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# Identifying Therapeutic Alliance Patterns Among a Feasible Clinical Measure to Improve Treatment Outcome

Tara Marie Staehlin

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IDENTIFYING THERAPEUTIC ALLIANCE PATTERNS AMONG A FEASIBLE CLINICAL  
MEASURE TO IMPROVE TREATMENT OUTCOME

A Dissertation

Presented to the Faculty of  
Antioch University Seattle  
Seattle, WA

In Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Psychology

By  
Tara Marie Staehlin  
August 2016

IDENTIFYING THERAPEUTIC ALLIANCE PATTERNS AMONG A FEASIBLE CLINICAL  
MEASURE TO IMPROVE TREATMENT OUTCOME

This dissertation, by Tara Marie Staehlin, has been approved by the committee members signed below who recommend that it be accepted by the faculty of the Antioch University Seattle at Seattle, WA in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

IDENTIFYING THERAPEUTIC ALLIANCE PATTERNS AMONG A FEASIBLE CLINICAL  
MEASURE TO IMPROVE TREATMENT OUTCOME

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Background: Research has shown a link between therapeutic alliance and treatment outcome, but the definition of alliance and the focus of research has varied across studies. The present study evaluated a possible association between the alliance strength and treatment outcome, which is operationalized by participants' outcome scores and the difference between their first and last self-reported alliance scores, in a sample of children and adolescents seeking treatment at a community mental health facility. Method: 96 children and 239 adolescents who received mental health treatment at a local community clinic were asked to complete two feasible self-reported measures during each therapeutic session, including the Child Session Rating Scale (CSRS) or the Session Rating Scale (SRS) and the Child Outcome Rating Scale (CORS) or the Outcome Rating Scale (ORS) for the current study. Results: Due to the small number of children participants in the alliance groups, it was not possible to explore the relationship between therapeutic alliance and treatment outcome. However, the adolescent participants who ended therapy with a strong therapeutic alliance had a positive treatment outcome when compared to participants who ended therapy with a poor alliance. Overall, the results were inconclusive for the children sample due to the low number of participants and data collected. The overall results for the adolescent sample did show that therapeutic alliance was a significant predictor of treatment outcome. Conclusions: From these results, we can conclude that therapeutic alliance is

an important factor in mental health treatment with young clients. Conversely, the exploratory analyses also suggest that there may be other factors that influence treatment outcome. Possible explanations, such as other stakeholders involved, number of sessions attended, and models/techniques used in treatment, are examined. Implications for practice and suggestions for research are discussed. This dissertation is available in open access at AURA, <http://aura.antioch.edu/> and Ohio Link ETD Center, <https://etd.ohiolink.edu/etd>

Keywords: outcome measures, therapeutic alliance, children, adolescents

## Dedication

This dissertation is dedicated to the clients and clinicians of Lane County Behavioral Health Services in the state of Oregon. Without your involvement, this project would not have been possible. Thank you for contributing to this research and assisting the field of psychology in better understanding the therapeutic process that you experience.

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I would like to thank Dr. Alejandra Suarez for her endless support and guidance through this process. As my dissertation chair, professor, and mentor, she has gone above and beyond anything I could have hoped for. I am grateful for her dedication and challenging me during each phase of my academic experience. Additionally, I would like to acknowledge my committee members, Dr. Jane Harmon Jacobs and Dr. Douglas Kerr. I am appreciative for their assistance and encouragement as I complete the dissertation process.

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## Chapter I: Introduction

Researchers have suggested that clinicians can increase the effectiveness of their work by understanding the concepts of therapeutic relationship and client change (Gelso & Carter, 1994; Lambert & Ogles, 2004). During development of the therapeutic relationship, client change is facilitated as the therapist encourages hope and offers patience, acceptance, genuineness, and unconditional regard (Gelso & Carter, 1994; Lambert & Ogles, 2004). Such support can strengthen the relationship or alliance between the client and therapist, forming a partnership and connection that foster a sense of safety. Under these circumstances, successful treatment outcomes may become more likely. In order to examine these two broad theoretical concepts—the therapeutic relationship and client change—researchers have dissected each separately as well as conjunctively, as overlapping constructs of the dyadic therapeutic process (Gelso & Carter, 1994; Lambert & Ogles, 2004).

In the field of clinical psychology, understanding the relationship between the therapeutic alliance and treatment outcome has posed an ongoing challenge. By learning the underlying processes that contribute to superior results of psychotherapy, clinicians can gain a better understanding of what works effectively in therapy and what does not.

Today, outcome-rating measures continue to be developed and refined to better capture data of various aspects of the therapeutic experience. In order to collect tangible data on treatment progress or lack thereof (Bordin, 1979), researchers have designed outcome measures to capture information pertaining to various patterns of alliance within the therapeutic dyad. Because such measures can assist clinicians and researchers in better understanding various facets and subtleties of the therapeutic relationship, studies that demonstrate their effectiveness are needed to encourage more clinicians to make consistent use of them.

## **Background**

Research has validated the use of feedback measures as supporting the client-counselor relationship, the development and analysis of goals and topics during treatment, the methods and techniques provided by the clinician, and the overall experience of the client. Additionally, feedback measures are a means of obtaining continuous feedback from clients about therapeutic efficacy significantly improves treatment outcome (Lambert, Hansen, & Finch, 2001a). Prior to the year 2000, many valid client feedback measures had been created which therapists could potentially employ in treatment; however, most had been designed for research purposes, and thus their completion required too much time for repeated clinical use. To address this lack of efficient tools for gathering patient feedback, Miller and Duncan (2000) developed two feasible rating scales, the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), with which clinicians can query a client at each session to obtain feedback on outcome and the therapeutic alliance (Duncan, Miller, Huggins, & Sparks, 2003; Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003; Johnson, Miller, & Duncan, 2000). These rating tools are compatible with most therapeutic models and orientations, particularly solution-focused and other brief counseling strategies, because they elicit immediate feedback on the essential aspects of the dyadic therapeutic process.

Since the development and implementation of the ORS and SRS in 2000, research has focused primarily on the instruments' validity and reliability; disregarding the factor of repetitive use over the course of treatment. Gillaspay and Murphy (2011) conducted randomized control trials (RCTs) to assess the measures' psychometric properties with nonclinical and clinical samples of adults, adolescents, and children, supporting its' validity and reliability. . One factor missing from their research has been the discussion of alliance patterns identified by the SRS

instrument, which the present study will address. Specifically, this study will identify alliance patterns by comparing clients' first and last SRS scores, then correlate them with treatment outcomes as measured by the ORS instrument.

Several areas of research relate to this dissertation's topic of alliance patterns and how they subsequently relate to treatment outcome: (a) the therapeutic relationship and client change, (b) the development and meaning of the therapeutic alliance and rapport, (c) feedback, treatment outcome, and efficacy, (d) the therapeutic alliance patterns found in treatment, (e) the SRS and ORS, and (f) use of the SRS and the ORS among adolescents and children. These studies will be further explored in the literature review.

### **Problem Statement**

Can treatment outcome be predicted by collecting therapeutic alliance ratings throughout psychotherapy? Outcome rating measures have not been used routinely as a part of the therapeutic session, a problem in theory and practice. This remains a concern despite interest in such measures from consumers of psychotherapy, professionals, and funders in the mental health industry (Miller, Duncan, Brown, Sparks, & Claud, 2003). Reasons for favoring outcome measures vary among each interested party. For example, clinicians may use outcome measures to gather information about a client's clinical status (e.g., "normal" or within the "clinical range") at intake and throughout the course of treatment. Both the clinician and client may value the use of outcome measures to guide treatment by pointing toward needed changes. Researchers may employ outcome measures to evaluate the amount of improvement for a specific sample over a specific period of time. Finally, organizations in search of funding may be able to use such measures to substantiate the value of their work.



The potential of outcome measures remains largely untapped, but that can be rectified. Despite the many valid reasons for using outcome measures, the vast majority of clinicians have declined to implement them routinely in a treatment setting. Reasons for this resistance include time constraints due to the extent of time required to fill them out, the additional paperwork they create for clinicians, and financial factors (Hatfield & Ogles, 2004, 2007). Some clinicians do not believe the instruments to be helpful, or feel that they interfere with the clinician's autonomy and/or the effects of treatment. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) were created to offset the limitations of previous measurement instruments, offering clinicians a more practical means of soliciting regular client feedback in treatment (Hafkenscheid, Duncan, & Miller, 2010).

If clinicians working with youth prove better able to develop the therapeutic alliance with children, as a result of employing the ORS and/or SRS, their progress will not only increase active participation in youth-oriented mental health services, but also demonstrate client change, fueling the possibility of better outcomes in treatment for all age levels (Low et al., 2013). To date, the ORS and SRS have been used most commonly with adults, resulting in a research gap for their use with children (Gillaspy & Murphy, 2011). A few studies have found that incorporating the ORS and SRS in solution-focused brief therapy among youth provided immediate and useful feedback to clinicians (A. Campbell & Hemsley, 2009; Duncan, Sparks, Miller, Bohanske, & Claud, 2006). The immediate feedback assists in establishing a collaborative and trusting relationship with young clients, which constitutes a particularly significant responsibility for clinicians working with youth, whose dropout rate in the mental health field surpasses that of adults (Wierzbicki & Pekarik, 1993). Still, further studies are needed to better understand the impact of outcomes measurements among young clients.

## **Purpose Statement**

Determining how outcome varies in relation to alliance patterns will not only assist researchers in uncovering additional factors that influence psychotherapy, but also contribute to the body of evidence supporting the benefits of utilizing brief outcomes measures in treatment. Uncovering other data regarding alliance patterns in relation to treatment outcome will further the purpose of this research. More specifically, this study will examine alliance patterns developed in treatment of children (ages 6–12) and adolescents (ages 13–17) by analyzing a specific brief alliance measure.

## **Significance of the Study**

The more clinician utilizes outcome measure with youth, the more researchers can glean productive information on how to best assist the child and adolescent populations. In order to understand what young clients routinely need in treatment, clinicians may use the following outcome measures, the ORS/CORS and SRS/CSRS. Such insights of clients' needs are made possible by collecting feedback. Concurrently, the measures encourage collaborative participation from the clients.

Outcome measures not only give short-term and long-term data points of clients' progress, or lack thereof, they can also be a means of collecting direct feedback from clients. This project investigates the under-researched population of children and adolescents in therapy using the ORS/CORS and SRS/CSRS to encourage treatment change. In addition, this project will explore how these measures provide information about the therapeutic alliance in relation to treatment change.

This study will examine therapeutic alliance measured by the SRS in relation to the therapeutic change, measured by the ORS. Productive interpretation of feedback obtained

through both the ORS/CORS and SRS/CSRS can potentially improve treatment outcome, reduce dropout rates, and lower the expense and time devoted to therapy (Miller, 2011). Supporting treatment with outcome measures allows clinicians in the field to promote clinical excellence and therapeutic change.

### **Research Question(s)**

RQ1–Quantitative: Is treatment change, as measured by the CORS, positively correlated with self-reported therapeutic alliance scores, as measured by the CSRS, for children (ages 6–12) attending a behavioral outpatient treatment clinic?

RQ2–Quantitative: Is treatment change, as measured by the ORS, positively correlated with self-reported therapeutic alliance scores, as measured by the SRS, for adolescents (ages 13–17) attending a behavioral outpatient treatment clinic?

For the purpose of this study, the researcher identified changes in alliance between the client and therapist, as well as possible correlations with outcomes. Alliance patterns will be determined by pairing the first and last scores provided by clients using the Session Rating Scale (SRS). Each score will be placed within ranges of categorical data (good (39–40), fair (37–38), and poor (36 and below)). The pair of scores for each participant will form a pattern (e.g., good/fair). Once those patterns are identified, the corresponding outcome effect of the Outcome Rating Scale (ORS) for each client will be correlated with his/her alliance pattern to uncover the significance of the alliance patterns in influencing treatment outcome. For an example: When a good/good alliance pattern is produced by the pre- and post- SRS/CSRS measures, what is the corresponding outcome score on the ORS/CORS? This study will examine the data to determine the extent to which these variables, treatment outcome and therapeutic alliance, are related. That

is, this study seeks to better understand how outcomes vary relative to patterns of alliance across treatment.

Reviewing the essential components of the study, the researcher utilized a naturalistic data set, required specific inclusion criteria, determined explicit categorization for alliance patterns, and established the standard for treatment outcome. The clinical sample consisted of 96 children, ages 6–12, and 239 adolescents, ages 13–17, receiving treatment at a county behavioral mental health facility located in Oregon. Each participant was required to have attended a minimum of two sessions and have completed two sets of measures (ORS/CORS & SRS/CSRS). Detailed statistical analyses are described below. These alliance pattern levels will be categorized as good/good, fair/good, poor/good, good/fair, fair/fair, poor/fair, good/poor, fair/poor, and poor/poor. The treatment outcome will be determined by the sum of squares for each group. Each age group will be analyzed separately.

### **Operational Definitions**

**Treatment outcome.** This term refers to the desired and undesired results of psychotherapy. Generally, outcome refers to the attainment of the goals set in therapy for each client. However, in this particular study, outcome refers to the change or lack of change in treatment over time determined by the four domains of the ORS/CORS (Individually/Me, Interpersonally/Family, Socially/School, and Overall/Everything). To review the four domains of functioning, clients routinely fill out the ORS/CORS at the beginning of each treatment session to review changes that have transpired during the past week. Therefore, each client accumulates several ORS/CORS scores over the course of treatment. However, the researcher will be calculating the difference between the first and last ORS/CORS scores.

**Alliance patterns.** There are many factors to consider when recognizing and understanding therapeutic alliance patterns, including challenges the therapist and client face throughout treatment, discovering different stages of alliance, and the length of treatment. Therapeutic alliance develops across treatment with the assumption that it is subject to change caused by various ruptures and repairs that occur within the therapeutic dyad. According to Horvath and Luborsky (1993), “This fluctuation in alliance level may account for the modest correlation between outcome and alliance averaged across sessions” (p. 566). Patterns emerge in treatment, indicating various stages of alliance per client. Later phases of therapy may exhibit stronger alliance levels related to the degree of success in resolving ruptures.

In the present study, alliance patterns were identified among all participants in a strategic manner. The alliance patterns are measured according to predetermined categories identified by the SRS/CSRS score. A score of 39–40 was classified as “Good,” a score of 37–38 was considered “Fair,” and a score of 36 or below represented “Poor.” Rather than examining alliance patterns across every session, the researcher considered only the first and last sessions. Therefore, two SRS/CSRS scores were examined for each participant, constituting each participant’s alliance pattern (good/good, fair/good, poor/good, good/fair, fair/fair, poor/fair, good/poor, fair/poor, and poor/poor). The mean alliance pattern for each group were then calculated and compared with mean treatment outcome scores to determine whether a relationship exists at the group level between alliance pattern and outcome.

## Research Hypotheses

1. There is a difference across the nine groups in the mean change in ORS/CORS score from baseline to treatment. The null hypothesis is that there is no difference across the nine groups.
2. The good/poor group will have the lowest change in ORS/CORS score from baseline to treatment and the poor/good group will have the highest change, compared to all of the other groups.
3. The groups that do not improve in alliance (i.e., poor/poor, fair/fair, fair/poor, good/fair and good/poor) will not have a positive change in ORS/CORS scores.

## Identification of Variables

**Independent variable.** Alliance patterns, the independent variable in this study, was measured by the Session Rating Scale (SRS) and the Child Session Rating Scale (CSRS) for younger clients. Adolescent clients, ages 13 to 17 years and 11 months, received the SRS, while younger clients, ages 6 and 12 years and 11 months, were administered the CSRS. Developed by Johnson et al. (2000), the SRS/CSRS is a self-report inventory that focuses on four aspects of therapeutic alliance reflected during the counseling sessions. The four areas of the SRS/CSRS include (a) relationship/listening, (b) goals and topics/how important, (c) approach or method/what we did, and (d) overall experience in the session. It is a four-item instrument, a brief visual analogue scale that measures the aspects of alliance as defined by Bordin (1979), keeping in mind the client's theory of change developed by Gaston (1990). The authors report strong evidence of internal-consistency reliability for SRS of .88 (Duncan, Miller, Sparks, Claud, et al., 2003) and .93 (A. Campbell & Hemsley, 2009) respectively among clinical adult samples. Reliability for children and adolescents has not been reported.

**Dependent variable.** The dependent variable in this study was the overall treatment outcome, which is measured in terms of the Outcome Rating Scale (ORS) for adolescent clients and Child Outcome Rating Scale (CORS) for younger clients—another brief visual analogue self-rating instrument created by the same authors (Johnson et al., 2000). Miller and Duncan (2000) modeled the ORS after Lambert et al.'s (1996) Outcome Questionnaire 45.2 (OQ-45.2) with the intention of covering the same areas of client functioning as those assessed in the questionnaire. Namely, the four areas of the ORS/CORS include (a) individually/me, (b) interpersonally/family, (c) socially/school, and (d) overall well-being/everything. Thus, the ORS/CORS contains a four-item instrument for measuring client treatment outcome which, much like the OQ-45.2, covers three main areas: individual, relational, and social (Miller et al., 2003). Bringhurst, Watson, Miller, & Duncan (2006) reported that the “measure has high internal consistency (.93) and test-retest reliability (.84),” as well as a moderate to high validity when compared to other outcome measures (p. 24). In addition, Duncan et al. (2006) conducted a study focused on children and adolescents, yielding results of which indicated that the ORS/CORS provides a moderate validity and strong reliability, as well as a high coefficient alpha supporting construct validity. Thus, it would appear the CORS/ORS is appropriate for use with children and adolescents as a means of identifying variance across the populations.

### **Assumptions and Limitations**

Before conducting the research, three limitations were apparent. First, the study was limited in terms of the degree to which its findings, for the selected population of children and adolescents at a county mental health agency in rural Oregon in the United States, can be generalized to other populations. A second potential limitation of the study was that the independent and dependent variables reflect measures of participants' perceptions, not actual

behaviors. In essence, the study does not address actual participation in treatment nor does it address actual aspects that make up a person's therapeutic and life experiences. Rather, the researcher intended to highlight the values of the therapeutic alliance, the patterns created in that alliance, and the outcomes associated with those patterns. Finally, any time an instrument is used, such as the ORS/CORS and SRS/CSRS used in this study, accuracy of the results depends upon the known reliability and validity of that instrument.

Although some information about the instruments' reliability and validity is known, there are limitations in measuring what they purport to measure. The known weaknesses for the ORS/CORS include the following: (a) children may continually rate high marks in hopes that doing so will result in early termination, (b) the measures may not be appropriate for lower cognitive levels or deficits (e.g., a lack of consideration of any reading or learning disorders), and (c) the measures may become redundant, resulting in an insincere response or producing indifferent marks (Gillaspy & Murphy, 2011). In turn, the known weaknesses for the SRS/CSRS include the following: (a) children may not rate truthfully for fear of hurting the clinician's feelings, (b) the instructions may be too confusing for young clients, and (c) children's cognitive levels may influence their understanding and scoring (Gillaspy & Murphy, 2011). Lastly, both measures are visual analog scales, leaving room for clients and clinicians to interpret each tally-mark subjectively (Miller, 2011).



## Chapter II: Review of the Literature

It is important to investigate therapeutic alliance in relation to treatment outcome in order to better understand successful and unsuccessful therapeutic experiences. The therapeutic relationship has been found to account for why clients improve or fail to improve in psychotherapy (Bachelor & Horvath, 1999; Duncan, 2010, 2014; Norcross, 2001). Research has focused more on the alliance levels between the therapist and client, one component of the relationship, at different points in treatment, rather than on any other factor of the therapeutic process (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Apart from the existence of these alliance patterns, it would be neglectful to disregard the fact that some clients do improve in treatment, while others remain stagnant, deteriorate, or leave treatment prematurely (Barret, Chua, Crits-Christoph, Gibbons, & Thompson, 2008).

Therapeutic alliance is relevant universally to clinicians and clients, and has been widely studied providing useful information about what makes psychotherapy work for so many. Landsford (1986), for instance, considered the importance of uncovering negative experiences in therapy sessions and addressing them with clients in order to repair the relationships. In fact, she has supported the idea that revealing and resolving these negative encounters between the therapist and client constitutes the process of developing alliance. Landsford also noted that eliciting feedback from clients and discussing these matters in a transparent manner increased the therapeutic alliance. Although it is well understood that alliance plays a large part in successful therapeutic relationships, research still shows a dearth of understanding of alliance patterns. One instance of this uninvestigated topic involves the question of how alliance patterns impact differences in treatment outcome.

Research on alliance is not limited to the concept of patterns; it also may relate to best practice and treatment outcome. During the 1990s, research exploring the field of alliance focused on better understanding the relationship between the accuracy of therapist's interventions and his or her skill with the development and maintenance of the therapeutic alliance. Crits-Christoph, Barber, and Kurcias (1993) conducted a study which examined the accuracy of interpretations in relation to the development of alliance. Their findings supported the idea that the interpretation capabilities of the therapist help to determine the development and strengthening of alliance. They invited further research on unknowns, such as whether "(1) when initial alliance is low, therapist accuracy serves to improve the alliance, (2) when initial alliance is high, high levels of accuracy are needed to maintain the alliance and inaccuracy leads to deterioration in the alliance, or (3) both processes could be occurring" (Crits-Christoph et al., 1993, p. 32). The current research is informed by an awareness of broader studies such as these. However, the present researcher concentrated primarily on findings and issues associated with alliance patterns in relation to treatment outcome.

### **The Therapeutic Relationship and Client Change**

In the middle of the 20th century, academics and professionals began to question the effectiveness of psychotherapy by looking into therapeutic alliance (Drozd & Goldfried, 1996). Even previous to this research, Freud may have been the first clinician to note the importance of the therapeutic relationship through his explorations of transference, countertransference, and the therapeutic alliance (Bachelor & Horvath, 1999). In 1951, Carl Rogers shifted the psychodynamic approach to the therapeutic relationship by calling attention to the existential experience that develops between the therapist and client, rather than viewing the client as seeking out the services of an expert (Bachelor & Horvath, 1999). He also noted the important

qualities clinicians' exhibit in order to foster such a relationship (e.g., empathy, genuineness). Rogers thought these qualities, as well as the client's own view of the therapist, would promote change.

Several stances have emerged on what establishes the therapeutic alliance, some emphasizing the client's preserved intentions for the therapist, while others the collaboration of treatment between the client and therapist (Gaston, 1990). In any case, the therapeutic relationship, with all its constructs, plays a major role in the course of treatment, client change, and therapeutic outcome. Clients' view of the therapeutic role can contribute to the alliance development (Bachelor & Horvath, 1999). One way to legitimize psychotherapy through the phenomenon of *therapeutic outcome* is by looking at the therapeutic relationship that develops between the client and therapist (Gelso & Carter, 1994; Lambert & Ogles, 2004; Murphy & Duncan, 2007). A component of the therapeutic relationship is the alliance factor between therapist and client, which appears to be the most influential factor in relation to treatment outcome (Lambert & Ogles, 2004; Wampold, 2001). Miller, Duncan, and Hubble (2005) summarized the core elements that build the therapeutic alliance and create the client theory of change, which have been identified in the literature. Those elements are shared goals between the client and therapist, an agreement on means, methods, or tasks of treatment, and the emotional bond developed between the client and therapist. Information more specific to the therapeutic alliance can be found in other sections of this literature review.

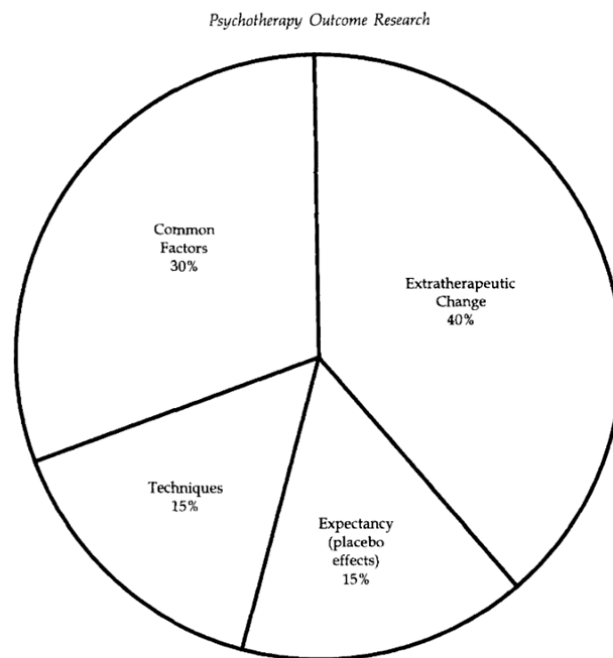
When investigating research, considering the opposite stance assists in fully understanding the overall concepts, discovering novel ideas and uncovering missing pieces. With that said, one of the first psychologists to contest the legitimacy of psychotherapy outcomes, which in turn led research to the focus increasingly on alliance, was Hans Eysenck. Based on the

findings of his own research and with support from many behaviorists, he concluded that no evidence supported the claim of any differences in treatment outcome for those in therapy versus those who did not receive therapy (Bachelor & Horvath, 1999; Eysenck, 1952). Pursuant to these findings, the field stepped up its evaluation of what is done in therapy and what results from it in order to provide evidence that psychotherapy and the field of psychology do in fact serve a purpose.

The challenging and critical task of assessing client improvement or treatment outcome during psychotherapy has proved to be a source of great speculation within the field. One way to evaluate psychotherapy services is by determining whether any change has transpired. Even here, however, there is much debate about what constitutes change and who determines the progress (Weiss, Rabinowitz, & Spiro, 1996). The clinician's ability to recognize the differences occurring during the therapeutic process determines the degree of therapeutic change, or lack of change. In fact, history has shown that most studies evaluating psychotherapy are based upon the therapist's viewpoint because therapists have been considered the 'objective' observer and trained expert (J. Campbell, 1990; Kaschak, 1978; Prager, 1982). However, Horvath and Symonds' (1991) research found that the therapeutic change can be better predicted by looking at the alliance factor than by the clinician's judgment alone. In other words, more insight can be gleaned by assessing both the client and clinician's view of the therapeutic alliance than by relying solely on the clinician's view.

