feeling afraid to go out of your house 1 2 3 4 5
26. Blaming yourself for things 1 2 3 4 5
27. Pains in lower back 1 2 3 4 5
28. Feeling blocked in getting things done 1 2 3 4 5
29. Feeling lonely 1 2 3 4 5
30. Feeling blue 1 2 3 4 5
31. Worrying too much about things 1 2 3 4 5
32. Feeling no interest in things 1 2 3 4 5
33. Feeling fearful 1 2 3 4 5
34. Your feelings being easily hurt 1 2 3 4 5
35. Other people being aware of your private thoughts 1 2 3 4 5
36. Feeling others do not understand you 1 2 3 4 5
37. Feeling that people are unfriendly or dislike you 1 2 3 4 5
38. Having to do things very slowly to insure correctness 1 2 3 4 5
39. Heart pounding or racing 1 2 3 4 5
40. Nausea or upset stomach 1 2 3 4 5
41. Feeling inferior to others 1 2 3 4 5
42. Soreness of muscles 1 2 3 4 5
43. Feeling that you are watched or talked about by others 1 2 3 4 5
44. Trouble falling asleep 1 2 3 4 5
45. Having to check and double-check what you do 1 2 3 4 5
46. Difficulty making decisions 1 2 3 4 5
47. Feeling afraid to travel on buses, subways or trains 1 2 3 4 5
48. Trouble getting your breath 1 2 3 4 5
49. Hot or cold spells 1 2 3 4 5
50. Having to avoid things, because they frighten you 1 2 3 4 5
51. Your mind going blank 1 2 3 4 5
52. Numbness or tingling in parts of your body 1 2 3 4 5
53. A lump in your throat 1 2 3 4 5
54. Feeling hopeless about the future 1 2 3 4 5
55. Trouble concentrating 1 2 3 4 5
56. Feeling weak in parts of your body 1 2 3 4 5
57. Feeling tense or keyed up 1 2 3 4 5
58. Heavy feelings in your arms or legs 1 2 3 4 5
59. Thoughts of death or dying 1 2 3 4 5
60. Overeating 1 2 3 4 5
61. Feeling uneasy when people are watching or talking about you
62. Having thoughts that are not your own
63. Having urges to beat, injure or harm someone
64. Awakening in the early morning
65. Having to repeat actions such as touching or washing
66. Sleep that is restless or disturbed
67. Having urges to break or smash things
68. Having ideas or beliefs that others not share
69. Feeling very self-conscious with others
70. Feeling uneasy in crowds such as shopping or at movies
71. Feeling everything is an effort
72. Spells of terror panic
73. Feeling uncomfortable about eating
74. Getting into frequent arguments
75. Feeling nervous when you are left alone
76. Others not giving you proper credit for achievements
77. Feeling alone even when you are with people
78. Feeling so restless you couldn’t sit still
79. Feelings of worthlessness
80. The feeling something bad is going to happen to you  
81. Shouting or throwing things  
82. Feeling afraid you will faint in public  
83. Feeling people will take advantage of you if you let them  
84. Having thoughts about sex that bother you a lot  
85. The idea that you should be punished for your sins  
86. Thoughts & images of a frightening nature  
87. The idea that something serious is wrong with your body  
88. Never feeling close to another person  
89. Feelings of guilt  
90. The idea that something is wrong
Appendix D

Demographic Questionnaire

PLEASE NOTE THAT YOUR RESPONSES ARE STRICTLY CONFIDENTIAL. PLEASE TRY TO ANSWER AS MANY QUESTIONS AS POSSIBLE TO THE BEST OF YOUR KNOWLEDGE. THANK YOU FOR YOUR PARTICIPATION.

