DEVELOPMENT AND EVALUATION OF AN ALLIANCE WORKBOOK

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Jennifer Klimek Holmberg
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This dissertation entitled
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BY
JENNIFER KLIMEK HOLMBERG

has been approved for
the College of Arts and Sciences
and the Department of Psychology by

Timothy Anderson
Professor of Psychology

Leslie A. Flemming
Dean, College of Arts and Sciences
The current study involved the development and evaluation of a new method to facilitate the formation of the alliance. A paper-and-pencil Alliance Workbook was developed, a key feature of which was the elicitation of specific client reactions to the alliance. The workbook was completed by clients after their first two sessions of therapy and reviewed by therapists in between sessions as a tool to provide direct, specific assessment of the state of the alliance. The study compared 2 conditions: Therapy as usual vs. therapy as usual in conjunction with the Alliance Workbook. Participants were 101 therapist and client dyads at Ohio University Counseling and Psychological Services. Nineteen therapists with diverse theoretical orientations and years of clinical experience participated. The effects of using the workbook were examined on the alliance (via the Working Alliance Inventory, Horvath & Greenberg, 1986), outcome (via the Outcome Questionnaire, Umphress, et al, 1997), and session smoothness and depth (via the Session Evaluation Questionnaire, Stiles, 1980) across 3 sessions of treatment. Use of the workbook resulted in more frequent discussions of therapy tasks and goals as expected, but did not result in higher alliances, better outcomes, or more smoothness or depth for all therapy participants. There is preliminary evidence that the workbook may provide a boost in the strength of the alliance between sessions 1 and 2 for clients with initially low alliances. Findings suggest that there are many factors that potentially mediate the efficacy of the workbook, including whether therapists read their clients workbook responses as intended. Results indicated that within the workbook condition, sessions were rated as deeper (i.e., more emotionally stirring, meaningful) after therapists read their clients’ workbooks compared to when therapists had not read their clients workbooks. The study revealed that clients are willing to utilize the Alliance Workbook to reveal very specific thoughts and feelings about the treatment process.
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Development and Evaluation of an Alliance Workbook

Overview

Psychotherapy research has demonstrated that few reliable differences exist in the outcomes of diverse forms of therapy (Shapiro & Shapiro, 1983; Smith & Glass, 1977). This finding has led to investigations of the change-inducing ingredients found across diverse forms of psychotherapy, or, common factors (Frank, 1961), and the proposal that common factors be purposefully enhanced in order to generate superior therapeutic outcomes (Wampold, 2001; Weinberger, 1995). The patient-therapist relationship (i.e., therapeutic alliance) is a common factor that has been the focus of a large body of empirical research over the past few decades. Investigators have demonstrated that the strength of the therapeutic alliance is positively correlated with outcome (Gaston, Marmar, Gallagher, & Thompson, 1990; Horvath & Symonds, 1991; Luborsky, 1990; and Martin, Garske, & Davis, 2000), however, attempts to manipulate the alliance in order to achieve superior outcomes have been fewer in number and less successful (e.g., Henry, Schact, Strupp, Butler & Binder, 1993). Several researchers have undertaken systematic study of therapist actions that address problems in the alliance (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Safran, McMain, Crocker, & Murray, 1990; Safran & Muran, 1996). Standard practice in psychology is to assess then intervene. Previous research has focused on the investigation of therapist interventions with the assumption that therapists can accurately assess the alliance and potential problems within it in the first place. This assumption is problematic because other research (e.g., Hill, Thompson, & Corbett, 1992; Regan & Hill, 1992; Rennie, 1994) illustrates the difficulties therapists have in accurately reading their clients’ perceptions about the treatment process.

The present study describes the development and evaluation of a new method to facilitate the alliance, a key feature of which is the elicitation of specific client feedback in order to help therapists more accurately assess the state of the alliance. To begin, a brief review of the theoretical literature on the alliance will be presented followed by theoretical propositions regarding the role of the alliance in relation to outcome. Empirical literature on the alliance as a predictor of outcome will be reviewed and research efforts focusing on therapist actions that maintain and repair the alliance will be examined. Rationale for the development of the alliance workbook as a method to facilitate the therapeutic alliance is
explored followed by a description of its content development. Last, methods and procedures for empirically validating the workbook within a clinical population are presented along with a discussion of the results.

The Alliance as a Common Factor

This section entails a review of various theoretical conceptualizations of the alliance beginning with Freud, followed by later psychodynamic, humanistic and cognitive-behavioral theorists. Although recognition of the alliance by proponents of diverse schools of therapy lends support for the alliance as a common factor, it has also presented theoretical challenges regarding the exact nature of the alliance. To conclude this section on the alliance as a common factor, inconsistencies and controversies regarding the alliance will be discussed and Bordin's (1979) pantheoretical conceptualization of the alliance will be advanced, in part, as a theory that reconciles some of the inconsistencies.

Freud (1913) was the first to speak of the importance of the alliance, maintaining that therapist and patient should not proceed with the major technique of psychoanalysis (i.e., transference interpretations) until a well developed rapport had been established with the patient. He elaborated on this as follows:

The first aim of treatment consists in attaching him to the treatment and to the person of the physician. To ensure this one need to do nothing but allow time. If one devotes serious interest in him, clears away carefully the first resistances that arise and avoids certain mistakes, such an attachment develops in the patient of itself, and the physician becomes linked up with one of the imagos of those persons from whom he was used to receiving kindness. It is certainly possible to forfeit this primary success if one takes up from the start any standpoint other than that of understanding. (Freud, 1913, p. 360)

Following Freud's work, later psychodynamic theorists (Greenson, 1967; Sterba, 1929; & Zetzel, 1956) elaborated on and modified the concept of the therapeutic relationship. In contrast to Freud's view of the alliance as a prerequisite, secondary in emphasis to classic analytic techniques, his psychoanalytic successors placed more emphasis on the alliance, viewing it as a primary change agent that coincided with classic analytic techniques. For example, in his writings on the patient-therapist relationship, Greenson (1967) stated that in addition to traditional analytic techniques, the "other major
ingredient which is vital to the success or failure of psychoanalytic treatment" (p. 46) is the relationship between the therapist and client. Greenson felt that this relationship enabled the client to work purposefully in analysis, and to capture this defining feature, he coined the term, "working alliance."

Greenson (1967) developed his ideas about the working alliance largely from his clinical experiences with patients who were "unanalyzable." He found that a commonality among these patients was the experience of a therapeutic "stalemate," which he believed was due to a failure to develop a stable working relationship with the analyst. Greenson noted that such therapeutic impasses could be due to either a failure in the initial development of the alliance or a failure to maintain a durable working alliance. Through observation of clinical cases, he observed that rigid adherence to Freud's rule of abstinence (i.e., analyst anonymity and nonintrusiveness thought to prevent contamination of the transference) led analysts to appear too aloof and authoritarian in attitude, a stance which prevented the formation of a sound working alliance. In contrast, Greenson thought that analysts should display consistently serious, but not rigid, adherence to analytic technique, a stance believed to demonstrate to the patient the analyst's devotion to the patient and his/her problems.

Although the therapeutic relationship has historically been associated with psychoanalytic therapies, its importance has increasingly been addressed by theorists from other orientations. For example, within the client-centered tradition, Roger's (1957) asserted that therapist warmth, congruence, and positive regard were the "necessary and sufficient conditions" of therapeutic change. In contrast to psychodynamic theories which have historically emphasized the application of techniques (exploration, clarification, interpretation) as the primary agents of therapeutic change, Roger's maintained that the therapeutic relationship itself was the active ingredient in psychotherapeutic change.

Although behavioral and cognitive-behavioral therapies have typically placed emphasis on technique before the relationship, they too have acknowledged the importance of the alliance in psychotherapy. For example, Beck (1976) emphasized the patient-therapist relationship as a crucial aspect of cognitive therapy. He stated that a "genuine collaboration between the therapist and patient" is a critical feature in cognitive treatment and an important determinant of outcome (p.220). Beck referred to this
relationship as "collaborative empiricism," a joining of therapist and patient against the patient's problems. From a behaviorist perspective, Goldfried and Davison (1976) suggested that behaviorists who neglected the therapeutic relationship by relying solely on the principles of learning to effect behavior change were "out of touch with clinical reality" (p. 55).

Clearly, proponents of diverse forms of psychotherapy view the patient-therapist alliance as important, however, the divergent views of and labels utilized to describe the concept of the alliance have led to controversy regarding the nature and validity of the construct. Consider, for example, the various labels used to describe the construct. Zetzel (1956) theorized that the positive aspects of the mother-child relationship were repeated within the patient-therapist bond to create what she termed the therapeutic alliance. Formed via attachment to and identification with the therapist, Zetzel stressed the important role of this therapeutic alliance for successful analysis. Greenson's (1965) notions about the working alliance were similar to Zetzel's in that he conceptualized the working alliance as the positive aspects of the therapist-patient relationship, but he also added to this the importance of the patient's ability to work purposefully in analysis. Although Greenson's notion of the alliance is somewhat different from Zetzel's, to complicate matters, he used the terms working alliance and therapeutic alliance interchangeably. Added to this assortment of jargon is Beck's (1976) collaborative empiricism and Luborsky's (1976) helping alliance, which was proposed as the patient-therapist bond coupled with the patient's perceived helpfulness of the therapist. Thus, there has been substantial variability regarding the nomenclature and defining features of the alliance, and, as will be discussed in a later section, the underlying mechanisms responsible for the relationship between alliance and therapeutic outcome. A primary point of divergence among proposed alliance constructs is the role of the alliance in relation to other therapeutic interventions, and the relative emphases placed on the patient-therapist bond versus collaboration on tasks and goals. Although various conceptualizations of the therapist-patient relationship may, at first glance, appear somewhat inconsistent, it has been noted (Gaston, 1990) that inconsistencies among definitions of the alliance are actually complementary rather than contradicting. For example, alliance definitions which rest primarily on the bond between patient and
therapist are compatible with definitions of the alliance that stress the patient's active
collaboration; both are active, but independent components of the alliance. This
interdependence among components of the alliance was incorporated into Bordin's (1979)
tripartite model of the alliance, which will be discussed in the following section.

Before proceeding to a discussion of Bordin's theory, a brief mention of the
controversy surrounding the validity and utility of the alliance construct is warranted.
Although many clinicians and researchers have embraced the construct, some have denied
the validity of the alliance as a construct altogether. Controversy regarding the alliance
has been particularly prominent within traditional psychoanalytic circles, where debate has
ensued regarding the validity and role of the alliance in relation to transference phenomena
(Muran & Safran, 1998). For example, Brenner (1979) argued against the construct as a
valid or useful entity, asserting that the entire patient-therapist relationship is an expression
of transference and, accordingly, must be treated as resistance. Although this issue is
worthy of theoretical debate, a discussion of transference phenomena in relation to the
alliance construct is beyond the scope of the present paper. Regardless of how the alliance
is construed in relation to transference phenomena, a substantial body of empirical
research has demonstrated a consistent, positive relationship between alliance and
outcome. With this, the present paper will move forward on the assumption that the
alliance is a clinically useful construct and should be purposefully enhanced to facilitate
good therapy outcomes.

**Bordin's Working Alliance as a Pantheoretical Construct**

Recognizing the universality of the patient-therapist relationship among diverse
therapies, Bordin (1979) proposed the therapeutic working alliance as a pantheoretical
construct, and in doing so, was the first to formulate a *theory* of the therapeutic working
alliance. This section entails a description of Bordin's theory followed by a review of the
supporting empirical evidence. Because the current research was ultimately intended to be
generalizable across diverse forms of therapy, Bordin's conceptualization of the alliance
was utilized as a theoretical basis.

Bordin (1979) proposed that "the working alliance between the person who seeks
change and the one who offers to be a change agent is one of the keys, if not the key to
the change process" (p. 252). His synthesis of the alliance borrowed primarily from the
ideas of Greenson (1967) and Rogers (1951), both of whom emphasized the patient's active role within the relationship and in inducing therapeutic change. The idea that patients were active participants in psychotherapy was quite divergent from the views of theorists before Greenson and Rogers: In traditional analytic therapy, therapists treated patients. Indeed, Greenson's concept of the working alliance implied a more active and purposeful role for the patient than simply being treated, and Rogers further amplified this view by maintaining that patients should be the sole determinant of the therapeutic tasks and goals. Subsequent to Greenson and Rogers, Bordin's formulation of the alliance advocated for a uniquely middle ground: He asserted that mutual collaboration between therapist and client is the optimal therapeutic arrangement. He viewed the collaboration and the explicit negotiation about goals and tasks as an important part of alliance formation: Collaborating early on about goals and tasks would make the alliance stronger so as to withstand and overcome later strains and ruptures.

In accordance with these ideas, Bordin put forth the working alliance as a tripartite model comprised of (1) patient-therapist agreement on the goals of therapy, (2) patient-therapist agreement on the in-session tasks that presumably will lead to the achievement of the agreed upon goals, and (3) the patient-therapist bond which permits collaboration toward goals. The bond aspect of the alliance "is not seen as a separate or independent process, but as a form of active collaboration, the development of which is linked to the therapeutic agenda. The very act of negotiating and defining this agenda is central to the development of the positive alliance and to the therapeutic change process" (Horvath, 1994, p. 111). Bordin asserted his formulation of the working alliance as pantheoretical in the sense that, irrespective of the type of therapy being practiced, the alliance between therapist and client consists of a bond, and agreed upon goals and tasks (Bordin, 1994). In acknowledgment of the various theoretical stances of and therapeutic techniques employed by diverse therapies, Bordin asserted that the goals and tasks for therapy would vary widely between schools, thus the exact form of the working alliance would appear differently within diverse therapies. However, rather than the specific form of the alliance, Bordin asserted that the strength of the alliance would emerge as the significant predictor of outcome. That is, the kinds of tasks and goals agreed upon in therapy would be less important than the therapeutic bond coupled with the agreement on these tasks and goals.
Several years after Bordin proposed his theory of the alliance, Horvath (1981; 1982) designed an instrument to measure the working alliance and its component parts (bond, tasks, and goals). Although other instruments to measure the alliance existed before the development of Horvath's *Working Alliance Inventory* (WAI), very few were based on a theory-derived definition of the alliance and psychotherapeutic change (Gaston & Marmar, 1994). In this way, the WAI is fairly unique in its ability to link research with larger theory. Since its development, the psychometric properties of the WAI have been established and numerous studies have found a positive relationship between the WAI and psychotherapy outcome. There is a fair amount of evidence supporting the content validity of the WAI. That is, the items of the WAI have been deemed an accurate representation of the overall construct proposed by Bordin as well as the constituent parts (bond, tasks, goals). The WAI has also been shown to be significantly correlated with other measures of the alliance, an indication of convergent validity. Bordin's proposition that the components of the alliance are distinct, but interrelated aspects of the alliance has also received empirical support. Finally, in terms of predictive validity, consistent with Bordin's theory, the WAI has been shown to be positively related to outcome (Horvath, 1994; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000).

The substantial body of research that has been conducted on and with the WAI has provided support for Bordin's pantheoretical formulation of the working alliance. The alliance, as conceived by Bordin, has been shown to be positively related to outcome in psychotherapy, and there is evidence that the patient-therapist alliance is in fact, comprised of a bond, agreement on the goals to be accomplished in therapy, and agreement on the tasks to be utilized to accomplish the goals. It was noted previously that various definitions of the alliance have differed with respect to the relative emphases placed on tasks (techniques) versus the therapeutic bond (Gaston, 1990). Bordin's (1979) conceptualization of the alliance has been shown to capture both aspects. As such, "this conceptualization provides an important bridge between the 'relationship' and 'technique' aspects of therapy" (Horvath, 1994, p. 111). Because Bordin's conceptualization of the alliance (and the WAI) appear to adequately capture the alliance across diverse forms of psychotherapy, this formulation of the alliance was deemed appropriate for use in the present research.
Proposed Mechanisms Responsible for the Alliance-Outcome Association

Various mechanisms have been put forth to account for the relationship between alliance and outcome, but relatively few empirical investigations have ensued to substantiate these propositions (Westerman, Foote, & Winston, 1995). Proponents of various schools of thought have explained the function of the alliance in terminology consistent with the overarching theories of psychotherapy and behavior change to which they subscribe. Consequently, the role of the alliance in relation to outcome has been explained in various ways. Notions regarding the role of the alliance diverge primarily with respect to two issues: (1) whether the alliance is therapeutic in and of itself; and (2) the role of the alliance in relation to other psychotherapeutic interventions (Gaston, 1990). Divergence among these two issues has lead to the three basic views of the alliance which will be discussed in this section: (1) The alliance is exclusively responsible for therapeutic progress, (2) the alliance is a prerequisite for other therapeutic techniques, or (3) the alliance is both a prerequisite and a change agent in itself.

The views of Carl Rogers (1957) are representative of the view that the relationship between client and therapist is the sole mechanism for psychotherapeutic change. Stressing the bond aspect of the alliance, Rogers argued that therapist-offered accurate empathy, unconditional positive regard, and genuineness, were not only necessary, but sufficient for generating therapeutic change. In contrast, others view the alliance as a prerequisite to the successful employment of other therapeutic techniques. For example, Raue and Goldfried (1994) describe the alliance in cognitive-behavioral therapies in a compelling way by paralleling the role of the alliance in psychotherapy to the role of anesthesia in surgery: In surgery one must have adequate anesthesia before proceeding to the surgical procedures, and until the anesthesia is adequate, surgery cannot commence. If problems arise in the anesthesia during surgery, the anesthesia must be addressed before proceeding with the surgical techniques. Similarly, in psychotherapy, an adequate "dose" of the alliance must be present before other interventions are delivered, and when problems arise in the alliance, they must be addressed before patient and therapist resume.

Cognitive-behavioral theorists explain the mechanisms underlying the alliance-outcome relationship with the principles of cognitive and learning theories: Positive
alliances contribute to the efficacy of psychotherapy by increasing the reinforcement value of the therapist, by providing a context for modeling adaptive behavior, and by providing the therapist with leverage to overcome patient resistance to other therapeutic procedures (Raue & Goldfried, 1994). Beck (1976) posited the therapist-patient relationship as a joint effort, with the agreement on therapeutic goals serving as a safeguard against blindly moving in separate directions -- movement considered frustrating to therapists and distressing to patients. He recognized collaborative empiricism as useful to therapists because through the mutual negotiation of therapeutic goals, therapists could obtain important information regarding the efficacy of interventions utilized, as well as other information on how the patient is construing his/her therapeutic issues.

A final position regarding the mechanism of the alliance is that the alliance is both a prerequisite for the tasks of therapy and curative in itself. For example, contemporary experiential theorists consider the relationship to be an effective agent of change in itself, but also note its capabilities for facilitating other therapeutic tasks: Self-reflection is the primary task in experiential therapies, but this is best conducted within the context of a positive therapeutic relationship (Watson & Greenberg, 1994). Also consistent with the view that the alliance is both a prerequisite and a curative factor are the views of theorists who emphasize the role of the alliance as a backdrop for the unfolding and working through of important interpersonal themes related to the patients' pathology (e.g., Bordin, 1979; Henry & Strupp, 1994). Described next, the ideas of Henry and Strupp (1994) and Bordin (1979) are examples of the general theory that the alliance serves as a medium in which the repetition of the patient's maladaptive interpersonal schemas manifest. Accordingly, the systematic exploration and modification of these repetitive relationship patterns within the alliance is seen as a curative factor within psychotherapy (Bordin, 1979; Greenson, 1967; Henry et al, 1993; and Safran, 1993).