**Pay attention: therapeutic factors.** Based on Lambert, Shapiro, and Bergin's psychotherapy outcome research in 1986 psychotherapeutic effects are made of four sectors; they help explain why clients may improve in treatment (Lambert, 2003). Each sector accounts for various factors that contribute to variance of outcome in treatment (see Figure 1). The extra-

therapeutic changes, accounting for 40%, are factors comprised of the innate parts of the client (e.g., ego) and the environment (e.g., social supports) that assist in treatment recovery. The common factors (30%) refer to a number of variables that can occur in therapy (e.g., empathy, acceptance, or confrontation). These factors are subjective. The client's expectancy and hope (placebo effect) account for 15% of treatment change. In other words, the expectancy factor means that clients tend to believe improvements in their mental health develop simply by being in treatment. Therapeutic technique and specific models of treatment account for 15% of the factors of the psychotherapy effect. Lambert's (2003) model indicated that the client's idea of simply being in therapy had just as much weight as what type of therapy or specific intervention was implemented during sessions.

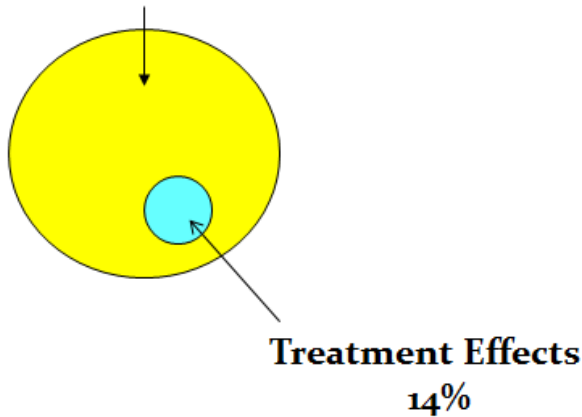


*Figure 1.* Percent of Improvement in Psychotherapy Clients as a Function of Therapeutic Factors. From "Psychotherapy Outcome Research: Implications from Integrative and Eclectic Therapists," by M. J. Lambert, in J. C. Norcross and M. R. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (p. 97), 2003, New York: Oxford University Press.

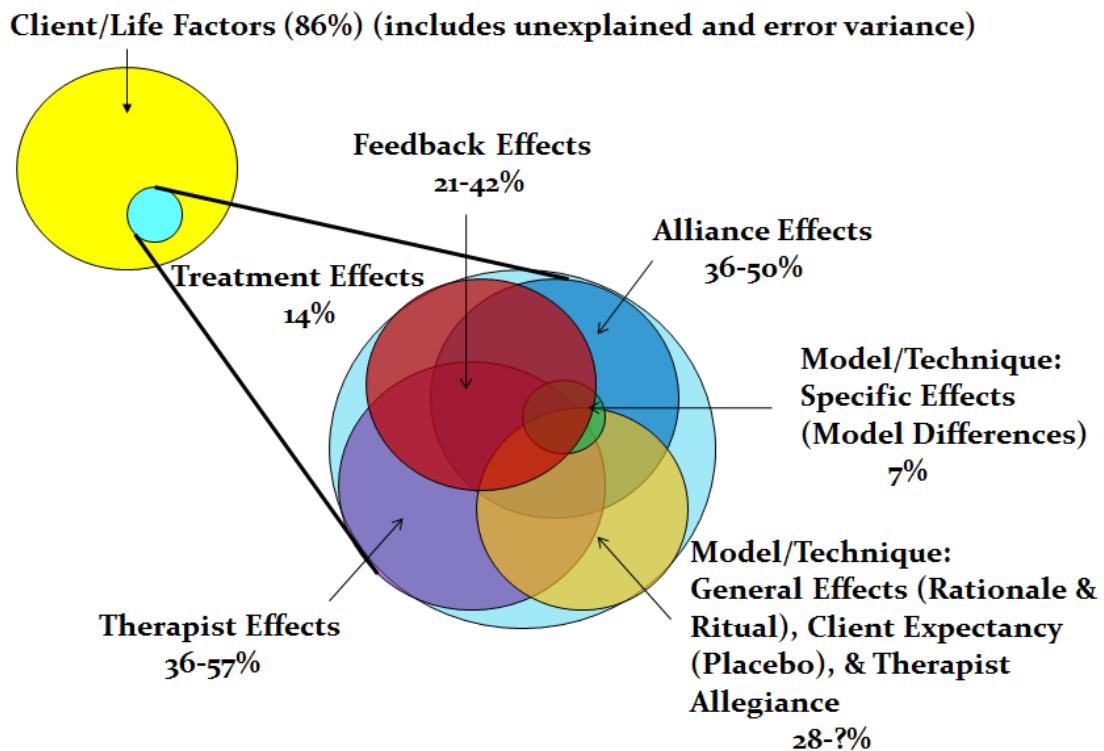
Three years later, Bachelor (1995) found that most clients gave credit for the quality of alliance to the therapist. The therapist's attentiveness and engagement during treatment (e.g., genuine interest, warmth, and awareness of the here-and-now with the client) demonstrated his or her quality of alliance. This too represented Lambert's (2003) common factors of the psychotherapeutic effects in treatment.

Identifying these therapeutic factors can equip clinicians with general guidelines to better understand the constructs of the therapeutic experience for the client. Duncan (2014) recognized Asay and Lambert's (1999) concept of the common factors as pertaining to the clinician's ability to serve the client in his or her current state. In this model, 86% of treatment results depend upon what the client brings to the process, referred to as the client/extratherapeutic factors or client/life factors (see Figure 2), while 14% are due to treatment effects. Examples of client/extratherapeutic factors include, but are not limited to, the client's strengths, personal motivation, pre-existing social supports, and socio-economic status. Treatment effects consist of alliance effects, model/technique general and specific effects, therapist effects, and feedback effects. Figure 3, a Venn diagram, shows the overlapping constructs of the treatment effects influencing therapeutic results or outcome.

**Client/Life Factors (86%) (includes unexplained and error variance)**



*Figure 2.* A Visual Representation of Asay and Lambert's (1999) Concept of the Extratherapeutic/Client Factors. From B.L. Duncan (Ed.), *On Becoming a Better Therapist*, 2<sup>nd</sup> ed. (p. 20), 2014, Washington, DC: American Psychological Association.



*Figure 3.* The Therapeutic Factors (14%) Magnified and Broken Apart into Specific Constructs. From B.L. Duncan (Ed.), *On Becoming a Better Therapist* (2nd ed.), (p. 20), 2014, Washington, DC: American Psychological Association.

Lambert and Ogles' (2004) research has shown the relationship between alliance and outcome to be more accurate than the clinician's judgment or opinion of how treatment progressed. Several other studies support the above findings and indicate a consistent connection between the alliance/relationship and treatment outcome (Ankuta & Abeles, 1993; Gaston, 1990, 1991; Gomes-Schwartz, 1978; Horvath & Greenberg, 1989; Lunnen & Ogles, 1998). In summary, alliance is a large portion of treatment effects, which overlaps several components that occur within the therapeutic experience.

The questions surrounding relationship versus technique have been debated in the field for over six decades, with one of the first extensive literature reviews of outcome research having been compiled by Bergin in 1971. In more recent research, Lambert and Barley (2001) presented a summary of how relationship factors correlate more highly with client outcome than do treatment techniques. However, Lambert and Barley continued to emphasize the relevancy of the manner in which clinicians should practice their technique, regardless of how the therapeutic relationship influences change in treatment.

According to a meta-analysis by Weiss et al. (1996), several studies have looked at clinicians' and clients' input in terms of making agreements on the presenting treatment issue, evaluating progress, and determining treatment outcomes. Defining the presenting therapeutic problem in treatment varied greatly between clinician and client; from the type of issue and degree of its severity to conceptualizing the problem abstractly versus concretely with specific details. The salient theme emerging from the meta-analysis was the lack of uniform evaluation methods and lack of agreement regarding the specific nature of change (e.g., what constitutes positive change). Speculation continues on who can best judge therapeutic change—the clinician



or the client. When determining outcome, the therapists and clients from 41 studies, over a 30-year period, agreed upon positive change rather than negative change as the defining factor in treatment outcome. Some researchers found that therapists tended to evaluate the outcome of therapy more positively than did their clients, while other studies found the opposite (Weiss et al., 1996).

**Children and adolescents.** Although the above literature, comprised of work done with adult clients, furnishes the basic theoretical understandings that support this dissertation, the researcher additionally reviewed studies of the therapeutic relationship with children and adolescents. Shirk and Karver's (2003) meta-analysis reviewed 23 studies which explored the association between treatment outcome and therapeutic relationship variables with young clients. The authors noted the significance of examining studies about youth due to their exclusion in past meta-analyses. Among their findings, diverse types and methods of treatment were included in the analysis but did not necessarily play a role in the results. A factor with a modest interaction to treatment outcome was the therapeutic relationship. The correlation between relationship and outcome was almost identical to that found by Horvath and Symonds' (1991) study with adults.

Karver, Handelsman, Fields, and Bickman (2005) conducted an extensive review of literature that focused on how the therapeutic relationship influences treatment outcome with young clients. They believed that both client and therapist characteristics influenced the therapeutic alliance and treatment outcome. In efforts to conceptualize a theoretical model, taking into account the different therapeutic relationship constructs, the authors proposed that both the client and therapist bring pre-existing characteristics (e.g., ways of thinking, feeling, and behaving) to treatments that influence the process. They theorized that if the therapist can

recognize these characteristics, he or she can tailor the treatment for each client. Karver et al.'s (2005) model is guided by both Carl Rogers' (1951) stance on empathy and building a warm environment and Strong's (1968) idea of interpersonal influence, in which the therapist's representation of expertise and high credibility leave impressions upon the client. Lastly, Karver et al. (2005) emphasized that the therapeutic relationship and therapeutic alliance were the same entity, only referred to by others as separate ideas. The therapeutic relationship/alliance is made up of three constructs: "emotional connection such as the affective bond with the therapist, cognitive connection such as hopefulness about treatment or willingness to participate in treatment, and behavioral participation in treatment" (Karver et al., 2005, p. 47). The authors believed unifying these constructs would result in a loss of information. To understand treatment outcome, the constructs should be weighed separately. Although this perspective and novel model of the therapeutic relationship and client change differs markedly from most, it is relevant among the current literature. Typically, feelings toward the therapist constitute an important construct for the therapeutic alliance and relationship, also referred as the "affective bond component" (Bordin, 1979; Safran & Muran, 2000b). Karver, Handelsman, Field, and Bickman's (2006) meta-analysis of 49 youth treatment studies aimed to uncovering therapeutic relationship variables, including clients' feelings about therapists, associated with treatment outcome. Their findings supported Shirk and Karver's (2003) previous conclusions, which showed that a consistent and strong therapeutic relationship is associated with treatment outcome. However, Karver et al. (2006) maintained that young clients' treatment outcomes are affected not only by the therapeutic relationship, but in a moderate to large degree, by the therapist's direct influence and interpersonal skills (e.g., warmth, empathy). There was little support for the client's affect toward the therapist in this particular study. Kaver et al. (2006)

suggested the need for further research regarding the affective bond component; in particular, the specific domains of the affective bond component that occur within the relationship at different points of the therapeutic process. They further proposed, “questions should be raised about what is being measured when one measures a therapeutic relationship or alliance” (p. 60).

Research regarding youth and adolescents were meager until the late 1990s, when a higher volume of studies emerged looking specifically at therapeutic relationship variables. Several meta-analyses of these studies provided an initial confirmation that relationship variables did offer moderately strong predictors of positive treatment outcome for children and adolescents (Karver et al., 2005, 2006; Shirk & Karver, 2003).

**Theory.** The theoretical framework for the present dissertation is the client-directed approach. Rogers’ (1951, 2003) humanist theory of client-centered or person-centered therapy emphasized three important principles that, if restricted by therapists due to a fear of loss of control, tend to have a detrimental effect on the therapeutic relationship. Those principles are genuineness, unconditional positive regard, and accurate, empathetic understanding. Holding these standards for clients furnishes the building blocks of trust, relationship alliance, and understanding of each other. Rogers (2003) believed the existential experience between the clinician and client is what sustains the therapeutic relationship; with the caveat that the clinician established and held the qualities to support that space. Elaborating on Rogers’ theory are Hubble, Duncan, and Miller’s (1999) ideas of becoming change-focused and recognizing that clients are the primary agents of change. Hubble et al. (1999) established the importance of the therapeutic alliance from the client’s perspective, stating, “[it] is the “trump card” in therapy outcome, second to the winning hand of the client’s strengths” (p. 412).

Rogers (1951, 2003) explains the idea that the therapist should operate less in terms of implementing techniques during therapy, and more in terms of fostering the therapeutic experience by developing a way of being with the client. His six essential conditions for this therapeutic growth (Casemore, 2006; Rogers, 1951, 2003) are: (a) psychological contact must exist between client and therapist, (b) the client is experiencing incongruence (vulnerability or anxiety), (c) the therapist is integrated in the relationship, (d) the therapist maintains unconditional positive regard toward the client, (e) the therapist experiences and displays empathic understanding, and (f) the therapist communicates to the client unconditional positive regard and empathic understanding, which the client recognizes to be genuine. While Hubble et al. (1999) suggested that the therapeutic relationship factors are a secondary contributor to therapeutic change, Rogers (1951, 1957) believed the therapeutic relationship to be the main element for change. Many of Rogers' colleagues (e.g., Rice, 1983; Watson, Greenberg, & Lietaer, 1998) supported the notion that the clinician must embody three main qualities in order to enable change through the therapeutic relationship: genuineness, empathy, and unconditional positive regard. The maintenance of these qualities can be supported through the use of outcome measures such as the ORS and SRS; thus supporting the client's theory of change throughout a feedback informed treatment process. Further explanation of these outcome measures will be discussed.

### **The Development and Meaning of the Therapeutic Alliance and Rapport**

Some professionals have viewed the therapeutic alliance as one concept (Martin et al., 2000), while others have considered it a multifaceted experience (Gaston, 1990), and still others have seen it is as a changing attribute of the therapeutic process (Karver et al., 2005; Safran & Muran, 2000a). Before *therapeutic alliance* became a well-known term, Freud wrote about the

concept in terms of the beneficial attachment that develops between the therapist and patient (Bachelor & Horvath, 1999). Therapeutic “alliance” was first introduced into the field of psychology by Elizabeth Zetzel (Horvath & Luborsky, 1993; Zetzel, 1956). She believed alliance to be a fitting term that described the experience of transference in the client’s relationship with the therapist. However, due to the proliferation of evolving definitions, other professionals have not always understood or agreed upon the theoretical conceptualization of the therapeutic alliance. Horvath and Luborsky (1993) included the following constructs of alliance: therapeutic bond, working alliance, therapeutic relationship, and helping alliance. The alliance between the client and therapist signified a positive and trustworthy relationship—a necessary condition for an efficacious treatment outcome (Gaston, 1990).

Whether or not alliance represents transference as Zetzel (1956) described, it has been supported by many as a significant factor in the therapy experience. For example, Bordin (1979) has stated that the alliance between two people is the foundation for the change process. On the other hand, Greenson’s work (1967) focused on three different aspects of the therapeutic experience: transference, relationship, and working alliance. He described transference as inappropriate and impractical responses between the client and the therapist; the relationship, which is quite the opposite, consists of genuineness and appropriate feelings; and lastly, the working alliance is thought of as the collaboration and willingness to work contributed by both the client and psychoanalyst.

The working alliance, although it may be represented in many forms (e.g., therapeutic alliance, working alliance, helping alliance) is found across a variety of treatment approaches and therapeutic orientations impacting treatment outcome (Bordin, 1979; Horvath & Bedi, 2002). Bordin (1979) has suggested that better understanding specifications of the therapeutic alliance

lead to the discovery of more proficient methods of attaining a successful outcome. Those specifications, which are components of the emotional bond, are the (a) effectiveness of therapy, (b) interpersonal characteristics between client and therapist, and (c) therapeutic demands.

Specifically, Bordin's model of the therapeutic alliance proposes there are three components agreed upon by the therapist and client: (a) the goals of treatment, (b) the interventions to reach those stated goals, and (c) the acceptance and unquestionable bond between therapist and client.

Despite the plethora of theories about what the therapeutic alliance entails or what constructs build a successful coalition between the therapist and client, there are questions which remain unanswered; what is the therapeutic alliance? How is it developed? Does the alliance depend upon the therapist's and client's level of trust and/or guardedness toward one another? (Horvath & Bedi, 2002). Dismissing the customary view that the therapeutic alliance is dependent upon the therapist's ability to establish rapport and interaction, Bordin's model (1979) of alliance attempts to answer those questions. It suggests that alliance is a collaborative effort between the therapist and client to build a strong relationship with a positive bond, which includes respect, trust, and care (Horvath & Bedi, 2002). Additionally, it is an active partnership in which both parties agree upon treatment goals and how those goals will be accomplished (Horvath & Bedi, 2002).

An approach, standing in contrast to Bordin's model, is Safran and Muran's (1996; 2000a) depiction of the therapeutic alliance as a fluid phenomenon between the client and therapist in which ruptures and repairs occur during treatment. Among these ruptures and repairs, alliance emerges as unavoidable and as an agent of change for the client. Safran and Muran (1996) provided a basis for understanding how alliance fluctuates in treatment, resulting in patterns—a relevant point for the present study.

**Basic principles.** Given common insurance restrictions on the number of therapy sessions and people's level of commitment to the process, establishing therapeutic alliance early in treatment is more crucial than ever. Safran, Muran, and American Psychological Association (1998) discussed a number of basic principles that guide the conceptualization and management of alliance during short-term psychotherapy. The first principle is for the clinician to express warmth, genuineness, and respect toward the client in order to develop a connection that will lead to a strong therapeutic alliance. Because of the briefness of short-term therapy, building the alliance quickly is crucial for treatment success. Additional features supporting that development include establishing a co-equal collaboration of treatment, building trust, and creating safety.

The second principle is to form realistic goals. A clinician who trained in and is accustomed to traditional methods of psychotherapy may require a concerted effort to change their expectations toward goal setting. In short-term therapy, small behavioral changes learned in treatment and applied overtime can be extended to an overall shift in life-style (Coyne & Pepper, 1998).

The third principle focuses on psychoeducation regarding therapeutic tasks. More specifically, the therapist can help the client understand a specific intervention pertaining to the therapeutic alliance. This principle is particularly helpful when the purpose of the intervention is not readily apparent to the client, because it relieves anxiety the client may be feeling and builds additional rapport with the therapist.

The fourth principle is to develop and preserve therapeutic focus. This concept can appear in many different guises depending upon the therapeutic orientation and the client's presenting problem. Safran et al. (1998) offered examples placing a cognitive-behavioral focus on the collaboration between client and therapist, while other approaches might point out the

client's pathogenic beliefs as they arise, and yet others may focus on the dynamic issues that present themselves during sessions.

The fifth principle is to create a balance between the maintenance of the therapeutic activity and receptivity. It can appear to be a juggling act, but keeping the client engaged in the therapeutic process is not only a goal in treatment, it is also essential in building alliance. . Maintaining common receptivity in short-term therapy is also essential, allowing adequate responsiveness from the client for each moment in the therapeutic process (Safran et al., 1998).

The sixth principle, is easier to identify and maintain in long-term therapy. Coyne and Pepper (1998) have suggested that a clinician who can notice a clients' poor problem solving skills and minimize the tendency to reenact them in therapy develop and manage a better alliance. The modern therapist needs to be more vigilant in watching for these reenactment patterns. Nevertheless, transference and countertransference are virtually inevitable and trying to "avoid them can make it more difficult to recognize them when they occur" (Safran et al., 1998, p. 220), which jeopardizes the therapeutic alliance.

The seventh principle recommends addressing ruptures in the therapeutic alliance as early in treatment as possible (Safran et al., 1998). In short-term therapy, identifying and examining ruptures, which are generally associated with transference and countertransference issues, should take priority over anything else due to time restraints. Additionally, a clinician's attentiveness to identify different types of alliance ruptures is helpful in maintaining alliance throughout treatment. Depending on the therapeutic approach used, for example, a client may get the impression that the therapist, using a cognitive-behavioral approach, is being condescending because of the way the cognitive-behavioral intervention is introduced and managed. At the same time, another client might find a therapist utilizing a client-centered approach too nondirective.



Clients' perceptions of what they believe therapist may or may not be doing in treatment can result in ruptures of the therapeutic alliance.

The eighth principle recognizes the complexity of multiple alliances, such as those occurring in group settings where the therapist has alliance with the entity of the group and to each of its members. This also extends to work with couples and family therapy.

The last principle addresses termination for clients. Regardless of the inevitable feelings and conversations about termination, if the therapeutic alliance is strong, the client can recognize the support they have received, and both the clinician and client can process the closure successfully. According to Safran et al. (1998), closure of therapy can be the definitive rupture. This possible rift is dependent upon the client. Some may have feelings of resentment and grief, while others may have conflicting feelings such as gratitude as well as disappointment.

The above principles support many professionals' theoretical models of therapeutic alliance in cases where clients bring dysfunctional interpersonal relationship schemas to the therapeutic experience (Bordin, 1979; Horvath & Luborsky, 1993; Luborsky, 1977; Safran, Muran, & Wallner-Samstag, 1994). In brief, if the therapist responds to the client in typical ways, the dysfunctional cycle will continue; however, if the therapist recognizes the unhealthy patterns and schemas, bringing them to the client's attention, then process and change can occur. Studies have shown that therapists who maintain focus on addressing the therapeutic relationship in this manner promote a stronger therapeutic alliance with their clients (Kivlighan & Schmitz, 1992; Reandean & Wampold, 1991).

**Perspectives.** Opinions proliferate among researchers regarding which perspective of the therapeutic alliance should take precedence—the therapist's or the client's. Kramer, de Roten, Beretta, Michel, and Despland (2008) found that therapists are more likely to associate positive

outcome with strong and successful alliance. Horvath, Gaston, and Luborsky (1993) and others have found empirical evidence that the client's perspective of alliance is highly correlated with outcome. Considering both stakeholders, Kivlighan and Shaughnessy (1995) found that a better treatment outcome is more likely when therapists and clients agree on the quality of the therapeutic relationship. Gelso & Hayes' (1998) perspective of both the client and therapist creating the alliance together, coincides with Bordin's (1979) concept of the alliance as a collaborative effort that bonds the therapist and client.

The voices of both the therapist and client are important to recognize in order to better understand how the therapeutic alliance influences treatment outcome. By examining both the client's and therapist's viewpoints regarding alliance, researchers can better understand any possible influences provided by clinicians, the degree to which the therapist influences the client's perspective, and the differing perspectives (Kazdin, Whitley, & Marciano, 2006). Bachelor (1995) found that clients perceive positive alliance differently. For example, even though some clients value the collaborative component of the therapeutic alliance, others may attribute the positive alliance and treatment outcome to the therapeutic climate or gaining self-understanding. Furthermore, Horvath's (2001) more recent meta-analysis on the connection of alliance and outcome found that the clinicians' and clients' perspectives of the therapeutic alliance did not depend on the therapeutic orientation or intervention.

*An example.* The helping alliance has been studied in relation to clients' verbal comments during treatment. Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen's (1983) research examined clients' statements made during psychotherapy sessions (i.e., the clients' perspectives) in order to find a connection to alliance. Note, the authors used the term *helping alliance* in place of "therapeutic alliance" or "working alliance," which underscores the

helping relationship perceived by the client. Two methods of assessing alliance over the course of therapy were analyzed: (a) the Helping Alliance Counting Signs method, which counted signs of clients' statements relevant to the helping alliance and (b) the Helping Alliance Rating method, which utilizes two broad types of alliance. Results indicated that both forms of evaluation showed moderate agreement that client's perspectives indicated whether alliance was developed.

Luborsky et al.'s (1983) early research sets the foundation for the main purpose of this dissertation—that is, to explore the use of a brief outcome measure to identify possible alliance patterns in relation to treatment outcome. The study utilized a valid questionnaire, to assess alliance, which could be given to clients in session. The Helping Alliance Counting Signs method appeared to offer a simpler scoring process, but introduced some unreliability due to the difficulty of identifying and counting clients' statements. In contrast, the Helping Alliance Rating method is less time-consuming and therefore more practical. Both methods require that transcripts of therapy sessions be evaluated by an outside rater. The authors also underscored the important fact that the helping alliance research has the potential to provide a quantitative evaluation of alliance in relation to psychotherapy outcome.

**Therapeutic alliance with children and adolescents.** Adult outcome studies, as mentioned earlier, have shown empirical evidence that therapeutic alliance constitutes an important part of therapy and relates to treatment results (Horvath, 2001; Horvath & Symonds, 1991; Martin et al., 2000). Early studies that focused on therapeutic alliance occurring among children/adolescents and their therapists have produced similar evidence of these connections (Bickman et al., 2004; Dew & Bickman, 2005). According to one meta-analysis that examined 108 outcome studies among youth, therapy with children and adolescents had positive treatment

effects as evidenced by an effect size of 0.79, which is significantly higher than zero (Weisz, Weiss, Alicke, & Klotz, 1987). Weisz, Weiss, Han, Granger, and Morton (1995) revisited the meta-analysis years later and found that treatment resulted in stronger outcome if the clinician focused on the targeted problem in sessions. Better understanding of what youth need in therapeutic treatment, which includes identifying the presenting problem, assists clinicians producing quality treatment results, especially when only 20% of children and adolescents with mental disorders are identified and receive treatment (U.S. Public Health Service, 2000).

Understanding therapeutic alliance for children and adolescents may appear different than with adults because of youths' resistance in attending therapy. Typically, underage clients do not attend therapy of their own volition, but rather are brought in involuntarily by parents or other authority figures (Kazdin, 2003; McLeod & Weisz, 2005; Shirk & Saiz, 1992). Because parents and caregivers are the ones who actually escort their children to therapy, their degree of cooperation, participation, and feedback or perceptions of treatment has been found to influence dropout rates and participation (Kazdin, Holland, & Crowley, 1997), impacting therapeutic alliance.

Little attention has been devoted in the literature to the therapeutic alliance with parents and families (Karver et al., 2005). Regretfully, examining the role of this factor exceeds the scope of this dissertation. Goals held by the parents of clients can differ greatly from those of the children and adolescent clients themselves. Several studies have indicated that a positive relationship between the parent and therapist results in higher retention rates, increased engagement, and more satisfaction (Garcia & Weisz, 2002; Hoagwood, 2005). Yet contrasting results were found by Hawley and Weisz's (2005) study, revealing that stronger youth alliance corresponded with a greater decrease in symptomology and better outcome. Nevertheless,

additional studies have shown that weak parent alliance or discrepancies between youth-therapist alliance and parent-therapist alliance ratings result in low retention for the child client (Hawley & Weisz, 2005; Shelef, Diamond, Diamond, & Liddle, 2005; Shirk & Karver, 2003).

