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Persistently and Seriously Mentally Ill Individuals' Perception of the Working Alliance and Caseworker Characteristics

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PERSISTENTLY AND SERIOUSLY MENTALLY ILL INDIVIDUALS PERCEPTION OF THE WORKING ALLIANCE AND CASEWORKER CHARACTERISTICS

BY

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I have waited a long time to write this section. It is the only part of the dissertation process that I have actually looked forward to. In writing these acknowledgements, I refer not only to those who have assisted me with my dissertation but also those who have lent their talents, encouragement, and support throughout this 10 year journey. It is the people listed below that have made this achievement possible and I am eternally grateful to each one....

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My children, Arianna and Alessandro, who make everything worthwhile. Thank you for all your smiles, hugs, and kisses!

I am truly blessed.

DEDICATION

To my children, Arianna Rosaria and Alessandro Gaetano, in the hope that this process will inspire them to hold onto their dreams and to believe in themselves as much as their father and I do.

To my mother, Mary Ann D'Uva, who has always set a true example of love, patience, and endurance for which I continue to strive towards.

TABLE OF CONTENTS

LIST OF TABLES

Chapter I

INTRODUCTION

This chapter begins by introducing the topic of psychotherapeutic treatment for the seriously mentally ill client. A brief discussion of how conceptualizations of the mentally ill and treatment for this population has changed over time will be undertaken. The background of the problem under investigation will be outlined followed by a specific statement of the problem. The specific hypothesis being examined will be presented along with conceptual and theoretical definitions of the relevant terms used in this study. The chapter concludes with a discussion of the significance of the study, the limitations of the study, and a brief summary.

The conceptualization and treatment of individuals with serious mental illness has varied considerably over time. There are numerous examples throughout human history that highlight how poorly and inhumanely the mentally ill have been treated. Examples of this can be seen in ancient Greek society. In ancient Greece, strange behavior was attributed to a number of causes including possession by demons and disordered metabolisms or humors (Karon & Vandenbos, 1981). The remedies to this strange behavior were extreme and included death, torture, and restraints. A more recent example occurred in the 1940's. During this time, the Nazi's executed large numbers of the mentally ill because they were thought of as sick and useless. Despite these extreme examples, the overall approach towards mental illness during the early 1900's focused on finding physical causes and remedies for mental illness. Some of the biological

treatments that have been utilized are insulin coma, artificial epileptic seizures, electric

convulsive therapy (ECT), pre-frontal lobe lobotomies, tranquilizers, and

institutionalization. Although most of these treatments are no longer in use today,

modified versions of ECT and hospitalization are considered appropriate treatment. The

use of tranquilizers or psychotropic medication is by far the most widely used biological

treatment for mental illness today. First introduced in the 1950's, medications provide a

less drastic and destructive approach while facilitating a decrease in symptomatology

(Talbot, 1985).

Psychotherapy has also played a significant role in the treatment of the seriously

mentally ill. However, this role has changed a great deal over the last century. In the

early 1900's patients had little responsibility in their own treatment and had minimal

demands placed on them. The doctor and hospital provided all necessary intervention.

Slowly, in the 1930's attitudinal and theoretical shifts began to emerge that altered the

way psychotherapy was provided. With the aid of psychologists Harry Stack Sullivan,

Frieda Fromm-Reichmann, and others, the field of psychotherapy began to encourage the

patient to build a relationship with the therapist and to use that relationship as a way to

deal with the outside world (Karon & Vandenbos, 1981). Thus, the existing negative

conception of the mentally ill gradually became more positive and hopeful.

Early research on psychotherapy with the seriously mentally ill was not very

encouraging. In the 1960's and 70's, a number of studies were conducted on the

usefulness of psychotherapy with the persistently and seriously mentally ill (PSMI;

halfway houses, night and weekend hospitals, community vocational rehabilitation services, community clinics and traveling clinics became available to assist the mentally ill in their transition back into the community (Talbot, 1985).

Despite the initial enthusiasm for deinstitutionalization, over time two important observations were made. The first observation was that, even though medication was found to be effective in reducing symptoms, 40 to 50% of discharged schizophrenics relapsed within 1 year (Goldstien, 1989). The second observation was the realization that most schizophrenics social functioning was very limited despite medication (Goldstien, 1989). These realizations led to a search for other methods that could be combined with drug therapy to improve functioning. Consequently, there was a resurgence of interest in psychotherapy with this population.

In addition to the realization that medication alone was not sufficient, initial empirical findings about the effectiveness of psychotherapy with this population began to be challenged. Wasylenki (1992) reports that many of the major studies on this topic have serious limitations and, as a result, scientific conclusions cannot be drawn about the effectiveness of psychotherapy. In an earlier work, Lidz (1980) also identified serious limitations with the research on psychotherapy with PSMI clients. These discrepancies included the definition of intensive psychotherapy, differences in the amount of time the therapy is carried out, the use of untrained therapists, and a lack of controlled studies. The identification of these limitations provided more evidence toward the reexamination of the effectiveness of psychotherapy with the seriously mentally ill.

community with the least amount of support from health care providers (Gehrs &

Goering, 1994). This is accomplished through a combination of supportive counseling

and skill development. According to Anthony (1993), this approach has a recovery focus

which views the individual as able to make changes for himself. A client who was once

seen as ill, weak, and in need of life long care, is now viewed from a psychosocial

perspective as a capable, active participant in treatment. The emphasis is on developing a

collaborative relationship between the individual and the service providers in which both

parties play an important role (Cook, Pickett, Razzano, Fitzgibbon, Jonikas, & Cohler,

1996)

The collaborative relationship appears to be an important component in the

psychotherapeutic treatment of PSMI individuals. Wasylenki (1992) states that "the most

common theme running through case studies, empirical research, and subjective accounts

of the treatment of schizophrenia is the importance of the relationship between therapist

and patient" (p. 125). Other researchers have stated that it is widely accepted in the field

of psychology that therapeutic outcomes are associated with the quality of the relationship

between client and caregiver (Frank & Gunderson, 1990; Gaston, 1990; Gomes-Schwartz,

1978; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Goering and Stylianos

(1988) have stated that understanding how the relationship develops and what part it

plays in the recovery process is important both theoretically and clinically. However,

even with this knowledge, there is little information to identify which factors in the

relationship are most important. A number of researchers have posited the idea that the

alliance component of the therapeutic relationship may be an important predictor of positive outcomes with the PSMI population (Gehrs & Goering, 1994; Goering & Stylianos, 1988; Mosher & Burti, 1992; Solomon, Draine, & Delaney, 1995).

Background of the Problem

Empirical research has found that in general all theoretical approaches offer some beneficial effects but that the differences between the approaches in relation to outcomes is minimal (Greenberg & Pinsof, 1987; Shapiro & Shapiro, 1983; Smith & Glass, 1977). Since these results have emerged, a large number of theorists and researchers have focused on those therapeutic elements that are common to all forms of therapy (Gaston, 1990; Horvath & Greenberg, 1989). One generic factor that has shown a great deal of potential is that of the alliance component of the therapeutic relationship. The alliance refers to the collaborative aspects of the client/therapist relationship. Throughout the literature on psychotherapy, the alliance has been defined in numerous ways and has been given a variety of labels including therapeutic alliance, helping alliance and working alliance. However, despite these varying descriptions, Horvath and Symonds (1991) have noted that there is consensus among researchers on the central ideas of the alliance. These ideas are "1) the working alliance captures the collaborative element of the client-therapist relationship, and 2) it takes account of both therapists and client's capacities to negotiate a contract appropriate to the breadth and depth of the therapy" (p. 139). In order to avoid confusion that could develop from using different labels, this study will refer to the alliance component as the working alliance.

work with the persistent and seriously mentally ill (PSMI) population. These authors strongly recommended the application of the working alliance theory to this population. Since the mid 80's, the number of studies examining the working alliance and outcomes with this population has increased and provides evidence to support the idea that the working alliance is positively associated with outcomes with the PSMI population (Clarkin, Hurt, & Crilly, 1987; Frank & Gunderson, 1990; Gehrs & Goering, 1994; Goering, Wasylenki, Farkas, Lancee & Ballantyne, 1988; Neale & Rosenheck, 1994; Ralph & Clary, 1992; Solomon, Draine, & Delaney, 1995; Tyrrell, Dozier, Teague, & Fallot, 1999; Wasylenki, Goering, Lancee, Ballantyne & Farkas, 1985).

Despite the increasing number of studies examining the working alliance and outcomes with the PSMI population, this number is considerably less when compared to the literature base focusing on the broader issue of the working alliance. However, these studies consistently show that, similar to studies with traditional non-chronic clients, a strong alliance is associated with positive outcomes. In one study, the therapeutic alliance between client and therapist, as measured by the therapist, resulted in client's longer stay in therapy, taking medications as prescribed, and having an overall better outcome over time (Frank & Gunderson, 1990). This same study found that it took clients up to 6 months to form good alliances with their therapists. Two related studies (Goering, Wasylenki, Farkas, Lancee and Ballantyne, 1988; Wasylenki, Goering, Lancee, Ballantyne and Farkas, 1985) designed to explore the impact of rehabilitative interventions, showed that not only were rehabilitative strategies effective, but,

Over the last 20 years, researchers with varying definitions of the alliance have developed a number of alliance measures. These include the Helping Alliance (Luborsky, 1976), the Vanderbilt Psychotherapy Process Scales (Gomes-Swartz, 1978) the Therapeutic Alliance Scale (Marmar, Horowitz, Weiss, & Marziali, 1986) and the Working Alliance Inventory (Horvath & Greenberg, 1989). Among these various measures of the alliance one in particular appears most appropriate to the focus of the current study. This measurement tool, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) is based on a theory proposed by Bordin. Bordin's (1976, 1979, 1994) pantheoretical framework of the working alliance emphasizes the positive collaboration of the client and therapist with the goal being the reduction or elimination of emotional problems or discomfort. Bordin's concept contains three essential components; goals, tasks, and bonds. In order to measure this construct, Horvath and Greenberg (1989) developed the Working Alliance Inventory (WAI). This inventory has been widely used since its development and has been used successfully with chronic psychotic individuals receiving rehabilitation services. (Neale & Rosenheck, 1995; Ralph & Clary, 1992; Stylianos & Goering, 1989).

Several reviews of the research on the working alliance have suggested that the strength of the alliance can be used to predict outcomes in a number of different settings and populations (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, 1994). However, Goering and Stylianos (1988) have noted that although the concept of the working alliance has been applied to various populations, it has rarely been applied to

As research in the area of psychotherapy with the PSMI began to increase, new information about the understanding and treatment of mental illness became available. This information has made it possible to modify psychotherapeutic approaches in a more effective way for these individuals. In one review of the etiology and management of schizophrenia, Freeman (1989) attributed equal importance to environmental and genetic factors. Another study found that drug treatment alone is not enough to make a significant difference (Carpenter, 1986). With the knowledge that medication in combination with other forms of treatment has been effective for this population, the direction of treatment has shifted to include a focus on psychosocial factors.

Wasylenki (1992) asserts that there is much new knowledge about the psychosocial factors involved in schizophrenia. Anthony (1993) supports this by stating that the aftermath of deinstitutionalization has highlighted the importance of psychosocial factors in the treatment of schizophrenia. Throughout the deinstitutional era, mental health professionals began to realize two important aspects of those suffering from serious mental illness (Anthony, 1993). First, it became clear that the person with severe mental illness may have multiple residential, vocational, educational, and social needs that must be addressed by the social service system. Second, serious mental illness often results in significant functional limitations and disabilities. The multiplicity of need and the severity of the illness led to the development of the rehabilitative approach.

The concept of psychosocial rehabilitation is broad. The main goal is to assist people with psychiatric disabilities to perform skills needed to live and work in the

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The concept of psychosocial rehabilitation is broad. The main goal is to assist people with psychiatric disabilities to perform skills needed to live and work in the

Grinspoon, Ewalt, & Shader, 1972; May, 1968; Rogers, Gendlin, Kiesler, & Truax,

1976). The overwhelming conclusion of the majority of these studies was that

psychotherapy was not significantly effective with this population (Karon & Vandenbos,

1981; McGlashan & Keats, 1989). In his review of the literature, Gunderson (1979)

summarized these results by stating, "At the present time a reasonable conclusion to draw

from available evidence is that individual psychotherapy is not dramatically successful for

most schizophrenic people" (p. 368).

These results in combination with the long standing belief that schizophrenia and

other debilitating mental illnesses can be explained solely through genetic and biological

research and the belief that drug therapy is more beneficial than interpersonal approaches

resulted in a dramatic decrease in the use of psychotherapy with these individuals. With

the decrease in the use of traditional psychotherapy in the 50's, 60's, and 70's, alternative

treatment interventions focused on community based services. At the same time, the

damaging effects of long-term hospitalization were becoming evident. Since tranquilizers

and other drugs resulted in a decrease in patient symptoms and impairment, many people

believed that these patients were ready to live in the community from which they had

been separated for many years. This belief, that psychiatric patients could function

outside the hospital if supported by community services, led to the mass discharge of

patients who had been hospitalized for long periods in psychiatric institutions and was the

beginning of the Community Mental Health Movement. The deinstitutionalization era of

the 60's and 70's fueled a need for even more community-based services. Services such as

LIST OF FIGURES

Figure

additionally client interviews suggested that the alliance was an important factor in their improvement. Gehrs and Goering (1994) specifically examined the working alliance between rehabilitation therapists and clients with schizophrenia and its impact on rehabilitative outcomes. Their results showed that therapist and client perceptions of the quality of the working alliance were significantly correlated with client perception of progress and attainment of rehabilitation goals. The most recent study of the working alliance and outcomes with this population (Tyrrell, Dozier, Teague, & Fallot, 1999) found that certain client self-report outcomes were positively related to the alliance. The stronger the alliance the better the outcomes. In combination, these studies support the importance of the working alliance when providing psychiatric rehabilitative services for the individual with schizophrenia.

While the research discussed above focuses on the working alliance between client with persistent and serious mental illness and their therapist, there is also research that examines the working alliance between PSMI client and their caseworker. In a psychosocial rehabilitation treatment setting the majority of therapeutic interactions occur with the client's caseworker. In studies examining the working alliance in this type of setting the caseworker is considered the primary provider of therapeutic treatment. The important role of the caseworker in treatment is highlighted by the work of Wasylenki, Goering, Lancee, Ballantyne, and Farkas (1985) and Goering, Wasylenki, Farkas, Lancee, and Ballantyne (1988) who reported that their subjects acknowledged the importance of their caseworker in their lives by sharing that they finally felt "understood and accepted".

In studies focusing specifically on the working alliances between caseworker and client with a serious psychiatric disorder, the results again show a positive association with outcomes. Neale and Rosenheck (1994) found that both client and case manager perceptions of the alliance were related to positive outcomes. Solomon, Draine, and Delaney (1995) also focused on the development of an alliance between individual with serious mental illness and their case managers. This study found a positive relationship between certain outcomes including quality of life, attitudes about medication compliance, treatment satisfaction, and degree of symptomatology and the strength of the alliance. Both of these studies are consistent with the research discussed above.

Although the research with this population indicates that the working alliance does have an impact on certain subjective outcomes such as client perception of progress, quality of life, and attitudes about medication, little has been done to empirically identify the factors that are involved in developing a strong alliance. One area that has received some attention is that of client variables. A number of studies have been done to examine the client factors that contribute to the development of a strong alliance. Horvath (1991) summarized 11 studies which focused on client variables and the working alliance. He concluded that there were several client pre-therapy factors that had significant effects on the alliance. For example, clients who have been found to have poor alliances with their therapists, often have difficulty maintaining social relationships, have poor family relationships, little hope for success, poor object relations, and are defensive. At the same time, Horvath found that the certain diagnostic features of the client such as severity of

symptoms had a very small impact on the alliance. In other words, clients with more severe psychological symptoms were able to develop strong alliances with their counselors as well as those clients with less severe symptoms. Overall, this indicates that some interpersonal and intrapersonal client variables do impact on the alliance. However, the results of this study (Horvath, 1991) demonstrating that severity of symptoms has a very small impact on the alliance, in combination with the results of the studies examining the working alliance with the PSMI population indicate that this group of individuals, despite their interpersonal limitations, are able to develop working alliances with a treatment provider.

The research focusing on counselor variables in relation to the working alliance is minimal. Gurman (1977) and others have argued that their are at least two broad therapist factors that impact the therapeutic relationship. These two factors are therapist personal characteristics and therapist technical activity. Both factors have been empirically examined in relation to the working alliance (Horvath, 1994b). Within the domain of therapist personal characteristics researchers have examined several variables. One group of variables can be described as personal qualities and the other as professional experience. In relation to personal qualities, Dunkle and Friedlander (1996) found that therapists who reported less self-directed hostility, more social supports, and greater comfort with closeness had clients who rated the bond component of the working alliance more positively. Another study, Tyrrell, Dozier, Teague and Fallot (1999) examined attachment states of mind of both clients with mental illness and their

caseworkers. These authors found that attachment states did impact on the strength of the alliance. Stronger alliances were associated with a mismatch between client and caseworker on the deactivation versus hyperactivating dimension of attachment. In other words, caseworkers who were less dismissing formed stronger alliances with clients who were more dismissing than with clients who were less dismissing.

The second variable within the domain of therapist personal characteristics is professional experience. With regard to this variable and its impact on the working alliance there are some mixed results. Mallinckrodt and Nelson (1991) found that the more experienced therapists are, the stronger alliances they develop with their clients. A second study, however, found that there was no significant association between therapist professional experience and strength of the alliance (Dunkle & Friedlander, 1996). The most recent study exploring this variable, Kivlighan, Patton, and Foote (1998), found a significant interaction between therapist experience level and client need for attachment. The researchers found that clients who were less comfortable with intimate relationships have stronger alliances with therapists who have more experience. Overall, these initial studies of the relationship between the working alliance and therapist personal characteristics, defined as both personal qualities and professional experience, suggest that they do impact on each other.

