Working Alliance with Adolescents who Receive Mandated School-based Counseling Services

by

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Abstract

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Working alliance is widely recognized as one of the most important factors in understanding therapeutic outcomes. However, there is a lack of published research on the relationship between alliance and treatment outcome in the school setting. In particular, there is no empirical evidence of this relationship with mandated counseling in the schools. The purpose of this study was to investigate the relationship between working alliance and treatment outcome in mandated school-based counseling with adolescents. It also examined the relationship between adolescent development and working alliance, as well as other process variables that predict a strong working alliance in this type of counseling environment. This information is intended to provide a first step toward more effective, empirically-based counseling in the schools. Participants were recruited from both public non-public schools in suburban and urban regions of New York. Student participants ranged in age from 12 – 20 and represented grades 6 through 12; approximately 62% of the student participants came from public school settings, while 38% came from non-public settings. The majority of the participating counselors (73%) identified as cognitive-behavioral in theoretical orientation; and the majority were female (82%). Adolescent participants were asked to complete several questionnaires regarding their demographic features (Demographic Questionnaire), level of autonomy (Adolescent Autonomy Questionnaire), therapeutic alliance with their counselor (Working Alliance Inventory – Short Form), and a Current Versus Ideal Counseling Questionnaire. Counselors were asked to

complete a demographic questionnaire, as well as an outcome measure (Counseling Outcome Measure) for each student. Results indicate that working alliance is significantly related to counseling outcome/progress in the mandated school-based setting. Regression analyses suggest that client-rated working alliance can be predicted by examining adolescents' level of cognitive autonomy, the consistency between their current and ideal counseling scenario (i.e., expectations of counseling), their number of years in school counseling, and the counselor's level of experience. Additionally, student's number of sessions with the current counselor and the student's ratings of working alliance can be used together to predict counseling progress or outcome, as rated by the counselor.

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CHAPTER I

Introduction

For several decades research has suggested that the strength of the collaboration between client and counselor (i.e., working alliance) may be more influential to treatment outcome than the particular methods of therapy chosen (e.g., Bordin, 1979). Working alliance, or therapeutic alliance, "is defined as the extent to which a client and therapist work collaboratively and purposefully and connect emotionally, and is conceptualized as a common, or generic, factor in that it is believed to cut across various treatment approaches" (Thomas, Werner-Wilson, & Murphy, 2005, p. 19). Therefore, working alliance has now become widely recognized as a significant factor in understanding therapeutic outcomes (Thomas et al., 2005). In fact, Bordin (1979) proposed that the working alliance between the client and the counselor is the key agent in the change process.

According to Bordin (1979), working alliance involves the extent to which counselors and clients collaborate to determine the course of counseling and the strategies that will be used, as well as the sense of warmth and understanding they share with each other. Current definitions of the working alliance also emphasize the affective or collaborative elements in the therapeutic relationship such as liking, respect, and trust, as well as the quality of this bond in establishing the tasks and goals of treatment (Fitzpatrick & Irannejad, 2008).

There is an abundance of research demonstrating that a strong working alliance is related to positive treatment outcomes in counseling. More specifically, working alliance has been associated with positive treatment outcomes in adult patients and in children and adolescents who are treated in community-based settings or who are in inpatient treatment facilities (e.g., Botella et al., 2008; Hawley & Garland, 2008; Hintikka, Laukkanen, Marttunen, & Lehtonen,

2006; Horvath & Symonds, 1991; Samstag et al., 2008; Shirk & Karver, 2003; Tryon, Blackwell, & Hammel, 2008). This research will be discussed at length in the literature review.

Although there is ample research demonstrating the relationship between alliance and outcome, it is important that we understand how a good working alliance develops. Without a clear understanding of the process variables involved in working alliance formation and maintenance, counselors will not be able to employ any specific strategies to work toward a strong working alliance with their clients (Castonguay, Constantino, & Holtforth, 2006). Several researchers have investigated these variables with the adult population, and although there is still no clear answer, there are some themes in their findings. For example, research has shown that in order to form an alliance, the counselor must display an empathetic, accepting attitude toward the client, and develop a sense of shared commitment to the goals of treatment (Hatcher, 1999).

However, developmental considerations in the adolescent population suggest it may be inappropriate to generalize adult alliance research to the adolescents (Fitpatrick & Irannejad, 2008). In addition to developmental considerations, there are environmental differences that impact the therapeutic process for adolescents and adults. For example, counseling in the school setting, particularly mandated counseling, creates a unique therapeutic environment that is unlike that of a community or inpatient setting. First of all, counseling services in the school are typically offered during regular school hours and therefore the students' attendance has a higher level of publicity than in a more discrete after-school setting. Aside from the publicity of school-based counseling, there are other environmental factors that need to be considered. For instance, the typical adolescent client scenario is one in which the client is mandated to attend counseling (DiGiuseppe, Linscott, & Jilton, 1996). In addition, the school setting often limits the desired outcomes of counseling to academically-related outcomes or classroom behavior outcomes

(Fitzpatrick & Irannejad, 2008). These outcomes are not always consistent with the adolescents' own priorities and goals. Similarly, adolescents often lack a clear understanding of why they are in counseling, because they are referred by parents or by the school, and are not voluntarily seeking help. Therefore, parents, counselors, and school personnel often have treatment goals that are different from, or in strong opposition to, the adolescent's goals (DiGiuseppe et al., 1996). These, and other, contextual considerations will be further discussed in the literature review.

Finally, due to the transitional nature of the stage of adolescence, many youths experience this time as a period of maladaptation and increasing levels of psychopathology. Adolescence is therefore considered a critical period in development when one's trajectory can be significantly altered by positive or negative events and interactions (Holmbeck, O'Mahar, Abad, Colder, & Updegrove, 2006). Therefore, it is crucial that counselors who are working with these individuals approach treatment in a developmentally appropriate way, and build a relationship that will foster positive future outcomes (Holmbeck et al., 2006). This is only possible if the counselors understand how to form a strong working alliance with the adolescent clients in their schools. The combined information regarding a lack of working alliance research with this adolescent population, the developmental tasks of the stage of adolescence, and the specific differences in counseling in the schools versus community-based or inpatient settings, will highlight the gap in the literature regarding working alliance formation with adolescents who receive mandated school-based counseling.

The purpose of this study is to further our understanding of the working alliance in adolescent school-based counseling. Because counseling students is one of the most frequent activities that school psychologists perform (Fagan & Wise, 2007), this study should inform

school psychology practice in the schools. More specifically, this study will investigate the relationship between adolescent development and working alliance, as well as the process variables that predict a strong working alliance in mandated, school-based counseling with adolescents. This information will provide a first step toward more effective, empirically-based counseling in the schools, and will inform school psychologists and other school-based counselors about the techniques they can use in order to create a strong, positive working alliance relationship with their adolescent clients.