In addition to the complexities of accounting for parental roles in the therapeutic process, other factors can be revealed when examining alliance with young clients, including cognitive development. Given the fact that developmental differences distinguish children and adolescents from adult clients, researchers have neglected the development appropriate conceptualizations and instruments to examine therapeutic alliance among younger people. This brings the attention to Shirk and Karver's (2003) point regarding the ever-changing perception of treatment and developing relational aspects of the therapeutic relationship at various developmental stages. These factors, among others, mean that working with children and adolescents can present added complexity in relationships.

Zack, Castonguay, and Boswell (2007) have discussed the developmental differences between youth and adults, which impact alliance. Among their insights is the hypothesis that the less developed cognitive abilities in youth could account for a lack of recognition of the need for and benefits of treatment, and thus the high dropout rate. Weisz and Hawley (2002) have supported the idea that youth are less invested in treatment because they frequently attend involuntarily, which could support Zack et al.'s developmental hypothesis of resistance and poorly developed alliance. Youth bring to treatment a "different level of awareness, agency, and motivation than the typical adult and may have different goals for treatment than their referrers, or even have no interest in goals or therapy at all" (Zack et al., 2007, p. 280). Levels of willingness to attend therapy and participate actively are closely related to positive therapeutic

alliance (Karver et al., 2006). Therefore, further research needs to focus on development levels of youth associated with length of treatment and therapeutic alliance.

Along with developmental considerations impacting therapeutic alliance, research has also considered behavioral factors younger clients may exhibit. Kazdin et al. (2006) have conducted a meta-analysis covering 23 research studies, which investigated therapeutic alliance and behavioral difference among children. Results were similar to the previously mentioned meta-analyses regarding adults, with variance in the therapeutic alliance accounting for variance in treatment outcome. In the research, nine studies concluded that, among children exhibiting externalizing behaviors, stronger alliance factors correlated with better treatment outcome. These results provide support for the importance of focusing on target behaviors, but could also be influenced by the type of treatment for externalizing behaviors rather than for internalizing behaviors (Shirk & Karver, 2003). For an example, Kaufman, Rohde, Seeley, Clarke, and Stice (2005) have found that adolescents with symptoms of depression and a weak alliance with the therapist did not reach a good outcome in treatment. Furthermore, other studies with children who displayed aggressive behaviors or had previous abuse or maltreatment showed issues with building therapeutic alliance, resulting in poor treatment outcome and early termination due to interpersonal problems (Bickman et al., 2004; Eltz, Shirk, & Sarlin, 1995). Therefore, the formation of a strong alliance with these extreme clients proves to be particularly crucial to better outcome (Eltz et al., 1995; Kaufman et al., 2005; Shelef et al., 2005; Shirk & Karver, 2003). It is also apparent that inconsistencies arise among the literature of children and adolescents' therapeutic alliance in predicting treatment outcome, suggesting further research of this topic is imperative.

Clinicians' skills and personal attributes are other factors to acknowledge when understanding therapeutic alliance for children and adolescent clients. Several studies have identified therapist characteristics and techniques that positively impact the therapeutic alliance with children and adolescents (Ackerman & Hilsenroth, 2003; Creed & Kendall, 2005; Diamond et al., 2006; Dozier & Tyrrell, 1998). For instance, using collaborative expressions, such as "we," when setting goals builds rapport and a sense of joint decision-making. Other strategies that work well with children include offering encouragement and hope, speaking less formally, and placing less pressure on the child to reveal difficult issues. With adolescents, the clinician can encourage a collaborative sense of therapy and creating meaningful goals by presenting him/herself as an ally. Lastly, attending to the teenager's experiences and promoting trust, honesty, and respect for confidentiality assist in developing a strong alliance.

Although the child-therapist alliance is a topic of relatively new interest and lacks a sizeable accumulation of research, several studies have indicated that the child's perception of alliance with his/her therapist remains consistent and does not change over the course of treatment (Bickman et al., 2004; Green, 2006; Eltz et al., 1995). These findings are not congruent with the research on most adult therapeutic alliance patterns, which will be examined in a separate section of this dissertation. One concern in child/adolescent psychotherapy is the high rate of dropouts. This tendency toward early or premature termination of treatment throws into question the extent and development of the therapeutic alliance, as well as the association and motivation of termination. One study investigated appropriate termination versus early termination among clients of all ages and found therapeutic relationship issues to be the cause of only 16% of the variance (Garcia & Weisz, 2002). In other words, the variance of dropout rate related to the therapeutic alliance was less than one-sixth, and thus relatively minor. Garcia and

Weisz's research is but a single study examining youth and how early termination is associated with therapeutic alliance. More research is advised in this area.

Norcross (2001) has reviewed numerous studies that evaluated child or adolescent alliances of various kinds (e.g., parental, therapist) and during different stages of treatment (e.g., early, middle, late, post-treatment). Several studies have focused on alliance among children only (Champion, 1998; Chiu, McLeod, Har, & Wood, 2009; Green, 1996; Kazdin, Marciano, & Whitley, 2005; Kazdin et al., 2006; Kazdin & Whitley, 2006; McLeod & Weisz, 2005), while others have reviewed the relationship of outcome and alliance among adolescents (Auerbach, May, Stevens, & Kiesler, 2008; Colson et al., 1991; Creed & Kendall, 2005; Darchuk, 2007; Diamond et al., 2006; Eltz et al., 1995; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000; Gavin, Wamboldt, Sorokin, Levy, & Wamboldt, 1999; Handwerk, Smith, Thompson, Spellman, & Daly, 2008; Hawley & Garland, 2008; Hintikka, Laukkanen, Marttunen, & Lehtonen, 2006; Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; Holmqvist, Hill, & Lang, 2007; Karver et al., 2008; Kaufman et al., 2005; Shirk, Gudmundsen, Kaplinski, & McMakin, 2008; Smith, Duffee, Steinke, Haung, & Larkin, 2008; Tetzlaff et al., 2005; Zaitsoff, Doyle, Hoste, & le Grange, 2008), and only a few have considered both children and adolescents (Adler, 1998; Green et al., 2001; Hawley & Weisz, 2005). Results indicated a moderate association between treatment outcome and therapeutic alliance. Furthermore, type of treatment did not add strength to the association, leaving therapeutic alliance the only factor identified to account for variance. Because no earlier meta-analyses have been conducted, it is difficult to compare the results and determine why there is a strong relationship between alliance and outcome.



Emerging empirical research has supported the idea that relationship does matter in the therapeutic dyad for both adults and youth. Although several variables call for further exploration (i.e., the level of interpersonal skills of the client and therapist, the client's diagnosis, and whether any relationship can be found between alliance and specific treatment factors) alliance has been related to positive treatment outcome. Zack et al.'s (2007) review of the literature concluded, "the quality of the alliance seems to predict both premature termination (in the case of weak alliance, especially as rated by caregiver) and symptom reduction (in the case of strong alliance, as rated by youth) for youth across different treatment approaches" (p. 285). When a young client leaves treatment early with symptoms unmanaged, it is fair to say the quality of alliance was weak. When a young client had a reduction in symptoms, it is fair to say the quality of alliance was strong.

### **Therapeutic Alliance Patterns Found in Treatment**

**Theory.** Historically, therapeutic alliance literature has focused on the development of alliance across treatment presented as several theories. Many theorize that the pattern of alliance typically fluctuates throughout therapy. James Mann's model (1973) outlined three phases of alliance patterns: (a) a developing strength of alliance at the start of treatment, (b) a dip in alliance in the middle of treatment due to client dissatisfaction and resistance toward treatment methodologies and techniques, and (c) the return of a strong alliance as treatment is finalized. The pattern is referred to as "high-low-high" or "U-shaped" (Bordin, 1979; Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, & Multon, 1997).

Edward Bordin's (1979) theory of alliance patterns in psychotherapy resembled Mann's (1973) theory, but with variations. Rather than describing a "high-low-high" pattern, he believed alliance occurs in a cyclical fashion (i.e., deterioration and restoration, repeated). Furthermore,

Bordin's theory suggested that stable alliance is present at the start of therapy. He believed both clients and therapists are innately good and that trust is present in the relationship until challenged. He experienced that increased liability causes ruptures, and then the alliance strengthens, mending the tears. This cyclical model continues as therapy progresses.

Others have focused on the strength of alliance fluctuating across multiple sessions. Gelso and Carter (1985) emphasized the necessity of a strong relationship between the client and therapist in order to repair ruptures that occur in each session treatment period. More specifically, Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, and Gallop (2011) studied session-to-session alterations in alliance to determine whether changes in depressive symptomology accompanied them. Their study concluded that change in symptomology did not occur early in treatment, but rather between the 10th and 16th session, at which point reversal causation appeared. As an increase in alliance transpired, a decrease in Beck Depression Inventory (BDI) scores followed, supporting Bordin's (1979) theory of the "strong" alliance. Using a mixed-method longitudinal analysis, Crits-Christoph et al. aggregated four of the alliance scores per participant across treatment, taking the average alliance score. Although this study did not uncover specific alliance patterns, the findings indicated that multiple sessions had a larger effect and acted as better predictors of outcome than a single session of therapy. These authors supported the theory that alliance is an evolving phenomenon and that with a strong bond a substantial treatment outcome is possible, even likely.

Horvath and Luborsky (1993) have proposed a two-phase model of alliance. In the first phase, which spans the initial five sessions, the therapeutic alliance is developed. As time and treatment pass, the client's level of function deteriorates and challenges can become exacerbated. In the second phase, as this level of distress, combined with changes in the therapist's standpoint

and additional biases, alliance patterns fluctuate. Horvath and Luborsky largely supported Bordin's (1979) idea of "rupture and repair" in the cyclical rotation of the therapeutic alliance. Further investigation of alliance ruptures and how clinicians repair them to provide effective treatment has been at the forefront of much research (Kivlighan & Shaughnessy, 1995, 2000; Safran, 1993; Safran, Crocker, McMain, & Murray, 1990; Safran et al., 1994; Stevens, Muran, Safran, Gorman, & Winston, 2007).

**Pattern differences.** A number of studies have found therapeutic alliance to relate to treatment outcome in a pattern and can be interpreted graphically. For example, the work of Kivlighan and Shaughnessy (1995, 2000) suggested a curvilinear pattern depicting "an initially high level [of alliance] that declines and subsequently returns to the former level" (Kivlighan & Shaughnessy, 2000, p. 362). This theory of the curvilinear pattern of therapeutic alliance coincides with Mann's (1973) perspective of the three phases of treatment. Those phases state that clients enter therapy with the optimism that therapy will help clients, reach a point in treatment when they become frustrated and have a negative reaction to the therapist, and finally, near the end of treatment, clients move toward a positive reaction accepting of the reality of their situation.

Another term for the graphic representation of alliance is the quadratic pattern ("U-shaped" or "V-shaped"). In Gelso and Carter's (1994) later work, the quadratic pattern of alliance appeared in short-term therapy and was associated implicitly and explicitly with an early working alliance formation. Their work supported Bordin's (1979) theory of the tear-and-repair process. Kivlighan and Shaughnessy's (2000) findings of the curvilinear alliance pattern supported the idea that quadratic patterns relate more to therapeutic outcome than other patterns identified. However, among Kivlighan and Shaughnessy's research it was noted that a more

linear growth pattern, in which the initial alliance rating was low and progressively rose until the end of treatment, was seen.

A study of two samples, with identical results, showed clients with a flat-line pattern of alliance. This “stable” pattern of alliance, tracked using a repeated measure, indicated no pattern of growth of alliance over time (data points represent a straight line across treatment). The authors speculated that this straight pattern could represent a failure to develop a therapeutic alliance.

In an earlier study, Morral, Iguchi, Belding, and Lamb (1997) found several patterns of alliance. Using a cluster analysis, the authors identified different patterns of alliance from the clients’ perspective. Those patterns were labeled as: improving, stable-good, stable-poor, and deteriorating. Results were not only related to clients’ perspective of treatment, but also to the type of treatment offered. A similar study found similar patterns: improving, deteriorating, and rebounding (Heppner, Neville, Smith, Kivlighan, & Gershuny, 1999). The aforementioned studies indicated the many varied possibilities of therapeutic alliance patterns that can potentially be identified in treatment, depending on the measure used and/or the statistical analyses employed.

**Research overview.** Several studies have looked at patterns of alliance and outcome in individual therapy (Aguirre McLaughlin et al., 2014; Kivlighan & Shaughnessy, 1995, 2000; Piper, Ogrodniezuk, Lamarche, Hilscher, & Joyce, 2005; Stevens et al., 2007), with most of them supporting the idea that a linear pattern of alliance directly affects treatment outcome, which contradicts the concept of “ruptures and repair” alliance.

Piper et al. (2005) have examined the relationship between the level of alliance patterns recorded over the course of treatment and outcome. Their study enlisted 107 participants

attending short-term complex grief therapy, who were matched with therapists after completing a Quality of Object Relations screening tool. The methods of therapy employed were either interpretive or supportive. The treatment team developed the method of measure used, which tracked the main components of Greenson's (2008) working alliance. Greenson's therapeutic model consisted of three components: (a) transference, (b) the working alliance, and (c) the real relationship. Piper et al.'s measure of alliance demonstrated a high internal consistency with a Cronbach's alpha of 0.91 for client ratings and 0.92 for therapist ratings. A linear pattern of alliance change over time was analyzed. A significance among client ratings of  $t(93) = 6.83$ ,  $p < .000$  was indicated, and the pattern of alliance increased by 0.66 points across treatment. In addition, the data was analyzed to detect a curvilinear pattern, showing no results among any participants. Overall, tracking client-rated alliance showed that a strong alliance developed at the beginning of therapy leads to favorable outcome.

In another study, Stevens et al. (2007) examined 44 therapist-client dyads, who were using different forms of manualized treatment (brief adaptive psychotherapy, cognitive-behavioral therapy, and brief relational therapy). Both client and therapist, before treatment, completed the Working Alliance Inventory (WAI) measure. Across treatment, a linear pattern was found. Among half of the participant-dyads, the experiences of the tear-and-repair alliance occurred but did not relate to outcome. When clients had a positive outcome, an associated increase in alliance strength was present.

Kilvighan and Shaughnessy (1995) studied alliance among 21 therapist-client dyads. Unfortunately, their results are not generalizable because the participants were recruited from a university counseling center and do not represent most of the country's population. Nevertheless, the findings remain noteworthy. The WAI inventory was completed by participants at the end of

each session (treatment occurred between 5 and 17 sessions). Both clients and therapists displayed a linear pattern of alliance. Additionally, results indicated a significant correlation between the mean alliance and the linear pattern of alliance among therapists. However, there were no significant findings among the client ratings. These results have left researchers speculating whether therapists tend to overrate the positive alliance relationship. Patton et al. (1997) also utilized the WAI and endorsed the linear and high-low-high patterns over short-term psychoanalytic treatment.

Aguirre McLaughlin et al. (2014) examined the rupture-repair relationship patterns (repaired, unrepaired, and no ruptures) in clients with prolonged post-traumatic stress disorder (PTSD). Besides completing the PTSD assessment tools, participants filled out the California Psychotherapy Alliance Scale (CALPAS), a 24-item self-report measure. A high score on the CALPAS related to a strong alliance between clients and clinician. All participants experienced prolonged exposure therapy over the course of 10 weeks, completing the measure every other session (five measures per participant), after which their PTSD symptoms were assessed. Of the 116 participants, 82 experienced several rupture-repair ratings of alliance showing a high-low-high pattern (28% repaired ruptures, 18% unrepaired ruptures, and 54% no ruptures). Overall, 46% of participants experienced ruptures. Unrepaired ruptures resulted in poor outcome, experiencing the highs and lows of alliance (repaired-ruptures) was not problematic for the therapeutic relationship, as evident by a moderate effect size ( $d = 0.47$ ). An additional finding was a moderate relationship between alliance and outcome. Note: the findings have not held true in past similar studies (e.g., Westra, Constantino, & Aviram, 2011).

Findings from several studies (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004), using the WAI measures and analyzed via cluster analyses, found several different types of alliance

patterns formed during short-term therapy (e.g., four sessions); Stiles et al. (2004) coined the concept *shape-of-change*, which is the alliance patterns formed using a “cluster analysis of within-subject regression coefficients predicting alliance ratings for each session” (Kramer, de Roten, Beretta, Michel, & Despland, 2009). In Kivlighan and Shaghnessy’s (2000) study, a cluster analysis found consistent linear and quadratic patterns. The quadratic patterns had a significant association with treatment outcome, furnishing a better predictor of positive outcome than linear patterns. These findings are important to the field because the authors brought to light the examination of the relationship between alliance strength, alliance development, and treatment outcome. Stiles et al.’s (2004) study showed numerous patterns (a linear growth cluster, a stable alliance cluster, a shallow U-shaped curve, and a positive slope), but none of them were able to predict treatment outcome. During the second half of the study, the authors looked at the rupture-and-repair sequences that occurred across treatment. Surprisingly, the clients who experienced the highs and lows of the therapeutic alliance fared better in treatment.

In another study, the methodology of rating alliance early in treatment at a single interval was questioned (de Roten et al., 2004). These researchers attempted to explore the effects and meaning of surveying clients at each session; the report did not state the total number of sessions clients experienced. The measure used was the Helping Alliance Questionnaire (HAQ-I), an 11-item inventory with a 6-point Likert scale that measures the participant’s perspective of the help/support they receive from the therapist and the collaborative work that occurs during the session. The authors, using a cluster analysis, analyzed the questionnaire for a pattern (stable or linear growth) and a level of alliance. Findings are consistent with other studies (Kivlighan & Shaghnessy, 2000; Stiles et al., 2004) using cluster analysis to identify patterns among multiple data points. However, rather than having several data points across a period of treatment, the

multiple data points were from the questionnaire based on one session. Variability in rupture and repair alliance patterns was not accounted for, and the “U-shape” or “V-shape” pattern was not found. The findings supported neither Gelso and Carter’s (1994) nor Safran and Muran’s (1996) model. Rather, Horvath and Symond’s (1991) view of early alliance development was supported by de Roten et al.’s (2004) data, most likely because of there being only one therapy session. The authors did find the linear growth pattern of alliance to be associated with therapy outcome. Tracking alliance over more than one session reveals developing patterns and provides evidence that a growing alliance is indicative of significant improvement. Yet, it is possible to measure alliance each session, even if there is only one session.

In summary, many researchers have attempted to determine patterns of alliance over the course of psychotherapy. Some have focused their search on the strength of alliance with treatment outcome, while others have focused on the relationship between alliance patterns and outcome. More specifically, research interests have also looked into single session ratings (de Roten et al., 2004; Horvath & Symonds, 1991) and over multiple sessions in brief therapy (Crits-Christoph et al., 2011). Among these studies, the patterns found have been stable, linear, and quadratic. Depending upon their statistical analyses, researchers found a mix of alliance patterns, such as linear and quadratic (Patton et al., 1997), linear and tear-and-repair (Stevens et al., 2007), and others (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004). Overall, findings have been inconsistent: some research has revealed positive associations and significant predictions of outcome with alliance patterns, while other research has not.

**Children and adolescents.** Despite the substantial body of research on therapeutic alliance as an important construct of psychotherapy for adults, it has been only within the last decade that researchers have begun to investigate the impact of therapeutic alliance for youth



(Eltz et al., 1995). As mentioned in a previous section, children and adolescents often attend therapy involuntarily (Shirk & Saiz, 1992). Dropout rate among children and families in therapy, because of premature termination, are as high as 65% (Armbruster & Kazdin, 1994). Such a high number indicated the importance of establishing the therapeutic alliance with and elicit feedback from younger people in order to retain much needed treatment. Yet, there is a lack of research looking into alliance patterns for this group.

There is a profound deficit in literature examining the therapeutic alliance with youth. The following areas of research are what have been provided thus far. More than 10 years ago, Shirk and Karver (2003) completed a meta-analysis on the relationship between therapeutic alliance and treatment outcome with children, comparing findings to adult studies. When 23 studies were analyzed for the alliance factor in the therapeutic relationship with underage clients, the effect-size was 0.21, a number similar to that of an adult meta-analysis showing an alliance-outcome relation effect size of 0.22 (Martin et al., 2000). However, differences between child clients and adult clients were present: children with externalizing problems had stronger associations of alliance to outcome, therapists and observers rated higher alliance scores than did children, and alliance scores obtained later in treatment were more strongly related to outcome than alliance scores collected early. Even though most of the results correspond to adult findings, these relevant differences have surfaced and need further exploration.

Another study interested in younger clients' alliance and treatment outcome examined adolescents in treatment for substance abuse (Tetzlaff et al., 2005). These authors were interested in looking at the relationship between treatment satisfaction, working alliance, and post-treatment substance use. Additionally, they had hoped to find support that treatment satisfaction and working alliance would predict post-treatment substance use. Instruments used were the

WAI-short form, Treatment Satisfaction Index (TSI), and the Substance Problem Scale-Past Month (SPSM). The correlation between treatment satisfaction and the working alliance was moderately positive (an effect size of 0.36). More significantly, treatment satisfaction had a negative correlation with post-treatment substance use ( $r = -0.05$ ); meaning when clients had a higher satisfaction with therapy they had less substance use after treatment and vice versa. Although results were not strong, the authors were able to note some relationship occurring.

In similar research, Garner, Godley, and Funk (2008) studied adolescents in substance abuse treatment to identify predicting factors that contribute to early therapeutic alliance. The researchers found that several client factors (e.g., general social support, cautious personality, recovery environment risk, etc.) were significant predictors of client-rated alliance, though these factors explained only 10% of variance. Despite other research findings (Diamond et al., 2006; Tetzlaff et al., 2005), Garner et al. (2008) were among the first to find empirical evidence that client factors predict alliance from both therapist and client.

Green's (2006) selective literature review investigated the possible mechanisms of alliance for children and adolescents. However, he incorporated both the client's and therapist's perspectives of alliance, which is based on Hougaard's (1994) approach on the personal alliance. Major factors of the personal alliance include task alliance contributions from both the professional and client. Therapist factors, such as professional development and attitude, and client variables, such as making use of social relationship with the therapist, all contribute to the process of personal alliance. Hougaard's model supports Bordin's (1979) theory of how a strong relationship assists in the process of therapeutic change.

Green (2006) also reviewed a number of measures used for alliance in empirical studies that conducted adult and child/adolescent mental health. He concluded that alliance could be

difficult to measure among children and adolescents because the level of cognitive development affecting their understanding of alliance and the purpose of treatment (Shirk & Saiz, 1992). The strong aversion of some clients to attend treatment and difficulty determining the focus of treatment may also pose challenges to measure alliance (Diguiseppe, Linscott, & Robin, 1996). These impediments explain the lack of empirical studies focusing on therapeutic alliance in child and adolescent psychotherapy. In closure, Green (2006) specified the following implications for further research:

- Therapeutic alliance with parent and with child should be considered separately.
- Repeated measure designs are called for looking at the interaction of symptom change and alliance between sessions.
- More detailed investigation is in order of patient variables predicting alliance, such as pre-treatment social functioning. (pp. 432–433).

Several researchers have found further explanations to why alliance development varies due to age. Green (2006) and Diguiseppe et al. (1996) believed there were significant differences between studies of adult clients and younger participants, which therapists should acknowledge. The main difference they noted occurs when children and adolescents enter therapy in the precontemplative stage of change; they can be resistant to the process. Diguiseppe et al.'s (1996) literature review found there are multiple ways to build alliance with youth; there is no one “right” way. Among the various ways to build alliance is addressing any failure to agree on goals and tasks with the therapist. The authors investigated three approaches to overcoming this barrier: emotional scripts and social problem-solving skills, motivational interviewing, and strategies for overcoming resistance. The common constructs found in the approaches involve psychoeducation regarding how to evaluate consequences of specific behaviors and thinking of

alternatives. Therefore, like other researchers (e.g., Karver et al., 2008), Disguisepe et al. supported the idea that therapist engagement strategies predict the strength of therapeutic alliance. Overall, the authors suggest further research is needed on the effectiveness of different strategies in the growth of the therapeutic alliance. Interestingly, many have suggested that the therapeutic approach and technique used do not affect the development of alliance.

Researchers have adopted several methodologies and positions when accounting for the therapeutic alliance-outcome relationship. Some have reviewed specific treatment problems, such as substance abuse (Diamond et al., 2006; Garner et al., 2008; Tetzlaff et al., 2005); others have focused on when to measure alliance, such as early or late in treatment (Crits-Christoph et al., 2011; Garner et al., 2008; Martin et al., 2000); and still others have searched for predicting variables that relate to the alliance-outcome relation (Martin et al., 2000). Beyond this, researchers have pursued interest in the parental therapeutic alliance (Guzder, Bond, Rabiau, Zelkowitz, & Rohar, 2011) or the parent-child alliance (Leon, Wallace, & Ruby, 2007). Concerning patterns in alliance scores from children and adolescents, there is no existing published research to date. This dissertation will provide valuable evidence regarding therapeutic alliance patterns as they relate to treatment outcome among youth.

### **Effect of Psychotherapy, Feedback, and Outcome Measures**

Learning how to improve outcome and contribute to success in treatment, independent of techniques or models used, has been shown to be beneficial for clinicians (Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Norcross, 2001). While the literature has shown the importance of alliance for treatment outcome, instruments to measure alliance and outcome are also relevant for the present dissertation study and literature review. Outcome measures are active feedback

tools and used in assessing alliance during mental health treatment. In addition, outcome measures are considered a component of standard practice.

Standard or evidence-based practice points to the importance of the therapeutic relationship and alliance because the client's bond with the therapist has been shown, by research, to be a major contributor to the overall success of treatment. The most common definition of evidence-based practice is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. [It means] integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). The American Psychological Association (2006) offered the following definition: "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273).

Norcross and Wampold (2011) presented a summary of what the interdivisional task force on evidence-based therapy relationships found among a series of meta-analyses. Findings clearly supported the prominence of the therapeutic relationship to the contributions of psychotherapy outcome. More importantly, to employ evidence-based practices without acknowledging the relationship would be misleading and inadequate for the standards of the field. As discussed in a previous section, several different perceptions of the therapeutic relationship and alliance have been postulated (e.g., the clinician's, the client's). With so many differing opinions about what is going on in the therapeutic experience, how do we know if alliance is established and therapy is effective? How do we know if the therapeutic relationship accounts for why clients change, improve, or have better outcome?