1. Your gender (circle one)  
a. male  
b. female

2. Your age at last birthday _____

3. What is your highest educational level (grade) _____
   If appropriate, what is your partners' highest educational level _____
   If you live with your parents, please give this information for:
   a. your father _____
   b. your mother _____

4. What do you think is your family's yearly income is (your best estimate). Please circle the number that applies:
   1. $5,000/yr or less  ($416/mo or less)
   2. $5,000/yr to $9,999/yr  ($417/mo to $832/mo)
   3. $10,000/yr to $14,000/yr  ($833/mo to $1249/mo)
   4. $15,000/yr to $19,000/yr  ($1250/mo to $1666/mo)
   5. $20,000/yr to $29,999/yr  ($1667/mo to $2499/mo)
   6. $30,000/yr to $50,999/yr  ($2500/mo to $4166/mo)
   7. $50,000/yr or more  ($4167/mo or more)

   What kind of work do you do ______________________
   What kind of work does your partner do (if applicable) ______________________

   If you live with your parents:
   What kind of work does your father do ______________________
   What kind of work does your mother do ______________________

Which of the following best describes your birth family's background?
   1. African-American  _____
   2. Latino, Chicano, or Hispanic  _____
   3. White  _____
   4. Asian  _____
   5. Native American  _____
   6. Other (please specify)  _____  _____

6. Please state briefly why you are seeking therapy
Appendix E

Informed Consent

INFORMED CONSENT

TREATMENT OUTCOME

The purpose of the study you are volunteering for is to assess the relationship you have with your therapist and how you respond to therapy. It is hoped that the results will help therapists be more effective and helpful to their clients. You will be asked to complete a paper and pencil questionnaire, which will focus on your psychological symptoms, your psychological well being, and your relationship with your therapist. You will be asked to fill out a questionnaire on these issues at three points in the therapy process: 1) sessions 1-3, 2) sessions 8-10, and 3) sessions 16-20; the amount of time required in filling out the questionnaire will be approximately 20 or 30 minutes each time. The duration of this study will be from session 1 to session 20, a maximum of 5 months. A graduate student will administer the questionnaires. Your therapist will NOT be given any information on your specific responses. These responses are confidential.

Your name will NOT be included on the survey and YOUR ANONYMITY WILL BE MAINTAINED AT ALL TIMES. The questionnaires will be kept in a locked cabinet, available only to the researchers.

All questions you may have will be answered. You may refuse to answer any questions at any time. You can withdraw from the study at any time. There will be no penalty (i.e., You can continue to receive therapy at the Counseling Center) even if you choose to withdraw from the study.

The results of this study, if published, will be done with provision that all identifying information be withheld. If you have any questions about this study, you may call Dr. Faith McClure (909) 880-5598 or Dr. Edward Teyber (909) 880-5592, Psychology Department California State University, San Bernardino, CA 92407.

This research study has been approved by the Institutional Review Board (IRB) of California State University, San Bernardino. If you have questions about research subjects' rights or in the event of a research-related injury, you may contact the IRB (909) 880-5027.
I acknowledge understanding of the nature and purpose of this study and freely consent to participate.

Place a check mark here _____      Today's Date _____
Appendix F

Debriefing Statement

DEBRIEFING

Thank you for your participation in this study. As indicated in the informed consent form, the purpose of this study is to assess the relationship you have with your therapist and how you respond to therapy. At various times, we will ask you about symptoms you might have, how satisfied you are with how you feel, and about your relationship with your therapist. Your therapist will NOT have this information about your responses. We hope that this study will help us identify ways to make therapy more beneficial.

If any of the questions asked were disturbing to you, please discuss these with your therapist. You may also call Dr. Faith McClure (909) 880-5598 or Dr. Edward Teyber (909) 880-5592, Psychology Department, California State University, San Bernardino, 550 University Parkway, San Bernardino, CA 92407, if you have any questions or concerns.

There are also support groups in the community, most of which provide free group support. Information about available support groups near your home may be obtained by calling the California Self-Help Center, toll free (800) 222-Link.

Dr.'s McClure & Teyber may also be contacted if you would like a copy of the results from this study when it is completed.
REFERENCES


Derogatis, L. R. (1983). The SCL-90 scoring, administration and procedures, manual I (for the revised version). Baltimore: John Hopkins university School of Medicine, Clinical Psychometrics Research Unit.