Recently, Henry and Strupp (1994) have advanced the role of the alliance by describing it as a psychotherapeutic technique. These authors contend that patients' maladaptive interpersonal patterns (which include thoughts about the self, thoughts about others, and expectations of others) will manifest within the therapeutic alliance. The pathology of many patients who enter into treatment is, in large part, related to negative introjects (very rigid thoughts/beliefs about the self)(Henry, Strupp, & Schact, 1990).
Henry and Strupp (1994) propose that the modification of patient introjects is an important agent of change across all therapies. When patients have strongly negative introjects the alliance plays an especially significant role because it becomes the crucial backdrop for either the reinforcement or potential modification of unhealthy introjects. According to the theory of interpersonal complementarity, patients with negative introjects will pull for therapist behaviors (e.g., therapist counterhostility) that will serve to reinforce these negative introjects. It is crucial that therapists avoid reinforcing patients' negative introjects in this way, because even very small, unintentional amounts of hostile therapist communications serve to reinforce patients' previous negative introjects and thus negatively affect therapy outcome (Henry et al., 1986). In this way, the alliance plays a crucial role as an arena for new interpersonal learning; learning that disconfirms negative introjects, thus, potentiates positive therapeutic change.

Similarly, Bordin (1994) explained that therapeutic outcome is affected by patient and therapist collaboration on the three features of the working alliance (bond, tasks, goals). He proposed that this collaborative relationship serves as a prerequisite to other therapy techniques in that the establishment of a strong bond was necessary to create a safe environment in which patients may explore their problems. Additionally, Bordin proposed that therapeutic change is fostered through therapists' attending to patients' key relational issues which often manifest during the process of forming the alliance. (Horvath & Greenberg, 1994). He posited that therapeutic change varies according to (1) the strength of the bond, (2) the power of the therapeutic tasks in potentiating change towards the agreed upon goals and (3) the dynamics of strains that take place within the alliance. Typically, strains in the alliance have been conceptualized in theory-specific language. For example, in traditional psychoanalytic circles, strains in the alliance are conceptualized as reenactments of transference pathology. Or, as in the case of contemporary psychodynamic theory, as cyclical maladaptive patterns (Strupp & Binder, 1984). In Bordin's pantheoretical terms, strains are conceptualized without allegiance to a specific orientation: He simply states that the types of problems that cause a person to seek psychotherapy will manifest "either in the process of entering into a meaningful partnership and/or in participating in the work of therapy as represented by the therapeutic tasks" (Bordin, 1994, p.18). In other words, many of the problematic behavior patterns
that first bring clients into treatment are likely to appear within the alliance, and it follows that resolving these problems within the alliance is an important factor for therapeutic change.

In summary, there are several different views on the role of the alliance in relation to outcome and the underlying mechanisms responsible for this relationship. Some believe in the power of the alliance alone to generate positive outcomes, others believe in the efficacy of interventions specific to their theoretical orientations but contend that establishing a healthy alliance is a necessary prerequisite to employing these techniques. Still others, (Bordin, 1979; Henry & Strupp, 1994) contend that the alliance is both a prerequisite for other techniques and is curative in its own right. Research investigations of the mechanisms responsible for the relationship between alliance and outcome have been few in comparison with the theoretical propositions put forth on the subject. Although the exact nature of this mechanism has not been determined, it has been found that the relationship between alliance and outcome appears consistent regardless of the type of psychological interventions used (Martin, et. al., 2000) which suggests that the alliance itself is responsible for a proportion of therapeutic change. However, empirical research has not yet been able to determine the exact relationship between the alliance and other interventions. For the purposes of the present research, Bordin's theory was particularly well-suited because of its pantheoretical nature and because it subsumes the majority of the proposed roles of the alliance (i.e., that the alliance is both a prerequisite and is curative in itself).

**Research on Alliance and Outcome**

In the last three decades there has been a significant amount of research on the alliance and its relationship to outcome. Research investigations (Gaston, Marmar, Gallagher, & Thompson, 1990; Horvath & Symonds, 1991; Luborsky, 1990; and Martin, et. al., 2000) have concluded that there is a significant, positive relationship between alliance and outcome. The alliance-outcome relationship has been demonstrated across diverse forms of therapy, with diverse clinical populations, and with therapists possessing various levels of training and experience. Outcome has been operationalized in diverse ways as well: Alliance has been shown to be predictive of drug use and recidivism, social adaptation, symptomatic changes, and changes in interpersonal problems (Binder &
Strupp, 1997).

Horvath and Symonds (1991) compiled the results of 20 different data sets reporting a relationship between the quality of the working alliance and therapy outcome. Using metaanalytic procedures, a "moderate but reliable association between good working alliance and positive therapy outcome was found" (p. 139). The authors note that although the overall effect size (ES=.26) was not very large, it is similar to effect sizes of other important psychotherapy variables in the empirical literature. They also noted that, due to certain procedures within their metaanalysis (inclusion of all statistical relationships analyzed in each study, regardless of whether they were described or reported as significant) they believe this estimate of average effect size is likely to be conservative.

Included in their metaanalysis were clinical research studies of individual psychotherapy that reported a quantifiable relationship between alliance and a later measure of outcome. Research studies included were from 1978 to 1990, mean sample size was 49 (SD=39.8), average length of treatment was 20.6 sessions (SD=12.36), and therapist experience averaged 8.1 years (SD=5.7). Studies included used various measures of the alliance and sources of ratings (i.e., client, therapist, and observer ratings of the alliance and outcome). Of the 20 data sets analyzed, 7 investigated psychodynamic interventions, 10 were eclectic, 2 were cognitive, and 1 investigated a gestalt intervention. Length of treatment did not influence the relationship between alliance and outcome. The overall effect size of studies included within the metanalysis was .26 (F= 8.48, p<.001), a highly significant effect. Martin, et al. (2000) conducted a similar, but more comprehensive metanalysis on the relationship between alliance and outcome and found an effect size consistent with Horvath & Symonds' analysis. This study included 58 published and 21 unpublished studies conducted between 1977 and 1997, and reported an overall alliance-outcome effect size of .22.

**Therapist Actions that Maintain the Alliance**

Findings from metaanalytic research investigations have provided substantial empirical support for the notion that the alliance plays a crucial role in the outcome of diverse forms of therapy. This section is devoted to a review of the relatively recent area of research investigating therapist actions that maintain strong alliances. Such research
efforts have included attempts to discover the processes involved in the creation of alliance ruptures (Safran, Crocker, McMain, & Murray, 1990), therapist actions that repair alliance ruptures (Forman & Marmar, 1985; Kivlighan & Schmitz, 1992; Safran & Muran, 1996), and investigations examining the effects of training therapists to address and repair problematic alliances or negative process episodes (e.g., Henry, Strupp, Butler, Schact, & Binder, 1993). Such research efforts stem from the empirically supported notion that the therapy process across time is marked by episodes characterized as alliance ruptures (Safran, et al., 1990) or negative process (Binder & Strupp, 1997) which are damaging to the overall alliance and the therapeutic outcome. Alliance ruptures vary in frequency, intensity, and duration but are common in even the most successful therapy cases. Presumably, a critical element of successful therapy is the therapist's ability to detect and manage problems in the alliance as they arise across the course of therapy (Binder & Strupp, 1997; Safran et al., 1990).

Binder & Strupp (1997) explain that the alliance is "part of a broader set of attitudes, values, expectations, sentiments, and interpersonal interaction patterns that constitute the therapeutic process" (p. 123). Both alliance ruptures and negative process are presumed to result in a decrease in the strength of the therapeutic alliance. Alliance ruptures have many manifestations, but common examples include overt expression of negative sentiments toward the therapist, indirect communication of negative sentiments or hostility, and disagreement about the tasks or goals of therapy (Safran et al., 1990). Negative process may be characterized by any of these alliance ruptures, however, researchers have typically studied negative process in terms of episodes where client and therapist are engaged in an interpersonal cycle involving client negativity or hostility to which therapists respond in a countertherapeutic manner (i.e., with reciprocal hostility, criticism, negativity)(Binder & Strupp, 1997).

In what appears to be the earliest empirical investigation of therapist actions that address the alliance, Foreman and Marmar (1985) discerned therapist actions that discriminated improved from poor, unimproved alliances. Independent judges reviewed videotaped sessions to create alliance ratings on the California Therapeutic Alliance Scale at sessions 2, 5, 8, and 11. Six cases were selected on the basis of poor alliance ratings at the second session. After session 2, 3 of the cases had improved alliances and good
outcomes, and 3 cases continued to have poor alliances and ended with relatively poor outcomes. On the basis of theoretical and empirical literature, a list of therapist actions presumed to be related to the alliance was compiled. Videotaped segments of each of the 6 therapy cases (treatment consisted of 12 sessions of short-term dynamic therapy by experienced therapists) were reviewed with special attention to therapist actions in the sessions that preceded alliance improvement. Results indicated that in improved alliance cases, therapists (1) addressed patient defenses; (2) addressed patient guilt and expectation of punishment; and (3) linked patient defenses to their problematic feelings in relation to the therapist. Interpretations of patient feelings about the here-and-now relationship with the therapist were associated with improved alliances whereas avoidance or neglect of here-and-now relationship issues was associated with poor alliances and outcomes. Although this study explored alliance processes within a small sample and cases were reviewed by only one person (Foreman) who was not blind to other process and outcome ratings of the cases, these results showed preliminary support for the existence of specific therapist actions that address and repair faulty alliances.

In a similar study, Kivlighan and Schmitz (1992) attempted to replicate the findings of Foreman and Marmar (1985) by using a more systematic, empirically supported means of rating therapist actions. Using Q-sort ratings of five dimensions previously found to underlie therapist technical activity (e.g., supportive versus challenging, distant versus involved, permissive versus controlling, thematically versus concretely oriented, and here-and-now versus there-and-then oriented). Fifteen cases were selected for analysis on the basis of first session WAI scores (Working Alliance Inventory) that were below the mean within an original sample of 60 cases. By session 4, 7 of the cases continued to have poor alliance (WAI scores below the mean for the 15 cases), and 8 cases had improved (above the mean) alliance scores. Counselors were fifteen, Master's level counseling students, each of whom had four sessions with an undergraduate student recruited for the study. Sessions were rated by two independent judges for technical behaviors present and results were analyzed for technical activity that discriminated between the two types of cases. All dyads began with relatively poor alliances (compared to the normative WAI scores reported by Horvath and Greenberg (1989)), and statistical comparisons showed that at session four, the continuing poor alliance and improved alliance groups were significantly
different in strength of the alliance-- such that the improved group resembled the normative sample in terms of strength of alliance whereas the continuing poor alliance group remained below the normative group.

Kivlighan and Schmitz's (1992) results indicated that counselors in the improved alliance group focused more on interactions within the therapist-client relationship (here-and-now), tended to be more challenging, and increased their use of both of these technical activities over the course of the four sessions. The results of both of these studies (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992) are promising in that certain therapist actions have, indeed, been associated with improved alliances. In particular, the results of these studies may be taken to emphasize the importance of therapists recognizing problems in the alliance and addressing them rather than neglecting to discuss alliance issues.

Safran and colleagues (Safran et al, 1990; Safran & Muran, 1996) also investigated therapist actions that are reparative of alliance ruptures, however, these researchers began their research efforts with an extensive research program to elucidate the specific interactional processes involved in the creation of alliance ruptures as well. They have undertaken a systematic research program designed to (1) discover the specific patient and therapist behaviors that are characteristic of alliance ruptures and their subsequent repair; and (2) develop a manual containing therapist behaviors that address the alliance in patients who have difficulty forming or maintaining the alliance. To date, these researchers have developed a model of alliance ruptures based on empirical investigations of successful resolution cases. In contrast with previous research (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992) which identified nonsequential therapist strategies that addressed poor alliances, Safran and colleagues delineated a sequential, interactional model: Their model describes the initial patient behaviors that signal an alliance rupture and outlines the sequence of verbal exchanges between patient and therapist that typifies the resolution of alliance ruptures. Analysis of therapy sessions in which an alliance rupture had occurred and was subsequently resolved showed that resolution was a result of therapists perceiving that an alliance rupture had occurred and acting on this perception by facilitating client expression of negative feelings. These authors are currently undertaking an investigation to determine if therapists who use a manualized form of these
alliance-reparative procedures can successfully treat patients with previously poor alliances in other forms of therapy (Safran & Muran, 1996).

Members of the Vanderbilt Psychotherapy Research group have already conducted a similar study. Although not intended as a direct investigation of therapist behaviors influencing the alliance, the Vanderbilt II psychotherapy research project (Henry et al., 1993) revealed important information regarding patient and therapist contributions to the alliance and attempts to train therapist to attend to problems within the therapeutic alliance. This research project investigated the effects of training in Time-Limited Dynamic Psychotherapy (TLDP, Strupp & Binder, 1984), a form of therapy which "focuses on intensive scrutiny and management of interpersonal patterns in the therapeutic relationship as the medium of change" (Henry et al., 1993, p. 438). In this way, TLDP is a psychotherapy designed to utilize the therapeutic alliance as the agent of change, thus, therapist actions that facilitate and maintain a good working alliance are of prime importance.

The Vanderbilt II project entailed one year of manualized, supervised training in TLDP and used experienced therapists and real psychotherapy clients. It was designed to be an empirically sound investigation of the effects of training yet ecologically valid at the same time (training resembled three semesters of graduate training in TLDP). Training was comprised of didactic presentations of TLDP, readings in the treatment manual, presentations of clinical examples, and treatment of a patient with concurrent, small group supervision by the authors of the manual. Supervision entailed viewing videotaped sessions conducted by the therapists in training with special attention to patients' cyclical maladaptive patterns and how these were reenacted within the therapeutic relationship. The specific TLDP strategies taught required therapists to address transactions in the therapeutic relationship, encourage patients to explore thoughts/feelings about the relationship, and encourage the patient to discuss how the therapist feels/thinks about the patient -- all specific actions that address the alliance. The underlying assumption is to address these interactions, and in particular, interpersonal patterns that are problematic within the relationship.

Each therapist in the project had 2 patients before training, 1 during the year of training, and 2 patients after training. Henry et al. (1993) reported on therapist behaviors
that changed from pre- to post-training cases. These authors found that manualized training was effective in the sense that therapists in post-training exhibited higher technical adherence to TLDP strategies. Post-training, therapists were more active (as seen by high frequency of thought units), which is consistent with the tenets of TLDP. However, therapists after training also exhibited greater frequencies of complex communications (mixed messages which frequently contain an embedded criticism) and hostile messages, both of which have been shown to be countertherapeutic (Henry et al., 1986; Henry, Schact, & Strupp, 1986). These were very disconcerting findings especially given the fact the "TLDP was designed, in part, to reduce expression of therapist hostility toward difficult and negative patients" (Henry et al., 1993, p. 438).

Henry, Schact, Strupp, Butler, and Binder (1993) investigated these apparently negative effects of training further by examining mediating factors involved in the changes seen in the post-training phase. Interestingly, when therapist introjects were analyzed as a mediator of this effect, the authors found that therapists with hostile introjects were largely responsible for the increase in negative and complex communications found in the post-training cases. These same therapists had the greatest technical adherence to TLDP principles but also the greatest tendency to exhibit hostile communications. It was concluded that, indeed, therapists could be trained to exhibit behaviors believed to contribute to maintenance and repair of the alliance, yet securing positive outcomes apparently involves therapeutic finesse beyond mere technical adherence to supposed alliance maintaining strategies.

Overall, the results of the Vanderbilt II project were very informative, but only moderately successful. Training resulted in technical adherence to TLDP strategies believed to promote a healthy alliance, but the results of this technical adherence were sometimes countertherapeutic. Therapists were able to apply the technical strategies but may have done so in a mechanical manner or with poor-timing. Additionally, the application of alliance-maintaining techniques was especially problematic for therapists with hostile introjects. These therapists accounted for most of the negative effects in the post-training cases.

In summary, research on therapist actions that promote the alliance has been both promising and perplexing. The science of the alliance is such that we can describe it, but
the field is still searching for ways to control it. Several groups of researchers have undertaken investigations in search of therapist actions that repair and maintain the alliance (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Safran, et al., 1990; Safran & Muran, 1996). The general consensus seems to be that alliance issues must be attended to in a thoughtful, nondefensive manner with particular attention to exploration of client feelings. Implicit within previous research efforts on therapist actions that address the alliance is the assumption that therapists can swiftly and accurately identify problems within the alliance. However, as described in the next section, there is reason to believe that therapists are often unaware of their clients’ feelings within respect to the treatment process and the alliance. The current study represents another investigative attempt to control the alliance using a novel method designed, in part, to facilitate therapist detection of alliance issues.

Development and Evaluation of a Workbook to Facilitate Development of the Alliance

Empirical investigations have found a strong relationship between early alliance and outcome (Horvath, 1994; Sexton, Hembre, & Kvarme, 1996), a finding which makes sense at an intuitive level: If clients and therapists fail to develop a trusting, collaborative relationship early on, and fail to agree on what needs to be done in therapy, the likely result will be client disengagement from therapy (Horvath & Greenburg, 1994). Horvath and Greenberg (1994) explain the alliance in early sessions as a "series of windows of opportunity, decreasing in size with each session" (p. 3). This depiction is supported by empirical data showing that the alliance forms largely within the first session of psychotherapy (Sexton et al., 1996) and is fairly well established by the third session (Horvath, 1994). Taken together, these findings highlight the critical nature of the alliance and its early establishment in the treatment process.

Rationale for a Method to Facilitate Formation of the Alliance. The current research involved the development and empirical evaluation of a paper-and-pencil "Alliance Workbook" (see Appendix A) that was used interactively by patients and their therapists for the purpose of facilitating early strong alliances. In light of evidence in support of Bordin's (1979) model of the alliance, and because the current research was not intended to align itself with a specific theoretical orientation, Bordin's pantheoretical model was used to guide the development of the workbook. To review, Bordin's theory
emphasizes the mutual collaboration of patient and therapist. Specifically, good alliances are those in which there is a strong bond between patient and therapist that is accompanied by an agreement on the goals of therapy and agreement regarding the in-session tasks utilized to accomplish these goals. Horvath and Greenberg (1986) note that the Working Alliance Inventory (a measure designed to operationalize Bordin's tripartite model of the alliance) was developed not only as a device to predict therapy outcome, but also for use as a clinical tool to alert therapists of weaknesses in the alliance so they may subsequently implement remedial procedures. There has been substantial research on the first of these aims, however, to date, the working alliance inventory has not been widely used as a clinical tool to assess potential problems in the alliance (Horvath & Greenberg, 1986).

One of the primary aims of the current study was to develop a tool that would alert therapists to the presence of potential problems within the developing alliance. Theoretically, the WAI could be used to this end, however, the psychometric properties of the WAI deem it of questionable utility for this purpose. Studies using the WAI have revealed that client responses tend to be distributed on the positive end of the scale. Thus, the WAI appears to lack the sensitivity that is needed to detect the full range of responses that are associated with potential problems in the developing alliance. It is important to note here that although the WAI has a skewed distribution, many studies have demonstrated that there is still adequate variability to detect hypothesized effects within research investigations. That is, although the mean WAI scores are on the positive end of the scale, there is enough variability around the mean to contribute to meaningful statistical analyses related to the working alliance. The instrument is valid as a research tool, but because clients tend to respond toward the ceiling, it may have limited use as clinical tool to detect problems in the alliance. For this reason, the development of an alliance workbook sensitive enough to elicit a full range of client-perceptions of the developing alliance appeared worthwhile.

In brief, the alliance workbook requires clients to answer questions and reflect on each component of the alliance immediately after their first two sessions and for therapists to review the completed workbook prior to subsequent sessions. The primary rationale underlying the workbook is simple: The workbook explicitly informs clients about the
importance of the bond, goals, and tasks within successful therapies, and primes them to collaborate (as Bordin, 1979, intended) with their therapists on the initial formation of the alliance, thereby increasing their active involvement in the therapy process. Therapists, in turn, are privy to rare client feedback regarding potential deficits within the developing alliance and may make adjustments as seen necessary and/or discuss problematic aspects of the alliance with their clients as a means to facilitate its development.