Wampold (2001) examined the effects of various psychotherapeutic aspects that clinicians consider (e.g., absolute efficacy, relative efficacy, specific effects, placebo effects, working alliance, allegiance, and competence). After he reviewed multiple meta-analyses, he defined absolute efficacy as the effects of treatment compared to no treatment. With an aggregated effect size of .81 from 13 studies, the meta-analysis provided evidence to support psychotherapy to be very effective.

Wampold's (2001) evidence supporting the claim that psychotherapy is an effectual form of treatment included the following findings: (a) any and all models were equally useful, (b) no specific therapeutic domain influences treatment outcome, (c) the presence of a working alliance, and d) the allegiance of the therapist are factors that give psychotherapy an efficacious status. Wampold inspected the relative efficacy of different treatment methods, which he found to be equally comparable. In addition, he found little evidence for specificity in therapeutic domains (e.g., social support, relaxation skills, cognitive component, emotional expressiveness, behavioral activation, etc.) contributing to treatment or the benefits of psychotherapy. Between two meta-analyses, a key component of psychotherapy was identified as working alliance (Wampold, 2001). In conjunction with alliance, he noted a correlation between the allegiance of the therapist and treatment outcome. Further evidence showed that a therapist accounts for a large proportion of variance. In outcome however, it is still unclear which component(s) of the therapist provides the means for successful treatment.

The degree of efficacy of psychotherapy has been questioned in the field for some time now. Minami et al. (2008) discussed the effectiveness therapeutic services have on clients; 40–70% of clients who receive services show substantial benefits. Furthermore, they assert that the average treated person is better off than 80% of the untreated sample in most studies (e.g., the

effect size of therapy is almost 80%). Although this information sounds positive and encouraging for the field, proving the efficacy in this work can be difficult at times, especially work with children and adolescents. According to the research, only 1% of the therapeutic change is attributable to the therapeutic technique used in treatment (Wampold, 2001). With that information, professionals must speculate as to the value and purpose of their own training. Obtaining feedback from clients, however, which strengthens the therapeutic relationship, contributes more than having the skills to make adjustments and improvements in therapy (Lambert, Hansen, & Finch, 2001). Indeed, feedback can play an important role in relation to the therapeutic outcome. In the following sections, client feedback and outcome measures will be reviewed.

**Client communication.** Providing positive feedback or validation toward the client's relayed message is imperative in the development of the therapeutic relationship. This is true not only for paraphrasing client words, but also in obtaining feedback from the client regarding the therapeutic experience. Anker, Duncan, and Sparks (2009) were able to demonstrate that continuous client feedback improves therapy outcome regardless of the treatment strategies used. However, as mentioned earlier, therapists can be poor judges of the client's therapeutic outcome, which has led to the development of outcome measures (Lambert, Whipple, & Hawkins, 2003).

Joyce and Piper (1998) conducted a study examining the therapeutic alliance and expectations for a typical therapy session in relation to therapy outcome. The authors' intentions were to assess predictive relationships by measuring likely components that occur in treatment originating from both the therapists and clients. Findings showed that establishing the expectations for treatment and knowing what the therapy sessions will entail strongly relate to the therapeutic alliance. The authors found that an array of factors contributed to the benefits of

therapy, including the quality of alliance, client expectancy, and quality of object relations, which is defined as “a person’s internal, enduring tendency to establish certain types of relationship with others” (p. 238). This study strongly supports the benefit of feedback therapists can gain by communicating openly with clients.

The most prevalent factor in psychotherapy is to measure and obtain feedback is the relationship between client and therapist (Norcross, 2001). Beneficial evidence, for measuring the therapeutic relationship, can be demonstrated in over a thousand studies (Duncan, Miller, Wampold, & Hubble, 2010), and nearly as many assessment measures are available (Ogles, Lambert, & Masters, 1996). Therefore, choosing which measurement tool to use can be challenging.

While there are hundreds of measures to consider, there has been a push back from clinicians to incorporate such tools into their practice. One deterrent to using such feedback measures is the extra time required to implement the tool and record results. Another reason to not utilize measures is the perceived notion of more work for the clinician. To counteract the time management concern and the increased workload, clinicians could consider brief measures to help obtain continuous feedback from patients. The Outcome Rating Scale and Session Rating Scale are both short self-report measures that assess the therapeutic relationship and progress in treatment (Miller & Donahey, 2001; Miller & Duncan, 2000; Tartakovsky, 2011). These measures will be explained further in a separate section of this document.

Consistently using brief outcome measures is only one part of the feedback process in psychotherapy; with other pieces to consider. According to Miller and Bargmann (2012), establishing the mood and setting for the therapeutic process also assists the therapist in helping the client feel more comfortable and be more willing to disclose truthfully on the feedback



measure. Setting up a safe therapeutic relationship and space helps both the client and therapist successfully handle confrontations that arise in the sessions while using the feedback measures (Fleming & Asplund, 2007; Prescott & Miller, 2014).

The following studies provide examples and evidence of how obtaining feedback through the use of outcome measures result in better treatment. Lambert et al.'s (2002) exploratory analysis, a replicated study of Lambert et al.'s (2001) prior research, examined clients' responses to treatment by using the Outcome Questionnaire (OQ-45) assessment tool and a color-code rating system. The questionnaire covered three areas: "(a) subjective discomfort (intrapsychic functioning), (b) interpersonal relationships, and (c) social role performance" (p. 93), as well as sensitivity toward change over a short period. In the study, 1,020 clients participated, completing the OQ-45 at the beginning of each session with the length of treatment indeterminable. The two groups (experimental and control) showed a significant difference among the mean total score on the questionnaire, and clients who received treatment had an improvement score with an average change of 12.06 points. The difference in the pre- versus post-treatment scores between the two groups was also significant. Much like the first study, Lambert et al.'s (2002) research supported the hypothesis that feedback to the therapist would result in better outcome. An effect size of 0.40 suggests a high probability that early detection of poor treatment response and less feedback provided to the clinicians impacts outcome. The authors also found that "feedback about poor treatment response to providers nearly doubled the number of clients who returned to a normal state of functioning" (Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen, & Goates, 2002, p. 100).

**Outcome measures.** Clinicians have many reasons for choosing to use or not to use outcome measures in their practice. Hatfield and Ogles (2004) have conducted a nationwide

survey of 2,000 psychologists. Among the 600 participants who responded, the most prevalent reason for using outcome measures was to track client progress. The second highest reason was to identify a need to change or alter treatment. Are these outcome measures a better way to recognize clients' needs, or do they merely represent a more standardized approach in a manualized culture?

There is a need, desire, and benefit to using outcome measures, yet clinicians are not using them. Bickman et al. (2000) surveyed 539 clinicians working with children and adolescents to obtain opinions regarding outcome measures used in treatment. Many of the surveys returned provided substantial input about the valuable information outcome assessments provide (e.g., therapeutic alliance, maltreatment experienced, current stressors, family functioning, relationship with parents, etc.). Only 23% of the clinicians indicated that they utilize such measures continuously in their practice, but many of the respondents expressed interest in using outcome assessments. When clinicians continually measure the quality of the relationship and the client's perspective of progress, as well as discussing those observations with clients, outcomes can improve by up to 65% and the number of clients who drop out is reduced by about half (Miller, Hubble, & Duncan, 2007). Although these are examples of the potential benefits of using outcome assessments, few clinicians elect to use them.

Hatfield and Ogles (2004) conducted a similar survey to investigate the prevalence of the use of outcome measures used in practice. Two thousand surveys were sent out, of which the authors received back 996 (49.8%). Of those respondents, 37% of the clinicians ( $n = 324$ ) reported using outcome measures in treatment, with 74% completed by clients. The authors were surprised at the increase in utilization of outcome assessments. Findings included the following:

(a) clinicians use such assessments to track their clients' progress and to regulate treatment

alterations if needed, (b) clinicians' desires to use outcome measures starting at the beginning of treatment to determine levels of severity and functioning, interpersonal relationship functioning, maintenance of therapeutic gains, and tracking symptomology, (c) clinicians liked the available data the outcome measures provided, which enabled them to better judge when to implement new strategies in treatment and to track dose-effect, and (d) the authors believe there is a change in practice and point-of-view, because most of the clinicians did not endorse the use of outcome measures due to pressure from managed care requirements. Regardless of these findings, the majority of clinicians do not use these assessment tools. Hatfield and Ogles (2004) pointed out barriers in using outcome measures: additional paperwork, insufficient resources, encumbrance put upon clients, attitudes that outcome measures are not useful in treatment, concern that collected information could be misused by others, and interference in practitioner autonomy.

As mentioned, a large variety of outcome measures is available, but many are not used for various reasons. Below appears an overview of the early and valid outcome measure utilized more often. Several of these scales are applied to measure alliance that children and adolescents hold with their therapist: the Vanderbilt Therapeutic Alliance Scale (O'Malley, Suh, & Strupp, 1983), the Working Alliance Inventory (Horvath & Greenberg, 1989), and the Therapeutic Alliance Scales (Shirk & Saiz, 1992). Several other measures will also be identified.

***Stages of Change Scale (SCS).*** McConaughy, Prochaska, and Velicer (1983) developed the Stages of Change Scale (SCS), which measures client's readiness to change based upon five-stages from an integrative model of change; (a) pre-contemplation, (b) contemplation, (c) decision making, (d) action, and (e) maintenance. During each stage, clients are asked to complete an eight item, five-point Likert scaled questionnaire. Clinicians determine client's readiness to change by reviewing the overall highest score of each phase. The SCS's internal

consistency, with a Cronbach's alpha ranging from .79 to .84, is sufficient. The SCS can be a useful tool to assist therapists in determining the client's resistance or willingness to work in therapy; it can also offer a prediction of treatment outcome for that specific client (Norcross et al., 2011). However, contrast to the dissertation topic, it does not provide client feedback regarding the therapeutic alliance and relationship.

An evaluation of the SCS was completed, as 60 participants partook in a more recent study where the researchers requested them to complete the inventory prior to their first psychotherapy session (Derisley & Reynolds, 2002). A lack of detail in the procedural section of the report leaves readers questioning the legitimacy of the study. Additionally, the third stage, *decision making*, was not accounted for. The psychometric properties supported the measure's reputation of a high internal consistency and reliability of the alpha coefficient range. Typically, individual beliefs were consistent with the Stages of Change model and conceptualization. Fundamental questions arose regarding the high score methodology and inclination. Additionally, due to the lack of research regarding the SCS, reliable clinical norms are yet to be developed.

***Pennsylvania scales.*** The Penn Helping Alliance Scales were one of the first inventories developed to identify helping alliance during psychotherapy (Alexander & Luborsky, 1986; Luborsky, 1984; Luborsky et al., 1983). The Penn Scales consist of several versions, one being the Helping Alliance Counting Signs (HAcs) version that counts signs of alliance between the therapist and client in session. The Helping Alliance Rating system (HAr), another version, included two signs of alliance (the therapist's helping alliance and the collaborative partnership) from the client's perspective. When utilizing the Penn Scales the clinical observer determines and counts the signs of alliance by reviewing the session transcript. . The difference between the

two versions is the use of a 10-point rating scale on the HAR. The Helping Alliance Questionnaire was derived by combining the HAcS and HAR (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). On this questionnaire, the patient self-rates 11 items that cover both types of signs of alliance. The questionnaire was later converted to a therapist version, allowing the therapist to rate the therapeutic alliance from his/her perspective (Gerstley et al., 1989). Eventually, the Penn Scales were expanded to capture the patient's, therapist's, and observer's perspectives.

***Vanderbilt Therapeutic Alliance Scales (VTAS).*** The Vanderbilt Scales were originally designed for adult clients and collected information regarding the dynamic and integrative conceptualizations of alliance (O'Malley et al., 1983). The scale is an 80-item inventory of the therapist-patient relationship and therapeutic process. Both negative and positive facets of the interactions, behaviors, and attitudes between the client and therapist are examined to identify what elements may or may not obstruct treatment. A clinical observer rates each item using a five-point scale (1 = *not at all* to 5 = *a great deal*).

A revised version of the Vanderbilt Scales, the Vanderbilt Therapeutic Alliance Scales (VTAS), was created to rate therapeutic alliance for adolescents participating in family therapy (Diamond et al., 1999). The two areas for which responses are elicited from both the teenagers and caregivers are the collaborative working rapport and empathy. The internal consistency, alpha of 0.95, was found to be high.

***Outcome Questionnaire 45 (OQ-45).*** The Outcome Questionnaire 45 (OQ-45) was developed with the intention of tracking the progress of weekly or session-by-session change from feedback given directly to the clinician (Lambert, Hansen, Umphress, Lunnen, Okiishi, Burlingame & Reisinger, 1996; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins,

2001; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006). The assessment tool is a 45-item questionnaire given to clients in order to establish an initial state of disturbance and track it through the entirety of the therapeutic process. The OQ-45 has been normed on over 12,000 treated clients and can indicate when an undesirable treatment outcome may occur (Lambert, 2012).

Whipple et al.'s (2003) study examined several outcome measures, including the OQ-45, to determine whether client feedback impacts treatment outcome and the number of sessions attended. Nine hundred and eighty-one adult participants were randomly assigned to either an experimental (feedback) or a control (no-feedback) group. For the experimental group, each participant completed the OQ-45 at the initial intake and before each therapy session. The scores were plotted on a graph, determining where the client fell according to the clinical cutoff and how treatment progressed session-by-session. Clinical cutoff scores indicate significant symptoms: (a) the total score has a cutoff of 63 or more, (b) the symptom distress score has a cutoff of 36 or more, (c) the interpersonal relations score has a cutoff of 15 or more, and (d) the social role score has a cutoff of 12 or more (Lambert, 2004). Results of the study indicated that the clients in the experimental group, who used the support measures, remained in treatment longer and had better outcome. This study and outcome tool supports the growing body of evidence that obtaining feedback from clients creates significant client change, lowers dropout rates, and leads to overall improved treatment outcome.

The OQ-10.2, a brief screening tool derived from the Outcome Questionnaire (OQ-45.2), is intended to identify adult clients' level of distress and well-being to determine the need for a more comprehensive psychological assessment (Lambert, Finch, Okiishi, Burlingame, McKelvey, & Reisinger, 1998). According to the Mental Measurement Yearbook, the 10

questions chosen from the initial 45 differentiated patients with psychiatric disorders from members of the community that were considered non-patients. Utilizing a cutoff score of 19, the OQ-10.2 has been shown to recognize 75.7% of patients and 83.7% of non-patients who exhibit enough psychological distress to warrant further assessment (Lambert et al., 1998).

Seelert, Hill, Rigdon, and Schwenzfeier (1999) have conducted a study using the OQ-10.2 with 292 participants who were seeking medical assistance at a local clinic. Participants were asked to fill out the outcome questionnaire as they waited for their doctor appointment. A Cronbach's alpha coefficient of 0.88 revealed consistency. Well-being and psychological distress were noted among the results. Using this measure among clients seeking general medical attention can be most beneficial because the symptoms of being seen by a medical physician may or may not be related to psychological distress. Another noteworthy observation is that a milder degree of these symptoms may be present among these scores, especially among diverse populations in primary care settings.

The OQ-10.2 presents with many advantages and two major concerns. One advantage is the internal consistency of the OQ-10.2, various scores such as .82, .92, and .88, indicate accuracy and seem to be measuring the broad construct of the measure (Lambert et al., 1998). Another advantage is the test-retest values show an interval of .62 (average range). Additionally, with a cutoff score of 12, the OQ-10.2 shows good specificity and sensitivity, indicating good criterion validity. Lastly, the measure is brief, which in the world of short-term therapy is a good feature for an outcome scale.

The two major concerns with the OQ-10.2 is the lack of guidelines for interpreting the total score and when to move forward with an assessment referral. Misinterpreting the instrument may overlook or overestimate the need for a more in-depth assessment. An administrator not

versed in when and why to use the OQ-10.2 could inappropriately use this assessment, perhaps for diagnostic means or during an outcome study.

Several other versions of the OQ-45 have been designed to be used with younger clients. The Y-OQ-2.01 is a 64-item screening tool given to parents to assist in identifying and tracking outcome of youth (ages 4 – 17) who have had mental health treatment or are in need of treatment (Burlingame et al., 2005; Tzoumas et al., 2007). The tool consists of six sub-scales (interpersonal distress, somatic, intrapersonal relations, critical items, social problems, and behavioral dysfunction), which are rated using a five-point Likert-type scale to pinpoint exact areas of change in functioning. The internal consistency ( $\alpha = 0.97$ ) and test-retest reliability ( $r = 0.83$ ) are significant. Additionally, the Y-OQ-12 is another version of the OQ-45 used to assess youth through the parents' perspective. It consists of 12 items using a five-point Likert-type scale that measures psychosocial distress. The internal consistency was similar to the Y-OQ-2.01 tool. Tzoumas et al. (2007) conducted a study that implemented both the Y-OQ-2.01 and the Y-OQ-12. Findings showed that such outcome measures act as screening tools for psychological distress and current functioning among youth. Both versions had high internal consistency and a significant correlation (0.86), suggesting they elicit similar content from clients. The authors recommend using the Y-OQ-12 as a routine screening tool, coupled with the Y-OQ-2.01 to evaluate treatment outcome over time.

***Working Alliance Inventory (WAI).*** Research has shown the Working Alliance Inventory (WAI) is one of the most common instruments used among adult participants (Horvath & Greenberg, 1989). The developers of the inventory designed it to measure Bordin's (1979) alliance model among all types of therapy, to investigate the relationships between the theoretical constructs and alliance, and to relate therapeutic change to the alliance measure. It contains



several 12-item questionnaires that assess different types of alliance (e.g., goal-oriented, bond with therapist). Furthermore, Horvath and colleagues were also interested in gaining information from all perspectives involved in the therapeutic process (e.g., client, therapist, and clinical observer-rater). Although many other versions of the WAI have been created (Horvath, 1994), the original inventory retains a strong reliability (ranging from  $r = .85$  to  $.93$ ) and correlations with other outcome measures (Horvath & Greenberg, 1989).

DiGiuseppe et al. (1996) modified the reading level of the WAI so the researchers could investigate adolescents' working alliance. The study consisted of 90 adolescents and their therapists. Internal consistency was strong ( $\alpha > 0.90$ ) and the total scores addressing the agreement of goals, tasks, and therapeutic bond were demonstrated. The adolescent sample provided one significant factor—the general alliance factor. With these results, the authors speculate the idea that “younger patients may fail to discriminate between different aspects of the [therapeutic] relationship” (p. 91). Faw, Hogue, Johnson, Diamond, and Liddle (2005) employed the adapted version and found the same adequate internal consistency,  $\alpha > 0.90$ .

***Therapeutic Alliance Scales (TAS)***. The Therapeutic Alliance Scales has been one of the only assessment tools explicitly designed for young children ages 7 to 12 (Shirk & Saiz, 1992). The pilot study included children and therapists at an inpatient setting. The analysis revealed an internal consistency of the bond and negativity scales for children with a Cronbach's  $\alpha > 0.72$  and  $0.74$ , moderately acceptable. The therapists also showed favorable internal consistency with a Cronbach's  $\alpha > 0.88$  and  $0.72$ . Tasks and collaborations items were acknowledged, however, the affective items between the patient and therapist showed more overlapping ratings (Shirk & Saiz, 1992). Several other studies using the TAS have found similar results (Hawley & Weisz, 2005; Creed & Kendall, 2005; Kronmuller et al., 2002).

***Adolescent Therapeutic Alliance Scales (ATAS).*** A slightly different version of the TAS was developed to be used with adolescents: the Adolescent Therapeutic Alliance Scale (ATAS). Faw et al. (2005) researched the 14-item scale in a pilot study with African American teenagers in family prevention program. Like the original version of the scale, the ATAS assesses each contribution to the therapeutic dyad (client and therapist) that assists with the development of the therapeutic bond, tasks, and goals. Faw et al. (2005) discussed the anticipated ebb and flow of the ratings measured, with reliability occurring at the beginning and end of treatment and dipping in the middle. The connection of improved alliance with more favorable retention rates and treatment outcome did not occur. As did DiGiuseppe et al. (1996) study with the WAI, Faw et al.'s (2005) investigation used a factor analysis and found that the ATAS measured one construct for adolescents at 61.3% of total scale variance and provided strong internal consistency reliability ( $\alpha > 0.90$ ).

***Integrative Psychotherapy Alliance Scales (IPAS).*** The Integrative Psychotherapy Alliance Scales (IPAS) is another alliance measure used with children and adolescents in family therapy (Pinsof & Catherall, 1986; Quinn, Dotson, & Jordan, 1997). The IPAS examines the therapist-client relationship as one factor of the relational construct. The original components of the IPAS included the self-therapist, other-therapist, and group-therapist. Later, a fourth domain, within-system, was added (Pinsof, Zinbarg, & Knoblock-Fedders, 2008). Much like the other alliance measures, the IPAS has a theoretical structure which includes analyzing the relational constructs of the tasks, goals, and bonds within the dyad.

The creators of the IPAS wanted to emphasize Bordin's (1979) concept that the therapeutic "alliance can be torn and repaired" throughout the therapeutic process, "and that if tears are not repaired, therapy fails" (Pinsof et al., 2008, p. 285). Furthermore, the ups and downs

that occur during therapy are best tracked session by session over a two to three session interval period. The IPAS consists of several scales that attempt to measure alliance among different stakeholders: a 26-item individual therapy alliance scale, a 29-item couple therapy alliance scale, and a 29-item family therapy alliance scale (Pinssof & Catherall, 1986).

***Therapy Process Observational Coding System-Alliance Scale (TPOCS-A).*** More recently, McLeod and Weisz (2005) have developed the Therapy Process Observational Coding System-Alliance Scale (TPOCS-A). This nine-item instrument measures the alliance with the therapist comparing children and their parents. More specifically, it looks at the bond and task within alliance. Coders rate each therapy session using a Likert scale (0 = *not at all* to 5 = *a great deal*) and attempt to analyze the child-therapist and parent-therapist alliance. The authors designed the measure with an observer-rated design because it is less prone to a bias effect and best used with youth clients (Fjermestad et al., 2012).

In the pilot study, 22 youths from an outpatient community mental health clinic and their parents were asked to fill out the alliance scale throughout treatment (McLeod & Weisz, 2005). Results indicated that the parent and child forms did not show any significant correlation, and the bond and task domains overlapped, suggesting they are not independent relational constructs. The internal consistency for the child form revealed an  $\alpha = 0.95$  and the parent form showed an  $\alpha = 0.89$ . Also, there were results of early alliance with an alpha between 0.93 (child) and 0.87 (parent), and of a late alliance with an alpha between 0.91 (child) and 0.79 (parent). Lastly, the correlation between the early and late alliance was 0.54 ( $p < .01$ ). McLeod and Weisz's (2005) study, as well as a similar study by Fjermestad et al. (2012), support the idea that alliance work among children is based on the clinician engaging the client in the therapeutic interventions and developing a strong bond early in treatment. This single factor theory is present among the

literature; however, Fjermestaed et al. (2012) have made a valid point by suggesting that researchers need to consider external and internal influences such as methodology, developmental levels, or lack of specificity or structure in self-reported measures.

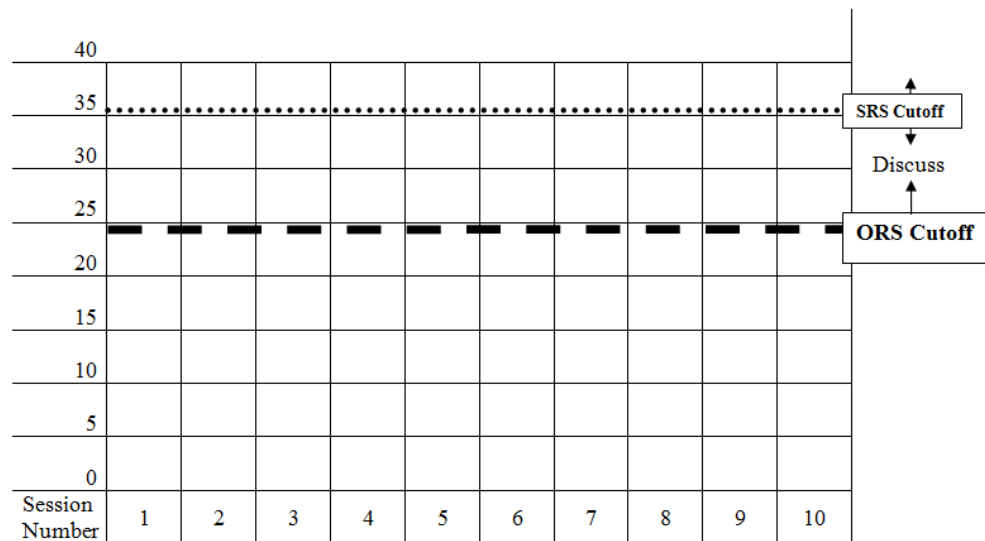
**Concluding remarks.** There appears to be a growing body of evidence and empirical support regarding the importance of therapeutic alliance among children and adolescents as a critical element in the therapy process. In fact, evidence favors the relationship of alliance between youth and therapist with positive treatment outcome, which is defined as a less deteriorated state when compared to the intake status. Although the above research provides only a snapshot of what types of outcome measures are in use, this dissertation will focus on two specific tools: the Outcome Rating Scale and the Session Rating Scale (Duncan et al., 2003a, 2003b; Miller et al., 2003). These tools, and more specifically the youth versions, will be examined and studied further.

### **Session Rating Scale (SRS) and Outcome Rating Scale (ORS)**

Introducing alliance and feedback measures into treatment poses challenges. Often the administration of the measure is lengthy and complicated and time is required for the scoring and interpreting of the results. According to Murphy and Duncan (2007), most therapists are overworked, with extensive hours and responsibilities, and view having to complete and keep track of outcome measures as only adding to a stressful work experience rather than helping with treatment outcome.