The second general factor believed to impact on the working alliance is therapist technical activities. Therapist technical activity has historically been difficult to define. Kivlighan (1990) describes technical activity as "the way that therapists interact with

clients, prescribed by or wedded to a theoretical position" (p. 27). The majority of studies examined therapist technical activity by focusing on therapist technique and intervention. Kivlighan (1990) in a study of counselor intentions, found that assessment, support, and explore intentions were negative predictors of the working alliance. In addition, Kivlighan and Schmitz (1992) found that in counseling dyads where the alliance improved over time, therapists were challenging, thematically oriented and here and now focused. Other studies have also found that interventions which focus on dealing with the relationship issues between client and counselor are associated with improving alliances over time (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Luborsky, Crits-Chrisoph, Mintz, & Auerbach, 1988). Henry and Strupp (1994) report that the counselor's internal representation of past relationships has a strong influence on the quality of the working alliance. Safran, Muran, and Wallner Samstag (1992) lend additional support to this with their finding that the therapist's ability to accept responsibility for their own difficulties with a client leads to improved alliances. Although, the research focusing on counselor technical activity in relation to the working alliance is limited, the evidence does indicate that counselor technical activity, as well as therapist personal characteristics, impacts the alliance and highlights a need for further exploration.

To summarize, there is some evidence that indicates that therapist personal characteristics and therapist technical activities are associated with the strength of the working alliance in settings with traditional clients. In contrast to the number of studies

examining counselor variables, only one study has focused on caseworkers working with the persistent and seriously mentally ill. This study focuses on the caseworker personal characteristic of attachment (Tyrrell, Dozier, Teague, & Fallot, 1999). The results indicated that the attachment state of the therapist does impact on the strength of the working alliance. This study is consistent with Dunkle and Friedlander (1996) who also found that counselor attachment states impacted on the working alliance in traditional client-counselor dyads. The minimal empirical evidence that caseworker personal characteristics are related to the alliance with PSMI clients and the lack of studies examining therapist technical activity and the alliance with the PSMI population exposes a gap in the literature that must be addressed. The current study will explore the two domains identified above, therapist personal characteristics (defined as therapist personal qualities and experience) and therapist technical activity and their impact of the strength of the working alliance.

In reviewing the existing studies examining therapist factors and the working alliance, an observation can be made. In all of the studies, therapist factors are assessed in one of two ways, therapist self report or observer rating. None of the studies discussed examined client perceptions of their therapist or caseworker. While therapist self-report and observer rating are important methods of assessment, there are at least two reasons for focusing on client perceptions as well. Foremost, both the research on the working alliance and its relation to treatment outcomes as well as the research on therapist characteristics and its relation to outcomes has shown that client perception is a stronger

predictor of outcomes then therapist perception. In their meta-analysis of the empirical

findings on the working alliance and outcomes, Horvath and Symonds (1991) found the

following effect sizes (expressed as correlation coefficients): .17 for therapist perceptions

and .21 for client perceptions. When both alliance and outcomes were assessed through

client perception, the effect size (expressed as a correlation coefficient) increased to .31.

Additionally, client perception has traditionally been used in studies of outcome to assess

counselor variables such as emotional well-being, values, attitudes, theoretical

philosophy, personality traits, expertness, attractiveness and trustworthiness (Beutler,

Machado, and Neufeldt, 1994). Based on this information, the majority of studies

examining the working alliance and outcomes with PSMI clients have utilized client

perception as the mode of assessment for both the working alliance and a variety of

outcomes (Frank & Gunderson, 1990; Gehrs & Goering, 1994; Neale & Rosenheck,

1995; Ralph & Clary, 1992; & Solomon, Draine, & Delaney, 1995). These studies have

shown consistent positive evidence for the use of client perceptions with this population.

Together, this information suggests that the use of client perception for both the working

alliance and caseworker characteristics is consistent with a majority of the studies in both

areas.

A second reason for utilizing client perception is a practical one. Based on a

counseling psychology perspective, it makes sense to focus on practical real life issues

that can be modified to improve treatment. For example, it is much more difficult to

provide psychoeducation about changing a caseworker's hostile introject or attachment

style (both entrenched personality traits), than it is to focus on changing how a

caseworker's actions are perceived by a client with PSMI. By focusing on client

perception, it is hoped that practical information and suggestions will be obtained that can

more easily be incorporated into a psycho educational plan and implemented by

caseworkers in the field.

In sum, the working alliance has been shown to be positively associated with

outcomes with PSMI clients. Although there is some research on the therapist factors that

contribute to the strength of the alliance, the number of studies exploring the impact of

caseworker factors on the alliance is very limited. The broad therapist factors that have

been shown to have some impact on the strength of the alliance are therapist personal

characteristics and therapist technical activity. More specifically, the variables that have

been empirically examined within these domains can be described as personal qualities,

professional experience, and therapist intervention. In addition, all of the studies in this

area assess counselor variables through therapist self report and observer rating. Until

now, there have been no studies examining client perception of caseworker personal

qualities, experience and intervention in relation to the working alliance. For the reasons

discussed above, consistency and practicality, a study exploring PSMI clients' perceptions

of their caseworkers and its impact on the working alliance is needed.

Although there is evidence to suggest that all three identified variables may be

associated with a strong working alliance, when focusing on PSMI individuals there is

some speculation that one variable, personal qualities, may be a better predictor than the

other two. This speculation is based on support from three areas, theoretical discussions of relationship factors involved in the treatment of the seriously mentally ill, empirical findings on the curative factors involved in psychosocial treatment, and a recognition of aspects of treatment with these individuals that are uniquely different from the treatment of more traditional clients.

A number of theorists discuss the relationship factors involved in the treatment of PSMI (Persistently and Seriously Mentally Ill) clients and have proposed various therapist/caseworker qualities as important (Frank, 1971; Goering & Stylianos, 1988; Mosher & Burti, 1992). Some of these qualities include the worker's personal characteristics which promote feelings of hope and optimism and that are non-judgmental. Mosher and Burti (1992) identify five relational principles that caseworkers should have to enhance their relationships with their clients. These principles include the ability to demonstrate flexible attitudes and the ability to act as a partner with the client. However, there are no empirical findings to support or dispute the ideas of these theorists. The work of these authors emphasize the importance of the therapist personal qualities in working with these individuals.

The area of research that comes closest to focusing on caseworker qualities is the examination of curative factors in rehabilitation centers (Hoge, Farrell, Munchell, & Strauss, 1988; Schreer, 1988; Svensson & Hanson, 1999; Van den Langenberg & Decker, 1989). These studies attempt to identify those general factors present in rehabilitation centers that the client perceives as therapeutic or curative. Interpersonal contact was

chosen in each one of the above studies as one of the most curative factors identified by clients. These results indicate that in these treatment centers the ability to interact with others in order to feel accepted and supported is very important to the client. Therefore, it would seem that the client may be sensitive to the caseworker qualities that encourage this interpersonal contact. Although interpersonal contact is an important factor in treatment, these studies do not describe how this factor relates specifically to caseworkers. Further analysis is needed to describe the client perceived variables involved in interpersonal contact with caseworkers.

When exploring the working alliance with the PSMI population in a psychosocial rehabilitation program there are two important issues which distinguish it from treatment with more traditional clients. Individuals with serious and persistent mental illness have, by the nature of their illnesses, ineffective or marginally effective social skills and lack a stable sense of self (Goering & Stylianos, 1988). Their capacity for relating to others is significantly effected by their illness and often leads to a fear of relationships that may become intimate. As a result, the PSMI client enters the relationship at a distinct disadvantage. In order for someone with a persistent and serious mental illness to begin the treatment process in an effective way , he must feel he is not putting himself at serious risk. It would seem therefore, that the client's perception of their caseworker's personal qualities could have a major impact on how much, if at all, the client will feel safe and engage in the working alliance.

The second issue to consider is the role the caseworker plays within the context of

a psychosocial rehabilitation day program. This role requires a significant degree of interchange with clients on a number of different levels throughout the day. For example, the client may not only have an individual session with their caseworker during the course of the day but might also be in a cooking group with the caseworker, have lunch with the caseworker, and observe the caseworker interact with other clients and staff. This allows the client to witness the caseworker's behavior in different situations and develop a more comprehensive image of the caseworker then would normally be possible with a traditional client/counselor relationship. Due to the increased contact over various situations, the client is exposed to more of the personal qualities of their caseworker then would otherwise be expected in counseling. Their perception of their caseworker in these situations may certainly impact on the working alliance between them. Both of these treatment considerations highlight additional support for the importance of the caseworker's personal qualities.

The present study is an examination of client perceptions of the caseworker variables of personal qualities, experience and technical interventions and their association with client perception of the working alliance in individuals with persistent and serious mental illness. This section has presented information related to the topics of the working alliance and caseworker variables. The overall working alliance research as well as the working alliance research specifically with PSMI clients was briefly reviewed to establish its positive association with outcomes. Research was then presented on the impact of therapist personal characteristics and technical activity on the working alliance

for both traditional and PSMI clients. Additional evidence focusing on the impact of the caseworkers personal qualities was also discussed.

Statement of the Problem

The psychotherapeutic treatment of PSMI individuals has changed a great deal over time. Today, these individuals are viewed as capable partners in their own treatment. This thinking is reflected in the psychosocial rehabilitation model. At the same time, research on the working alliance, or the collaboration of client and therapist, has shown positive associations with treatment outcomes. The psychosocial rehabilitation model compliments the theoretical ideas of the working alliance. In fact, research on the working alliance with the PSMI population has also shown a positive association with treatment outcomes. One of the differences involved in examining the working alliance in this setting as opposed to a more traditional counseling setting is that the primary provider of treatment is often the client's caseworker.

Research on the impact of therapist variables on the working alliance focuses on two domains: therapist personal characteristics and therapist technical activity. The majority of the studies indicate an association between both therapist technical activity and therapist personal characteristics and strength of the alliance (Dunkle & Friedlander, 1996; Foreman & Marmar, 1985; Kivlighan, 1990; Kivlighan, Patton, & Foote, 1998; Kivlighan & Schmitz, 1992; Mallinckrodt & Nelson, 1991). Unfortunately, there is only one study which focuses specifically on the impact of caseworker personal characteristics on the working alliance with PSMI clients (Tyrrell, Dozier, Teague, & Fallot, 1999).

Significance of Study

This study focuses on identifying client's perceptions of caseworker personal

qualities, experience and interventions that are associated with a strong alliance. A

review of the working alliance literature indicates that treatment outcomes with the

seriously mentally ill are affected by the quality of the working alliance. Since positive

outcomes are the goals of all treatment programs, information about how to develop or

enhance the alliance could be beneficial to treatment.

While research on the working alliance theory has been extensive with the general

population, there is limited research in the area of serious mental illness. The present

study will contribute to the knowledge of the working alliance with the seriously mentally

ill population. It is anticipated that this study will provide information about how PSMI

individuals perceive their caseworkers personal qualities, intervention, and experience

level. As noted by Wasylenki (1992), research has begun to change original conceptions

of the schizophrenic client. Today, the person with persistent and serious mental illness

is viewed as being responsive to psychosocial and interpersonal interventions. This study

encourages those individuals that work with the PSMI population to be aware of and

focus on the their client's ability to develop relationships and recognizing the positive

impact these relationships can have on their rehabilitation. It is anticipated that this study

will lend additional support to this view by providing more information about the

caseworker factors involved in achieving a strong working alliance.

Identifying specific caseworker personal qualities and interventions that impact on the development of the alliance from the client's perspective could provide significant information to caseworkers. The caseworker is responsible for the initial steps toward the development of an alliance. The worker must provide an atmosphere and environment that is conducive to its development. Often, this task can be difficult and frustrating, especially with clients who have poor social and interpersonal skills. With the knowledge of what clients perceive as beneficial about their personal qualities and interventions, caseworkers may be able to reevaluate their approach and develop more effective ways of facilitating the development of the alliance.

Finally, the results of this study may influence the development and design of psychosocial rehabilitation programs in two ways. First, directors interested in improving the treatment outcomes of their programs may need to examine their programs to determine if they are organized in a way that encourages the development of strong alliances. This may include a re-evaluation of program schedule, treatment philosophy and hiring practices. Second, directors and supervisors may begin to emphasize the importance of the caseworkers role beyond the provision of basic casework services. Caseworkers could be taught the benefits of developing a strong working alliance with their clients. Caseworkers could also be taught the importance of their clients' perceptions of this alliance. Various personal qualities and interventions could be

encouraged and modified through education, training, and supervision. This may also lead to exploring other ways of developing and enhancing the alliance between clients and caseworkers.

<div align="center">Definition of Terms</div>

<u>Working Alliance</u>

In the literature, terms such as therapeutic alliance and helping alliance, have been used to describe what is referred to, in this study, as the working alliance. The construct of working alliance or the relationship factor between client and therapist in therapy has been explored by a number of schools of psychology including psychodynamic, humanistic, and social learning (Barrett-Lennard, 1985; Bowlby, 1988; Greenson, 1965; Greenson, 1967; Luborsky, 1976). For the purpose of this study, working alliance will be defined using the theory proposed by Bordin (1976, 1979, 1984). In Bordin's formulation, the working alliance is defined as the positive collaboration between the client and the therapist toward the improvement of the client's sense of well being. The alliance is comprised of three important factors; goals, tasks, and bonds. Based on Bordin's theory, Horvath and Greenberg (1986) developed an assessment of the working alliance. Operationally, working alliance will be defined as the sum of the client's scores on the Working Alliance Inventory (WAI). While four scores can be generated from the WAI (overall score, bond subscale, task subscale, and goal subscale) only the overall score will be utilized. Several studies have shown that the three subscales are highly

correlated with each other ($\underline{r}$'s ranging from .69 to .92) and therefore do not measure three discrete factors (Horvath, 1994a; Horvath & Greenberg, 1989; Ralph & Clary, 1992).

<u>Caseworker Variables</u>

Case management is considered to be one of the most popular forms of service delivery to individuals with serious mental illness (Gerhart, 1990; Kanter, 1991; Miller, 1983; Moxley, 1989; Rubin, 1992). Although, there are several models of case management, this study focuses on PSMI clients in a Psychosocial Rehabilitation setting. Therefore, the caseworkers in this study will follow a rehabilitation model of case management. In this model, "the case manager's (worker's) overall responsibility is to increase the functioning of his/her clients so that the client can be both personally satisfied and successful in the residential, vocational, educational, and or social environment of his/her choice" (Ralph & Clary, 1992, p. 3). The caseworker variables under investigation are client perception of personal qualities, experience, and intervention. These variables will be operationally defined using the Therapist Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, & Langlotz, 1986). This scale was developed to assess the perceived behavior of therapists by their clients. The format of the scale is a checklist that contains 29 pairs of words that are diametrically opposed to each other. Each pair describes an aspect of the therapists behavior. Examples of some of the pairings are talkative/quiet, genuine/fake, and passive/active. Clients will rate on a Likert scale from 1 to 6 the degree to which the pair describes their caseworker. Factor analysis conducted on past research has identified three main factors that can be extracted

from the data; positive regard/interest, competency/experience, and activity/direct guidance. Based on a review of the items of each scale the following correspondences were determined. The positive/regard factor corresponds with the personal quality variable, the competency/experience factor corresponds with experience, and the activity/direct guidance factor corresponds with caseworker intervention.

<center>Limitations</center>

This study has a number of limitations. Correlational in design, this study will not show a cause and effect relationship. In addition, because this study is correlational, it will not use random assignment, nor any control groups. Clients will be asked to focus on their relationship with their primary caseworker, but it will be difficult to control for the effects of other factors (e.g., other program staff, residential staff, family involvement, and psychiatrist involvement). This study will not be able to determine if a change in perception occurs at different stages of the alliance or changes when the alliance comes to an end. Another limitation is that the measurement of the alliance and caseworker variables are subjective ratings by the client rather then objective measures of behavior. However, the reason for utilizing patient perception is supported by the working alliance research which has found that client perceptions are the most strongly associated with positive outcomes (Gaston, 1990; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, 1994).

An additional limitation of this study is generalizability. Generalizability is a problem for two reasons. First, this study focuses on a program that follows a

This study found a connection between caseworker personal characteristics defined as attachment state of mind and the strength of the alliance. The limited number of studies in this area indicates a need for more research to further clarify the impact of caseworker personal characteristics and technical activity on the working alliance with PSMI clients. In the existing studies, therapist personal characteristics have been defined as personal qualities and professional experience and technical activities has been defined as intervention. This study will define caseworker personal characteristics and technical activity using the same variables. The purpose of this study is to explore the association between client perception of caseworker personal qualities, interventions, and experience with client perception of the working alliance in a population of persistently and seriously mentally ill individuals engaged in a psychosocial treatment program. Additional information was also presented which supports the contention that the client's perception of their caseworker's personal qualities will have a greater impact on the working alliance than professional experience or caseworker intervention.

Hypothesis

Persistently and seriously mentally ill (PSMI) clients' perceptions of the working alliance, as measured by the total score on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), will be related to the clients' perception of their caseworkers' positive regard, competence/experience, and activity/guidance as measured by the factor structure of the Therapist Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, & Langlotz, 1986).

psychosocial rehabilitation model and thus can only be generalized to programs that follow a similar model. The second problem with generalizability is that the clients' diagnoses are not uniform. The demographics of psychosocial rehabilitation program is such that there is often a mixture of diagnoses treated within the same setting (thus, the term persistently and seriously mentally ill). Therefore, the sample will include those suffering from major mental illnesses including schizophrenia, bi-polar disorder, and major depression who have had at least one psychiatric hospitalization. In addition some clients may be dually diagnosed with one of the following; personality disorder, drug addiction, or developmental disorders. This combination of diagnosis is consistent with other research examining the working alliance in psychosocial rehabilitation programs (Clarkin, Hurt, & Crilly, 1987; Frank & Gunderson, 1990; Gehrs & Goering, 1994; Goering, Wasylenki, Farkas, Lancee and Ballantyne, 1988; Neale & Rosenheck, 1994; Ralph & Clary, 1992; Solomon, Draine, and Delaney, 1995; Tyrrell, Dozier, Teague, & Fallot, 1999; Wasylenki, Goering, Lancee, Ballantyne & Farkas, 1985). The results of this study can only be generalized to subjects with these type of disorders who are in treatment in a similar psychosocial rehabilitation program.

<center>Summary</center>

In this chapter, the changing approaches to the therapeutic treatment of the seriously mentally ill were reviewed. In contrast to the early 20th century, today the mentally ill are viewed as more active and capable. The field of psychosocial rehabilitation, incorporating the psychiatric, psychological, medical, social work, and

rehabilitation fields, has become a leading force in changing long held beliefs that these individuals are sick, weak, and unable to help themselves. With renewed interest in psychotherapy with these clients, focus can be directed on identifying the factors that are most effective in contributing to positive outcomes. Wasylenki (1992) and others have identified the working alliance or therapeutic relationship between client and therapist as an essential ingredient in psychotherapy with the seriously mentally ill. Although, the importance of the working alliance in the treatment of the PSMI client has been established, the factors that are associated with this alliance in this setting is limited. One factor that has not been adequately explored is that of caseworker variables. The broad topic of caseworker variables has been limited to a focus on client perceptions of caseworker personal qualities, interventions, and experience. The purpose of this study is to identify whether these client perceived variables are associated with a strong working alliance in PSMI clients in a psychosocial rehabilitation program. Additionally, the purpose is to determine if the personal quality variable has a greater impact on the alliance then either of the other two variables under investigation.

