THE PROVIDER-CONSUMER RELATIONSHIP AND INDIVIDUAL WELL-BEING: PERSPECTIVES OF ADULTS WITH SERIOUS MENTAL ILLNESS AND THEIR MENTAL HEALTH CARE PROVIDERS

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ABSTRACT

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Using a sample of 60 adults with mental illness in an inpatient state hospital, the present study examined the relative contribution of mental health consumers’ reports of working alliance and provider directiveness in consumers’ perceptions of recovery-oriented service delivery, personal loss from mental illness, and individual well-being. Using a subsample of mental health consumers (n = 19) and their mental health providers (n = 9) the present study examined the congruence of perception between providers’ and consumers’ views of working alliance and provider directiveness in understanding individual well-being for consumers and providers. Findings suggest that consumers’ reports of working alliance and provider directiveness accounted for a significant proportion of the variation in their reports of recovery-orientation of services. Consumers’ reports of working alliance accounted for a significant proportion of the variance in consumers’ reports of their individual well-being. However, consumers’ scores on relationship measures were not significantly related to their reports of personal loss from mental illness. In a subsample of providers and consumers, dyadic analyses suggest that consumers’ reports of a stronger working alliance were related to providers’ reports of higher levels of directive practices. Dyadic results also suggest that greater congruence of perceptions of working alliance among consumer-provider dyads was positively related to consumers’ perceptions of recovery-oriented service delivery. Implications of findings for research and clinical practice are discussed.

Keywords: recovery, serious mental illness, therapeutic working alliance, provider directiveness
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INTRODUCTION

A recovery-oriented paradigm has dominated community mental health service delivery for the last twenty-five years. A recovery-orientation is now the accepted and preferred model of community mental health service delivery for adults with serious mental illness (Davidson, Lawless, & Leary, 2005a; O’Connell, Tondor, Croog, & Evans, 2005). Recovery is characterized by a shift from a focus on individual deficits and symptom identification to the concept that adults living with serious mental illness can live meaningful lives despite the presence of ongoing symptoms (Anthony, 1993; Lysaker & Buck, 2008; Randal et al., 2009). Providers are beginning to transition recovery-oriented service principles to inpatient psychiatric hospitals (Bartholomew & Kensler, 2010; Smith & Bartholomew, 2006; Swarbrick, 2009), which typically operated according to a medical or disease model approach where aspirations of “recovering” from mental illness were not supported. However, the degree to which recovery principles have been implemented in state psychiatric hospitals is unclear (Tsai & Salyers, 2008).

Contemporary recovery principles in hospital settings call for shared power and decision-making in the provider-consumer dyad. For example, consumers’ journeys in recovery are predicated on a strong therapeutic alliance, which is an essential element of a recovery paradigm and allows consumers to take the lead in their treatment (Anthony, 1993; Oades et al., 2005; Green et al., 2008; Randal et al., 2009; Swarbrick, 2009). Consumers’ reports of greater working alliance with providers has been found to be a significant predictor of consumers’ reported reduction in psychiatric symptoms, improvement in quality of life, achievement of individual goals, and increase in social functioning (Howgego et al., 2003; McCabe & Priebe, 2004). Research suggests a strong provider-consumer alliance could mitigate consumers’ sense of personal loss from mental illness (Neimeyer, 2001; Stein et al., 2005). In an effort to assist
consumers, mental health providers may inadvertently push or guide consumers, who may not be ready, into treatments or activities in the name of recovery (Davidson et al., 2005b).

Providers’ directiveness is inconsistent with recovery-oriented and self-determination service goals that call for choice, autonomy, and wellness (Davidson et al., 2005b; Farkas et al., 2005; McCann & Clark, 2004; Swarbrick, 2006). Providers’ directiveness has been shown to increase client resistance (Beutler et al., 2001; Bischoff & Tracey, 1995), and consumers’ views of greater directive behaviors from providers are associated with lower working alliance (Sheehan & Burns, 2011). Provider-consumer relationship factors may not only be associated with consumers’ sense of well-being and distress, but may also relate to mental health providers’ own sense of professional and personal growth.

There is some evidence suggesting that providers report that they benefit professionally (e.g., job satisfaction) and personally (e.g., personal growth) from their direct work with consumers in a recovery-oriented service system (Kraus & Stein 2013; Stein & Craft, 2007). Although inconsistent with recovery principles, there is also some evidence suggesting that community mental health providers see directiveness with consumers as a necessary relationship factor to providing services (Healy, 2008; Osborn & Stein, 2015). Interestingly, perceived differences in the strength of the working alliance between either provider or consumer may not necessarily lead to negative associations from consumers’ perspectives (Marmarosh & Kivlighan, 2012). Therefore, in a recovery paradigm, both providers and consumers may benefit in unique ways from their individual work together. Yet, few studies have simultaneously examined the relationship factors of working alliance and provider directiveness from the perspective of consumers in hospital settings. It is presently unclear how consumers’ views of their relationship with providers are associated with individual well-being. Although research has
examined relationship characteristics such as working alliance from providers’ and consumers’ perspectives, most studies aggregate results and do not match individual perspectives. Research that focuses on provider-consumer relationship factors from the perspective of both members of the dyad may be central to understanding how congruence of perception regarding providers’ and consumers’ views of their relationship are associated with individual well-being for both consumers and providers.

The present study was conducted in one state psychiatric hospital to examine the association between consumers’ views of their relationships with providers and reports of individual well-being. Specifically, after controlling for demographic and mental health characteristics, the present research examined the relative contribution of consumers’ views of working alliance and provider directiveness in explaining variation in consumers’ perceptions of recovery-orientation of inpatient services, personal loss from mental illness, and general well-being. Using a matched subsample of consumer-provider dyads, the research also investigated how consumers’ and providers’ views of their professional relationship are associated with individual well-being factors for consumers and for providers. The present study also explored how the congruence of perception regarding consumers’ and providers’ reports of working alliance was associated with individual well-being and consumers perceptions of recovery-orientation of inpatient services. To contextualize the present study, a brief review of the literature is provided including an overview of recovery, working alliance, directiveness, well-being factors associated with the dyadic provider-consumer relationship, and limitations of current literature.
LITERATURE REVIEW

Recovery

Almost two decades ago, Anthony (1993) defined mental health recovery as, “A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles....development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness” (p. 2). Swarbrick (2006) suggests that, “recovery is a personal, unique process of (re)gaining physical, spiritual, mental, and emotional balance after one encounters illness, crisis, or trauma” (p.1). Randal et al. (2009) write that recovery in mental health connotes achieving a meaningful life in the midst (or absence) of illness, and encompasses the notions of purpose, taking responsibility, having a renewed sense of hope, having meaningful relationships, and making decisions about one’s own treatment. Taken together, personal recovery is a holistic, unique, process or journey in which consumers engage in.

Recovery-oriented service delivery is a systemic approach to delivering and assisting in the personal recovery of consumers. Jacobson and Curtis (2000) suggest that core elements of recovery programs include education about severe and persistent mental illness, consumer and family involvement such as peer-support and self-help networks, support for consumer-operated services, emphasis on relapse prevention and management, incorporation of crisis planning and advance directives, innovations in contracting and financing mechanisms, definition and measure of outcomes, review and revision of policies, and stigma reduction initiatives. Farkas, Gagne, Anthony, and Chamberlin (2005) write that recovery-oriented programs should be person-centered and strengths-based by including the consumer in the design, plan, implementation, and evaluation of services. These authors further suggest that providers should respect consumers’ rights to make their own decisions about treatment goals and services, and acknowledge the possibility of consumers living a satisfying life beyond the disability (Farkas et al., 2005).
The concept of client autonomy is also a fundamental principle of the recovery movement. A recovery paradigm asserts that providers should instill a belief and expectation that recovery from mental illness is possible and that consumers’ own actions will influence their wellness (Randal et al., 2009). Therefore, there is a respect for consumers’ role in their individual journey towards recovery. In their community-based qualitative study, Light and Tse (2006) used a series of focus groups with sixteen providers from various helping professions (e.g., occupational therapists, social workers, clinical psychologists, psychiatric nurses, and psychotherapists) to determine what constitutes a collaborative relationship between consumer and provider. Results suggested that providers should focus on the autonomy of consumers in order to increase collaboration between provider and consumer. Although providers offer scaffolding to increase consumers’ autonomy, Anthony (1993) contends that consumers must assume the primary responsibility for their transformation from a disabled person to a person in recovery. This latter principle is noteworthy, in that providers’ working alliance must allow consumers the ability to act autonomously.

For example, Deegan (1996) claims that consumers’ autonomous decision-making about factors such as symptom management are essential for successful recovery. Interestingly, the training of most current mental health professionals does not prepare them for the challenge of reconciling the expectations of a risk-averse society with those of serving clients for autonomy, and may lead to services that are either paternalistic or neglectful (Randal et al., 2009). Further, Deegan (1996) writes that staff members may dangerously misjudge consumers’ abilities and only see negative signs and symptoms of illness. Providers working in community mental health face considerable challenges in trying to reconcile a consumer movement that emphasizes client
empowerment and autonomy, while maintaining ethically sounds practices such as non-
maleficence (Davis, 2002).

Studies suggest that recovery-oriented service delivery is starting to be adopted in community mental health settings. For example, Hardiman and Hodges (2008) found that there was familiarity among providers with recovery-based principles and a belief in the recovery model. O’Connell et al. (2005) found that providers, consumers, and family members generally agreed that their agencies provide services consistent with a recovery orientation. The authors found that mental health agencies were rated lowest by providers on items regarding involvement of consumers in service design and management (O’Connell et al., 2005), which are central components of a recovery paradigm. In a more recent study, Kidd et al. (2011) examined 67 Assertive Community Treatment teams. The authors found that recovery-oriented services were being delivered and further, that consumers with a serious mental illness who received recovery-oriented services appeared to have a better outcome clinically. The authors used the Recovery Self-Assessment to measure perceptions of recovery-oriented service delivery.

Finally, in her thorough review and content analysis of the literature, Magnabosco (2006) found that there is research indicating that 106 separate implementation activities and strategies were being implemented across eight separate states. Although at a variety of levels of implementation, Magnabosco (2006) found that these services included Assertive Community Treatment, Family Psychoeducation, Integrated Dual Diagnosis, Illness Management and Recovery, and Supportive Employment. Despite existing challenges to recovery-oriented service delivery (Kraus & Stein, 2013; O’Connell et al., 2005), evidence suggests the creation and implementation of recovery-oriented services in community mental health is occurring.
Interestingly, much of the research over the last few decades has focused on community mental health; however, researchers began applying community principles to inpatient hospital settings.

**Recovery and the State Psychiatric Hospital**

The treatment of individuals in psychiatric hospitals in the United States has a checkered history (Deutsch, 1936; Goffman, 1961; Grob, 1994; Lamb, 2001; Luchins, 1988). The longevity of patients’ psychiatric hospital stays, combined with the perceived chronicity of mental illness (Shean, 2008), resulted in thousands of patients warehoused in psychiatric hospitals for undetermined lengths of time with little expectation of returning to the community (Goffman, 1961). Operating under the medical model, state psychiatric hospitals focused on symptoms and illness management, and did not support the notion that persons living with mental illness have the same expectations for a meaningful life as those without mental illness (Swarbrick, 2009).

Psychosocial rehabilitation (PSR), a precursor to contemporary recovery principles, emerged in the late 1950s and was pioneered in institutional settings (Paul & Menditto, 1992). Although not universally implemented (Tarasenko, Sullivan, Ritchie, & Spalding, 2013), PSR was recognized as a comprehensive treatment of choice for individuals with severe mental illness and included services such as token-economy, social and occupational skills training, pharmacotherapy, psychotherapy, psychoeducation groups, with the primary outcome of discharge from the hospital to the community (Longo, Marsh-Williams, & Tate, 2002; Tarasenko et al., 2013). PSR, however, tended to focus on adaptive functioning and not necessarily holistic treatment by including consumers’ well-being and values (Swarbrick, 2009). In other words, to meet the demands of deinstitutionalization treatment focused on a minimal set of skills to facilitate discharge and prevent psychiatric relapse. Treatment lacked a focus on consumers' values, short and long-term personal (not treatment) goals, and skills to manage societal and internalized
stigma regarding living with mental illness. These additional skills may help consumers not simply live, but thrive in the community.

Limited by contemporary mental health service delivery standards, PSR was a clear improvement from medical model service delivery and provided benefits for consumers. There is research suggesting that a transition to PSR and recovery-oriented care is associated with consumers and provider outcome objectives. Eastern State Hospital for example, made a formal transition to a PSR model of mental health service delivery in 1996 (Longo, Marsh-Williams, & Tate, 2002). A core team of clinicians and providers made systems level changes by adding social and independent living services, community reintegration, recreation and leisure activities, psychoeducation groups (e.g., work skills, anger management, dual diagnosis, polydipsia, and HIV/sex education), a Treatment Mall where consumers could attend individually tailored psychoeducation groups and services (Longo, Marsh-Williams, & Tate, 2002). These providers reported that 78% of the original groups of consumers involved during the transition phase were discharged, and recidivism rates and seclusion and restraints also declined. In the last several years, the hospital again made formal steps to transition and implement a recovery-oriented model of inpatient service delivery, as similar outlined by Swarbrick (2009). PSR therefore, provided a bridge from the previous medical model to contemporary recovery principles in many inpatient hospitals.

Alternatively, Tarasenko et al., (2013) reported that the reduction of rehabilitation and recovery programs at one state hospital was associated with an increase in seclusion and restraint, decrease in fostering adaptive behaviors and recovery, decrease in discharge rates, and general increase in hospital expenditures. Smith and Bartholomew (2006) write that for many state hospital professionals presently, “the statement that ‘they’re too sick to recover’ is
perceived as obvious and inevitable” (p. 86). Thus, many providers continue to adhere to an outdated notion that many people do not overcome mental illness (Corrigan et al., 2012). Further, there is a misconception that hospitals are short-term institutions to stabilize patients and return them as quickly as possible to the community (Nolting, 2010). Although, hospital’s made attempts to integrate PSR and modern recovery principles, a considerable gap remains between medical and recovery-oriented paradigms and the degree to which recovery principals have been implemented in state psychiatric hospitals is unclear (Tsai & Salyers, 2008).

Available research suggests that recovery-oriented practices are being implemented in inpatient state hospitals (Martz & Newbill, 2014; Swarbrick, 2009). For example, peer support; a recovery-oriented service has been adapted for inpatient settings (Shattell, Andes, & Thomas, 2008). In their qualitative study of ten consumers in an inpatient hospital, Bouchard, Montreuil, and Gros (2010) found that peer support was associated with greater reports of improved mental health (e.g., feeling less alone, anxious, and stressed) and quality of life (e.g., more relaxed, hopeful, comforted, rested, and supported). In a sample of 110 inpatient consumers with serious mental illness, Mancini, Linhorst, Menditto, and Coleman (2013), evaluated the response of a statewide initiative to implement recovery-oriented services. Specifically, the researchers looked at the outcome to, Procovery, a 14-week consumer-developed and focused approach to provide education and develop hope through a structured mutual support group. Results indicated that consumers reported an overall improvement in satisfaction with their lives, an increase in beliefs that providers support their recoveries; however, there were no significant increases in well-being, quality of life, social relationships, and social exclusion (Mancini, Linhorst, Menditto, & Coleman, 2013). The researchers noted that consumers may not have received enough of a treatment dose to yield a significant increase in well-being, quality of life, social relationships,
and social exclusion or may not have been able to overcome the challenges of long-term hospitalization.

Recovery principles have also been adapted for inpatient consumers with a forensic status. Simpson and Penney (2011) write that concepts from best practices in recovery-based general mental health services should routinely inform forensic mental health practice and the development of recovery-based interventions for forensic patients. Forensic consumers, however, have additional recovery tasks, which include managing risk, and coping with discrimination, public fear, trauma, stigma, and social exclusion. Recovery principles can be included, however, in a system that is adversarial and risk management focused. Specifically, Simpson and Penney (2011) write that by providing attention to personal strengths and well-being within correctional and forensic psychiatric populations which is consistent with a recovery paradigm and supports the recent evolution in the field of violence risk assessment to focus on protective factors alongside risk.

Livingston, Nijdam-Jones, Lapsley, Calderwood, and Brink (2013), conducted a 19-month, repeated measures and mixed methods design, with 25 inpatient forensic consumers. These researchers sought to create services, which would support consumers’ recoveries and increase their engagement and autonomy through peer support, creation of a patient advisory committee, and a patient research team. Results indicated that consumers who participated in at least one peer support group reported greater scores on a measure of recovery, decreases in internalized stigma, and 45.8% reported “moderate” or “extreme” improvements in increasing consumers preferences for treatment decisions at follow-up (Livingston et al., 2013).

Regardless of consumers’ civil commitment or forensic statuses, state hospitals may pose unique challenges to recovery implementation and although strides have been made, there is still
a disbelief in the viability of scholarly aspirations of recovery. In their sample of 910 community and inpatient providers, Tsai and Salyers (2008) found that when compared to a community sample, staff in state hospitals reported significantly lower levels of personal optimism, consumer optimism (e.g., ability to live independently, to successfully cope with symptoms, achieve goals), and agency recovery-orientation. Taken together, research indicates that inpatient state psychiatric hospitals, although slow to transition, have made strides to implement recovery-oriented services which include a focus on peer support, autonomy, and choice. Perhaps not surprising, research suggests that the quality of the therapeutic alliance was one of the strongest determinants of inpatient forensic consumers’ satisfaction during their course of hospitalization (Coffey, 2006) and necessary for consumer and provider well-being (Swarbrick, 2009).

**Provider-Consumer Relationship Factors: Working Alliance**

The therapeutic relationship between mental health providers and consumers is of considerable interest to scholars (Horvath & Symonds, 1991; Martin, Graske, & Davis, 2000). Lambert and Barley (2002) write that the therapeutic alliance appears to be the single most important factor in psychotherapy regardless of technique or theoretical orientation. In their hallmark research, Horvath and Greenberg (1989) studied six counselors delivering services to 31 client-participants to establish the psychometric properties of their Working Alliance Inventory. At one-month follow-up, 30 – 46% of the variance of conflict resolution in psychotherapy could be accounted for by the therapeutic alliance. In other words, between about one-third to almost one half of the multidimensional factors that contribute to conflict resolution or successful completion of a clients’ goal were explained by the therapeutic alliance. Horvath and Symonds (1991) conducted a meta-analysis with a total of 24 studies investigating outcome satisfaction in psychotherapy as a function of the working alliance, finding an overall effect size
of .26. The researchers further found that working alliance and a satisfactory outcome was not impacted by the type or length of therapy. Other writers have noted as much as 40% of the variance in therapy outcome is due to extra-therapeutic factors (Lambert, 1992).

A good “fit” between clinician and consumer is likely a prerequisite for producing the kind of working alliance needed to assist consumers with their recovery-oriented goals (Green et al., 2008). In a working alliance in community mental health, both clinician and client are in charge and there is a sharing of power between client and clinician for mutually agreed upon goals (Anthony, 1993; Peebles et al., 2007). In her qualitative study of adults with mental illness (N=25) living in the community, Ásmundsdóttir (2009) identified supports and barriers to personal recovery from the consumers’ perspectives and worked with professionals to create new ideas for service delivery for persons with mental illness. Ásmundsdóttir (2009) writes that consumers being in charge of their life was fundamental to the recovery process, but was not easily achieved. The author argues that paternalistic approaches may facilitate mental health problems, as well as do a lack of respect, stereotyping, labeling, and discrimination. Thus, prescriptive service delivery or an approach of “clinician knows best” may do more harm than good when trying to facilitate consumers’ recoveries. Therefore, the function of the relationship between providers and consumers is that of a working *alliance*. Qualitative findings from Green et al. (2008) indicated that many of the discussions with adults with mental illness emphasized the importance of receiving information and support from clinicians about medications, and responsiveness to requests for medication changes when necessary.