CHAPTER II

Literature Review

This chapter will provide a review of the literature pertaining to three constructs that constitute the main focus of this dissertation: the developmental tasks of adolescence, the formation of a working alliance, and environmental considerations of mandated school-based counseling. School psychologists often provide counseling to students as part of their duties (Fagan & Wise, 2007), and it will be proposed that this service cannot adequately be delivered without consideration of these three constructs. Jacob, Decker, and Hartshorne (2011) cite Tharinger and Stafford (1995) who "described counseling in the schools as a process of ongoing, planned interactions between a student and"… a school psychologist or other mental health practitioner (Jacob et al., 2011, p. 170).

The first section will begin with a discussion of adolescence as a developmental stage. This will include definitions and relevant theoretical perspectives of adolescence, an overview of the developmental tasks required of adolescents, as well as the potential psychological effects of dealing with such tasks. It will be organized in relation to biological development, cognitive development, and social role development.

The next section of the chapter will define and examine the working alliance construct. First, definitions will be provided in order to clarify and operationalize the construct. Then, an overview of the working alliance literature will be provided in four smaller sections: the relationship between working alliance and treatment outcome, the formation of working alliance from the counselor's perspective, the formation of working alliance from the client's perspective, and a view of working alliance formation that includes both the client and the counselor

perspective. In addition, measures of working alliance and limitations of the current research will be reviewed.

Following the discussion of working alliance and working alliance formation, there will be a section that discusses the uniqueness of the counseling scenario in mandated school-based counseling with adolescents. This section will provide an overview of environmental and developmental considerations that are uniquely present in this very specific counseling setting. It will end with a discussion of the relationship between the mandated adolescent school-counseling scenario and working alliance.

Developmental Stage of Adolescence

Because the proposed study will involve high school (adolescent) participants, it is important to first define this stage of development, and then to consider how variations in development may play a role in the research. Overall, researchers agree that adolescence is a developmental stage marked by significant changes in a variety of areas. Many people define adolescence as the time period between ages 13 and 19, or as beginning when a child reaches puberty, often without any clear indication of when it is over. Some researchers also break adolescence down into sub-categories, and include distinctions such as early, mid, and late adolescence (Burt, Resnick, & Novick, 1998). Conceptually, Dorn, Dahl, Woodward, and Biro (2006) define adolescence as:

> the interval between childhood and the assumption of adult roles and responsibilities, a broad interval of maturation that encompasses physical, mental, and emotional development, as well as coincident cognitive changes and change in social roles (p. 33).

Overall, as will be seen in the following sections, adolescence can be difficult to define, and therefore difficult to measure. Very often researchers classify adolescent participants based

on age, without assessing further developmental characteristics that can be used to more clearly and accurately define their stage of development. This is a great limitation to the generalizability of research with this population, as there is substantial variability in the developmental status of adolescents at varying ages. Barry and Pickard (2008) support this statement, noting that there is variability in the timing of developmental processes, and therefore we cannot rely solely on a person's age to make inferences about developmental level and/or developmental course. Arguably, one must decide which aspect of adolescent development is of particular interest for the intended research, and then specifically measure that construct. It is thought that age, by itself, will prove to be an inadequate indicator of adolescent development.

For the purpose of this review, the definition of adolescence provided by Holmbeck et al. (2006) will be used in order to organize and discuss three main elements of adolescent development. According to Holmbeck et al. (2006) there are three major developmental changes that happen throughout adolescence; these include biological changes, psychological/cognitive changes, and changes in social role redefinition. These changes are considered primary changes because they occur across cultures and they occur prior to the developmental outcomes of adolescence (Holmbeck et al., 2006). Due to the cross-cultural utility of this definition, it was chosen as a useful way to conceptualize this developmental stage in a culturally-sensitive, appropriate manner. In addition, although the three changes may overlap and influence each other, each type of change also plays its own significant role in development, and therefore each will be discussed briefly in the following sections.

Biological changes. Biological changes during adolescence are mainly centered on puberty and the physical/hormonal changes that occur. According to Holmbeck et al. (2006),

pubertal status and timing have an impact on the quality of relationships, adolescents' mood and emotional expression, and indicators of psychosocial adaptation.

Pubertal timing is often related to problems associated with adolescents who are at risk for a variety of adaptational difficulties (i.e., early maturing girls can be at risk for depression) (Teunissen et al., 2010). Because pubertal status and timing vary on an individual basis, an adolescent's age cannot always provide suitable information regarding stage of biological development and level of risk factors. Therefore, as previously noted, age is not a reliable indicator of development during this period. As researchers, we must consider the physical and psychological maturational heterogeneity across adolescents (Dorn et al., 2006). For instance, van Jaarsveld, Fidler, Simon, and Wardle (2007) examined the impact of pubertal timing on adolescent behavior and risk factors. They found that early and late physically maturing adolescents (boys and girls) experienced different levels of risk factors and stress than those who physically matured during the more "typical" time period. In particular, early maturing adolescents were found to develop unhealthier lifestyles across the domains of smoking, physical activity, sedentary behavior, and breakfast routine (i.e., how often they eat breakfast) (van Jaarsveld et al., 2007). Therefore, the biological changes of this stage of life have important implications for psychological health and counseling, and these changes must not be assumed to occur consistently across individuals. However, biological changes related to puberty and adolescent development will not be considered the primary developmental area of concern in the current study, and therefore biological development will not be directly measured.

Cognitive changes and the need for autonomy. Several theorists have postulated about the stages of cognitive development across the lifespan, including cognitive development during the stage of adolescence. One noteworthy contribution to this research is that of Jean Piaget.

Piaget (1972) who theorized that adolescence is a time of cognitive development marked by attainment of formal operational thinking. The formal operational stage is Piaget's most complex stage of cognitive development. During this stage one is able to think about thought as its own object. Metacognitive abilities are reached, and the formal operational thinker becomes able to think abstractly, to reason hypothetically, and to hypothesize beyond concrete objects and manipulation (Piaget, 1972).

These normative cognitive changes during the stage of adolescence are of particular importance because they allow adolescents to evaluate their relationships with others and to evaluate their own identity (Holmbeck et al., 2006). When adolescents are able to evaluate the adults in their lives, particularly parents, and obtain an increased awareness of themselves as individuals, this typically leads to a push for autonomy and a desire for more control over their lives (Blakemore, 2009; Harter, 1990; Holmbeck et al., 2006; McElhaney et al., 2009). However, as previously noted, adolescent development varies on an individual basis, both intra-individually and inter-individually. In other words, not only do adolescents develop at varying rates from one another, but they also develop at varying rates within themselves. For instance, adolescents may have already matured biologically (e.g., puberty) but may not have matured cognitively (e.g., formal operations) (Beckert, 2007). This phenomenon is not uncommon, as cognitive development is thought to continue into one's early to mid-20's, particularly development of the executive functions (e.g., judgment and reason) (Beckert, 2007). This again highlights the importance of measuring adolescent development based on specific areas of change, rather than based on age.