This chapter reviewed the literature supporting the use of the working alliance theory with the seriously mentally ill client and the need to explore the role of caseworker personal qualities on the strength of the alliance. There was a discussion of the significance of this research topic and how it might have an impact on both the literature focusing on the working alliance with the PSMI population and clinical practice. In order to critically analyze this work, the limitations of this study were also identified.

Chapter II

REVIEW OF THE LITERATURE

The purpose of this study is to examine the association between the perception of the working alliance and caseworker variables in individuals with persistent and serious mental illness. The specific caseworker variables under investigation are client perception of personal qualities, interventions, and experience. These variables will be assessed by the Therapist Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, & Langlotz, 1986). The working alliance will be assessed by the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Chapter II provides the theoretical background of the research, as well as a review of the related literature and is organized under two main headings. First, the theory behind the working alliance construct is discussed and an overview of the literature on the working alliance and outcomes is presented. This is followed by a review of the literature specifically focusing on the working alliance with the persistent and seriously mentally ill. The second half of the chapter reviews the literature on the therapist factors that have been examined in relation to the working alliance. Again, particular attention is paid to those studies with the persistent and seriously mentally ill. Additionally, theoretical perspectives and clinical aspects of the case management relationship with this population will be presented. A related section of the literature focusing on the curative factors with this population is also presented. The chapter concludes with a brief summary.

Working Alliance Research

Theory and Background

With the publication of a number of studies focusing on psychotherapeutic treatment approaches (Greenberg & Pinsof, 1987; Luborsky, Singer, & Luborsky, 1975; Shapiro& Shapiro, 1983; Smith & Glass, 1977), the belief that no particular theoretical orientation is more effective than another and that the most salient factor related to positive outcome is the relationship between client and therapist have been strongly supported. This realization has focused attention on identifying a generic factor or factors in counseling that play a pivotal role in positive outcomes (Horvath & Greenberg, 1989). Of the possible generic in-therapy factors examined in the literature, Luborsky (1994) reports that the therapeutic alliance has been shown to have the second most number of studies showing a significant impact on outcomes. The nature of this therapeutic relationship has been described in numerous ways and through various orientations.

Freud's (1912) early writings refer to the patient developing an attachment to the analyst as part of the transference process. Various other psychoanalytic theorists including Freud, modified and expanded on this original concept. Ego psychologists have also contributed to the understanding of the therapeutic alliance by describing the attachment between therapist and client as representing a "new object relationship" that is based on current factors rather than early memories (Bibring, 1937). According to Horvath and Luborsky (1993) psychoanalytic thinking centers on the debate of whether

the alliance is a manifestation of transference with the therapist or whether it is separate and distinct from the concept of transference. When viewed as part of the transference process, the alliance is based on emotions and thoughts associated with unresolved relationships rather then the actual relationship between client and therapist. The alternative view recognizes that past experiences may influence the relationship, but that other more reality based factors also have an impact on the alliance.

Rogers' (1951, 1957) client-centered approach postulates that empathy, regard, unconditionality, and congruency on the part of the therapist are the central conditions for therapeutic change. The relationship, as conceptualized by Rogers, places the responsibility for the therapeutic relationship solely on the therapist and considers only the actions of the therapist to be necessary in its development. It is assumed that the client will accept what is offered and change as a result regardless of the client's own participation. In this description the collaborative elements of the alliance are missing.

Horvath and Luborsky (1993) report that a number of studies have been conducted on Roger's theory of unconditional regard. When empirically compared, alliance theory and Rogers' Therapist Offered Conditions (TOC) has shown some degree of correlation. However, when examining outcomes, some researchers found that the alliance was more predictive than Roger's TOC (Greenberg & Adler, 1989; Horvath, 1981; Jones, 1988; Mosely, 1983). In a study by Salvio, Beutler, Wood, and Engle (1992) the TOC dimensions were found to have a strong but considerably smaller impact then the alliance dimensions on treatment outcomes. Horvath and Luborsky (1993) suggest that these

explain a generic factor that crosses theoretical boundaries and has a positive effect on therapeutic outcomes.

Bordin's Working Alliance Theory

According to Horvath and Symonds (1991) the relationship between client and therapist and its influence in therapy is one of the oldest themes of psychological research. Many theorists agree that the concept of the therapeutic alliance provides a good basis for understanding how therapy works (Frieswyk et al., 1986; Hartley, 1985; Orlinsky & Howard, 1986). Bordin's (1976, 1979, 1994) theoretical framework of this alliance has been one of the most influential.

Bordin's theory, first described in 1976, focuses on describing the relationship between client and therapist that promotes change. The theoretical foundation of his theory is in psychoanalytic and object relations theory. However, Bordin diverts from this perspective by clearly distinguishing between the therapeutic relationship as a reflection of unconscious projections (transference), and the therapeutic relationship as a unique connection between client and therapist based on conscious thought, feelings, and behavior. This theory proposes that the alliance between client and change-agent must be collaborative. Bordin describes a strong working alliance as "a condition in which a person seeking change has found that the change agent can participate in the effort to shed light and open new doors with out reducing the partnership to the pairing of a leader-therapist with an assistant-patient. Its strength revolves around the experience of

new possibilities in the patient struggle rather then faith in a charismatic therapist-magician" (Bordin, 1994, p. 15).

Bordin's formulation of the working alliance theory involves three elements. The first element is the strength of the alliance. The working alliance is a positive collaborative relationship that develops between client and therapist and is composed of three things; goals, tasks, and bonds. Goals are the mutual agreements between client and therapist about the outcomes that are the targets of interventions. Bordin believes that these change goals should be mutually determined and negotiated between both parties. Tasks are the specific activities that the partnership will use to facilitate change. Bonds refer to the positive connections between client and therapist that develop as a result of a commitment/involvement in a shared activity and are usually based on mutual respect and trust. Together these three factors are very important in understanding the concept of the working alliance.

The second element in Bordin's formulation is the power of the therapeutic tasks. Tasks refer to "the specific activities that the partnership will engage in to instigate or facilitate change" (Bordin, 1994, p. 16). Power refers to the strength of the tasks in achieving the desired outcome. The power of the tasks is based on a number of things including theoretical orientation. Although the three elements discussed above are present in all therapeutic alliances, the power may vary depending on the theoretical orientation of the therapist. For example, the interventions a behaviorist uses will differ from that of a psychoanalyst or a humanist.

Measurement of the Working Alliance

A number of researchers have developed tools to measure the alliance (Horvath and Greenberg, 1989). Some of these instruments are empirically derived while others are theoretically derived. Most of these instruments have been designed with separate scales for the client, the therapist, and an observer. Horvath and Greenberg (1989) have developed an instrument based on Bordin's pantheoretical theory. Their instrument is called the Working Alliance Inventory (WAI). The WAI provides an overall assessment of the working alliance, as well as three subscales in conjunction with Bordin's definitions of bonds, tasks, and goals.

There are two main reasons for the use of the WAI in this study. First, there does not appear to be any clear empirical evidence that the various alliance tools significantly differ from each other in terms of the construct they measure or in prediction of outcomes. For example, in three studies (Adler, 1988; Safran & Wallner, 1991; Tichenor & Hill, 1989) comparing different instruments, the amount of shared variance between the instruments ranged from 12% to 76%. In a review of the empirical information available on alliance tools, Horvath (1994b) concluded that there is a good amount of evidence to support the idea that each tool is assessing a related underlying construct and that no tool is significantly better then the rest. In addition almost all alliance tools have shown a positive association with outcomes (Luborsky, 1994).

The second reason is related to the population under investigation. While many of the alliance scales have been used with traditional populations, the majority of studies

The third element in Bordin's formulation of the working alliance is the dynamics of the strains within the relationship. Bordin defines strain as "the appearance of a significant deviation in the patient's commitment to the working alliance, whether it is with regard to goals, tasks, or bonds" (Bordin, 1994, p. 18). He distinguishes between strains that are present in the formation of the alliance and those that develop further along in the process. Specific to this study, Bordin notes that those clients who have more severe pathology require more time in the alliance building phase in order to develop a strong and effective alliance.

Bordin's working alliance theory also incorporates a number of other important factors that distinguish it from other psychological theories. The first is that it emphasizes client/counselor interdependence. In other words, both counselor and client are actively and equally engaged in the partnership. The second is that the working alliance is not considered an intervention in and of itself. Rather it is seen as a way of enabling and facilitating change. Finally, it is the theoretical orientation of the therapist that will determine how and when the goals, tasks, and bonds will be developed. All these factors contribute to the pantheoretical concept of the working alliance as a generic factor that can transpose a number of varied psychological orientations in order to reduce or eliminate emotional problems or discomfort. As a result, Bordin's working alliance theory has been the cornerstone of a significant amount of research. The majority of this research has focused on examining the first element of the theory, the strength of the alliance. The current study also focuses on the strength of the alliance.

results may indicate that TOC dimensions are a prerequisite to the development of the alliance. Watson and Greenberg (1994) have stated that another reason the TOC dimensions have shown less of an impact on treatment outcomes than the working alliance is due to the complexity of the relationship factors and the difficulty in operationalizing them.

The various labels that have been used to describe the alliance aspect of the client/therapist relationship often correspond with the theoretical position of the researchers and the related tools used to assess the alliance. The current study is utilizing the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) to assess the alliance between caseworker and client for two reasons. First, the WAI has been used far more often with the PSMI population in a reliable and valid way than any of the other assessments (Gehrs & Goering, 1994; Neale & Rosenheck, 1995; Ralph & Clary, 1992; Solomon, Draine, & Delaney, 1995; Tyrrell, Dozier, Teague, & Fallot, 1999). Second, when the various assessment tools have been empirically examined, no major differences were found (Horvath & Symonds, 1991; Luborsky, 1994) between the constructs examined. Because each assessment tool appears to be equally effective, and the WAI has a proven record with the population under investigation, the WAI was chosen as the most appropriate assessment of the alliance in this study. Therefore, from this point on the therapeutic relationship will be referred to as the working alliance. The term "working alliance" was first used by Greenson in 1965. The Working Alliance theory proposed by Bordin (1976, 1979, 1994) is an outgrowth of the effort to identify and

with PSMI individuals have utilized the WAI (Gehrs & Goering, 1994; Neale &

Rosneheck, 1995; Ralph & Clary, 1992; Solomon, Draine, & Delaney, 1995; Tyrrell,

Dozier, Teague, & Fallot, 1999). In fact, Stylianos and Goering (1988) evaluated the

WAI with the PSMI population using similar methods to Horvath and Greenberg (1989)

and concluded that the WAI was a valid and reliable way to measure the alliance with this

population in a rehabilitation setting.

Relation Between Working Alliance and Outcome in Psychotherapy

There have been four major reviews of the working alliance research and its

impact on outcomes in psychotherapy. The first of these reviews, Gaston (1990), focused

on reviewing the studies that have attempted to identify the components of the working

alliance and those studies that empirically investigated the role of the alliance in

psychotherapy outcome. The period of time under review was 1978-1990. Prior to 1978,

most of the research done on the patient- therapist relationship was done utilizing the

Relationship Inventory (Barrett-Lennard, 1962). This inventory was based on the work of

Rogers (1957). After 1978, various assessments began to emerge to measure the alliance.

Gaston reviewed 11 studies from this period which examined alliance and outcome.

Nine of the 11 studies reviewed showed the alliance was positively associated with

various outcomes. Of the two studies that did not show a significant positive association

with outcomes, one found only a minimal association between one measure of the

alliance (WAI) and symptomatic change and no association for the other measures under

investigation (Tichenor & Hill, 1989). An additional study, Johnson (1988) found no

association between the alliance and treatment outcome. Despite these two studies, Gaston concluded that there is a strong empirical evidence of the predictive power of the working alliance and outcomes.

Horvath and Symonds (1991) conducted a meta-analysis of 24 studies examining the relation between the quality of the working alliance and treatment outcomes. Their goals were to determine the strength of the relation between the working alliance and outcomes as well as identify the variables associated with this relation. The researchers reported an overall effect size of .26. Further investigation of the various factors that may impact on the strength of the relation between the working alliance and outcomes was also conducted. These results indicated that a number of factors did not have a significant impact. These factors were length of treatment, type of treatment, number of subjects, phase of treatment, and measurement instrument. The one factor that did have a significant impact on the predictive ability of the working alliance was the source (client, therapist, or observer) of the assessment. Client assessments of the alliance were consistently superior predictors of outcome then therapist assessments. This meta-analysis seems to support Gaston's (1990) literature review by providing additional empirical evidence for the connection between the working alliance and treatment outcomes.

Horvath and Luborsky (1993) further examined the role of the alliance in psychotherapy. Their review supports both Gaston (1990) and Horvath and Symonds (1991) while expanding the topic further. As in the other reviews, type of treatment,

length of treatment, and type of measurement were not found to significantly impact on the relation between the alliance and outcome. Client assessment of the alliance was again noted as the superior predictor of outcome. However, in two other areas the researchers provided additional information. After a review of the literature, the authors concluded that the type of outcome being measured and the phase of treatment at the time of assessment do impact on the relation between alliance and outcome. Although a variety of outcomes have been utilized in alliance research, the general finding is that outcomes that are subjective and geared toward the individual are better predictors than more objective broad ranged ones. Horvath and Luborsky report that further research has modified initial beliefs that the phase of therapy was not a significant predictor of success. This research now indicates that early alliance is a better predictor of positive outcomes then middle, averaged, or late phase alliance.

Finally, Luborsky (1994) reviewed 18 studies and identified a number of factors that may influence the relation between the working alliance and outcome. Luborsky stated that in his review he found that the alliance strongly predicted outcome of psychotherapy. Of the 24 samples examined within the 18 studies, 19 showed the working alliance to be a significant positive predictor of treatment outcomes. Some of his interpretations were supportive of previous reviews on the same topic. For example, type of treatment and type of measurement where found to have very little or no impact on working alliance and outcome. The client's assessment was shown to be more predictive then therapist or observer although all were predictive. However, Luborsky

did present an interpretation that was slightly contradictory to previous reviews. Luborsky stated that although early sessions have been shown to be better predictors, there is still not enough evidence about the time course of the alliance to draw any conclusions. Luborsky also identified a number of factors that have some influence on the alliance/ outcome association. Those factors are the similarities between client and therapist, client's level of mental health, clients degree of improvement since beginning therapy, overlap with outcome measures, and therapist behavior. Although more research is needed on these factors, Luborsky acknowledges the alliance's role as one of the curative factors in therapy.

Together these reviews present a great deal of evidence linking outcomes and the working alliance between client and counselor. However, most of the studies under review were with outpatient clients with a variety of issues and presenting problems. Very few of these studies examined the relationship with the seriously mentally ill population. Since the present study focuses on individuals with this difficulty, a review of the research on the alliance and outcomes with this population is needed.

Working Alliance Research with the Persistently and Seriously Mentally Ill (PSMI)

Research on the working alliance and the seriously mentally ill individual has not been as extensive as research on the working alliance with other populations. In general, this lack of research is most likely connected to the overall view of the 60's and 70's that psychotherapy with these individuals was mostly ineffective. In the last 10 to 15 years, this thinking has been challenged by a number of sources both theoretically and

empirically as discussed in Chapter I. The result has been a reevaluation of
psychotherapy with this population. The effectiveness of the working alliance is one area
in which minimal positive progress has been made and which indicates a need for further
research.

The relationship factor has already been established as an important aspect of
psychotherapeutic treatment in a wide variety of settings and populations. Some theorists
have identified this factor as important in the treatment of the PSMI population as well.
Goering and Stylianos (1987) have stated that "the nature and strength of the relationship
that develops between therapist and the (schizophrenic) client may be one of the most
potent therapeutic ingredients of effective rehabilitative interventions" (p.271). Mosher
and Burti (1992) have emphasized that "as a psychosocial intervention, rehabilitation
must involve important relationships between workers and users" (p. 12).

Since much of the current treatment of the PSMI client occurs within the
psychosocial rehabilitation arena, it is important to examine the applicability of the
working alliance within this framework. Psychosocial rehabilitation focuses on the
acquisition of skills and the development of social competency. Goering and Stylianos
(1987) state that the working alliance as described by Bordin is "readily generalizable to
rehabilitative interventions" (p.278). Although there have been some theoretical
presentations which posited the belief that the therapeutic alliance is an important factor
related to rehabilitative outcomes, the amount of clinical research in this area remains
minimal (Goering & Stylianos, 1988; Mosher & Burti, 1992). The relatively few studies

that have examined the working alliance with the PSMI population in a rehabilitative setting, have shown positive effects between the therapeutic alliance and treatment outcomes (Clarkin, Hurt, & Crilly, 1987; Frank & Gunderson, 1990; Gehrs & Goering, 1994; Neale & Rosneheck, 1995; Solomon, Draine, & Delaney, 1995; Tyrrell, Dozier, Teague, & Fallot, 1999).

One of the first studies to examine the alliance with this population was Clarkin, Hurt, and Crilly (1987). In this study, the researchers focused on alliances within an inpatient setting. The description of the alliance in this study differs from others in that it is a measure of the client's alliance with the entire treatment team as opposed to one treatment provider. This global rating was determined after the fact by a third person observer. Three major areas were explored, demographic information, treatment history factors and psychopathological information. No relationship was found between the alliance and any of the demographic (e.g. sex, age, education etc.) or treatment history factors (e.g. age at first hospitalization, total number of hospitalization, amount of time in hospitals etc.). However, the researchers also found a positive relationship between therapeutic alliance and patient functioning at the time of discharge. The stronger the alliance the client developed with the treatment team the better the client's level of functioning was at discharge. In addition, those patients with a diagnosis of the following; childhood, adjustment, somatoform, or substance abuse disorders showed significantly lower alliance scores then clients with affective disorders, anxiety disorders, schizophrenia or other noneffective psychotic disorders.

Frank and Gunderson (1990) explored the relationship between the therapeutic

alliance and outcome with schizophrenics in outpatient individual therapy. A number of

outcomes were examined including psychotherapy utilization, treatment compliance,

change in patient functioning, and medication compliance. The alliance was assessed

using the Psychotherapy Status Report (Stanton et al., 1984). This report was completed

by each therapist on a monthly basis. Results indicated that there was a positive

relationship between the quality of therapist rated alliance and most outcome measures.