In community mental health a working relationship between consumer and provider is said to occur in the form of equal participation in the creation of treatment goals and decisions, such as decisions that need to be made about consumers’ housing arrangements, employment,
illness education and management, and selection of psychotherapy homework (Green et al., 2008; Oades et al., 2005; Randal et al., 2009; Sowers, 2005). Alverson et al. (2007) write that it is necessary to build an alliance between client and care providers in which treatment and recovery are based upon a mutual exchange of questions, concerns, knowledge, values, and goals. Decisions about medications, suicide plans, and possible in/voluntary decisions for inpatient treatment provide a great need for a strong relationship where a consumer is offered choices. Therefore, the provider-consumer relationship is not one-sided and requires openness on the part of provider and consumer (Kraus & Stein, 2013). Finally, when providers work with consumers without a strong working alliance, providers may not have a clear understanding of consumers’ goals because consumers may verbally defer to providers while remaining silent about their preferences (Woltmann & Whitley, 2010).

In their community-based qualitative study, Light and Tse (2006) used a series of provider focus groups (e.g., occupational therapists, social workers, clinical psychologists, psychiatric nurses, and psychotherapists), to describe what constitutes a collaborative relationship between consumers and providers. The authors found that from mental health providers’ perspectives, using consumers’ language, expressing hope to clients, being open to new ideas, and asking consumers what they want increased the likelihood of a successful collaborative relationship. Mental health providers working in a strengths-based recovery-oriented paradigm and maintain a strong working relationship are not supposed to manipulate or coerce (Drake & Deegan, 2008). Although there are times when consumers are not able to offer consent or have insight into their current difficulties as a result of psychiatric symptoms, most persons with schizophrenia can achieve long and meaningful periods of recovery, optimistic outlook on life, and a sense of self-worth (Lysaker & Buck, 2008). A recovery-oriented approach
dictates that effective treatment is built upon providers’ understanding of the preferences and goals of the consumers with whom they work, which is antithetical to providers’ directive approaches (Davis, 2002) and detrimental to a working alliance (Monahan et al., 2005).

**Provider-Consumer Relationship Factors: Provider Directiveness**

From consumers’ perspectives, working alliance does not include directiveness by mental health care providers, but rather focuses on choice and autonomy in identifying and pursuing preferred futures (Anthony, 1993; Farkas et al., 2005; Peebles et al., 2007; Randal et al., 2009). In the context of their relationship with consumers, providers may intentionally or unintentionally engage in directive relationship practices. For example, Davidson et al. (2005b) warn of the dangers of increased social pressure on consumers to recover and of the possibility of clinicians’ prematurely encouraging clients to take on new challenges that they may not be ready for in the name of “recovery” (Davidson et al., 2005b). Davidson’s et al. (2005b) notion of increased social pressure from providers to have adults with mental illness “recover” without regard for their present circumstances or individual preferences may occur when mental health providers engage in directive practices.

Operationally speaking, mental health provider directiveness within a recovery-oriented service system is defined as specific and purposeful behavioral actions that mental health providers engage in, without a malicious intention, that are inconsistent with consumers’ desires (Osborn & Stein, 2015). Based on Davidson’s observations and the present operational definition, provider directiveness is in opposition to mental health recovery principles that call for shared participation in decision-making between consumer and provider (Davidson et al., 2005b). The current operational definition is consistent with definitions of directiveness found in the literature. For example, directive interventions by providers are those which would tend to
lead, direct, or control the verbal activity during the therapy session, such as by forcing a topic whereas nondirective interventions tend to give responsibility of decisions and choices to the client (Hagebak & Parker, 1969). Other contemporary researchers define directiveness as “the degree to which practitioners try to influence clients to accept a solution or course of action preferred by the practitioner” (Healy, 2008, p. 72). Providers’ directive relationship practices are particularly problematic in the context of consumers’ recovery goals and may negatively affect their perceptions of individual well-being. This latter notion is important in that the treatment setting may also influence the frequency of directive practices, despite aspirations of recovery-oriented service delivery.

**Understanding Consumer Well-being**

A mutual and collaborative working alliance is an essential, foundational comportment, of recovery-oriented service delivery (Anthony, 1993; Coffey, 2006; Green et al., 2008; Oades et al., 2005; Randal et al., 2009). Working alliance fosters consumers’ abilities to be equal participants in treatment decisions and effective patient-clinician communication is at the heart of shared decision making (Wills & Holmes-Rovner, 2006). Research shows that nearly all psychiatric patients, even the majority of those with severe disorders such as schizophrenia, are capable of understanding treatment choices and making rational decisions (Carpenter, Gold, Lahti, et al., 2000; Grisso & Applebaum, 1995; Stroup, Appelbaum, Swartz, Patel, et al., 2005). Shared decision making is also central in illness management and recovery-oriented service delivery (Mueser, Corrigan, et al., 2002).

When an effective alliance is formed, research suggests that the provider-consumer relationship may be associated with multiple factors for consumers. For example, in his community study of adults with mental illness ($N = 160$), Kondrat (2012) found that those
consumers who reported a perceived stronger relationship with their case managers, tended to report less self-stigma and greater quality of life. Specifically, the case manager-consumer relationship accounted for 25% of the variance in quality of life scores. Similarly, in their study of adults with schizophrenia and providers ($N = 22$ dyads), Gehrs and Goering (1994) found that rehabilitation therapists’ and consumers’ perceptions of working alliance were significantly associated with increased goal attainment and fewer reported problems. In their qualitative study of inpatient consumers with serious mental illness ($N = 20$), Storm and Davidson (2010) found that even though providers were viewed as being nice and supportive, consumers did not always feel that they were being seen or heard as persons with their own individual preferences and desires. In their review of the literature, McCabe and Priebe (2004) determined that the working alliance is an effective predictor of mental health consumers’ perceptions of fewer symptoms, increased social functioning, and greater quality of life. Similarly, in a meta-analytic review of 84 studies using a validated working alliance measure, Howgego et al. (2003) found that the working alliance was the greatest predictor of factors such as symptom reduction, quality of life, and target goal completion, for adults with mental illness receiving community mental health services. Recently, Kvrgic et al. (2013) wrote that using the provider-consumer relationship to focus on consumers’ individual recovery goals and symptoms may promote consumers’ perceptions of recovery-orientation.

Other researchers have studied the role of personal loss in understanding consumers’ perceptions of their well-being. Stein, Dworsky, Phillips, and Hunt (2005) found that consumers often report a perceived sense of personal loss due to their mental health difficulties. Using a community sample of adults with serious mental illness ($N = 158$), these researchers developed the 20-item Personal Loss from Mental Illness scale designed to quantify consumers’ perceptions
of perceived losses such as personal, relational, and psychosocial loss, because of their psychiatric disabilities. Stein et al. (2005) found that participants who reported a greater sense of personal loss from mental illness also reported more interpersonal loneliness, mental health symptoms, and difficulties with alcohol. Individuals’ perceived sense of loss from mental illness or trauma can eventually be incorporated into their sense of self. It is possible that supportive relationships in psychotherapy could increase consumers’ well-being by decreasing their sense of personal loss through meaning making or reconstructing their personal narrative to provide continuity and understanding (Neimeyer, 2001). Although empirically unanswered, it is reasonable to suggest that consumers’ reports of a stronger provider-consumer working alliance would be associated with a lower sense of personal loss.

Interestingly, in the context of a recovery-oriented paradigm, it is acceptable for consumers to report a strong perceived alliance, while simultaneously endorsing active symptoms of their mental illness. Consumers’ perceived well-being extends beyond reports of symptom reduction (Corrigan et al., 2012; Ryan & Deci, 2000). Therefore, correlates other than symptom reduction may provide a more robust understanding of the contributions of the provider-consumer alliance, such as perceptions of recovery, general well-being, and perceptions of personal loss.

Provider directiveness is another important relationship factor salient to consumers’ perceptions of well-being. Researchers have found that providers’ directiveness increased client resistance (Beutler et al., 2001; Bischoff & Tracey, 1995). Recently, Karno and Longabaugh (2005) found that less directiveness by therapists improved drinking outcomes of reactant clients ($N = 141$) in treatment. These findings suggest that clinicians may be able to enhance consumers’ perceptions of treatment and recoveries by minimizing the use of directive interventions. Other
investigators found that when a consumer perceives that his or her autonomy is limited they are more likely to report a weaker provider-consumer alliance (Sheehan & Burns, 2011). Specifically, in their study of newly admitted inpatients ($N = 164$), Sheehan and Burns (2011) found that clients who perceived high levels of coercion tended to rate their admitting physician more poorly that those who experienced low levels of coercion. These effects were found when controlling for voluntary and involuntary admission status of consumers. To decrease perceptions of coercion, the authors note that specifically, the modality for intervention lies in increasing the therapeutic relationship (Sheehan & Burns, 2011). Similarly, researchers found that when consumers perceive civil commitment hearings negatively, they tend to report a negative working alliance with their providers (Donnelly, Lynch, Mohan, & Kenney, 2011). Therefore, it is not surprising that authors have specifically argued against practices that tend to direct, control, or limit consumers’ autonomy (Drake & Deegan, 2008).

**Understanding Mental Health Care Provider Well-being**

Although previous research noted well-being associations for adults living with mental illness, it is possible that mental health clinicians are impacted by dyadic provider-consumer relationship factors. Researchers often focus on the less desirable associations of working with clients with mental illness (Linley & Joseph, 2007). For example, research suggests that the considerable demands faced by mental health providers in the community mental health system often result in professional burnout and job dissatisfaction (Carney et al., 1993; Gitter, 2006). Some research, however, suggests that the level of recovery-orientation at an agency may have positive benefits for mental health providers themselves. Salyers, Tsai, and Stultz, (2007) found that providers who had high levels of personal optimism and had positive views of consumers were more likely to view their agency as more recovery-oriented. In their community sample of
114 community mental health providers, Kraus and Stein (2013) found that providers’ perceptions of agency recovery-orientation were positively related to their job satisfaction after controlling for individual characteristics such as age, level of education, and caseload size.

There is also initial evidence to suggest that when providers build a strong working alliance with consumers, a critical element to recovery-oriented service delivery, they tend to report greater satisfaction in their respective jobs. In their qualitative study of twelve psychiatric nurses working in community mental health, Wilson and Crowe (2008) found that the therapeutic alliance was the most important contribution to nurses’ reports of satisfaction in their job. Further, in addition to influencing providers’ professional job satisfaction and perceptions of recovery, working directly with consumers may provide additional associations for providers’ personal lives and well-being.

In their study of master’s and doctoral level clinicians \( (N = 156) \), Linley and Joseph (2007) found that participants’ perceived positive well-being was associated with scores on measures of the sense of coherence of personality, empathy with clients, the therapeutic bond of the working alliance, and social support. In another study using a sample of 98 community case managers, Stein and Craft (2007) found that helping professionals reported personal growth as a result of their direct work with consumers receiving recovery services. The researchers found that the age of participants and length of job tenure was significantly positively associated with overall reports of case manager personal growth, which is unique given the prevalence of professional burnout and turnover in community mental health (Gitter, 2006). Taken together, dyadic working alliance factors between providers and consumers likely impact mental health providers’ perceptions of professional (i.e., professional burnout, perceptions of recovery) and personal well-being (i.e., general well-being, personal growth).
Contrary to consumers, perceptions from mental health providers suggest there is some support for the use of provider directiveness relationship practices. For example, in her qualitative study of community social workers ($N = 17$), Healy (2008) found that participants reported intentionally engaging in multiple levels of directive actions which included: providing information/options, problem solving, guiding/coaxing, directing, pressuring, independent action (e.g., mandated reporting). Data analysis revealed that clinicians engaged in these actions as a result of time worked their clients, safety concerns, perceived decisional capacity of clients, perceived agreement, and moral responsibility on participants behalf to act (Healy, 2008). When discussing the implications of her findings, Healy (2008) writes that, “high levels of directiveness may be used to secure practitioners’ preferences” (p. 86).

More recently, Osborn and Stein (2015) developed and administered a 9-item self-report measure assessing provider directiveness in a community sample of multidisciplinary providers ($N = 105$) working with adults who have a serious mental illness. The measure assessed the degree to which providers endorsed engaging in specific, yet, subtle behaviors that limit the autonomy and choice of their clients (Osborn & Stein, 2015). Findings indicated that the provider directiveness measure negatively correlated with a measure of working alliance ($r = - .30, p < .01$); unexpectedly however, provider directiveness were positively associated with perceptions of personal growth ($r = .24, p < .05$). Findings suggest that providers who reported greater gains in their personal and professional well-being as a result of working directly with consumers who have a serious mental illness, also reported engaging in more directive practices with consumers.

Provider directiveness (Osborn & Stein, 2015) highlights a distinction between a consumer’s ability to make autonomous decisions and the provider’s desire to make decisions for
a consumer because the provider feels that he or she knows “what’s best” for the consumer. For example, a mental health provider can seemingly be receptive to his or her client’s autonomous wishes or desires about a specific treatment, but pressure or direct a client into seeking an outcome congruent with the provider’s own desires. Further, providers’ decisions to employ leverages do not depend on the inability of persons with serious mental illnesses to make treatment-related decisions for themselves (Appelbaum & Redlich, 2006). Thus, providers may employ leverages regardless of consumers’ in/ability to demonstrate capacity for informed decision making in treatment, which limits consumers’ recoveries by denying autonomy.

Limitations of Existing Research on the Provider-Consumer Working Alliance

A number of researchers have investigated the therapeutic working alliance over the last several decades. However, methodological limitations such as using working alliance as a dependent variable, and sample selection and statistical analysis issues have hindered our understanding of the role working alliance in service delivery for people with serious mental illness. In studies of adults with mental illness and research with clinicians, researchers often use working alliance as a dependent variable to understand specific factors that predict or are related to working alliance. In their study of inpatient adults with mental illness (\(N = 75\)), Donnelly et al. (2011) found no significant difference in participants that perceived their physicians are more coercive across multiple time points during legal proceedings as measured by the Working Alliance Inventory. In their randomized controlled trial (\(N = 50\)), Wykes, Rose, Williams, and David (2013) determined that the type of anti-psychotic medication participants received affected their views of working alliance. Specifically, the researchers determined that those participants receiving long acting injectable risperidone were more likely to report lower scores on the Working Alliance Inventory measure.
In a community study of 160 consumers diagnosed with serious mental illness and substance use disorders, Kondrat and Early (2010) used hierarchical linear modeling to understand the role of consumers’ perceived stigma and working alliance. The researchers found a significant interaction affect between case managers’ and consumers’ perceived stigma scores, which explained 25% of the variance in scores on the Working Alliance Inventory. Findings suggested that some case managers are better able to reduce the effects of consumers’ perceived stigma, which resulted in higher alliance scores (Kondrat & Early, 2010). Using a sample of adults with mental illness (N = 61) receiving community services, Hicks, Deane, and Crowe (2012) used measures of recovery to predict scores on the Working Alliance Inventory at two times points. Results suggested that initial scores on a recovery measures significantly predicted increased scores on working alliance at Time 2, $F(2,58) = 11.131, p = .00$, Adjusted $R^2 = 0.252$.

Bartle-Haring et al. (2012) measured individuals ($n = 52$) and couples ($n = 96$) in treatment with 15 therapists to understand factors associated with higher scores on the Working Alliance Inventory. Results of hierarchical linear modeling suggested that 91% of the scores on alliance measure was explained at the Level 1, client characteristics level, for individuals in treatment and sex of the client and experience of the therapist were not significant predictors. Further, results of hierarchical linear modeling suggested that the sex of therapist was not a significant factor in male and female couples’ ratings of alliance and female, but not male scores of alliance, tended to change over time. Findings also suggested that about 9% of the variance in female partners’ scores and 33% of the variance in male partners’ scores lies at the therapist level (Bartle-Haring et al., 2012). Taken together, these studies help to document specific factors associated with or predictive of consumers ratings of therapeutic working alliance. However, within the context of a recovery paradigm, the consumer-provider alliance is thought to be the
foundation from which treatment progresses and not an end point per se. Therefore, building a therapeutic alliance is seen as essential so a provider and consumer can together navigate the consumer’s recovery in accordance with the consumer’s goals.

When working alliance is used an independent variable, researchers often predict clinical factors for consumers and not for providers. Recently, Arnow et al. (2013) sampled 243 consumers and their clinicians to understand how the working alliance affects symptoms of depression. Specifically, the researchers used the Working Alliance Inventory as an independent variable to predict scores on the Hamilton Rating Scale for Depression as well as looked for an interaction effect on the type of therapy clients received. Similarly, Weiss and colleagues (1997) obtained a sample of consumers (N = 31) receiving pharmacotherapy to understand the predictive potential of working alliance on the clinical factors of depression and symptom reduction. Findings suggested that 3% of the outcome variance was explained by patients’ ratings of alliance (Weiss et al., 1997).

Other researchers have investigated the role of working alliance in reducing depression (DeRubeis & Feeley, 1990; Feeley et al., 1999), psychosis (Priebe & Gruyters, 1995; Tattan & Tarrier, 2000), and post-traumatic stress disorder symptoms (Marmar et al., 1986). Thus, researchers tend to assess how perceptions of working alliance and treatment reduce participants’ clinical symptoms and improve psychosocial adjustment. Symptom reduction is unquestionably an important goal of treatment; however, recovery-oriented service delivery is wellness oriented and encourages holistic care. Therefore, consumers’ symptom reduction is likely one of several important goals (e.g., obtaining housing and employment, spending time with friends, making new friends, etc.) related to their recoveries.
Another limitation in existing working alliance literature is a single perspective design, generally from consumer’s viewpoint (Chao, Steffen, & Heiby, 2012; Hicks, Deane, & Crowe; 2012; Solomon, Draine, & Delany, 1995). Available multiple perspectives designs often contain considerable research addressing consumers’ and case managers’ views as opposed to mental health clinicians (De Leeuw, Van Meijel, Grypdonck, & Kroon, 2012; Neale and Rosenbeck, 1995). Although limited, working alliance research with mental health clinicians and clients suggests that clients’ reported changes in treatment may occur even with a mismatch of working alliance perceptions.

In a sample of therapist-client dyads ($N = 82$) from a university community clinic and university counseling centers, Marmarosh and Kivlighan (2012) assessed how perceived disagreement in the working alliance relates to clients’ reported symptom reduction. Specifically, these researchers hypothesized that there would be greater symptom reduction when the client’s perceptions of working alliance are stronger than the therapist’s perceptions of working alliance and when the therapist’s perceptions of working alliance are stronger than the client’s perceptions of working alliance (Marmarosh & Kivlighan, 2012). Surprisingly, results of hierarchical linear modeling indicated that the greater the disagreement on working alliance scores, the greater the symptom improvement. Further, results suggested that the consequences of disagreement were the same regardless of whether client ratings of working alliance were higher than therapist ratings of working alliance or therapist ratings of the working alliance were higher than the client ratings (Marmarosh & Kivlighan, 2012). These findings suggest that differences in the strength of a working alliance do not appear to be negatively associated with clients’ symptom reduction and an alliance is more adaptive than a “strong alliance.”
The correlational nature of most research studies on this topic also serves to limit our understanding of the role of therapeutic alliance in mental health recovery. For example, in their study of 22 therapist-client dyads, Gehrs and Goering (1994) analyzed their data with Pearson’s product-moment correlation coefficients to understand associations of working alliance with consumers’ reported goal attainment and perceived problems in their lives. Correlational analysis provides an estimate of the strength of an associate and the degree to which it did not occur due to chance; however, there is no assessment of causality or direction of the associations. Further, correlation analysis does not provide control for potential covariates such as age or gender and it is also not possible to simultaneously examine therapist and client scores on alliance measures with factors such as symptom reduction. Other researchers conduct statistical psychometric evaluations and are not treatment or outcome related. For example, some researchers (Busseri & Tyler, 2003; Hatcher & Gillaspy, 2006) used the Working Alliance Inventory – short form to assess the reliability and validity of a short form version of the 36-item version (Horvath & Greenberg, 1989). Taken together, when working alliance researchers are not evaluating the psychometric principles of measures, they are also not taking advantage of refined statistical analyses such as repeated measures, hierarchical linear modeling, or linear mixed model regression analysis which allow for missing data, unbalanced groups, and control of known covariates of interest.