Keeping in mind the preserved added stress of applying outcome measures to a clinician's caseload, short and feasible measures have been created and implemented in the field (Duncan & Miller, 2000; Johnson et al., 2000). The Outcome Rating Scale (ORS) was designed to record therapy outcome within a few minutes at the beginning of each session (Duncan &

Miller, 2000). In the same fashion, the Session Rating Scale (SRS), which tracks the therapeutic alliance between the therapist and client, was designed to be completed at the end of each therapy session. Both instruments offer brief measures for capturing overall functioning in treatment and clients' therapeutic alliance with clinicians. The present dissertation's method section contains a more detailed description of both measures. Meanwhile, the diagram below shows the scoring graph for both the SRS and ORS (see Figure 4). The diagram indicates the clinical cutoff scores for the SRS (36) and ORS (25) for adults.



*Figure 4.* The ORS/SRS Graph. From “How being bad can make you better: Helping every single client,” by B. L. Duncan, in B. L. Duncan (Ed.), *On becoming a better therapist* (p. 67), 2010. Washington, DC: American Psychological Association.

It is most effective to start the ORS with clients from the first session in order to establish a baseline score. The ORS provides an effective tool to inform case conceptualization and treatment planning. It can track changes in overall functioning over time and may be effective in shortening treatment. In some cases the ORS may also be effective in identifying appropriate

interventions. This outcome measure is relatively new, created in 2000, and has been introduced in clinics in various parts of the United States and Europe (Hafkenscheid et al., 2010).

As with the ORS, the SRS is most effective when used starting from the initial session to establish a baseline score. Rating the session's effectiveness and overall therapeutic bond, the SRS helps promote honest feedback to strengthen the therapeutic alliance. There has been an observed inter-correlation between relationship (the SRS) and overall outcome (the ORS) in treatment when using both measures consistently among adult clients (Hafkenscheid et al., 2010).

The SRS was originally developed as a 10-item Likert-scale measure, intended to gather information about the therapeutic alliance from patients, based on Bordin's (1979) definition of alliance and Gaston's (1990) client's theory of change (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003). It was first given to 39 patients at a psychotherapy clinic. While results showed strong reliability, the length of 10-items was still too lengthy, prompting the creators to reduce the instrument to four-items.

Miller et al.'s (2006) found that the ORS and SRS measures, used by 75 "in house" therapists with 6,424 clients over a two-year interlude proved quite relevant. The clients involved in the study were from "Resources for Living (RFL), an international Employee Assistance Program (EAP) based in Austin, Texas" (p. 7). Among the high validity rate and reliability, these measures demonstrated improved retention and outcome, as well as a likeable measure among the therapists. Those therapists who elected not to use the ORS and SRS, failing to inquire about feedback from their clients, found that clients "were three times less likely to return for a second session" (p. 14).

A previous study by Miller et al. (2003) featured 86 participants in the nonclinical group and 435 participants in the clinical group. Researchers asked participants in the clinical group to take the ORS at the beginning and ending of treatment, which consisted of 3 to 10 clinical sessions. In addition, the researchers asked the non-clinical group to take the ORS, as well as the Outcome Questionnaire 45.2. Using a Cronbach's coefficient alpha, results for all four administrations of the ORS was 0.93 and the test-retest reliability was 0.66 for the second session. A similar result of the reliability of the ORS was conducted by the Center for Clinical Informatics (Miller et al., 2006). This study showed a statistically significant improvement between the pre-test and the post-test scores with a  $p > .00001$ . The ORS indicated sensitivity to change when psychotherapy interventions were present.

Change is the goal for psychotherapy treatment, and for most clients it does not matter how that change comes about, but sometimes there are barriers preventing or delaying change and other times change can be difficult to assess. When using straightforward, feasible measures such as the ORS and SRS, clients note their progress within a session or two (Miller & Duncan, 2000, 2004). Despite the progress, outcome measures like these also have drawbacks. For example, clients want to please their therapist, yet there are no controls for social desirability in the measures. Therefore, they rely on the client's ability to accurately interpret his/her distress level. If therapists do not explore clients' distress levels truthfully, the measures will not be useful for anyone. Additionally, the ORS and SRS do not assess for clinical risk factors, such as alcohol abuse and suicide ideation (Duncan et al., 2006), which play a role in building alliance and making treatment progress. Clinicians have to be aware of these limitations to take further precautions with other instruments, interviewing techniques, and interventions.

**Further empirical evidence.** Substantial evidence has shown that collecting client feedback in a session-by-session manner strengthens effectiveness for treatment outcome and therapeutic alliance. The Outcome Rating Scale (ORS) (Miller & Duncan, 2000; Miller & Duncan, 2004) and the Session Rating Scale (SRS) (Miller & Bargmann, 2012; Miller & Duncan, 2004) were developed to be usable in every session. The Partners of Change Outcome Management System (PCOMS), a part of The Heart and Soul of Change Project, came together to employ both measures to improve psychotherapy treatment through the use of client feedback (Duncan, Miller, & Sparks, 2004; Miller et al., 2005). Since the creation of these feasible outcome-alliance measures, several studies have investigated the reliability and validity of the scales.

Gillaspy and Murphy (2011) completed an overview of the studies that utilized the ORS and SRS. According to their findings, five studies used one or both of the measures. Amongst one of those studies, Miller et al. (2003) used the ORS with two groups, nonclinical ( $n = 86$ ) and clinical ( $n = 435$ ), over several weeks. The nonclinical group was also administered the OQ-45.2 measure. Moderate stability of the coefficient alpha ( $\alpha = 0.93$ ) and test-retest reliability of 0.66 was evident. Another study, by Bringhurst et al. (2006), similarly compared the ORS with the OQ-45.2. Participants consisted of only an  $n = 98$ , from a nonclinical group. The results indicated a much higher test-retest reliability of 0.80 and a correlation coefficient  $\alpha = 0.97$ . Overall, these statistical properties indicated that the ultra-brief measure of the ORS had similar results to the OQ-45.2, a more in-depth instrument, at assessing global subjective distress. Bringhurst et al.'s study showed that the ORS had sufficient concurrent validity and moderate to high reliability across several administrations. One finding that warrants further examination was that female participants scored significantly lower on the ORS than male participants.



Duncan et al. (2003) was another study investigating the SRS's reliability and validity. There were two groups of clients; one group elicited from an outpatient clinic (closed cases from a community agency) and the second group, coming from the same clinic, was formed of closed cases from a home-based intervention program. To examine three constructs of the SRS (e.g., reliability and concurrent validity, construct validity, and feasibility), participants were randomly separated into three groups. Two other measures (the Helping Alliance Questionnaire II (HAQ-II) and the working alliance inventory (WAI)) filled out by the clients were reviewed and compared to the SRS. Among all three groups, results showed a test-retest reliability of 0.64 and a coefficient alpha of 0.88. Concurrent validity was shown between the HAQ-II and SRS ( $r = 0.48, p < 0.01$ ). The authors also reviewed the relationship between the alliance and outcome, finding the SRS scores from the 2nd or 3rd session and last session to have a correlation of 0.29 ( $p < 0.01$ ). In addition, the feasibility of the SRS had a 96% compliance rate due to the brief and easy design.

In more recent studies, researchers have investigated the psychometric properties in both the ORS and SRS (Anker et al., 2009; A. Campbell & Hemsley, 2009, Hafkenscheid et al., 2010; Miller et al., 2006, Reese, Norsworthy, & Rowlands, 2009). The Dutch Jewish Mental Health Services in Amersfoort, the Netherlands (Hafkenscheid et al., 2010), conducted one of the studies. Findings and methodology were similar to American studies. In addition to administering the Dutch translation of the ORS and SRS to clients, the therapists completed the Therapist Satisfaction Scale (TSS) after each session. There were 126 client participants and 18 therapists, with a combined total of 1,005 ORS and SRS forms completed.

Mean initial ORS scores (19.3) were similar to Miller and Duncan's (2004) study (19.6). The clinical cutoff scores (ORS: 25, SRS: 36) were either not identified or showed a lower

percentage of occurrence in the Dutch sample. Overall, psychometric properties were as follows: correlation between the ORS and SRS  $r = 0.28$ , reliability from the first and tenth session was between 0.90 and 0.91, and the alpha coefficient exceeded 0.80. Test-retest reliability was between 0.49 and 0.65, within the same range (0.49 and 0.66) of American studies (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003; Miller et al., 2003). One major difference for the Dutch study was the lower ORS scores at the end of treatment. The authors suggested this could be accounted for by either a lack of general change or cross-cultural differences.

Among other studies utilizing both measures, findings showed improved treatment outcomes grounded by clinically significant change (Miller et al., 2006, Reese et al., 2009). Miller et al. (2006) found improvements in both client retention (clients staying with one therapist during the entire length of treatment) and positive treatment outcome with ongoing feedback. In fact, the researchers reported a significant change in the internal effect size from 0.79 at the initial baseline to 0.93 at the end of treatment.

To study continuous feedback assessment, Reese et al. (2009) employed the Partners for Change Outcome Management System (PCOMS) with two samples (sample A and sample B) of participants attending individual therapy (total  $n = 148$ , each sample of 74). The PCOMS consists of the continuous use of the ORS and SRS. Each sample consisted of two groups, the feedback group (using the ORS and SRS each session) and the no-feedback group (using the ORS during the first and last therapy sessions only). All participants in both groups completed a pre- and post-treatment ORS, however, the feedback group also completed the ORS during each session of treatment. Change was evident in the feedback groups, as well as overall feelings of positive alliance with the therapist. A medium to large effect size was present in both samples

(sample A,  $d = 0.54$ ; sample B,  $d = 0.49$ ). Among the limitations of the study, not monitoring treatment integrity of the PCOMS was a red flag. Although the measures were completed, it was unclear whether all therapist-client dyads discussed the results. Some therapists stated they were too busy or forgot that part of the process, indicating review of the measures was not consistent.

A. Campbell and Hemsley (2009) were interested in comparing the ORS and SRS to longer measures (OQ-45, WAI, Depression Anxiety Stress Scale-21, Quality of Life Scale (QOLS), Rosenberg Self-Esteem Scale (RSES), and General Self-efficacy Scale (GPSE). Sixty-five participants completed all assessment tools within the first two sessions. Internal consistency among the subscales for each measure revealed a range of  $\alpha = 0.89$  to  $0.95$ . The SRS and ORS were not strongly correlated; however, on the ORS, the “overall” and “individually” scales were strongly correlated ( $r = 0.7$ ,  $p < 0.01$ ). Furthermore, moderate to strong correlations were found between the ORS and RSES, GPSE, and QOLS. Consistently moderate correlations with the WAI and SRS were significant. This strong positive correlation with other well-established, longer assessment tools supports the use of the ORS and SRS. Even though the sample size was small, the results were promising. The availability of comparable scales that are relatively easy to administer and quick to score is encouraging, as it allows therapists to provide scores to clients in the moment, resulting in enhanced opportunity for alliance development in brief therapies.

Gillaspy and Murphy’s (2011) review of the literature brought up several limitations for the use of the ORS and SRS (the PCOMS system). First, an evaluation of the therapists’ skills and training was lacking, which weakened reliability for implementation of the scales. Because only 10 to 75 therapists were involved in the aforementioned studies, generalizability was also weak. When assessing treatment outcome alone, the ORS was the only measure evaluated, with no other measure used for comparison. In addition, a possible “researcher alliance” may have

been in effect, because in several of the studies the scales' developers, themselves, were involved.

Additional limitations Gillaspay and Murphy (2011) were that the measures neglect to address other factors brought into the session, the possibility that perception of alliance can vary, and the phenomenon of transference may provoke positive responses from clients. The instruments' domains could be too narrow, boxing in the client's focus of treatment and excluding pertinent information and experiences. Likewise, the client perception of the alliance could differ greatly from the therapist's point of view. There may be an inflation of positive responses on the measures because clients tend to want to please the clinicians, which is another limitation the scale does not address. Gillaspay and Murphy believed the above limitations of the measures are important considerations therapists must keep in mind when interpreting scores. Regardless of these limitations, internal consistency and test-retest reliability have been strong for both the ORS and SRS. Furthermore, the ORS and SRS in comparison to the OQ-45.2, an established measure, evinces a moderately strong concurrent validity.

### **SRS and ORS Used Among Adolescents and Children**

A few years after the ORS and SRS were created, the developers modified the instruments to be administered to children and adolescents, resulting in the Child-ORS (CORS) (Duncan et al., 2003a) and the Child-SRS (CSRS) (Duncan et al., 2003b). The terminology on the forms is age appropriate and images of smiling/frowning faces help communicate with a younger audience. The developers emphasized the importance of having caregivers (e.g., parents, teachers, etc.) complete the same version of the scales as the young participant in order to keep results consistent. This practice pertains to studies where researchers assess caregivers' ratings.

The current dissertation does not control for this variable; rather, data from children and adolescents only were examined.

The Heart and Soul of Change Project is an initiative promoting the use of client based outcome feedback, also known as the Partners for Change Outcome Management System (PCOMS) developed by Scott Miller and Barry Duncan (Duncan, 2012) and based on Lambert's (2004) Outcome Questionnaire-45 (OQ-45). Duncan (2012) states,

The clinical process of PCOMS boils down to this: identifying clients who aren't responding to clinician business as usual and addressing the lack of progress in a positive, proactive way that keeps clients engaged consistently while therapists collaboratively seek new directions (p. 96)

As clients use the ORS/CORS and SRS/CSRS measures, clinicians can note specific changes or plateaus to identify the need for a new action plan. To support such a method, Norcross and Wampold's (2011) research has shown the strong relationship of alliance with high rates of treatment sustainability and benefits. The use of the ORS/CORS and SRS/CSRS promotes such alliance by maintaining an open feedback system. The Heart and Soul of Change Project offers support to research and training, but more importantly the project benefits clinical practice (Duncan, 2012). Utilizing this approach toward psychotherapy, no matter what orientation or technique is being applied, offers a way to monitor treatment results. The Heart and Soul of Change Project also provides guidance and tools, such as the PCOMS Therapist Competency Checklist, information on the National Consensus Statement on Mental Health Recovery (including the following categories: self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope), and the PCOMS Organizational Readiness Checklist (Duncan, 2012).

**Using PCOMS in schools.** Sparks and Muro (2009) explored the importance of the client's view of treatment in a wraparound community-based program, a program that offers

ongoing support and connection with community resources. Considering the practical and ongoing use of the ORS/CORS and SRS/CSRS as an outcome-alliance tools and a way to gain continuous feedback, the authors believed it ideal for such a program. When the measures were completed and analyzed with the client in a collaborative manner, the relationship was fostered, increasing opportunities for client-change. Clinicians ask adolescents and caregivers to fill out the ORS and SRS, while children under the age of 13 fill out the CORS and CSRS. These new adaptations to the measures has increased the opportunity to gain useful insight and feedback from child clients' point of view.

Sparks and Muro (2009) also offered a practical example of using the measures in a wraparound service for a family involved in a Child Protective Services (CPS) case. All family members and stakeholders from school (e.g., teachers) provided consistent weekly ratings, indicating a good working relationship. Verbal statements from all parties were helpful in this case, including, the data provided from the ORS/CORS and SRS/CSRS, which added “powerful corroborative scientific evidence” (p.70).

In more recent studies (Cooper, Stewart, Sparks, & Bunting, 2013; Murphy & Duncan, 2007), researchers evaluated the PCOMS effectiveness in school-based mental health services. Cooper et al. (2013) analyzed data from 288 children (7 – 11 years) in a school setting who had been experiencing psychological distress. The authors were interested in identifying clinical change on the CORS from baseline (pre-counseling) to endpoint (post-counseling). Ratings of the Strengths and Difficulties Questionnaire (SDQ), completed by teachers, indicated lower levels of stress among this sample of children. Researchers loosely defined psychological distress as experiences of social, emotional, and behavioral difficulties. The CORS offered a “clinical” cutoff point (31 for children, 27 for caregivers/teachers), assessing clinical change by

comparing the initial and last scores. The SDQ scores were also compared to the CORS to reveal any correlations between the measures. Results showed a 12.36-point reduction of psychological distress on the CORS and a pre-post effect size of 1.49. Furthermore, 87% of the children showed clinical improvement. The scores across treatment had moved into the nonclinical range by termination. Overall, when incorporating systematic feedback such as the PCOMS into a school-based counseling program, results were favorable with a reduction of psychological distress for young children.

**Creating and shaping conversation.** Sundet (2010) examined the use of the SRS/CSRS and ORS/CORS at a family unit (day-care and outpatient services) in a Norway Hospital. The most common diagnoses seen at the unit were conduct disorder, obsessive-compulsive disorder, attention deficit/hyperactivity disorder, and developmental or emotional problems. Participants of the study included four therapists and ten families (30 people total). Researchers interviewed all participants regarding the use and description of the SRS and ORS. Results of the interviews indicated six different types of conversations elicited by the use of the measures:

Conversations about feedback, progress, and change; conversations that created routine and structure; conversations that expressed experiences, meanings, and perspectives about the therapeutic work; conversations characterized by the not-knowing position; externalizing conversations and conversations that brought forth a product or result. (Sundet, 2010, p. 84)

Furthermore, therapists supported the use of the ORS/CORS and SRS/CSRS because they encouraged such conversations to occur. While these instruments are assessment measures, they have additionally been incorporated as treatment tools for building the relationship and allowing change to occur.

Sundet's (2010) study provides qualitative data to support the use of the ORS/CORS and SRS/CSRS among families. He made a connection to Vygotsky's (1978) perspective that using

“tools as mediating action helps us see how standardized measures as conversational tools can expand options for conversation and action in a therapeutic context” (Sundet, 2010, p. 91).

Moreover, collaboration between all participants in the therapeutic process characterizes the heterogeneity of post-modern psychotherapy.

**Further empirical evidence.** Research (Miller et al., 2003) has provided a large database examining the use of the Child Outcome Rating Scale (CORS) with children and the ORS with adolescents and caretakers. The CORS and ORS were analyzed in relation to a comparison measure, the Youth Outcome Questionnaire 30 (YOQ). The main intention of the research was to explore the reliability and validity of a brief outcome measure with younger people in mental health treatment in comparison to a more typically used outcome measure.

Much of the literature on using the ORS and SRS with children and adolescents is based on treatment provided at outpatient treatment centers. In fact, there are only a few published studies using the ORS/CORS and SRS/CSRS with young participants (Miller, 2011). In one particular study, researchers intended to elicit a voice from youth in order to build therapeutic rapport and increase successful treatment outcome (Duncan et al., 2006). Participants consisted of three different clinical groups (adolescents, caretakers, and either child/caretaker dyads or adolescent/caretaker dyads) and three different non-clinical groups (all caretaker and youth dyads). The non-clinical groups completed two rounds of the CORS, ORS, or Youth Outcome Questionnaire 30 (YOQ), during the tenth day and 21st day of the treatment program. The clinical groups completed multiple administrations of the ORS over a two-to-four year treatment period. Results of the study showed that the ORS and CORS presented strong reliability (coefficient  $\alpha = .93$  and  $.84$ ). These high coefficients of reliability compared positively with the normative coefficient alpha for the YOQ. While the ORS and CORS are limited



psychometrically in comparison to the YOQ because of the minimal categories and questions they present, their brevity makes them a more feasible measure for immediate feedback for clients and clinicians.

Duncan et al.'s (2006) study showed further indications that the CORS and ORS tended to be sensitive to change for participants attending psychotherapy and to be more stagnant for people not in treatment. This sensitivity to change supports construct validity for the measure. Further evidence of construct validity can be noted when reviewing the initial scores and final outcome scores of the ORS/CORS between the clinical sample and the nonclinical sample. When comparing all participants' measures scores, (ORS/CORS/YOQ among children, adolescents, and caretakers) correlations provided additional confirmation for strong construct validity (Duncan et al., 2006). Because of the strong correlation between the two measures, (ORS/CORS and YOQ) results provided as much empirical support for the ORS/CORS as for the YOQ. Furthermore, Duncan et al. (2006) showed a strong internal consistency of the ORS/CORS for adolescents (0.93) and children (0.84). Overall, the ORS/CORS was as effective as the longer measure (e.g., OQ-45), yet was more practical for clinicians' daily use. The measures gave voice to young clients, enabling them to play a role in their own treatment.

While the measures are sensitive to change, noticing exactly what that is can be challenging. Using both the ORS/CORS and SRS/CSRS together, better known as the Partner of Change Outcome Management System (PCOMS), was intended to encompass many facets of change (Miller, Duncan, Sorrell, & Brown, 2005). Hanna (2002) offered several client-specific precursors to change that align well with and provide support for the use of the ORS and SRS. Those characteristics are as follows: the sense of perseverance for change, willingness to experience difficult situations in the therapeutic process, awareness of the problem at hand,

confronting the problem, effort put forth toward change, hope for change as identified by the client, and necessary social support. The characteristics of change put forth come from using the measures together, provide many opportunities for autonomy and equality in treatment for young clients.

**Making FIT fit.** The Children and Young People's Improving Access to Psychological Therapies program (CYP-IAPT) routinely monitored outcome using various assessment tools, including the ORS/CORS and the SRS/CSRS (Low et al., 2013). Among Low et al.'s findings in reviewing the literature was that over 3,000 children and adolescents in a four-year validation study using the ORS/CORS showed strong reliability, validity, and feasibility. The authors intently expressed how important it is for the client to see change (e.g., scores moving across the clinical cutoff line on the ORS/CORS and SRS/CSRS graphs, see Figures 5 and 6) in treatment, and how this experience assists in building alliance and supporting client change. Although administering measures to a mandated or involuntary client can prove problematic, Low et al. (2013) suggested encouraging child clients, who are resistant, to fill out the ORS/CORS "from the perspective of the referrer who has concerns about how they are doing" (p. 5). After the client fills out the measure for him or herself, a comparison can be made between the two ratings. Low et al.'s work furnished a quick summary of the extensive manuals (Miller & Duncan, 2004) for using feedback informed treatment (FIT) and the outcome (ORS/CORS) and alliance rating (SRS/CSRS) measures.

**Concluding remarks.** There are unfortunately few studies directly inspecting the use of the ORS/CORS and SRS/CSRS with children and adolescents. The research study for this dissertation will utilize these measures to explore the patterns of therapeutic alliance across

treatment with young clients. In addition to identifying patterns of alliance, further investigation of how those patterns relate to and/or predict treatment outcome will be examined.

### **Chapter III: Methodology**

In the previous section, an introduction to the proposed area of research was presented, including a description of the current study's research problem, several research purposes, hypotheses that will direct the data analysis, and an identification of several terms fundamental to the study. In addition, a review of literature relevant to the two major variables—therapeutic alliance and treatment outcome—established a background of contextual support for the study. The researcher's intent was to examine the relationship between the therapeutic alliance and treatment outcome via the methodology described below.

#### **Research Design**

This study used a quantitative, correlational research design. The dependent variable was the overall treatment outcome, which was measured in terms of the Outcome Rating Scale (ORS) among adolescent clients and in terms of the Child Outcome Rating Scale (CORS) among child clients. The independent variable was the alliance patterns measured by the Session Rating Scale (SRS) among adolescent clients and the Child Session Rating Scale (CSRS) among child clients.

#### **Measures**

The current study used two measures with each participant. The first measure was the Outcome Rating Scale (ORS), which was used among the adolescent participants. For the child participants, a modified version of the ORS was given, which was called the Child Outcome Rating Scale (CORS). Both versions of the scale were given to measure the participants' self-report on treatment outcome throughout the course of treatment. Based on the research to date, the normed clinical cutoff for adolescents (aged 13–17) using the ORS has been set at 28, while the normed clinical cutoff for children (aged 6–12) using the CORS has been set at 32 (Bargmann & Robinson, 2011; Maeschalck & Miller, 2012; Seidel & Miller, 2012).

The second measure administered to the adolescent participants was the Session Rating Scale (SRS). The child participants were administered an age-appropriate version called the Child Session Rating Scale (CSRS). Again, both versions of this second measure were a self-reported instrument measuring the participants' perception of the therapeutic alliance. The clinical cutoff for both versions has been set at 36 (Bargmann & Robinson, 2011; Maeschalck & Miller, 2012). Please also refer to Figure 5 for a visual representation (a plot graph typically used in sessions with clients) of the ORS and SRS cutoff scores for adolescents. Additionally, refer to Figure 6 for a visual representation of the CORS and CSRS cutoff scores for children; this plot graph is typically used in treatment with clients to record their scores. Several studies have provided support for the measures being feasible, reliable, valid, and accounting for change (Duncan, Miller, Wampold & Hubble, 2010; Miller, 2011). Note: all measures were used in the present study were for examination only and working copies can be obtained at <https://heartandsoulofchange.com>. Additionally, all measures are free for individual use, but groups require a license.

### ORS/SRS Graphs

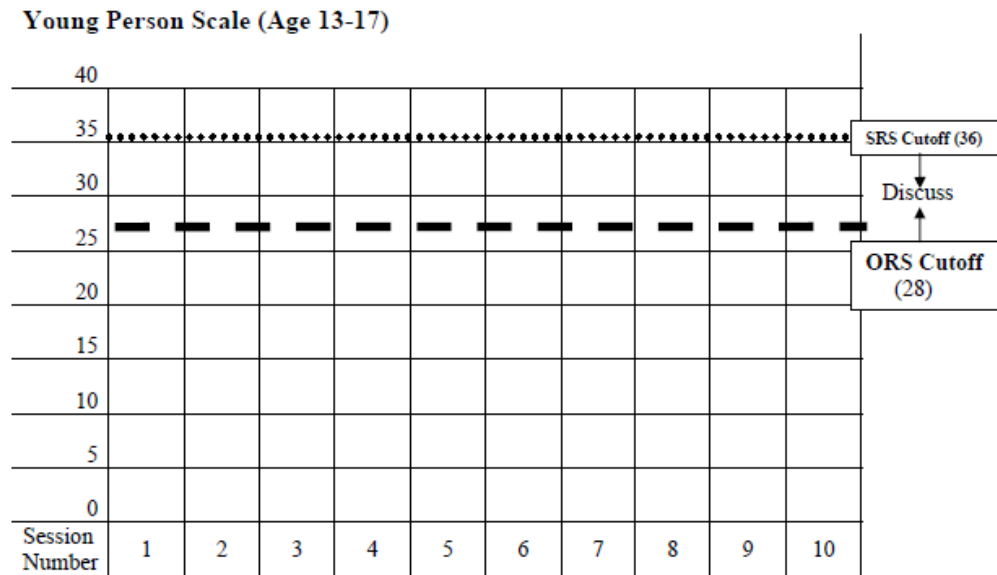


Figure 5. The ORS/SRS graph for young clients (ages 13–17). From Low et al. (2013, p. 23).