For example, those participants who were considered to have a good alliance

demonstrated longer lengths of stay in treatment, improved medication compliance, and a

positive change in some aspects of patient functioning. Some of the aspects of patient

functioning that did demonstrate a significant positive impact were global

psychopathology, social functioning, and ego functioning. Some aspects of patient

functioning that did not demonstrate a significant impact were cognitive distortions,

primary process thinking, and affect expression.

Gehrs and Goering (1994) narrowed the broader focus of alliance research and

outpatient psychotherapy with the PSMI population by exploring the alliance in a

psychosocial rehabilitation program. Their study focused on assessing the working

alliance between the client with schizophrenia and rehabilitation therapist and its impact

on treatment outcomes over a three month period. Overall, this study found that the

alliance as measured by the Working Alliance Inventory (WAI) did positively impact on

client's and therapist's perception of goal attainment. Two additional findings were made.

First, the study found that there was no significant change in outcomes over time for either client or therapist perceptions. Second, surprisingly, therapist perceptions were more strongly correlated with outcome than client perceptions. This finding is contradictory to the majority of the working alliance literature which has found that client perceptions are most often better predictors of outcomes. The researchers suggested three possible explanations for this result. First, therapist perceptions of the alliance impacted more strongly on treatment progress than client perceptions. The second explanation is the reverse of the first, therapist perceptions of the alliance were influenced by the perceptions of progress more so than clients perceptions. The final proposed explanation is rater bias. Therapists who believed they were more empathetic may have also rated client progress more positively.

Three studies have focused specifically on the working alliance and case management. The first study is an explanation of the WAI and its applicability to case management with the PSMI population. Although no outcomes were measured in this study, Ralph and Clary (1992) explored various aspects of the inventory itself. Their research was a pre-test post-test control group design with repeated post-test measures. They found that both client and case manager responses are consistent over time lending a good deal of evidence to the reliability of the instrument. Overall, their research supported the use of the WAI with this population but encouraged the use of the total point value rather then the individual subscales.

Neale and Rosenheck (1995) also examined the working alliance between client

and case manager. Their study focused on examining the relationship between the working alliance and outcomes that were both subjective and objective. In this study of veterans under 65 with a serious mental illness including schizophrenia, psychosis and major affective disorder, results showed that the perception of the working alliance was significantly related to perceived outcome by both client and case manager. In addition, case manager's rating of the alliance was also predictive of more objective outcomes including community living skills, symptom severity and global functioning.

The third study focusing specifically on case management is Solomon, Draine, and Delaney (1995). These researchers investigated the working alliance between PSMI client and case manager with a rehabilitative focus on outcomes after 2 years of service. This study also examined the difference in alliance between PSMI clients and their case managers who were consumers and those who were not. Consumers refers to individuals who have a major psychiatric disorder and are involved in some form of regular and consistent treatment. Some consumers who have been able to effectively manage their illness find employment within the mental health field. In the program under investigation, some consumers were employed as case managers. The outcomes under investigation included quality of life, contact with friends and family, degree of social activity, attitudes toward medication compliance, satisfaction with treatment, degree of symptomatology and contact with family and friends. Results indicated that both client and case manager perception of the working alliance did significantly impact on subjective outcomes including quality of life, attitudes toward medication, and

satisfaction with treatment but did not significantly impact on more objective outcomes such as days hospitalized and reduction in symptomatology. No differences were found between alliance with consumer case managers versus non-consumer case managers. This study appears to support Horvath and Luborsky's (1993) finding that the working alliance is a better predictor of subjective, individualized measures of outcome than of more objective broad ranged assessments.

The most recent study incorporating the working alliance and outcomes with the seriously mentally ill is Tyrrell, Dozier, Teague, and Fallot (1999). Their study focuses on the importance of client and caseworker attachment states of mind. Participants in this study were diagnosed with a serious psychiatric disorder such as schizophrenia or bipolar disorder. Researchers found that in relation to the working alliance, clients formed alliances based on an interaction of client and caseworker deactivation. Deactivation refers to a dimension of attachment that is considered dismissing and that is assessed through the Attachment Q sort (Kobak, 1989). In other words, clients who were less deactivating formed stronger alliances with more deactivating caseworkers and clients who were more deactiving formed stronger alliances with less deactivating caseworkers. The alliance as perceived by the client was also associated with some client self-report outcomes including global life satisfaction, global assessment of functioning and the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erlbaugh, 1961). This study provides recent evidence to support the positive association between the alliance and outcomes with the PSMI population.

Summary

This section presented Bordin's theory of the alliance and discussed the WAI (Horvath & Greenberg, 1989) which is based on his theory. The alliance as measured by the WAI, as well as other assessment tools, has been shown to be positively associated with treatment outcomes with traditional outpatient counseling clients. Within the last 10 years, there has been some research focusing on the working alliance and outcomes with the PSMI population. The majority of these studies have confirmed a similar positive association between alliance and outcomes. In six of the studies reviewed, the working alliance was found to be positively related to a variety of outcomes (Clarkin, Hurt, & Crilly, 1987; Frank & Gunderson, 1990; Gehrs & Goering, 1994; Neale & Rosneheck, 1995; Solomon, Draine, & Delaney, 1995; Tyrrell, Dozier, Teague, & Fallot, 1999). The outcomes under investigation ranged from subjective assessments (e.g. satisfaction, attitudes toward medication compliance, perception of progress toward goals, etc.) to more objective assessments (e.g. demographic variables, cognitive distortion, primary process thinking, days of hospitalization etc.). Although not in every case, the alliance appears to be a better predictor of subjective rather than objective assessments. In addition, client and therapist rated alliance seemed to be equally predictive of subjective outcomes (Neale & Rosenheck, 1995; Solomon, Draine & Delaney, 1995). While caseworker rated alliance appears to more predictive of objective measures (Frank & Gunderson, 1990; Neale & Rosenheck, 1995). Only one study, Gehrs and Goering (1994), found that although both sources (client and therapist) were related to positive

outcomes, therapist rated alliance had stronger correlations then client. Overall, at this time it seems reasonable to conclude that the working alliance is positively associated with outcomes with this population.

Caseworker Characteristics

The first section of this chapter established that the working alliance between therapist and client is very important to the success of psychotherapeutic treatment. It was further established that the alliance is very important to the success of treatment with the PSMI population. The current section focuses on the therapist factors that influence the strength of the working alliance. The two general factors that will be examined are therapist personal characteristics and therapist technical activities. Since this study is focusing on the alliance between persistently and seriously mentally ill clients and their caseworkers, theoretical considerations and empirical evidence will also be presented related to the caseworkers role in the alliance.

Therapist Personal Characteristics

Within the domain of personal characteristics and the working alliance, there are a number of variables that could be examined. However, the literature in this area is very limited. The majority of studies have focused on therapist experience while a smaller number have looked at other therapist characteristics such as attachment state and ability to develop healthy relationships. The later characteristics have been referred to as personal qualities. This section will critically review all of the studies that focus

specifically on the therapist personal characteristics of experience and personal qualities and their impact on the working alliance.

Experience. The first study to examine experience level and its relation to the working alliance was Mallinckrodt and Nelson (1991). In this study counselors were classified into one of three groups: novice, advanced trainee, and experienced counselor. Clients were outpatients from traditional counseling settings (university or community counseling centers). Results indicated that training level did have a significant impact on the working alliance. Alliances with counselors classified in the experienced group had stronger alliances then counselors in either of the other two groups. The largest difference was found on the goal scale of the WAI. An intermediate but significant difference was found on the task scale and no difference was found on the bond scale. The authors proposed that the bond component of the alliance is least effected by experience because building rapport is emphasized from the very beginning of counselor training. They also suggest that tasks are the next aspect mastered by the counselor and finally identifying and communicating goals are often mastered after many years of working in clinical settings.

This study does have some weaknesses that need to be addressed. The small size of the experienced counselor group ($\underline{n}$=8) compared to the other two groups (novice, $\underline{n}$=18; advanced trainee, $\underline{n}$=24) and the lack of diversity in clients (female, $\underline{n}$=41; male, $\underline{n}$=17) limits the generalizability of the study. Perhaps the most important weakness of the study is the use of arbitrary levels of training to classify the counselors. The

researchers developed their own standards for the criteria for each group. Unfortunately, there is no agreed upon standard for determining experience within the counseling field. Therefore, other standards could be developed based on different criteria that may change the results of this study. In addition, the use of these classifications may have hidden more subtle differences between the counselors. These differences may not have been able to emerge by automatically assigning counselor's to predetermined groups. Future research should focus on developing a more standardized system of defining experience.

The second study focusing on experience and the working alliance is Dunkle and Friedlander (1996). In this study, experience was considered a continuous variable. Beginning with their practicum training, counselors were given one point for each year of experience. Clients were outpatients at university counseling or training centers. The researchers hypothesized that experience would be positively related to the goals and tasks subscales of the WAI and not significantly related to the bond subscale. This study was a mailed survey with a return rate of 29%. Results of this study indicated that experience did not significantly impact client ratings of the goal, task, or bond scales of the WAI. A post hoc analysis, redefining experience as an ordinal variable (based on highest educational degree) also produced non significant results. Both Dunkle and Friedlander (1996) and Mallinckrodt and Nelson (1991) found that experience was not significantly related to the bond subscale however, the results relating to the task and goal subscales are in contradiction. While Mallinckrodt and Nelson (1991) found that experience was significantly related to the task and goal subscale of the WAI, Dunkle and

Friedlander (1996) did not find a significant relationship between these variables. The contradictory results of these two studies may be attributed to differences in the two samples. The counselors in the Dunkle and Friedlander (1996) study demonstrated a wider range of experience (1-27 years) than did Mallinckrodt and Nelson (1991; average years experience post doctoral was 3.17). As noted above, it seems possible that defining experience in terms of years may be masking important differences between counselors that otherwise go undetected. Since the assessment of experience level as both an ordinal and a continuous variable has produced contradictory results, perhaps additional methods of assessment should be utilized to help clarify this issue.

Kivlighan, Patton, and Foote (1998) attempted to address these contradictory results by examining whether client attachment state would moderate the effect of counselor experience on the working alliance. The researchers in this study followed the method of Dunkle and Friedlander (1996) and operationalized experience as a continuous variable. However, in addition to assessing the client perception of the working alliance, the researchers also examined the client's ability to develop healthy relationships. Both clients and counselors were recruited from a university counseling center. This study also found no significant relationship between counselor experience and the working alliance. However, level of comfort with intimacy was found to moderate the relationship between counselor experience and working alliance. In other words, in clients who demonstrated a low level of comfort with intimacy, counselor experience was related to the strength of the working alliance. At the same time, in clients who demonstrated either a moderate or

high level of comfort, counselor experience was unrelated to the strength of the working alliance.

Several factors related to the client and counselor participants in this study are limitations. Client participants were not randomly sampled and the total number was small. The university counseling center limits the types of cases that are treated at the facility. Therefore, regardless of level of experience, all counselors were treating individuals with the same range of difficulty. In addition, because the researcher did not count experience prior to graduate school and treated all graduate students as having the same beginning level of experience, they may have inadvertently discounted experience that may have been relevant. Although, some limitations do exist, this study and the others discussed do support the idea that therapist experience may impact on the working alliance in unique ways and encourages further examination.

Personal qualities. There are two studies which fall under this heading. In addition to examining the impact of counselor experience on the working alliance, Dunkle and Friedlander (1996), also examined several therapist personal qualities. The personal characteristics that were explored were the therapist's level of self-directed hostility (Intrex Introject Questionnaire; Benjamin, 1982), the quality of the therapists' social support network as defined by the Social Provisions Scale (Cutrona & Russell, 1987), and the therapist's ability to develop healthy relationships as defined by the Adult Attachment Scale (Collins & Read, 1990). All variables were assessed through therapist self-report. This study focused on how these factors influenced the working alliance

between therapist and client in university counseling centers. Two hundred and fifty-two survey packets were mailed to 21 university counseling centers. A total of 73 were returned. Results indicated that the clients of the therapists who reported less self-directed hostility, more social support and greater ability to form healthy relationships were more likely to rate the emotional bond factor of the working alliance higher than those clients whose therapist scored on the other end of these dimensions. Although there are several limitations to this study including generalizability, low response rate and inability to monitor assessment periods, this study does provide support for the influence of therapist personal characteristics on the working alliance and treatment outcomes.

The second study that examines therapist personal qualities and the working alliance is directly relevant to the current study because it is the only study that directly examines the impact of caseworker personal characteristics on the working alliance with the persistent and seriously mentally ill. Tyrrell, Dozier, Teague and Fallot (1999) define one specific caseworker personal quality variable as attachment state of mind. The overriding purpose of their study was to examine the impact of attachment state of mind of both client with serious mental illness and their caseworker on treatment outcomes. In doing this they also examined the impact of caseworker attachment state of mind on client perception of the working alliance. Participants were recruited from a community based case management program. Results indicated that clients had stronger alliances when they were mismatched with caseworkers on the deactivating versus hyperactivating dimension of attachment. In other words, clients who were more deactivating (avoids

discussion of emotional topics and rejects help from treatment providers) had stronger alliances with caseworkers who were less deactivating (very focused on attachment relationships). The reverse was also found, clients who were less deactivating had stronger alliances with caseworkers who were more deactivating.

Despite the fact that the working alliance has been strongly associated with positive outcomes with the PSMI population, the caseworker factors involved in the formation of a strong alliance with this population have only begun to be explored. Tyrrell, Dozier, Teague, and Fallot (1999) have examined one piece of a very large puzzle. The results of their study indicate that examining caseworker personal qualities may be one way of better understanding the working alliance with this population. However, in reviewing the existing studies of therapist and caseworker personal qualities and the working alliance two limitations can be seen. The first limitation of the research on this topic is the difficulty in defining therapist personal qualities. For example, in each of the studies discussed, therapist/caseworker characteristics were defined differently. In the first study, therapist qualities were described using a complex combination of self-directed hostility, social support network, and ability to develop healthy relationships. In the second study, caseworker personal qualities were defined as attachment state of mind. Each definition adds to the understanding of the role of therapist personal qualities in the alliance but makes it more difficult to develop a single, comprehensive picture. Problems in defining personal characteristics maybe one reason that the research in this area is limited (Beutler, Machado, Neufeldt, 1994). The second limitation of these studies is

related to the source of the assessment. Both studies rely on therapist subjective self evaluation. There are two problems with this type of procedure. First, it creates a subjective view of personality characteristics. Second, it does not take into account the client's perception of these traits. The research shows that while recognizing the actual presence or intensity of certain characteristics in a therapist does have an impact on some outcomes, the client's perception of these qualities also has a strong impact (Beutler, Machado, Neufeldt, 1994). In fact, reviews of the working alliance literature have consistently shown that the client's perception of the alliance is more predictive of positive outcome than that of the therapist or objective rater (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, 1994). Based on this, it seems important to examine the role of client perception of therapist personal qualities on the working alliance.

Therapist Technical Activities (Interventions)

Kivlighan (1990) has stated that one problem in focusing on technical activity and alliance is that technical activity is a difficult construct to define. Technical activity has been considered to be the way in which therapists interact with their clients. This interaction is determined by the theoretical position of the therapist and thus can vary greatly. Theories influence the therapeutic process in two ways. First, theories emphasize how a therapist should intervene and what tasks should be utilized (e.g. cognitive restructuring, free association, systematic desensitization, etc.). Operationally, these different interventions have been defined as response modes (Elliot, Hill, Stiles,

Friedlander, Mahrer, & Margison, 1987). Second, theories provide an explanation for the intervention. In other words, it describes why the intervention was used. This aspect is often referred to as therapeutic intentions (Hill, Helms, Tichenor, Speigel, O'Grady, & Perry, 1988).

Kivlighan (1990) explored the impact of therapeutic intentions on the working alliance. He hypothesized that therapist intentions would account for a significant proportion of variance in client rated working alliance. Forty-two undergraduate psychology majors volunteered as clients for extra credit. Pre-practicum graduate students in a counseling skills course served as counselors. Therapist intentions were operationally defined using the Intentions List developed by Hill and O'Grady (1985). Seven distinct clusters of intentions can be derived from this list. They are Set limits, Assess, Explore, Restructure, Educate, Change, and Support. Intentions were observer rated. Regression analysis indicated that overall, when the effect of client interpersonal attitudes had been controlled, therapist intentions accounted for a moderate but significant amount of variance in the working alliance. Further analysis also showed that three clusters of Intentions, Assess, Explore, and Support were significantly related to the working alliance in a negative direction. Kivlighan proposed some reasons for this surprising result. Because the students were not fully trained counselors they may have used global reassurances rather then personal and situational efforts to support and encourage. Also, they may have focused prematurely on exploring issues the volunteer "client" was not ready to discuss. Most importantly, Kivlighan posited that the use of

58

these particular intentions may place the client in a passive role. Since the working alliance emphasizes collaboration this may have registered as a weakened alliance.

One of the major limitations of this study is the participants. The use of students as clients rather then real clients seeking assistance and the untrained status of the student counselors certainly limits the generalizability of the study and also questions whether these results would hold up in an actual clinical setting. It is possible that some "clients" volunteered with no real personal problem in order to get extra credit. These individual's perception of and participation in counseling would certainly differ from those who truly did have a personal problem. Thus, this questions the accurateness of these responses. In addition, the untrained student counselors, not having a full understanding of how and why to intervene, may have certainly impacted their performance and resulted in a weakened alliance. Despite the preliminary analysis conducted by the author to address these issues, this remains a threat to the internal validity of this study.

Neidigh (1991) further examined this issue by exploring the impact of two variables, client interpersonal traits and therapist observable behavior, on the therapeutic relationship. Additionally, the interaction between these two variables was examined. Client interpersonal traits were assessed through the Sixteen Personality Factor Questionnaire (Cattell, Eber, & Tatsuoka, 1967). Therapist observable behavior was assessed with the Facilitative Relationship Indicators Checklist (Neidigh, 1988). This checklist is an observer rated measure of eight non-verbal behaviors and five verbal therapist behaviors. The Barrett-Lennard Relationship Inventory (1962) was used to

assess client perception of the therapeutic relationship. Although this study does not utilize the working alliance inventory as a measure of the therapeutic relationship, it is important to evaluate its findings. Subjects were undergraduate students who wished to discuss a personal problem for extra credit. One counselor with a masters degree met with each of the 75 subjects. Half of the subjects were assigned to a facilitative condition in which the therapist attempted to engage in all of the behaviors on the Facilitative Relationship Indicators Checklist (Neidigh, 1988) and half were assigned to a non-facilitative condition in which the therapist refrained from engaging in any of the behaviors on the checklist. Results indicated that both client interpersonal traits and therapist behavior were significantly related to client perception of the therapeutic alliance. Specifically, clients in the facilitative condition perceived counselors more positively then did those clients in the non-facilitative condition. In addition, those clients grouped as warm on the 16PF rated the alliance significantly more positive in the facilitative condition than those clients grouped as cool or neutral. In contrast, there was no difference between warm, cool, or neutral clients' ratings of the alliance in the non-facilitative condition.