Over the last three decades, studies enhanced our understanding of how to define and measure therapeutic working alliance, and factors associated with self-reported working alliance from the separate perspectives of providers and clients. Yet, research examining relationship factors between mental health providers and consumers is often conducted in an effort to understand significant predictors of an alliance; however, in a recovery paradigm working
alliance is a necessary foundation not product. A significant amount of research is also conducted in community, university, or counseling settings and tends to measure consumers’ symptom reduction. A paucity of available research has systematically obtained the perspectives of adults living with mental illness in inpatient hospital settings to understand their views of their relationships with providers. A detailed understanding could provide insight into consumers’ perceptions of a service delivery paradigm shift in inpatient hospital settings, specifically toward recovery principles. Further, a systematic examination of consumers’ views of their relationship with providers could provide an understanding of which specific relationship characteristics are associated with consumer’s individual well-being. With the addition of mental health providers it would be possible to understand how providers’ relationships with consumers are associated with their individual well-being. Lastly, it would be innovative to match inpatient consumers’ and providers’ views of their professional relationship to systematically understand if they are congruent and how their matched relationship views are associated with individual well-being.
PRESENT STUDY

The present study examined the role of consumers’ professional relationships with mental health providers in describing consumers’ perceptions of recovery-orientation of inpatient services and individual well-being for adults with serious mental illness. Specifically, the research purposefully obtained the views of consumers living in an inpatient hospital setting to understand how their views of working alliance and provider directiveness are associated with reports of the level of recovery-orientation of inpatient services, feelings of personal loss due to mental illness, and overall well-being. In addition, the present research obtained the perspectives of mental health providers regarding their professional relationships with a subsample of consumers to examine aspects of professional relationships from both consumer and provider perspectives. This phase of the research examined the extent to which providers’ views of working alliance and provider directiveness were associated with providers’ own views of professional burnout, personal growth, and well-being. Yoked consumer and provider data was used to investigate the level of congruence of perception between consumers’ and providers’ views their working alliance and provider directiveness. Further, the research examined the relationship between congruence of perception and consumers’ perceptions of recovery-orientation of inpatient services and providers’ well-being.

The study was designed to address the following three main research questions:

1. Are consumers’ perceptions of the relationship factors of working alliance and directiveness significantly associated with reports of recovery-oriented service delivery, personal loss from mental illness, and well-being? Based on previous research it was expected that: (1) consumers’ scores on working alliance would be positively associated with reports of recovery-orientation and well-being and negatively associated with
consumers’ reports of personal loss from mental illness; and (2) scores on directiveness would be negatively associated with reports of recovery-orientation and well-being, and positively associated with reports of personal loss from mental illness.

2. What is the nature of associations between perceived working alliance and provider directiveness from the perspectives of both consumers and the mental health care providers with whom they work? Based on previous research, it was expected that: (1) perceptions of working alliance would be negatively related to perceptions of directiveness for both consumers and providers; and (2) providers’ and consumers’ perceptions of working alliance would be positively related.

3. Is congruence of perception between mental health care providers’ and consumers’ reports of working alliance and provider directiveness at the dyadic level related to individual perceptions of well-being for consumers and providers? Based on previous research, it was expected that: (1) level of congruence of perception between consumers’ and providers’ reports of working alliance and provider directiveness would be positively related to both consumers’ and providers’ reports of individual well-being.
THE PROVIDER-CONSUMER RELATIONSHIP AND PERCEIVED WELL-BEING

METHOD

Context for the Present Study

The study was conducted at Eastern State Hospital from February until April 2015. It is important to provide a brief overview of this psychiatric hospital setting to help contextualize the present study methods and results. Opened in 1773, Eastern State Hospital was the first public hospital in America dedicated exclusively to the treatment of people with mental illness. Presently, Eastern State Hospital is the largest inpatient state psychiatric hospital in the Commonwealth of Virginia. The hospital’s census fluctuates, but during the course of the present study held an average daily census of 281 out of 302 possible patients. During the fiscal year of 2013 the hospital had 242 admissions, which parallels the national trend in decreasing admissions since 1977 (“Comprehensive State Plan,” 2013). However, the rate of admissions increased in the past year, with 290 admissions from January to May 2015. The hospital employs 17 licensed clinical psychologists, 16 social workers, 52 registered nurses, 66 licensed practicing nurses, 252 certified nursing assistants, 14 medical doctors, and 2 peer support specialists. Eastern State Hospital provides services for acute psychiatric admissions from the community, jails, and other mental health facilities. Consumers are typically under voluntary or involuntary civil commitment, temporary detention status for evaluation, or forensic status, which is primarily composed of individuals acquitted Not Guilty by Reason of Insanity (NGRI) and individuals found incompetent to stand trial (IST), and ordered for restoration to competency to stand trial (CST).

The hospital operated primarily according to a PSR model of service delivery until 2006 when a statewide initiative caused Eastern State Hospital to begin transitioning to a Recovery-Oriented System of Care to support consumer recovery, self-determination, empowerment, and
person-centered planning (“Comprehensive State Plan,” 2013). In the hospital’s most recent progress update, a recovery committee has been created which works in collaboration with peer support specialists and the recovery coordinator to disseminate and collect consumer satisfaction surveys and increase consumers’ choices and transparency between providers and consumers (“Facility Comprehensive Plan,” 2014). Peer support specialists are consumers with at least one year of mental health recovery who adhere to a specialized code of ethics and choose to participate in an advanced state facilitated training which includes education on recovery, mental illness, crises intervention, ethics, cultural awareness, trauma informed care, and agency or systems intervention. Once certified, peer support specialists work in community and inpatient settings to provide mental health services with consumers, families, staff, and the public.

The hospital has also initiated short and long-term goals for recovery implementation, such as staff education, increasing paid employment for consumers, increasing consumers’ access to family and friends, increasing collaboration with community mental health centers and community reintegration and access, improve knowledge of recovery principles, and improve individualized treatment planning (“Facility Comprehensive Plan,” 2014). These goals parallel scholarly aspiration of recovery-oriented implementation and service delivery (Swarbrick, 2009). During consumer’s course of hospitalization, all consumers are involved in some degree of active treatment such as receiving medications and psychoeducation groups. However, many consumers also attend consumer clubhouses and day treatment at their catchment CMHCs, have grounds and/or community privileges, work jobs in the hospital and community, see additional outpatient providers, and spend multiple nights per week at various community and/or family placements. Thus, the hospital has consumers at all levels of mental health recovery.
Procedure

Participants were recruited for the study from Eastern State Hospital by the principal investigator who was serving as a pre-doctoral intern in clinical psychology at the hospital. The study received approval from the Human Subjects Review Board (HSRB) at Bowling Green State University, and from the hospital’s Institutional Review Board (IRB) and Local Human Rights Community Committee (LHRC), which is composed of mental health professionals, consumers, and community members. The LHRC acts as an external check to the hospital’s internal IRB and conducts services such as fact-finding hearings, policy review and recommendation, and complaint resolution.

Study information was disseminated to the hospital’s psychology department via email (See Appendix A). The principal investigator attended multiple forensic, civil, and departmental psychology group supervision meetings to talk about the study and obtain support from staff. Additional office “drop-in” meetings and “community meetings” were attended to provide information about the study to providers and consumers about the research.

Consumers were recruited in the PSR hall and on the hospital’s psychiatric units. After describing the study in detail and ensuring consumers met eligibility criteria, interested consumers signed a paper informed consent (see Appendix D) and completed paper-and-pencil relationship measures and measures on recovery, personal loss from mental illness, well-being, and demographic questions. Consumers were given $5.00 in hospital vouchers as a token of appreciation for participation in the research.

To obtain a yoked subsample of providers and consumers, interested providers contacted the principal investigator by email and were provided a unique online survey link and the
consumer recruitment materials. Specifically, using the Consumer Nomination Form (see Appendix B) providers were asked to nominate up to five consumers who they see individual one-on-one therapy work. Providers gave a brief introduction to the study and gave potential consumer participants the form and an envelope. The principal investigator placed larger envelopes in nursing stations around the hospital in which consumers were instructed to place the forms. Providers next completed the remaining materials via an online survey hosted by SurveyGizmo.com and signed an online informed consent (see Appendix C). The survey asked providers how many consumers they nominated, to enter the initials of their clients, and then presented two relationships measures per consumer nominated. Providers also completed measures on personal growth, burnout, and well-being, along with demographic questions.

The principal investigator then approached consumers who were nominated via completed Consumer Nomination Forms to describe the study in detail and ensure consumers met eligibility criteria. Interested consumers also signed a paper informed consent (see Appendix D) and filled out paper-and-pencil relationship measures and measures on recovery, personal loss from mental illness, well-being, and demographic questions. The principal investigator was available to assist consumers if needed. All consumers were given $5.00 in hospital vouchers as a token of appreciation for participating in the research.

**Consumer Participants**

The present study was composed of 60 mental health consumers (47 men and 13 women). Mental health consumers were eligible to participate in the research if they were at least 18 years of age and diagnosed with a severe mental illness as defined by the DSM-IV-TR (e.g., major depression, schizophrenia, post-traumatic stress disorder). A serious mental illness is defined by markedly severe impairments, since the time of illness onset, in one or more areas of
functioning: employment, independent living, and self-care. Consumer could not have a legal
guardian or authorized representative. Consumers living with developmental disabilities,
dementia, or profound communication deficits were excluded.

Consumer demographic and treatment characteristics for the sample are found in Table 1
and Table 2. Consumers in the overall sample were an average of 40.1 years old ($SD = 13.4$) and
the majority were single (68%), with no children (62%), and protestant or other Christian
religious preferences (53%). The present sample was primarily Caucasian (47%) and African
American (42%). Less than half of the sample reported having a GED or high school diploma or
below (48%), and about one third of the sample had some college or technical school training
(32%). Although consumers have the option of paid employment in the hospital, the majority
reported that they are not currently working (58%) and are also not members of NAMI (78%).
Consumers were similar in regards to individual demographics with individuals across the
Commonwealth of Virginia (e.g., Age: 23 to 59; Race: 62% white and 29% African American)
who receive community and inpatient services (“Comprehensive State Plan,” 2013).

Consumers reported that their current course of hospitalization was an average of 32.6
months ($SD = 46.4$ months). A majority of consumers in the present sample reported that they
were at least somewhat involved in their mental health treatment (57%) and the remainder
reported that they were very involved (43%). The majority of the present sample reported that
they were living independently or with family members prior to entering the hospital (71%).
Sixty-one percent of consumers were diagnosed with schizophrenia or schizoaffective disorder
and almost one quarter were diagnosed with bipolar disorder (23%). The majority of consumers
reported that their symptoms were a little or not at all serious (77%) and that they were
hospitalized an average of 7.1 ($SD = 9.8$) times. Forty-seven percent of consumers reported
receiving mental health services for ten years or more. A majority of mental health consumers were involuntarily civilly committed (87%) and under forensic status (60%). A majority of consumers reported receiving psychotropic medications (83%) and psychosocial rehabilitation services (40%) in the hospital.

**Dyadic Sample Characteristics**

**Provider Participants and Descriptive Statistics.** The mental health care provider sample was composed of nine licensed clinical psychologists (four men and five women). Mental health care providers were eligible to participate if they: (1) were licensed clinicians; and (2) worked with consumers who have a serious mental illness as categorized by the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000), 3.) worked in the mental health field for at least five years, and 4.) practiced a recovery-oriented model of service delivery. Providers in the sample were an average age of 42.3 \( (SD = 14.7) \) years old. The majority of providers were Caucasian (67%) and had worked in the mental health system for an average of 14.5 \( (SD = 13.0; \text{range } 2 – 36) \) years. Providers reported earning an average income between $65,000 and $74,999 and a majority (56%) reported that they have a caseload size of less than 25 clients. Providers reported spending on average 5.2 \( (SD = 2.8) \) hours per week in individual and group \( (2.89, SD = 1.8) \) therapy. Twenty-two percent \( (n = 2) \) reported that they spend 10 to 14 hours per week in direct contact, 33\% \( (n = 3) \) reported that they spend 15 to 19 hours per week in direct contact, and 44\% \( (n = 4) \) reported that they spend 25 to 29 hours per week in direct contact.

**Consumer Participants and Descriptive Statistics.** The consumer subsample was composed of 19 mental health consumers (17 men and 2 women). These consumers were a subset of the overall sample of 60 mental health consumers; however, only these 19 mental
consumers were nominated by mental health providers to participate in the present research. Providers’ nominations of specific consumers allowed for direct matching of consumers’ and providers’ responses on study variables of interest. The consumer subsample also met the study inclusion criteria. This subsample of consumers were an average of 37.9 ($SD = 13.9$) years old and most were not married (68.4%) and did not have children (57%). The subsample was primarily Caucasian (53%) and that majority of consumers reported that they had some college or technical school (77%). Sixty-eight percent of consumers were not working for pay in the hospital.

Regarding their mental health treatment characteristics, consumers reported that their current course of hospitalization was an average of 37.33 months ($SD = 55.6$ months). A majority of consumers reported that they were at least somewhat involved in their mental health treatment (84%). The majority reported that they were living independent or with family before coming to the hospital (83%). Half of the sample reported that they had a mental health diagnosis of schizophrenia or schizoaffective disorder (50%) and about one-third reported a diagnosis of bipolar disorder (32%). The majority of consumers reported that their mental health symptoms were not at all serious (74%) and were hospitalized an average of 3.52 times ($SD = 2.6$). Eighty-four percent were admitted under an involuntary order and over one-half had a forensic status (58%).

Less than one-half of consumers reported being in individual therapy work for less than 5 months (44.4%) and over one-third for longer than one year (37%). Most consumers reported that they did not pick their psychologist (90%) and were primarily referred by their treatment team providers (68.4%). The entire subsample reported that they took psychotropic medications, attended PSR group treatment, and over one-third went to a clubhouse (37%).
An overview of the specific measures that were completed by these consumers and providers in the study is found in Table 3.

**Consumer Preliminary Analysis.** A series of independent samples t-tests (e.g., Group 1: matched subsample vs. Group 2: unmatched sample) were used to describe differences between the 19 consumers matched with providers and the remaining 41 consumers on study variables of interest. No significant group differences were found on consumers’ mean scores on measures of recovery, personal loss from mental illness, provider directiveness, symptoms, number of hospitalizations, or age. Significant group differences were found on a measure of well-being, such that consumers in group 1 (matched subsample) reported significantly greater well-being scores \((M = 77.32, SD = 9.46)\), than consumers in group 2 \((M = 70.20, SD = 12.82)\), \(t(58) = 2.16, p < .05\). Significant differences were also found on a measure of working alliance, such that consumers in group 1 (matched subsample) tended to report greater working alliance scores \((M = 4.31, SD = .53)\), than consumers in group 2 \((M = 3.61, SD = .14)\), \(t(58) = 3.19, p < .01\).

**Consumer Measures**

**Working Alliance Inventory – Short Revised.** This measure (Hatcher & Gillaspy, 2006; see Appendix E) is a paper and pencil self-administered assessment consisting of 12 items measured on a five-point Likert scale \((1 = \text{Never} \text{ to } 5 = \text{Always})\). The measure is derived from the original 36-item version (Horvath & Greenberg, 1989). The Working Alliance Inventory (WAI) is the most widely used assessment to measure the working alliance between therapist and consumer (Hatcher & Gillaspy, 2006). The subscales are goals (i.e., agreement about the goals of therapy), tasks (i.e., agreement about the tasks of the therapy), and bonds (i.e., the bond between client and therapist). The WAI-SR has demonstrated adequate construct and convergent validity.
and internal consistency reliability in both the therapist and client forms (Hatcher & Gillaspy, 2006). The internal consistency reliability for the present study was .87.

**Provider Directiveness.** This measure (Osborn & Stein, 2015; see Appendix F) is a 9-item self-report measure designed to detect specific and purposeful behavioral actions that mental health providers engage in, without a malicious intention, that are inconsistent with consumers’ desires. Respondents use a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) to answer items such as “When I feel my clients are not capable of collaborating, I determine treatment goals for them” and “I have encouraged clients to have ongoing contact and interaction with family members, even if clients at times express concerns about doing so.” Previous researchers found the measure had adequate construct validity and internal consistency reliability (Osborn & Stein, 2015). Item language was modified for the present study to apply to consumers. Six of the nine original items were retained to insure adequate internal consistency reliability, which for the present study was .58.

**The Recovery Self-Assessment-Revised.** This measure (O’Connell et al. 2005; see Appendix G) is a 32-item self-administered measure assessing perceptions or practices that are considered to be consistent with a recovery service orientation. Essentially, the RSA-R measures the degree to which recovery services are being implemented in a given agency. The RSA-R offers a measure for helping professionals and clients; however, only the consumer version was used in the present study. The RSA-R has acceptable internal consistency and five factors including: life goals, involvement, diversity of treatment options, choice, and individually-tailored services (O’Connell et al., 2005). Participants answered questions such as, “Staff believe that I can recover” and “Staff believe that I have the ability to manage my own symptoms” on a
five-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). The internal consistency reliability for the present study was .95.

**Personal Loss from Mental Illness scale.** This measure (Stein, Dworsky, Phillips, & Hunt, 2005, see Appendix H) was used to understand the personal, relationship, and psychosocial losses reflected in having confronted the challenges of mental illness. The scale consists of 20-items, such as “The plans I make for each day often do not get done,” which participants rate on 5-point Likert scale (1 = *Strongly disagree* to 5 = *Strongly agree*). Factor analysis revealed four distinct components of the measure: Roles and Routines, Former Relationships, Former Self, and Future. Internal consistency coefficients for the four subscales ranged from .68 to .98, and the measure has shown convergent validity with measures of loneliness, psychiatric symptoms, and alcoholism and divergent validity with personal growth and positive well-being (Stein et al., 2005). The internal consistency reliability for the present study was .76.

**Colorado Symptom Index.** This measure (Shern et al., 1994; see Appendix I) is a brief, 14-item self-report measure which asks participants to report the frequency with which they experience specific symptoms that are grouped into two major constellations (anxiety and psychosis). Items are answered with respect to how often one has experienced each symptom within the last month (5 = *At least every day*, 4 = *Several times a week*, 3 = *Several times a month*, 2 = *Once during the month*, 1 = *Not at all*). Scores on the CSI range from 14 to 70, with higher (total) scores indicating more frequent psychiatric symptoms. Psychometric evaluations of the measure have reported excellent internal consistency and test-retest reliability (Boothroyd & Chen, 2008). The internal consistency reliability for the present study was .87.
The BBC Well-being Scale. This measure (Kinderman, Schwannauer, Pontin, & Tai, 2011; see Appendix J) is a 24-item self-report measure designed to assess one’s general well-being in three domains (psychological well-being, physical health, and well-being and relationships). Items such as, “Do you feel depressed or anxious?” and “Are you satisfied with yourself and your achievements?” are answered on a four-point Likert scale (1 = strongly disagree to 4 = strongly agree). A greater total score is indicative of greater general well-being. The measure has demonstrated good internal consistency, and construct and concurrent validity (Kinderman et al., 2011). The internal consistency reliability for the present study was .91.

Demographic Questionnaire. Demographic data (see Appendix K) such as age, gender, ethnicity, education level, and marital status was collected on all participants. Additionally, consumers will also be asked to answer questions regarding their mental health symptoms and history.

Provider Measures

Working Alliance Inventory – Short Revised. This measure (Hatcher & Gillaspy, 2006; see Appendix L) is a paper and pencil self-administered assessment consisting of 12 items measured on a five-point Likert scale (1 = Never to 5 = Always). The measure is derived from the original 36-item version (Horvath & Greenberg, 1989). The WAI is the most widely used assessment to measure the working alliance between therapist and consumer (Hatcher & Gillaspy, 2006). The subscales are goals (i.e., agreement about the goals of therapy), tasks (i.e., agreement about the tasks of the therapy), and bonds (i.e., the bond between client and therapist). The WAI-SR has demonstrated adequate construct and convergent validity and internal consistency reliability in both the therapist and client forms (Hatcher & Gillaspy, 2006). Internal consistency reliability for the present sample was .90.
Provider Directiveness. This measure (Osborn & Stein, 2015; see Appendix M) is a brief 9-item self-report measure designed to detect specific and purposeful behavioral actions that mental health providers engage in, without a malicious intention, that are inconsistent with consumers’ desires. Respondents use a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) to answer items such as “When I feel my clients are not capable of collaborating, I determine treatment goals for them” and “I have encouraged clients to have ongoing contact and interaction with family members, even if clients at times express concerns about doing so.” Previous researchers found the measure had adequate construct validity and internal consistency reliability (Osborn & Stein, 2015). Six of the nine original items were retained to insure adequate internal consistency reliability, which for the present study was .42.