As adolescents do mature cognitively, they often seek increased levels of individuation and autonomy. Subsequent gains in personal autonomy and freedom of choice play a role in

increased self-esteem throughout adolescence (Harter, 1990). In addition, as adolescents become more evaluative of the adults in their lives, they strive for greater autonomy from their parents and also begin developing more significant relationships with peers. Therefore, during this stage, classmate support becomes more predictive of self-esteem than parental support. Due to this shift, it is very important for adolescents to feel secure in how their classmates view them. Adolescence is a time when self-evaluation is heavily dependent on perceived acceptance by our peers, more so than that of parents or other adults in our lives (Harter, 1990).

Definitions and assessment of cognitive autonomy. Because adolescents' cognitive development and the subsequent need for greater autonomy will be hypothesized to play a large role in counselors' development of a working alliance relationship with adolescent clients, it is important to take the time to define autonomy and discuss assessment techniques. Autonomy is a complex construct that has been conceptualized in a variety of different ways by many theorists and researchers. This diversity in conceptualization and definition makes it difficult to compare theories and to compare empirical results found in the literature (Noom, Dekovic, & Meeus, 2001). In order to clarify some of this ambiguity, Noom et al. (2001) conducted a study aimed at examining the different theoretical perspectives and finding a general conclusion on the concept of adolescent autonomy. To begin, they analyzed the theories in which autonomy plays a central role; the psychodynamic, the cognitive, and the eclectic approaches. For instance, psychodynamic researchers stress the relational changes between parents and adolescents, and highlight the transformation of this relationship into one that is egalitarian. Cognitive perspectives discuss the importance of adolescent decision-making and the perception of control as the main elements of autonomy. This perspective focuses on the cognitive and behavioral components involved in decision-making, such as listing alternatives, making choices and

decisions, and being aware of one's responsibility in the process. Finally, the eclectic perspectives integrate the relational and cognitive aspects, as well as connecting these aspects with additional elements (Noom et al., 2001).

Although all three theories define autonomy in their own way, there are three dimensions that Noom et al. (2001) suggest to be universal. These dimensions are attitudinal autonomy, emotional autonomy, and functional autonomy, and they represent the cognitive, affective, and regulatory aspects of adolescent autonomous behavior. According to the authors, attitudinal autonomy is achieved when adolescents are able to define their goals and they are able to think before acting; emotional autonomy refers to the process of becoming emotionally independent from parents and peers; and functional autonomy reflects the regulatory process of independently developing and implementing strategies to achieve one's goals.

Based on the theories reviewed by Noom et al. (2001), the authors developed a scale to measure the three dimensions (attitudinal, emotional, functional) of cognitive autonomy in adolescents. Development began with a conceptual analysis, followed by a pilot study of 36 items. After pilot testing these items, a confirmatory factor analysis was performed on the 15 selected items on the Adolescent Autonomy Questionnaire (Noom, 1999) that resulted from the aforementioned pilot study. Results of the analysis indicated that the three-factor model utilized in the measure was significantly better than using one total factor. Although this measure has not been used extensively in further research, preliminary evidence suggests that it has potential to be a psychometrically sound measure of adolescent autonomy.

Another measure to assess adolescent autonomy is the Cognitive Autonomy Self Evaluation Inventory (CASE Inventory) (Beckert, 2007). This instrument is a 27-item scale with a six point Likert-scale used to measure Evaluative Thinking, Voicing Opinions, Decision

Making, Self Assessing, and Comparative Validation, as components of overall cognitive autonomy (Beckert, 2007). In recent research, Lee, Beckert, and Goodrich (2010) used the CASE inventory to assess adolescent cognitive autonomy, and they found suitable reliability for the scale.

At this time, there are no other measures that have been used extensively in the research to measure adolescent autonomy. Although further research is necessary to fully establish the psychometric properties and utility of these measures (Adolescent Autonomy Questionnaire (Noom, 1999) and the CASE Inventory (Beckert, 2007)), they provide a useful first step in measuring this important construct.

Autonomy considered cross-culturally. Another important thing to consider when discussing autonomy is how the construct relates cross-culturally. Some authors have questioned whether or not autonomy is a universal need, or if it is only a western ideal. In particular, questions have been raised about the need for autonomy in a collectivist culture. If the need for autonomy is in fact only experienced in the western world, participants of varying cultural backgrounds could confound the results of the proposed study. Therefore, a brief discussion of self-determination theory will address this concern.

The construct of autonomy is a critical component in self-determination theory (SDT), a theory of intrinsic motivation (Deci, 1992). While the discussion of autonomy thus far has focused on developmental research, much of the literature on autonomy is also found in the context of motivational research. This connection makes intuitive sense, as individuals are thought to experience self-determination (e.g., intrinsic motivation) when they fully endorse their behavior and they feel in control over their own actions (i.e., autonomy) (Deci, 1992). SDT proposes that all humans have three basic needs that underlie self-determined behavior;

autonomy, competence, and relatedness. Autonomy, which is fundamental to the experience of self-determination, refers to the inner endorsement of one's actions, and a sense that one's actions are truly one's choice (Reeve, Nix, & Hamm, 2003). Studies have shown that autonomy leads to enhanced outcomes, such as academic competence, achievement, and well-being (Patall, Cooper, & Robinson, 2008; Ryan & Deci, 2000; Vansteenkiste, Lens, & Deci, 2006). The other two basic needs outlined by SDT are competence (i.e., the desire to establish mastery over a task) and relatedness (i.e., a feeling of connectedness to our social context, and the development of positive, supportive interpersonal relationships) (Furrer & Skinner, 2003; Vansteenkiste et al., 2006). Unlike autonomy, competence and relatedness are seen as important mediators, but they only lead to the experience of self-determination in autonomy-supportive contexts (Ryan & Deci, 2000).

Although autonomy is implicated in all intrinsically motivated behavior, it is experienced differently from culture to culture. Initially, autonomy was studied from the western viewpoint, which values independence. Investigators believed that the experience of autonomy was uniform and it resembled the independent emphasis on personal choice and determination. However, SDT research proposes that collectivistic cultures have a different conceptualization of autonomy. When children from collectivist cultures have close relationships with people, they internalize the choices of related others and they do not see these others as being outside of their self-systems (Bao & Lam, 2008). Therefore, in collectivist cultures autonomy is experienced both when individuals have control over their own actions, as well as when they endorse the choices of those who are seen as an extension of themselves. Even though the experience of autonomy may be different, studies have shown that its beneficial effects, such as high achievement, well-

being, and healthy adjustment outcomes hold for culturally diverse samples (Chirkov, Ryan, Kin, & Kaplan, 2003; Vansteenkiste, Zhou, Lens, & Soenens, 2005).

Based on this research, it will be expected that adolescent participants who come from a collectivist cultural background will still endorse the need for autonomy as they develop cognitively. It is hypothesized that in the counseling relationship, there will continue to be an association between a strong working alliance and the adolescents' sense of autonomy in the relationship. Specifically, these adolescents will be more willing to accept the choices and direction set forth by the counselor if there is a strong working alliance because this will allow the adolescent to see the counselor as a related individual who is acting on behalf of his or her best interest.