This study suffers from some of the same weaknesses that Kivlighan's (1990) study does. Both studies are analogue and do not take place in real clinical settings. Therefore, some of the same difficulties with student participation may be encountered. Also, the analogue nature of the study limited the length of therapy to one session. The impact of this abbreviated therapy is not known and needs to be considered when

evaluating this study. In addition, the author acknowledges that there may have been some cross contamination between "clients" and research assistants who had been assisting with the study. Indicating a possible Hawthorne effect with some of the "clients" who may have had an idea what the researchers were looking for.

A third study, Foreman and Marmar (1985), examined therapist technical activity in a slightly different way than the studies already discussed. In their study, they contrasted therapist technical activities in alliances that were initially poor and improved over time with therapist technical activities in alliances that were initially poor and stayed poor over time. Their study found that therapists in alliances that improved over time engaged in several different activities that therapists in poor alliances did not. Therapists in improving alliances were found to engage in the following activities more often: address the client's defenses, address the client's guilt, address the client's problematic feelings in relation to the therapist, and link the problematic feeling with the therapist to the client's defenses. Unfortunately, due to a number of factors the validity of this study is limited. First, no statistical analyses were conducted because only six dyads participated in the study. The second factor is related to the assessment of the therapist's actions. The researchers did not present information on the reliability or validity of the assessment instruments used in the study. In addition, the authors note that the raters of the therapist behavior were aware of the purpose of the study. Both of these issues question the validity of the assessments of therapist actions made in this study.

Kivlighan and Schmitz (1992) attempted to refine this study by addressing some of the limitations. The assessment of therapist activity was improved by using the Psychotherapy Process Q-Sort (Jones, 1985). This method of assessment is designed to be a standard language and rating procedure for the therapy process. This method provides scores on the following five dimensions: supportive versus challenging, distant versus involved, permissive versus controlling, thematically oriented versus concretely oriented, and here-and-now oriented versus there-and-then oriented. Selection of subjects followed the same procedure described in Kivlighan (1990). Results indicated that counselors in alliances that were improving over time demonstrated more challenging behavior, more thematically oriented behavior and more here and now oriented behavior. Results also indicated that over the course of therapy, therapist in improving alliances increased the use of these behaviors more than therapists in continuing poor alliances.

Once again the limitations of this study are connected to the selection of subjects. The same problems arise in this study as in Kivlighan (1990). In both studies, students volunteered to be clients for extra credit and counselors were pre-practicum graduate students. This fabricated clinical setting limits the generalizability of the study and questions whether one would find the same results in an actual clinical setting.

In summarizing the literature focusing on therapist factors and the working alliance, it appears that there is evidence that indicates certain factors do impact on the perception of the working alliance. Overall, the research on therapist factors and the working alliance focus on two general areas, therapist personal characteristics and

therapist intervention. Within the area of personal characteristics, two main factors have

been examined, experience and personal qualities. Results of these studies have been

mixed. In terms of experience, some have found a connection between higher levels of

experience and perception of the working alliance while others have not (Dunkle &

Friedlander, 1996; Kivlighan, Patton, & Foote, 1998; Mallinckrodt & Nelson, 1991). The

two studies that examined personal qualities found an association between therapist

personal qualities defined as attachment state of mind, self-directed hostility, and ability

to form relationships and perception of the working alliance (Dunkle & Friedlander,

1996; Tyrrell, Dozier, Teague, & Fallot, 1999). In regards to therapist interventions and

the working alliance, four studies were reviewed. Overall, therapist interventions were

found to impact on the perception of the working alliance. Unfortunately, three of the

studies were analog and the one remaining clinical study suffers from some serious

limitations. Taken together, there is enough evidence to suggest that caseworker

characteristics will impact on the perception of the alliance. However, the assessment

tools used previously have been inconsistent and the methods used have been shown to be

limited. In order to expand and clarify the knowledge in this area further clinical research

is needed.

Theoretical Considerations

As discussed in the previous section, therapist factors of personal qualities,

experience and technical activities have been found to impact on the working alliance.

The current section will explore the evidence suggesting that with PSMI clients, personal

qualities will have a greater impact than the other two. The evidence for this, comes in three areas, theoretical discussions of therapist factors that are important when working with PSMI clients, a review of research with PSMI clients focusing on curative factors of psychosocial programs and finally the recognition of aspects of treatment with this population that are uniquely different from traditional therapy.

The counselor's personal qualities and their effect on therapy has been described from many different perspectives. Reid (1977) has said that "in spite of his training, the therapist is a human being first, and a professional person second" (p. 601). Felicetti (1982) has stated that the worker is the therapy. In his work with emotionally disturbed children, he teaches all of his staff that "the therapy is who you are and how that plays itself out in your relationship with the children" (p. 27). Knobel (1990) expands on this idea by describing a "therapeutic disposition" that all helpers must have. He identifies several factors that comprise this disposition or personality. These factors are authenticity as a person, freedom to think and act according to personal ideological principles, pleasure in living and relating, skill and desire to help others, cognitive affective insight, theoretical and technical knowledge, ability to question oneself, self-knowledge, experience, capacity for empathy, sense of humor, and creativity. From the perspective of these clinicians, it seems reasonable to consider the therapist's personal characteristics as an important aspect of the therapeutic process. A number of other authors have also emphasized this point.

Frank (1971) in his therapeutic discussion of the common features of all psychotherapies also emphasized the importance of the therapist's personal characteristics. He states that it is the personal qualities of the therapist that strengthen the patient's expectation of hope and that these qualities must be present regardless of theory or training. These qualities include optimism and the ability to facilitate clear, consistent, realistic and positive expectations in all clients (Mosher & Burti, 1992).

In addition to these discussions of general therapist qualities, there has also been some discussion about those qualities that are specifically necessary for working with individuals suffering from persistent and serious mental illness. In an effort to clarify those caseworker qualities that facilitate the development of more effective relationships, theoretical position as well as personal accounts will be investigated.

In reviewing the personal accounts of individual struggles with mental illness it becomes apparent that certain caseworker personal qualities are important. In one account (Leete, 1987), the individual describes exactly what worker qualities were helpful and which were not. This author stated that the staff's attitudes were extremely important in her recovery. Staff that were encouraging, treated her as a partner in her recovery, honestly addressed weaknesses, pointed out strengths and helped her to improve them, and believed in her potential were most helpful. She also stated that teaching specific problem-solving techniques and daily living skills helped a great deal in building her confidence. In a second personal account, the author clearly states that the therapists who were most helpful were the ones who where the most empathetic to "my problems, my

illness and who showed open concern and caring for me as a person" (Fox, 2000, p. 292).
Both of these accounts appear to highlight the individual's perception of their
caseworkers personal qualities and ability to connect with others as an important factor in
their treatment.

Mosher and Burti (1992) have stated that the relationship between caseworker and
client is very important and should be a central part of treatment. They have outlined five
relational principles that are specific to rehabilitation caseworkers. These principles are:
(a) response flexibility - the ability to be constantly aware of the changing situations and
adapt goals and plans as necessary avoiding a rigid stance, (b) concrete problem focus -
focused on day to day problems that will provide opportunities for immediate successes
that will enhance self-esteem and build confidence, (c) consultation - in order to involve
others in the process and expand education and options, (d) partnership - ability to
approach clients with an open and non-judgmental attitude avoiding the attitude that
clients are unable to help themselves and (e) expectation of self-help - a minimalist
attitude in which the worker expects that the client can do certain things for themselves
and intervenes only when necessary in order to promote a sense of competency. By
applying these principles, Mosher and Burti believe that clients will strive to imitate and
identify with workers over time and by doing so will achieve positive change. However,
in order to apply them the worker would most likely require certain personal qualities.
For example, the ability to be flexible and non-judgmental are necessary in order to
follow these principles. In addition, the attitude that the PSMI client is a capable

individual able to do many things for themselves would also be an important quality to have in following through with the principles outlined by Mosher and Burti (1992). Currently, there is no research available that attempts to explore the relevance or validity of these relational principles in a clinical setting.

A review of the theoretical discussions concerning the important qualities of the counseling relationship was undertaken for three reasons. First, it is important to establish that in all forms of counseling, a counselor's personal qualities are believed to be an important factor in treatment. The second reason is to highlight the point that within the treatment process PSMI clients place a great deal of value on their caseworkers attitudes, beliefs and actions. Finally, to acknowledge that even the specific principles geared toward individuals working with this population emphasize the need for certain personal qualities of the caseworker.

Curative Factors Research

Although there has been positive empirical support for the role of therapist variables in the working alliance with the general population, there is minimal research specific to the PSMI population. In fact only one study focusing on a specific caseworker variable, attachment state of mind, and its relation to the working alliance could be found. This study, Tyrrell, Dozier, Teague, and Fallot, 1999, was reviewed in two separate sections of this chapter. The majority of studies that attempt to identify factors involved in strong alliances or outcomes focus on what is referred to as curative or therapeutic factors. In general, curative factors are defined as factors within the treatment process

that are considered to be therapeutic or helpful.

Two of the earliest studies examining curative factors in a partial hospital setting with PSMI individuals are Hoge, Farrell, Munchell, and Strauss (1988) and Schreer (1988). Both studies utilized the same methods and procedures including the Patient Interview Schedule (Hoge et al., 1988) to identify which factors were considered most important to the clients. In Hoge et al. (1988) results identified the most important factors as: Interpersonal Contact, Structure and Medication. By contrast, Interpersonal Contact, Feedback, and Universality were identified as the three most important factors in the Schreer (1988) study. On closer examination, Schreer determined that Interpersonal Contact consisted of the following factors: acceptance, belonging, companionship, support and sharing, staff enthusiasm, and hope for the future. The difference in response order was attributed to the fact that the Hoge population was more chronic than the Schreer population. For example, more individuals were diagnosed with schizophrenia, other psychotic disorders, and personality disorders in the Hoge study than in the Schreer study. This difference may be the reason certain factors such as medication and structure were rated higher by the Hoge study.

A third study, Van den Langenberg and Dekker (1989), examined curative factors in two psychotherapeutic communities (1 adult residential and 1 adult semi residential). In this study, Self-understanding was found to be the most important curative factor. This was followed by Learning from Interpersonal Actions and Self-disclosure. All three of the studies discussed, assessed curative factors by utilizing raters who categorized

individual responses into a pre-set group of possible factors. High inter-rater reliability scores were demonstrated by each of the studies. The striking similarity between these studies is that interpersonal contact was listed as one of the most important factors in each study. While the remaining factors vary from study to study and are most likely influenced by differences in the populations under investigation (e.g. chronicity, treatment environment, location etc.), the Interpersonal Contact factor remains constant. Although not explicitly stated, it seems reasonable that the factor, Interpersonal Contact/Actions, especially as described by Schreer is strongly influenced by the caseworker and other staff at the facility.

Svensson and Hansson (1999) take this line of research to the next level by exploring what curative factors are associated with the alliance. Their results indicate that at each stage of treatment (initial, working, discharge), two curative factors were associated with the alliance. Curative factors and the alliance were assessed by the patient. Results showed that during the initial stage of treatment the two curative factors associated with the therapeutic alliance were encouragement/reassurance and awareness, during the working stage the two factors were personal insight and talking to someone who understands and in the discharge stage the two factors were self-understanding and problem solution. Each of these phases contains an element of interpersonal interaction with the counselor (e.g.. Encouragement and Reassurance, Talking to Someone Who Understands, Problem Solution) and is in line with the previous three studies discussed.

A review of patient identified curative factors was undertaken for two reasons. First, the research focusing specifically on caseworker characteristics and the working alliance is very limited. Second, it highlights the importance of personal contact in the treatment of the persistently and seriously mentally ill. This review found that not surprisingly, PSMI clients identified interpersonal contact as one of the most important curative factors in their treatment. While this provides some indirect additional support for the importance of caseworker personal qualities, further research is needed to define and describe these qualities.

Case Management in Psychosocial Rehabilitation Programs

Psychosocial rehabilitation programs offer an effective treatment modality for people with persistent and serious mental illness (Cook, Pickett, Razzano, Fitzgibbon, Jonikas, & Cohler, 1996) The approach is a combination of three different fields. The field of rehabilitation which focuses on developing skills and providing training, the field of mental health which provides counseling and support and the field of psychiatry which focuses on medication. In order to clarify the contention that the personal qualities of caseworkers in psychosocial rehabilitation programs are associated with better alliances, it is important to understand the basic principles psychosocial rehabilitation programs operate under. Cook, Pickett, Razzano, Fitzgibbon, Jonikas, and Cohler (1996) have outlined several of these principles. They are a) Client choice - the client is expected to be an active participant in the entire treatment process, b) Biopsychosocial approach - the understanding that mental illness impacts a number of different aspects of a person's life,

c) Emphasis on Strength and Wellness - focus is placed on enhancing strengths and starting from a place of health and not illness, d) Situational Assessment - clients are observed in natural and simulated environments rather then strictly relying on diagnosis, e) Social and Community Integration - treatment is conducted in natural settings with a focus on integration into the community, f) Services are on-going and delivered on an as needed basis - Clients can return at any time for further treatment or can continue for additional support and g) Relationships with service providers emphasize advocacy and partnership

Dibella, Weitz, Poynter-Berg, and Yurmark (1982) emphasize additional aspects of psychosocial rehabilitation programs. These authors highlight the fact that in this type of program a therapeutic milieu is offered which provides a larger group process. These programs also provide a larger variety of interconnected therapeutic experiences within each day. The caseworkers, who provide a great deal of services in this setting, operate under these principles. In addition, Wasylenki, Goering, Lancee, Ballantyne, Farkas (1985) describe the caseworker as assisting the PSMI client in navigating, fragmented, uncoordinated services and facilities that the client needs. Based on these principles and descriptions, it seems apparent that the role of the caseworker can be very complex.

While there are many similarities between the client/therapist relationship and the client/caseworker relationship there are also some differences. It is these differences that may lead to a greater emphasis from the client's perspective on their caseworkers personal qualities than their caseworkers experience level or technical activity. The first difference

is related to the amount of face to face time each spends with the other. While a therapist may spend between an hour or two a week with each client they treat, a caseworker often spends many more hours per week working with their client in hands on activities. This allows the client to observe the caseworker on a variety of different levels. While a therapist assists in developing an improved sense of self, coping skills, and a decrease in symptoms, the caseworker is interacting with the client on day to day real life problems such as social security issues, residential problems, transportation issues, medication issues and so forth. The therapist provides an opportunity for open, non-judgmental discussion of problematic issues and offers acceptance, interpretations and suggestions. The caseworker, while also providing a non-judgmental and accepting atmosphere, acts as a real life model of healthier coping. The client can observe and interact with the caseworker in order to practice much of what may be discussed in therapy.

The second difference that allows for a stronger focus on the personal qualities of the caseworker relates to the overall goals of therapy and case management. The role of the client in therapy is a more emotionally challenging one with less direct benefit then that of the client working with a caseworker. In therapy the focus may be on sensitive issues requiring the client to look at things that cause stress or that are related to long standing difficulties. The relationship with a caseworker is much less emotionally challenging. The focus is often on concrete issues that have a direct effect on the client's every day life. Support and advocacy for the client is one of the caseworker's most important roles. In addition, the role of the caseworker often takes on aspects of an

extended family. Kruger (2000) states that "ordinary family supports and social networks are lost to the person with a psychiatric disability; but they are in fact replaced and restored by the staff of mental health care agencies" (p. 34).

While both the therapist and caseworker are important to the overall well being of a client in psychosocial rehabilitation, the overall principles of this type of program as well some basic differences between the relationships indicate that the personal qualities of the caseworker may be associated with a more positive working alliance then other caseworker variables.

<u>Summary</u>

The last section of Chapter II reviewed the literature on caseworker and therapist variables associated with the working alliance. Two overriding areas were discussed, therapist personal characteristics and therapist technical activity. It was found that each of the three factors representing these areas should be related to the working alliance as perceived by PSMI clients in a psychosocial setting. That is, client perception of caseworker personal qualities, experience and technical activity should impact on the working alliance. Further discussion and review highlighted three sources of evidence that indicate that the personal quality factor may have a greater impact then either of the other two.

In conclusion, after a review of the related literature on the working alliance and outcomes with the persistently and seriously mentally ill population and a review of the related literature on caseworker/therapist variables related to the working alliance, it is

apparent that a study focusing on client perceptions of the working alliance and caseworker characteristics is needed. In regards to the working alliance, it was shown that in numerous studies client perception of the working alliance was a better predictor of outcomes than either therapist or observer ratings. Despite the source of assessment the working alliance was shown to be significantly correlated with positive outcomes in both traditional and PSMI clients. Therefore, in order to improve outcomes it makes sense to determine what factors serve to strengthen the working alliance.

Therapist factors that might influence the working alliance have only begun to be explored. The few studies that exist on this topic have focused on the following therapist variables, personal qualities, experience, and intervention. The majority of these studies have also focused on traditional outpatient clients. Only one study focusing on PSMI clients and their caseworkers could be found. All of the studies indicate that therapist factors do impact on the working alliance. Since client perception of the alliance has been consistently found to be a better predictor of outcome than other sources, client perception of caseworker characteristics would be consistent and practical. Chapter II discussed and reviewed all of the relevant literature pertaining to the statement of the problem.

secondary illness including but not limited to: alcohol/drug addiction or mental retardation. This mixture of diagnoses is typical for partial hospital programs oriented toward adult psychiatric treatment. It is also similar to the population descriptions of other studies focusing on the persistently and seriously mentally ill and the working alliance (e.g. Frank & Gunderson, 1990; Gehrs & Goering, 1994, Neale & Rosenheck, 1994, Ralph & Clary, 1992; Solomon, Draine & Delaney, 1995).