As previously discussed, there have been research efforts to identify therapist behaviors that maintain or repair the alliance, but relatively less attention has been paid to the initial development of the alliance and to therapist detection of alliance issues. In the next few sections, two procedures reported to facilitate the development of the alliance, both of which utilize direct client feedback in a way similar to the alliance workbook, will be described. An underlying assumption of these procedures as well as the current workbook is that it is beneficial for therapists to be knowledgeable about their clients' reactions to treatment. Because this is an integral assumption underlying the proposed research, the empirical findings applicable to this assumption will be examined. As will be discussed, previous research has yielded inconsistent support for this assumption, including some evidence that therapist awareness of clients' negative reactions to their therapy may result in inferior session outcomes. Inconsistencies in this research literature will be discussed and aspects of the current research, designed to counteract the potentially harmful effects of negative client feedback, will be described. Other proposed benefits of the workbook including an increase of client involvement and emotional disclosure will also be described in relation to the empirical literature.

**Previous Procedures Designed to Facilitate the Alliance.** To date, there are no known workbooks designed specifically to facilitate the development of the alliance. However, a review of the literature revealed two procedures that have been designed for similar purposes. Barnard and Kuehl (1995) describe ongoing evaluation (a procedure used between client and therapist designed to help therapists monitor client-therapist fit along key dimensions of the therapeutic process) as a means to develop and enhance the working alliance. In this procedure, therapists routinely set aside a portion of the therapy hour to ask clients a set of specific questions about their satisfaction with the process and progress of treatment. Client reactions to and satisfaction with the alliance and treatment
progress are solicited as a way to monitor and nurture the therapy process. This procedure has several proposed benefits. Use of ongoing evaluation facilitates collaboration between therapist and client, an aspect of therapy which is related to good outcomes. Therapist involvement in the process of ongoing evaluation also communicates to clients the notion that discussion of the process and progress of treatment is valued, which may facilitate the tendency for subsequent client disclosures. Ongoing evaluation also permits therapists to engage in applied research on their impact in therapy, which can provide them with valuable information regarding the efficacy of therapy with their individual clients. Obtaining feedback from clients through ongoing evaluation thus allows therapists to adjust to the needs and idiosyncrasies of individual clients. As such, the ongoing evaluation procedure may contribute to the professional development of therapists. A final proposed benefit is that by utilizing ongoing evaluation, therapists convey an attitude of respect toward their clients and communicate that client thoughts and feelings are valued which may result in client empowerment. Although Barnard and Keuhle's (1995) description of ongoing evaluation is very compelling, to date, there have not been empirical investigations on the efficacy of this procedure. A potential problem with this procedure is that clients were asked to share both positive and negative reactions to the therapy in the presence of their therapist. The authors acknowledge that clients are sometimes concerned about hurting their therapist's feelings, a consideration that is supported by previous research which found that clients' verbal satisfaction ratings are 10% higher than written ratings (LeVois, Nguyen, & Attkisson, 1981).

Bischoff, et al., (1996) developed a similar procedure designed to facilitate the therapeutic process. *Therapist-conducted consultation* (TCC) involves therapists consulting with their clients outside of their regular therapy sessions in order to solicit feedback regarding client satisfaction with the treatment process and progress. Although therapists may routinely inquire about client satisfaction within regular treatment sessions, TCC is proposed to be a superior method of eliciting client feedback because normal "checking-in" about client feelings and thoughts may elicit vague responses and clients may be uncertain about which types of responses are being sought from their therapists. Indeed, this is one of the disadvantages of the ongoing evaluation procedure described above. In contrast, TCC orients and prepares clients to give direct, pertinent information
regarding treatment and communicates to them that this is acceptable, encouraged, and highly desired by their therapists. A proposed, indirect benefit of TCC is that it models healthy, direct communication about important interpersonal processes, problem-solving, and healthy responses to constructive criticism. In their study of 13 therapist-client dyads using TCC, the developers of the procedure found that "both therapists and clients almost universally reported that TCC is a useful therapeutic tool" (p. 374) and all clients involved in the procedure thought it would result in improved outcomes in their counseling sessions. Although Bischoff et al. (1996) collected preliminary data on client and therapist reactions toward TCC, they did not include a control group or systematic exploration of the effects of TCC on the process or outcome of therapy. Thus, despite clients' and therapists' positive endorsement of the procedure, conclusions about its therapeutic efficacy or relationship to objective measures of the alliance could not be drawn.

The Assumption Underlying Client Feedback. Barnard and Keuhle's (1995) ongoing evaluation and Bischoff et al's (1996) therapist-conducted consultation operate under the intuitive assumption that therapists must be aware of what clients are experiencing in order to effectively plan treatment interventions and nurture the therapeutic alliance. In other words, "lacking accurate perceptions of client experiences, counselors cannot know what problems need to be addressed" (Regan & Hill, 1992, p. 168). Similarly, Stiles (1987) asserts that the more clients can make known their inner experiences to therapists, the greater the potential for therapeutic healing. The alliance workbook examined in the current study was also based, in part, on these assumptions. Accordingly, an examination of the relevant literature regarding assumptions about client disclosure and its impact on therapeutic outcome is warranted. Of particular importance to the current study are research investigations that address client disclosure or nondisclosure of feelings regarding the therapeutic process and the alliance, therapist awareness of these feelings, and the impact of these processes on treatment outcome.

The Merits of Client Feedback within the Relationship. Regan and Hill (1992) investigated feelings and thoughts left unsaid by clients in brief psychotherapy. They found that clients frequently left things unsaid, particularly negative thoughts and feelings regarding the process of therapy. Therapists in their study had accurate perceptions of only 17% of the negative things left unsaid by their clients. Thus, when clients had
negative inner experiences about the therapy process, therapists were largely unaware that anything was wrong. From the perspective that client disclosure serve to facilitate client improvement and therapists' ability to plan effective treatment, one would assume that frequent client nondisclosure would portend poorly for therapy outcome. Regan and Hill (1992) found that, in comparison with cases where therapists remained unaware of clients' hidden negativity, when therapists accurately perceived clients' negative reactions to the therapy process, clients reported less satisfaction with their treatment. Thus, the results of this research do not support the theory that client disclosure of negative feelings benefits outcome -- at least in terms of client-rated satisfaction. The authors suggest that one interpretation of these findings is that therapists "operate more effectively if they operate under a slight delusion that clients are reacting positively to them" (Regan & Hill, 1992, p. 173). Underlying this conclusion, it is possible that counselors in the study felt uncomfortable when they perceived client negativity and mismanaged their discomfort by delivering an ineffective intervention.

In a similar study, Hill, Thompson and Corbett (1992) studied several types of client nondisclosure and found that clients hide negative reactions more than any other kind of reaction to the therapy and that therapists were least accurate in perceiving when clients had negative reactions as opposed to other types of hidden reactions (e.g., hopefulness). These researchers operationalized outcome as client and therapist ratings of the perceived helpfulness of single therapist interventions. In comparing cases where therapists accurately detected hidden client negativity versus cases where clients had hidden negativity which was unnoticed by therapists, they found that when therapists accurately perceived negative hidden client reactions, they subsequently delivered an intervention that therapists themselves later rated as less helpful. Clients, however, did not rate these same interventions as less helpful. Hill et al. propose that awareness of client negativity may make therapists anxious, they may take negative client reactions personally, and/or may feel less confident in their therapeutic skills.

The results of both of these studies suggest that therapists are largely unaware of their clients' unspoken negative feelings and the few instances in which they are aware of covert negative process are negatively associated with various outcome indices. Some cautionary notes about these findings must be mentioned. Although both of these studies
found negative associations between therapist awareness of clients' hidden negativity and outcome ratings, it is important to consider the type of outcome ratings reported. For example, in the Regan & Hill (1992) study, outcome was reported as client satisfaction, and in the Hill et al. (1992) study, outcome was reported as therapists' retrospective helpfulness ratings of single interventions. Neither study reported associations between therapist detection of hidden client negativity and alliance measures or measures of global treatment outcome. Also, both studies failed to analyze exactly how therapists reacted to perceived client negativity or what interventions they delivered subsequent to this knowledge. This leaves open a realm of possible intervening variables between the detection of clients' hidden negativity and subsequent outcome ratings. How therapists managed their clients' negative process is an extremely important factor that was not mentioned in either of these studies. Previous research (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Henry, et al., 1993) has revealed variability in the ways therapists manage the presence of negative process, some of which are positively related to alliance and outcome, some of which appear to have negative effects on later alliance and outcome ratings. In light of these findings, are we to believe, as Regan and Hill (1992) suggested, that therapists operate best under the delusion that clients feel positively about the process of therapy? This may be true under certain circumstances (e.g., when therapists ignore the issue or process it with an attitude of underlying hostility) but there is also research which demonstrates that, at times, therapists can manage negative process in a way which facilitates positive alliance and outcomes (Foreman & Marmar, 1985; Henry et al., 1992; Kivlighan & Schmitz, 1992; Rhodes, Hill, Thompson, & Elliot 1996).

Because the current study involved a workbook specifically designed, in part, to detect the presence of clients' negative feelings, it is important to turn now to those studies that demonstrate positive effects of therapists' knowledge of client negativity.

**Therapists Effective Management of Negative Process.** Rhodes, et al. (1996) analyzed differences in therapy cases marked by resolved versus unresolved misunderstandings between therapist and clients. The authors explain misunderstanding events as instances where therapists do or say something to a client that does not resonate with the client's experience at that moment or with the client's general sense of self. Examples include therapists being critical of a client choice, therapists not paying attention
to clients, or therapists giving unwanted advice. In general, clients perceive misunderstanding events as times where therapists do something that is a breach of what they want or need. Conceptualized in this way, misunderstandings are very closely related to, if not the same concept as, alliance ruptures. Consider Bordin's (1979) construct of the alliance as a mutually negotiated contract involving bond, and agreement on tasks and goals. In this light, misunderstanding events are a breach of this contract, or, an alliance rupture.

Returning to the Rhodes et al. (1996) study, results indicated that:

A good relationship, clients' willingness to assert negative feelings about being misunderstood, and therapists' facilitation of a mutual repair effort through maintaining a flexible and accepting stance typically led to resolution. In contrast, a poor relationship, therapist unwillingness to discuss or accept clients' assertion of negative reactions to being misunderstood, or therapists' lack of awareness of clients' negative feelings led to unresolved misunderstandings and often to clients quitting therapy. (Rhodes et al., 1996, p. 473)

A serious limitation of this study is its retrospective nature and characteristics of the clients sampled. Data were collected using therapists' recollections of their own previous experiences as therapy clients. However, this study also lends tentative support to the notion that there are certain conditions under which therapists and clients effectively deal with negative process. It appears that for this to occur, clients must be willing to disclose negative feelings related to the therapy process and therapists must convey an accepting and understanding attitude toward these client feelings and demonstrate an ability to nondefensively discuss these issues and adjust accordingly.

The results of the Rhodes et al. (1996) study are consistent with more empirically rigorous explorations of the resolution of alliance ruptures (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Safran et al., 1990). Researchers in these alliance rupture studies identified cases (through objective alliance measures) in which problems in the alliance occurred but were successfully resolved. The mere existence of these studies provides evidence that at least some therapists can, without manualized training in alliance reparation, detect and successfully resolve problems within the alliance. A consistent finding among such studies is the importance of therapists noticing and addressing alliance
problems with the client rather than ignoring or otherwise neglecting to discuss such issues.

Returning now to the assumption underlying the current study (that therapist awareness of and subsequent processing of negative client reactions will increase the strength of the alliance), research has found some cases where therapists *may* operate better if they remain ignorant of client negative reactions (Hill et al., 1992; Regan & Hill, 1992), however, studies that more carefully scrutinized therapist actions have revealed that therapist awareness of client negativity is beneficial to the alliance as long as therapists are able to *effectively* process the negative affect with clients. Continued discussion of this latter point is crucial in order to further advance the rationale for the current research. The Vanderbilt II research project provides important insights into therapists' ability to *effectively* manage problematic alliances. Although the alliance workbook is vastly different from the therapist training in TLDP that occurred in the Vanderbilt project, the aims of these research projects were somewhat similar: Both were designed as ways to assist therapists in facilitating the therapeutic alliance. Because the Vanderbilt project resulted in limited success toward this aim, it is important to discuss how the current research differs.

The Vanderbilt II project involved training therapists to recognize and openly address with clients, problematic alliances and negative process. The assumption underlying this research was that the alliance was adequately formed initially and the alliance ruptures therapists were trained to attend to were subsequent manifestations of clients' core interpersonal pathology. Within the language of TLDP, these alliance ruptures were construed as negative process which involved client and therapist engaging in a maladaptive interpersonal cycle -- with the client pulling for certain therapist behaviors (e.g., criticism, hostility) that portend poorly for therapeutic progress (Henry, et al, 1986). Essentially, the alliance problems that were the focus of the Vanderbilt II project were manifestations of transference which required a great deal of therapist sophistication, self-knowledge, timing, and processing skills.

**Aspects of the Alliance Workbook Designed to Increase Effective Management of Negative Client Feedback.** As previously noted, the current research deals not with the resolution of alliance ruptures related to client pathology or transference, rather, it was
intended to focus on the developmental phase of the here-and-now aspects of the alliance. The current research focused on alliance formation which involves a mutual process of collaboration between therapist and client, presumably separate from transference phenomena (Greenson, 1967). The focus within the developmental phases of the alliance is not on client pathology, but on the here-and-now, collaborative relationship between client and therapist. The current research was designed to facilitate the detection of clients' negative feelings regarding the alliance within the first two sessions. It must be acknowledged that clients' negative feelings may, in some cases, be early manifestations of their interpersonal pathology, but within the alliance-forming initial two sessions of therapy, it would typically be clinically advisable to treat negative client reactions as valid, here-and-now concerns. In the first few sessions of treatment, for therapists to make a transference interpretation or otherwise indicate that negative client reactions are a manifestation of client pathology would be extremely poor timing in most cases, and probably harmful to the developing alliance.

Another distinguishing feature of the current research involves a difference in the assumption of how client negativity surfaces. Previous research on resolution of alliance ruptures (e.g., the Vanderbilt project, Safran's sequential model) began with the alliance rupture being noticed by the therapist. In contrast, the current research assumes (with support of Hill et al, 1992; Regan & Hill, 1992; and Rennie, 1994) that clients are likely to withhold negative reactions to the therapy process. Thus, the workbook was designed specifically to maximize the likelihood of clients admitting to negative process if it is present. Although the difficulty with which therapists manage negative process is acknowledged here, several unique aspects of the alliance workbook were proposed to help therapists circumvent these difficulties. For example, the management of the here-and-now, initial collaborative relationship is presumed to be an easier clinical responsibility than the maintenance of the alliance over time (which often involves the management of transference and countertransference phenomena). Additionally, the workbook was designed to facilitate the development of the alliance by partitioning the formidable responsibility of establishing a strong alliance into smaller, more easily manageable parts (i.e., attending and adjusting to aspects of the bond, tasks, and goals) that comprise the overall alliance.
Another aspect of the alliance workbook designed to counteract the known difficulties clients and therapists have with negative process involves the role-induction procedures incorporated into the workbook. The workbook primes clients and therapists to expect the possibility of dealing with potential problems within the alliance and to view this as a normal, manageable aspect of any developing relationship. Specifically, included in the workbook is client information regarding the effectiveness of psychotherapy and the importance of the alliance and active client involvement as part of their role in therapy. Included in this information is acknowledgement of the difficulty but importance of being open about reactions to the process of therapy, particularly the alliance. Similarly, therapists in the study participated in role-induction procedures informing them of the enormous frequency of misunderstandings within therapy even within very strong alliances, and the importance of maintaining a nondefensive, accepting, encouraging attitude toward both positive and negative client feedback. These role-induction procedures were designed to neutralize, make acceptable, and decrease the pressures involved with potential interpersonal conflict. They were intended to create a normalized expectation that negative process may occur within the first few sessions as therapist and client struggle to negotiate the terms of the alliance. Ultimately, it was theorized that this would normalize the occurrence of negative process, which might increase the likelihood that therapists and clients would view problems in the alliance as opportunities for growth, not signs of personal condemnation.

The effectiveness of role-induction procedures in psychotherapy has received empirical support. Psychotherapy is a unique form of social interaction wherein the participants must be familiar with their roles and responsibilities if the interaction is to prove successful (Orne & Wender, 1968). "An important determinant of the success or failure of psychotherapy is the degree to which the patient understands the rules of the game" (p. 1202). With this, therapy outcomes are expected to be enhanced when clients and therapists have expectations about their respective roles in therapy that are congruent (Friedlander & Kraul, 1983). Several studies have investigated the impact of role-induction procedures on client outcomes in psychotherapy. When clients are provided information on outcome expectancies (e.g., information regarding the effectiveness of psychotherapy) and/or role expectations (e.g., information on expected client and therapist
behaviors), outcomes are better than for comparable groups of clients not exposed to role induction procedures (Friedlander & Kraul, 1983).

Additionally Proposed Benefits of the Alliance Workbook. Although the workbook was designed primarily as a therapeutic tool to facilitate the development of strong alliances, several aspects of the workbook were also proposed to positively relate to outcome. Although the workbook is called an Alliance Workbook, in many ways it is broader than this and is comprised of component parts that are not traditionally thought of as alliance-promoting. For example, workbooks and other task assignments have previously been used in psychotherapy to help facilitate patient change. Facilitation of the alliance through a workbook format appears well-suited for the college population through which the current research was conducted: College students are accustomed to "homework" and possess the written communication skills required for the workbook. Freidberg (1996) notes that using workbooks in conjunction with therapy is beneficial for several reasons. Workbooks require participants to become "active collaborators" in the counseling process and workbooks offer structure and direction for both patient and therapist. Finally, workbooks can offer a tangible way for patients to record process and progress notes. One potential problem with workbooks, and in particular, the alliance workbook, is that it may encourage clients to rely too much on the workbook rather than open communication of important therapy events with the therapist. The role-induction parts of the alliance workbook were designed to address this specifically by alerting clients to the fact that the workbook is not intended as replacement for direct communication with their therapist. Rather, it is merely to be used as a tool to help organize and explore one's thoughts and feelings regarding treatment progress and the quality of the alliance.

L'Abate (1991) notes that the use of writing in psychotherapy has the advantage over the customary reliance on verbal communication in that writing can be very "explicit and specific, qualities that become confused in speaking, no matter how clearly one may speak" (p. 87). The use of writing assignments or workbooks in psychotherapy have typically been used to address specific skill deficits outside the therapy office. The alliance workbook is unique in that it addresses aspects of client experience which occur within the therapy hour. Jordan and L'Abate (1995) note that programmed writing, by definition, consists of materials assigned to patients to be completed outside of therapy and is used as
a "way to keep patients centered between sessions and to assume personal responsibility for change. It is a way for them to experience self-mastery and self-knowledge, by getting feelings and thoughts out in the open, sharing them with a partner or family friends and, later on, with the therapist. Programmed writing has often been used as a springboard for further discussions, evaluations, and corrective feedback by the therapist" (p., 226). The alliance workbook is intended to work in a similar manner. It was designed to facilitate client exploration of thoughts and feelings regarding their goals for therapy, their progress in therapy, and their relationship with their therapist. The alliance workbook differs from most programmed writing. Whereas most programmed writing is intended solely for patient mastery and learning, the alliance workbook is intended to facilitate mastery and learning within each unique patient and therapist dyad. Additionally, the workbook is not intended as a tool for therapists to provide corrective feedback to clients, rather, the workbook is a tool to facilitate client provision of corrective feedback to the therapist, who, in turn, may utilize this information to increase the strength of the alliance.

The activity of using the workbook was presumed to increase clients' active involvement in their own treatment. Previous empirical research has shown that clients' active involvement in the therapy process is positively related to outcome (Gomes-Schwartz, 1978; Moras & Strupp, 1982; O'Malley, Suh, & Strupp, 1983). By answering questions regarding their relationship with their therapist, their desires and perceived progress regarding therapeutic goals, and their satisfaction regarding the in-session tasks, clients using the workbook would presumably become more aware of and actively involved with the therapeutic process and progress of their own treatment. Thus, in addition to its effects on the alliance, the workbook was designed to result in increased client involvement and responsibility for their own treatment, which would be related to better outcomes.