Social role changes and identity formation. Another aspect of the developmental stage of adolescence involves social role changes. Expected roles in society, in families, with peers, and gender-based roles, can undergo change as children move into adolescence and as they re-evaluate their place in the world. This is an important factor for school psychologists to be aware of, because psychopathology can often result from a failure to integrate the conflicting role expectations that many adolescents face (Holmbeck et al., 2006).

Social role expectations are one component of an overall developmental task of identity formation, one of the major tasks of this developmental stage. As previously noted, during adolescence there are changes that impact self-identity, the need for autonomy, and the adolescents' roles in relationships and in society (Harter, 1990). Identity formation requires individuation from the parents and the need for distinctiveness and uniqueness (Harter, 1990). Although there are many different variables that factor into identity formation (e.g., gender, race, ethnicity, sexual orientation), research has shown that incorporating all of these different

characteristics and roles into one functional identity can be challenging (Consolacion, Russell, & Sue, 2004). According to Greene (2009), "psychological health is predicated on the acceptance and integration of the disparate elements of the self and of the family, in both the biological and national or ethnic sense" (p. 312). Harter (1990) corroborates this statement, stating that a failure to integrate the multiple self-concepts recognized by adolescents can lead to pathology or a maladaptive continuation of distress. In sum, it is important to consider conflicts in role expectations as well as conflicting facets of one's identity when evaluating the developmental status of an adolescent.

In the present study, social role changes will not be measured directly as an indicator of development, although it will reveal itself through the measures of autonomy and through questionnaires regarding students' expected role in the counseling process.

Rationale for Focusing on Adolescents

It is clear from the previous discussion that adolescence is a time marked by major developmental transitions and growth. Although most adolescents make these transitions without significant emotional problems, there are still a number of risk factors associated with this developmental stage (Kerig & Wenar, 2006). Therefore, effective counseling may be a critical component in making a healthy transition into and out of adolescence. For instance, moodiness, self-depreciation, and depression all peak in adolescence; and psychopathologies such as suicide, schizophrenia, alcohol and drug abuse, and eating disorders sharply rise during adolescence (Kerig & Wenar, 2006).

Researchers have made important connections between the aforementioned cognitive development and the prevalence of certain psychopathologies during this time period. For instance, Bava and Tapert (2010) examined adolescent brain development and risk factors

related to alcohol and substance abuse. The authors noted that the adolescent brain undergoes significant changes in neurochemistry, fiber architecture, and overall tissue composition. They hypothesized that there is an asynchronous development of reward and control systems that increase adolescents' responsivity to incentives and risky behaviors. This aspect of development may result in adolescents being more vulnerable to risk taking, which may account for the high levels of substance use among adolescents (Bava & Tapert, 2010). Alcohol and drug abuse should be of great concern to school psychologists, as binge pattern alcohol consumption and marijuana use are common, and are associated with identifiable neural consequences. For instance, deficits in attention, memory, and executive functioning are apparent in these adolescent substance users (Bava & Tapert, 2010).

The high rates of adolescent depression have also been discussed in conjunction with normative cognitive development. For example, Davey, Yucel, and Allen (2008) note that adolescent development is often accompanied by a population-wide increase in the vulnerability to depression. Some researchers believe that the increased vulnerability to depression results from the delayed development of the prefrontal cortex compared to limbic areas. Davey et al. (2008) theorize that the development of the prefrontal cortex is the central explanation in the rise in vulnerability to depression during the adolescent period. Their model suggests that the prefrontal cortex development during this period allows for representation of complex goals at the same time that social rewards become much more prominent and motivating. Prefrontal cortical development enables adolescents to make decisions in complex social environments and to set complex goals; however, the cost is a heightened vulnerability to depression when anticipated future rewards are not attained (Davey et al., 2008). While there may be several models used to explain this phenomenon, most researchers can agree that adolescent cognitive

development is associated with increased prevalence of depression during this developmental stage.

Another area of high risk in adolescence is the development of eating disorders. Alonso, Rodriguez, Alonso, Carretero, and Martin (2005) note that, "although young and adolescent girls are the most vulnerable, males are also frequently affected, and the early years of adolescence and the late years of youth present a high incidence of these disorders" (p. 980). The authors conducted a study to estimate the prevalence rates of developing eating disorders in secondary school students. Results of their study showed that 7.8% of the secondary school population had a high risk of developing eating disorders, although females presented a higher percentage of risk (12.3%) than males (3.2%) (Alonso et al., 2005). This study highlights the relatively large numbers of adolescents in the secondary school level who struggle with eating disorders, and who are likely to need some type of counseling as they deal with such issues.

Overall, because adolescence is a period of transition and change (i.e., biological, cognitive, and social role development), and it is a time of vulnerability for a number of psychopathologies (e.g., substance abuse, depression, eating disorders), it is proposed that schools need to be able to offer effective counseling to this population in order to make their transitions as adaptive and successful as possible.

Working Alliance

Introduction to construct and definitions. Working alliance is thought to be a generic factor in the therapeutic or counseling process, suggesting that it remains relevant and significant regardless of treatment approach (Thomas et al., 2005). In fact, Bordin (1979) proposed that the working alliance between the client and the counselor is the key agent in the change process, and that it consists of three main dimensions: goals, tasks, and bond. In other words, a strong

working alliance is dependent on client-counselor agreement on treatment goals, collaboration and agreement regarding the tasks of counseling, and the level of emotional bond, or trust, that is created between client and counselor. These dimensions include the extent to which the counselor and clients collaborate to determine the course of counseling and the strategies that they will use, as well as the sense of warmth and understanding they share with each other (Bordin, 1979).

Current definitions of the working alliance also emphasize the affective or collaborative elements in the therapeutic relationship such as liking, respect, and trust, as well as the quality of this bond in establishing the tasks and goals of treatment (Fitzpatrick & Irannejad, 2008).

Relationship between working alliance and treatment outcome. There is an abundance of research demonstrating that a strong working alliance is related to positive treatment outcomes in counseling. The term working alliance was first used by Greenson (1967), when he noted that a positive collaboration between client and counselor is one of the most significant components of successful counseling (Horvath & Symonds, 1991). Since then, working alliance has been associated with positive treatment outcomes in adult patients, and in children and adolescents who are treated in community-based settings or who are in inpatient treatment facilities. This research and the relevant findings will be discussed in the following section. The purpose of this discussion is to highlight the significant role that working alliance plays in the counseling process. It will be argued that development of a positive working alliance strongly influences the outcomes of counseling, and that this relationship is consistent across treatment modalities and settings.