Procedure

This study adhered to all ethical principles involving human participant research in accordance with the American Psychological Association's ethical principles (1992). The researcher was the primary person responsible for collecting data and assuring that no participant's welfare was compromised by participation in this study. Participation was completely voluntary and individuals could withdraw at any point during or after the interview. All participants were told that this project is part of a doctoral dissertation designed to explore the case management relationship. This study did not require nor did it deceive or conceal any information. No undesirable consequences were observed from the interview or instruments being used. Every effort was made to reduce any possible discomfort. Additionally, clients were told that this study was not in anyway connected to the program and that it would not impact their treatment. Participants were also told that the results of the study would be available for those who are interested. Consent to conduct this study was given by the Institutional Review Board governing this central New Jersey medical center and by the Institutional Review Board of Seton Hall

Chapter III

METHODOLOGY

This study examined the relationship between client perception of caseworker personal qualities, experience and interventions, and client perception of working alliance. This chapter describes the methods and procedures that were used to conduct this study. It also includes a description of the individuals that participated in this research study. Each of the instruments used will be described and discussed. Administration procedures, design, and method of data analysis are also described.

Participants

A power analysis indicated that with an alpha level of .05, a moderate effect size of .30, three independent variables, and a desired power of .80 the number of participants needed was 29 (Cohen & Cohen, 1983). Participation in this study was voluntary. All participants for this study were members of the same psychosocial rehabilitation program designed to treat the PSMI population in the community. In order to participate in the study, individuals must have been active members of the program for at least 3 months and have been assigned to the same caseworker for 2 of those months. There were two exclusionary criteria for participation in this study: a) active psychotic process (assessed by the program's clinical team), b) clients for whom the researcher had previously acted as a caseworker. All participants were diagnosed with a serious mental illness including but not limited to: schizophrenia, manic-depression, major depressive disorder, and borderline personality disorder. Additionally, some clients were diagnosed with a

University, South Orange, New Jersey.

The study was conducted in two phases; the recruitment phase and the assessment phase. The recruitment phase occurred first and lasted approximately 1 week. The assessment phase occurred after the recruitment was completed and lasted approximately 2 weeks.

Two methods were used during the recruitment phase. First, flyers explaining the project and asking for participation were put up throughout the building by the researcher. Second, the researcher visited the program on three separate occasions during the same week. During these visits information about the study was verbally presented during the program's daily community meeting. Information explaining the procedures of the study and reinforcing the confidentiality and voluntary nature of the study was given (see Appendix A). After the researcher presented this information, cards were given to all clients present. The group was then instructed that if they were interested in participating they could fill out the cards with their name and the days they attend program and if they were not interested in participating they could simply throw the card away. The group was instructed to put the completed cards in a sealed box provided by the researcher. The researcher then left the room so that clients were able to make a decision of whether or not to participate without the researcher present. After approximately 5 minutes the researcher returned and removed the box. The only person with access to this box was the researcher. The researcher retrieved the cards and scheduled clients for an interview to occur during the assessment phase.

The assessment phase consisted of a 30 minute interview with each of the interested volunteers. The interviews occurred during the regular program hours. All participants were interviewed individually. On the day of the interview a plain sealed envelope with the scheduled time and location of the interview in it was given to the client. At the scheduled time of the assessment interview, the researcher located the client and asked if they were still interested in participating. At that time, whether the client agreed to participate or declined, the card was destroyed. All participants were presented with a written informed consent prior to the beginning of the interview.

The interview consisted of four items; the informed consent, demographics questionnaire, the WAI and the TBC. The researcher read all directions to the participant and then read each item and the possible responses. The researcher also provided two visual clues: a) the response scale being used was written clearly on a piece of paper and attached to a bulletin board in front of the participant and b) the response scale was written clearly on a piece of paper that the participant could hold. A list of standard dictionary definitions for each word on the Therapist Behavior Checklist and the key words on the WAI were developed (see Appendix B). This list will was used by the researcher if a participant has difficulty understanding the meaning of any of the words. The researcher recorded the responses given. At the end of the interview period, the client was given the opportunity to ask questions and thanked for participating.

If at any point during the interview process, the client appeared to become upset or agitated, the researcher would immediately stop the interview. If the client decides to

experience and activity/guidance as independent variables (TBC; Bennun, Hahlweg,

Schindler, Langlotz, 1986). The analysis was performed using the SPSS statistical

package.

Instruments

Two instruments, the Working Alliance Inventory (WAI; Horvath & Greenberg,

1989) and the Therapist-Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, &

Langlotz, 1986) were used to assess the relevant variables. These instruments were

selected to assess the client's degree of alliance with their caseworker and the behaviors

the client perceives their caseworker to exhibit. A brief demographics questionnaire was

also utilized. This will obtain information about client age, gender, length of time in

program, length of time working with their caseworker, number of other caseworkers, and

gender of the caseworker.

Working Alliance Inventory

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was used to

measure the strength of the alliance between client and caseworker. The WAI has a

client, counselor, and observer version. For the purposes of this study, only the client

version was used. The WAI is a 36 item self-report measure completed by the client.

Responses to the inventory are arranged on a 7 point Likert scale ranging from never (1)

to always (7). Total scores can range from 36 to 252. The higher the score, the stronger

the alliance. The WAI is based on Bordin's (1979) pantheoretical theory of the

client/counselor relationship. The WAI can be used as either a total score of the alliance

no longer participate, the researcher would immediately stop the interview. The researcher would inquire as to the state of the individual and, if needed, utilize de-escalation techniques. The clinical staff of the program would be contacted as soon as possible to ensure further assessment and care of the client. The researcher would not leave any client who is experiencing difficulty until a connection is made with the appropriate clinical staff of the program. The clinical staff will be aware of the project and its location so that they can be reached easily. However, none of these situations occurred during the data collection phase of this study.

The interviews were conducted at the program site. A regular office was used to conduct the interviews. The office contained a desk and two chairs. A bulletin board was placed in clear view of the participant. There was also a phone with access to internal numbers in the building and an intercom system in case of emergencies.

Research Design and Statistical Analysis

This study is a one-measurement cross-sectional correlational design. There is no group assignment. Participants completed two assessment instruments and a brief demographics form in an interview format. Participants were asked to focus on their relationship with their program caseworker and the behaviors they perceived their caseworker to exhibit. There was one assessment period per client. Data from the two assessment instruments were scored and analyzed. A standard multiple regression was be performed between perception of the working alliance as the dependent variable (WAI; Horvath & Greenberg, 1989) and client perception of caseworker positive regard,

or can be broken down into three subscales: bond, agreement on task, and agreement on goals. However, a number of researchers have reported that these scales are highly correlated and therefore may not measure separate factors (Horvath & Greenberg, 1989; Ralph & Cleary, 1992). Therefore, in this study the total score was used to represent the client's perception of the alliance.

Reliability. In terms of reliability, the WAI has demonstrated good internal consistency in several studies with Cronbach alpha coefficients ranging from of .84 to .93 (Horvath & Greenberg, 1994). Additional support for the reliability of the WAI comes from Plotnicov (1990) whose test-retest assessment over a three month period was .80. In studies specifically using PSMI participants, the WAI demonstrated Cronbach alpha coefficients in the range of .89 to .96 (Neale & Rosenheck, 1992; Solomon, Draine & Delaney, 1995). This data suggests that the WAI is stable for use with the population under investigation. An internal reliability coefficient will be generated prior to statistical analysis of the current data.

Validity. Validity of an instrument can be assessed from at least four different perspectives: content, construct, criterion, and face. Beginning with content validity, Horvath and Greenberg (1989) developed the WAI to operationalize Bordin's theoretical formulations. During construction of the inventory, the primary objective of the researchers was to confirm content validity by having the inventory items match Bordin's theory as close as possible. Horvath and Greenberg (1989) used a process of repeated-ratings and item analysis by experts and professionals until consensus was reached on the

36 items for the inventory. The final items of the WAI were found to have 88.7% agreement between raters.

Construct validity has been approached from two directions. First, the WAI has been compared to other relationship measures. Convergent analysis has shown that the WAI does correspond with other similar measures. For example, Saffran and Wallner (1991) found a correlation of .87 between the total score of the California Psychotherapy Alliance Scale (CALPAS; Marmar, Gaston, Gallagher, & Thompson, 1989) and the total score of the WAI. Greenberg and Adler (1989) and Tichenor and Hill (1989) also found slightly lower correlations between the WAI and other measures of the therapeutic relationship such as the Helping Alliance and the Vanderbilt Psychotherapy Process Instruments.

The WAI has also been compared to instruments that are theoretically distinct from itself. Tests of discriminant validity of the WAI have mostly focused on comparing the WAI to the Counselor Rating Form (CRF; Barak & LaCrosse, 1975). The CRF is based on the clinical application of Strong's (1968) theory of social influence. It is a measure of a counselor's attractiveness, trustworthiness, and expertness. Results of these studies have shown that the correlation between the WAI and the CRF are significantly lower than the correlations between the WAI and other measures of the alliance (r's ranging from .05 to .73; Horvath & Greenberg, 1989; Horvath & Greenberg, 1994a).

Criterion validity can be assessed by examining the WAI's relationship to treatment outcomes. Since this topic was covered in detail in chapter II, a summary will

be provided at this point. Horvath and Symonds (1991) meta-analysis found an overall effect size between the working alliance and treatment outcomes (expressed as a correlation coefficient) of .26. This indicates the working alliance is moderately associated with outcome. Other studies have also found significant correlations between outcome and the WAI with both traditional and PSMI clients ranging from .16 to .54 (Gehrs & Goering, 1994; Kivlighan & Shaughnessy, 1995; Neale & Rosenheck, 1995; Solomon, Draine, & Delaney, 1995)

An examination of the face validity of the WAI by the researcher indicates that items do appear to measure the working alliance as it is described by Bordin. Additionally, the length, wording, and readability appear to be appropriate for this population. However, because the WAI is worded for clients working with a therapist two minor adjustments to the inventory were needed to reflect differences in treatment modality and administration (See Appendix C for a the adjusted version of the WAI). The first adjustment is that the term "therapist" was replaced with "caseworker" and the term "sessions" was replaced with "work". In addition, explanatory wording was developed for certain key words in case it was needed by the interviewer for further clarification. These adjustments are based on the methodology of Neale and Rosenheck (1992) and Ralph and Clary (1995). Neale and Rosenheck (1992) reported high internal consistency reliability scores for the adjusted scale (Cronbach's coefficient alpha: WAI-C = .93). These adjustments were also utilized by Solomon, Draine, and Delaney (1995) in their study of the working alliance and consumer case-management. These results indicate that

the minor adjustments do not significantly change the reliability or validity of the inventory.

<u>Therapist Behavior Checklist</u>

The Therapist Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, & Langlotz, 1986) will be used to assess the perceived behavior of therapists by their clients (See Appendix D). The format of this instrument is a checklist that contains 29 pairs of words describing aspects of the therapist's behavior that are on opposite ends of the same continuum. Examples of some of the pairings are talkative/quiet, genuine/fake, and attentive/inattentive. One word of the pair is placed on the left side of the page and the other word is placed on the right. Clients are then asked where along the continuum their caseworker fits. Responses on the continuum range from 1 to 6. Total scores range from 29-174 with higher scores indicating more positive assessments. Factor analysis conducted on past research has identified three main factors that can be extracted from the data: positive regard/interest, competency/experience, and activity/direct guidance (Bennun, Hahlweg, Schindler, & Langlotz, 1986; Bennun & Schindler, 1988). Examples of the item pairs that load on each factor are: positive regard/interest (attentive/inattentive, interested/appears in different, cooperative/uncooperative, friendly/unfriendly), competency/experience (experienced/inexperienced, helpful/unhelpful, calm/flustered, unassertive/assertive), and activity/guidance (purposeful/hesitant, gives feedback/ gives no feedback, passive/active, indecisive/decisive, clear/confusing). Scores for each factor are calculated by summing

the following items; positive regard (item numbers 5,7,8,13,14,15,20,23,25, and 27),

experience (item numbers 1,2,4,6,9,10,11,12, and 19), and activity/guidance (item

numbers 3,16,17,18,21,22,24,26,28, and 29).

Reliability. The reliability of the TBC is based on two studies of internal

consistency. Bennun, Hahlweg, Schindler, and Langlotz (1986) found Gutman alpha

scores ranging from .82 to .91 for each of the three factors in two different studies

reported in the same article. An internal reliability coefficient will be generated prior to

statistical analysis of the current data.

Validity. Evidence of the validity of the TBC is based on three sources. First, the

TBC was compared to its counterpart, the patient version of the checklist (Bennun,

Hahlweg, Schindler, and Langlotz; 1986; Bennun & Schindler, 1988). The patient

version assesses the perceived behavior of a patient by the therapist. Correlations

between both versions were significant and ranged from .68 to .81 indicating that patients

and therapists have a similar perception of the treatment process. These results provide

some evidence for convergent validity.

The second important area of the TBC's validity is its relation to treatment

outcome. In the three studies utilizing the TBC, there is evidence of criterion validity.

The treatment outcomes under investigation were client and therapist perceived benefit,

client and therapist perceived reduction of symptoms, client comparison of self before

and after treatment, and an objective measure of symptom change. The results of the

studies demonstrated significant positive correlations between perceived therapist

behavior and the identified outcomes (Bennun, Hahlweg, Schindler, & Langlotz; 1986; Bennun & Schindler, 1988).

Finally, the face validity of this assessment indicates that it would be a good match for the population under investigation. The length, wording, and readability is appropriate for the intended use. Because the assessment is a list of common, easily understood adjectives there is less chance of misinterpretation or confusion. Additionally, the three factors extracted from the TBC (positive regard, experience, and activity guidance) matched the variables under investigation more than any other instrument available. Overall, there seems to be enough evidence to determine that the TBC has met acceptable standards of reliability and validity.

Summary

This chapter described the individuals who participated in this study. Inclusionary and exclusionary criteria were included. The design of the study was outlined. The research method including administration procedures, data collection, and description of both instruments was provided. The procedure for the analysis of the data was also identified and described.

Chapter IV

RESULTS

The purpose of this chapter is to report the results of a simultaneous multiple

regression of data from this study of persistently and seriously mentally ill individuals in

a psychosocial rehabilitation program. The research hypothesis evaluated was that

persistently and seriously mentally ill clients' perceptions of the working alliance would

be related to the clients' perception of their caseworker's positive regard, experience, and

activity/guidance. Prior to reporting the results, a description of the participants is

provided. This is followed with a discussion of the relevant decision points throughout

the analysis including transformation of the data and use of an additional statistical test,

the Pearson correlation coefficient.

Demographics

This section presents a description of the participants and the program under

investigation.

Participants

Thirty three subjects were interviewed for this study. Two of the interviews were

eliminated because they failed to meet the inclusionary criteria of having been a member

of the program for 3 months and having worked with the same caseworker for at least 2

months. The remaining 31 packets (17 male and 14 female) were used for the analysis.

The average age of the participants was 50 years $\pm$ 11.8 (range = 25 - 76). The average

length of time in the program was 2.4 years $\pm$ 2.3(range = 4 months - 12 years). The

average length of time working with the current caseworker was 1.3 years $\pm$ 1.3 (range = 2.5 months - 5 years). An initial assessment was made to determine if there was a pattern to the casework/client dyads in terms of gender. A chi-square analysis showed that there was no significant relationship between gender of caseworker and gender of client, $X^2(1,N=31) = 1.37$, $p=.24$. This indicates that the gender of the client does not change the probability of that client having either a male or female caseworker.

Program

The program has a case management staff of 11 and a client roster of 90. Caseloads range from 5-10 individuals per caseworker. There are four male and seven female caseworkers. The average age of the caseworkers was 42 years $\pm$ 9.8(range = 24-55). The educational backgrounds of the caseworkers are as follows; five have a bachelors degree in psychology or some related field, four have either an M.S.W. or Masters degree, one has an AA degree and one is an LPN. The length of time working in the program ranged from 7 months to 17 years. The average length of time was 7.8 years (SD=5.6). However, only four of the caseworkers have worked there less then the average.

Reliability and Descriptive Statistics

Reliability tests of both the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) and the Therapist Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, Langlotz, 1986) were conducted. Both were determined to have high internal consistency with Cronbach alpha coefficients of .96 (WAI) and .95 (TBC). As a

reminder, the total score of the WAI was used in the analysis. This score was obtained by adding all of the items on the inventory. Three separate scales were determined from the TBC; positive regard, experience, and activity guidance. While the high alpha coefficient for the WAI is a positive indicator of reliability, the high alpha for the TBC may be an indicator of potential problems. This is because the TBC is designed to report three separate scales and not one overall score. Therefore, a high alpha may indicate that the scales are measuring the same underlying construct. The means and standard deviations of the WAI and the TBC scales are presented in Table 1.