The Maslach Burnout Inventory. This measure (Maslach, Jackson, & Leiter, 1996; see Appendix N) is a 22-item self-report measure designed to assess professional burnout of individuals in the helping professions (i.e., mental health workers, social workers). Participants are asked to rate statements using a seven-point Likert-type scale (1 = never to 7 = everyday). The MBI yields three subscales tapping feelings of Emotional Exhaustion (seven-items), Depersonalization (seven-items), and Personal accomplishment (eight-items). The subscales demonstrated acceptable internal consistency (Maslach et al., 1996). Internal consistency reliability ranged from: Depersonalization $\alpha = .71$, Personal Accomplishment $\alpha = .63$, Emotional Exhaustion $\alpha = .90$.

Case Manager Personal Growth Scale. This measure (Stein & Craft, 2007; see Appendix O) is a 16-item self-administered measure that assesses case managers’ sense of personal growth as a result of their work with consumers. The measure uses a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) and mean score to answer items such as
“Seeing the struggles of consumers has made me more willing to take on challenges in my own life.” Previous research demonstrated that the measure has adequate construct and discriminate validity (Stein & Craft, 2007) and internal consistency reliability (Osborn & Stein, 2015; Stein & Craft, 2007). Internal consistency reliability in the present sample was .80.

**The BBC Well-being Scale.** This measure (Kinderman, Schwannauer, Pontin, & Tai, 2011; see Appendix P) is a 24-item self-report measure designed to assess one’s general well-being in three domains (psychological well-being, physical health, and well-being and relationships). Items such as, “Do you feel depressed or anxious?” and “Are you satisfied with yourself and your achievements?” are answered on a four-point Likert scale (1 = strongly disagree to 4 = strongly agree). A greater total score is indicative of greater general well-being. The measure has demonstrated good internal consistency, and construct and concurrent validity (Kinderman et al., 2011). Internal consistency reliability in the present sample was .88.

**Demographic Questionnaire.** Demographic data (see Appendix Q) such as age, gender, ethnicity, education level, and marital status was collected on all participants. Additionally, demographic data collected included participants’ employment history, education history, case collaboration, and direct contact per week with clients.
RESULTS

Overview of Statistical Analyses

In the following sections, *t*-tests are first used to compare consumers’ mean scores on the present study’s dependent variables of: (1) recovery-orientation of inpatient services; (2) personal loss from mental illness; and (3) well-being, and relationship variables of: (1) working alliance; and (2) provider directiveness, with comparison groups. Chi-squared analysis was employed next to understand significant differences between categorical independent variables (i.e., gender, admission status, legal status, ethnicity, age, marital status, current working status, education level, religion, NAMI membership, length of hospitalization, number of hospitalizations, mental health service involvement, and perceived severity of illness). Statistical analyses used independent samples *t*-tests and one-way analyses of variance (ANOVA) procedures to assess differences between the present study’s dependent and independent variables. Lastly, continuous dependent and independent variables were entered analyzed with Pearson product-moment correlation coefficients. Hierarchical multiple regression analyses were used to understand their relative contribution of relationship variables, and mental health and demographic characteristics in explaining variation in consumers’ scores on recovery-orientation of inpatient services, personal loss from mental illness, and well-being.

Using a subsample of matched provider-consumer dyads, *t*-tests were used to compare mental health care providers’ mean scores on the present study’s dependent variables of: (1) personal growth; (2) professional burnout; and (3) well-being, and relationship variables of: (1) working alliance; and (2) provider directiveness, with comparison groups previously published in the literature. Chi-squared analyses were employed to understand if the categorical independent variables (i.e., gender, admission status, legal status) significantly varied by ethnicity, age,
marital status, years in the mental health system, number of direct contact hours with consumers per week, and caseload size. Statistical analysis employed Pearson product-moment correlation coefficients to understand significant associations between mental health care providers’ dependent well-being variables, relationship measures, and independent variables (e.g., years in the mental health system).

Two-way random inter-class correlation coefficients were used to investigate congruence of perception between scores on providers’ and consumers’ relationship measures of working alliance and provider directiveness. A series of Pearson product-moment correlation coefficients were calculated to understand significant associations between scores on the congruence of perception variable and measures of recovery.

**Consumer Preliminary Analysis**

**Consumer Descriptive Statistics.** The Statistical Package for the Social Sciences (SPSS, version 21) was used for all statistical analyses. Means and standard deviations of main study variables can be found in Table 5. A series of one-sample t-tests were conducted to understand differences between the present study variables of interest with comparison groups reported in previously published research. Mean scores on the WAI scale for the present sample were modest, indicating moderate to high consumer perceptions of working alliance with mental health providers ($M = 3.83, SD = .85$). These mean scores for the present sample of mental health providers were compared to a sample of 243 inpatient consumers (Munder et al., 2010). Results of t-test analysis revealed that consumers’ mean scores in the present sample were significantly greater than a sample of inpatient consumers, $t(59) = 3.83, p < .05, d = .27$. Mean scores on the Provider Directiveness scale were modest ($M = 3.35, SD = .69$), indicating consumers tended to agree with statements regarding directive practices from their providers. Mean scores on the
RSA-R for the present sample were modest, indicating high consumer perceptions of recovery-orientation of inpatient services ($M = 3.90$, $SD = .81$). Results of $t$-test analysis for the RSA-R revealed that mean scores for the present sample were not significantly different, $t(59) = -1.81$, $p = ns$, from a community-based sample of 326 persons in recovery reported by O’Connell et al. (2005).

Mean scores on the PLMI scale for the present sample were modest, indicating that consumers’ responses were average and they tended to not over or under endorse experiences of loss ($M = 3.06$, $SD = .63$). These mean scores were compared to a sample of 158 persons in recovery (Stein et al., 2005). Results of $t$-test analysis revealed that mean scores for the present sample on the PLMI were significantly different, $t(59) = -2.94$, $p < .01$, $d = -.37$, such that consumers in the present sample reported experiencing significantly less personal loss as a result of mental illness than a community-based sample of consumers.

Mean scores for the CSI scale for the present sample were modest ($M = 30.38$, $SD = 12.04$), indicating that consumers endorsed a minimal to moderate amount of mental health symptoms. These mean scores were compared to a sample of 695 adult Medicaid enrollees who indicated a need for mental health services within the last six months (Boothroyd & Chen, 2008). Results of $t$-test analysis revealed that mean scores for the present sample were significantly different, $t(59) = -6.76$, $p < .001$, $d = -.86$, such that consumers in the present study reported experiencing significantly less mental health symptoms relative a community-based sample.

Mean scores on the BBC Well-being scale for the present sample were modest ($M = 72.45$, $SD = 12.5$), indicating that consumers tended to report moderate to high perceptions of well-being. These means scores for the present sample of mental health consumers were compared to a sample of 1,940 broader community members (Kinderman et al., 2011). Results of
t-test analysis revealed that mean scores for the present sample were significantly different, \( t(59) = 11.31, p < .001, d = 1.4 \), such that the present sample of mental health consumers reported significantly greater global well-being than a sample of community members.

**Consumer Differences Based on Sample Characteristics.** A series of Chi-square tests were performed to test for significant differences between categorical independent variables of gender (i.e., male vs. female), admission status (i.e., voluntary vs. involuntary commitment), and legal status (i.e., forensic vs. civil commitment). When possible, categorical variables were collapsed into smaller, meaningful categories (see Table 4).

Results of chi-square analysis revealed that the distribution of males and females was similar to one another on the basis of participants’ ethnicity, age, marital status, current working status, education level, religion, NAMI membership, length of hospitalization, number of hospitalizations, mental health service involvement, and perceived severity of illness. In addition, the distribution of involuntary and voluntary committed consumers were similar to one another on the basis of participants’ ethnicity, age, marital status, current working status, education level, NAMI membership, length of hospitalization, number of hospitalizations, mental health service involvement, and perceived severity of illness. Analyses showed that there was an association between admission status (voluntary vs. involuntary commitment) and religious preference, \( \chi^2 (2, 60) = 10.57, p < .01 \). Examination of the cell frequencies showed that consumers under a forensic status were more likely to report a protestant religious preference.

Results of chi-square analysis revealed that the distribution of consumer under forensic status and no forensic status were similar to one another on the basis of participants’ ethnicity, age, marital status, education level, religion, NAMI membership, length of hospitalization, number of hospitalizations, mental health service involvement, and perceived severity of illness.
Analyses showed that there was an association between legal status (none vs. forensic) and current working status, $\chi^2 (1, 60) = 10.28, p < .00$. Examination of the cell frequencies showed that consumers under a forensic status were more likely to report that they are currently working for pay in the hospital.

**Consumer Demographic Differences.** Independent samples $t$-tests and one-way analyses of variance (ANOVA) procedures were performed to assess demographic differences on main study measures of perceptions of recovery-orientation of inpatient services, personal loss, and well-being. Specifically, a series of independent samples $t$-tests examined whether scores on main study variables differed as a function of gender (male or female), race (Caucasian vs. minority), current working status (employed vs. not employed), NAMI membership (member vs. no membership), length in the mental health system (less than 10 years vs. more than 10 years), level of mental health service involvement (not at all or a little involved vs. somewhat or very involved), admission status (voluntary vs. involuntary commitment), legal status (none vs. forensic), and perceived severity of illness (not at all or a little severe vs. somewhat or very severe). Results indicated that scores on a measure of recovery were not significantly different based on gender, race, working status, NAMI membership, admission status, legal status, or perceived severity of illness. Significant differences in scores of recovery were found regarding level of mental health services involvement, such that consumers who reported that they were *somewhat or very involved* ($M = 4.0, SD = .71$) were more likely than consumers who reported that they were *not or a little involved* ($M = 3.3, SD = .94$) to report greater scores on a measure of recovery-orientation of inpatient services, $t(58) = -3.04, p < .01$.

Results indicated that scores on a measure of personal loss were not significantly different based on gender, race, working status, NAMI membership, level of mental health
service involvement, admission status, legal status, or perceived severity of illness. Results indicated that scores on a measure of well-being were not significantly different based on gender, race, working status, NAMI membership, admission status, legal status, or perceived severity of illness. Significant differences in scores of well-being were found regarding level of mental health services involvement, such that consumers who reported that they were *somewhat or very involved* ($M = 74.3$, $SD = 11.9$) were more likely than consumers who reported that they were *not or a little involved* ($M = 65.7$, $SD = 11.6$) to report greater scores on a measure of recovery, $t(58) = -2.3$, $p < .05$.

One-way analyses of variance (ANOVA) were also performed to assess whether the main study variables varied as a function of age (categorized in three groups: 34 years or less, 35 to 54 years old, and 55 years or older), marital status (categorized in three groups: single, married or living with a partner, and divorced/widowed/separated), education level (categorized in three groups: high school or less, some college/associates degree, and bachelor’s degree or higher), religion (categorized in three groups: Protestant/Catholic, other religion, no affiliation/Atheist/Agnostic). Scores on a measure of recovery did not vary as a function of age, marital status, education level, or religion.

Scores on a measure of personal loss from mental illness did not vary as a function of age, marital status, education level, or religion. Scores on a measure of well-being from mental illness did not vary as a function of age, marital status, education level, or religion.

One additional ANOVA was conducted to describe the relationship with the CSI measure of mental health symptoms and consumers’ perceived illness severity. Scores of a measure of mental health symptoms varied as a function of perceive severity of illness, $F(1, 59) = 9.10$, $p < .01$. Specifically, consumers who reported that their symptoms were *somewhat or very serious*
(M = 38.36, SD = 13.34) tended to report greater scores on a measure of mental health symptoms, than consumers who reported that their symptoms were *not at all or a little serious* (M = 27.96, SD = 10.64). This suggests that consumers tended to consistently answer items on a symptoms measure with how they view their overall level of mental illness severity.

**Consumer-provider Relationship and Consumer Well-being.** Pearson product-moment correlation coefficients were computed to assess the relationship between main study variables and independent variables of interest. Correlations between key study variables can be found in Table 5. In general, significant scores ranged from low to moderate (rs .26 – .58).

Results indicate that scores on measures of recovery were significantly associated with scores on measures of working alliance (r = .39, p < .01), provider directiveness (r = .38, p < .01), and well-being (r = .55, p < .01). This suggest that consumers who perceived the hospital as providing greater recovery-oriented services also tend to report a stronger perceived working alliance and greater use of directive interventions from their providers, and greater sense of general well-being. Consumers’ scores on a measure of personal loss were significantly negatively related to scores measures of working alliance (r = -.29, p < .05), positively related to self-reported symptoms (r = .27, p < .05), well-being (r = -.37, p < .01), and positively related to number of hospitalizations (r = .32, p < .05). This suggests that consumers who feel that they have experienced more personal loss as a result of living with mental illness also reported a lower working alliance with their providers, a lower sense of general well-being, and a greater report of mental health symptoms and hospitalizations.

Consumers’ scores on a measure of general well-being were significantly correlated with measures of working alliance (r = .58, p < .01), and reported symptoms (r = -.46, p < .01). This suggests that consumers who reported greater general well-being in their lives, also reported a
stronger working alliance, and lower reports of mental health symptoms. Consumers’ scores on a measure of working alliance were significantly associated with scores on measures of reported symptoms ($r = -.26, p < .05$). This suggests that consumers who perceived a stronger working alliance with their providers tend to also report fewer mental health symptoms.

Taken together, preliminary analyses of consumers’ responses indicated that their average scores on working alliance were higher than an inpatient sample of mental health consumers. Consumers’ average scores on a measure of recovery were not significantly different than a community-based sample of mental health consumers. On average consumers tended to report significantly less perceived personal loss due to mental illness and mental health symptoms than community-based consumers. Consumers’ average scores on a measure of well-being were significantly greater than community respondents. Those consumers under a forensic status were more likely to report protestant religious views and work for pay while in the hospital. Consumers’ scores on a measure of recovery significantly varied as a function of their perceived level of involvement in their mental health services. Similarly, consumers’ scores on a measure of well-being significantly varied as a function of perceived severity of mental health symptoms.

Consumers who perceived the hospital as providing greater recovery-orientation of inpatient services also tended to report a stronger perceived working alliance and use of directive interventions from their providers, and greater sense of general well-being. Consumers who felt that they have experienced more hardship because of living with mental illness also tended to perceive a lower working alliance with their providers, a lower sense of general well-being, and a greater report of mental health symptoms. Consumers who reported greater general well-being in their lives, also tended to perceive a stronger working alliance with their providers, and report
lower mental health symptoms. Consumers who perceived a stronger working alliance with their providers tended to report fewer mental health symptoms.

A number of personal demographic and mental health demographic characteristics were not significantly associated with dependent variables of interest. Specifically, consumers’ racial identity, admission status (i.e., voluntary or involuntary civil commitment), and legal status (i.e., NGRI or none), were not significantly associated with dependent variables and are not included subsequent consumer data analysis. Level of involvement was associated with dependent variables; however, is not included in additional analyses due to its subjective nature. ANOVA analysis revealed that perceived severity of illness, although associated with dependent variables, accesses the same construct as the psychometrically evaluated self-report measure of mental health symptoms. Therefore the latter measure will be included in additional analyses along with number of hospitalizations as measures of consumers’ objective mental health demographic characteristics. Age and gender are also included in additional analysis as measures of consumers’ personal demographic characteristics.

**Consumers’ Views of Recovery-Orientation, Personal Loss, and Well-being**

A series of three hierarchical multiple regression analyses were conducted to examine the relative contribution of consumers’ personal and mental health demographic characteristics, and self-reported therapeutic relationship factors of working alliance and provider directiveness in accounting for variation in their reports of individual well-being. Specifically, perceived inpatient recovery-orientated services, personal loss from mental illness, and overall well-being were used as the criterion variables. Regression results are presented in Table 6.

In the first regression analysis, the criterion variable was consumers’ mean score on the Recovery Self-Assessment-Revised (RSA-R). Step 1 consisted of personal demographic
variables (e.g., age and gender), Step 2 consisted of mental health demographic variables (e.g.,
number of psychiatric hospitalizations and total scores on a measure of mental health symptoms),
and Step 3 consisted of therapeutic relationship factors (e.g., mean scores on measures of
working alliance and provider directiveness). In the second regression analysis, the criterion
variable was consumers’ mean scores on the Personal Loss from Mental Illness scale (PLMI) and
the regression equation contained the same order of predictor variables as the first regression
analysis. In the final regression analysis, the criterion variable was consumers’ total scores on the
BBC Well-being Scale (WBS) and the regression equation contained the same order of predictor
variables as the previous two regression analyses.

**Recovery-Orientation.** When using perceptions of recovery-orientation of inpatient
services as the criterion measure, the overall regression model was significant, $F(6, 51) = 4.08, p < .01$ (see Table 6) and explained 35% of the total variance in perceived agency recovery-orientation. In Step 1, there were no demographic variables were significant. In Step 2, the
number of psychiatric hospitalizations ($\beta = -.03, p < .05$), but not the total symptoms explained
14% of the variance in perceptions of recovery-orientation. In Step 3, the inclusion of working
alliance ($\beta = .28, p < .05$) and provider directiveness ($\beta = .31, p < .05$), accounted for an
additional 17% of the variance in the prediction of perceived recovery-orientation. These
findings suggest that after accounting for personal and mental health demographic
characteristics, consumers with a perceived stronger relationship and greater use of directive
practices from providers were more likely to report higher perceptions of recovery-orientation of
inpatient services.

**Personal Loss from Mental Illness.** When using personal loss as the criterion measure,
the overall regression model was not statistically significant, $F(6, 51) = 2.21, p < ns$ (see Table
6). These findings suggest that consumers’ personal and mental health demographic characteristics, and therapeutic relationship factors did not significantly contribute to understanding proportions of variation in consumers’ reports of personal loss from mental illness.

**Well-being.** When using consumers’ perceptions of well-being, the overall regression model was significant, \( F(6, 51) = 7.36, p < .00 \) (see Table 6) and explained 50% of the total variance in reports of well-being. In Step 1, personal demographic variables were not significant. In Step 2, total symptom scores (\( \beta = .38, p < .01 \)), but not the number of psychiatric hospitalizations accounted for 14% of the variance in reports of well-being. In Step 3, the inclusion of working alliance (\( \beta = 7.6, p < .00 \)), but not provider directiveness accounted for an additional 30% of the variance in reports of well-being. These findings suggest that after accounting for personal and mental health demographic characteristics, consumers with a perceived stronger relationship and lower reports of mental health symptoms were more likely to report higher perceptions of general well-being.

**Consumer – Provider Dyads**

**Provider Descriptive Statistics.** Providers’ mean scores on the WAI scale for the present sample were in the mid-range, indicating providers reported moderate to high perceptions of working alliance with consumers (\( M = 3.79, SD = .61 \)). Providers’ mean scores were compared to a sample of 32 counselor trainees at a Midwestern university (Taber, Leibert, & Agaskar, 2011). Results of \( t \)-test analysis revealed that providers’ working alliance mean scores were significantly lower than a sample of university-based providers, \( t(18) = -.2.60, p < .05 \). Mean scores on the PDS for the present were modest, indicating providers reported mild to moderate perceptions of directive practices with consumers (\( M = 2.72, SD = .54 \)). Providers’
mean scores were compared to a sample of 105 community mental health providers in Virginia (Osborn & Stein, 2015). Results of t-test analysis revealed that providers’ mean scores were significantly higher, indicating a greater use of directive practices than a community-based sample of providers, $t(18) = 2.43, p < .05$.

Mean scores on the CMPG scale were in the mid-range, indicating providers reported moderate to high perceptions of personal growth ($M = 3.60, SD = .45$). Providers’ mean scores were compared to a sample of 105 community mental health providers from Virginia (Osborn & Stein, 2015), and were not significantly different, $t(8) = -1.98, p = ns$.