For instance, Horvath and Symonds (1991) conducted a meta-analysis of 24 studies relating the quality of working alliance to therapy outcomes. Inclusion criteria for the meta-

analysis were as follows: (a) the relationship construct measured in the study had to be identified by the authors as either "working," "helping," or "therapeutic" alliance; (b) the study had to report a quantifiable relationship between the alliance and outcome measured; (c) research included was clinical, rather than analog; (d) all studies had 5 or more subjects in order to distinguish case studies from group designs; and (e) only research involving individual treatment was included, and group therapy was excluded from this review. Overall, the authors found a moderate correlation between good working alliance and positive treatment outcome. The effect sizes (ES) for all of the data were combined, creating an overall weighted effect size (ES_w). Results showed that the combined ES_w was .26, and the statistic corresponding to the combined effect size was 8.48; this value was highly significant *($p < .001$)*. Types of treatment included in these studies were those that utilized psychodynamic interventions, eclectic interventions with a mixture of orientations, cognitive therapies, and Gestalt therapies. In addition, although number of clients and length of treatment ranged considerably between studies, there was no evidence that these variables systematically biased the results (Horvath & Symonds, 1991).

In addition, studies in this meta-analysis were compared on the basis of client-rated, counselor-rated, or observer-rated, working alliance (Horvath & Symonds, 1991). The results of this comparison suggest that client-rated working alliance is a better predictor of outcome than counselor- or observer-rated working alliance. Interestingly, third-party observer ratings of working alliance were also a better predictor of treatment outcome than counselor-rated alliances. This suggests that it is the client's ratings of the working alliance relationship that most strongly predict treatment outcome. In other words, if the client feels that there is a collaborative, supportive relationship between client and counselor, this is a significant predictor of treatment outcome. In addition, the counselors' ratings are the least effective predictors of

treatment outcome, with client and observer ratings being more predictive (Horvath & Symonds, 1991). In a study on working alliance formation with adolescent substance abusers, Auerbach, May, Stevens, and Kiesler (2008) corroborated these findings, noting that clients' perception of the alliance tended to be stronger than counselors', and that client and counselor working alliance ratings were not significantly correlated with each other.

More recently, Horvath, Del Re, Fluckiger, and Symonds (2011) conducted a similar meta-analysis to examine alliance-outcome research between 1973 and 2009. As an extension to previous meta-analyses, the authors included Italian, German, and French studies in the literature search. Overall, 201 studies were included in the analysis, which reflects the extreme growth in alliance literature over the past decade (Horvath et al., 2011). Results of the analysis indicated that there was overall effect size of .275, which is statistically significant at the $p < .0001$ level; this suggests a moderate and highly reliable relationship between working alliance and treatment outcome (Horvath et al., 2011). The authors concluded by suggesting that the counselors' ability to create a high quality alliance with the client is a critical component in treatment outcome. Therefore, "alliance development is a skill and/or capacity that therapists can and should be trained to develop just as they are trained to attend to other aspects of their practice" (p. 15).

Similar to Horvath and Symonds (1991), Shirk and Karver (2003) conducted a meta-analysis of 23 studies examining the association between therapeutic relationship variables and treatment outcomes with children and adolescents. It is important to consider differences in the literature in regard to age and developmental level, as the proposed study will focus on the adolescent population. Shirk and Karver (2003) note that from a developmental perspective, the working alliance relationship may be even more critical in child/adolescent treatment than it is in adult counseling because children/adolescents typically do not refer themselves for treatment,

may not recognize the existence of problems, and are often in opposition to their parents about the goals of counseling. Furthermore, there is a developmental trend toward increasing autonomy from adults, which can represent an additional obstacle in alliance formation with adolescents (DiGiuseppe et al., 1996). Given these considerations, the contribution of the therapeutic relationship to outcome could vary as a function of client developmental level, and therefore it is important to distinguish research with populations at varying developmental levels (Shirk & Karver, 2003).

Inclusion criteria for both Horvath and Symonds (1991) and Shirk and Karver (2003) were largely the same, although Shirk and Karver (2003) did not restrict their analysis to research with individual therapy. These authors also included family therapy and parent management training in the meta-analysis, noting that these represent common forms of adolescent and child treatment. However, separate analyses were conducted in order to evaluate the strength of relationship–outcome associations for child patients only across different modes of treatment (Shirk & Karver, 2003).

The purpose of their analysis was to address two areas of interest. First, the authors examined the overall strength of the association between therapeutic relationship variables and outcomes in child psychotherapy. Second, they examined whether or not the associations were moderated by patient and/or therapist characteristics, or by methodological factors in the studies. Several variables were considered as possible moderators. For instance, patient characteristics included as potential moderators were child's age and type of presenting problems. Treatment characteristics included were type of treatment, mode of treatment, level of structure of treatment, and context of treatment. Methodological moderators included timing and source of relationship measurement, content and source of outcome measurement, shared versus cross-

source measurement of relationship and outcome variables, study design, and degree to which study treatments produced beneficial effects. To address these issues, the authors conducted a meta-analysis of research relating therapeutic relationship variables to treatment outcomes with children (Shirk & Karver, 2003).

The results of the analysis showed that the therapeutic relationship (i.e., working alliance) is related to treatment outcome across diverse types and modes of child and adolescent treatment. More specifically, the relationship between working alliance and treatment outcome was consistent across behavioral and non-behavioral interventions, as well as being consistent across individual, family, and parent treatment approaches. Overall, the estimated association between working alliance and outcome was identical to the alliance-outcome estimate with adults (Shirk & Karver, 2003).

Finally, Shirk, Karver, and Brown (2011) conducted a similar meta-analysis of alliance–outcome associations in individual youth therapy. This study focused only on individual therapy, rather than including family or group treatments, in order to provide a more direct comparison to the alliance literature with the adult population. There were 16 studies included in the meta-analysis, including 1306 participants with 658 youth (children and adolescents) and 648 parents. The authors noted that this is the first meta-analysis to use inclusion criteria highly similar to that in the adult literature (Shirk et al., 2011). Overall, results from the 16 studies were consistent with the adult literature, with a weighted mean correlation of .22 ($p < .001$) between alliance and outcome. The results also suggest that the alliance is important for outcome in both behavioral and non-behavioral types of treatment. In addition, there was a slightly stronger relationship between alliance and outcome for children than for adolescents (Shirk et al., 2011). This finding points to possible differences in alliance formation with youth at different

developmental stages (i.e., children and adolescents), which is central to the rationale for the current study.

Adult outcome research. While meta-analyses are useful for general conclusions, there are a number of individual studies in recent literature that provide substantial evidence for the relationship between working alliance and treatment outcome. For example, Botella et al. (2008) conducted a study to examine the relationship between outcome of therapy (improvement) and process of therapy (working alliance) in 239 adult clients receiving out-patient therapy on a weekly basis. Counselors were all Master's or Ph.D. level clinical psychologists and psychotherapists with experience ranging from 3 to 17 years of practice. Based on previous literature, the authors developed three hypotheses. First, there would be a significant positive association between client-rated therapeutic alliance and therapy outcome in terms of symptomatic improvement. Second, the strength of the therapeutic alliance in clients who terminate treatment prematurely would be less than patients who end treatment successfully. Finally, there would be a relationship between temporary weakening of the alliance and therapy outcome in terms of general improvement and the number of sessions needed to improve. The results of this study showed that therapeutic alliance plays a crucial role in predicting therapy outcome. In addition, lower strength of working alliance was related to early termination of therapy. Finally, the average rating of therapeutic alliance was not affected by temporary weakening of the alliance (Botella et al., 2008). This last point is important to note, as a temporary weakening of the alliance may occur at different periods in the therapeutic process. However, average ratings are not affected by temporary highs and lows in the alliance relationship.