Another potential benefit of the alliance workbook lies within clients’ written exploration of feelings. The workbook requires clients to write, in open-ended format, about their emotional reactions to aspects of the developing alliance with their therapist. Writing about emotional experiences has received empirical support as a therapeutic process in itself (Pennebaker, 1997). In the last decade, numerous studies have demonstrated a relationship between writing about emotional experiences and subsequent
improvements in emotional and even physical health. These studies follow an experimental paradigm in which individuals are randomly assigned to either a control condition (subjects are instructed to write about superficial topics) or an experimental condition (subjects are instructed to write about deep thoughts and feelings and important issues). In comparison with writing about superficial topics, writing about important emotional issues has been associated with better immune functioning, decreases in physician visits, improvements in mood, and significant reductions in stress (Pennebaker, 1997). Although the alliance workbook does not follow the typical paradigm, it does require clients to write about their emotional experiences related to aspects of the alliance. Although this section of the workbook was designed to provide therapists with very explicit details of potential client-perceived problems within the alliance, it also may have a cathartic effect, thus may relate to better outcomes.

Social Skills and Use of the Alliance Workbook. It has been noted that addressing alliance issues requires timing and skill on the part of the therapist. The successful processing and management of alliance issues may also be related to client characteristics. More specifically, degree of client and therapist social skills may be factors which mediate the dyad's ability to utilize the workbook to strengthen the alliance. Similar to the alliance construct, there is no single definition of social skills. However, there is apparent consensus regarding the most basic components of social skills. Broadly defined, most researchers and theoreticians agree that social skills encompass the ability to send and receive information. Riggio (1986) further conceptualized social skills as comprised of six dimensions. These dimensional social abilities include the ability to effectively communicate affect and attitudes, the ability to accurately decode others' emotions, beliefs or attitudes, the ability to express oneself verbally, fluently, and to initiate conversations, and the ability to receive and understand verbal messages. Similar to social skills, psychotherapy itself may be broadly defined as the sending and receiving of information, thus it is clear that each of these social skills plays an important role in the efficacy of psychotherapy. Indeed, research has indicated a positive relationship between therapist social skills and therapy outcome (Anderson, Crowley, Klimek, Deisseroth, & Weis, 1998).

The alliance workbook may be conceptualized as a tool to facilitate the sending and receiving of alliance-related information within the therapy dyad. Clients using the
workbook are encouraged to broach alliance issues with their therapist. Individuals with high social skills tend to have histories of successful social interactions and also have the ability to initiate conversations (Riggio, 1986). Thus, a client with high social skills would appear more likely to broach alliance issues with his/her therapist than would a low-skilled client who may lack a history of successful interactions and may also have difficulty initiating conversations. Whereas highly skilled clients are likely to possess skills that enable them to communicate on their own, presumably, lower skilled patients may benefit more from a tool to help them communicate their therapy needs.

Similarly, therapists with higher social skills may also be more adept at utilizing client feedback from the workbook to strengthen the alliance. A high skilled therapist presumably has greater capacity for sensing alliance problems and may also have a greater capacity to respond to alliance issues with sensitivity and social grace. Although client social skills will be analyzed within the present study, due to the small number of therapists participating in the study, therapist social skills were not a part of the quantitative analysis.

**Summary.** There is a need for a tool to help therapists become aware of and effectively manage pertinent alliance issues within the initial alliance. The alliance workbook was developed for this purpose. Previous research has shown that clients frequently withhold negative reactions regarding the therapy process. An underlying assumption of the workbook is that therapeutic alliances will be strongest when clients and therapists can openly acknowledge, confront, and resolve negative process associated with the developing alliance. Modeled after Bordin's (1979) formulation of the alliance, the workbook was designed specifically to detect the presence of potential problems with respect to the patient-therapist bond, and any areas of dissatisfaction with respect to the goals and tasks of treatment. Previous studies have demonstrated the extent to which therapists have difficulty managing negative process. The current study may be contrasted from previous research efforts in that its focus was on the initial development of the alliance and the here-and-now problems within its development. This was presumed to be an easier task than what was required of therapists in earlier studies-- the management of transference and countertransference reactions that occur later on in the therapy process. Nevertheless, some additional aspects of the alliance workbook were designed to
counteract potential therapist difficulties in managing negative client reactions. First, the workbook was designed to partition the alliance into its component parts (bond, tasks, goals) and to elicit client reactions to each. Thus, therapists using the workbook receive feedback regarding specific, manageable aspects of the alliance, which is presumably an easier task to respond to than detecting and managing unspecified negative process that might otherwise occur without the use of the workbook. Second, both clients and therapists were exposed to informational procedures designed to prepare them for their respective roles and to prime them for the possibility of confronting any areas of client dissatisfaction within the alliance. These role-induction procedures were hoped to normalize the working through of client negativity, thereby increasing the chance of the dyad managing this activity in a healthy, non-defensive, non-blaming manner that would facilitate further strengthening of the alliance. Finally, in addition to aspects of the workbook designed specifically to strengthen the alliance, other benefits with direct relation to outcome were proposed. These included increased client involvement, positive effects associated with the use of programmed writing, and a potential cathartic effect from expressive writing within the workbook.

**Research Design and Hypotheses.** The current study compared two conditions: Therapy as usual versus therapy as usual in conjunction with the alliance workbook. In the control condition, it was expected that the presence of client negative reactions or dissatisfaction with the therapy process would be largely undetected by therapists, thus there would be minimal opportunities to correct for potential problems within the developing alliance. In contrast, the workbook condition was intended to increase client and therapist awareness of the alliance and willingness to discuss alliance issues. Heightened awareness of alliance issues and increased willingness to openly acknowledge and discuss potential problems within the alliance were hypothesized to provide more opportunities for alliance discussions which were hypothesized to strengthen the alliance. Thus, the first hypothesis was as follows:

*Hypothesis 1: Compared to controls, the workbook group was expected to exhibit more positive change in the alliance.*

The workbook is unique from procedures used in previous studies in that its use was intended to address problems in the developing alliance (in contrast to maintaining an
already established alliance. It was designed, in part, to increase the salience of potential alliance problems in the first sessions of therapy so that they may be swiftly addressed and corrected. Conceivably, therapy dyads for whom the alliance is developing well in the first few sessions may not need a corrective tool. As such, the workbook was proposed to be especially useful in identifying and repairing those instances in which there are potential problems in the developing alliance. The following hypothesis stems from this:

*Hypothesis 2:* Among those with low alliances at session one, subjects in the workbook condition were expected to exhibit more positive change in alliance than subjects in the control condition.

The use of the alliance workbook was expected to affect patients’ involvement in their treatment process and to increase their awareness of and contemplation of treatment issues. Use of the workbook was intended as a means to provide critical patient feedback about the alliance and to create opportunities for therapists to understand not only areas in need of improvement, but also to verify what aspects of the treatment process are going well. In these ways, the workbook was intended to have an impact on sessions that would be experienced by clients and therapists alike.

*Hypothesis 3:* Clients and therapists in the workbook condition were expected to rate their sessions as being deeper (i.e., more emotionally meaningful, valuable) and smoother (i.e., greater ease in relating) than dyads within the control condition.

Because client social skills may influence ability to profit from the workbook, client social skills were hypothesized to mediate the relationship between the use of the workbook and the strength of the alliance. Specifically, clients who have relative difficulty expressing themselves both verbally and nonverbally were hypothesized to benefit the most from using the workbook.

*Hypothesis 4:* Among clients with low ability in emotional expression (ability to send nonverbal messages), those in the workbook condition will show more positive change in the alliance than those in the control condition.

*Hypothesis 5:* Among clients with low ability in social expression (ability to initiate and engage others in conversation), those in the workbook condition will show more positive change in alliance than those in the control condition.

Finally, because the alliance workbook also includes components that are more
directly related to outcome, (e.g., written emotional disclosure, increased client involvement, etc.) outcome was expected to be influenced as follows:

**Hypothesis 6: Clients in the workbook condition will have more reduction in symptom scores across sessions than will participants in the control condition.**

**Method**

**Participants**

Participants were clients and therapists at Counseling and Psychological Services (CPS) (Ohio University) who agreed to participate in an individual psychotherapy study in conjunction with their regularly scheduled therapy sessions. Clients seen at the counseling center were full time, undergraduate and graduate students who presented with a range of problems typical of university counseling centers (e.g., adjustment disorders, mood disorders, anxiety disorders, eating disorders, and interpersonal problems). Data was collected over a two-year period between 2000 and 2002. Control data was collected during the first year, followed by workbook condition data during the second year.

**Clients.** 179 clients initially agreed to participate in the study and completed at least 1 session. 78 of these clients dropped out of the study after their first session, leaving 101 clients who completed 2 or more sessions. A portion of these subjects dropped out of the study after 2 sessions, leaving 60 clients who completed 3 sessions within the study. Because most data analyses in the study examined patient change across sessions, subjects who ended the study after one session were excluded from most analyses. It should be noted that drop out from the study was not an indicator of treatment drop out. Subjects dropped out of the study at a higher rate than drop out from treatment: 40% of subjects who dropped out of the study after session 1 continued for at least 1 more session, and 44% of clients who dropped out of the study after session 2 continued on for additional sessions with their therapist. Speculatively (as this variable was not measured), reasons for study drop out may have been due to (1) clerical errors such as subjects not receiving the proper study forms for subsequent sessions; (2) subjects forgetting to return their study forms to the clinic; and/or (3) subjects requesting to end the study because it was too time-consuming to complete all of the study forms.

The demographic information presented here refers to subjects who completed 2
or more sessions within the study ($n=101$). This sample was 82% female, 93% Caucasian, college students, most of whom (55%) had no previous therapy experiences. The sample was evenly distributed across year in school (18% freshmen, 19% sophomore, 24% junior, 21% senior, 18% graduate students). Distributions of all demographic variables were proportionate across conditions of the study. It should be mentioned here that subjects who agreed to participate in the study may not have been representative of the general client population at university counseling centers. Data was collected for two years, during which time all clients who presented at the clinic ($N=2700$) were invited into the study, yet only 178 of these (approximately 15%) agreed to participate. Invitation into the study was made with a brief statement that explained the time requirements necessary for participants. Although reasons for choosing to participate in the study were not measured, it is quite conceivable that this small proportion of clients who agreed to participate in the study may not have been typical of the average university counseling center client.

Table 1

Number of Subjects by Condition and Session

<table>
<thead>
<tr>
<th></th>
<th>Completed Session 1</th>
<th>Completed Session 2</th>
<th>Completed Session 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Condition</td>
<td>85</td>
<td>47</td>
<td>29</td>
</tr>
<tr>
<td>Workbook Condition</td>
<td>94</td>
<td>54</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>179</td>
<td>101</td>
<td>60</td>
</tr>
</tbody>
</table>

Therapists. Nineteen therapists contributed cases to the study (ten were males). There were 10 professional therapists (mostly doctoral level) and 9 graduate trainees.
Five doctoral level psychologists at the clinic accounted for 71% of subjects seen in the study. These therapists had between 5 and 32 years of full-time clinical practice. Graduate trainees in the study had between one month and 3 years of clinical experience. Therapists had a range of theoretical orientations including cognitive-behavioral, psychodynamic, interpersonal, feminist, and eclectic.

**Materials**

**Client and Therapist Demographic Questionnaires.** After their initial sessions, clients completed a brief demographic questionnaire (see Appendix B) that included questions regarding age, gender, ethnic status, and previous experiences with counseling. Prior to participation in the study, therapists also completed a brief questionnaire (see Appendix C) regarding age, gender, years of clinical experience, and theoretical orientation.

**Social Skills Inventory.** The Social Skills Inventory (SSI; Riggio, 1986) was completed by clients as a measure of ability along various dimensions related to social and communication skills. The SSI is self-report measure which requires subjects to respond to 90 items on a 5-point scale ranging from "Not at all like me," to "Exactly like me." The SSI assesses three types of communication skills: Expressivity, sensitivity, and control. Three subscales measure the *nonverbal* realms of these skills: The Emotional Expressivity (EE) scale is the ability to send nonverbal messages; the Emotional Sensitivity (ES) scale measures the general skill to receive and decode nonverbal communications; and the Emotional Control (EC) scale measures the ability to regulate one's own nonverbal communication. Three more subscales measure *verbal* expressivity, sensitivity, and control: The Social Expressivity (SE) scale measures verbal speaking skill and ability to initiate and engage others in conversation; Social Sensitivity (SS) measures the ability to decode and understand verbal communication and general knowledge of social norms; and the Social Control (SC) scale measures the ability to adjust one's social behavior and modify one's social self-presentation to fit given social situations. The six subscales may be summed to yield a total score, or they may be measured separately as indices of specific social skills. The psychometric properties of the SSI are good: Test-retest reliability for the total SSI score is .94. Coefficient alphas for the six subscales range from .75 to .88, which is indicative of adequate internal consistency. Additionally, the patterns of
correlations among the SSI subscales and other indices of social skills provided support for the convergent and discriminant validity of the SSI (Riggio, 1986). The Social Expressivity and Emotional Expressivity subscales were analyzed for the current study because they appeared to be the two social skills that would mediate the treatment process the most.

**Working Alliance Inventory.** Subjects completed the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) after their first three sessions. The WAI is a 36-item self-report measure of clients' perceptions of the alliance. The instrument has 3 subscales (bond, task, and goal subscales) each containing 12 items designed to operationalize Bordin's (1979) tripartite model of the working alliance. Clients rate each item on a 7-point scale ranging from never to always. All three subscales have good reliability: The bond and task subscales have internal consistency estimates of .92 and the goal subscale reliability is estimated at .89. The subscales are summed to obtain a composite score indicative of the overall strength of the working alliance. The composite score also has good reliability with a coefficient alpha of .93. The predictive validity of the WAI has been established as well; the WAI has been shown to be related to various indices of therapeutic outcome. Composite scores were used for the current research.

**Session Evaluation Questionnaire.** Clients and therapists completed the Session Evaluation Questionnaire (SEQ) (first version) (Stiles, 1980) after each session. The SEQ is a scale designed to measure the impact of psychotherapy sessions in terms of depth/value (degree of emotional impact), smoothness (ease of relating within session), and post-session positive feelings. It is comprised of 22 bipolar adjective pairs in a 7-point semantic differential format. Respondents place an “X” on each 7-point scale to indicate their relative agreement within each bipolar adjective pair. Session depth and smoothness are rated with eleven adjective pairs following the stem “This session was…” (e.g., bad-good, difficult-easy, valuable-worthless, shallow-deep). The second set of adjective pairs form the positive feelings scale and are preceded by the stem “Right now I feel…” (e.g., happy-sad, angry-pleased, confident-afraid). Internal consistency ratings range from .80-.90 (Stiles et. al, 1990). There is evidence that therapists’ SEQ ratings correlate with outcome at 3 months (when SEQ ratings are averaged across multiple sessions), however, the correlation of SEQ ratings with outcome may vary according to therapist (i.e., some
therapists’ SEQ ratings correlate with outcome, other therapists’ ratings do not). Clients’ and therapists’ smoothness and depth ratings were used for the current study.

**Outcome Questionnaire.** Prior to their first sessions, all subjects completed the Outcome Questionnaire (OQ; Umphress, Lambert, Smart, Barlow, & Clouse, 1997) as a measure of pre-treatment psychological distress, and completed it again after sessions 2 and 3 as an index of symptom change. The OQ was designed as a measure to track progress and outcome on a session by session basis (Wells, Burlingame, Lambert, Hoag, & Hope, 1996). It is a 45-item self-report measure that requires respondents to rate their feelings on a broad range of items indicative of general well-being and psychological functioning. Three subscales of the OQ measure symptom distress, interpersonal relations, and social role performance. Because the three subscales are highly correlated and have not been shown to assess unique domains (Umphress et al., 1997), the OQ total score was used. The psychometric properties of the OQ are quite good: Internal consistency is high (coefficient alpha = .93) and there is support for its construct validity. Within a university counseling center, the OQ was shown to have concurrent validity of .78 with the general symptom index of the SCL-90-R (another psychometrically sound measure of general distress).

**Alliance Retrospective (AR).** This measure was designed by the investigator as a direct means of assessing whether use of the workbook achieved two of its intended manipulations: Frequency and quality of alliance discussions, and frequency of client-perceived negative process. Subjects completed the Alliance Retrospective (see Appendix D) after sessions 1, 2, and 3. The measure contains nine items developed to assess the frequency of alliance-related discussions within session (questions 1,2 and 7), and as an assessment of client-perceived quality of alliance-related discussions (questions 3,4,5,6,8, and 9). The frequency and quality of two general types of alliance-related discussions are assessed: Discussions regarding negative process, and discussions regarding the therapeutic tasks and goals.

**The Alliance Workbook.** Designed by the principle investigator, The Alliance Workbook (see Appendix A) is a series of paper-and-pencil worksheets that was completed by subjects in the workbook condition after their first two sessions of treatment. The workbook content was generated from Bordin's (1979) tripartite
formulation of the working alliance and from the empirical and theoretical literature on alliance ruptures and negative process (Binder & Strupp, 1997; Henry et al., 1993; Hill et al., 1992; Safran, 1993; Safran & Muran, 1996; Safran et al., 1990). The content development of the workbook began with the generation of a large pool of potential items. These items were then reduced to a smaller pool based on the degree of conceptual relatedness to the working alliance construct. Informal pilot testing was done using one therapist who gave several different versions of the interactive workbook to her clients. Further revisions of the workbook were made based on therapist and client feedback regarding the utility of various components of the workbook.

There are five interrelated features of the workbook intended to contribute to the hypothesized effects on alliance and outcome. Although these features will be briefly described here, Table 2 contains a more detailed description of the specific content areas of the workbook and their rationale in the empirical and theoretical literature. The first feature of the workbook is the role-induction or role preparation features included in the "orientation" section of the workbook and interspersed throughout the workbook. These features are intended to generate positive outcome expectancies and increase clients' understanding of their role in treatment, especially their role in collaborating with their therapist about the goals and tasks for therapy. These features are also intended to increase the likelihood of clients broaching alliance-related discussions with their therapists.

Second, clients are asked to respond to questions regarding their therapeutic goals, and their perceptions regarding the in-session tasks and the adequacy of the bond. These questions were designed to increase client awareness of specific aspects of the alliance. This awareness, coupled with their previous role preparation, was intended to increase clients' active involvement in and responsibility for processing alliance issues on their own and to increase the likelihood that clients would broach alliance-related issues with their therapists.

A third feature of the alliance workbook designed to facilitate the alliance is a section which requires clients to engage in an open-ended format of written emotional disclosure related to the therapeutic alliance. The instructions for this page are a modified form of the instructions typical within the emotional disclosure research paradigm.
Table 2.