Mean scores on the BBC Well-being scale for the present study were in the mid-range ($M = 77, SD = 8.56$), indicating providers tended to report moderate to high perceptions of well-being. Providers’ mean scores were significantly higher when compared to a sample of 1,940 broader community members (Kinderman et al., 2011), $t(8) = 7.86, p = .00$, indicating greater reported well-being. Mean scores on the three dimensions of the MBI for the present sample were: emotional exhaustion ($M = 16.55, SD = 6.73$), depersonalization ($M = 13.22, SD = 5.10$), and personal accomplishment ($M = 43.90, SD = 4.62$). A series of t-tests indicated that the present sample of mental health providers scored significantly lower on emotional exhaustion, $t(8) = -3.63, p = .007$, and were significantly higher in their average scores on depersonalization, $t(8) = 3.64, p = .007$, and personal accomplishment, $t(8) = 7.07, p = .00$, than a community sample of 114 case managers (Kraus & Stein, 2013).

**Significant Differences Based on Sample Characteristics.** A series of Chi-square tests were performed to test for significant differences between categorical independent variables of gender (i.e., male vs. female). When possible, categorical dependent variables were collapsed into smaller, meaningful categories.
Results of chi-square analysis revealed that the distribution of males and females was similar to one another based on participants’ ethnicity, age, marital status, years in the mental health system, number of direct contact hours with consumers per week, and caseload size.

**Provider-Consumer Relationship and Well-being.** Pearson product-moment correlation coefficients were computed to assess the relationship between providers’ \(N = 9\) main study variables and independent variables of interest. Specific descriptive statistics and correlations between key study variables can be found in Table 7. In general, significant scores ranged moderate to high \((rs .71 – .92)\).

Results indicate that scores on the emotional exhaustion subscale of the Burnout Inventory were significantly associated with the depersonalization subscale of the Burnout Inventory \((r = .90, p < .01)\). This suggests that providers who reported greater feelings of depersonalization in their work also felt more emotionally exhausted. The number of years worked in the mental health system was associated with the personal achievement subscale of the Burnout Inventory \((r = -0.71, p < .05)\). This also suggests that providers, who have worked longer in the field, tend to report less personal achievement. Lastly, the number of years worked in the mental health system was associated with greater age \((r = -0.92, p < .01)\). No additional dependent or independent variables were significantly associated.

**Consumer-Provider Dyadic Analysis.** The present study sought to utilize Linear Mixed Model (LMM) regression analysis, a parametric linear model for clustered, longitudinal, or repeated-measures data that quantifies a relationship between a continuous dependent variable and its predictors (West, Welch, & Galecki, 2007). Nested study designs are common in studies that use matched scores on measures of working alliance where a therapist may rate multiple clients (Bartle-Haring et al., 2012; Hatcher et al., 1995), such as the present study. The model
accounts for shared variance amongst participants’ observations to reduce the risk of an inflated alpha and Type I error (rejecting the null hypothesis when it is accurate or accepting a false alternative hypothesis). Results of G*Power analysis, using a similar sample (Snijders, 2005), indicated that a sample size of 47 is desirable.

Unfortunately, the present study (N = 19 dyads) was unable to obtain an ideal sample size to allow for LMM with a random intercept to statistically converge. The following sections present inter-class correlation coefficient analysis and a series of bivariate correlational analysis, which allows for an understanding of the association of key dyadic variables of interest. Specifically, two datasets containing providers’ and consumers’ scores on variables of interest were generated which allowed for associations to be computed at the provider level (N = 9) with aggregated consumer variables and at the consumer level (N = 19) with providers’ aggregated responses, see Tables 8 and 9 respectively.

**Association Between Consumer and Provider Relationship Variables.** At the provider level, a series of Pearson product-moment correlation coefficients were calculated to describe significant associations between consumers’ and providers’ independent and dependent variables of interest. Consumers’ self-reported symptoms were negatively associated with providers’ scores on a measure of personal growth (r = -0.72, p < .05). This suggests that consumers’ lower reports of mental health symptoms were associated with providers’ greater reports of personal growth.

Providers’ scores on a measure of provider working alliance were significantly positively associated with providers’ scores of well-being (r = 0.69, p < .05) and with consumers’ reports of personal loss from mental illness (r = 0.70, p < .05), and negatively associated with scores on a measure of provider personal growth (r = -0.77, p < .05). This suggests that providers who
reported a strong working alliance with consumers, also reported a greater sense of personal well-being. Providers’ greater perceptions of working alliance with consumers were related to consumers’ higher perceptions of loss from mental illness. Additionally, findings suggest that providers who report high perceptions of working alliance also report lower perceptions of personal growth from working directly with consumers. Providers’ reports of direct contact with consumers were significantly negatively correlated with consumers’ reports of working alliance ($r = -.74, p < .05$) such that less direct contact with consumers was associated with consumers’ views of greater working alliance with providers.

At the consumer level, consumers’ scores on a measure well-being were significantly associated with scores on a personal loss from mental illness ($r = -.51, p < .05$). This suggests that consumers with greater perceived well-being also reported lower levels of personal loss from mental illness.

*Congruence of Perception.* A series of two-way random inter-class correlation coefficients were computed to assess the relationship between providers’ and consumers’ scores on the two relationship measures (e.g., working alliance and provider directiveness). This type of analysis is generally used when data are clustered or longitudinal, when the usual assumption of independence of responses is not appropriate, and clusters of paired data are correlated with variables of interest (Rodriguez & Elo, 2003). This analysis was desirable in the present study because at the individual level providers offered multiple ratings of consumers which created repeated measures of groups or clusters of provider-consumer data. As seen in Table 10, results indicate that consumers’ and providers’ scores on measures of working alliance were not significantly associated with one another ($r = -.004, p < .ns$). Results indicate that consumers’ and providers’ scores on measures of directiveness were not significantly associated with one
another \((r = -.02, p < ns)\). Consumers’ mean scores on directiveness were significantly associated with providers’ scores on working alliance \((r = .46, p < .05)\). This suggests that when providers reported a strong working alliance, consumers also reported greater levels of perceived directiveness practices. Consumers’ mean scores on working alliance were significantly positively correlated with providers’ scores on directiveness \((r = .49, p < .05)\). This suggests that when providers reported using greater directive practices, consumers also reported a stronger working alliance with providers.

A new dataset was generated at the provider level to understand the degree of provider-consumer congruence of perception regarding their working alliance. Specifically, the dataset contained providers’ average working alliance scores for the respective consumers they rated and consumers’ average working alliance scores for the respective provider they rated. This resulted in nine provider working alliance mean scores for the individual clients they rated and nine, aggregated, matched consumer working alliance mean scores for the provider they rated. Next, consumers’ and providers’ scores on measures of working alliance were dummy coded to create a variable to measure the level of congruence of perception between the matched scores. The variable was generated by subtracting consumers’ mean scores on working alliance from providers’ mean scores on working alliance and taking the absolute value of the difference. This calculation resulted in one score between the matched \((N = 9)\), aggregated provider-consumer working alliance scores. Scores closer to zero indicated greater congruence between providers’ and consumers’ working alliance scores and scores closer to one indicate lower levels of congruence of perception. A series of Pearson product-moment correlation coefficients were calculated to understand significant associations between scores on the congruence of perception variable and study variables.
Results indicate that the level of congruence of perception scores were significantly associated with providers’ reports of direct contact with consumers \((r = -0.65, p < 0.05)\), and consumers’ perceptions of recovery-orientation of inpatient services \((r = -0.79, p < 0.05)\). This suggests less congruent perceptions of working alliance by providers and consumers were associated with providers’ reports of less direct contact time with consumers. Thus, a greater mismatch in provider-consumer views of working alliance was related to provider’s reports of less frequent direct contact with consumers. Findings further suggest that less congruent consumer and provider perceptions of working alliance were associated with consumers’ perceptions of lower recovery-orientation of inpatient services. Therefore, the less the congruence of perceptions between providers’ and consumers’ on working alliance the lower consumers’ reports of recovery-orientation of inpatient services.
DISCUSSION

The present study examined the views of 60 adults with serious mental illness in an inpatient psychiatric hospital to understand associations between consumers’ views of their relationships with mental health providers and their reports of well-being. Specifically, the study investigated the relative contribution of working alliance and provider directiveness in understanding consumers’ perceptions of recovery-orientation of inpatient services, personal loss from mental illness, and general well-being. Using a subsample of matched mental health consumers \((n = 19)\) and providers \((n = 9)\) the present study investigated how both consumers’ and providers’ views of relationship factors are associated with individual well-being factors. The present study also examined if congruence of perception between providers’ and consumers’ reports of working alliance and provider directiveness at the dyadic level contributed to an understanding of individual perceptions of well-being for consumers and providers.

Findings indicate that consumers’ views of higher levels of working alliance and provider directiveness were associated with consumers’ reports of higher levels of recovery-orientation of inpatient services and greater individual well-being. Consumers’ views of greater working alliance were also associated with reports of less personal loss from mental illness and mental health symptoms. After controlling for individual and mental health characteristics, consumers’ reports of greater working alliance and provider directiveness accounted for a significant proportion of the variation in perceptions of recovery-orientation of inpatient services. Consumers’ reports of greater working alliance, but not provider directiveness, accounted for a significant proportion of the variance in reports of consumers’ general well-being. The relationship variables of working alliance and provider directiveness did not significantly account for variation in consumers’ reports of personal loss from mental illness.
Consumer-Provider Relationship and Consumer Well-being

During the last two decades, state psychiatric hospitals transitioned to recovery-oriented models of service delivery; yet, the degree to which recovery principles have been implemented in state psychiatric hospitals remains unclear (Tsai & Salyers, 2008). Contemporary recovery principles call for shared decision-making and non-directive practices (Alverson et al. 2007; Davidson et al., 2005b; Green et al., 2008; Oades et al., 2005; Randal et al., 2009; Sowers, 2005), which are facilitated through an effective provider-consumer working alliance. If effectively established, it is possible that both consumers and providers could benefit from a strong therapeutic relationship. The present study was intentionally conducted in an inpatient hospital to understand if consumers’ reports of relationship characteristics of working alliance and provider directiveness were associated with the individual well-being characteristics of perceptions of recovery-orientation of inpatient services, personal loss from mental illness, and well-being.

Recovery. Findings in the present study supported the hypothesis that relationship characteristics significantly contributed to the prediction of greater reports of recovery-orientation in hospital services. The finding that greater scores of working alliance contributed to reports of hospital recovery-orientation is not altogether surprising. A mutual and collaborative working alliance is an essential, foundational component, of recovery-oriented service delivery (Anthony, 1993; Coffey, 2006; Green et al., 2008; Oades et al., 2005; Randal et al., 2009). Few studies examine both working alliance and consumers’ perceptions of recovery-orientation of inpatient services in the same study. Present findings add to the existing literature by systematically understanding how inpatient hospital consumers’ reports of working alliance
contribute to perceptions of recovery-orientation when controlling for unique individual and mental health characteristics. Working alliance appears to be a reliable predictor of consumers’ perceptions of inpatient recovery-oriented services. Consumers in the present study reported perceptions of highly recovery-oriented inpatient services, which suggests Eastern State Hospital has in part shifted from medical model practices from the perception of consumers.

Contrary to the present study hypothesis is the finding that consumer’s reports of greater provider directiveness were significantly related to higher perceptions of recovery-orientation of inpatient services. Directiveness is seen as antithetical to recovery principles (Davidson et al., 2005b; Davis, 2002). Available research indicates that providers’ directiveness increased client resistance (Beutler et al., 2001; Bischoff & Tracey, 1995), and that less directiveness by therapists may be desirable in treatment (Karno & Longabaugh, 2005). Further, provider directiveness as articulated in the present study is a more nuanced phenomenon than overt forms of coercion such as involuntary commitment, which is typically justified in the name of client safety and treatment adherence (Sjöstrand & Helgesson, 2008). It is unlikely, however, that consumers are reporting that they are overtly coerced during their course of hospitalization, which necessitates further discourse.

It is possible that consumers in the present state hospital setting desire the knowledge and practices of providers, which may expedite discharge from the hospital and reduce the risk of rehospitalization. Since 2006, Eastern State Hospital has made attempts to transition the hospital setting and services from a medical and PSR model to a recovery-oriented model of inpatient service delivery. Specifically, hospital providers, staff, and the setting itself (e.g., dozens of recovery, self-determination, hope, messages on walls throughout the building) work to provide interventions to help consumers own the notion that recovery is possible. Further, providers
educate and offer skills in the hospital (e.g., medication education to increase adherence, see Sun, Liu, Christensen, & Fu, 2007), which can be applied in consumers’ respective communities in an attempt to decrease discharge time and risk of psychiatric relapse in the community. Anecdotally, one of the most common questions the principal investigator was asked by consumers throughout his clinical internship was, “Tell me what I have to do to leave here.” When providers answer questions like this from consumers, they need to offer a rationale so consumers understand how providers’ answers were derived. Offering rationales to treatment decisions may help contextualize providers’ responses and decrease the risk of consumers perceiving providers as controlling, punitive, and paternalistic. It is possible that consumers were equating providers answering their questions as a form of provider directiveness.

It is also possible that consumers perceive providers’ directive practices not as paternalistic, but as attempts to create an individually tailored treatment plan. Randal et al. (2009) writes about the importance of approaching consumers as individuals and uniquely tailoring services. Many consumers at Eastern State Hospital, for example, are assigned without their consent into a Wellness Recovery Action Plan (WRAP) group, consistent with directive practices by providers; however, the purpose is to create an individually tailored book and plan of consumers’ symptoms, triggers, coping skills, supports, etc. The plan acts as a decision tree, which is unique for each consumer, and research indicates that consumers who develop WRAP plans report decreases in psychiatric symptoms, increased quality of life, and hopefulness (Cook et al., 2012).

Additionally, Eastern State Hospital has made systematic changes to implement recovery-oriented services, however, it is still a “hospital” with existing medical model practices. It must be acknowledged that consumers in the present study may report greater provider
directiveness because they are “patients,” and accept services and treatments or run the risk that disagreement or dissention are easily viewed by providers as “symptoms.” For example, Rosenhan (1973) writes of the challenges individuals face once they are diagnosed and labeled with a mental illness and how providers misattribute common or “sane” behaviors as psychopathology and not potentially normal reactions to environmental or interpersonal experiences. Consumers may acquiesce to providers’ requests to avoid appearing “psychiatrically unstable” and not prepared for discharge.

**Personal Loss from Mental Illness.** Unexpectedly, findings in the present study did not support the hypothesis that the relationship characteristics, working alliance and directiveness, significantly contributed to the prediction of lower reports of personal loss from mental illness. Previous researchers found that participants who reported a greater sense of personal loss from mental illness also reported more interpersonal loneliness, mental health symptoms, and difficulties with alcohol (Stein et al., 2005). There are a number of possible reasons for these unexpected findings.

At first glance it seems that long-term inpatient consumers “should” report greater personal loss from mental illness. Although strides have been made, a hospital is unquestionably not a desired setting for any individual to thrive. For example, in their qualitative study of adults with schizophrenia ($N = 14$), Stein and colleagues (2014) found that consumers generally reported some changes in their psychiatric hospitalization experiences across four decades of intermittent hospital stays. However, qualitative analysis revealed that during consumers’ course of hospitalizations, a majority of consumers reported harsh treatment by staff, lack of personal control, limited information regarding treatment options, and poor communication with providers (Stein et al., 2014). Thus, it appears that consumers’ experiences while hospitalized are
consistent with items measured on the personal loss from mental illness scale for example, “Having a mental illness has kept me from being an important member of my family,” “Having a mental illness has taken away my normal daily routine,” and “Other people often tell me not to look to far into the future.”

A closer look at the descriptive statistics analyses, however, reveals that consumers in the present study reported significantly less personal loss than a community sample of adults living with serious mental illness (Stein et al., 2005). It is possible the measure did not pick up on possible idiosyncratic differences between inpatient and community consumers. Many consumers living with mental illness still experience symptoms; however, this does not preclude them from living in the community for long periods of time. Lysaker and Buck (2008) write that many persons with schizophrenia can achieve long and meaningful periods of recovery. Further, findings in the present study indicated that consumers were currently hospitalized an average of 32.6 months at the time of the study with an average of 7.1 hospitalizations. It is likely that consumers’ experiences with mental illness in the present study reflect a smaller proportion of adults’ general experiences living with mental illness and require a different course of treatment and services. If consumers’ experiences with mental illness in a state hospital are unique, it would make sense that their perceptions of loss from mental illness are too. Further inquiry is needed to refine the personal loss from mental illness measure with a state hospital sample to understand how or if the provider-consumer relationship is associated with consumers’ perceptions of personal loss.

**Well-being.** Findings in the present study supported the study’s hypothesis. Consumers’ perceptions of working alliance, but not provider directiveness, predicted consumers’ scores on well-being measures. Well-being is a core principle of recovery-oriented service delivery
(Farkas, Gagne, Anthony, & Chamberlin, 2005) and working alliance is often studied in relation to treatment adherence (Wykes, Rose, Williams, & David, 2013) and symptom reduction (Arnow et al., 2013; DeRubeis & Feeley, 1990; Feeley et al., 1999; Marmar et al., 1986; Prieb & Gruyters, 1995; Tattan & Tarrier, 2000; Weiss et al., 1997). Consumers’ perceived well-being, however, extends beyond reports of symptom reduction (Corrigan et al., 2012; Ryan & Deci, 2000). Thus, understanding how working alliance contributes to consumers’ reports of well-being in the same study is important and adds to available literature. Not surprisingly, consumers in the present study endorsed active symptoms of mental illness while simultaneously reporting greater views of working alliance and recovery. Therefore, providers reportedly establish a working alliance with consumers in an inpatient setting even when consumers report active symptoms of mental illness; the quality of this relationship as opposed to number and frequency of symptoms may provide a more robust understanding of consumer’s present well-being.

Multiple Perspectives Findings

The present study used a yoked subsample of nineteen consumers and nine providers to understand the relationship between measures of working alliance and provider directiveness. Dyadic analysis looked at the association between consumers’ and providers’ reports of working alliance and provider directiveness and individual measures of well-being, namely personal growth, professional burnout, well-being, caseload size, personal loss, recovery, number of hospitalizations, and average symptoms. Congruence of perception was assessed by comparing associations between consumers’ and providers’ reports of working alliance and provider directiveness and direct comparison of working alliance scores with individual well-being.

Providers-Consumer Relationship and Well-being. Findings in the present study partially concurred with the present study hypotheses. Providers’ reports of working alliance
were associated with greater provider well-being, but negatively associated with personal growth as a result of working with consumers. Similarly, other researchers found positive associations with working with consumers (Linley & Joseph, 2007; Osborn & Stein, 2015; Stein & Craft, 2007). It is noteworthy that in the present study providers’ reports of greater working alliance were associated with lower reports of personal growth, which is contrary to previous research (Osborn & Stein, 2015). Although the sample size in the present study was very small, this provocative finding necessitates further inquiry. For example, a majority of providers in the present sample disagreed with the following statements, “I have become more aware of the importance of my family since working as a provider,” and “I have found I can learn a lot about myself from working with consumers.” It is perplexing that providers could perceive a strong working alliance and simultaneously report few personal contributions of a unique therapeutic relationship with consumers.

Findings in the present study also indicated that providers’ reports of less direct contact time with consumers were also associated with consumers’ views of greater working alliance. The notion that the less providers interact with consumers would be related to consumers’ perceptions of higher working alliance appears counter intuitive. However, Tarrier and Taylor (2014) report, that cognitive behavioral therapy for schizophrenia is generally delivered over 20 sessions, between three and nine months. It is possible providers’ frequency of contact is less important than the quality of services they deliver. The present study suggests that consumers generally reported a strong therapeutic working alliance with providers and perceptions of greater recovery-orientation of inpatient services.

Consistent with present study’s hypotheses, consumers’ reports of greater well-being were associated with reports of lower personal loss from mental illness. More importantly
however, findings in the present study also indicated providers’ reports of greater working alliance were associated with consumers’ reports of greater personal loss from mental illness. It is significant that consumers who report struggling due to the hardship of living with mental illness work with providers who report not just a professional relationship but a strong therapeutic bond. If providers shared their views of the bond they perceive with consumers, such feedback could mitigate consumers’ perceptions of personal loss or well-being.