In another interesting study, Samstag et al. (2008) investigated the therapeutic relationship by examining the interrelationships of the working alliance, interpersonal complementarity (i.e., friendly behaviors), and narrative coherency (i.e., a reflection of "internal working models" or mental representations of self-other experiences) with adult clients. In addition, they examined the validity of these measures for identifying patients who are at risk for either premature termination or poor therapy outcome. The participants consisted of patient-therapist dyads classified as premature dropout (DO), poor outcome (PO), and good outcome (GO). The authors hypothesized that DO cases would have the most problematic therapeutic relationships, evident by lowest ratings of working alliance and positive complementarity, the greatest frequency of hostile interpersonal behavior, and the least coherent session narratives. Likewise, the GO group was hypothesized to have the least problematic relationship, highest ratings of alliance and positive complementarity, minimal hostility, and highly coherent narratives. Finally, the authors expected the PO group to fall between the DO and the GO groups. Results indicated that DO dyads had the worst alliance ratings, compared to the other two treatment conditions, but the PO group demonstrated the highest occurrence of hostile interpersonal behavior. The findings suggest that it is not only important to prevent premature termination, but also important to address any hostile interactions that occur throughout the therapeutic process (Samstag et al., 2008). Very often, treatment of children and adolescents does not allow for a literal premature termination in services, as parents and/or school personnel may be requiring the individual to attend treatment sessions. However, withdrawal from or resistance to treatment activities may be an equivalent scenario to adult termination when considering the behavior of children and adolescent clients.

Adolescent outcome research. While adult literature is useful for creating hypotheses about the adolescent or child population, it is critical to examine research that makes use of the specific population of interest, which in this case is the adolescent population. However, much of this literature involves adolescents who are being treated in inpatient or community-based settings, and therefore it is still not a direct representation of the school population of interest.

For instance, Hawley and Garland (2008) examined the relationship between working alliance and therapy outcomes in 78 adolescents referred for community-based outpatient therapy. The authors used youth, parent, and therapist reports of working alliance. The purpose of this study was to investigate the stability of alliance from 1 to 6 months of treatment, the consistency among adolescent, parent, and therapist reports of alliance, and the relationship between alliance and outcome in terms of symptoms, functioning, satisfaction, and environmental impact. The results suggested that adolescent working alliance is relatively stable over time and is associated with decreased symptoms, improved family relationships, increased self-esteem, and higher levels of perceived social support and satisfaction with therapy. In contrast, parent and therapist ratings of alliance were only associated with very few therapy outcomes, and most were within person associations (i.e., parent-rated alliance related to parent-rated outcomes) (Hawley & Garland, 2008). This is consistent with the aforementioned results of research with the adult population (Horvath & Symonds, 1991), in that client ratings of working alliance are more predictive of treatment outcome.

Similarly, Hintikka, Laukkanen, Marttunen, and Lehtonen (2006) examined the effects of the working alliance on treatment outcome in 45 adolescent inpatients. The purpose of this study was to extend the results of previous literature on working alliance and adolescents to that of the inpatient psychiatric population. The authors suggested that a positive working alliance during

inpatient psychiatric treatment may improve cognitive performance and result in a more realistic acknowledgment of one's possibilities, along with enhanced social competence. Specifically, they investigated whether the working alliance was associated with changes in cognitive performance, psychosocial functioning, and the patient's self-image. The findings of the study indicated that a positive working alliance predicts positive changes in cognitive functioning and positive changes in family relationships among inpatient adolescents (Hintikka et al., 2006).

Karver et al. (2008) conducted a related study, which explored the relationship between working alliance and adolescent treatment involvement. Although treatment involvement is not a direct measure of treatment outcome, this study is included in the review under the assumption that increased treatment involvement is related to more positive treatment outcomes. Participants were 23 adolescents with depressive symptoms who were being treated at a general pediatric emergency department or inpatient unit of a child psychiatric hospital after a suicide attempt. Results of their study indicated that working alliance was significantly related to variance in adolescent treatment involvement across treatment types (cognitive behavioral therapy and nondirective supportive psychotherapy). These findings are unique in that a strong relationship was found between the alliance and client involvement across separate sessions, across informants, and across therapeutic approaches. This relationship supports the authors' hypothesis that a positive working alliance promotes client involvement in therapeutic tasks, regardless of treatment approach (Karver et al., 2008).

In sum, working alliance has been associated with positive treatment outcomes in adult patients, and in children and adolescents who are treated in community-based settings or who are in inpatient treatment facilities. In a review of the working alliance literature, Castonguay, Constantino, and Holtforth (2006) stated that it is safe to assume that regardless of the problem

or the type of treatment, counselors should try to establish, monitor, and maintain a positive relationship and a strong level of collaboration with their clients. However, as can be seen from the review of the literature thus far, there is a lack of research on working alliance and treatment outcome in a school-based setting, and therefore this needs to be addressed with future research.

The formation of working alliance/process variables. Although there is an abundance of research on the relationship between alliance and outcome, it is important that we understand how a good working alliance develops. Without a clear understanding of the process variables involved in working alliance formation and maintenance, therapists will not be able to employ any specific strategies to work towards a positive working alliance (Castonguay et al., 2006). Some previous research has shown that in order to form an alliance the therapist must display an empathetic, accepting attitude towards the client, and develop a sense of shared commitment to the goals of treatment.

For instance, Tryon and Winograd (2011) conducted a meta-analysis aimed at examining the effects of goal consensus and collaboration on treatment outcome. Overall, 15 studies with a total sample size of 1,302 were used in order to analyze the goal consensus-psychotherapy outcome effect sizes for the meta-analysis. The results of the analysis demonstrated a medium effect between goal consensus and psychotherapy outcome (r = .34; d = .72). In addition, 19 studies with a total sample size of 2,260 clients were used for the analysis of collaboration-psychotherapy outcome effect sizes. Results indicated that a more collaborative relationship between client and therapist greatly improved patient experience and well-being. In general, the results of the meta-analyses indicate a strong relationship between patient-therapist goal consensus and positive therapy outcomes, as well as between patient-therapist collaboration and positive therapy outcomes (Tryon & Winograd, 2011).

In addition, Eltz, Shirk, and Sarlin (1995) examined the relationship between maltreatment experiences (i.e., abuse from caregiver), working alliance formation, and treatment outcome in 38 psychiatrically hospitalized adolescents. Results indicated patients who had experienced maltreatment demonstrated poorer initial alliances with their counselor than those who had no experience of maltreatment. In addition, these adolescents who were unable to develop positive working alliances with their counselors showed the poorest treatment outcomes. The authors note that possible reasons for poorer alliance formation and treatment outcome are "decreased feelings of safety in new situations, reluctance to trust others, and increased emotionality, which may negatively affect relationships" (Eltz et al., 1995, p. 428). The results of this study suggest that adolescent clients' feelings of safety and trust in the counseling situation are important variables in alliance formation, and therefore in treatment outcome.