<table>
<thead>
<tr>
<th>Content Area/Client Activity</th>
<th>Intended Purpose</th>
<th>Relevant Research/Theoretical Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information re: efficacy of therapy and client roles (1983)</td>
<td>Create positive outcome expectations and congruence re: client roles</td>
<td>Orne &amp; Wender (1968); Friedlander &amp; Kraul</td>
</tr>
<tr>
<td>Clients list and provide a conceptualization of their problems including how they may be contributing to the problem(s) and what actions they might take.</td>
<td>Provides a structured time and format for clients to process their problem(s).</td>
<td>Freidberg (1996); L’Abate (1995)</td>
</tr>
<tr>
<td></td>
<td>May increase client responsibility for and involvement in their treatment.</td>
<td>Jordan &amp; L’Abate (1995)</td>
</tr>
<tr>
<td></td>
<td>May increase client-therapist agreement on goals. Provides therapists with direct way to assess agreement and how clients are conceptualizing issues.</td>
<td>Bordin (1979); Beck (1976)</td>
</tr>
<tr>
<td>Clients respond to questions regarding the in-session tasks of treatment including satisfaction with tasks, and task preferences for subsequent sessions.</td>
<td>May increase client-therapist agreement on tasks. Provides therapists with direct way to assess agreement on tasks.</td>
<td>Bordin (1979); Beck (1976)</td>
</tr>
<tr>
<td>Clients respond to questions regarding the client-therapist bond.</td>
<td>Introduces clients to importance of the bond. Increases client-therapist awareness of potential problems within the bond which need to be addressed.</td>
<td>Bordin (1979)</td>
</tr>
<tr>
<td>Clients are encouraged to broach alliance issues with therapist, discuss any areas of confusion, dissatisfaction.</td>
<td>Increases client-therapist discussions of the alliance --&gt; increase collaboration --&gt; increase strength of alliance.</td>
<td>Bordin (1979)</td>
</tr>
<tr>
<td></td>
<td>Increases therapists’ attention to the alliance --&gt; increase opportunities to correct potential problems.</td>
<td>Binder &amp; Strupp (1997); Henry &amp; Strupp (1994); Forman &amp; Marmar (1985) Kivlighan &amp; Schmitz (1992); Rhodes et al. (1996); Safran et al. (1990)</td>
</tr>
</tbody>
</table>
Table 2: continued.

<table>
<thead>
<tr>
<th>Content Area/Client Activity</th>
<th>Intended Purpose</th>
<th>Relevant Research/Theoretical Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients record own progress</td>
<td>Cathartic effect which is related to improvements in symptoms.</td>
<td>Pennebaker (1997).</td>
</tr>
<tr>
<td>notes within the context of the emotional disclosure paradigm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General use of the workbook</td>
<td>Increases likelihood that clients will admit to negative responses to treatment if present --&gt; therapist understanding of important treatment issues --&gt; informs treatment interventions.</td>
<td>Hill et al., (1992); Regan &amp; Hill (1992); Rennie (1994)</td>
</tr>
<tr>
<td></td>
<td>Increases client active involvement in treatment. Involvement is positively related to outcome.</td>
<td>Gomes-Schwartz (1978); Moras &amp; Strupp (1982); O'Malley, Suh, &amp; Strupp (1983)</td>
</tr>
<tr>
<td></td>
<td>Increases collaboration between client and therapist --&gt; increases building of positive alliances</td>
<td>Bordin (1979); Barnard &amp; Kuehl (1995)</td>
</tr>
<tr>
<td></td>
<td>Increases discussion of process which may facilitate continued client disclosure of important information re: treatment process and progress.</td>
<td>Barnard &amp; Kuehl (1995)</td>
</tr>
<tr>
<td></td>
<td>Therapist use of the workbook conveys respect and value of client thoughts/feelings; may empower clients.</td>
<td>Bischoff et al., (1996)</td>
</tr>
<tr>
<td></td>
<td>Offers structure and direction for clients and therapists. Provides a tangible way for clients to record their progress and process issues.</td>
<td>Barnard &amp; Kuehl (1995)</td>
</tr>
<tr>
<td></td>
<td>May help clients assume more personal responsibility for change.</td>
<td>Jordan &amp; L’Abate (1995)</td>
</tr>
</tbody>
</table>
Table 2: continued.

<table>
<thead>
<tr>
<th>Content Area/Client Activity</th>
<th>Intended Purpose</th>
<th>Relevant Research/Theoretical Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists engage in applied  research on their impact on individual clients.</td>
<td>Barnard &amp; Keuhl (1995)</td>
<td></td>
</tr>
<tr>
<td>Therapist and client discussion of alliance issues.</td>
<td>Models healthy communication about interpersonal processes, problem solving, and healthy responses to constructive criticism.</td>
<td>Bischoff et al. (1996); Raue &amp; Goldfried (1994)</td>
</tr>
<tr>
<td>Discussion of alliance issues is superior to ignoring alliance issues.</td>
<td>Rhodes et al., (1996); Forman &amp; Marmar (1985); Kivlighan &amp; Schmitz (1992)</td>
<td></td>
</tr>
</tbody>
</table>

(Pennebaker & Francis, 1996). Instructions were modified to direct clients to write specifically about the therapeutic alliance. This exercise serves several functions. Emotional disclosure about important life events has previously been associated with positive changes (Pennebaker, 1997; Pennebaker & Francis, 1996). Additionally, the free-response format is intended to resemble a client-generated progress note intended to stimulate continued thinking about treatment issues. Although this free-response page may elicit repetitions of what clients have already alluded to in previous parts of the workbook, it is important to vary the response formats within client workbooks (Schumacher, Wantz, & Taricone, 1995).

Used interactively as intended, the workbook provides therapists with the rare opportunity to receive immediate, specific feedback regarding their contributions to the alliance. Although receiving positive feedback regarding the alliance is intended to be useful to therapists, in light of the known client tendencies to withhold negative feedback (Hill et al., 1992; Regan & Hill, 1992; Rennie, 1994), the workbook was designed especially to detect the presence of potential problems within the alliance. To this end, the wording of the alliance workbook was designed to maximize the opportunities for clients to admit to negative alliance-related feelings. To illustrate, rather than asking, *Was there a time when you felt misunderstood in today's session?*, misunderstandings are elicited
through the following statement: *In today's session, I felt misunderstood when my therapist...* Statements worded this way were designed to provide therapists with information regarding potential problems within the alliance, and with specific information regarding how therapists may have contributed to the alliance issue in question.

**Design and Procedure**

**Clients.** Students who requested services at CPS were given the option of participating in a study which involved utilization of various written materials designed to facilitate their therapy experience. Included in the customary intake forms at CPS was a brief statement about the study and an explanation that participants would be given useful information about the treatment process and would be required to complete a number of study forms after their first three sessions. Interested clients were given session one materials including informed consent (see Appendix E) immediately after their intake. Clients were encouraged to complete these forms in a separate, quiet room made available to them after their sessions, however, an unknown number of clients took their forms out of the clinic and returned them later. Clients in the workbook condition were informed that their responses to workbook items would be seen by their therapist in between sessions but responses to all other study questionnaires would be used anonymously for research purposes only. All materials were color coded in order to easily distinguish therapist-reviewed forms (i.e., the workbook) from research forms. Clients returned all completed materials to the clinic secretary who distributed the forms to their designated locations (therapists’ mailboxes or to the investigator). Table 3 illustrates the procedural order and materials used at each session within both conditions.

**Therapists.** All therapists working at CPS between 2000 and 2002 were invited to participate in the study. Prior to participation in the study, all therapists completed informed consent. Due to the long period of data collection, three therapists who participated in the control condition did not participate in the workbook condition, and nine therapists provided cases for the workbook condition but did not contribute to the control condition. In the control phase of the study, therapists conducted therapy as usual, but were responsible for distributing the study forms to participating clients immediately after their first three sessions. Prior to the workbook condition phase of the
Table 3.

Client Procedures Within Each Condition

<table>
<thead>
<tr>
<th>Time of Measure</th>
<th>Control Condition</th>
<th>Workbook Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Session 1</td>
<td>OQ</td>
<td>OQ</td>
</tr>
<tr>
<td>Post-Session 1</td>
<td>Demographics</td>
<td>Demographics</td>
</tr>
<tr>
<td></td>
<td>WAI</td>
<td>WAI</td>
</tr>
<tr>
<td></td>
<td>SSI</td>
<td>SSI</td>
</tr>
<tr>
<td></td>
<td>AR</td>
<td>AR</td>
</tr>
<tr>
<td></td>
<td>SEQ-Patient form</td>
<td>SEQ-Patient form</td>
</tr>
<tr>
<td></td>
<td>Orientation¹</td>
<td>Orientation²</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alliance Workbook</td>
</tr>
<tr>
<td></td>
<td>SEQ-Therapist</td>
<td>SEQ-Therapist</td>
</tr>
<tr>
<td>Post-Session 2</td>
<td>WAI</td>
<td>WAI</td>
</tr>
<tr>
<td></td>
<td>OQ</td>
<td>OQ</td>
</tr>
<tr>
<td></td>
<td>AR</td>
<td>AR</td>
</tr>
<tr>
<td></td>
<td>SEQ-Patient form</td>
<td>SEQ-Patient form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alliance Workbook</td>
</tr>
<tr>
<td></td>
<td>SEQ-Therapist</td>
<td>SEQ-Therapist</td>
</tr>
<tr>
<td>Post-Session 3</td>
<td>WAI</td>
<td>WAI</td>
</tr>
<tr>
<td></td>
<td>OQ</td>
<td>OQ</td>
</tr>
<tr>
<td></td>
<td>AR</td>
<td>AR</td>
</tr>
<tr>
<td></td>
<td>SEQ-Patient form</td>
<td>SEQ-Patient form</td>
</tr>
<tr>
<td></td>
<td>SEQ-Therapist</td>
<td>SEQ-Therapist</td>
</tr>
</tbody>
</table>

Note. 1 = Written therapy “orientation” included brief information about the therapy process. 2 = Written therapy “orientation” included brief information about the therapy process, and information on how to use the alliance workbook, potential benefits of the workbook, and specific information and guidance about giving therapists direct feedback. OQ= Outcome Questionnaire; WAI= Working Alliance Inventory; SSI= Social Skills Inventory; AR=Alliance Retrospective; SEQ= Session Evaluation Questionnaire.
study, therapists were given additional instructions on the use of the workbook. Within
the workbook condition, therapists conducted therapy as usual and gave their clients the
study forms plus the alliance workbook for completion. Therapists then reviewed their
clients completed workbook exercises prior to subsequent sessions.

**Training Seminar.** Immediately prior to the beginning of the workbook condition
phase of the study, the principle investigator presented a two-hour training seminar to five
of the professional, full-time therapists who participated in the study (the same five
therapists who contributed 71% of the analyzable data). The seminar contained (1) an
overview of Bordin's (1979) pantheoretical formulation of the working alliance (2) a brief
literature review of the relationship between alliance and outcome, (3) a presentation of
the workbook and its intended usage, (4) an acknowledgment of the prevalence of
negative process within psychotherapy and the difficulty with which therapists deal with
this, (5) role-induction procedures designed to prepare therapists to expect negative
process, to view it as a normal part of the developing alliance, and to see the workbook as
an opportunity for immediate modification of problematic alliances with current clients and
as an opportunity for professional development, (6) presentation of good and bad case
examples of therapist responses to clients' negative reactions within the alliance, and (7) a
discussion of guidelines on how therapists may address negative process in a
nondefensive, empathic way. Therapists who were not available at the time of the seminar
received similar written instructions on how to use the workbook. Therapists were
instructed to collect their clients’ completed workbook exercises from their clinic mailbox
for review prior to subsequent sessions with each study client. In an unknown number of
cases, clients’ completed workbook responses were not made available to therapists prior
to their next sessions. For this reason, and possibly others (e.g., therapists may not have
had time to review the workbook exercises, therapists may have forgotten to review the
exercises), there were a number of cases in which therapists did not review their clients
workbook responses in time for the client’s subsequent therapy session. This issue will be
addressed more fully elsewhere.

**Results**

The current research, like much psychotherapy research, dealt with a relatively
small sample size. At each session of the study, subject numbers decreased due to either therapy dropout, or discontinuation from the study. Of the 179 subjects who began the study at session 1, 101 of them remained at session 2 and 60 subjects remained at session 3. Most of the analyses in the study examined patient change across sessions, particularly change between sessions 1 and 3 (because the alliance is known to be largely formed by session 3). Although a sample size of 60 provided adequate statistical power to detect group differences in most analyses, certain analyses examined a subset of clients within the sample, thereby further reducing the number of subjects (and statistical power). In order to increase statistical power in some analyses, patient change across sessions 1 and 2 was also analyzed.

**Manipulation Checks.** Prior to analyzing the primary research hypotheses regarding alliance and outcome, it was important to examine whether use of the workbook accomplished the proposed, in-session effects: Did use of the workbook facilitate client-therapist discussions of therapy tasks and goals, and promote client and therapist awareness of and subsequent discussion of negative process as intended? Several manipulation checks (frequency of task/goal discussions, awareness of negative process in sessions, and frequency of discussions about negative process) were performed in order to assess whether these intended effects of the workbook occurred.

Responses from patients’ Alliance Retrospective (AR) surveys were tabulated across sessions and entered into a series of chi-square analyses in order to make comparisons between the two conditions. In the first of these analyses, responses to item one (frequency of client reported task and goal discussions) were examined across conditions. As hypothesized, clients in the workbook condition reported having more sessions where tasks and/or goals were directly discussed with their therapist than did clients in the control condition, \(X^2 (4, n=340) = 5.60, p<.02.\) 98.3% of all workbook condition sessions contained discussions of therapeutic tasks and goals (175 of 178 sessions), whereas 93.2% of control condition sessions (151 out of 162) contained such discussions according to clients.

A second chi-square analysis was performed to determine whether subjects in the workbook condition were more likely to be aware of and report the presence of negative process within their sessions. Results of this chi-square analysis indicate that subjects in
the control and workbook conditions were equally likely to notice and report negative process, \(X^2(4, n=340) = .007, \text{ns}\). According to results of the AR analyses, a very small percentage of sessions in each condition were deemed by clients to contain instances of negative process (e.g., client dissatisfaction with something the therapist said or did, clients’ feelings being hurt by therapist, clients feeling misunderstood by therapist): Only 9.3% of control sessions (15 out of 162) and 9.0% of workbook condition sessions (16 out of 178) contained client-perceived negative process as measured by the Alliance Retrospective questionnaire.

A final manipulation check was performed to examine whether workbook condition subjects were more likely than controls to discuss negative process with their therapist. Chi-square analysis revealed that among sessions in which clients perceived negative process (n=31), a very small proportion of these sessions (only 2 control and 3 workbook sessions) contained client-therapist discussions of negative process as reported by clients on the Alliance Retrospective. Contrary to what was expected, subjects in the workbook condition were no more likely to have discussions of negative process than were subjects in the control condition, \(X^2(4, n=31) = .168, \text{ns}\).

In summary, the results of these manipulation checks indicate that the use of the workbook resulted in some, but not all, of its intended effects. Clients in the workbook condition engaged in more discussions of therapy tasks and goals, thus providing preliminary support for the effectiveness of the workbook in facilitating such discussions. However, frequency of client-perceived negative process and subsequent in-session discussion of negative process (as measured by the AR) did not appear to be influenced by the use of the workbook.

**Hypothesis 1: Compared to controls, the workbook group was expected to exhibit more positive change in the alliance.** Table 4 shows the mean alliance scores for subjects at each of the three sessions. A one-way analysis of covariance (ANCOVA) comparing third session WAI scores with first session WAI scores as the covariate was not significant, \(F(1,56) = 0.16, p>.05\). This result indicates that changes in the strength of the alliance between the first and third sessions were equivalent across groups. It should be noted that this analysis included only those subjects who completed three sessions of therapy within the study. When compared to other subjects (e.g., those who completed
only 1), it was evident that subjects who completed 3 sessions had higher initial alliances, \( t(1, 134) = -2.24, \ p < .05 \). Indeed, there was a trend in the data indicating that higher initial alliances (i.e., at session 1) were related to subjects continuing on for more sessions (\( r = .18, \ p < .05 \)). Thus, subjects who contributed analyzable data (i.e., subjects who remained in the study for two or more sessions) conceivably had higher alliances to begin, and presumably, less need for improvement. The next hypothesis addresses this issue.

Table 4

<table>
<thead>
<tr>
<th>Condition</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controls</td>
<td>207.2 (24.9)</td>
<td>209.9 (27.1)</td>
<td>213.4 (28.3)</td>
</tr>
<tr>
<td>Workbook</td>
<td>208.9 (22.7)</td>
<td>209.2 (23.0)</td>
<td>211.7 (23.7)</td>
</tr>
</tbody>
</table>

**Note:** Standard deviations are in parentheses.

**Hypothesis 2:** Among those with low alliances at session one, subjects in the workbook condition were expected to exhibit more positive change in alliance than subjects in the control condition. To test this hypothesis, subjects were separated into “low” and “high” alliance groups on the basis of their WAI composite scores after the first session. A median split (Mdn=210 for the whole sample) was used to separate the groups, and scores from subjects in the “low WAI” group (n= 26) were used for the analysis. A one-way ANCOVA was performed using session 3 WAI composite scores as the dependent variable and session 1 WAI composite scores as the covariate. Results indicated that the control and workbook groups did not differ in magnitude of change in the alliance by session 3, \( F(1,23)=.025, \ p>.05 \), which suggests that among subjects with relatively low alliances at session 1, use of the workbook did not facilitate additional improvement in the alliance.

The same analysis was also performed using the data from the second session as the dependent variable: Mean WAI ratings at session 2, controlling for the strength of the alliance at session 1, were 189.4 (SD= 24.9) and 202.7 (SD=24.6) for the control and
workbook groups respectively, $F(1,43)=3.279$, $p<.08$, an effect that approached significance.

*Hypothesis 3a.* *Patients and therapists in the workbook condition will have higher “smoothness” ratings on the SEQ than will participants in the control condition.*

Client and therapist ratings for session smoothness were moderately correlated at sessions 2 ($r=.387$, $p<.001$) and 3 ($r=.385$, $p<.01$). Due to this correlation, client and therapist

Table 5

**Means and Standard Deviations of SEQ Smoothness Ratings**

<table>
<thead>
<tr>
<th>Source of Rating</th>
<th>Patients</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condition</strong></td>
<td><strong>Session 2</strong></td>
<td></td>
</tr>
<tr>
<td>Control (n=45)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>5.39</td>
<td>5.10</td>
</tr>
<tr>
<td>$SD$</td>
<td>0.99</td>
<td>1.28</td>
</tr>
<tr>
<td>Workbook (n=50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>5.22</td>
<td>5.16</td>
</tr>
<tr>
<td>$SD$</td>
<td>0.99</td>
<td>1.19</td>
</tr>
<tr>
<td><strong>Session 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control (n=27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>5.30</td>
<td>4.99</td>
</tr>
<tr>
<td>$SD$</td>
<td>0.83</td>
<td>1.28</td>
</tr>
<tr>
<td>Workbook (n=28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>5.00</td>
<td>4.88</td>
</tr>
<tr>
<td>$SD$</td>
<td>1.08</td>
<td>1.52</td>
</tr>
</tbody>
</table>

**Note:** The Session Evaluation Questionnaire Smoothness Index is a 7-point scale in which higher scores indicate greater smoothness.
smoothness ratings were analyzed together, however, the ratings from session 2 (n=95) and 3 (n=55) were analyzed separately in order to test for differences at session 2 separately, which would allow for higher n and increased statistical power. Client and therapist ratings on the SEQ at session 3 were entered into a multiple analysis of variance (MANOVA) with condition as the fixed factor. The multivariate effect was not significant, F (2,52) = .66, ns. Results of this analysis indicated that use of the workbook did not affect client or therapist-rated smoothness at sessions 2 or 3. A separate multivariate analysis was performed at session 2, the results of which were also non-significant, F(2,92)=.53, ns. Means and standard deviations pertaining to these analyses are shown in Table 5.

Hypothesis 3b. Patients and therapists in the workbook condition will have higher “depth” ratings on the SEQ than will patients and therapists in the control condition. Therapist and patient “depth” ratings were not correlated at either session 2 (r=.153, ns) or session 3 (r=.286, ns), therefore, SEQ depth ratings were analyzed separately for client and therapist. A one-way analysis of variance (ANOVA) was performed on client-rated depth at session 2, F(1,99)= 1.52, ns. As seen in Table 6, depth scores for clients in the workbook condition at session 2 were nearly identical to the control condition subjects during session 2. There was not a treatment effect for client-rated depth at session 3, F(1,57)=.171, ns. Therapist-rated depth at session 2, F(1,108)=1.75, ns, and session 3, F(1,62)=0.323, ns, were not significant.