Taken together, results from the present study indicate that providers report benefits from their direct work with consumers with mental illness. Providers reported strong working alliances with consumers which were also associated with self-reports of greater well-being. Findings also indicate that consumers report benefits from the provider-consumer relationship. Consumers’ reports of greater personal loss from mental illness were associated with perceptions of greater working alliance with providers, suggesting that even when consumers are distressed they are still able to form a working relationship with providers.

**Congruence of Perception.** The present study expands on previous studies of working alliance by simultaneously including relationship variables of working alliance and provider directiveness and directly matched scores between consumers and providers. Findings in the present study provide support for the study’s hypothesis regarding consumers’ and providers’ perceptions of working alliance and provider directiveness in a sample of hospitalized consumers. Three key findings emerged regarding consumers’ and providers’ views of working alliance, provider directiveness, and recovery-orientation of inpatient services.

Present study findings indicated that consumers’ mean scores on provider directiveness were significantly positively associated with providers’ scores on working alliance. Contrary with the present study hypothesis are the findings that consumers’ mean scores on working
alliance were significantly positively associated with providers’ scores on directiveness. The most telling finding in the present study is related to consumers’ and providers’ congruence of perception. Specifically, consumers’ and providers’ less congruent views of working alliance were associated with consumers’ perceptions of lower recovery-orientation of inpatient services.

Together these findings suggest that providers’ views of a strong working alliance are associated with consumers’ reports of greater perceived directive practices and providers’ reports of greater directive practices are associated with consumers’ views of a strong working alliance with providers. Further, providers’ and consumers’ more congruent views of working alliance are associated with consumers’ perceptions of higher recovery-orientation of inpatient services. These three findings are provocative as directiveness is antithetical to scholarly recovery-oriented inpatient service delivery goals and consistent with antiquated medical model practices of the last century which reduce consumer autonomy.

Contemporary research, however, suggests that providers engage in directive practices with consumers (Healy, 2008; Osborn & Stein, 2015), that directive practices are associated with unpleasant outcomes for consumers (Beutler et al., 2001; Bischoff & Tracey, 1995; Karno & Longabaugh, 2005), and to working alliance (Monahan et al., 2005). Research suggests that individuals with schizophrenia are capable of understanding treatment choices and making rational decisions (Carpenter, Gold, Lahti, et al., 2000; Grisso & Applebaum, 1995; Stroup, Appelbaum, Swartz, Patel, et al., 2005), and providers’ decisions to engage in directive practices may not depend on the inability of persons with serious mental illnesses to make treatment-related decisions for themselves (Appelbaum & Redlich, 2006). Drake and Deegan (2007) write that, “coercion is a flagrant violation of recovery values” (p. 75). Therefore, it is surprising and
novel that findings in the present study suggest consumers do not necessarily believe provider directiveness is nontherapeutic.

In their study of 187 consumers with mental illness, Jaeger and Rossler (2010) found that consumers’ perceptions of fairness in treatment were negatively associated with perceived coercion. Consumers who reported informal coercion, however, did not differ from consumers who did not report informal coercion in their perceptions of treatment effectiveness. These authors contend that consumers with higher insight might recognize that practices such as informal coercion can be effective and may evaluate them as fair. Jaeger and Rossler (2010) write that if providers are transparent with consumers regarding their informal coercive practices, it may reduce consumers’ perceptions of coercion. Thus, an effective working alliance is paramount to consumers’ successful recoveries. Consumers in an inpatient hospital likely prefer a working and helping relationship over the specific practices which occur during the course of treatment and hospitalization, and providers’ directive practices as measured in the present study may not disrupt the therapeutic process.

Transparency during consumer’s course of hospitalization ideally may occur in the process of the therapeutic relationship. If consumers’ goals are obtained (e.g., privilege increase, discharge, etc.), they may not appraise provider directiveness as “bad.” Although limited, available research lends support to this notion. For example, in their community sample of nine case managers and 42 consumers, Stanhope, Marcus, and Solomon (2009) found that actions which are not overtly coercive, such as persuasion, were not significantly related to feelings of coercion by the consumer. Researchers used the Working Alliance Inventory-Short, four of the five subscales of the Therapeutic Limit Setting Measure which reflected a continuum of coercive strategies by case managers, and the Perceived Coercion measure which was measured with two
subscaler of the Modified Admission Experience Survey. Not surprisingly, working alliance and perceived coercion were significantly negatively associated. However, results also indicated that consumers’ perceptions of case manager coercion (i.e., Therapeutic Limiting Setting measure), were not associated with Perceived Coercion (Stanhope et al., 2009). These authors added that provider behaviors may be interpreted differently by consumers depending on the existing relationship between the case manager and consumer and a poor bond between consumer and case manager is related to the consumer’s perception of coercion. Taken together, Stanhope et al. (2009) reported that case managers’ behaviors of low-end coercive strategies were not related to consumers’ views of perceived coercion.

Other authors similarly report that a strong working relationship between consumer and provider may mitigate consumers’ perceptions of coercion (Appelbaum & Le Melle, 2008; Olofsson & Norberg, 2001; Stanhope et al., 2009). Recent research found that a strong alliance increased the effectiveness of consumers’ adherence to treatment and consumers reported fewer symptoms at termination (Goldsmith, Lewis, Dunn, & Bentall, 2015). These authors also found than an ineffective alliance was associated with treatment or session adherence, although not a decrease in mental health symptoms.

A lack of transparency in the therapeutic relationship may make consumers feel that they are not key stakeholders in their treatment because they do not understand the purpose of providers’ interventions. In their qualitative study of 20 inpatient mental health consumers and service providers Storm and Davidson (2010) found that consumers were not always clear on what participation in their care meant. For example, many consumers did not view their attendance at interdisciplinary treatment team meetings as useful or as an opportunity to collaborate with providers. Providers’ transparency may play a critical role in increasing
consumers’ participation in treatment and reduce consumers’ perceptions of providers’ directive practices.

Finally, in the context of the therapeutic relationship, directive practices may be attempts to provide individually tailored services for consumers, consistent with aspirations of recovery-oriented service delivery. Provider directiveness is a series of actions or behaviors. Provider directiveness possibly evokes change as consumers see it, which could be perceived as meaningful in an inpatient hospital setting that relies on structure, continuity, and predictability. In their qualitative study of 12 adults with mental illness in an inpatient hospital, Bos et al. (2012) found that participants experienced the supportive and strictly structured treatment setting created by providers as a positive environment for personal change. Findings also suggested that participants need a clear external structure, as long as they could gain control of their emotions, behavior, and motivation. Bos et al. (2012) write that providers consistently reminded participants that they still had the ability to make choices despite being in an intentionally controlled treatment setting, which resulted in participants’ perception that recovery occurred through their own volition. Taken together, an effective and transparent working alliance may increase the possibility that consumers perceive providers’ directiveness as a treatment intervention designed to increase their autonomy and self-determination.

**Study Limitations**

The present study has a number of limitations that impact interpretation of its findings. Study findings are based on a small, non-random sample of adults with serious mental illness who were inpatients at Eastern State Hospital, one state psychiatric hospital in Virginia. The degree to which present findings represent the views of consumers throughout Eastern State Hospital or inpatients at other state psychiatric hospitals is unclear. Psychiatric symptoms and
other indices of psychiatric status of the present sample of adults may be more pronounced when compared to a community sample of consumers. However, it should also be noted that a number of adults who participated in the study were considered “discharge ready” and psychiatrically stable, and may have remained in the hospital due to a lack of community placement and collaboration and/or forensic status. Moreover, only adults who were able to provide their own consent participated in the present research. Consumers who had legal guardians or authorized representatives because they have been deemed to not have the ability to understand the risks and benefits and make informed decisions and consumers with cognitive and/or intellectual disabilities were not included in the present study.

The subsample of matched consumers and providers was also small and sample size did not allow for more robust statistical analysis of the data obtained such as linear mixed model regression analysis. Licensed psychologists were recruited given their role in delivering one-to-one psychotherapeutic services; however, not all psychologists at Eastern State Hospital participated in the research. Further limiting the generalizability of findings, psychologists may have selected consumers who were more psychiatrically stable or consumers with whom they felt that they had a strong therapeutic alliance.

The study relied exclusively on consumers’ and providers’ self-reports of their professional relationships that may be affected by participants’ memory, effort or motivation, and social desirability. The present study used a cross sectional research design and cannot address issues of causation among study variables.

The present study also has several strengths worth considering. The present sample size of 60 mental health consumers was recruited across a variety of units around the hospital and across admission and legal statuses. Further, findings in the present study indicated that
consumers’ perceptions of key variables of interest did not significantly differ as a function of forensic or no forensic status and voluntary and involuntary civil commitment status. The present study also used working alliance as a predictor variable in the consumer regressions models to systematically understand its contribution to consumer well-being, whereas other researchers may use working alliance as the dependent variable (Arnow et al., 2013; Donnelly et al., 2011; Hicks, Deane, & Crowe, 2012; Kondrat & Early, 2010; Wykes, Rose, Williams, & David, 2013). This latter tenant is noteworthy because findings in the present study add to an understanding of how working alliance and provider directiveness contribute to consumers’ reports of factors other than symptom reduction. Moreover, findings also provide support that recovery-oriented service implementation is occurring in one state psychiatric hospital from the perspective of adult mental health consumers.

The present study also obtained the perspectives of consumers and mental health providers, specifically licensed psychologists. Previous researchers obtained perspectives of consumers (Chao, Steffen, & Heiby, 2012; Hicks, Deane, & Crowe, 2012; Solomon, Draine, & Delany, 1995) or case managers (Neale & Rosenbeck, 1995), which does not allow for an understanding congruence of key stakeholders’ perceptions. Other researchers have utilized correlational analysis to understand the association between consumer and provider perceptions of working alliance (Gehrs & Goering, 1994), and the current findings add to this literature by utilizing adults with serious mental illness and psychologists.

**Future Directions for Research and Practice**

**Recovery and Consumer Well-being.** With support at the national policy level and from consumers with mental illness and their families, a recovery-oriented paradigm is the accepted and preferred model of service delivery (Davidson, Lawless, & Leary, 2005a; O’Connell,
Tondor, Croog, & Evans, 2005). The degree to which recovery-oriented service delivery has been implemented in state psychiatric hospitals, however, is not well understood (Tsai & Salyers, 2008). Findings in the present study provide support that inpatient mental health consumers identified recovery-oriented principles and consumers’ perceptions of working alliance and provider directiveness also accounted for a significant proportion of their perceptions of recovery-orientation of inpatient services. Missing in the present study are providers’ perceptions of recovery oriented-service delivery. Future research could include the provider version of the RSA-R (O’Connell et al., 2005) in larger multiple perspective consumer-provider sample to understand how consumers’ and providers’ congruence of perceptions on matched therapeutic relationship variables are associated with provider and consumer individual well-being and recovery-orientation of inpatient services. A larger sample size of matched providers and consumers would further allow for more robust statistical analysis.

It may also be possible to understand how an agency climate of recovery influences consumers’ and providers’ sense of well-being. Future research with a larger sample of providers, which includes measures of individual well-being, such as personal growth (Stein et al. 2005) and job satisfaction could provide a bridge to understand how recovery, provider-consumer working alliance, and well-being are associated. Such research could provide additional support to the few studies (Kraus & Stein, 2013; Linley & Joseph, 2007; Osborn & Stein, 2015; Stein & Craft, 2007), which indicate that providers benefit from direct work with consumers living with mental illness.

Although consumers reported relatively low perceptions of personal loss from mental illness, future research could obtain perspective of inpatient consumers to better understand how consumers’ reports of loss from mental illness are uniquely different in a state hospital setting. A
phenomenological approach could use consumers’ voices to provide a rationale on how their conversations with providers influence their sense of loss during hospitalization which could inform psychometric reevaluation of the personal loss from mental illness measure. Presently, providers could implement psychosocial group treatment to enhance consumer perceptions of loss from mental illness by specifically engaging in meaning making strategies based on consumers’ experiences. A pre-post design would allow for an understanding of change in consumer perception. Such an intervention may begin a dialogue between consumers and providers enhancing consumer recovery and enhancing provider and consumer bond. Also, providers could measure consumer’s working alliance at admission and discharge. The present results indicated that working alliance is a reliable predictor of perceptions of recovery, and such an intervention could help consumers begin reflecting early on and throughout the course of hospitalization on their views of providers and recovery.

**Directiveness.** Given that provider directiveness is antithetical to essential and foundational recovery-oriented service goals which call for a mutual and collaborative work (Anthony, 1993; Coffey, 2006; Green et al., 2008; Oades et al., 2005; Randal et al., 2009) and is associated with unpleasant outcomes for consumers (Beutler et al., 2001; Bischoff & Tracey, 1995; Karno & Longabaugh, 2005), findings in the present study necessitate future research. As an oppressed and marginalized population, individuals living with mental illness typically endure a challenging road to recovery. Provider directiveness remains a quantified, but nuanced, phenomenon in mental health service delivery. Until provider directiveness is better understood, providers should deliver treatment which does not reduce consumer autonomy. Results in the present study should not be interpreted at this time that consumers are “Okay” with provider directiveness without further refining and enhancing the psychometric properties of the provider
directiveness measure, empirically differentiating provider directiveness from coercion, and obtaining consumers’ perceptions regarding providers’ directive practices.

Replication of the present study with a larger sample is required to better understand the relationship between consumers’ perceptions of providers’ directive practices and working alliance within a recovery-oriented paradigm. Replication will allow for additional psychometric evaluation of the provider directiveness measure, specifically regarding the measures internal consistency reliability, factorial structure, and construct validity. Such an investigation should also include similar measures of working alliance and provider directiveness, recovery, individual well-being, and a measure of coercion.

If provider directiveness were differentiated from coercion, it could parse out specific behaviors and interventions that are coercive from those that are directive and perhaps consistent with consumers’ values. For example, the provider directiveness measure could be compared with the Therapeutic Limiting Setting scale (Neale & Rosenheck, 2000) to establish convergent validity. Further, the measure could be compared with the McArthur Perceived Coercion Scale (Gardner et al., 1993) to establish discriminant validity. Zolnierek (2007) suggests that providers may not recognize or acknowledge “how their seemingly innocuous behavior may be experienced by psychiatric patients, and this lack of awareness may have significant ramifications for the individuals who experience mental illness” (p. 104). It is likely that these subtle behaviors which are consistent with provider directiveness and if operationalized could bring about awareness on the part of providers. It may also help create a “cut off” of acceptable behaviors.

Should provider directiveness be differentiated from coercive practices, it is necessary to obtain consumers’ perspectives regarding directive practices. It is not enough to potentially
determine that provider directiveness is not coercion and for providers to continue applying the behaviors and interventions regardless of consumers’ desires. It is critical to obtain consumers’ rationales or lived voices and experiences regarding the role of directiveness in their mental health recoveries. Other researchers have used a phenomenological approach to look at consumers’ experiences in an inpatient hospital regarding coercion (Katsakou et al., 2010; O’Donnoghue et al., 2010) and this method would likely prove fruitful to understand consumers’ views of the role of provider directiveness in treatment.

If future phenomenological enquiry indicated that consumers were “Okay” with providers’ directive behaviors, it might suggest that further recovery implementation work is necessary. Apathy or learned helplessness is not consistent with scholarly aspirations of recovery-oriented service delivery which promote autonomy, agency, and self-determination (Davidson et al., 2005b; Farkas et al., 2005). Collaboration and transparency between consumers, providers, and the state hospital setting may provide an ongoing dialogue on the status of implementation of recovery-orientated services.

Continued investigation of provider directiveness and working alliance from the perceptions of providers and consumers is necessary to understand how these nuanced behaviors are associated with individual reports of well-being and recovery-oriented service delivery. Such research could highlight the unique professional and personal benefits that mental health providers and adults with mental illness may achieve from their professional relationships.
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### Consumer Personal Demographic Characteristics.

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<th>N = 60</th>
<th>n (%)</th>
<th>n (%)</th>
</tr>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>47</td>
<td>78.3</td>
<td>32</td>
</tr>
<tr>
<td>Women</td>
<td>13</td>
<td>21.7</td>
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<tr>
<td><strong>Religious preference</strong></td>
<td></td>
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</tr>
<tr>
<td>Protestant/Other Christian</td>
<td>32</td>
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<td>32</td>
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<tr>
<td>Catholic</td>
<td>7</td>
<td>11.7</td>
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<td>1</td>
<td>1.7</td>
<td>1</td>
</tr>
<tr>
<td>Muslim</td>
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<tr>
<td><strong>Marital Status</strong></td>
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<td>Separated/Divorced</td>
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<td><strong>Living situation</strong></td>
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<tr>
<td>Independently/No supervision</td>
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<td>15</td>
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<td>With family</td>
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<td>House/apartment with supervision</td>
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<td>5.0</td>
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<tr>
<td>Group home/residential facility</td>
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<td>15</td>
<td>9</td>
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<td>Other</td>
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</tr>
<tr>
<td>Pre high school/below 8th grade</td>
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<td>40</td>
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<td>Some high school</td>
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<td>10</td>
<td>18</td>
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<td>High school graduate/GED</td>
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<td>30</td>
<td>8</td>
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<td>Some college/technical school</td>
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<td>31.7</td>
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<td>Associate’s degree</td>
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<td>8.3</td>
<td>5</td>
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<tr>
<td>Bachelors degree</td>
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<td>8.3</td>
<td>5</td>
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<tr>
<td>Advanced degree</td>
<td>1</td>
<td>1.7</td>
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</table>

*Note.* * indicates missing data for one participant.
Table 2

**Consumer Mental Health/Treatment Demographic Characteristics.**

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<th></th>
<th>N = 60</th>
<th>n (%)</th>
<th>n (%)</th>
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<td>NAMI member</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>(21.7)</td>
<td>28</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>(78.3)</td>
<td></td>
</tr>
<tr>
<td>Perceived severity of symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all serious</td>
<td>28</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>A little serious</td>
<td>18</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Somewhat serious</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very serious</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived level of involvement in mental health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not involved</td>
<td>3</td>
<td>(5.0)</td>
<td>25</td>
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<tr>
<td>A little involved</td>
<td>10</td>
<td>(16.7)</td>
<td></td>
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<td>Somewhat involved</td>
<td>21</td>
<td>(35)</td>
<td>35</td>
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<tr>
<td>Very involved</td>
<td>26</td>
<td>(43.3)</td>
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<td>(26.7)</td>
<td>8</td>
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<td>Schizoaffective disorder</td>
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<td>(33.3)</td>
<td>19</td>
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<td>Major depression</td>
<td>2</td>
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<td>5</td>
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<td>Bipolar Disorder</td>
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<td>(23.3)</td>
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<td>OCD</td>
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<td>PTSD</td>
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<td>(1.7)</td>
<td>10</td>
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<td>Personality disorder</td>
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<td>(3.3)</td>
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<td>Unknown</td>
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<td>(3.3)</td>
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<td>Other</td>
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<td>(1.7)</td>
<td>50</td>
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<tr>
<td>How long receiving MH Services</td>
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<tr>
<td>Less than 1 year</td>
<td>4</td>
<td>(6.7)</td>
<td>24</td>
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<tr>
<td>1-2 years</td>
<td>4</td>
<td>(6.7)</td>
<td>4</td>
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<tr>
<td>3-5 years</td>
<td>15</td>
<td>(25)</td>
<td>5</td>
</tr>
<tr>
<td>6-10 years</td>
<td>8</td>
<td>(13.3)</td>
<td>11</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>28</td>
<td>(46.7)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>5</td>
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</table>

*Note.* * indicates missing data for one participant.
Table 3

*Procedure for Study Measures of Interest.*

<table>
<thead>
<tr>
<th>Provider Measures</th>
<th>Consumer Measures</th>
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<tbody>
<tr>
<td>Demographics</td>
<td>Demographics</td>
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<tr>
<td>Working Alliance Inventory</td>
<td>Working Alliance Inventory</td>
</tr>
<tr>
<td>Provider Directiveness</td>
<td>Provider Directiveness</td>
</tr>
<tr>
<td>Maslach Burnout Inventory *</td>
<td>Recovery Self-Assessment – Revised *</td>
</tr>
<tr>
<td>Case Manager Personal Growth scale *</td>
<td>Personal Loss *</td>
</tr>
<tr>
<td>BBC General Well-being Scale *</td>
<td>BBC General Well-being Scale *</td>
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<td></td>
<td>Colorado Symptom Index</td>
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</table>