### CORS/CSRS Graphs

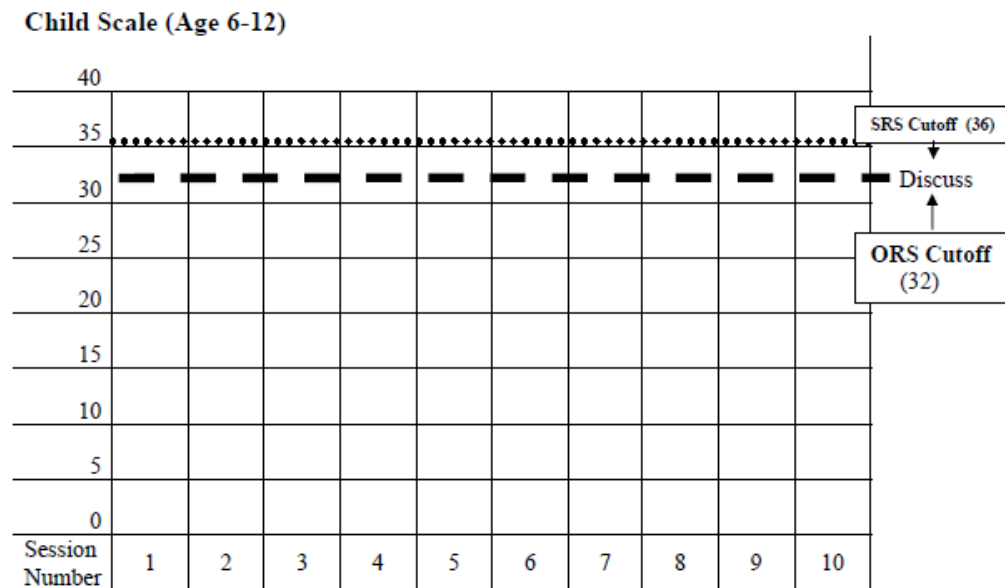


Figure 6. The CORS/CSRS graph for children (ages 6–12). From Low et al. (2013, p.23).

**Outcome Rating Scale (ORS).** The Outcome Rating Scale (ORS) was normed for adolescents (ages 13+) and adults. The Child Outcome Rating Scale (CORS) was normed for children (ages 6 – 12) (Bargmann & Robinson, 2011). Both forms of the instrument are a feasible client-rated four-item measure covering well-being in four areas of a client's life: (a) individual, (b) interpersonal, (c) functioning, and (d) overall well-being (Duncan et al., 2004; Duncan, Miller, Huggins, & Sparks, 2003; Duncan, Sparks, & Institute for the Study of Therapeutic Change, 2007; Miller et al., 2003; Miller et al., 2006). The ORS/CORS was administered at the beginning of each session, asking clients to recall and rate their functioning in the different areas of well-being since their last therapeutic session. The clients were instructed to place a hash mark on the 10-centimeter line appearing under each of the four domains. Please refer to appendices A and C for the specific measures.

**Session Rating Scale (SRS).** The Session Rating Scale (SRS) and the Child Session Rating Scale (CSRS) are both four-item feasible client-rated measures of the therapeutic-alliance (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003; Miller & Bargmann, 2012). The instrument is to be completed at the end of every session. As with the procedures for the ORS/CORS, clinicians asked clients to place a hash mark on each line of the four domains of alliance (relationship, goals and tasks, approach and methods, and overall). Please refer to appendices B and D for the specific measures.

**Scoring both measures.** Below each item, on each measure, a ten-centimeter line appears. Clinicians were trained to simply measure with a ruler to determine where on the ten-centimeter line each hash mark fell. Each item has a possible score of 10. The ORS/CORS contains four numbers, as does the SRS/CSRS. For each measure, the numbers of each item are then added together to determine a total, with a possible score of 40.

The following is an example: A client places a hash mark on each line found on the SRS/CSRS, which are under each four main areas (relationship, goals and tasks, approach and methods, and overall). The clinician then places a centimeter ruler over each line to determine where each hash mark falls. The relationship line will have a number, the goals and tasks line will have a number, and so on. There will be four numbers representing each domain of the alliance measure. Scores can vary between zero and 10, and have decimal points. The four numbers are then added up to comprise a total number—the alliance score for the session. The same process applies for the CORS/ORS.

### **Data Collection**

**Research setting.** Lane County Behavioral Health, referred to hereafter as LCBH, is a non-profit mental health agency located in the town of Eugene, Oregon. LCBH offers services to children, adolescents, and families in Lane County through its Child and Adolescent Program (CAP), an official part of the county's Health and Human Services Department.

CAP is a comprehensive program providing psychoeducation, screening and referral, and treatment services for 6 to 17-year-old children and adolescents in the community. Treatment services include orientation to services, mental health assessment, psychiatric evaluation, individual and family therapy, child and family team meetings, medication management, care coordination to facilitate linkages to community partners, determination of level of need for higher levels of care, crisis intervention, skills training and behavioral support, parent training and support, and support groups meeting needs in the community (e.g., adolescent DBT group and collaborative program solving). CAP serves approximately 943 clients per year, providing approximately 5,705 clinical sessions, and has a staff of about seven therapists. All clinicians hold a master's degree or higher from an accredited university, are licensed as independent



health care providers (i.e., LCSW, LMFT, MA ATR-BC, or equivalent), and have two years of supervised post-graduate counseling experience working with child and adolescent populations.

CAP serves children, adolescents, and families in Lane County who are insured by the Oregon Health Plan, uninsured, or who present with significant barriers to appropriate services in the private sector. The program offers a variety of cognitive, behavioral, and expressive therapies, such as individual, family, art, and play therapies, as well as Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), parent-child interaction therapy, circle of security parenting, and collaborative problem solving. An initial screening guides the treatment team in determining appropriate care, which may include a face-to-face interview with a therapist for a mental health assessment. It is highly recommended that the individual client (child or adolescent) and family participate in treatment planning. If needed and deemed appropriate, a referral for a psychiatric evaluation and medication management may be supplied.

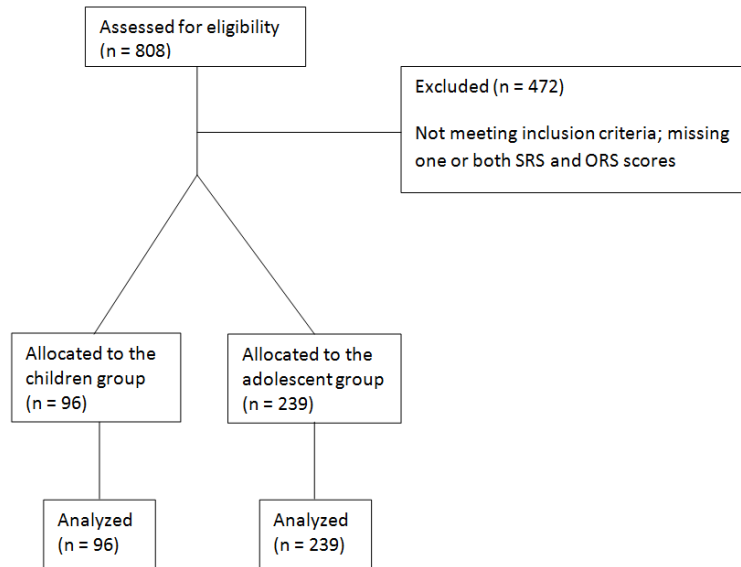
It is important to note that the specific population examined consisted of youth living in a relatively rural area in the western United States, and that findings are not generalizable to other populations.

**Archived data.** After submitting an IRB and gaining approval, the researcher utilized an existing database provided by Lane County Behavioral Health Services, specifically its Child and Adolescent Program (CAP). The researcher was given limited access with a temporary username and password. The useable data was manually transferred and saved onto a secure and private computer owned by the researcher. All information was inputted into fully encrypted files protected with passwords. The computer and back-up drive were also encrypted with a password known to only the researcher. The original data remained on LCBH's online database. Names of research participants and therapists were not used when manually transferred, for the purposes of

privacy and confidentiality. Each participant was assigned a number as the data was transferred onto the researcher's computer, as mentioned earlier, for the protection of participant identity. All research materials will be destroyed three years after the conclusion of the present study or seven years after publication.

**Privacy protocol.** The recorded data was transferred and saved to a password-protected personal computer. The data was organized in an Excel spreadsheet, which was encrypted using a program called AxCrypt on the same password-protected computer. All documents created with data analyses were protected using the same encryption program, as well as being saved on an encrypted back-up drive. Hard copies of all data analyses, which were printed for consultation purposes, were stored in a secure, locked filing cabinet located in the researcher's private desk. The back-up drive, computer, and all research materials were also stored in the same locked filing cabinet. The Excel spreadsheets were utilized as the primary format of the data for the data analysis process. For the purposes of privacy and confidentiality, no patient or clinician names appeared on any of the documents. All patients and clinicians were assigned specific numbers as identifiers in order to maintain privacy protections for all participants in the study. Three years after the completion of this study, or seven years if the results are published, all research materials will be destroyed.

**Participants.** Using pre-existing archival data, the researcher examined 808 potential client files, excluding 472 because the clients did not meet the inclusion criteria. Please refer to Figure 7 and the protocol described below for further explanation. The participants for this study consisted of 335 youth who were inactive clients at the time of data analysis. The final client sample consisted of 96 children and 239 adolescents.



*Figure 7.* Flowchart of study participants.

At the time data was collected, the participants consisted of children between the ages of 6 and 12 years and 11 months, and adolescents between the ages of 13 and 17 years and 11 months. The data was collected from the clinical supervisor, master level clinicians, and a child/adolescent psychiatrist, all of whom saw patients and administered the ORS/CORS and SRS/CSRS instruments. The subjects had been referred to the outpatient community mental health clinic, located in southern Oregon, for a variety of behavioral concerns and mental health conditions by primary care physicians, child welfare workers, schools, courts, and parents. A majority of clients were referred to be assessed for cognitive and behavioral health concerns. Unfortunately, the database provided to the researcher did not include demographics such as race or guardianship of the participants.

**Inclusion criteria.** Each participating client was required to meet the inclusion criteria of having a pre- and post-SRS/CSRS score, as well as a pre- and post- ORS/CORS score. The data collection occurred in a series of two stages:

1. Baseline assessment. Data was collected from all participants, in both groups, at the beginning of treatment. Both the SRS/CSRS and ORS/CORS measures were given.
2. Treatment assessment. All participants completed at least two sessions of therapy, completing a second set of SRS/CSRS and ORS/CORS measures.

**Procedures.** The data was collected at one behavioral health clinic located in Eugene, Oregon; all data pre-existed the beginning of this research. Clients had been invited to complete the measures at each therapeutic session. All participating clients completed the ORS/CORS at the beginning of each therapeutic session in order to obtain their perspective of their well-being in four domains: individual, interpersonal, social, and overall. As clients were asked to rate their sense of well-being in each domain they would place a hash mark on a 10-centimeter line indicating how they viewed that area of well-being, more healthy or less healthy. Because the line was 10-centimeters long, each domain had a possible high score of 10 and low score of zero. After the clients completed their rating the clinicians would use a centimeter ruler to score each domain. The total score, a sum of the four domains, was tallied. Total scores marked in the 20s or below designate significant distress, while a score of 40 represented the highest possible well-being.

At the end of each session, clients were asked to complete the SRS/CSRS in order to measure therapeutic alliance between themselves and the clinician. Much like the ORS/CORS, the SRS/CSRS measures four domains: relationship, goals and topics, approach or method, and overall alliance. The scoring procedure is identical to that for the ORS/CORS. For the SRS/CSRS, total scores of 39 – 40 indicate a strong or good alliance, total scores of 37 – 38 demonstrate a fair alliance, and total scores of 36 or below indicate a poor alliance (Duncan &

Miller, 2008). Clients were encouraged to discuss the low scores in a non-defensive manner to distinguish and adjust incipient alliance problems.

### **Data Analysis Plan**

The main objective of the current exploratory analysis was to examine the within-subject changes in alliance that affected the within-subject changes in treatment outcome. The data source included approximately 335 clients nested within approximately 11 clinicians. Clients consisted of children ages 6 to 11 years and 11 months, and adolescents' ages 12 to 16 years and 11 months. Because the children were given a slightly different version of the measures than the adolescents, children (29% of the sample) and adolescents (71% of the sample) were analyzed separately.

The alliance pattern groups were set according to clients' scores on the first and last SRS/CSRS measures. The following are the nine possible alliance pattern groups: good/good, good/fair, good/poor, fair/good, fair/fair, fair/poor, poor/good, poor/fair, and poor/poor. These alliance pattern groups or categories were based on Duncan and Miller's (2008) research and comprehensive summary of outcome-informed, client-centered treatment. Clients were clustered into the predetermined categories (nine alliance pattern groups). The process data consisted of session-by-session alliance scores set by the SRS/CSRS and session-by-session outcome scores set by the ORS/CORS. Within-subject changes in treatment outcome were computed as the difference in ORS/CORS at the final and initial treatments.

***ANOVA.*** A one-way analysis of variance (ANOVA) of clients' SRS/CSRS scores and ORS/CORS scores was conducted in order to discover whether the differences in means occurred across alliance pattern groups. More specifically, a one-factor between-subjects ANOVA was used due to having only one independent variable with multiple levels (alliance

pattern groups) and different subjects in each condition. The dependent variable was the overall treatment outcome produced by the ORS/CORS difference score in each group. The independent variable was the alliance pattern groups determined by the pre- and post-SRS/CSRS measures. The sample size of 96 children had 32.3% and 78.9% power, respectively, to detect a medium effect size ( $f = 0.25$ ) at a 0.05 alpha level. The sample size of 239 adolescents had 76.8% and 99.8% power, respectively, to detect a large effect size ( $f = 0.40$ ) at a 0.05 alpha level. Again, two separate one-way ANOVAs were conducted based on age, as previously described.

It was predicted that a within-group variability would be present because of individual difference among subjects, which would be treated alike within groups and/or experimental error. The one-way ANOVA test statistic used an F-ratio to determine the statistical significance of the results. The researcher used statistical software (SPSS) that provided the p-value. Based on the preset alpha level ( $p < .05$ ), the researcher determined whether the results were significant with the p-value. If the p-value was less than or equal to the alpha ( $p \leq .05$ ), the researcher would reject the null hypothesis and indicate the result to be statically significant. If the p-value was greater than alpha ( $p > .05$ ), the researcher would fail to reject the null hypothesis, and the result would be statistically nonsignificant (n.s.). Assuming the null hypothesis was true, the researcher could reject the null only if the observed data were so unusual that they would have occurred by chance (5% of the time). The smaller the alpha, the more stringent the test (the more unlikely a statistically significant result if there is no actual difference among the group data). This statistical analysis was performed and described in the next chapter.

Note: this study was not intended to examine each clinician's alliance patterns for the purpose of distinguishing who may or may not have been the "better" clinician. Rather, this

study looked at the goodness of fit of the measures at a specific mental health clinic and for specific age ranges.

In the following chapter, the researcher will explain how she determined the internal validation of the alliance patterns (using the variables to understand the groupings), as well as the significance of external validation or the relationship between the alliance patterns of the SRS/CSRS and the treatment outcome (ORS/CORS). Furthermore, the researcher determined that if one of the group means differed from the other means, using a Tukey HSD (Honestly Significant Difference) post-hoc test was the best follow-up analysis to confirm the results. In addition, a one-sided *t*-test administered to analyze the groups to see if no improvement in alliance was related to change in ORS/CORS score. The purpose of the present study was to identify any possible relationship between alliance and treatment outcome. In order to find out if these two variables were related, an analysis of variance (ANOVAs) was used for each group.

### **Assumptions**

***ANOVA.*** When using one-way analysis of variance to analyze the data, three assumptions were reviewed. The following assumptions are for fixed effect independent measures (Rutherford, 2001). The first assumption addresses the concern that each group sample is drawn from a normally distributed population. However, many distributions do not follow the normal curve in which case the ANOVA may yield incorrect results. It is wise to consider whether it is reasonable to believe that the groups' distributions follow the normal curve. The second assumption, that the populations' variance in each condition are homogeneous, is important in principle and can be checked only approximately by using an estimate of the sample standard deviations. In practice, researchers are safe in using ANOVA if the largest sample standard deviation is not larger than twice the smallest. The third assumption states that within

each condition, scores are independent of each other. In other words, the groups consist of different individuals and individuals are not measured more than once.



## Chapter IV: Results

This study sought to answer the following questions: (a) Is treatment outcome, as measured by the CORS, correlated with self-reported therapeutic alliance scores, as measured by the CSRS, for children (ages 6–12) attending a behavioral outpatient treatment clinic? (b) Is treatment change, as measured by the ORS, correlated with self-reported therapeutic alliance scores, as measured by the SRS, for adolescents (ages 13–17) attending a behavioral outpatient treatment clinic? This study captured change in alliance by comparing self-reported alliance in the first and final therapy sessions. This chapter will discuss participants obtained from an archival sample, as well as describe results of the descriptive statistics, analysis of variance (ANOVA), and post-hoc analyses.

### Sample Size

Using a convenience sample, the participants for the study consisted of 335 youth who were inactive clients at LCBH, a non-profit mental health agency in Eugene, Oregon. All clients at LCBH were exposed to both measures, the SRS/CSRS and the ORS/CSRS, throughout treatment by the mental health clinicians. In order to participate in the study, clients were required to be between the ages of 6 and 12 years and 11 months, and adolescents between the ages of 13 and 17 years and 11 months. In addition, clients were required to have both a pre- and post-SRS/CRS, as well as a pre- and post-ORS/CORS.

The first clinical sample was comprised of a final total of 96 children between the ages of 6 and 12 years and 11 months. The second clinical sample consisted of a final total of 239 adolescents between the ages of 13 and 17 years and 11 months. Each participant completed at least two therapy sessions. A total of 335 participants completed pre- and post-SRS/CSRS and ORS/CORS measurements, which were accessible for data analysis.

## Descriptive Statistics

Descriptive statistics for the study variables are presented in several tables found in each sub-section. For the reader's convenience, the information presented in the tables offer a general overview of the variables that were used in the study.

**Gender.** A total of 335335 clients met the inclusion criteria for the analysis. Of all participants, 191 (57%) were identified as female; 144 (43%) were identified as male ( $N = 335$ ). Among the child participants, 42 (44%) were females and 54 (56%) were males ( $N = 96$ ). Among the adolescent participants, 149 (62%) were females and 90 (38%) were males ( $N = 239$ ).

**Age.** Among the child participants, there was a good representation of ages between 6 and 12, with a mean age at 9.5 years ( $N = 96$ ;  $SD = 1.96$ ). Please refer to Figure 8 for further information on ages of the child group. Among the adolescent participants, there was a good representation of ages between 13 and 17, with a mean age at 14.6 years ( $N = 239$ ;  $SD = 1.02$ ). Please refer to Figure 9 for further information on the ages of the adolescent group.

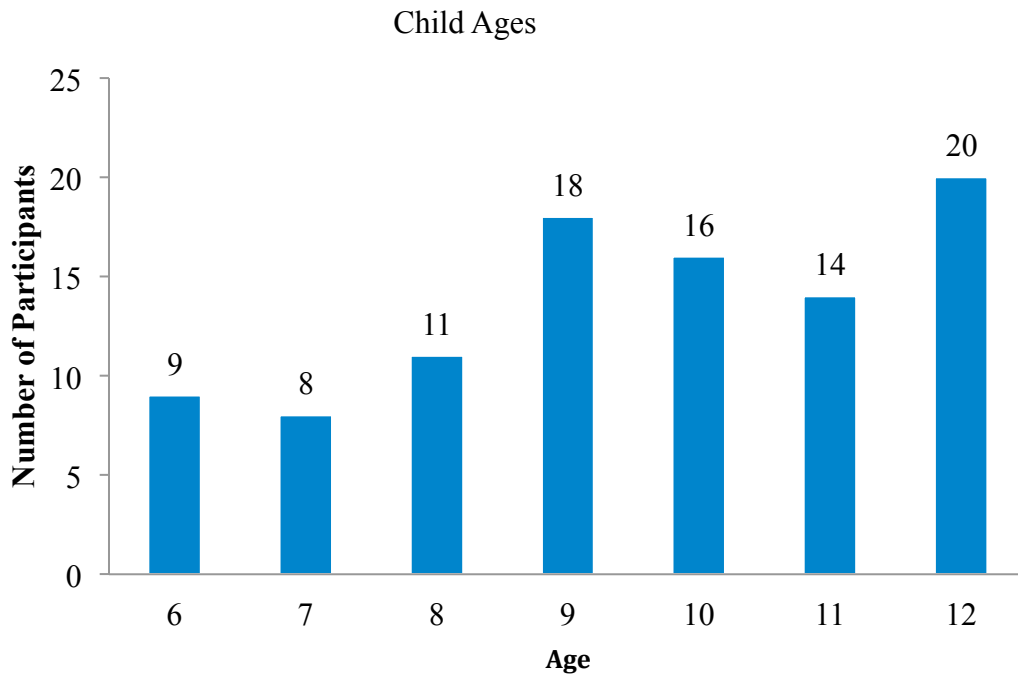


Figure 8. Bar chart of ages of the child group.

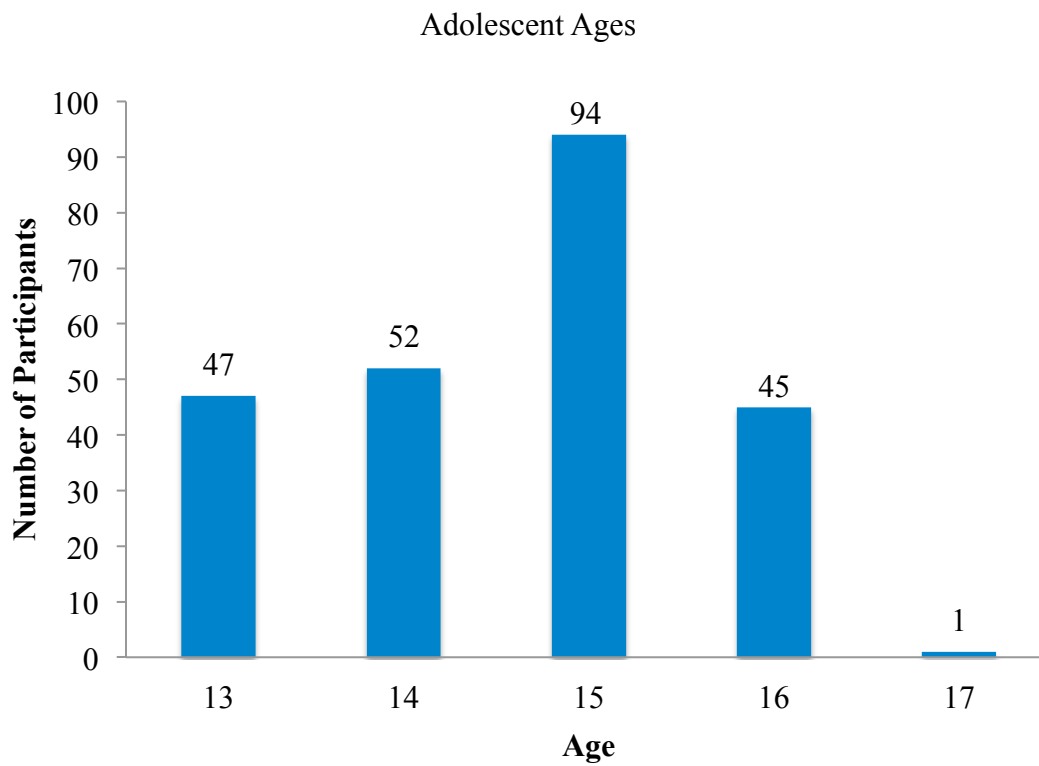


Figure 9. Bar chart of ages of the adolescent group.

**Number of visits.** Mean number of visits of child participants was 13.09 ( $N = 96$ ;  $SD = 8.68$ ). The minimum number of visits was 2 and the maximum was 55. Mean number of visits for adolescent participants was 12.32 ( $N = 239$ ;  $SD = 8.90$ ). The minimum number of visits was 2 and the maximum was 50 (refer to Table 1).

**Assessment and outcome.** Children showed a treatment outcome increase of 6.79 points from first to last session, on average. Average alliance increased from a poor (32.56) to a fair (37.01) rating before therapy (baseline) and after treatment, respectively. Full descriptive statistics are shown in Table 1.

Adolescents showed a treatment outcome increase of 8.26 points from first to last session, on average. The data showed slight increase in alliance with rating scores remaining in the poor alliance category. Average alliance increased from a poor (33.31) to a fair (36.96) rating before therapy (baseline) and after treatment (refer to Table 1).