It has also been noted that the therapist needs to skillfully facilitate the client's active engagement in working towards these goals in therapy (Hatcher, 1999). For example, in the aforementioned study by Karver et al. (2008), several process-oriented suggestions were made by the authors considering the findings regarding alliance and treatment involvement. Based on the results of their study, Karver et al. (2008) suggest that pushing adolescents to talk before they are ready can lead the adolescent to be less open with the counselor, leading to less treatment involvement and poorer alliance formation. In addition, failing to acknowledge emotions expressed by the adolescent clients, and not demonstrating care when trying to understanding what an adolescent is saying are behaviors likely to hurt the working alliance relationship. Another interesting finding in this study was that therapist emphasis on recalling previous client information was associated with negative client ratings. The authors suggest that when counselors overemphasize a prior session it distracts from their ability to attend to the current

session and current discussion. In addition, counselors may be bringing up previous information in order to challenge what the client is currently saying, suggesting a criticism and therefore resulting in impaired alliance formation with the adolescent (Karver et al., 2008).

Although the clients' involvement and active engagement in treatment have been shown to be important factors in alliance formation and outcome, the patient's readiness to collaborate on a goal may be a function of personal characteristics and of environmental circumstances or supports (Bordin, 1979). In addition, there is still much to be determined when it comes to the precise variables that correlate with a good working alliance. Recently, Peluso, Liebovitch, Gottman, Norman, and Su (2011) began exploring the possibility of using a mathematical model to understand, and subsequently predict, the dynamics of the therapeutic relationship. In a similar article, Liebovitch, Peluso, Norman, Su, and Gottman (2011) state that "the success of psychotherapy depends on the nature of the therapeutic relationship between a therapist and a client." Therefore, these authors are attempting to outline a mathematical model of this relationship in brief psychotherapy. While this research is still in its early phases, it provides clear evidence that there is still much to be determined about the nature of the therapeutic relationship and the factors that contribute to a positive working alliance.

In addition, as in any relationship, there is not always agreement as to the strength of the relationship from both parties (i.e., the client and the counselor). Therefore, it is important to identify differences in client-rated versus counselor-rated working alliance, as well as differences in their ability to predict treatment outcome.

Counselors' perspective of working alliance. According to Horvath (2001), there are three client characteristics that contribute to therapist ratings of working alliance. These client features are problem severity, type of impairment, and quality of object relations or attachments.

However, the research is somewhat inconclusive as to the precise relationship of these variables, and whether there is a direct relationship, an interaction effect, or moderating variables at play. In addition, as mentioned previously, much of the research on working alliance suggests that client-rated working alliance may be a better predictor of outcome than therapist-rated alliance (i.e., Horvath & Symonds, 1991). Therefore, the present study will focus on the clients' ratings of working alliance as indicators of a positive working relationship and as predictors of treatment outcome.

Clients' perspective of working alliance. According to Horvath (2001), several therapist factors relate to working alliance, as rated by the client. These characteristics include communication skills, empathy and openness, experience and training, therapist's personality and intrapersonal process, and collaboration with the client (Horvath, 2001). The value of an open, flexible stance as opposed to relational control or rigid expectations on the part of the therapist is a consistent theme across much of the literature (Horvath, 2001).

Bachelor (1995) also investigated the client's perception of working alliance, and the client-identified process variables related to a good working alliance. While the results of this study indicate that there may actually be several different types of good working alliance, there were several factors that were consistent across all types. For example, therapists who were nonjudgmental, careful listeners, empathetic, and created a climate of trust were valued most by clients. In addition, interventions that fostered understanding and therapist expertise were commonly reported in good working alliance relationships (Bachelor, 1995). Consistent with Bachelor (1995), Auerbach et al. (2008) conducted a study examining working alliance formation with adolescent substance abusers. Auerbach et al. (2008) found that for both

counselors and clients, interpersonal affiliation (i.e., friendliness) was the relationship dimension that most strongly predicted the perception of a working alliance.

Watson and Geller (2005) examined the relationship between relationship conditions, treatment outcome, and working alliance in cognitive-behavioral therapy and process-experiential therapy. The authors hypothesized that working alliance (measured by the WAI (Horvath & Greenberg, 1986)) mediates the association between relationship conditions (as measured by the Relationship Inventory (Barrett-Lennard, 1962)), and therapy outcome (as measured by the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), and the Rosenberg Self-Esteem Inventory (Rosenberg, 1965). In other words, this study examined the differences in clients' perceptions of the relationship conditions of empathy, acceptance, positive regard, and congruence in two different forms of therapy, and identified the relationship between these conditions, the working alliance, and the treatment outcome. As was hypothesized, the results supported previous research and demonstrated the importance of relationship conditions when developing positive therapeutic outcomes. These results also suggested a mediating role for the working alliance. In other words, the relationship conditions facilitate the development and maintenance of a good working alliance across different therapies with different theoretical viewpoints. In sum, it appears that therapists who are empathetic, accepting, and encouraging of the clients are more likely to form agreement regarding the tasks and goals of therapy and develop a stronger therapeutic bond than those who do not include these traits (Watson & Geller, 2005).

Likewise, Bedi, Davis, and Arvay (2005) examined the client's perspective on the process variables involved in forming and improving the working alliance in therapy. The

participants in this study were adults involved in individual counseling at the current time or within the past two years. Participants were only selected if they believed that they had a positive relationship with their counselors. Participants were interviewed using the Critical Incident Technique, and results indicated 107 critical incidents, which were separated into eight categories. These categories (from highest percent of critical incidents to lowest) were: General Counseling Skills, Counseling Environment, Expression of Positive Affect and Sentiment, Tracking the Counseling Process, Personal Attributes of the Counselors, Punctuality and Use of Time, Going Beyond Normative Expectations, and Positive First Encounters. In sum, the most important factors appeared to be as simple as smiling, self-disclosure, leaning forward, use of reflective statements, providing verbal support, and the counseling environment (Bedi et al., 2005).

Bedi, Davis, and Williams (2005) also studied critical incidents in the formation of working alliance from the client's perspective. According to the authors, there is a scarcity of research concerning clients' subjective understanding of what contributes to a good quality alliance. The purpose of their study was to identify and categorize the variables that clients consider important in forming and improving the working alliance. Clients were asked to provide descriptions of observable behaviors and verbalizations that they felt had helped form or strengthen their alliance with the therapist. A total of 376 critical incidents were identified by the 40 participants, and they were organized into 25 categories. The results suggested that many of the key factors are quite simple, such as eye contact, smiling, warm greetings, paraphrasing, identifying client feelings, encouraging client, and referring to material in previous sessions. The results also suggested several factors that have been under researched at this point, including therapist's personal characteristics and therapeutic environment. In addition, most of the

participants noted at least one technical activity factor as critical in the development of alliance, indicating that therapist technique may be an important factor to consider. Finally, although much of the literature has highlighted the importance of collaborative factors (e.g., Tryon & Winograd, 2011), these factors were rarely acknowledged by the participants in this study. Rather, it appeared that these adult clients assigned much of the responsibility for alliance formation to the therapist, rather than the collaboration of the two (Bedi et al., 2005).