<div align="center">Transformation of the Data</div>

An important assumption of regression analysis is that the data should be normally distributed. Before any regression analysis was undertaken, this assumption was tested for the three predictor variables as well as the outcome variable. The distributions of all of the variables were significantly negatively skewed (positive regard, $z = 8.18$, $p<.0001$; experience, $z = 5.36$, $p<.0001$; activity guidance, $z = 6.92$, $p<.0001$; WAI, $z = 4.74$, $p<.0001$). Additionally, all of the distributions were significantly leptokurtic (positive regard, $z = 4.16$, $p<.0001$; experience, $z = 3.10$, $p<.001$; activity guidance, $z = 3.7$, $p< .0001$; WAI, $z = 2.56$, $p<.01$). Figures 1 through 4 are a graphic presentation of the four distributions. The shapes of these distributions indicate that clients overwhelmingly responded with high scores to a majority of the items on both inventories. In other words, the majority of clients rated their alliance with their caseworker as well as their caseworker's characteristics very positively. There are a

Table 1

Mean Scores and Standard Deviations of the Total WAI and the Three Scales of the TBC

Scale	$\underline{N}$	Minimum Score	Maximum Score	Mean	Standard deviation
WAI	31	101	249	217	31.2
Pos Reg.	31	25	60	56	6.9
Experience	31	27	54	49	5.4
Act/Guid.	31	13	60	53	9.3

Note. Pos Reg indicates Positive Regard and Act/Guid indicates activity guidance
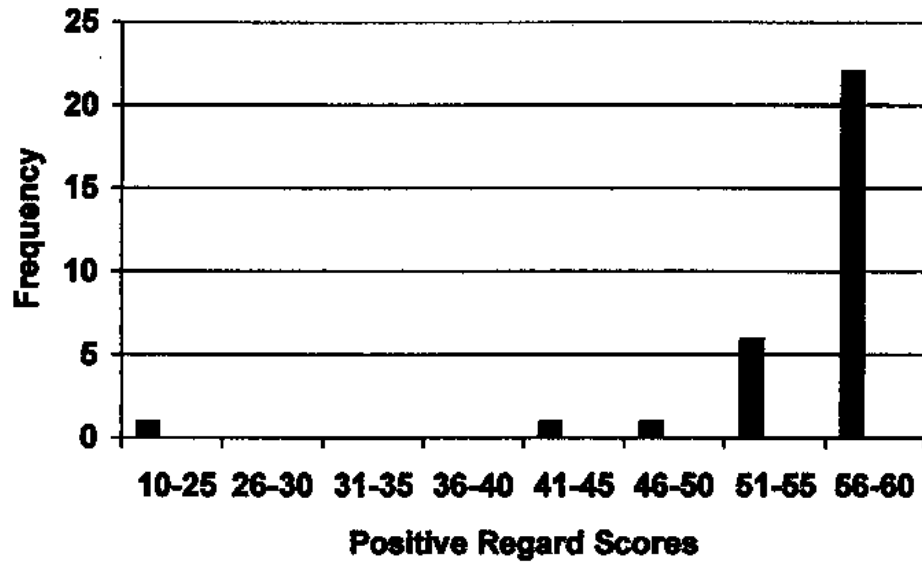
Figure 1. Frequency distribution of positive regard scores. Score can range from 10 to 60. N=31.
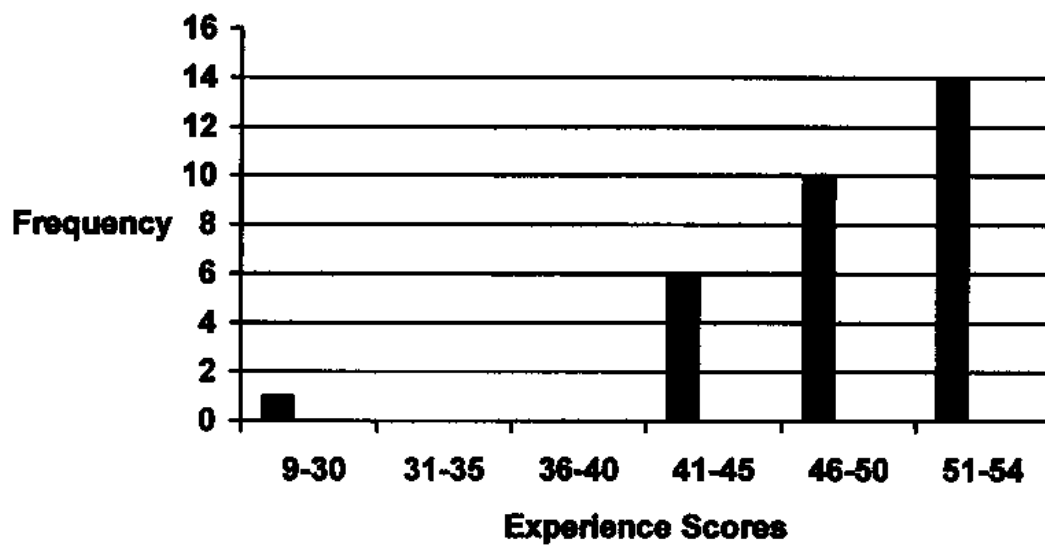
Figure 2. Frequency distribution of experience scores. Scores can range from 9-54.

N=31.
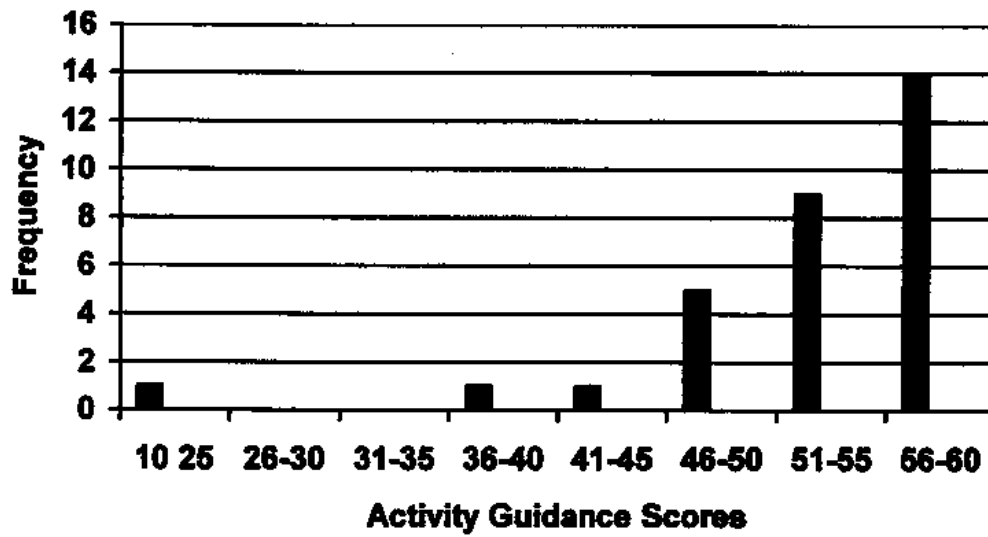
Figure 3. Frequency distribution of activity/guidance scores. Total score can range from 10-60. N=31.
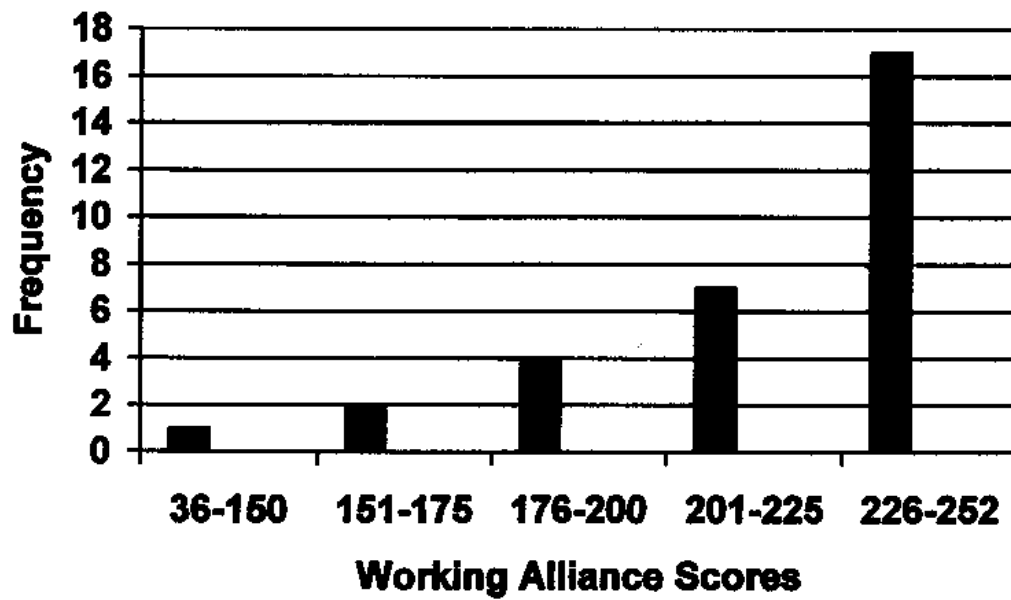
Figure 4. Frequency distribution of the Working Alliance Inventory total scores. Scores can range from 36-252. N=31.

couple of possible reasons for this outcome. One possible explanation is a leniency bias. A leniency bias would indicate that clients were unrealistically rating their caseworker because they were closely connected with them. A second possible reason is related to the clients' concerns for the confidentiality of their responses. Despite the reminders about confidentiality, clients who have some level of paranoia, may have felt their caseworker would see their responses and thus wanted them to be positive.

In order to address the significant skewness and peakedness of the data, transformation of the data was considered. Since transformation would not notably increase the difficulty of interpretation and because it would improve the multiple regression analysis, the transformation was undertaken. The data was transformed using the reflect and logarithm method suggested by Tabachnick and Fidel (1989). After this method was applied, the skewness of the distributions was substantially improved for three of the variables (positive regard $z = 1.56$, $p>.05$, experience $z = .52$, $p>.05$, activity guidance $z = .14$, $p>.05$). The WAI was less negatively skewed but still indicated significance ($z = 2.6$, $p<.01$). In regards to kurtosis, the distributions were also substantially improved (positive regard $z = .63$, $p>.05$, experience $z = .97$, $p>.05$, activity guidance $z = 1.20$, $p>.05$, WAI, $z = 1.05$, $p<.01$). Table 2 compares the z scores of each variable before and after data transformation.

Table 2

z Scores of the WAI and the TBC Scales Before and After Data Transformation

Scale	Before Transformation	After Transformation
Skewness		
WAI	4.74*	2.6*
Positive regard	8.18*	1.56
Experience	5.36*	.52
Activity guidance	6.92*	.14
Kurtosis		
WAI	2.56*	1.05
Positive regard	4.16*	.63
Experience	3.10*	.97
Activity guidance	3.7*	1.20

Note. * Indicates significance

Regression Analysis

Simultaneous multiple regression was performed on the transformed scores with WAI scores as the outcome variable and positive regard, experience and activity guidance as the predictor variables. While the overall model was significant, $F_{(3,27)} = 5.03$, $p<.01$, accounting for 36% of the variance, none of the individual predictors significantly contributed to the prediction model (see Table 3). This suggests that there was a multicolinearity problem (Tabachnick & Fidel, 1989). The three predictor variables were found to be highly correlated with each other (positive regard/experience $r = .87$; positive regard/activity guidance $r = .91$; experience/activity guidance $r = .82$). In addition, because the high correlations suggest that the three scales were tapping into the same underlying construct, a total score for the TBC was computed by summing the original scores of the three scales. A correlation coefficient was then calculated between total WAI and total TBC. This correlation was significant, $r = .86$, $p<.01$, indicating that client perception of their working alliance with their caseworker is highly related to client perception of their caseworker as having overall positive qualities. The more positively clients perceived the working alliance with their caseworker the more they perceived their caseworker as having positive characteristics. Despite the significant results, it is unclear how to interpret the total TBC score since a total score is not usually calculated for this scale. In other words, what does a high total TBC score represent. It appears to represent an overall positive perception of caseworker characteristics. Unfortunately, there is no research to support this interpretation. Because of the possible leniency bias and the

research to support this interpretation. Because of the possible leniency bias and the difficulty in interpreting the total TBC score , the significant results of the correlation and the multiple regression must be interpreted with caution.

Table 3

Simultaneous Multiple Regression Predicting Working Alliance from Positive Regard, Experience, and Activity/Guidance (N = 31)

Variables	WAI(DV)	PR	EX	AG	$\underline{B}$	B
Positive regard(PR)	.87				.38	.30
Experience(EX)	.76	.87			.22	.16
Activity guidance(AG)	.82	.91	.82		.22	.20
				Intercept = .82		
Means	217.4	56.1	48.9	53.1		
Standard Deviations	31.2	6.9	5.4	9.3		R^2=.36
						Adjusted R^2=.29
						R=.60**

Note. **p<.01

Chapter V

DISCUSSION

This study examined the hypothesis that persistently and seriously mentally ill clients' perception of the working alliance would be related to the clients' perception of their caseworker's personal qualities, experience, and intervention. The working alliance was measured by the total score on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The three caseworker factors were measured by the factor structure of the Therapist Behavior Checklist (TBC; Bennun, Hahlweg, Schindler, Langlotz, 1986). The factors derived from the TBC are positive regard (personal qualities), experience (experience), and activity/guidance (intervention). The results of this study partially support this hypothesis. The working alliance inventory scores were found to be significantly related to the overall assessment of caseworker variables. In other words, the stronger the perception of the alliance with the caseworker the more positive the perception of the caseworker's characteristics. However, none of the three caseworker factors under investigation were found to contribute a significant portion of unique variance to the working alliance.

Despite the significant correlation between perception of the working alliance and perception of caseworker factors as a whole, these results must be interpreted with caution. There are two reasons for this caution. First, the data collected was significantly negatively skewed indicating that the participants had overwhelmingly given very

positive responses on all of the scales. For example, 80% of clients gave either the highest possible response (7) or the second highest response (6) on all but one of the items on the TBC (passive/active). In addition, on six of these items (experienced/inexperienced, helpful/unhelpful, interested/appears indifferent, gives feedback/gives no feedback, friendly/unfriendly, and careful/careless) 95% of clients responded with either the highest possible score or the second highest score. Although the transformation of the data did result in normalizing the distribution for the TBC factors, the WAI distribution was improved but still significantly skewed. Therefore, analysis becomes less robust (Tabachnick & Fidel, 1989). Secondly, collapsing the TBC factors into one total score makes interpretation of the data more difficult. The TBC has been found to assess three factors (positive regard, experience, and activity guidance) and has not been used as an overall assessment of therapist behavior. The actual interpretation of the combined score is not clear. It appears to indicate the extent to which a therapist or in this case a caseworker can be described as exhibiting more positive or negative qualities. However, there is no literature or research to support this interpretation. For these reasons, the results of this study must be interpreted cautiously.

Explanation of the Findings

The lack of variability and significant findings may be explained in two ways. First, the consistently high scores on both the WAI and the TBC may indicate that the PSMI population under investigation had difficulty making the distinctions required by the scales. As noted above, 80% of clients gave the highest or second highest response

on all but one item of the TBC. On the WAI, 75% of clients gave the highest or second highest response on 25 of the 36 items. This is an overwhelming majority of clients. This seems to indicate the clients were responding from a very global perspective and that determining the finer distinctions may have either been too difficult or not of interest to them. In fact, during the interviews, the majority of clients responded quickly and did not spend a great deal of time considering the less extreme responses. This type of global response pattern should be considered when examining client perceptions with this population.

The second possible explanation for the global response pattern is an error of leniency. Rosenthal and Rosnow (1991) have stated that an error of leniency occurs "when respondents rate someone who is very familiar, or someone with whom they are ego-involved, in an unrealistically positive manner" (p. 121). This description appears to fit with the results of this study in two ways. First, the demographics of the participants indicate that clients have been members of the program an average of 2.4 years and have worked with their current caseworker for an average of 1.3 years. In addition, the majority of caseworkers have worked in the program for over 7 years. This appears to indicate that this group of participants have had a substantial amount of time to become familiar with and attached to each other. Overall, clients seem to have had a genuinely positive feeling for their caseworker both in terms of their relationship and in how they perceived their caseworker. So much so that they wanted to make sure that their caseworkers were viewed positively by others. During the interviews the researcher

observed comments from the clients such as "My caseworker is the best there is", "I think my caseworker is the best one here", and "I'm gonna give my caseworker an A". These positive feelings may have made it difficult to realistically rate their caseworkers.

A second possible explanation for the error of leniency may have been a concern that their responses would not be kept confidential and that their caseworker would somehow find out how they responded. Several steps were taken to ensure confidentiality. For example, confidentiality issues were discussed at several points throughout the process. At the time of the interview, the researcher reinforced that no names were on the questionnaires and that there would be no way of identifying their responses. In a population were feelings of paranoia may be present, it is possible that these assurances may not have been enough to counteract the feelings of mistrust. However, since no objections or verbal comments were made indicating a lack of mistrust and because participation was voluntary, this seems like a less likely possibility. Despite this, the possibility is still worth considering.

A selection bias may have also contributed to the results. Since the study was voluntary, it is possible that only those subjects who had favorable feelings toward their caseworker and the program volunteered. Therefore, if only those clients who had positive feelings participated this would not be a representative sample of the clients in this program. As a result, this selection bias may explain the large majority of positive responses on both the WAI and the TBC.

A final possible explanation for these findings relates to the fact that the data was

collected by the researcher. It is possible that the presence of the researcher may have influenced the responses of the clients. Clients may have wanted to please the researcher and therefore responded positively. This method of data collection also raises the possible influence of experimenter bias as a concern. However, the instruments used had established criteria for recording and did not require interpretation. In addition, the researcher attempted to maintain consistency in behavior throughout the recruitment and assessment phases.

Integration of Findings with Past Literature

An important step in assessing the value of a study is determining where it fits within the literature base of the topic. The results of this study are supportive of some of the literature on the working alliance with PSMI clients. The majority of studies focusing on the working alliance and the PSMI population have examined the alliance's impact on treatment outcomes (Clarkin, Hurt, & Crilly, 1987; Frank & Gunderson, 1990; Gehrs & Goering, 1994; Neale & Rosneheck, 1995; Solomon, Draine, & Delaney, 1995; Tyrrell, Dozier, Teague, & Fallot, 1999). Although this study did not examine outcomes, the high scores on the WAI lend additional support to the importance of exploring the working alliance between caseworker and client with persistent and serious mental illness. This study helps in identifying client perception of the working alliance as an important factor that is present in psychosocial rehabilitation treatment. In order to develop a better understanding of both the role of the alliance and the role of caseworker characteristics in the treatment of the persistently and seriously mentally ill, further

studies are needed.

In regards to the literature on caseworker characteristics, no direct support was found. Participants with a strong alliance were found to rate their caseworker high on all three factors under investigation. Previous research on therapist factors and the alliance found that self report and observer assessed factors representing therapist personal qualities (Dunkle & Friedlander, 1996; Tyrrell, Dozier, Teague, & Fallot, 1999), therapist experience (Dunkle& Friedlander, 1996; Kivlighan, Patton, & Foote, 1998) and therapist technical activity/interventions (Forman & Marmar, 1985; Kivlighan, 1990; Kivlighan & Schmitz, 1992; Neidigh, 1991) were significantly associated with the alliance. The current study found that client's perception of these factors, as measured by the TBC, were also highly correlated with a strong working alliance. Due to the limited amount of research that specifically examines caseworker characteristics and the working alliance (Tyrrell, Dozier, Teague, & Fallot, 1999) there is little with which to directly compare the results of the current study. The overall finding of this study supports the idea that client perception of their caseworker characteristics does impact on their perception of the working alliance. Unfortunately, the current study does not provide any specific information about what caseworker factors are most influential or how this influence develops. These are areas that need continued research.

The current study diverges with past research on the TBC. The existing studies using the TBC (Bennun, Hahlweg, Schindler, & Langlotz, 1986; Bennun & Schindler, 1988) reported moderate correlation between the factors. The current study found high

correlation between the factors. Although the populations used with the previous research were psychiatric inpatients and significantly impaired, these patients did not have the same disabilities as those in the current study. In addition, because the initial studies were conducted in England and Germany, it is possible that the standards for psychiatric hospitalization are different from those of the United States.