Table 1  
*Descriptive Statistics of Independent and Dependent Variables*

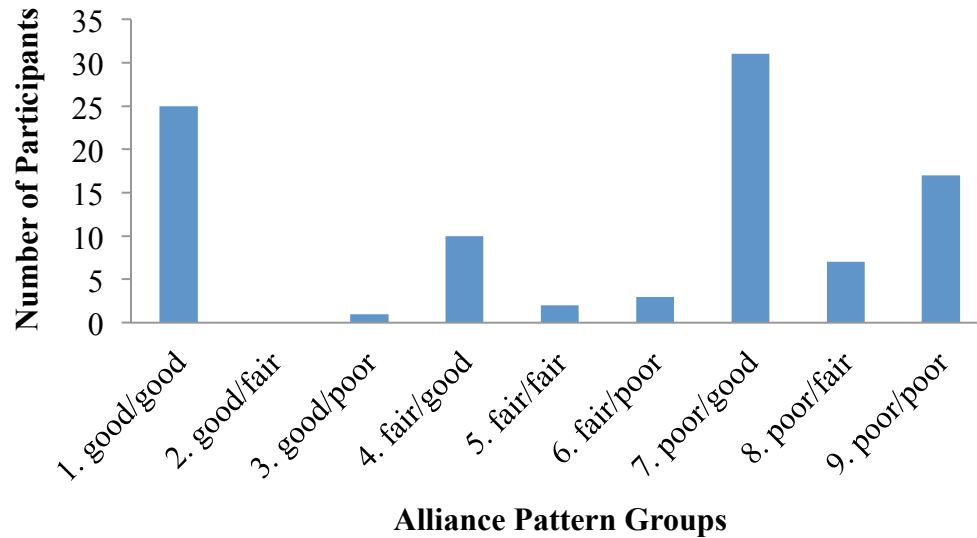
	Children				Adolescents			
	Mean	Std. Deviation	Minimum	Maximum	Mean	Std. Deviation	Minimum	Maximum
<b># Visits</b>	13.09	8.68	2	55	12.32	8.9	2	50
<b>Outcome</b>								
baseline	27.45	7.69	3.82	40	21.99	8.14	2.3	39.6
treatment	34.24	7.08	7.42	40	30.26	8.03	5.23	40
difference	6.79	8.52	-27.88	31.03	8.26	9.6	-29.56	34.14
<b>Alliance</b>								
baseline	32.56	7	12.63	40	33.31	6.12	11.86	40
treatment	37.01	5.56	10	40	36.96	4.92	12.73	40

### Analysis of Variance (ANOVA)

The researcher began the data analysis by running a between subjects one-way ANOVA for the child sample. No significant effects of therapeutic alliance on treatment outcome were found at the  $p=.05$  level for the 9 alliance pattern groups among the child sample [ $F(7, 88) = 1.56, p = 0.157$ ]. The ANOVA results indicated no differences between the alliance pattern groups. Therefore, the null hypothesis,  $H_0$ : There will be no statistically significant difference between the nine groups on the mean score of the ORS, was accepted. The researcher acknowledges that the analysis was restricted due to limited representation, low number of participants among some alliance pattern levels. Had there been more participants in these groups (e.g. good/fair), the study would have been better powered to detect statistical significance. Due to the inadequate representation in some groups, a recoded ANOVA was conducted for further clarification (refer to post-hoc analysis). Table 2 shows the number of participants in each alliance pattern of the child sample, as well as the mean and standard deviation. Figure 10 also shows the number of participants among each group of the child sample.

Table 2  
*Descriptive Statistics of Demographic Variables for the Child Sample*

Alliance Pattern Groups	Mean	Standard Deviation	N
1. good/good	5.10	5.80	25
2. good/fair	0	0	0
3. good/poor	0	0	1
4. fair/good	10.72	9.04	10
5. fair/fair	10.48	4.57	2
6. fair/poor	8.24	6.88	3
7. poor/good	9.20	8.35	31
8. poor/fair	5.25	6.01	7
9. poor/poor	2.89	11.63	17



*Figure 10.* Bar chart showing number of participants among the alliance pattern groups of the child sample.

A between subjects one-way ANOVA was conducted to compare the effect of therapeutic alliance patterns on treatment outcome among the adolescent group. A significant effect of therapeutic alliance on treatment outcome was found at the  $p = .05$  level for the nine alliance pattern groups among the adolescent sample [ $F(8, 230) = 5.81, p < 0.001$ ]. The ANOVA results indicated a significant difference between the alliance pattern groups. As a result, the null hypothesis,  $H_0$ : There will be no statistically significant difference between the nine groups on the mean score of the ORS, was rejected. Table 3 shows the number of participants in each alliance pattern of the adolescent sample, as well as the mean and standard deviation. Figure 11 also shows the number of participants in each alliance pattern group of the adolescent sample.

Table 3

*Descriptive Statistics of Demographic Variables for the Adolescent Sample*

Alliance Pattern Groups	Mean	Standard Deviation	N
1. good/good	6.87	8.91	57
2. good/fair	5.35	8.89	7
3. good/poor	-20.06	0	1
4. fair/good	8.27	9.53	31
5. fair/fair	10.71	6.43	5
6. fair/poor	-13.41	15.24	3
7. poor/good	12.09	9.96	72
8. poor/fair	9.26	11.06	11
9. poor/poor	6.24	5.81	52

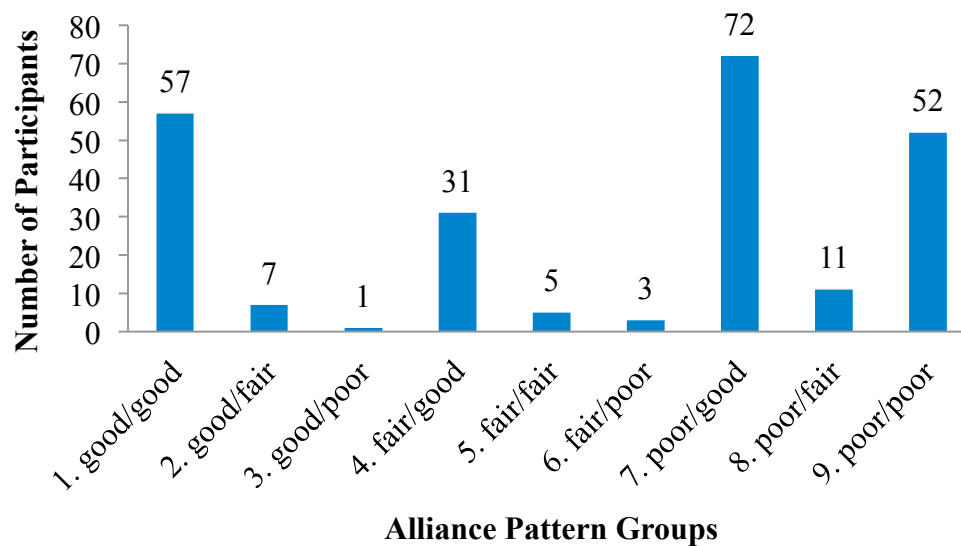


Figure 11. Bar chart showing number of participants in each alliance pattern group of the adolescent sample.

**Addressing assumptions.** The assumptions for an ANOVA are as follows: (a) each group sample is drawn from a normally distributed population, (b) the populations show a homogeneity of variance, and (c) all samples are drawn independently of each other.

The researcher for the current study reviewed all assumptions for the given preexisting data. It was initially established that the first assumption of normality was determined for both sample groups through the descriptive statistics provided by SPSS, with the skewness falling within the range of -2 and +2, as well as the kurtosis value falling within the range of -7 and +7. The second assumption, that the populations show homogeneity of variance, was also supported by SPSS and tested using Levene's Test of Equality of Error Variances. Each data point represented a different patient among the observational data, therefore, each point should be consistent with the third assumption that all samples were drawn independently from each other. There was the possibility of a correlation between patients having the same therapist; however, this was not a focus of the study and will be addressed in the limitation section.

### **Post-Hoc Analysis**

**Post-hoc ANOVA.** The original ANOVA showed there were not enough participants in each group to reliably estimate mean outcome. The researcher could not compare the nine groups because there was not a precise representation for each group. Therefore, the researcher collapsed the groups into three new groups. For both the child and adolescent samples, the researcher recoded the groups to reflect final therapeutic alliance score. The first new group consisted of all previous groups that ended with a *good alliance*, the second new group consisted of all groups that ended with a *fair alliance*, and the third new group consisted of all previous groups that ended with a *poor alliance*. Table 4 and Figure 12 shows the regrouping of the child sample, and Table 5 and Figure 13 shows the regrouping of the adolescent sample.



Table 4  
*Child Sample Recoded*

Recoded Groups	Original Alliance Pattern Groups	Mean	Standard Deviation	N
<i>good alliance</i>	1. good/good 4. fair/good 7. poor/good	7.88	7.81	66
<i>fair alliance</i>	2. good/fair 5. fair/fair 8. poor/fair	6.41	5.92	9
<i>poor alliance</i>	3. good/poor 6. fair/poor 9. poor/poor	3.52	10.83	21

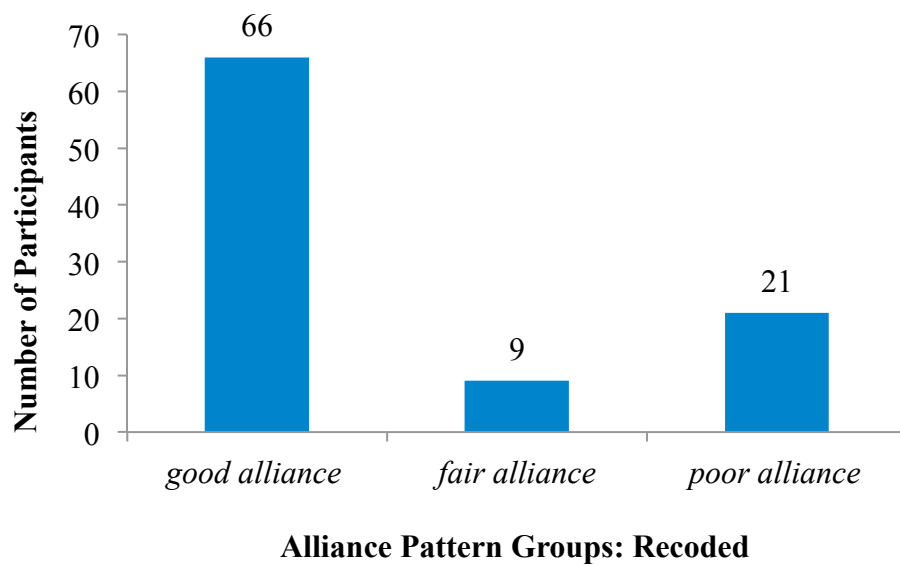


Figure 12. Bar chart showing number of participants in the recoded groups of the child sample.

Table 5  
Adolescent Sample Recoded

Recoded Groups	Original Alliance Pattern Groups	Mean	Standard Deviation	N
<i>good alliance</i>	1. good/good	9.49	9.76	160
	4. fair/good			
	7. poor/good			
<i>fair alliance</i>	2. good/fair	8.39	9.45	23
	5. fair/fair			
	8. poor/fair			
<i>poor alliance</i>	3. good/poor	4.72	8.43	56
	6. fair/poor			
	9. poor/poor			

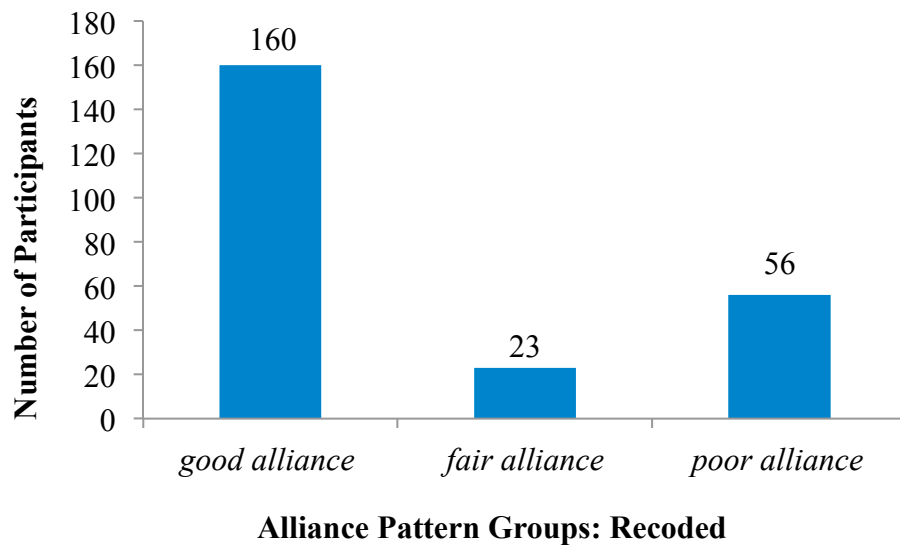


Figure 13. Bar chart showing number of participants in the recoded groups of the adolescent sample.

In a similar fashion, the researcher conducted a between subjects one-way ANOVA for the recoded child sample. Again, there were no significant effects of therapeutic alliance on treatment outcome at the  $p = .05$  level for the three alliance pattern groups among the child sample [ $F(2, 93) = 2.15, p = 0.123$ ]. The post-hoc ANOVA results indicated no differences

between the alliance pattern groups. Therefore, once again, the analysis showed no statistical significance between the groups on the mean scores of the CORS.

The one-way ANOVA for the recoded adolescent sample further supported a significant effect of therapeutic alliance on treatment outcome at the  $p = .05$  level for the three recoded alliance pattern groups among the adolescent sample [ $F(2, 236) = 5.30, p = 0.006$ ]. The post-hoc ANOVA indicated a significant difference among the recoded alliance pattern groups. Therefore, the significant difference among the three recoded groups on the mean scores of the ORS was further supported.

For the post-hoc ANOVA, the recoded adolescent sample, the assumption that the populations showed homogeneity of variance was accounted for using the Levene's Test of Equality of Error Variances. It tested the null hypothesis that the error variance of the dependent variable, the ORS/CORS, was equal across groups. An additional post-hoc analysis examined the specific difference between the recoded alliance pattern groups for the adolescent sample.

**Tukey HSD.** Because a statistically significant result was found among the adolescent sample, a post-hoc test was performed to make pairwise comparisons between the alliance pattern groups. The Tukey HSD post-hoc test, a mean separation test, was selected because it was designed to compare each of the conditions to every other condition (Tukey, Brillinger, Cox, & Braun, 1984). The statistic used in the Tukey HSD post-hoc test determines which group differed significantly from one another. For unequal sample sizes, which were presented in the current data, SPSS implemented the Tukey-Kramer, a modified statistic of the Tukey HSD test. The Tukey HSD statistic prefers that all sample sizes be equal, and when this is not the case, the Tukey-Kramer procedure corrects for that error (Cribbie, 2003; Toothaker, 1993). It is important

to note that the Type I error levels were not guaranteed, indicating a higher chance of rejecting the null hypothesis when it is true.

The Tukey HSD test compared each recoded alliance pattern group for the adolescent sample. After every possible pair-wise comparison, evidence of statistical significance was found between the *good alliance* and *poor alliance* at the final session (refer to Table 6). Therefore, if an adolescent client ended therapy with a *good alliance* score, change on the ORS was significantly higher than if the client ended therapy with a *poor alliance* score, on average by 4.77 points.

Table 6

*Tukey HSD Comparison for Adolescent Recoded Alliance Pattern Groups*

Comparisons	Mean differences	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
<i>good alliance vs. poor alliance</i>	4.77*	1.47	1.32	8.23
<i>fair alliance vs. good alliance</i>	-1.10	2.10	-6.06	3.86
<i>poor alliance vs. fair alliance</i>	-3.67	2.34	-9.18	1.84

\*  $p < 0.05$

**Tukey HSD summary.** The results suggested that when clients end treatment with *good alliance* compared to *poor alliance*, outcomes are stronger at the end of treatment. The Tukey HSD test required equal sample size among groups, homogeneous subsets. The harmonic mean recognizes this assumption and corrected for it, using the Tukey-Kramer statistic. The researcher predicted that the good/poor group would have the lowest change in the ORS/CORS score from the baseline to treatment and the poor/good group would have the highest change compared to all the other groups. The Tukey HSD test provided support for the second hypothesis by indicating that the adolescent group with a good alliance at the end of therapy had statistically significant

treatment outcome. The means plot (Figure 14) shows the mean differences of ORS, with a significant difference between the *good alliance* group and the *poor alliance* group.

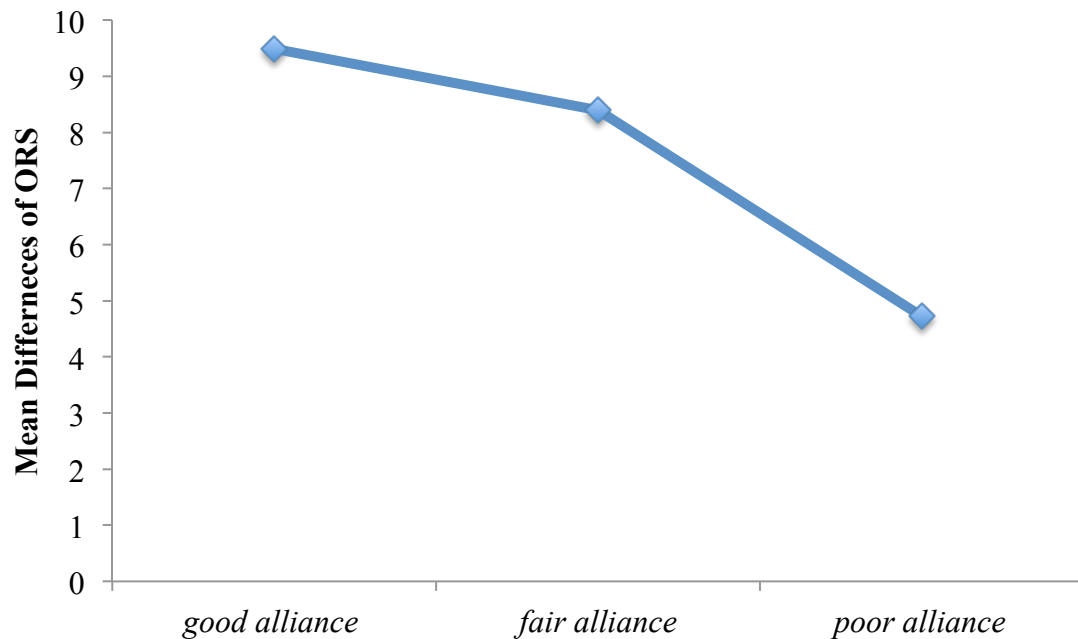


Figure 14. Means plot of Tukey HSD comparison for Adolescent Recoded Alliance Pattern Groups

**One-sided t-test.** As an additional post-hoc analysis, the researcher conducted one-sided *t*-tests for both populations (see Table 7). Both child and adolescent samples were redistributed based on how the alliance (SRS/CSRS) progressed over time and relabeled as either the *same/improved* group or the *declined* group. Participants who showed improvement or no change in therapeutic alliance were clumped together. The participants with the following pre/post alliance scores were put into the *same/improved* group: good/good, fair/good, poor/good, fair/fair, poor/fair, and poor/poor. Participants that declined in therapeutic alliance, according to the SRS/CSRS scores, were also clumped together. Therefore, participants with the following pre/post alliance scores were put into the *declined* group: good/fair, good/poor, and

fair/poor. In summary, the two groups were defined based on how the alliance progressed over time.

The third hypothesis predicted that the groups that did not improve in alliance (i.e., poor/poor, fair/fair, fair/poor, good/fair and good/poor) would not have a positive change in ORS/CORS scores. A post-hoc one-sided *t*-test was conducted with the redistributed recoded alliance pattern group data for both child and adolescent samples. The researcher was interested to see if a difference would be detected between the means for the recoded groups of both samples.

Calculating a more robust post-hoc analysis for the child sample showed the third hypothesis was not supported. There was no difference between the means among the *same/improved* group and the *declined* group. It is important to note that the sample size for the *declined* group was much lower. Results indicated that alliance did not affect treatment outcome. The change in CORS on average was 6.81 if alliance stayed the same or improved over the course of treatment. If alliance declined, the change in CORS on average was 6.18. This difference was not statistically significant with a *p*-value of .871. Additionally, a mean difference between groups of 0.63 was not clinically meaningful. In summary, regardless of the strength of the therapeutic alliance over time, treatment outcome was similar for all child clients.

However, the third hypothesis for the adolescent sample was supported. Significance was found relative to an impact to outcome, meaning alliance did affect treatment outcome. Change in ORS on average was 8.76 if alliance stayed the same or improved over the course of treatment. If alliance declined, the ORS on average was -2.08. This difference was statistically significant with a *p*-value of .031. Furthermore, a mean difference between groups of 6.68 was

clinically meaningful, showing that therapeutic alliance impacts treatment outcome among adolescent clients.

Table 7  
*Post-hoc t-test*

	Recoded Original Data		<i>t</i>	<i>df</i>	<i>p-value</i>
	<i>same/improved</i>	<i>declined</i>			
Child	6.81 (8.61)	6.18 (6.97)	.175	3.41	.871
Adolescent	8.76 (9.07)	-2.08 (14.26)	2.49*	10.39	.031

*Note.* \* =  $p \leq .05$ , \*\*\* =  $p \leq .001$ . Standard Deviation appears in parentheses below means.

The assumption of homogeneity of variance was accounted for during the post-hoc analysis. The independent *t*-test does not assume the variance of the two groups to be equal. If the groups are not equal, that variation affects the Type I error rate. There was a minor violation of homoscedasticity; consequently, the method of Welch-Satterthwaite with a confidence interval of 95% was used.

## Chapter V: Discussion

The aim of the current study was to examine the association between therapeutic alliance and treatment outcome among both child and adolescent clients. Specifically, the study assessed the Session Rating Scale/Child Session Rating Scale (SRS/CSRS) and Outcome Rating Scale/Child Outcome Rating Scale (ORS/CORS) to determine whether any relationships between therapeutic alliance and treatment outcome existed. Due to the well-studied influence of alliance as a major factor on the therapeutic experience and treatment outcome (Ankuta & Abeles, 1993; Asay & Lambert, 1999; Bachelor, 1995; Bachelor & Horvath, 1999; Duncan, 2010, 2014; Drozd & Goldfried, 1996; Gaston, 1990, 1991; Gomes-Schwartz, 1978; Horvath & Greenberg, 1989; Lambert, 2003; Lunnen & Ogles, 1998), the study's aim was to find out if there was a relationship between therapeutic alliance and treatment outcome among younger clients. In addition, this study further researched the brief instruments that measure therapeutic alliance for both young clients as well as adults. The measurement tools (SRS/CSRS) used simply, but elegantly, broke down the therapeutic alliance into areas of the therapeutic relationship that build upon the idea of therapeutic alliance. Furthermore, the measures (ORS/CORS) used to identify treatment outcome accounted for different areas of life that support overall well-being.

The current study chose to investigate the variables of the therapeutic alliance and treatment outcome among two samples, one group of child participants and one group of adolescent participants receiving mental health treatment at a county facility in a rural area of Oregon. More specifically, the present study looked at the change in alliance across treatment and any relationships it might have to treatment outcome. Past research measuring therapeutic alliance and treatment outcome using the Outcome Rating Measures (ORS) and Session Rating



Measures (SRS) has mostly concentrated on adult participants. As research has supported the importance of the therapeutic alliance for successful mental health treatment, it is equally important to provide further research on how younger clients respond because it provides insight for best practice. The researcher's hope is that this study will bring more awareness to the relationship between therapeutic alliance and treatment outcome, as shown using a feasible measure that can be used during each therapeutic encounter. It is important that we, as health professionals, strive to gain a better understanding of how the alliance aspect of the therapeutic relationship can influence treatment outcome, in hopes that we can be better equipped to improve clients' sense of well-being.

### **Therapeutic Alliance**

The independent variable of therapeutic alliance was measured quantitatively using the Child Session Rating Scale (CSRS) and Session Rating Scale (SRS) developed by Johnson et al. (2000). This measure was given to all participants at the end of the mental health appointment. The researcher collected and reviewed the data with the interest in the pre- and post-treatment scores of the SRS/CSRS. For the measure given to child participants (CSRS) and the measure given to the adolescent participants (SRS), alliance was rated by looking at four different areas; relationship, goals/topics, approach/method and overall (refer to Appendix B and D). Each area was addressed with one rating and had the highest possible score of 10. Therefore, the entire measure had the highest possible score of 40. The questions that assessed the relationship between the therapist and clients accounted for the following factors: being heard by the therapist, being understood by the therapist, and feeling respected by the therapist. The question that measured the goals/topics looked at the client's perspective of whether or not the session covered what needed to be discussed. The question regarding approach/method was intended to

measure the therapist's approach to therapy. Finally, the overall section of the form measured the overall satisfaction of the client's experience with the therapist in that particular session.

When considering the present study's results for the child sample regarding the alliance patterns quantitatively, it is interesting to note that the initial groupings of the participants were not evenly distributed. There were larger numbers in groups that either did not show a change in therapeutic alliance or indicated a hindrance in the alliance. The literature has shown that younger clients who display externalizing problems tend to present with a stronger relationship of alliance to outcome (Shirk & Kraver, 2003). Additionally, literature has shown that when younger clients hold a strong dislike for mental health treatment they find it difficult to focus on treatment because they simply do not want to be there, alliance is difficult to establish; therefore, measuring therapeutic alliance can be challenging (Diguseppe et al., 1996; Green, 2006). While the current study did not investigate the issues participants may have been exhibiting, it does call for further research in order to determine if those additional factors contribute to the stagnant nature of or decline in treatment, shown in the therapeutic alliance patterns of the pre- and post-treatment scores. The child participants in the current study may have misunderstood what the measure was asking regardless of whether the therapist explained it at the beginning of treatment. Some research has gone even further to report how cognitive development of young clients could impact their understanding of alliance and even their understanding of treatment (Green, 2006; Shirk & Saiz, 1992). Future research could further explore this possible connection between cognitive development and full understanding of therapeutic alliance.

Reviewing the present study's results of the alliance patterns for the adolescent sample qualitatively, similar results were identified. The number of participants in each group was not evenly distributed; there were larger groups with alliance patterns either remaining stagnant or

resulting in a lower alliance rating compared to the initial score. A difference between the two age groups lie in the number of participants in each sample, with a larger number of adolescent participants compared to child participants. Shirk, Karver, and Brown's (2011) meta-analysis on developing alliance with children and adolescents indicated some variability in the alliance-outcome link across age groups, which is consistent with the current study's findings; however, the meta-analysis lacked statistical significance. The authors suggested that alliance development and treatment outcome may be less differentiated with younger clients, noting also that the presenting problem in therapy varies, which can impact the development of the therapeutic alliance.

In addition to the possible factors described above that may explain the distribution of participants in the alliance pattern groupings, other elements may play a role. Client and therapist characteristics have been considered as reasons for whether alliance develops and whether it influences treatment outcome (Karver et al., 2005). The therapist's engagement strategies could play a role in the alliance strength (Disguiseppe et al., 1996), indicating that the current study's clinicians' approach to building rapport could have been a factor. However, therapeutic engagement styles were not measured, nor were they the focus of the current research. Regardless, these factors do relate to the idea that only 1% of therapeutic change, meaning progress in treatment, is due to techniques of the clinicians (Wampold, 2001). Additionally, there are multiple ways to develop (Low et al., 2013; Kivlighan & Shaughnessy, 2000; Morral et al., 1997; Safran & Muran, 1998) and measure alliance (Bickman et al., 2000; Hatfield & Ogles, 2004; Miller & Duncan, 2000). At what point to measure alliance in treatment is another debatable consideration that future research could examine.