Hypothesis 4: Among clients with low ability on the emotional expressivity subscale, those in the workbook condition will show more positive change in the alliance than those in the control condition. In order to define a group of subjects as low on emotional expressivity a median split was calculated (Mdn=47 for the whole sample), and subjects who scored below the median were included in this analysis. Mean alliance scores at sessions 2 (n=52) and 3 (n=32) for this group of subjects are shown in Table 7. A one-way analysis of covariance (ANCOVA) was performed using total alliance scores at session 2 as the dependent variable, and total alliance scores at session 1 as the covariate, F(1,49)=1.72, ns. Another ANCOVA was performed using session 3 alliance as the dependent variable, and session 1 alliance as the covariate. This test was not
Table 6
Means and Standard Deviations of SEQ Depth Ratings

<table>
<thead>
<tr>
<th>Source of Rating</th>
<th>Patients</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control (n=45)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>5.22</td>
<td>4.78</td>
</tr>
<tr>
<td>SD</td>
<td>1.01</td>
<td>1.17</td>
</tr>
<tr>
<td>Workbook (n=50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>5.45</td>
<td>5.05</td>
</tr>
<tr>
<td>SD</td>
<td>.93</td>
<td>1.01</td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control (n=27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>5.22</td>
<td>4.85</td>
</tr>
<tr>
<td>SD</td>
<td>1.17</td>
<td>1.19</td>
</tr>
<tr>
<td>Workbook (n=28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>5.34</td>
<td>5.02</td>
</tr>
<tr>
<td>SD</td>
<td>0.84</td>
<td>1.15</td>
</tr>
</tbody>
</table>

significant $F(1,29)=.830$, ns. These results indicate that patients who have low social skills in the area of emotional expressivity do not show greater change in the alliance as a result of use of the alliance workbook.

Hypothesis 5: Among clients with low ability on the social expressivity subscale, those in the workbook condition will show more positive change in alliance than those in the control condition. A median split was calculated in order to separate high and low subjects on social expressivity ($Mdn=42$ for the whole sample). Subjects below the median on this variable were included in this analysis. Mean alliance scores at sessions 2
Table 7.

**Means and Standard Deviations for Subjects who Scored Low on Emotional Expressivity**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Control Condition</th>
<th>Workbook Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>WAI Total at Session 1</td>
<td>200.35</td>
<td>28.98</td>
</tr>
<tr>
<td>WAI Total at Session 2</td>
<td>208.99</td>
<td>22.54</td>
</tr>
<tr>
<td>WAI Total at Session 3</td>
<td>220.47</td>
<td>19.43</td>
</tr>
</tbody>
</table>

(n=54) and 3 (n=38) for this group of subjects are shown in Table 8. A one-way analysis of covariance (ANCOVA) was performed using total alliance scores at session 2 as the dependent variable, and total alliance scores at session 1 as the covariate, F(1,51)=.003, ns. Another ANCOVA was performed using session 3 alliance as the dependent variable, this test was not significant, F(1,35)=1.302, ns. These results indicate that patients who have low social skills in the area of social expressivity do not show greater change in the alliance as a result of use of the alliance workbook.

Table 8

**Means and Standard Deviations for Subjects who Scored Low on Social Expressivity**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Control Condition</th>
<th>Workbook Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>WAI Total at Session 1</td>
<td>207.37</td>
<td>26.46</td>
</tr>
<tr>
<td>WAI Total at Session 2</td>
<td>209.71</td>
<td>25.24</td>
</tr>
<tr>
<td>WAI Total at Session 3</td>
<td>218.83</td>
<td>24.63</td>
</tr>
</tbody>
</table>
Hypothesis 6: Clients in the workbook condition will have more reduction in symptom scores across sessions than will participants in the control condition. A t-test using condition as the fixed factor and residualized OQ scores (i.e., pre-OQ statistically removed from OQ at session 3) as the dependent variable was performed. Results indicated that there were not group differences in outcome at the third session, $t(1,57) = -.57, p>.05$. Mean residualized difference scores for controls and workbook subjects were −1.24 and 1.20 respectively. Table 9 shows mean OQ scores for each session for subjects who completed all 3 sessions.

Post-hoc Analyses

Frequency of negative process within the workbook condition. Due to the surprisingly low percentage of negative process endorsed by clients on the Alliance Restrospective, workbook responses were inspected as an alternative method of quantifying this variable. Clients’ workbook responses were examined for endorsement of negative process items (e.g., “My feelings were hurt when my therapist…” “I felt criticized when my therapist…”). Frequencies of these items were tabulated within the workbook condition and revealed that 40% of all workbook condition sessions contained at least 1 client response indicative of negative process (e.g., “My feelings were hurt when my therapist ‘seemed eager to leave the session today”). Discrepancies between these two methods of quantification (the Alliance Retrospective versus the Alliance Workbooks) will be discussed elsewhere.

Table 9
Means and Standard Deviations on the Outcome Questionnaire

<table>
<thead>
<tr>
<th>Time of Measure</th>
<th>Control Condition</th>
<th>Workbook Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Treatment</td>
<td>71.23 (21.21)</td>
<td>78.79 (17.71)</td>
</tr>
<tr>
<td>Post-Session 2</td>
<td>72.12 (24.26)</td>
<td>79.60 (19.11)</td>
</tr>
<tr>
<td>Post-Session 3</td>
<td>63.57 (22.98)</td>
<td>73.46 (24.76)</td>
</tr>
</tbody>
</table>

Note. Standard deviations are in parentheses.
Did therapists read their clients’ workbook responses prior to therapy sessions? At sessions 2 and 3 within the workbook condition, therapists were asked, “Did you read your client’s workbook responses prior to today’s session?” Table 10 depicts frequencies of responses to this question. Several post-hoc exploratory analyses were performed to examine the effects of therapists reading versus not reading their clients’ workbook responses prior to session 2, the hypothesis being that therapist knowledge of their patients’ workbook responses would contribute to higher alliance and session-impact ratings. Session 2 was selected based on it being the first session wherein there was an opportunity for therapists to read their clients’ workbook responses. It was suspected that the blank responses were indications that therapists did not read the workbook prior to the session. As such, “no” responses and blank responses were combined and compared with “yes” responses. This yielded two groups of subjects; clients whose therapists read their workbook and clients whose therapists did not read their workbook prior to session 2. A MANOVA was performed using this variable as the fixed factor, and WAI scores at sessions 2 and 3 as the dependent variables.

As can be seen from Table 11, the means are in the hypothesized directions, however, the multivariate $E$ was not significant, $E(3,25) = .774$, ns, perhaps due to insufficient statistical power. Next, the effects of therapists reading the workbook on session-impact ratings were examined. Client and therapist SEQ ratings were used as dependent variables in a MANOVA, $E (8,18) = 3.09$, $p<.05$. The statistical power for the multivariate $E$ was .85, which was adequate to detect effects. There were several

<table>
<thead>
<tr>
<th>Did Therapists Read the Workbook?</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes” therapists read</td>
<td>39</td>
<td>24</td>
<td>63 (61%)</td>
</tr>
<tr>
<td>“No” therapists did not read</td>
<td>8</td>
<td>6</td>
<td>14 (13%)</td>
</tr>
<tr>
<td>Item was left blank.</td>
<td>20</td>
<td>7</td>
<td>27 (26%)</td>
</tr>
</tbody>
</table>

Table 10

Frequencies of Sessions Prior to which Therapists Read the Alliance Workbook
significant group differences, each in the hypothesized direction: Therapists having read
Table 11

*Means and Standard Deviations of WAI scores for Selected Workbook Subjects*

<table>
<thead>
<tr>
<th>Subjects</th>
<th>WAI1</th>
<th>WAI2</th>
<th>WAI3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists read the workbook</td>
<td>208.6 (25.8)</td>
<td>213.0 (21.9)</td>
<td>215.8 (19.5)</td>
</tr>
<tr>
<td>Therapists did not read the workbook</td>
<td>208.2 (17.8)</td>
<td>202.7 (22.9)</td>
<td>204.6 (30.2)</td>
</tr>
</tbody>
</table>

*Note.* WAI= Working Alliance Inventory.

the workbook resulted in higher client-rated depth at session 3 ($F_{(1,25)} = 3.0, p<.05$),
and higher therapist-rated depth at session 2 ($F_{(1,25)}=8.7, p<.01$) and session 3 ($F_{(1,25)} = 8.5, p<.01$). Client-rated depth at session 2 ($F_{(1,25)}=2.6, p=.08$) and therapist-rated smoothness at session 2 ($F_{(1,25)} = 4.5, p=.08$) approached statistical significance. Client-rated smoothness at session 2 ($F_{(1,25)} = 1.1, ns$) and 3 ($F_{(1,25)} = .149, ns$) were not significant. These results show that therapists reading their clients’ workbook responses had an impact on subsequent sessions (see Table 12).

A final series of MANOVAs examined whether session ratings for the subgroup of workbook condition patients whose therapists read their workbook responses would be superior to the control group. Alliance scores at sessions 2 and 3 were entered into a MANOVA, $F_{(3,44)} = .06, ns$. All SEQ indices were also entered into a MANOVA, $F_{(8,36)} = 1.13, ns$.

**Discussion**

This study found, as hypothesized, that the workbook increased the frequency of self-reported task and goal discussions within therapy sessions. Because this statistically significant increase was near the absolute ceiling of the scale (93% and 98% of sessions within the control and workbook conditions respectively), and because other hypotheses
Table 12
Means and Standard Deviations of Session 2 SEQ Indices

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Therapist-Ratings</th>
<th>Client-Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Smoothness</td>
<td>Depth</td>
</tr>
<tr>
<td>Read</td>
<td>5.31 (1.06)</td>
<td>5.58 (0.68)</td>
</tr>
<tr>
<td>Controls</td>
<td>4.99 (1.22)</td>
<td>5.12 (1.05)</td>
</tr>
<tr>
<td>Not Read</td>
<td>4.44 (1.31)</td>
<td>4.38 (1.17)</td>
</tr>
</tbody>
</table>

Note. “Read” are workbook condition subjects whose therapists read their workbook responses prior to the second session. “Controls” are all control subjects. “Not read” are workbook condition subjects whose therapists did not read their workbook responses prior to the second session.

were not supported, the findings raised more questions than answers in regard to the practical effect of using a therapeutic alliance workbook. Patients who used the workbook in this study did not have more awareness of negative process within their sessions, nor did they have higher frequencies of discussions of negative process as a result of using the workbook. The Alliance Retrospective (AR) questionnaire that was developed to measure these intended manipulations of the workbook may have lacked the sensitivity and specificity needed to measure negative process within therapy sessions. Post-hoc analysis of the frequency of negative process reported within the workbook condition was obtained via quantification of actual workbook responses. This analysis revealed that 40% of workbook condition sessions contained at least one instance of client-perceived negative process, a figure that was much larger that the 9% figure generated from the AR. Hence, within the workbook condition, the AR clearly underreported the frequency of negative process, however, the extent to which it underreported the frequency of negative process in the control condition is not known. A thorough discussion of the issues related to the validity and interpretation of the
manipulation checks is found in subsequent sections.

Contrary to what was hypothesized, patients in this study did not experience more change in alliance as a result of using the workbook: Analysis of covariance revealed that both groups of subjects showed the same amount of change in alliance across sessions. Similarly, patients in the study had equivalent reductions in symptom scores across sessions. Therapist and client-rated smoothness and depth were also measured and results indicated that the workbook did not have an effect on these session impact ratings. Social skills were hypothesized to influence the degree to which participants would benefit from using the workbook. Patients with relatively low ability to express themselves verbally and nonverbally (affectively) were expected to show more change in alliance as a result of using the workbook. Results failed to support this hypothesis: Patients with relatively low expressive social skills showed the same degree of change in alliance regardless of condition. Among patients with relatively low alliances after their first session, it was predicted that use of the workbook would result in more change in alliance across sessions. Results indicated that patients with initially low alliances had equivalent increases in the alliance at session 3, however, an analysis of covariance performed at session 2 revealed a hypothesized group difference that approached statistical significance. This analysis provided preliminary evidence that patients with initially low alliances may benefit from use of the alliance workbook, however, these results must be interpreted with caution.

Several post-hoc analyses were performed to examine variables that were hypothesized as potential mediators of the effectiveness of the workbook. Specifically, the effects of therapists reading versus not reading the workbook were examined. The data revealed that within the workbook condition, therapists reading the workbook did not have an effect on alliance scores, but did have an effect on session impact ratings. These results showed that when therapists read the workbook prior to sessions, both clients and therapists rated the sessions to be deeper and more emotionally meaningful compared to sessions that occurred after therapists had not read the workbook. This effect must also be interpreted with caution because it is not known whether therapists reading the workbook resulted in higher than expected session ratings or, conversely, whether the effect of therapists not reading the workbook resulted in lower than expected session
The primary purpose of this investigation was to explore the impact of the Alliance Workbook on the development of the alliance in early sessions of psychotherapy. The following questions were addressed: Did the workbook affect in-session behaviors as intended (i.e., increased frequency of discussions about tasks and goals, greater attunement to and discussion of negative process), was the workbook effective in facilitating stronger alliances and better outcomes, and were client social skills a mediating factor for the effectiveness of the workbook? Null findings raised many questions about possible unmeasured mediating factors, including the degree of client effort in responding to the workbook, whether therapists read the workbook prior to subsequent sessions as intended, and whether therapists were able to respond therapeutically to client feedback provided within the workbook. A more thorough examination of the data, conclusions, and interpretive caveats follows.

In-Session Effects of the Workbook: Manipulation Checks

Prior to analyzing the effects of the workbook on alliance and outcome, it was important to determine whether the use of the workbook resulted in its intended, in-session, mediating effects. Specifically, it was hypothesized that use of the workbook would result in higher frequency of discussions about tasks and goals, greater awareness of the presence of negative process, and more frequent discussions of negative process, which, in turn, would presumably facilitate stronger alliances. Results showed that clients who used the workbook, indeed, had a higher frequency of direct discussions about therapy tasks and goals than clients who did not use the workbook. Thus, use of the workbook helped facilitate an initial focus on therapy tasks and goals as intended. Although the vast majority of sessions in both conditions included discussions of tasks and goals, use of the workbook nearly eliminated sessions in which task and goal discussions did not occur. In the early sessions of treatment, it is especially important to have such discussions if clients and therapists are to come to an agreement on the tasks and goals for therapy. Thus, to an extent that was statistically significant (but not necessarily clinical meaningful) use of the workbook did result in one of the primary intended effects. There is preliminary support for the effectiveness of the workbook in facilitating task and goal discussions, an important aspect of the developing alliance. Participants who utilized the workbook
clearly had a higher frequency of these discussions, but the quality and outcome of such discussions, and their affect on the alliance, remains unknown.

Although results indicated that use of the workbook facilitated task and goal discussions, the evidence regarding the ability of the workbook to increase client awareness of and discussions of negative process was inconclusive. Results from the Alliance Retrospective indicated that within both conditions there was an equally low number of sessions that contained client-perceived negative process (only 9% of sessions). This figure was surprisingly low in light of previous research (Binder & Strupp, 1997; Safran, et al., 1990) that has highlighted the frequency of negative process or alliance ruptures that occur even within successful therapy cases. For this reason, the investigator looked to an alternative means of quantifying negative process – the workbook itself. Frequencies of negative process were tabulated through examination of the actual workbook responses, and it was discovered that the frequency of negative process was much higher (40% of sessions) than was determined via the Alliance Retrospective. A similar cross-comparison for the control condition could not be obtained because clients in the control condition, by definition, did not utilize the workbook.

Within the workbook condition, which of these frequencies is accurate and how can these findings be interpreted? To answer these questions, the differences between the two methods of data collection (the Alliance Retrospective versus the alliance workbook) must be considered. The Alliance Retrospective elicited information about negative process by asking clients to check any or all of three broad statements about negative process that may have occurred in their sessions (“I am dissatisfied with an aspect of how my therapist responded to me,” “I have negative feelings about something my therapist said or did today,” and/or “I have negative feelings about how my therapy is being conducted). In contrast, the workbook contained items designed to evoke highly specific client recollections of negative process (e.g., “My feelings were hurt when my therapist…” “I felt criticized by my therapist when…” “I felt misunderstood during my session when…”).

The workbook items were specific to the extent that there is no doubt whether clients perceived negative process: When clients responded to workbook items, they did so using their own words to describe specific instances of negative process from their
therapy sessions. It should be noted that clients were instructed to leave the incomplete sentences blank if the question stem was not applicable to their therapy session. Thus, the easier, less time-consuming response would have been to leave the item blank or write “n/a” however, in forty percent of workbook sessions, clients took the time to list very specific examples of what they perceived as negative process. For these reasons, this figure (as opposed to the nine percent frequency estimated by the Alliance Retrospective) is considered the more accurate estimate of the true frequency of client-perceived negative process within the workbook condition.

Comparison of the Alliance Retrospective responses and the workbook responses revealed that most clients who reported specific instances of negative process within the workbook did not report negative process in the Alliance Retrospective for the same session. Table 13 provides examples of workbook responses from four clients who had negative process items endorsed within their workbooks. Typical of most clients who endorsed negative process within their workbook responses, clients A and B did not endorse negative process within their Alliance Retrospectives. Conversely, clients C and D indicated negative process within both formats. Why was the workbook more effective in eliciting client-reported negative process? First, the highly specific semantics in the workbook may have been more effective at evoking recollections of negative process. Additionally, informal review of workbook responses showed that for sessions in which clients wrote about negative process, the vast majority appeared to walk away from their session with overall positive feelings about their therapy experience (this information could be gathered from the last workbook exercise which required clients to write freely about their collective feelings about their therapy session). Further, it appeared that when clients did indicate negative process on the Alliance Retrospective, it was typically after sessions that they considered almost entirely negative, both in terms of the feelings within the alliance and about the helpfulness of sessions. Wholly negative reactions like these (as illustrated by clients C and D) appeared to occur very infrequently. By and large, examination of actual workbook responses revealed that most clients appeared quite pleased with their sessions. Thus, it could be that when clients had overall positive feelings about their sessions, and then completed the Alliance Retrospective, they either did not recall any specific negative process, or perhaps felt uncomfortable admitting to
Table 13

**Selected Workbook and Alliance Retrospective (A.R.) Responses**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Item</th>
<th>Patient Workbook Responses</th>
<th>A.R. Negative Process?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>6</td>
<td>Going through biological, jargon-filled explanations</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>I feel like we didn’t get to really talk through things, I felt the discussion was more medical based than emotion based. I don’t really think we got to talk about me as a person. He pretty much looked through a book and checked off any symptoms I had… For the most part, I really enjoyed my session today, I just hope we can talk more next time.</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>7</td>
<td>(Therapist) asked me some things I wasn’t sure I was ready to tell, but how was he to know?</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Seemed a bit anxious to leave the session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Told me he was recommending me for medication. I didn’t know how he could tell after only one session.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>When I sat down and he asked me something about why I was there, my first thought was, ‘well you should know, assuming you read the papers I filled out.’ Maybe he just did that to get me started, I don’t know… I felt comfortable in his presence and felt he was genuinely concerned… He made me feel like he was interested in the things I had to say.</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>6</td>
<td>He didn’t really prompt me to talk/explain, just smiled and nodded and then told completely unrelated anecdotes.</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Feeling like this guy had no idea what I was really trying to say.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Said, “Well, yes, you will have to look perfect if you want to be an actress.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Seemed to find pot/drinking as the reason for everything bothering me</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>I will feel horrible if the man who was my therapist today reads this, But I just really don’t think he could help me at all. He was very patronizing and just seemed to nod and say okay to whatever I said. He seemed to focus on things that I tried to explain are not of focus to me.</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>7</td>
<td>Not being able to discuss what I really came in for.</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>6 and 3</td>
<td>He told me I was a perfectionist, and he took a minor problem and lectured me on it.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>We couldn’t communicate what my real reason for coming was.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Talked more about physical and material aspects than what I wanted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>I did not like this session at all. I was uncomfortable talking about certain things. I felt analyzed and criticized. I just wanted a stranger to listen to me. I even asked to end the session early because he wasn’t telling me anything I didn’t already know. I wanted to discuss the emotions behind (my behaviors) rather than the behaviors themselves. I felt that all we did was run around in circles. This session did not help me at all.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Incomplete statement items “1” = I felt frustrated when my therapist… 2= “I felt criticized when my therapist” 3= “My feelings were hurt when my therapist” 4= “I felt misunderstood when my therapist” 5= “I felt confused when my therapist…” 6=“Some things my therapist said or did today that I feel were unhelpful were…” 7= “The most difficult aspect of my session today was…” 8= Positive and negative statements found within last workbook exercise in which clients could write about all of their post-session thoughts and feelings.
general negative process after a session about which they felt positively overall. In order to verify these theories, a more formal study would be necessary.