The findings of this study contribute to the existing literature in two ways. Since a number of studies have found that the working alliance is positively associated with treatment outcomes for PSMI individuals, further investigation of the working alliance in this setting was warranted. The current study was designed to take a further step by exploring factors that may be associated with the working alliance in this population. A review of the literature led to three conclusions. First, the therapist characteristics that have been most often examined in relation to the working alliance were personal qualities, experience and interventions. Second, there was only one existing study that examined caseworker characteristics and the working alliance with the PSMI population. Third, up to this point no studies had been conducted which examined client perception of these factors. Since client perception was the favored source of assessment of the working alliance, it seemed pertinent to investigate client perception of caseworker characteristics as well. The results of this study support the contention that, from the PSMI client's perspective, positive characteristics of a caseworker in a psychosocial rehabilitation program are associated with the working alliance. However, it does not provide specific information about which characteristics are more associated with the

working alliance. Thus it encourages further exploration of the caseworker factors that contribute to a positive working alliance with this population.

The second way in which this study contributes to the existing literature stems from the use of client perception of caseworker characteristics. There were two main reasons for the choice of client perception as the source of assessment for the three caseworker characteristics (personal qualities, experience, and intervention). The first reason was because client perception of the working alliance had been shown in numerous studies to be the better predictor of outcomes. Measuring all of the factors within the study in the same manner was considered reasonable and consistent. The second reason was that it was believed that an assessment of client perception would yield more practical applications for clinical practice. This belief is supported by Mosher and Burti (1992) who strongly emphasize that the interpersonal process between PSMI client and caseworker be based on client perceptions of personal needs. The results of this study indicate that PSMI clients do have strong feelings about their caseworkers. However, they also indicate that assessing PSMI client perception may entail special considerations not taken into account with this population. For example, the overall global pattern of responses on both the WAI and the TBC indicate that clients may have either had some difficulty assessing finer distinctions or that they tend to view their caseworkers from a dichotomous perspective. This does raise some questions as to the validity of client perception as a method of assessment with this population. At the same time, client perceptions have historically been an important tool of assessment and should

not be overlooked because of difficulties or special considerations with this population. Further exploration of the tendency of PSMI clients under investigation to respond in a global manner is needed to clarify and resolve this conflict.

Implications

The current study has research and applied implications that should be considered. In terms of research, this study highlights the need for additional research on assessing PSMI client perceptions. In regards to the TBC, this scale may not have been designed in such a way as to detect variability in an accurate way. For example, the items themselves were set up in a dichotomous fashion (e.g. helpful/unhelpful). In research with the WAI and this population, none of the studies reviewed reported a significant negative skew. This indicates that there may have been something different about the current sample that resulted in this negative skew. One of the explanations considered was a leniency bias. This study indicates that more attention and exploration should be paid to determining the accuracy of client perceptions.

In terms of clinical application, this study reinforces the importance of the relationship between PSMI client and caseworker. Although no information regarding specific traits or characteristics were found, it does encourage caseworkers to be aware of their overall personal presentation to their clients. Knobel (1990) has said that "the best therapeutic agent is the therapist" (p.62). The results of this study encourage caseworkers to be aware of the high regard in which they may be held by their clients and to use this in positive ways to improve their alliances with their clients and assist them in working

toward their goals in productive and creative ways. Wright and Davis (1994) suggest that therapists "closely monitor and shape their own behavior, taking into account the patient's life situation, symptoms and sociocultural experience so that they can respond in ways that are genuine, friendly, and helpful" (p. 42). Alternatively, if the caseworker does not acknowledge the possible impact of their personal characteristics or the importance of the alliance it could result in lost opportunities and counterproductive actions. Overall, it appears to be in the best interest of the PSMI client in a psychosocial rehabilitation setting, to allow for the development and continuation of working alliances with their caseworkers. This study indicates that encouraging positive caseworker self-presentation may be one way to do this. However, the specifics of what this positive presentation entails is not clear at this point and requires further examination.

Limitations

This study suffers from several limitations. In terms of the internal validity of the study, a number of limitations are present. First, the leniency bias and the selection bias discussed earlier may have influenced the way clients responded. Clients may have had very positive feelings for their caseworkers and felt it was their responsibility to make their caseworkers look good. Second, the fact that the researcher conducted all of the interviews leads to speculation concerning the unintentional impact this may have had on the participants. In addition, the possibility of experimenter bias must be considered.

Another source of limitation for this study is the Therapist Behavior Checklist. This scale is a limitation for two reasons. First, the design of the TBC may have

contributed to the global pattern of responses observed in the data. The TBC is designed in such a way that each item is presented in good versus bad format (see appendix D). Although there were six possible responses, the large majority of clients chose the extreme positive response. Perhaps a less bipolar scale design would have avoided this problem. The second limitation is that the three scales were so highly correlated that the scale appears to have been measuring one underlying construct rather than three distinct factors. As a result, the scores were summed to obtain a total score. However, since the TBC total score has not been reported in any research utilizing the TBC this score must be interpreted cautiously.

The generalizability of this study is limited to psychosocial rehabilitation programs with a similar combination of clients and caseworkers. The results can not be generalized to other populations or those PSMI clients who are not clients in psychosocial rehabilitation treatment programs.

Future Directions

It has been established in the literature that strong working alliances between persistently seriously mentally ill clients and their caseworkers are associated with positive treatment outcomes. This study is an initial step in understanding what caseworker factors impact the perception of the working alliance in PSMI clients engaged in psychosocial rehabilitation treatment. This study began to explore this question by examining client perception of caseworker characteristics. The results reinforce the notion that client perceptions of positive caseworker characteristics are associated with

strong working alliances. However, it does not provide any specific findings about the kinds of characteristics that are most often associated with the working alliance. Based on the results of this study, a number of avenues for future research are warranted.

First, this study was only an initial step towards understanding the impact of caseworker characteristics on the working alliance. Since only one other study could be found focusing on caseworker characteristics and the working alliance, this indicates that there is still much left to be explored. This study examined three possible factors, but what other caseworker characteristics may be important in forming alliances? Are client and caseworker perceptions of these characteristics the same? If not, how do they differ?

A second direction of future research may be to find other ways of measuring the three factors under investigation in this study. Unfortunately, the TBC did not prove to be a successful choice in determining client perceptions of the three factors under investigation. Perhaps, comparing client perceptions of positive regard, experience, interventions could be compared with self-assessments and observer assessments.

Within the field of psychosocial rehabilitation, the consumer movement is very strong. In other words, individuals with PSMI are encouraged to take active roles in their treatment and to take part in providing treatment to others when they are able. This emphasis also supports a focus on research using client perception as a source of assessment. However, this study indicates a need for further research focusing on developing accurate ways of assessing client perception. A suggestion for future research may be to simply ask clients "How experienced would you say your caseworker

is?" rather then using the words "experience and inexperienced". In this way a

dichotomy of good versus bad is not set up. The relevancy of this suggestion is an area

that would require further research.

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Appendix A

SCRIPT FOR RECRUITMENT PURPOSES

The following will be read to the clients of the Park Place program during their morning community meeting. All staff will be asked to leave the room before I begin.:

Hello everyone. My name is Letizia Duncan. First, I would like to thank everyone for letting me join your meeting so that I can tell you about my research project. I am a counseling psychology doctoral student at Seton Hall University and I am in the process of completing my dissertation. For those of you who do not know what a dissertation is, I will tell you. It is an extensive research project that is designed to find information that will improve and expand the field of counseling psychology. Throughout my education I have worked in programs such as this. During that time I have become very interested in understanding what makes programs like, Park Place successful. One of the things, I have discovered is that the relationship between caseworker and client is very important. So, what I have decided to do for my dissertation is to try to better understand the caseworker/client relationship. The reason I am here today is to ask for your participation in a study to do just that.

Before you decide whether to participate or not there are a few important things you need to know.

1. This study is being done as part of my doctoral dissertation as a student at Seton Hall University and is in no way connected to Park Place or Jersey Shore Medical Center.
2. This study is completely voluntary. You do not have to participate. If you choose not to participate it will in no way effect you treatment at Park Place or JSMC. If you decide to participate and then change your mind, you can withdraw at any time. Withdrawal from the study will in no way effect your treatment at Park Place or JSMC.
3. This study is confidential. I will need to know your name in order to schedule an interview time with you but once that is complete, the card with your name on it will be destroyed. No names will be connected to the actual questionnaires used. Also, staff will not be aware of who is participating in the study and the names of caseworkers will not be asked.
4. If you decide to participate in the study, I will set up a 30-minute interview with you during regular program hours. During that time I will ask you a series of questions related to your caseworker and give you a list of possible responses. It is your job to choose the response that best matches your perception of your caseworker.

If after all this you decide that you would like to participate, I will tell you what to do. I am going to hand out cards to everyone. Then I will leave the room for 5 minutes. If you decide to participate, write your name and the days you attend program on the card. Then place the card in this sealed box which I will leave in the room. If you do not want to participate simply through the card away and no questions will be asked. When I return to the room, I will simply thank everyone and take the box with me. Once I take the box out of the room, I will schedule those that have completed a card for an appointment and provide the necessary information (i.e., time and place). When the study is complete, I will be happy to come back and tell you all what the results were. I know I have said a lot and you may have some questions so I will take the time now to answer any questions you might have. Thank you very much for listening to me and considering participation in this study.

Appendix B

WORKING ALLIANCE INVENTORY
DEFINITIONS

3.   OUTCOME: the result or consequence

6.   PERCEIVES: understands or comprehends. Aware of through the senses.

9.   CLARIFY: to make clearer or explain.

11. EFFICIENTLY: able to produce results with out wasting time, energy or money.

12 & 16. ACCOMPLISH: to succeed, acheive, fulfill, complete, to finish,

15. CONCERNS: problems or interests.

17. WELFARE: well-being

30. REHABILITATION: getting better or recovery

31. FRUSTRATED: annoyed, disappointed, discouraged

THERAPIST BEHAVIOR CHECKLIST
DEFINITIONS

3.   GENUINE: real, sincere

5a. ATTENTIVE: gives attention, is observant, considerate and thoughtful

5b. INATTENTIVE: careless, negligent

6a. UNASSERTIVE: not confident or certain, does not put oneself forward or stand up for self

6b. ASSERTIVE: to be confident and certain, to put oneself forward, stands up for self

7b. INDIFFERENT: showing no interest,

8a. SYMPATHETIC: having or showing kind feelings for others, agrees with a feeling/op.

8b. UNSYMPATHETIC: not showing kind feelings for others, disagreeing with a feeling/op.

9a. CONSISTENT: tends to keep to the same principles in words and actions

9b. INCONSISTENT: failing to keep the same principles in words and actions

10a. FLUSTERED: to become nervous, excited, and confused. Nervous excitement.

12. REQUESTS ELABORATION: requests details and more information

16a. PURPOSEFUL: acts with a specific plan or aim.

16b. HESITANT: doubtful, undecided, fail to act promptly

18a. PASSIVE: not acting or resisting

19b. TENSE: strained, rigid, stretched tight

22a. SUPERFICIAL: concerned only with what is on the surface, not thorough, shallow

22b. THOROUGH: doing all that should be done, complete

26a. INDECISIVE: putting off decisions, not settling things

26b. DECISIVE: conclusive, determined, giving a clear result.

29a. PLAIN: simple, without a lot of decoration.

Appendix C

WORKING ALLIANCE INVENTORY

INSTRUCTIONS
(To be read to participants)

I will read you some sentences that describe some of the different ways a person might think or feel about his or her caseworker. As I read the sentences, think of your caseworker.

For each statement, I will read seven possible responses. You will also have the seven possible responses on a sheet in front of you. In addition, the responses are posted on this blackboard/bulletin board. The possible responses are: Never (1), Rarely (2), Occasionally (3), Sometimes (4), Often (5), Very Often (6), and Always (7).

If the statement describes the way you always feel (or think), say "always" or "7". Either the word response or the number response is acceptable. If the statement never applies to you, say "never" or "1". Use the numbers or words in between to describe the variation between these extremes. You must verbally respond to the question.

Please remember that this questionnaire is confidential and anonymous; neither your case manager nor the agency will see your answers.

Thank you for your cooperation!

		Never 1	Rarely 2	Ocassi- onally 3	Some- times 4	Often 5	Very Often 6	Always 7
1.	I feel uncomfortable with my caseworker.	1	2	3	4	5	6	7
2.	My caseworker and I agree about the things I will need to do to help improve my situation	1	2	3	4	5	6	7
3.	I am worried about the outcome of our work (results).	1	2	3	4	5	6	7
4.	What I am doing in case management gives me new ways of looking at my problems	1	2	3	4	5	6	7
5.	My caseworker and I understand each other.	1	2	3	4	5	6	7
6.	My caseworker perceives accurately what my goals are.	1	2	3	4	5	6	7
7.	I find what I am doing in case management confusing	1	2	3	4	5	6	7
8.	I believe my caseworker likes me	1	2	3	4	5	6	7
9.	I wish my caseworker and I could clarify the purpose of case management sessions.	1	2	3	4	5	6	7
10.	I disagree with my caseworker about what I ought to get out of case management.	1	2	3	4	5	6	7
11.	I believe the time my caseworker and I are spending together is not spent efficiently (productively)	1	2	3	4	5	6	7
12.	My caseworker does not understand what I am trying to accomplish through our work together.	1	2	3	4	5	6	7

13. I am clear about what my
     responsibilities are in casemanagement
     activities   1   2   3   4   5   6   7

14. The goals of case management
     are important.   1   2   3   4   5   6   7

15. I find what my caseworker and I
     are doing in our work together are
     unrelated to my concerns(problem) 1   2   3   4   5   6   7

16. I feel that the things I do with my
     caseworker will help me to
     accomplish the changes that I want 1   2   3   4   5   6   7

17. I believe my caseworker is
     generally concerned for my
     welfare (well-being)   1   2   3   4   5   6   7

18. I am clear as to what my
     caseworker wants me to do in our
     work together.   1   2   3   4   5   6   7

19. My caseworker and I respect
     each other.   1   2   3   4   5   6   7

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

21. I am confident in my
     caseworker's ability to help me.   1   2   3   4   5   6   7

22. My caseworker and I are working
     goals that we both agree are
     important.   1   2   3   4   5   6   7

23. I feel my caseworker
     appreciates me.   1   2   3   4   5   6   7

24. We agree on what is important
     for me to work on.   1   2   3   4   5   6   7

25. As a result of case management
     meetings, I am clearer as to how
     I might be able to change.   1   2   3   4   5   6   7

26. My caseworker and I trust
each other.   1   2   3   4   5   6   7

27. My caseworker and I have
different ideas on what my
problems are.   1   2   3   4   5   6   7

28. My relationship with my
caseworker is very important
to me.   1   2   3   4   5   6   7

29. I have the feeling that if I say or
do the wrong things, my caseworker
will stop working with me.   1   2   3   4   5   6   7

30. My caseworker and I work
together on setting goals for my
rehabilitation (getting better)   1   2   3   4   5   6   7

31. I am frustrated by the things I am
doing in our meetings
(frustrated/disappointed)   1   2   3   4   5   6   7

32. We have established a good
understanding of the kinds of changes
that would be good for me   1   2   3   4   5   6   7

33. The things that my caseworker
is asking me to do don't
make sense.   1   2   3   4   5   6   7

34. I don't know what to expect as
the result of my work with my
caseworker.   1   2   3   4   5   6   7

35. I believe the way we are
working with my problem
is correct.   1   2   3   4   5   6   7

36. I feel my caseworker cares
about me even when I do things
that he/she does not
approve of   1   2   3   4   5   6   7

Appendix D

THERAPIST BEHAVIOR CHECKLIST

INSTRUCTIONS
(To be read to participants)

I am going to give you a piece of paper with a new set of responses. The responses for this series of statements are as follows:

Very	Somewhat	A little	A little	Somewhat	Very
1	2	3	4	5	6

Then I will place two cards on either side of the responses. Each card will have a word or two written on it. The words on one card will be the opposite of the words on the other card. For example, happy (on one card) and sad (on the other card).

Your job is to choose the response in front of you that best matches your perception of your caseworker. For example, if the words were happy and sad. Then you would ask yourself, is my caseworker more often happy or sad. If you decided he is happy more of the time, then you would ask yourself if he is very happy, somewhat happy or a little happy. If you decided he is sad most of the time then you would ask yourself if he was a little sad, somewhat sad or very sad. If you have any questions please ask them at any point.

Please remember that this questionnaire is confidential and anonymous; neither your case manager nor the agency will see your answers.

Thank you for your cooperation!

**note to IRB - all of the following pairs will appear on index cards when conducting the study. I have presented them in this format to save space and to give a complete description of all test items.

		Very	Some What	A Little	A Little	Some What	Very	
1.	Talkative	1	2	3	4	5	6	quiet
2.	Experienced/ skilled	1	2	3	4	5	6	inexperienced
3.	Genuine	1	2	3	4	5	6	fake
4.	Helpful	1	2	3	4	5	6	unhelpful
5.	Attentive	1	2	3	4	5	6	inattentive
6.	Unassertive	1	2	3	4	5	6	assertive
7.	Interested	1	2	3	4	5	6	appears indifferent
8.	Sympathetic	1	2	3	4	5	6	unsympathetic
9.	Consistent	1	2	3	4	5	6	inconsistent
10.	Quiet/calm	1	2	3	4	5	6	flustered/nervous
11.	Gives clear instruction	1	2	3	4	5	6	gives confusing instruction
12.	Inquiring/ requests elaboration	1	2	3	4	5	6	rarely requests elaboration
13.	Concentrates	1	2	3	4	5	6	lacks concentration
14.	Gives time	1	2	3	4	5	6	gives little time
15.	Cooperative	1	2	3	4	5	6	uncooperative
16.	Purposeful	1	2	3	4	5	6	hesitant
17.	Gives feedback	1	2	3	4	5	6	gives no feedback
18.	Passive	1	2	3	4	5	6	active
19.	Relaxed	1	2	3	4	5	6	tense

		Very	Some What	A Little	A Little	Some What	Very	
20.	Friendly	1	2	3	4	5	6	unfriendly
21.	Disorganized	1	2	3	4	5	6	organized
22.	Superficial	1	2	3	4	5	6	thorough
23.	Natural	1	2	3	4	5	6	unnatural
24.	Careful	1	2	3	4	5	6	careless
25.	Patient	1	2	3	4	5	6	impatient
26.	Indecisive	1	2	3	4	5	6	decisive
27.	Easygoing	1	2	3	4	5	6	hard to get along with
28.	Clear	1	2	3	4	5	6	confusing
29.	Plain	1	2	3	4	5	6	lively