## **Treatment Outcome**

The dependent variable of the treatment outcome was measured quantitatively using the Child Outcome Rating Scale (CORS) and Outcome Rating Scale (ORS) developed by Johnson et al. (2000). This measure was given to all participants at the beginning of each mental health appointment. The researcher was interested in the pre- and post-treatment scores for the ORS/CORS. For the measure given to child participants (CORS) and the measure given to the adolescent participants (ORS), treatment outcome was rated by looking at four different areas, which included personal well-being, interpersonal relationships, social interactions, and general sense of well-being (refer to Appendix A and C). Each area was addressed with one rating and had the highest possible score of 10. Therefore, the entire measure had the highest possible score of 40. Each question assessed different areas of the clients' subjective experience of improvement between therapy sessions.

The present study's literature review covered several theories (Asay & Lambert, 1999; Bachelor, 1995; Duncan, 2010, 2014; Lambert, 2003; Lambert & Barley, 2001; Lambert & Ogles, 2004; Wampold, 2001) regarding therapeutic change, which included the importance of and how to measure treatment outcome and therapeutic alliance. Several definitions have been developed, signifying guidelines, and many factors hold significance, including client/extratherapeutic factors and therapeutic factors such as alliance effects and therapist effects. The CORS and ORS measures were designed to gather information from the patient's perspective of treatment outcome over the past week in real time during each session (Duncan et al., 2006).

As it was noted earlier, Wampold (2001) studied the different factors that contribute to therapeutic change and found that therapeutic technique contributes only one percent. While the

therapeutic approach/method is a factor in the alliance measure used in the present study, it is not the only area that makes up the therapeutic alliance. Wampold found that gathering feedback from clients, which is exactly what the measures in the present study do, strengthens the therapeutic relationship. Therefore, the SRS/CSRS not only accounts for the therapeutic strategies applied, but also comprises a form of gathering feedback during each session. Additionally, gaining feedback from patients contributes to treatment outcome. This study supports both variables—the therapeutic alliance and the treatment outcome.

The present study found a difference in treatment outcome among the different alliance pattern groups for the adolescent sample. This information supports many studies (Ankuta & Abeles, 1993; Asay & Lambert, 1999; Bachelor, 1995; Bachelor & Horvath, 1999; Duncan, 2010, 2014; Drozd & Goldfried, 1996; Gaston, 1990, 1991; Gomes-Schwartz, 1978; Horvath & Greenberg, 1989; Lambert, 2003; Lunnen & Ogles, 1998), which indicate that the therapeutic alliance impacts psychotherapy treatment. More specifically, the results showed that when adolescent participants had alliance scores that either stayed the same or improved across treatment, the treatment outcome scores also improved significantly. Participants in the same sample that ended treatment in the poor alliance group did not improve in treatment outcome. Unfortunately, the child sample did not show a difference in outcome scores among the same/improved and poor groups.

### **Significant Findings**

The main purpose of this study was to examine any possible relationships between treatment outcome and therapeutic alliance. Most importantly, the hypothesis of whether therapeutic alliance across treatment was related to outcome was examined. That is, the theory was tested that when the outcome scores have the highest change, the therapeutic alliance scores

also improve, and when outcome scores have the lowest change, the therapeutic alliance scores also decrease. The researcher hoped to find correlations between higher outcome scores and higher alliance scores, as well as among lower outcome scores and lower alliance scores.

**Alliance pattern groups and ORS/CORS.** The researcher hypothesized that the mean change in the ORS/CORS would show a difference among the alliance pattern groups. Using an analysis of variance, the researcher found that the child sample showed results for the initial nine alliance pattern groups to reflect no significant changes in the mean scores of the ORS/CORS. Furthermore, the sample was recoded, increasing the number of participants in each group and decreasing the number of groups. A second ANOVA (post-hoc) was conducted in an attempt to find any significance among the child sample. Regardless of the recoding, the post-hoc analysis showed no correlations between the alliance and outcome for the child clients.

Instead, it is possible that, for children, other factors contribute more to treatment outcome than therapeutic alliance (Shirk et al., 2011). Cognitive development, enabling child clients to fully understand what is being asked of them, is one possible factor. Attachment and relationship development the children may or may not have been exposed to could be an additional factor for why treatment outcome did not correlate with therapeutic alliance. The number of therapy visits and duration between the visits may also be relevant to the findings. The current study's data represented a variation in the number of visits among all participants, child or adolescent. The data did not show much of a difference between the age groups (refer to Table 1). The number of visits would be an interesting factor to observe because it could influence the alliance factor between therapist and clients. In other words, whether clients attend therapy regularly may impact alliance development and treatment outcome.

Duncan (2010) spoke of the therapist factors contributing a large portion of the treatment effects. Therapist factors, accounting for 13% variance in effects of psychotherapy, account for as much as the therapeutic alliance (Wampold, 2001). When determining what contributes to treatment outcome, many argue that therapist factors may or may not play a role (Duncan, 2010; Kim, Wampold, & Bolt, 2006; Wampold & Bolt, 2006). An example of a therapist factor would be whether or not the therapist focused on client's strengths at the beginning, end, or during the duration of treatment (Gassman & Grawe, 2006). While the current study did not contribute to examining therapist factors, completely disregarding them as possible influences on the development of therapeutic alliance and impacting treatment outcome would be negligent.

Results were not consistent among the samples. In regard to the adolescent data set, results of the initial nine alliance pattern groups did show a significant change in the mean scores of the ORS/CORS. This result indicated, at least for the adolescent clients, that alliance did play a role in treatment outcome. The researcher recoded the sample in order to increase the number of participants in each group and decrease the number of groups, creating a more defined analysis. A post-hoc ANOVA also found statistically significant differences in mean outcomes in the recoded groups, further supporting the original analysis for the adolescent sample. The researcher can more confidently state that there exists a significant difference in treatment outcome among the alliance groups.

Based on the results of the analysis of variance and those of a meta-analysis (Shirk et al., 2011), therapeutic alliance is correlated with treatment outcome among youth. Furthermore, the meta-analysis indicated the importance of observing alliance across treatment with youth, rather than only at the beginning stages of therapy because it contributed to the alliance development. Additional studies (Anker, Owen, Duncan, & Sparks, 2010; Baldwin, Wampold, & Imel, 2007)

further support the current study's finding that strong alliance results in better outcome, especially when reviewing alliance at the end of treatment.

**Ending treatment with a poor alliance or a good alliance.** The researcher hypothesized that the alliance pattern group labeled *good/poor* would have the lowest change in ORS/CORS scores, while the group labeled *poor/good* would have the highest change in ORS/CORS scores. After the initial analysis showing differences in treatment outcomes among the alliance pattern groups for adolescents, the researcher conducted a further analysis comparing all groups in order to further support the findings and hypotheses. At this point in the analysis, the groups had been recoded into three groups based on the post-treatment alliance scores (*good alliance, fair alliance, and poor alliance*). The hypotheses, modified to correct for the recoded group, specified that the alliance pattern group labeled *poor alliance* would have the lowest change in ORS scores, while the group labeled *good alliance* would have the highest change in ORS scores.

The Tukey HD analysis showed there to be a significant difference between specific groups. The groups that showed a difference during the pairwise comparison were the *good alliance* group and the *poor alliance* group. There was evidence of statistical significance between good and poor alliance at the final session. If patients ended therapy with a good alliance score, the change in treatment outcome was higher than if patients ended with a poor alliance score. These findings are consistent with Duncan and Miller's (2008) comprehensive summary of the outcome-informed, client-directed approach to psychotherapy using the SRS/CSRS measure, which indicates that a client's SRS/CSRS score "that is good and remains good predicts a positive outcome" and a score "that is poor or fair and improves predicts a positive outcome even more" (p. 68).



**Difficulty with building alliance, difficulty with making a positive change in treatment.** The researcher also hypothesized that the groups that did not improve in alliance would not have a positive change in ORS/CORS scores. In order to test for this hypothesis, a post-hoc *t*-test analysis was conducted by regrouping the original alliance pattern groups into two categories, *same/improved* and *declined*. The *same/improved* group included participants who kept the same alliance or improved alliance across treatment. This group included the following pre/post alliance scores: good/good, fair/good, poor/good, fair/fair, poor/fair, and poor/poor. Participants who declined in therapeutic alliance across treatment, according to the SRS/CSRS scores, were clumped together. Therefore, participants with the following pre/post alliance scores were put into the *declined* group: good/fair, good/poor, and fair/poor.

The post-hoc *t*-test analysis for the child sample did not show any significance among the recoded, re-categorized alliance pattern groups. However, the post-hoc *t*-test analysis for the adolescent sample showed that when the participants' post-treatment alliance scores were the *same/improved*, the ORS was higher than when the end alliance scores were *declined*. Furthermore, the researcher found that when clients improved or maintained the therapeutic alliance at the end of therapy, the treatment outcome increased, and when clients declined in therapeutic alliance at the end of therapy, the treatment outcome decreased. While these findings support the hypothesis, it is important to note that the sample size for the recoded *declined* group was smaller than preferred. Duncan and Miller's (2008) development and research of the ORS and SRS support the current study's findings; patients who start therapy with a lower alliance score and improve tend to demonstrate a positive treatment outcome. The SRS/CSRS measures provide clinicians an opportunity to detect any alliance problems as they arise and a chance to fix them while eliciting feedback and better understanding clients' perspectives.

**Conclusions.** Based on the results of the current study and those of Shirk et al., (2011), the possibility must also be considered that, for younger clients, other factors could influence treatment outcome as much as the therapeutic alliance. Other factors, such as therapist effects (Duncan, 2014) and caregivers' alliance with the treatment providers (Shirk et al., 2011) could impose more of an impact on treatment outcome than expected. In fact, according to Duncan (2010), therapist effects could contribute as much to the therapeutic experience as alliance. However, each common factor could stand alone or interact with others, thus making it difficult to firmly indicate which factors weigh more than others in the treatment experience.

Readers of this study may have interest in learning what therapist effects entail and whether better understanding those effects could help them develop stronger alliances with clients, thereby influencing treatment outcome. According to Gassman and Grawe (2006) and supported by Duncan (2010), when therapists highlight clients' strengths rather than their problems or deficiencies, treatment outcomes are more successful. Other examples of therapist effects are the therapist's professional development and the therapist's awareness of treatment focus. The researcher of the current study suspects that some treatment factors, such as therapist effects, are more significant predictors of treatment outcome and are a part of the alliance composition,, especially for younger clients. One could infer that therapist effects are a component of the therapeutic alliance, rather than the two being separate entities. Alliance could be the platform on which to foster therapist effects, or vice versa.

Furthermore, for younger clients cognitive development and developmental issues could contribute to a limited understanding of mental health treatment and the ability to sustain therapeutic alliance, potentially accounting for the current study's results. While the adolescent sample showed significance in the status of the therapeutic alliance at the end of treatment

compared to the beginning and an impact of alliance on outcome, the results for the child sample did not substantiate the same inferences. Shirk et al.'s (2011) conclusion that alliance contributing to outcome tends to occur in isolation supports these results. For example, a meta-analytic review showed alliance development among younger clients later in treatment to be more predictive of outcome, which was the opposite of the pattern for adult clients (Shirk & Karver, 2003). Further research is needed regarding what factors influence treatment outcome among younger clients in particular, including the different pieces of what contributes to building alliance, in order to better understand how therapeutic alliance relates to treatment outcome.

### **Limitations of the Study**

Limitations of the current study include the small sample size among child participants. The statistical analysis revealed a much lower sample size for child participants than expected, resulting with few clients in each alliance pattern group. It would be beneficial for future research to gather a larger sample size to increase the power of the statistical analysis, thus improving the ability to detect significant findings, such as a difference in means between groups.

Another limitation was the number of alliance pattern groups. The researcher could have designed the study to initially include fewer alliance pattern groups in order to increase the power of the study. An uneven distribution of participants among the initial grouping resulted in low numbers for specific groups and no participants in the *good/fair* group of the child sample. Furthermore, several groups in the child sample were comprised of only one, two, or three participants. These low numbers in several groups were also found among the adolescent sample. If there had been more participants or fewer groups, the ANOVA would have been better

powered for detecting a difference in means between groups. Due to these limitations, the posthoc analyses were conducted.

One further limitation is that the current study did not take into account reasons why a relationship between the therapeutic alliance and treatment outcome may not exist. Shirk and Karver (2003) speculated that child clients may simply take longer to develop therapeutic alliance than do adult clients. This suggests that gathering evidence of therapeutic alliance throughout treatment may not be relevant; rather, collecting information regarding the therapeutic alliance later in treatment may provide a more reliable predictor of treatment outcome. The theory that therapeutic alliance evolves more slowly with children, may explain the trend shown among the data that therapeutic alliance did not usually progress from good to poor; if it did at all, it did so rarely. Typically, as treatment went on, the therapeutic alliance naturally increased (improved). Therefore, among the child sample, participants' treatment outcome scores improved regardless of their starting alliance scores.

While one reason could be that younger patients take longer to develop therapeutic alliance, one uncontrolled variable in the current study was the number of visits. Among both the child and adolescent samples, the number of visits greatly varied from 2 to 55. The number of visits could impact the development of therapeutic alliance, thereby influencing the treatment outcome. Alliance could mean something different if the length of treatment is longer rather than shorter. Further research could explore any possible relationships between therapeutic alliance and length of treatment for younger clients.

Lastly, another limitation of the current study was a lack in analyzing other sources of therapeutic feedback. The researcher could have taken into account the caregivers' and treatment providers' perceptions of the therapeutic alliance and treatment outcome by collecting SRS and

ORS data from those stakeholders. Shirk and Karver's (2003) meta-analysis supported a strong association between outcome and treatment providers' reports of the therapeutic relationship, when compared to child and adolescent clients' reports. Collecting information from caregivers could provide further insight into the therapeutic experience (Duncan et al., 2006; Shirk & Karver, 2003; Shirk et al., 2011). Additionally, administering the same measures the clients receive to caregivers would offer an opportunity to compare the perception of treatment. (Murphy, 2008; Tilsen, Maeschalck, Seidel, Robinson, & Miller, 2012).

### **Advantages of the Study**

The current study exhibited several advantages. In particular, not only were the measures valid, reliable and feasible (Duncan & Miller, 2008; Miller & Bargmann, 2012), they created a culture of feedback throughout treatment among the clients and clinicians. According to Lambert, Whipple, and Hawkins' meta-analysis (2003), when therapists receive consistent feedback within the sessions, treatment outcome increases by 65%. While feedback was not a particular focus of this study, the value of feedback supports that, the measures used fostered the therapeutic alliance, as well as collecting data on that alliance. The relevance of gathering feedback could imply that it is a part of the process of developing therapeutic alliance.

An additional advantage of the current research again regards the measures used. A helpful element of the measures is the establishment of a baseline for both the alliance and treatment outcome with the clients, which are also recorded throughout treatment. This is a helpful tool to which the clients are contributing as they view the changes within each session. The tool not only assists with developing the therapeutic alliance, but also guides treatment by involving the clients in the decision-making processes.

## **Implications for Practice and Future Research**

Findings from this study substantiate several important implications for the alliance factor between the young client and therapist. In general, the findings suggest that among adolescent participants, when therapeutic alliance scores are good at the end of therapy, the treatment outcome scores are higher. Specifically, the study provided empirical evidence showing that adolescent clients who developed stronger alliance with their mental health provider experienced a more positive change in their treatment outcome. In other words, their overall well-being and functioning in the following areas of life were rated higher: individually (personal well-being), interpersonally (family, close relationships), socially (work, school, friendships), and overall (general sense of well-being).

Regardless of the above-mentioned findings, the relationship between treatment change and self-reported therapeutic alliance scores warrants further investigation. In particular, future studies could explore the factor of caregiver involvement, for example, by comparing the child and adolescent alliance scores with caregiver scores. This exploration could also be applied to the treatment providers. Investigating these additional data could bring forth further evidence of the relationship between alliance and treatment outcome, as well as provide a better understanding of how psychosocial factors influence treatment recovery. Lambert's (2003) research on therapeutic factors includes clients' extra-therapeutic factors contributing 40% to treatment outcome. By gathering parental or caregiver feedback using the ORS, research could consider how stressors felt by caregivers impact the therapeutic alliance and treatment outcome for young clients.

Future research could also examine the instruments (SRS/CSRS and ORS/CORS) more closely, in order to inspect the relationship between each area of alliance and each area of

treatment outcome. Pinpointing specific correlations in an attempt to determine what exact components of alliance improve or hinder the therapeutic experience, as well as treatment/successful outcome, could better prepare and support the clinicians' work with youth. In addition to looking at the measures more closely, research could also examine any relationships between treatment effects (e.g., the therapist effects, models/techniques used in treatment, or the process of gathering feedback from all stakeholders) with the measures used. The possible implications of such research could offer specific information regarding the value and/or influence of alliance on treatment effects, as well as the value and/or influence of treatment effects on alliance.

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Appendix A

Child Outcome Rating Scale (CORS)

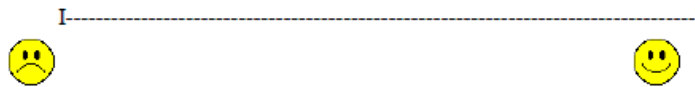
### Child Outcome Rating Scale (CORS)

Name \_\_\_\_\_ Age (Yrs): \_\_\_\_\_  
 Sex: M / F \_\_\_\_\_  
 Session # \_\_\_\_\_ Date: \_\_\_\_\_  
 Who is filling out this form? Please check one: Child \_\_\_\_\_ Caretaker \_\_\_\_\_  
 If caretaker, what is your relationship to this child? \_\_\_\_\_

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

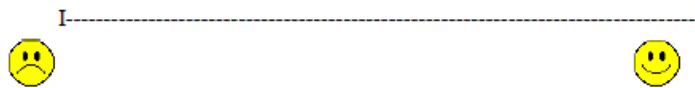
#### Me

(How am I doing?)



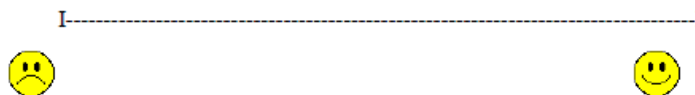
#### Family

(How are things in my family?)



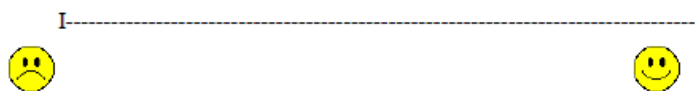
#### School

(How am I doing at school?)



#### Everything

(How is everything going?)



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Appendix B

Child Session Rating Scale (CSRS)

### Child Session Rating Scale (CSRS)

Name _____ Age (Yrs): _____
Sex: M / F
Session # _____ Date: _____

---

How was our time together today? Please put a mark on the lines below to let us know how you feel.

---

**Listening**

\_\_\_\_\_ did not always listen to me.      I ----- listened to me. \_\_\_\_\_

**How Important**

What we did and talked about was not really that important to me.      I ----- What we did and talked about were important to me. \_\_\_\_\_

**What We Did**

I did not like what we did today.      I ----- I liked what we did today. \_\_\_\_\_

**Overall**

I wish we could do something different.      I ----- I hope we do the same kind of things next time. \_\_\_\_\_

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Appendix C

Outcome Rating Scale (ORS)

## Outcome Rating Scale (ORS)

Name _____ Age (Yrs): ____ Sex: M / F Session # ____ Date: _____ Who is filling out this form? Please check one: Self _____ Other _____ If other, what is your relationship to this person? _____
--

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

**ATTENTION CLINICIAN: TO INSURE SCORING ACCURACY PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE.**

### Individually

I-----I

**Interpersonally**  
(Family, close relationships)

I-----I

**Socially**  
(Work, school, friendships)

I-----I

**Overall**  
(General sense of well-being)

I-----I

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Appendix D

Session Rating Scale (SRS V.3.0)

### Session Rating Scale (SRS V.3.0)

Name _____	Age (Yrs): _____
ID# _____	Sex: M / F _____
Session # _____	Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

#### Relationship

I did not feel heard, understood, and respected.

I-----

I felt heard, understood, and respected.

#### Goals and Topics

We did not work on or talk about what I wanted to work on and talk about.

I-----

We worked on and talked about what I wanted to work on and talk about.

#### Approach or Method

The therapist's approach is not a good fit for me.

I-----

The therapist's approach is a good fit for me.

#### Overall

There was something missing in the session today.

I-----

Overall, today's session was right for me.

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Appendix E  
Permissions

The Institutional Review Board (IRB) granted permission for the following study to occur and data to be collected between 04/13/2015 and 04/11/2016.



Tara Staehlin [REDACTED]

---

**Online IRB Application Approved: IDENTIFYING THERAPEUTIC ALLIANCE PATTERNS AMONG A FEASIBLE CLINICAL MEASURE TO IMPROVE TREATMENT OUTCOME** April 13, 2015, 5:24 pm

2 messages

---

asuares [REDACTED]

Mon, Apr 13, 2015 at 2:24 PM

To: [REDACTED]

Dear Tara Staehlin,

As Chair of the Institutional Review Board (IRB) for Antioch University Seattle, I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in your Ethics Application, your study has been approved.

Your data collection is approved from 04/13/2015 to 04/11/2016. If your data collection should extend beyond this time period, you are required to submit a Request for Extension Application to the IRB. Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,

Alejandra Suarez

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- Figure 1. Percent of improvement of Asay and Lambert's (1999) concept of the extratherapeutic client factors



Tara Staehlin [REDACTED]

---

**RE: Academic Permissions Request Form**

---

Academic Permissions [REDACTED]

Fri, Aug 12, 2016 at 6:44 AM

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Dear Tara,

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Kind regards,  
Tom McKibbin  
Permissions Executive

-----Original Message-----

From: no.reply@oup.com [mailto:no.reply@oup.com]  
Sent: 25 July 2016 07:22  
To: Academic Permissions  
Subject: Academic Permissions Request Form

URL: /academic/rights/permissions/request

a First name: Tara

b Last name: Staehlin

c Institution/Company: Antioch University Seattle

d Address: 9032 E SHOREWOOD DR  
Apt. 317

e Postcode: 98040

f Country: USA

g Telephone number: [REDACTED]

h Fax number: [REDACTED]

i Email: [REDACTED]

G Z TheirTitle: IDENTIFYING THERAPETUIC ALLIANCE PATTERNS AMONG A FEASIBLE CLINICAL  
MEASURE TO IMPROVE TREATMENT OUTCOME

H Z Author: Tara Staehlin

H Z Publisher: Antioch University Seattle

I Z Covers: Unspecified

I Z PrintRunHard: 3

I Z pubDate: unknown at this time

J Z Territory: USA

K Z Language: English

K Z Notes: This is my doctoral dissertation.

L Z Media1: illustration

M Z editedby1: J. C. Norcross and M. R. Goldfried

M Z Title1: Handbook of Psychotherapy Integration

N Z Material1: Figure depicting the percent of improvement in psychotherapy patients as function of therapeutic factors. From "Psychotherapy Outcomes Research: Implications from Integrative and Eclectic Therapists," by M. J. Lambert, (p. 97).

O Z ISBN1: 9780195167047

O Z OUPpubDate1: 09/28/2003

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## RE: Academic Permissions Request Form

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Tom

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- Figure 2. A visual representation of Asay and Lambert's (1999) concept of the extratherapeutic client factors
- Figure 3. The therapeutic factors (14%) magnified and broken apart into specific constructs
- Figure 4. The ORS/SRS Graph

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- Figure 5. The ORS/SRS graph for young clients (ages 13–17)
- Figure 6. The CORS/CSRS graph for children (ages 6–12)



David C. Low

Psychotherapist & Mental Health Consultant at the Family Institu--

...

Aug 25, 8:53 PM

#### Permission

Hi Dr. Low,

My name is Tara Staehlin and I have been corresponding with Dr. Duncan regarding the Outcome Rating Scale/Child Outcome Rating Scale and Session Rating Scale/Child Session Rating Scale. He has given me permission to examine the measures in my dissertation.

I am getting ready to publish my dissertation in our school library. The editor and librarian are asking me to obtain permission to use any figures/images/graphs I have added within my dissertation document from other sources.

I am reaching out to you to gain permission to use the graphs found on page 23 of your article ([https://www.han.nl/onderzoek/werkveld/projecten/alliantiegericht-werken-w/werkwijze/attachments/david\\_low\\_paper\\_for\\_cyp-lapt.pdf](https://www.han.nl/onderzoek/werkveld/projecten/alliantiegericht-werken-w/werkwijze/attachments/david_low_paper_for_cyp-lapt.pdf)).

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Could you please respond to this email clearly granting me permission to publish the graphs found in your article?

Thank you in advance!  
Respectfully,  
Tara Staehlin

--

Tara M. Staehlin, M.A.  
Psy.D. Candidate & Fellow  
Antioch University Seattle



Aug 25

Hi Tara,

You have my permission to use the graphs. I would love to know more about your dissertation. If it will be available online, I would love to have a look at it.

Best wishes

David

David C. Low





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- Appendix A. Child Outcome Rating Scale (CORS)
- Appendix B. Child Session Rating Scale (CSRS)
- Appendix C. Outcome Rating Scale (CORS)
- Appendix D. Session Rating Scale (SRS)



Tara Staehlin [REDACTED]

## Permission

3 messages

Tara Staehlin [REDACTED]

Thu, Aug 25, 2016 at 12:17 PM

To: Barry Duncan [REDACTED]

Hi Dr. Duncan,

I am getting ready to publish my dissertation in our school library. The editor and librarian are asking me to obtain permission to use the measures (Outcome Rating Scale, Child Outcome Rating Scale, Session Rating Scale, Child Session Rating Scale). I am reaching out to you because you have been extremely responsive and helpful. The librarian has asked me to include the following information so that everything is clearly stated.

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Could you please respond to this email clearly granting me permission to publish your measures?

Thank you in advance!  
Respectfully,  
Tara Staehlin

--

Tara M. Staehlin, M.A.  
Psy.D. Candidate & Fellow  
Antioch University Seattle

To: Tara Staehlin [REDACTED]

Thu, Aug 25, 2016 at 12:58 PM

Hi Ms Staehlin,

Congratulations on completing your dissertation! A great accomplishment to be sure.

You have my permission to publish the measures you mention in your email in the specified locations. Please be sure to identify that they are for examination only and working copies can be obtained at <https://heartandsoulofchange.com>. Please also say that they are free for individual use but groups require a license.

Again, Congrats.

Best Wishes,

Barry L. Duncan, Psy.D., Director