Although the exact reasons for the differences in reported frequencies can only be speculated, the highly specific nature of the workbook items would indicate that the frequencies derived from it are a more accurate estimation of the occurrence of negative process. Returning now to the original proposal that the workbook would facilitate greater awareness of negative process, due to the measurement problem with the Alliance Retrospective, the current research failed to provide evidence to either support or refute this hypothesis. Although negative process occurred in at least 40% of workbook condition sessions, the true frequency of negative process within the control condition could not be obtained. It is quite possible that use of the workbook did affect client awareness of negative process and that this 40% is attributable, in part, to the experimental manipulation. However, without a direct control comparison, this cannot be known with certainty. The current research cannot provide a definitive conclusion on this matter.

Another intended, in-session effect of the workbook was to facilitate patient-therapist discussions of negative process. According to the Alliance Retrospective, the workbook did not facilitate such discussions. When negative process occurred, it was discussed only 16% of the time, regardless of condition. One problem with this data is that the Alliance Retrospective was designed such that clients first identified whether there was negative process in the session (which previously has been deemed inaccurate) and then would answer additional questions about whether the negative process was discussed. When clients did not identify negative process on the Alliance Retrospective, they were instructed to skip the questions regarding discussions of negative process. For this reason, the Alliance Retrospective is likely to be an inaccurate indicator of the true frequency of negative process discussions, however, it is impossible to tell to what extent it underreported such discussions, and equally impossible to detect whether there were treatment differences.

In summary, use of the workbook accomplished some, but not all, of the in-session effects presumed to ultimately affect the strength of the alliance. Task and goal discussions were facilitated as hypothesized, but the investigation failed to provide an
accurate indication of whether the workbook facilitated heightened awareness of negative process or more frequent discussions of negative process as intended. At least forty percent of sessions in the workbook condition contained negative process, but it could not be determined whether this frequency was affected by clients’ use of the workbook, or whether this value was the same as it was in the control condition. Although the current research lacked the appropriate controls to establish that this value was attributable to the experimental manipulation, in light of known client reticence to provide critical feedback about the treatment process (Hill, et al., 1992; Regan & Hill, 1992), this forty percent figure appears too high to have occurred on its own without the use of the workbook. Anecdotally, most clinicians who review Table 13 would likely realize how rare this specific type of client feedback is within the treatment process, particularly in early sessions. Most clinicians might surmise that this specific feedback would not have been obtained without implementation of the workbook. Of course, this must be established through future research that permits direct comparisons between conditions. Another important consideration is although task and goal discussions increased, and it is suspected that client awareness and admission of negative process increased, less is known about how therapists handled this information and how it may have impacted sessions and the alliance. The next section addresses these issues.

Within-Session Effects of the Workbook: Session Impact

Clients and therapists completed the Session Evaluation Questionnaire in order to provide a general indication of the “impact” of their sessions. It was hypothesized that clients and therapists who used the workbook would report having sessions with greater emotional meaning (i.e., more depth) and also greater ease of relating within the therapy dyad (i.e., more smoothness). Results of the investigation failed to support these hypotheses: Use of the workbook did not affect client or therapist perceptions of the depth or smoothness of their sessions. Workbook participants did not rate their sessions as being deeper or more emotionally meaningful than did clients in the control condition. Similarly, there were no treatment differences in client or therapist ratings of the smoothness of the sessions.

There are several plausible interpretations for these findings. The most parsimonious explanation is that the workbook simply failed to have any effect on the
smoothness or depth of sessions. Alternatively, it may be speculated that the workbook did have an impact, but other factors were stronger influences and negated any effects of the workbook. There are myriad factors that affect the therapy process within any given therapy hour, and these factors combine to produce an overall evaluation of the session. Such factors may include, but are not limited to, previous therapy experiences, the quality of the alliance prior to the session, the patient’s affective state prior to session, therapist interventions and timing of interventions, client readiness for change, severity of patient symptoms, etc. These are just a few possibilities, most of which were not monitored or controlled for during the study. Thus, it is possible that the workbook had some positive effects, but they were not powerful enough to be detected above and beyond these other important therapy factors that contribute to the typical therapy session.

In addition to these factors that influence therapy sessions in general, within the workbook condition, there were several other factors that undoubtedly could have affected perceptions about the session, and the effectiveness of the workbook in general. For example, how much effort did clients put forth in completing the workbook exercises? Did therapists read the workbook before their sessions? Did therapists address any negative process or other important issues that they observed within the workbook? If so, did they do so nondefensively and with astute clinical timing? Was negative process (which occurred in 40% of workbook sessions) appropriately addressed and resolved? Systematic observation of these process variables were beyond the scope of the present study, thus relatively little is known about how therapists and clients actually utilized the workbook within their therapy process. The following discussion includes theories regarding possible effects of these workbook-specific process variables.

It is clear from visual examination of the workbook responses that clients put forth varying degrees of time and effort into their workbook responses. For example, in the last workbook exercise wherein clients were asked to write their deepest thoughts and feelings about their therapy process and progress, there was a broad range of length of patients’ written responses (and presumably time involved) to this exercise. The vast majority of clients appeared to put forth considerable time and effort into this workbook exercise. Informal estimates of response length showed that typical responses were approximately 100 words in length. The range went from zero words (e.g., clients who simply skipped
the whole exercise) to cases in which clients wrote over 300 words. Consider the following examples of actual client responses: Patient E had an unusually brief response with the following 19 words: “I still don’t think I can just try to strike up conversations with people. I don’t know what else.” Patient F provided another unusually brief response in 23 words; “It’s too early to say much, but I have listed the goals I want to meet. I hope to work on that more.” Next, consider patient G who wrote a profound statement in 60 words:

Coming to therapy was my last hope. I think if I hadn’t talked to someone, I probably would have ended my life. I don’t want to be this way and keep feeling this hurt. I feel like such a bitch. But after speaking with the therapist, I feel motivated to get back on track and start facing my problems again.

The next two examples were very typical in length: Patient H wrote:

When it was time to come to my first session I was a little nervous about how I thought that it would turn out. I am not the type of person who is very open about my own personal feelings and I was a bit skeptical as to if counseling was beneficial for people like me. But as I progressed into the session, I noticed that I was beginning to open up and talk more about my feelings once I knew someone was there to listen to me and what I had to say.

Patient J wrote a similar amount:

I’ve been to see a few counselors in the past, but this was the first time I truly felt comfortable talking to the other person. That really makes me feel good about my personal progress thus far, and it reassures me that (therapist) and I will be able to establish a relationship in which I can work through my feelings. Her reassurance that I’ve taken the right steps to this point reminded me that I am in control of what I do and that I am capable of getting through this. I’m extremely optimistic about the rest of my sessions.

What is clear from the above examples is that the sessions themselves affect client responses to this exercise. Clients who put forth considerable time and effort to attune to their inner, deepest feelings about their treatment experience and express them in writing may have felt their sessions were deeper or meaningful than clients who wrote only brief responses. Additionally, clients who were more insightful and introspective to begin, may
have written more in their workbook exercises, which could have an impact on subsequent sessions. In this way, the relationship between the depth of the session and the amount of effort in responding to the workbook could be reciprocal. Clients’ pre-treatment experiences with expressive writing, or simply their feelings about their writing abilities, also may have affected the extent to which they utilized the workbook, and ultimately how the use of the workbook affected their sessions and general therapy experience.

Therapists were asked to report whether they read their clients’ workbook responses prior to the sessions. Although the majority of the time (61%) therapists did report reading their clients workbook responses prior to sessions, at least 13% of sessions commenced without such therapist review. By virtue of the fact that a portion of sessions occurred in which therapists did not respond to this question, there were another 26% of sessions in which it was unclear whether therapists read the workbook responses before sessions. (It is suspected that cases in which therapists left this item blank may be indicative of therapists not having read their clients workbook responses - - an explanation of this will follow). Therefore, the frequency in which therapists failed to read the workbook responses may have been as high as 39% of workbook sessions. It should be noted that at least a portion of time, failure to read the workbook was due to the fact that patients’ workbook responses were not returned to therapists’ mailboxes in time for review. In other cases, therapists simply may not have had time to read the responses or may have forgotten to review them before sessions.

Therapists’ failure to read their clients’ workbook responses was problematic for two reasons. First, clients were under the impression that therapists would read their workbook responses prior to the subsequent session. This was made known to clients before they completed their workbook exercises. Many clients wrote about very profound feelings and issues within their workbooks, some of which may not have been expressed verbally during their therapy sessions. Consider how disheartening it may have been for a client to have written some of her deepest thoughts and feelings with the belief that her therapist would read them before the next session, only to attend that next session and have it become evident that the therapist was unaware of these profound insights and clearly had not read the workbook. Although the initial act of thinking and writing about these insights within the workbook may have been therapeutic in itself for patients, it may
have been equally countertherapeutic if therapists did not read these written responses, especially if clients interpreted this as lack of interest or caring on the part of the therapist, or as a reason to mistrust the therapist given the fact that clients were led to believe that therapists would read the workbook.

Second, and more specifically, clients were asked to take a risk in sharing honest, critical feedback about their treatment process. They were assured that their therapists were interested in such feedback in order to make corrective adjustments to facilitate clients’ therapy experiences. Previous research (Hill et al., 1992; Regan & Hill, 1992) has shown that clients are quite reticent to provide such feedback, yet within the current study, clients who used the workbook risked doing so in nearly half of all sessions (40%). In these instances, clients may have perceived negative process in their first sessions, wrote about it, expected a therapist response within the second session, only to discover that their therapist continued to make the same “error” in the second session because the therapist had not read the workbook. In such instances, it is conceivable that therapist inaction could have undermined any otherwise useful effects of the workbook in terms of session depth or smoothness, or in terms of clients felt experience within their therapy hour in general.

Clearly, when therapists did not read clients’ workbook exercises, it posed a risk in creating an alliance rupture when one did not exist previously, and/or making an existing alliance problem worse! To complicate matters further, when therapists did read the workbook responses and responded in some way to their clients, it could not be known with certainty whether their responses were therapeutic. Participating therapists did receive instruction on the importance of reading their clients workbook responses, and on the importance of responding to patient feedback in a nondefensive manner, however, whether therapists were able to respond therapeutically remains largely unanswered. Previous research (e.g., Henry, et al., 1993) illustrated that therapeutic responses to alliance and other interpersonal issues are related to therapist introjects. In the current study, it is possible that therapist introjects, or perhaps ego strength in general, could have influenced the quality and helpfulness of their responses to negative feedback. These therapist variables were not measured in the current study.

It is evident from the above discussions that there are a considerable amount of
prerequisites theorized as necessary for the workbook to achieve its intended therapeutic impacts. Several preconditions (e.g., client effort, therapist responsiveness) seem likely to mediate the potential effects of the workbook. Although most of these potentially mediating variables were not measured in the study, the investigator was able to examine the effects of therapist reading versus not reading their clients’ workbook responses prior to sessions. A discussion of these findings follows.

At sessions 2 and 3 within the workbook condition, therapists were asked, “Did you read your client’s workbook responses prior to today’s session?” As previously mentioned, in 26% of sessions, this question was left blank. It was suspected that a blank response was indicative of a “no” response. For this reason, blank responses were combined with “no” responses to create two groups: Subjects whose therapists had read their workbook responses prior to session two versus subjects whose therapists did not read their workbook responses prior to the session. Although no differences were found in overall alliance scores between these two groups, there were many differences between them with respect to session impact ratings, particularly session depth/value. When therapists read their clients’ post-session 1 workbook responses, therapists rated subsequent sessions (2 and 3) as deeper and more valuable than when therapists had not read the workbook. Additionally, client-rated depth at session 2 and therapist-rated smoothness at session 3 approached significance.

Clearly, whether therapists read the workbook had an affect on subsequent sessions, however, there are several ways to interpret these findings. Consider the following alternatives. A client reveals important aspects of himself within his written workbook responses, the therapist reads the workbook, develops an increased understanding of client dynamics, and utilizes this knowledge to continue to develop the treatment process, thus, making subsequent sessions deeper and more valuable. Alternatively, a client might have become aware that her therapist did not read her workbook responses, felt slighted, and then became more cautious and guarded with her feelings and explorations in subsequent sessions, thus negatively impacting the depth of those sessions. Either one of these scenarios could have accounted for the group differences in session impact scores, or perhaps a combination of the two. Unfortunately, the data do not provide answers as to whether reading the workbook enhanced subsequent
session impact, or whether failure to read the workbook resulted in lowered session impact ratings.

Returning now to the issue of blank responses to the question, “Did you read your client’s workbook responses prior to today’s session,” if this item was left blank for random reasons, it would be unlikely that including them with the “no” responses would have yielded group differences as they did. The fact that there were significant group differences in the hypothesized direction suggests that therapists leaving the item blank was not random. Although this cannot be determined with certainty, the data do support the suspicion that blank responses meant that therapists had not read their clients’ workbook responses. Taken together, these data indicate that therapists reading their clients’ workbook responses had an effect on the impact of subsequent sessions. Session impact ratings appeared to be influenced by this variable, however the interpretation of this finding is less certain. Does this mean that reading the workbook led to higher session impact? Or does it indicate that failure to read the workbook resulted in lowered session impact ratings? Future research is needed to clarify the meaning of these effects.

In summary, data from the current study revealed that for the whole sample, there were not group differences in terms of session impact. That is, when all clients were compared, the workbook did not appear to have any impact on depth or smoothness of sessions. Due to the fact that therapists reading the workbook produced differential effects on session impact ratings, the null findings for the whole sample must be interpreted with caution. They cannot be taken to indicate that the workbook had no effect on session impact. Rather, these findings support the theory that there are several preconditions which render the use of the workbook more or less effective – one of the preconditions being whether therapists read the workbook in between sessions as intended. The current data did not allow for tests of the other aforementioned preconditions (e.g., client effort, therapist interventions in response to the workbook feedback), however, it is not difficult to imagine the potential profound effects that these conditions might have on the effectiveness of the workbook. All of these uncertainties point to the need for future studies that employ observational data collection methods (e.g. tape recordings of sessions) in order to more carefully appraise how the workbook is utilized and how it impacts sessions.
Overall Effects of the Workbook on Alliance and Outcome

Although the workbook did serve to increase task and goal discussions, the effects of this on measures of overall alliance and outcome were not strong. Outcome, as measured by the OQ symptom index, was not affected by the use of the workbook. Mean OQ scores for both groups decreased across sessions, but there were no group differences between conditions. Similarly, overall alliance scores were nearly identical in both conditions and not statistically significant: Mean alliance scores for both groups in the sample improved between sessions 1 and 3, but there were no group differences in the magnitude of change.

The workbook was designed to facilitate improvements within the alliance, which, in turn, would be related to better outcomes. In light of the findings that the workbook produced few of its intended, in-session effects, it is a logical result that there were no observable differences in alliance and outcome. In order to affect alliance and outcome, something must first occur within sessions, and as previously discussed, there were minimal in-session effects. There was an increase in the likelihood of discussing tasks and goals in session, and a likely increase in client admission of negative process, but this evidently was not powerful enough to produce any noticeable improvements in either global alliance or outcome scores.

Effectiveness of the Workbook With Clients with Low Alliances

Many subjects began the study with relatively high alliances after their first session. This was an important consideration because patients with high alliances to begin, presumably have less need for improvements in the alliance, and therefore, less need for a workbook to facilitate the alliance. It was hypothesized that patients with initially low alliances, in particular, would benefit from the workbook. The data revealed that workbook condition patients with initially low alliances, indeed, had more improvement in alliance by the second session (an effect that approached statistical significance) than did controls. However, by the third session, the amount of improvement in the alliance was equal between groups. In other words, use of the workbook appeared to affect the alliance at session 2, but by session 3, the effect had leveled out such that clients who did not use the workbook had arrived at a similar quality of the alliance on their own (see Figure 1). How can these findings be interpreted? One possibility is that the near-significant findings at session 2 are attributable to random error and not to the
Figure 1

WAI scores of Subjects with Low Alliances at Session 1

Note:  C = Control condition subjects (n= 23 for session 1 and 2, n=14 for session 3)
W= Workbook condition subjects. (n=23 for sessions 1 and 2, n=12 for session 3)

experimental manipulation. Conversely, if we are to believe that this finding is, in fact, attributable to the use of the workbook, how can it be explained in light of the absence of group differences at session 3, and if this difference is a real treatment effect, is it a clinically meaningful difference? It should be noted here that some subjects who provided
alliance data at sessions 1 and 2 had dropped out of the study by session 3, therefore, the session 3 data was for a different sample. If the findings were attributable to the experimental manipulation, one interpretation of the null findings at session 3 is that the workbook condition subjects who had the highest alliances at session 2 may have been the same subjects who dropped out of the study by session 3, which could have accounted for what appears to be a reduction in alliance scores at session 3. This is one example of how the data was complicated to interpret, and illustrates the importance of replication studies to verify these tentative findings.

For therapy dyads who utilized the workbook, session two is a unique session in that it was the first opportunity for the effects of the workbook to be felt by client and therapist together within a session: It was the first session subsequent to clients completing the workbook for the first time and therapists reviewing their responses. For this reason, it is conceivable that the workbook might have a larger, more noticeable effect on session 2 compared to session 3, thus accounting for a boost in alliance at session 2 and a leveling out by session 3. Perhaps these low alliance subjects got what they needed from the workbook at session 2 and did not need “more of it” for session 3. This issue has been addressed previously in psychotherapy research (Stiles & Shapiro, 1989): psychotherapy process variables may reach a “good enough” level such that more is not necessarily better. Indeed, data from this analysis suggest that at least with clients with initially low alliances, one dose (i.e., completing the workbook only after the first session) is good enough to positively affect the alliance. Providing more of the workbook is not better.

Turning now to the issue of clinical meaning/utility, with low alliance clients, is there benefit to using a workbook that appears to boost the strength of the alliance at session 2, if by session 3, those who do not use the workbook achieve the same strength of the alliance? Although data in the current study do not provide a solution to this matter, the question itself is intriguing and generates additional inquiries for future research. For example, does the process of using the workbook (as opposed to not using it) lead to any qualitative differences in the therapy alliance undetectable by traditional alliance measures (e.g., the WAI)? Is there some unmeasured value in clients’ and therapists’ shared experience of using the workbook? Might the workbook be of value to
subjects who end treatment after two sessions (i.e., is there a value in leaving/ending treatment with a stronger alliance)? Future studies would be useful to (1) determine whether this boost in alliance at session 2 could be replicated (especially in light of the fact that this effect only approaches statistical significance in the current study; (2) study mediating variables that may account for the boost at session 2 and the leveling out of alliance scores by session 3; and (3) examine other qualitative differences in therapy dyads who use the workbook versus dyads who do not.

**Effectiveness of the Workbook with Clients with Low Social Skills.**

Clients’ social skills were hypothesized to mediate the effectiveness of the workbook, but the data did not substantiate these hypotheses. That client social skills were not related to the effectiveness of the workbook is not surprising in light of previous discussions illustrating the potential for unmeasured variables to mediate the usefulness of the workbook. For instance, there may be relationship between client social skills and ability to benefit from the workbook, but benefits may be mediated by still other treatment variables, therapist variables, and/or client variables. The true relationship between client social skills and the workbook, if one exists, is likely to be a complex interaction between client variables, and a multitude of other factors including therapist social skills, pre-treatment symptoms, interpersonal problems, previous experiences with therapy, only to name a few.