*Note.* * denotes a measure that is used as a dependent variable
Table 4

*Consumer Grouping of Demographic Variables for Chi-square testing.*

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<tr>
<th>Demographic Variable</th>
<th>n</th>
<th>Grouping Categories</th>
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<td>Ethnicity</td>
<td>25</td>
<td>Caucasian</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>All other minority groups (i.e., African American, Latino, Native American, Arab American)</td>
</tr>
<tr>
<td>Age</td>
<td>25</td>
<td>34 years old or less</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>35 to 54 years old</td>
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<td></td>
<td>13</td>
<td>55 years or older</td>
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<td>Marital Status</td>
<td>41</td>
<td>Single</td>
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<tr>
<td></td>
<td>8</td>
<td>Married or living with a partner</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Divorced, widowed, separated</td>
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<tr>
<td>Current Working Status</td>
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<td>Not Employed</td>
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<tr>
<td>Education Level</td>
<td>28</td>
<td>High School or Less</td>
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<tr>
<td></td>
<td>24</td>
<td>Some college/Associate’s degree</td>
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<tr>
<td></td>
<td>6</td>
<td>Bachelor’s degree or higher</td>
</tr>
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<td>Religion *</td>
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<td>Protestant/Catholic</td>
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<td></td>
<td>12</td>
<td>Other Religion (i.e., Muslim, Jewish, Buddhist)</td>
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<tr>
<td></td>
<td>11</td>
<td>No affiliation, Atheist, Agnostic</td>
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<tr>
<td>NAMI Membership</td>
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<td>No</td>
</tr>
<tr>
<td>Length in Mental Health</td>
<td>23</td>
<td>Less than 10 years</td>
</tr>
<tr>
<td>System</td>
<td>36</td>
<td>More than 10 years</td>
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<tr>
<td>Level of Mental Health Service Involvement</td>
<td>13</td>
<td>Not at all or a little Involved</td>
</tr>
<tr>
<td></td>
<td>47</td>
<td>Somewhat or very Involved</td>
</tr>
<tr>
<td>Severity of Illness</td>
<td>46</td>
<td>Not at all or a little Severe</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Somewhat or very Severe</td>
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</table>

*Note.* *Five participants did not answer this question.*
Table 5

<table>
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<th>Variables</th>
<th>M</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working Alliance</td>
<td>3.83</td>
<td>.85</td>
<td>--</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Provider Directiveness</td>
<td>3.35</td>
<td>.69</td>
<td>.18</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
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<td>3. Recovery Self Assessment-Revised (RSA-R)</td>
<td>3.90</td>
<td>.81</td>
<td>.39*</td>
<td>.37**</td>
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<tr>
<td>4. Personal Loss (PLMI)</td>
<td>3.06</td>
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<td>-.29*</td>
<td>.18</td>
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<tr>
<td>5. Symptoms (CSI)*</td>
<td>30.40</td>
<td>12.04</td>
<td>-.26*</td>
<td>.05</td>
<td>-.25</td>
<td>.27*</td>
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<td></td>
</tr>
<tr>
<td>6. Well-being Scale (WBS)*</td>
<td>72.50</td>
<td>12.25</td>
<td>.58**</td>
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<td>-.55**</td>
<td>-.37**</td>
<td>-.46**</td>
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<td>7. Number of hospitalizations</td>
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<td>.32*</td>
<td>.00</td>
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*Note. Correlations with * have a p<.05. Correlations with ** have a p < .01. *Measure is scored using a total score, rather than a mean score*
Table 6

*Consumer Hierarchical Regression Analysis (N = 60).*

<table>
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<th>Criterion Variable</th>
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<th>Step 2</th>
<th>Step 3</th>
<th>$R^2$</th>
<th>Adj $R^2$</th>
<th>R</th>
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<td>.01</td>
<td>.05</td>
<td>.01</td>
<td>.59**</td>
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</tr>
<tr>
<td></td>
<td>2. Number of psychiatric hospitalizations</td>
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<td>-.03*</td>
<td>-.02</td>
<td>.18*</td>
<td>.11*</td>
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<td></td>
<td>Symptoms</td>
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</tr>
<tr>
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<td>3. Working Alliance</td>
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<td>.28*</td>
<td>.35**</td>
<td>.27**</td>
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<td></td>
<td></td>
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<td></td>
<td>Provider Directiveness</td>
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<td></td>
<td></td>
<td></td>
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<td>Personal Loss</td>
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<td>.00</td>
<td>-.00</td>
<td>.02</td>
<td>-.02</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2. Number of psychiatric hospitalizations</td>
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<td>.02</td>
<td>.02</td>
<td>.16</td>
<td>.10</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Symptoms</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Working Alliance</td>
<td>.08</td>
<td>.16</td>
<td>.23</td>
<td>.12</td>
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<td></td>
<td></td>
</tr>
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<td>Well-being</td>
<td>1. Age</td>
<td>.05</td>
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<td>.17</td>
<td>.14</td>
<td>.05</td>
<td>.01</td>
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<td>1.3</td>
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<tr>
<td></td>
<td>2. Number of psychiatric hospitalizations</td>
<td>.14*</td>
<td>-.13</td>
<td>-.08</td>
<td>.20*</td>
<td>.13*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Working Alliance</td>
<td>.30**</td>
<td>7.62**</td>
<td>.50**</td>
<td>.43**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider Directiveness</td>
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<td></td>
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</tbody>
</table>

*Note.* *p* < .05. **p** < .01.
Table 7

Providers’ Means, Standard Deviations, and Correlations for all Study Variables (N = 9).

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working Alliance</td>
<td>3.80</td>
<td>.62</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Provider Directiveness</td>
<td>2.72</td>
<td>.54</td>
<td>-.95</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Personal Growth (CMPG)</td>
<td>3.60</td>
<td>.45</td>
<td>.03</td>
<td>-.66</td>
<td>--</td>
<td></td>
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<td>4. Well-being Scale (WBS) *</td>
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<td>-.57</td>
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<tr>
<td>5. Burnout Emotional Exhaustion</td>
<td>16.55</td>
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*Measure is scored using a total score, rather than a mean score.
Table 8
*Pearson Product-moment Correlations at Provider Level with Aggregated Consumer Variables.*

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*Note.* Correlations with * have a p<.05. Correlations with ** have a p < .01.
Table 9  
*Pearson Product-moment Correlations at Consumer Level with Provider Variables.*

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*Note.* Correlations with * have a p < .05. Correlations with ** have a p < .01.
Table 10

Two-way Random Inter-class Correlation Coefficients of Dyadic Relationship Measures.

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*Note. Correlations with * have a p<.05.
Hello,

My name is Andrew Osborn. I am a doctoral student in Clinical Psychology at Bowling Green State University. For my dissertation research, I am completing a research project to assess the contributions of a therapeutic working alliance on providers’ and consumers’ sense of well-being. Specifically, I am interested in measuring the presence of different variables regarding the relationship you have with the clients you work with that have a serious mental illness. I will further ask you to nominate up to 5 clients to participate in the study by filling out similar measures in regards to their direct clinical work with you.

The Human Subjects Review Board at Bowling Green State University approved this research study (Human Subjects Review Board approval, No., X). Your responses will be anonymous. That is, you will not be identified in any report nor will your identity be made known to your agency. No agency will be identified in the research paper or in any publication. Finally, clients whom you nominate to participate will not see any study materials that you report on and similarly, you will not see any materials that they report about you.

Participation in this study involves completing a paper and pencil questionnaire at a time of your convenience. I estimate that it will take you about X minutes to complete this survey. The anticipated risks to you as a result of participation in this study are no greater than those normally encountered in daily life. Additionally, for your participation, you will be given $5.00 in cash.

Thank you for your time.

Sincerely,
APPENDIX B

Consumer Contact Letter

I am writing to invite you to participate in a study that focuses on how individuals with mental illness view their relationships with mental health providers. Specifically, I am asking you to share your views about specific aspects of the relationship you have with your mental health provider and your sense of well-being.

Under the sponsorship of Dr. Catherine Stein, Andrew Osborn will be conducting this study. If you are interested in participating in the study, you will be asked to fill out a paper and pencil questionnaire that will take you about 30 minutes to complete. You will receive a $5.00 voucher for completing the study for use at Eastern State Hospital.

You are eligible to participate in the study if you:

(a) Are at least 18 years old
(b) Have a diagnosis of schizophrenia, schizoaffective disorder, psychosis NOS, major depression, PTSD, or bipolar disorder
(c) Have received mental health services for at least 1 year
(d) Are your own legal guardian
(e) Do not have cognitive, developmental or communication disabilities

Participation in the study is completely voluntary and what you report is confidential.

**No one at Eastern State Hospital will see your answers except for the principal investigator, and your name is not directly associated with your responses.**

If you start the questionnaire and decide you don’t want to participate, you can stop at any time. Whether you decide to participate or not, nothing about your relationship with Eastern State Hospital or Bowling Green State University will change.

If you are interested in learning more about the project please fill out this form, seal the envelope, and give the envelope to a staff member in the nursing station on your unit.

**Contact Information**

My Name: __________________________
APPENDIX C

Provider Informed Consent

Informed Consent for Research Project

Purpose
You are invited to participate in a study that focuses on understanding how aspects of the provider-consumer relationship contribute to your well-being. You will be asked to share your experiences resulting from your direct clinical work with adults who have serious mental illness and how these relationships impact your views of professional and personal well-being.

Eligibility Requirements
You are eligible to participate in this study if you are a 1.) licensed mental health provider (psychologist, social worker, counselor, etc.), 2.) who currently works with adults who have a serious mental illness, 3.) delivering recovery-oriented services, 4.) for at least five years.

Activities
You will be asked to complete an online survey questionnaire about your experiences and nominate up to 5 consumers on your caseload to inform about the study. Specifically, I will ask you to 1) nominate up to five consumers with whom you have most frequently worked with that are: diagnosed with serious mental illness, are at least 18 years old, do not have cognitive or intellectual difficulties or profound communication deficits, and have received mental health services for at least one year. Next, I will send you an email containing a link to an online survey. The survey will ask you about 2) your perceptions of your professional and personal well-being as a result of working with consumers; 3) basic demographic information about you; 4) your professional relationships with up to five consumers that you have nominated. It should take you approximately 30 minutes or less to complete the survey.

Risks
The anticipated risks to you are no greater than those normally encountered in daily life. If any question in the survey makes you feel uncomfortable, you do not have to answer it. You will also be provided with the contact information of the principal investigator should have questions as well as additional resources.

Benefits
By participating in this study, you have the opportunity to reflect on your experiences over the years providing direct services to consumers who have a serious mental illness. Specifically, you will be able to consider any benefits and costs as you see them, which might have resulted from working with consumers who have serious mental illness. The results of this study will help us understand how the relationship mental health professionals and the consumers with whom they work contribute to their sense of well-being. As a token of our appreciation for completing the survey questionnaire, you will be entered in a random raffle for one of eight fifty dollar gift cards, where the odds of winning are 40 percent or better.
Confidentiality
Every effort will be made to protect the confidentiality of survey responses. Your name will not be directly associated with any of your responses. No consumers, mental health professions, or other people at Name of Agency will have access to your responses. Further, you will not have access to any information regarding consumers who participated in the study. Any information that you provide will be reported across individuals in the study. Your participation in this study is voluntary and you can refrain from answering any or all questions without penalty or explanation. Data will be stored in a secure, password protected, computer database, behind a locked door. Survey responses will be stored in a locked file cabinet, behind a locked door in the Department of Psychology. A copy of this form with your name will be stored separately from your responses in a locked file cabinet in a locked room. Your decision to participate or not to participate in the research will in no way impact your association with your agency of employment, Bowling Green State University, or the Department of Psychology.

Online Survey Participation
Because the Internet is not 100% secure in terms of privacy, please do not leave the partially completed survey open or unattended if completing it on a public computer. You may want to clear the browser page history and cache when finished with the survey and should completely close the browser window upon completion of the survey.

Your Rights as a Participant
You are free to withdraw consent and to discontinue participation in the project at any time. If there is a question you would not like to answer, you can simple skip that question and go to the next one.

Should you choose not to participate or withdraw from this research study, it will not impact your employment position at your agency, your affiliation with Bowling Green State University, or the Department of Psychology.

As a participant, you have the right to have all of your questions about the study answered by the researcher, and you may request a summary or copy of the results of the study after it is completed.

• If you have questions or comments about this study, you can contact the Principal Investigator, Andrew Osborn, at (419) 372-4597, losborn@bgsu.edu.

• If you have additional questions or comments about this study, you can contact the Principal Investigator’s Advisor, Dr. Catherine Stein, at (419) 372-2278, cstein@bgsu.edu.
If you have any questions or concerns about your rights as a research participant please contact the Chair of BGSU's Human Subjects Review Board at (419) 372-7716, or at hsrb@bgsu.edu.

You may refuse to participate or withdraw your consent and discontinue participation in this study at any time.

If you are eligible to participate and wish to give your consent and continue, please select the option below and click on the “Next” button.

- I have been presented with and have read the statement of risks and benefits of participating in this project and I agree to participate. I certify that I meet the eligibility requirements for this study.

Next
APPENDIX D
Consumer Informed Consent

Purpose
You are invited to participate in a study that focuses on ways that people work with mental health care providers. You will be asked your opinion about your relationship with ________ (clinician’s name) and your sense of well-being. The mental health provider that nominated you will not be informed that you have completed the survey and no person at Eastern State Hospital will have access to or be able to see any of your responses except for the principal investigator.

Eligibility Requirements
You can participate in this study if you are at least 18 years old, have a current mental health diagnosis: schizophrenia, schizoaffective disorder, psychotic disorder NOS, major depression, PTSD, bipolar disorder, etc.), are your own legal guardian, and do not have cognitive, developmental or communication disabilities.

Activities
I will ask you to complete a paper and pencil survey about your experiences and views about: 1) your background (such as your age, gender) 2) your recovery and mental health experiences; 2) your sense of well-being; and 3) your relationship with your mental health provider. The survey will take about 30 minutes to complete. Once your survey is submitted, this will end your participation in the study.

Risks
The anticipated risks to you are no greater than those normally encountered in daily life. If a question in the survey makes you feel uncomfortable, you can skip that question or any other question you do not want to answer. If you feel any discomfort after completing the survey you can immediately speak with a staff member.

Benefits
By participating in this study, you can reflect on your views about mental health providers and your sense of well-being. The results of this study will help us understand how relationships between clients and clinicians affect one another. As a token of our appreciation for completing the survey, you will receive a $5.00 voucher for use at Eastern State Hospital.

Confidentiality
Your name will not be directly associated with any of your responses. Your responses will not be directly shared with anyone at Eastern State Hospital except for the principal investigator. In any written documents related to the research, any information that you provide will be included with information from other participants. Research data will be stored in a secure, password protected, computer database, behind a locked door. Survey responses will be stored in a locked file cabinet, behind a locked door in the Department of Psychology. A copy of this form with your
name will be stored separately from your responses in a locked file cabinet in a locked room.

**Your Rights as a Participant**
Your participation in this study is voluntary and you are free to stop at any time. If there is a question you don’t want to answer, you can skip that question and go to the next.

Should you choose not to participate or withdraw from this research study, it will not impact the services you receive at Eastern State Hospital, the Department of Psychology, or with Bowling Green State University.

As a participant, you have the right to have all of your questions about the study answered by the researcher, and you may request a summary or copy of the results of the study after it is completed.

- If you have any questions or comments about this study, you can contact the Principal Investigator, Andrew Osborn, at (419) 372-4597, losborn@bgsu.edu.
- You can also contact the Principal Investigator’s adviser, Dr. Catherin H. Stein, at (419) 372-2301, cstein@bgsu.edu.
- If you have any questions or concerns about your rights as a research participant please contact the Chair of BGSU's Human Subjects Review Board at (419) 372-7716, or at hsrb@bgsu.edu.

You may refuse to participate or withdraw your consent and discontinue participation in this study at any time.

*I have been presented with and have read the statement of risks and benefits of participating in this study and I consent to participate in the study. I certify that I meet the eligibility requirements for this study.*

_________________________________________  _______________________
Name of Participant                      Date
APPENDIX E

Working Alliance Inventory – Short Revised

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of ______ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.
   
   | 1 | 2 | 3 | 4 | 5 |
   | Seldom | Sometimes | Fairly Often | Very Often | Always |

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

   | 5 | 4 | 3 | 2 | 1 |
   | Always | Very Often | Fairly Often | Sometimes | Seldom |

3. I believe ___ likes me.

   | 1 | 2 | 3 | 4 | 5 |
   | Seldom | Sometimes | Fairly Often | Very Often | Always |

4. ___ and I collaborate on setting goals for my therapy.

   | 1 | 2 | 3 | 4 | 5 |
   | Seldom | Sometimes | Fairly Often | Very Often | Always |

5. ___ and I respect each other.

   | 5 | 4 | 3 | 2 | 1 |
   | Always | Very Often | Fairly Often | Sometimes | Seldom |

6. ___ and I are working towards mutually agreed upon goals.

   | 5 | 4 | 3 | 2 | 1 |
   | Always | Very Often | Fairly Often | Sometimes | Seldom |

7. I feel that ___ appreciates me.
8. _____ and I agree on what is important for me to work on.

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

12. I believe the way we are working with my problem is correct.
APPENDIX F

Provider Directiveness Measure – Consumer Version

Directions
We are interested in understanding ways that your counselor/therapist works with you. Please think about your counselor/therapist with whom you currently work when responding to the items below. Please circle the degree to which each statement generally describes what he or she does do in their work with you.

Questions
1. My counselor/therapist encourages me to have ongoing contact and interaction with my family members, even if at times I express concerns about doing so.

   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

2. My counselor/therapist encourages me to take control of my finances, even if I tell him/her I am not ready.

   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

3. Regardless of my expressed objections, my counselor/therapist advises me to start romantic relationships (e.g., dating) if I am not ready.

   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

4. My counselor/therapist urges me to remain on medication(s) despite my concerns about side effects.

   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

5. My counselor/therapist facilitates securing housing for me (i.e., group home, independent living, residential setting, etc.) when necessary, even if I do not want to be involved in the process.

   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

6. My counselor/therapist helps me pursue the goal of improving or expanding my friendships with others, even if I am not ready.

   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

7. Despite my objections, my counselor/therapist involves me in additional treatment programs if he/she feels that it would help me (e.g. club house, group therapy, AA or other support programs, etc.).
Strongly disagree    Disagree    Uncertain    Agree    Strongly agree

8. When my counselor/therapist feels I am not capable of collaborating, he/she determines my treatment goals.

Strongly disagree    Disagree    Uncertain    Agree    Strongly agree

9. My counselor/therapist assigns therapeutic “homework assignments,” even though I said that I did not want to complete them.

Strongly disagree    Disagree    Uncertain    Agree    Strongly agree
APPENDIX G
Recovery Self-Assessment – Revised
Consumer Version

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program.