**Summary and Conclusions**

Prior to the development of the Alliance Workbook, there were no known psychotherapy workbooks designed to facilitate the therapeutic alliance. The current study was the first of its kind at evaluating the effectiveness of such a workbook. Although the study provided few definitive findings regarding the overall impact of the workbook, it was informative in bringing to light the complexities and possible preconditions involved in its use. There was a methodological complication (i.e., failure of the Alliance Retrospective to provide an accurate comparison of the frequency of negative process and negative process discussions across conditions) that rendered interpretation of many of the results complicated. The Alliance Retrospective was a means of verifying that the workbook accomplished what it was intended to do: (1) increase task and goal discussions, (2) increase client awareness of negative process; (3) increase client-therapist
discussions of negative process. These were mediating variables that were intended to
ultimately affect the alliance. Interpretations of many of the findings in the study were
difficult without an accurate indication of whether these experimental manipulations
occurred as intended.

Use of the workbook clearly increased the likelihood of patients and therapists
engaging in discussions of therapy tasks and goals, but whether this increased frequency
was clinically meaningful is not known, as were the quality of these discussions and their
overall impact on the treatment process. Clearly, increasing the frequency of such
discussions alone, was not powerful enough to lead to treatment differences on many of
the major variables of interest in the study. Total alliance and symptom scores were
remarkably similar for both conditions at each session of the study.

In the workbook condition, a large proportion of sessions occurred in which
clients noticed and wrote about negative process. Again, due to the measurement problem
with the Alliance Retrospective (i.e., lack of specificity) it could not be determined with
certainty whether this high frequency of reported negative process within the workbook
condition was due to the use of the workbook. Clinical intuition would suggest, however,
that the frequency and specificity of the feedback obtained via the workbook is rare within
the typical treatment process. Although the discovery of the measurement problem with
the Alliance Retrospective was unfortunate for the current study, it inadvertently provided
indirect support for what has been found in previous research. Others (e.g., Bischoff et
al., 1996) have noted that verbal, “checking in” during therapy sessions often yields vague,
unhelpful responses from clients. One rationale for the creation of the present workbook
was that, presumable, if asked for specific feedback in a written format away from the
actual therapy session, clients would produce more specific, honest feedback. The current
research provided preliminary support for the effectiveness of the workbook in generating
highly specific client feedback.

What is known about the value of using the Alliance Workbook? Use of the
workbook facilitates client-therapist discussions of therapy tasks and goals, an important
aspect of the developing alliance. The highly specific format of the workbook appears to
generate more frequent and specific client feedback than would usually be obtained within
the typical therapy process. Use of the workbook does not result in more change in the
alliance or better outcomes for all therapy participants, although there is some evidence that the workbook may provide a quicker than usual increase in the strength of the alliance between sessions 1 and 2 for clients who begin treatment with low alliances. Use of the workbook, in general, does not positively affect the depth/value of sessions or the ease of relating within the dyad. However, therapists who employ the workbook should make certain to read their clients' workbook responses prior to sessions because this results in deeper, more valuable sessions compared to when the workbook is not read. Finally, it appears that client social skills do not mediate the effectiveness of the workbook; it was not differentially effective based on the degree of client social skills.

In conclusion, is the alliance workbook effective in enhancing the early treatment process? Maybe. Perhaps for some clients, under certain conditions, it may be a useful adjunct to therapy as usual, but this cannot be said for all therapy dyads under all conditions. One promising aspect of the current research is that it revealed that clients are willing to utilize the workbook. There was very little incentive for clients to participate in either condition of the study, yet drop-out rates were proportionate across conditions. Informal review of clients' workbook responses revealed that most clients who used the workbook seemed to take it seriously and put considerable time and effort into their responses. Because clients are willing to use such a tool that is inexpensive and likely to provide more specific feedback than clients typically offer about the treatment process, there is merit for its continued use and evaluation. One potential use of the workbook is for therapists in training. The workbook may provide a valuable method for therapists to collect data on how they affect their clients' qualitative experience within the treatment process. Therapists could use information from the workbook to evaluate how their clients typically respond to them in early sessions, and to identify highly idiosyncratic client responses that might be indications of early transference phenomena.

One of the most important findings from the current research is that despite known client reticence to provide critical (especially negative) feedback (Hill et al., 1992; Regan & Hill, 1992; Rennie, 1994), clients who used the workbook appeared quite willing to provide critical feedback about their treatment process. Such feedback provides crucial information that may help therapists identify alliance problems and subsequently make reparative interventions. Whereas previous research has focused on intervention strategies...
(i.e., therapist actions that address the alliance (e.g., Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Henry et al., 1993) the alliance workbook shows promise as a tool for early assessment of the state of the alliance. In contrast to previous research, the emphasis of the current study was on early detection of alliance problems, and less emphasis was placed on controlling subsequent therapist interventions. Because assessment is so crucial to subsequent interventions, future investigations may prove more productive by combining both aspects: The alliance workbook could be used as an assessment method employed by therapists who have previously participated in formalized training in methods to address the alliance.

More research is necessary to further examine the effectiveness of the workbook in influencing treatment process and outcome variables. There are many variables that possibly mediate the effectiveness of the workbook, including whether therapists read the workbook as intended, and the degree to which therapists responded therapeutically to their clients’ feedback. To this end, observation of in-session therapist interventions and client responses would also be a fruitful direction for future research.
References


Freud, S. (1913). On beginning the treatment: Further recommendations on the


Appendix A: The Alliance Workbook

Orientation

What makes therapy work?

Therapy is often effective in helping people who are experiencing problems they find distressing. Research shows that an important factor involved in successful therapy is the working relationship you have with your therapist. Within this relationship, it is important for you to feel supported, cared for, listened to, and treated with respect. It is also important that you and your therapist come to an agreement about your goals for therapy and have a mutual understanding of what sorts of things both of you will do in session in order for the goals to be met.

Another important factor that contributes to successful therapy is client involvement. Being actively involved in the process of your sessions makes you more likely to benefit from therapy. One way to be actively involved is to pay attention to your goals for therapy and how the work you do with your therapist will help you achieve these goals. If you are uncertain about aspects of your therapy, or perhaps even dissatisfied, it is important to discuss these issues with your therapist. Discussing these issues is a great way to stay involved with the process of your treatment.

Is there anything I can do to make my therapy more effective (and thus, increase the likelihood of achieving my goals).

Yes. Although the working relationship and client involvement are not the only factors involved in successful therapy, these factors are very important because they are partially under your control. The study that you are participating in is designed to facilitate both of these factors within your therapy, and thus, maximize the potential for good therapy outcomes.

What is involved with this study?

The study is very simple: Immediately after your first three sessions, you will be asked to answer some questions, in writing, that are designed to help you reflect on your therapeutic relationship and your progress. You will answer these questions in private, but will leave your responses at Counseling and Psychological Services for your therapist to review before your next session. Your therapist has chosen to participate in this study because he/she wants to provide you with the best treatment possible. Therapy is an extremely individualized endeavor, and your responses to the after-session questions will help your therapist tailor treatment to your needs.

The study involves therapy as usual, but simply requires you to be more involved with your therapy by answering questions about your relationship with your therapist and about your progress toward therapy goals. You will have customary, individual therapy sessions offered at Counseling and Psychological Services, only you will stay at the center for approximately 30 minutes after your first three sessions to reflect on the session and what you would like to see happen in future sessions.

Your responses to after-session questions will be seen by you and your therapist. Because we are using these materials within a study, the researcher will also see your responses, but will not have access to your name or any other confidential information. For this reason, we ask that you do not write your name on any of your materials except on the cover sheet where indicated. This cover sheet will let your therapist know that the responses are yours. The cover sheet will be removed and shredded before your responses go to the researcher so that you will remain anonymous.
Appendix A: continued

**How will participating in this study benefit me?**
Participating in the study is intended to benefit you in the following ways:

1. It will help you establish clear goals and will help you and your therapist monitor your early progress.
2. It will provide a structured time for you to reflect on your therapy and progress, thus increasing your involvement in and responsibility for your own treatment. Being more involved in your own therapy in this way is related to having better therapy outcomes.
3. It will help you and your therapist gauge the therapeutic relationship. Providing feedback to your therapist about this relationship will help him/her make adjustments that can improve your relationship. Having a good therapeutic relationship increases the likelihood of having positive therapy outcomes.

**A note about negative feedback.**
Your therapist wants honest, direct feedback about all aspects of your therapy including how he/she is responding. This includes both positive and negative feedback. Being honest about negative feedback is sometimes difficult for students. You might find yourself hesitating to write anything negative. Although this is a very understandable response to this task, we ask that you set aside any hesitation. If there are aspects of the therapy you are dissatisfied with, your therapist wants to know so he/she can make adjustments in order to provide you with a better therapy experience. Similar feedback procedures have been used before in therapy. The clients and therapists who used these found them to be very helpful.

**A reminder about communicating with your therapist.**
Using the after-session materials will provide you with a concrete way to reflect on your therapy experience. However, your written responses to the questions are *not intended to replace face-to-face communication* about important aspects of your therapy experience. We encourage you to use the materials to help you identify and understand your reactions to therapy, but to speak about these reactions with your therapist in person. Speaking about these kinds of issues with your therapist is a very normal, useful part of the therapy process.

**Note.** The Orientation shown here is the orientation for the workbook condition. A brief Orientation was also included for control condition subjects. 1 = indicates that the preceding paragraph was included within the orientation for the control condition.
EXERCISE 1: SESSION GOALS

Sometimes it’s hard to define exactly what your goals are. This is okay. Your goals should become clearer in future sessions with your therapist. Even if you know what the problem is, sometimes it’s hard to know why it is occurring. This is also common and should become clearer as your therapy progresses. For now, just record as much as you can as a way to help you structure your thoughts about your first session.

1. The problem I most want to work on in therapy is: (e.g., I feel depressed):

2. How much was I bothered by this problem in the last week?
   (circle one): Not at all Slightly Moderately Severely Very Severely

3. What are some possible ways other people or circumstances are contributing to this problem?

4. What are some possible ways that I am contributing to the problem?

5. What can I do to change this problem right now? (examples include: Continue to gain support from my therapist. Gain support from friends/family. Change something about my environment. Change the way I am behaving. Change my attitude/thinking about something).

6. Do you feel like you and your therapist have reached an agreement about which problems you should address in treatment? (Please circle yes or no)

   Yes. (As much as possible given this was my first session)

   No. (If no, please explain here):

Note: It is important for you and your therapist to come to a mutual understanding of what should be addressed in your therapy. Although it often takes a few sessions to reach this understanding, if you marked NO to question 6, it would be a good idea to begin to address this with your therapist during your next session.
EXERCISE 2: SESSION REACTIONS (PART A)

The most difficult aspect of today’s session was:

My therapist made this easier for me by:

My therapist made this more difficult for me by:

Some things my therapist said or did today that I feel good about or feel were helpful were:

Some things my therapist said or did today that I feel were unhelpful were:

I wish my therapist would have: Next session, I might like to focus more on:
EXERCISE 3: SESSION REACTIONS (PART B)

Please read the following information before completing this exercise:

In the beginning of all relationships, there is a period of time in which individuals learn the best way to relate to each other. This period of time is likely to include some aspects you feel good about but may also include some aspects about which you feel uncertain or perhaps uncomfortable. This is very normal since no relationships are flawless.

You may experience a similar period of time with your therapist. The good news is that your therapist is extremely interested in your welfare in general, and especially in how you are experiencing your work with him/her. An excellent way to work through any concerns you may have about your therapy is to discuss your concerns or dissatisfactions with your therapist. This very normal and useful part of the therapy process can often improve the quality of your therapy and may also provide you with new experiences and learning about healthy communication and problem-solving.

Instructions: Please complete the following statements about today’s session.

If the statement does not characterize any of your experiences today, write n/a

During today’s session, I felt understood by my therapist when:

During today’s session, I felt misunderstood by my therapist when:

I felt hopeful when my therapist:

My feelings were little hurt when my therapist:

I felt relieved when:

I felt frustrated when my therapist:

I felt confused when my therapist:

I felt somewhat criticized when my therapist:

During today’s session I felt cared for and supported when my therapist:

My therapist communicated a sense of respect for me by:
EXERCISE 4: PROCESS/PROGRESS NOTE

As a final exercise for today, you are asked to write a process/progress note about your session. Writing your own note about what the process of this session was like and any thoughts/feelings you have about your own progress is an excellent way to stimulate you to continue to think about important issues, whether it’s on your own, or with others.

Instructions: Your task is to write about your very deepest thoughts and feelings about coming to therapy today and what this experience was like for you. In your writing, try to let yourself go and write continuously about your emotions and thoughts about your session, including feelings you had within the presence of your therapist, feelings about what was said and done in your session, and what you are taking from your session today. The primary task is for you to reflect on your most basic thoughts and emotions about your session today.

Begin now and try to write for at least 5 minutes. Use the back of this sheet as needed.
Appendix B: Client Demographic Questionnaire

Please provide the following information about yourself:

Age _______

Gender ____________

Race/ethnicity:

___ African-American  
___ American Indian/Alaskan Native  
___ Asian/Pacific Islander  
___ Caucasian  
___ Latino/Hispanic  
___ Other (specify)

Year in School:  
___ Freshman  
___ Sophomore  
___ Junior  
___ Senior  
___ Graduate

Have you ever received therapy/counseling before?

If YES, approximately how many sessions did you receive?
Appendix C: Therapist Demographic Questionnaire

Age __________

Gender __________

How many years have you been practicing? ________________

Please place a mark next to the theoretical orientation that best describes your work with college students:

____ Cognitive-Behavioral

____ Client-centered

____ Psychodynamic

____ Interpersonal

____ Eclectic

____ Other (please describe)
Appendix D: Alliance Retrospective Questionnaire

1. The list below describes some things that may have occurred in your session TODAY. Place a check mark beside any that apply to your session today.

   __ I was/am dissatisfied with an aspect of how my therapist responded to me.
   __ I had/have negative feelings about something my therapist said or did.
   __ I had/have negative feelings about how my therapy is being conducted.

If you placed a check by any of the above items, please answer question 2. Otherwise, go to Question 7.

2. In today's session did you and your therapist discuss any of the circumstance(s) you checked from the above list? (For example, if you were dissatisfied with an aspect of how your therapist responded to you, did you and your therapist discuss the fact that you were dissatisfied?)

Note: Please mark YES whether the discussion you had today was about a checked item that occurred in today's session OR if the discussion was about a checked item that occurred in a previous session.

   YES   NO

If you answered YES to question 2, please respond to the following statements according to how characteristic they are of the discussion you had today. If you marked NO, go to question 7.

3. In discussing the issue(s) I checked above, my therapist seemed defensive.
   a. Extremely characteristic of the discussion
   b. Very characteristic of the discussion
   c. Slightly characteristic of the discussion
   d. Slightly uncharacteristic of the discussion
   e. Very uncharacteristic of the discussion
   f. Extremely uncharacteristic of the discussion

4. In discussing the issue(s) I checked above, my therapist showed respect for my feelings and opinions.
   a. Extremely characteristic of the discussion
   b. Very characteristic of the discussion
   c. Slightly characteristic of the discussion
   d. Slightly uncharacteristic of the discussion
   e. Very uncharacteristic of the discussion
   f. Extremely uncharacteristic of the discussion

5. The issue(s) I checked above were resolved through the discussion(s).
   a. Extremely characteristic of the discussion
   b. Very characteristic of the discussion
   c. Slightly characteristic of the discussion
   d. Slightly uncharacteristic of the discussion
   e. Very uncharacteristic of the discussion
   f. Extremely uncharacteristic of the discussion
Appendix D: continued

6. I am satisfied with the outcome of the discussion(s).
   a. Extremely characteristic of the discussion
   b. Very characteristic of the discussion
   c. Slightly characteristic of the discussion
   d. Slightly uncharacteristic of the discussion
   e. Very uncharacteristic of the discussion
   f. Extremely uncharacteristic of the discussion

7. The list below describes some possible topics you and your therapist may have discussed today. Please check any discussions you had in today's session:

   ___ My therapist and I discussed what I wanted out of therapy.
   ___ My therapist and I discussed my goals for therapy.
   ___ We discussed how our work together (what we are doing in-session) will help me get what I want out of therapy.
   ___ We discussed possible ways to work with my problem(s).

If you had any of the discussions listed in question 7, please respond to the following statements according to how characteristic they are of these discussion(s):

8. The discussion(s) was/were helpful.
   a. Extremely characteristic of the discussion
   b. Very characteristic of the discussion
   c. Slightly characteristic of the discussion
   d. Slightly uncharacteristic of the discussion
   e. Very uncharacteristic of the discussion
   f. Extremely uncharacteristic of the discussion

9. I am satisfied with the outcome the discussion(s).
   a. Extremely characteristic of the discussion
   b. Very characteristic of the discussion
   c. Slightly characteristic of the discussion
   d. Slightly uncharacteristic of the discussion
   e. Very uncharacteristic of the discussion
   f. Extremely uncharacteristic of the discussion
Appendix E: Informed Consent

Title of Project: Therapy Processes
Principle Investigator: Jennifer Klimek, M.A.
                    Timothy Anderson, Ph.D.
Department: Psychology
Name of Participant: ___________________________ Age: ______

Federal and university regulations require us to obtain signed consent for participation in research involving human subjects. After reading this statement, please indicate your consent by signing this form.

The following information is provided to inform you about the research project and your participation in it. Please read this form carefully and feel free to ask any questions you may have about the study and/or the information presented below.

1. **The nature of this research project.**
   
   (a) *The purpose of the study* is to gain a better understanding of what makes counseling effective.

   (b) *The procedures participants will be asked to follow in this study* include reading brief information about the therapy process and completing several questionnaires about your therapy experiences in your first 3 sessions.

   (c) *How long is the study?* To participate in the study, you will need to remain at Counseling and Psychological Services for up to 20 minutes immediately following your first 3 sessions. You do not have to commit to 3 sessions in order to participate in this study. If you only have one or two sessions, you may still participate. The study ends after your 3rd session, but you may continue to see your therapist after this.

2. **Discomforts, inconveniences, and/or risks.**

   There are no physical risks involved in this study. The inconvenience involved in this study is the requirement of staying at CPS after each of your first three sessions. In answering the research questionnaires after your sessions, you have the right to choose which information you reveal and you may discontinue participation at any time. Withdrawing from the study will not result in any penalty or loss of benefit.
Appendix E: continued

3. **Direct benefits to you that may reasonably be expected.**

   (a) *You will receive useful information about the therapy process.* Immediately following your first session, you will receive written information about the therapy process that you may find useful for your continued treatment.

   (b) *Participating in the study will provide you with a structured period of time and materials which may help you continue to process important issues related to your therapy.* Thinking about these issues may provide an important bridge between today's session and later sessions.

4. **Your rights, welfare, and privacy will be protected in the following manner:**

   (a) All data obtained will be kept confidential and accessible only to the principle investigator of this project. All written responses will be locked in a secure room and will not be marked with any identifying information. Your responses to questionnaires will be used only for research analyses. **In workbook condition consent form: When indicated, some of your responses will be seen by your therapist for the specific purpose of facilitating your treatment. You will know which responses will be seen by your therapist and which ones will only be used anonymously for research purposes.**

   (b) Should the results of this project be published, you will be referred to only by number.

   (c) Your participation is strictly voluntary and refusal to participate involves no penalty or loss of benefits to which you are otherwise entitled.

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*I have read this consent form and I understand the procedures to be used in this study and the possible risks, inconveniences and/or discomforts that may be involved. All of my questions have been answered. I freely and voluntarily choose to participate. I understand that I may withdraw at any time.*

*I agree that all risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for injury resulting from my participation in this research. I certify that I am at least 18 years old.*

Signature __________________________ Date __________________