1 2 3 4 5
1. Staff welcome me and help me feel comfortable in this program. 1 2 3 4 5 N/A D/K
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified. 1 2 3 4 5 N/A D/K
3. Staff encourage me to have hope and high expectations for myself and my recovery. 1 2 3 4 5 N/A D/K
4. I can change my clinician or case manager if I want to. 1 2 3 4 5 N/A D/K
5. I can easily access my treatment records if I want to. 1 2 3 4 5 N/A D/K
6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want. 1 2 3 4 5 N/A D/K
7. Staff believe that I can recover. 1 2 3 4 5 N/A D/K
8. Staff believe that I have the ability to manage my own symptoms. 1 2 3 4 5 N/A D/K
9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc. 1 2 3 4 5 N/A D/K
10. Staff listen to me and respect my decisions about my treatment and care. 1 2 3 4 5 N/A D/K
11. Staff regularly ask me about my interests and the things I would like to do in the community. 1 2 3 4 5 N/A D/K
12. Staff encourage me to take risks and try new things. 1 2 3 4 5 N/A D/K
13. This program offers specific services that fit my unique culture and life experiences. 1 2 3 4 5 N/A D/K
14. I am given opportunities to discuss my spiritual needs and interests when I wish.  1 2 3 4 5 N/A D/K

15. I am given opportunities to discuss my sexual needs and interests when I wish.  1 2 3 4 5 N/A D/K

16. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).  1 2 3 4 5 N/A D/K

17. Staff help me to find jobs.  1 2 3 4 5 N/A D/K

18. Staff help me to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.  1 2 3 4 5 N/A D/K

19. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer).  1 2 3 4 5 N/A D/K

20. Staff introduce me to people in recovery who can serve as role models or mentors.  1 2 3 4 5 N/A D/K

21. Staff offer to help me connect with self-help, peer support, or consumer advocacy groups and programs.  1 2 3 4 5 N/A D/K

22. Staff help me to find ways to give back to my community, (i.e., volunteering, community services, neighborhood watch/cleanup).  1 2 3 4 5 N/A D/K

23. I am encouraged to help staff with the development of new groups, programs, or services.  1 2 3 4 5 N/A D/K

24. I am encouraged to be involved in the evaluation of this program’s services and service providers.  1 2 3 4 5 N/A D/K

25. I am encouraged to attend agency advisory boards and/or management meetings if I want.  1 2 3 4 5 N/A D/K

26. Staff talk with me about what it would take to complete or exit this program.  1 2 3 4 5 N/A D/K

27. Staff help me keep track of the progress I am making towards my personal goals.  1 2 3 4 5 N/A D/K

28. Staff work hard to help me fulfill my personal goals.  1 2 3 4 5 N/A D/K

29. I am/can be involved with staff trainings and education programs at this agency.  1 2 3 4 5 N/A D/K
30. Staff listen, and respond, to my cultural experiences, interests, and concerns. 1 2 3 4 5 N/A D/K

31. Staff are knowledgeable about special interest groups and activities in the community. 1 2 3 4 5 N/A D/K

32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests. 1 2 3 4 5 N/A D/K
APPENDIX H

Personal Loss due to Mental Illness Scale

These questions deal with losses that some people who have mental health problems say that they have experienced. Please indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Somewhat Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having a mental illness has changed who I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. It’s hard for me to find a good reason to get out of bed some mornings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Chances are very good that I will get married and have a family of my own</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I doubt that I will have the same kind of future as other people my age.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I liked myself better before I became ill</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I miss the friends that I had before I became ill.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. People who knew me before I became ill would hardly recognize me now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Having a mental illness might stop me from getting or keeping a good job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Having a mental illness has kept me from being an important member of my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I don’t enjoy being around other people who have a mental illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I have things that I like doing everyday.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I have lost a lot of friends because of being mentally ill</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I feel that I don’t have the kind of friends that other people my age have.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I will probably never be able to own my own house.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
<tr>
<td>15. Having a mental illness has taken away my normal daily routine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I haven’t really changed very much because of having a mental illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. The plans I make for each day often do not get done.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. Other people often tell me not to plan too far into the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I don’t “plan” for the future, but I do have “hopes” about what I’d like to see happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. My future is as bright now as it was before becoming ill.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX I

Colorado Symptom Index

These next questions ask you about your mental health symptoms within the last month. Indicate how much you agree with each statement by choosing from the response options.

<table>
<thead>
<tr>
<th>How often in the last month…</th>
<th>Not at all</th>
<th>Once during the month</th>
<th>Several times a month</th>
<th>Several times a week</th>
<th>At least every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you felt nervous, tense, worried, frustrated or afraid?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Have you felt depressed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Have you felt lonely?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Have you had trouble making up your mind about something (like deciding where you want to go or what you are going to do, or how to solve a problem)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Have you had trouble thinking straight or concentrating on something you need to do (like worrying so much or thinking about problems so much that you can’t remember or focus on other things)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Have you felt that your behavior or actions were strange or different from that of other people?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Have you felt out of place or like you didn’t fit in?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Have you forgotten important things?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Have you had problems with thinking too fast (thoughts racing)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>10. Have others told you that you act paranoid or suspicious?</td>
<td></td>
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<tr>
<td>11. Have you heard voices, or seen things that other people don’t think are there?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have voices, thoughts, or feelings interfered with your doing things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you felt like hurting or killing yourself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you felt like seriously hurting someone else?</td>
<td></td>
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<td></td>
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</tbody>
</table>
APPENDIX J

The BBC Well-being Scale – Consumer Version

1 2 3 4
Strongly disagree disagree agree strongly agree

1. Are you satisfied with your physical health?
2. Are you satisfied with the quality of your sleep?
3. Are you satisfied with your ability to perform your daily living activities?
4. Are you satisfied with your ability to work?
5. Do you feel depressed or anxious?
6. Do you feel that you are able to enjoy life?
7. Do you feel you have a purpose in life?
8. Do you feel in control over your life?
9. Do you feel optimistic about the future?
10. Do you feel satisfied with yourself as a person?
11. Are you satisfied about your looks and appearance?
12. Do you feel able to live your life the way you want?
13. Are you confident in your own opinions and beliefs?
14. Do you feel able to do the things you choose to do?
15. Do you feel able to grow and develop as a person?
16. Are you satisfied with yourself and your achievements?
17. Are you satisfied with your personal and family life?
18. Are you satisfied with your friendships and personal relationships?
19. Are you comfortable about the way in which you relate to and connect with others?
20. Are you satisfied with your sex life?
21. Do you feel able to ask someone for help with a problem if you needed to?
22. Are you satisfied that you have enough money to meet your needs?
23. Are you satisfied with your opportunity for exercise and leisure activities?
24. Are you satisfied with your access to health services?
APPENDIX K

Consumer Demographics

Please fill in the blanks with the appropriate information or circle the response that best applies to you:

What is the name of the clinician you see here for counseling that referred you to this study? __________________________ They will not see your responses or know that you participated.

Your Gender:
(0) Male
(1) Female

2. Your Age (in years): ______

3. Your Marital Status:
(1) single / never married
(2) married / remarried
(3) living, as if married, with a partner
(4) separated / divorced
(5) widowed

4. How many children do you have? 
   (Include natural, adopted, step, and foster children) _____

5. Which of these groups best describes you?
   (1) Asian
   (2) African-American (or Black)
   (3) Caucasian (or White)
   (4) Hispanic
   (5) Native American/Alaska Native
   (6) Other/Multiracial, please specify: __________________________

6. Your highest level of education:
   (1) pre-high school (8th grade or below)
   (2) some high school
   (3) high school graduate or GED
   (4) some college or technical school
   (5) Associate’s degree
   (6) Bachelors’/college graduate (4 year degree)

7. Are you currently working for pay in the hospital:
   (1) Yes
   (2) No

8. When not in the hospital, what is your approximate annual income, before taxes, from all sources:
   (1) less than $20,000
   (2) $20,000-$29,999
   (3) $30,000-$39,999
   (4) $40,000 - $49,999
   (5) $50,000-$59,999
   (6) $60,000-$69,999
   (7) $70,000-$79,999
   (8) $80,000-$89,999
   (9) $90,000-$99,999
   (10) over $100,000

9. Did you have any of these financial services before coming to the hospital? (Please check all that apply)
   □ Social Security Benefits (SSA)
   □ Social Security Disability Income (SSDI)
   □ Supplemental Security Income (SSI)
   □ Family and/or spouse contribution
   □ Other sources(s), please specify: __________________________

10. Your religious preference:
    (1) Protestant/Other Christian
    (2) Catholic
    (3) Jewish
11. Are you currently a: (circle all that apply)
(1) member of NAMI (the National Alliance on Mental Illness- local, state, or national chapter)
(2) member of another support group, please specify:
(3) none of the above

12. Overall, how would you rate your level of involvement in mental health services (such as receiving case management, medication, therapy, etc.)? (Check all that apply.)
(1) not involved
(2) a little involved
(3) somewhat involved
(4) very involved

13. Before coming to the hospital, what was your current living situation?
(1) live independently in house or apartment with no formal supervision
(2) live with a family member
(3) live in house or apartment with formal supervision
(4) live in a group home / community residential care facility
(5) live in an inpatient psychiatric facility or hospital
(6) homeless
(7) other, please specify:

14. What do you believe is your current primary psychiatric diagnosis?
(1) schizophrenia
(2) schizoaffective disorder
(3) major depression
(4) bipolar / manic-depression
(5) panic disorder
(6) obsessive compulsive disorder (OCD)
(7) post traumatic stress disorder (PTSD)
(8) a personality disorder
(9) unknown
(10) other, please specify:

15. Do you have any other psychiatric diagnoses? If so, what are they:

16. In regard to your answer to the above question, how long have you been diagnosed?
(1) less than 1 year
(2) 1-3 years
(3) 3 - 5 years
(4) 5 - 10 years
(5) 10-20 years
(6) More than 20 years

17. How serious or severe would you say your illness/symptoms is right now?
(1) not at all serious
(2) a little serious
(3) somewhat serious
(4) very serious

18. How many times have you been hospitalized for mental health difficulties?

19. Which services have you used in the past six months? (Check all that apply.)
☐ Counseling or Psychotherapy (i.e., see a psychologist or counselor)
☐ Housing or Residential Services (i.e., Support Housing program, HUD, Section 8)
☐ Medications or Med. Management (i.e., see a psychiatrist)
Self-help or Consumer Run Services (e.g., Alcoholics Anonymous (AA), NA, Peer Support)
Assertive Community Treatment (ACT) (i.e., the PACT team)
Psychosocial Rehabilitation
Employment or Vocational Services
Alcohol or Drug Abuse Treatment (e.g., Dual Groups, Drug Counseling)
Case Management (i.e., see a case manager)
Clubhouse (e.g., Wernert Center, Connections Center)
Day Treatment Program
Partial Hospitalization (e.g., Genesis)
Other: __________________________

20. About how long have you been receiving mental health services?
(1) Less than 1 year
(2) 1 to 2 years
(3) 3 to 5 years
(4) 6 to 10 years
(5) More than 10 years

21. About how long have you currently been in individual counseling?
(1) Less than 1 month
(2) 1 to 2 months
(3) 3 to 5 months
(4) 6 to 10 months
(5) 10 to 12 months
(6) 1 year or more

22. Did you pick your counselor?
(1) Yes
(2) No

23. Are you a voluntary patient?
(1) Yes
(2) No

24. About how long have you been in the hospital?
___ (#) Days/Weeks/Months/Years (circle one)

25. How did you begin individual counseling?
(1) I asked for it
(2) Someone on my treatment team recommended it to me.
(3) Another hospital staff/provider recommended it to me.
(4) Other: __________________________
APPENDIX L

Working Alliance Inventory – Short Revised Provider Version

Instructions: Below is a list of statements and questions about experiences people might have with their client. Some items refer directly to your client with an underlined space -- as you read the sentences, mentally insert the name of your client in place of ______ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how _____ might be able to change.
   
   Seldom Sometimes Fairly Often Very Often Always

2. What _____ is doing in therapy gives me new ways of looking at my problem.
   
   Always Very Often Fairly Often Sometimes Seldom

3. I believe___likes me.
   
   Seldom Sometimes Fairly Often Very Often Always

4. ___and I collaborate on setting goals for their therapy.
   
   Seldom Sometimes Fairly Often Very Often Always

5. ___and I respect each other.
   
   Always Very Often Fairly Often Sometimes Seldom

6. ___and I are working towards mutually agreed upon goals.
   
   Always Very Often Fairly Often Sometimes Seldom

7. I feel that___appreciates me.
8. _____ and I agree on what is important for them to work on.

Always       Very Often       Fairly Often       Sometimes       Seldom

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

Seldom       Sometimes       Fairly Often       Very Often       Always

10. I feel that the things ____ does in therapy will help them to accomplish the changes that they want.

Always       Very Often       Fairly Often       Sometimes       Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for them.

Always       Very Often       Fairly Often       Sometimes       Seldom

12. I believe the way we are working with their problem is correct.

Seldom       Sometimes       Fairly Often       Very Often       Always
APPENDIX M

Provider Directiveness Measure – Provider Version

Directions
Working to help consumers achieve their goals is a complex process. Mental health professionals tell us that sometimes their clients are uncertain about what they want or need or are reluctant to make necessary changes in their lives.

We are interested in understanding ways that you work with consumers. Please think about the adults with serious mental illness with whom you currently work when responding to the items below. Please circle the degree to which each statement generally describes what you do in working with clients/consumers.

Questions
1. I have encouraged clients to have ongoing contact and interaction with family members, even if clients at times express concerns about doing so.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

2. I have encouraged my clients to take control of their finances, even if they tell me they are not ready.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

3. Regardless of my clients’ expressed objections, I have advised them to start romantic relationships (e.g., dating) if I think they are ready.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

4. I have urged my clients’ to remain on medication(s) despite their concerns about side effects.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

5. I have facilitated securing housing for clients (i.e., group home, independent living, residential setting, etc.) when necessary, even if clients did not want to be involved in the process.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

6. I have helped my clients pursue the goal of improving or expanding their friendships with others, even if they were not ready.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree
7. Despite their objections, I have helped clients get involved in additional treatment programs if I feel that it would help them (e.g. club house, group therapy, AA or other support programs, etc.).

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

8. When I feel my clients are not capable of collaborating, I determine treatment goals for them.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

9. I have assigned therapeutic “homework assignments,” even though clients said that they did not want to complete them.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree
**APPENDIX N**

**Maslach Burnout Inventory**

The following statements deal with how you may or may not feel about your work as a mental health professional (e.g., case manager). For each, please indicate how often you feel this way (Mark only one number for each item).

1. I feel burned out from my work.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

2. I feel like I am at the end of my rope.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

3. I feel I am working too hard on my job.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

4. I feel used up at the end of the workday.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

5. I feel emotionally drained from my work.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

6. Working with people directly puts too much of a stress on me.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

7. I feel frustrated at my job.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

8. Working with people all day is really a strain for me.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

9. I feel fatigued when I get up in the morning and have to face another day on the job.  
   - Never
   - Occurs 0
   - Occurs 1
   - Occurs 2
   - Occurs 3
   - Occurs 4
   - Occurs 5
   - Occurs everyday 6

10. I worry that this job is hardening me emotionally.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

11. I feel I treat some clients as if they were impersonal objects.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

12. I have become more callous toward people since I took this job.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

13. I feel clients blame me for some of their problems.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

15. I have accomplished many worthwhile things in my job.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

16. I feel very energetic.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

17. I can easily understand how my clients feel about things.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

18. I feel exhilarated after working closely with my clients.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

19. In my work, I deal with my emotional problems very calmly.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

20. I deal very effectively with the problems of my clients.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

21. I feel I am positively influencing other people’s lives through my work.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6

22. I can easily create a relaxed atmosphere with my clients.  
    - Never
    - Occurs 0
    - Occurs 1
    - Occurs 2
    - Occurs 3
    - Occurs 4
    - Occurs 5
    - Occurs everyday 6
APPENDIX O

Case Manager Personal Growth Scale

Below is a set of statements that describe how some helping professionals may feel as a result of working with consumers that experience a chronic mental illness. Please indicate how true each statement is for you at this time in your career. Please respond to the statements using the rating scale below:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I have made positive changes in my life as a result of my work with consumers.
2. I often think about the lives of some consumers when I encounter setbacks in my own life.
3. Working with consumers has led me to focus on strengthening my personal relationships.
4. Working as a case manager has caused a sense of spiritual growth for me.
5. I feel I have more to offer my family and friends as a result of my experience being a case manager.
6. I feel being a case manager has led to personal growth in several areas of my life.
7. I often hear profound “stories” from consumers that cause me to reflect on my own life.
8. I have found that working with consumers has caused me to try harder when I encounter personal problems.
9. The longer I work with consumers, the more I realize our lives are not that different.
10. I am more willing to “stand up” for others that experience stigma and discrimination since working with consumers.
11. I have found that I am more willing to help others in need since working as a case manager.
12. Working with consumers has led me to have a stronger religious faith.
13. I have become more aware of the importance of my family since working as a case manager.
14. I have found I can learn a lot about myself from working with consumers.
15. Seeing the struggles of consumers has made me more willing to take on challenges in my own life.
16. I am more open to help and support from family and friends since working as a case manager.
APPENDIX P

The BBC Well-being Scale – Provider Version

1. Are you satisfied with your physical health?
2. Are you satisfied with the quality of your sleep?
3. Are you satisfied with your ability to perform your daily living activities?
4. Are you satisfied with your ability to work?
5. Do you feel depressed or anxious?
6. Do you feel that you are able to enjoy life?
7. Do you feel you have a purpose in life?
8. Do you feel in control over your life?
9. Do you feel optimistic about the future?
10. Do you feel satisfied with yourself as a person?
11. Are you satisfied about your looks and appearance?
12. Do you feel able to live your life the way you want?
13. Are you confident in your own opinions and beliefs?
14. Do you feel able to do the things you choose to do?
15. Do you feel able to grow and develop as a person?
16. Are you satisfied with yourself and your achievements?
17. Are you satisfied with your personal and family life?
18. Are you satisfied with your friendships and personal relationships?
19. Are you comfortable about the way in which you relate to and connect with others?
20. Are you satisfied with your sex life?
21. Do you feel able to ask someone for help with a problem if you needed to?
22. Are you satisfied that you have enough money to meet your needs?
23. Are you satisfied with your opportunity for exercise and leisure activities?
24. Are you satisfied with your access to health services?
APPENDIX Q

Provider Demographics

Demographics

1. Age: ____
2. Gender: ____ Male ____ Female
3. Ethnic Background:
   ____ Caucasian  ____ Asian-American
   ____ African-American  ____ Pacific Islander
   ____ Hispanic  ____ Other: ____
4. Relationship Status:
   ____ Married  ____ Single, Never Married
   ____ Separated/Divorced  ____ In a Partnership
   ____ Widowed  ____ Co-habitating
5. Current Income:
   ____ less than $30,000  ____ $65,000 to $74,999  ____ $105,000 to $114,999
   ____ $30,000 to $39,999  ____ $75,000 to $84,999  ____ $115,000 to $124,999
   ____ $40,000 to $54,999  ____ $85,000 to $94,999  ____ $125,000+
   ____ $55,000 to $64,999  ____ $95,000 to $104,999
6. How long have you worked in the mental health field (example 2 years and 0 months)?
   _______ Months and _________ years
7. What is your primary theoretical orientation? _______________________________
8. Do you have a specialty in regards to psychotherapy practices (e.g., DBT, biofeedback, hypnosis, trauma, gender identity issues, LGBTQ, etc.)?
   __ No __ Yes
   a. If yes, please list _________________________
9. What is your current position at this agency? _______________________________
10. Approximately how many clients are on your caseload currently?
    ____ Less than 5  ____ 21 to 25
    ____ 5 to 10  ____ 25 to 30
    ____ 11 to 15  ____ 30 +
    ____ 16 to 20
11. Approximately how many hours per week do you spend in direct contact with clients?
    ____ Less than 5  ____ 20 to 24
    ____ 5 to 9  ____ 25 to 29
    ____ 10 to 14  ____ 30 to 34
12. About how many hours per week do you spend doing:
   a. Assessments (i.e., intake or diagnostic assessments): ____________
   b. Individual Therapy: ________________
   c. Group Therapy: ________________
   d. Supervision: ________________
   e. Psychological Testing: ________________
   f. Program Development/Evaluation: ________________
   g. Other: (name)_____________________

13. What types of diagnoses do your clients with serious mental illnesses typically have?
   (check all that apply)
   □ schizophrenia
   □ schizoaffective disorder
   □ major depression
   □ bipolar disorder
   □ panic disorder
   □ obsessive compulsive disorder (OCD)
   □ post traumatic stress disorder (PTSD)
   □ personality disorder NOS
   □ Borderline personality disorder
   □ narcissistic personality disorder
   □ antisocial personality disorder
   □ other, please specify: _______________________

14. Approximately what percentage of your SMI clients are currently employed?
   __________________

15. About how long do you generally see patients when meeting for individual therapy?
   (1) Less than 1 month
   (2) 1 to 2 months
   (3) 3 to 5 months
   (4) 6 to 10 months
   (5) 10 to 12 months
   (6) 10 to 12 months

16. Did you pick the patients you see for individual therapy?
   (1) Yes
   (2) No

17. If a patient is referred or recommended to you (by another provider) for individual therapy, can you decline to see the patient for therapy?
   (1) Yes
   (2) No