Similarly, Bedi (2006) examined the clients' perspective on working alliance formation in order to identify, categorize, and model clients' understanding of working alliance formation factors. The results of this study correspond to the 8 alliance formation categories developed by Bedi, Davis, and Arvay (2005) and the 25 categories developed by Bedi, Davis, and Williams (2005). Based on the Bedi (2006) study, validation, education, nonverbal gestures, and presentation and body language were rated among the most important categories, suggesting that they play a major role in the developing model of the client's perspective on the working alliance. The author concluded that several variables have been largely overlooked in previous alliance research, including counselor's personal characteristics, counselor's subtle nonverbal behavior, and the counseling environment. A final interesting note that the author made is that the working alliance factors identified by client participants were not necessarily accurate reports of actual events that took place in their counseling (Bedi, 2006). Clients may have been speculating about what they think makes a good working alliance, or may have had misperceptions about what actually went on. Therefore, it is important to measure what actually goes on in therapy, as well as what clients perceive to be important factors, in general.

Zhang and Burkard (2008) provided an interesting addition to the working alliance literature when they examined how client and counselor discussions of racial and ethnic

differences affected client ratings of working alliance. Fifty-one clients, ages 15 to 42, seeking treatment in a counseling center at a Midwestern university and at two community mental health agencies were surveyed in this study. There were 12 African Americans, 2 Asian Americans, 30 White Americans, 2 Hispanics, 1 Native American, and 4 participants who self-identified as "other" (biracial or multiracial). Several important findings emerged in this study. First, as hypothesized by the authors, "clients of color" indicated a more positive and stronger working alliance (as rated by the Working Alliance Inventory – Short Form (Tracey & Kokotovic, 1989)) with White counselors who openly discussed racial and ethnic differences between them during counseling than they did with counselors who did not discuss these issues. Interestingly, there were no significant differences between client ratings of counselor credibility or of working alliance when counselors of color discussed racial and ethnic differences with their White clients. The authors hypothesize that White clients may place less of an emphasis on discussion of racial and ethnic differences than clients of color. Finally, client ratings of counselor credibility and of working alliance were significantly related to the clients' gender. Specifically, men perceived a higher level of counselor credibility and working alliance than did women. However, it is unclear why this gender effect was present, as it is also inconsistent with other research. In sum, it may be important for counselors to learn how to appropriately recognize ethnic and racial differences with their clients in cross-racial counseling situations, particularly if the counselor is White (Zhang & Burkard, 2008).

Another process variable that may contribute to client ratings of working alliance is clients' pre-treatment expectation of their role in counseling (Patterson, Uhlin, & Anderson, 2008). In a recent study by Patterson et al. (2008), the authors hypothesized that client expectations play a role in psychotherapy process and outcome. They also noted that since the

1970's, only a small number of studies have examined the relationship between role expectations and working alliance.

Based on the previous research findings, Patterson et al. (2008) expected that clients' pretreatment expectations for personal commitment to therapy would positively predict clients' perceptions of working alliance. In addition, they hypothesized that clients' pretreatment expectations for counselor expertise would negatively correlate with their ratings of alliance. The study used an archival database of clients who were seen in an outpatient clinic at a university setting. Participants were 103 adult clients who were being seen by one of 31 therapists at the clinic. The participating clients completed an Expectations About Counseling-Brief Form (EAC-B) (H.E.A. Tinsley, 1982) prior to treatment, as well as a Working Alliance Inventory-Short Form Revised (WAI-SR) (Hatcher & Gillapsy, 2006) after their third counseling session. Participants' responses to the EAC-B were organized into a three-factor model consisting of Personal Commitment (e.g., expectations concerning how long one will remain in counseling, how openly one will express feelings, how much responsibility one will take), Facilitative Conditions (e.g., clients' expectations that the counselor will be genuine and accepting), and Counselor Enterprise (e.g., expectations that the counselor will offer advice during sessions, have insight into client's feelings, and help client solve problems) (Patterson et al., 2008).

Overall, results of this study indicated that clients' expectations concerning personal commitment to therapy play an important role in working alliance development (Patterson et al., 2008). More specifically, clients who expect to take responsibility and expect to commit to the work of therapy are more able to establish a strong, collaborative, productive relationship with their counselor (i.e., personal commitment is predictive of the task, bond, and goal dimensions of

working alliance). The authors concluded that counselors should take the time to address client expectations about the work involved in therapy and the commitment that is necessary for success in order to strengthen the working alliance relationship (Patterson et al., 2008).

Client and therapist ratings combined. In addition to literature on client or therapist perceptions individually, there are a number of authors who examined both types of ratings (client and therapist) at the same time. For instance, Sexton, Littauer, Sexton, and Tommeras (2005) examined the quality of the client-therapist connection (measured by a trained observer), as it related to the Working Alliance Inventory (Horvath & Greenberg, 1986). Results indicated that client-therapist connection and client personality characteristics accounted for more than 50% of the variance in the clients' and therapist' alliance ratings. The average session client-therapist connection ratings explained 20% of the variance in the clients' and 25% of the variance in the therapists' alliance ratings at the second session. This was considered an acceptable link between connection and alliance by the authors, and therefore suggests that alliance ratings by independent observers are adequate outcome predictors. In addition, this indicates that the observed client-therapist connection (i.e., clients are engaged and emotionally moved; therapists are warm, actively listening, and responding with a combination of cognitive and emotional content) reflects a significant part of the alliance.

Tryon, Blackwell, and Hammel (2007) conducted a meta-analysis to analyze the correlation of and mean difference between adult client and therapist ratings of working alliance, as well as factors that influence the alliance ratings. Fifty-two different data sets were analyzed in this study. The factors that were examined were client disturbance, length of therapy, therapist experience, alliance measures, and type of therapy. The results indicated that client and therapist working alliance ratings covary in a moderately consistent, positive way regardless of

client disturbance, therapist experience, therapy length, alliance measure, or type of treatment. The meta-analysis also revealed an effect for the difference between client and therapist ratings of working alliance, with client ratings being higher than therapist ratings. The authors offer several explanations for this difference. First, clients usually have little prior experience with therapy, and therefore have less to compare the relationship to than do the therapists. Likewise, clients may be comparing the therapeutic relationship to that of the relationship they have with other health service professionals, like physicians, which is known to be a less collaborative relationship than a therapist-client relationship (Tryon et al., 2007).

Hersoug, Hoglend, Havik, von der Lippe, and Monsen (2009a) examined pretreatment patient characteristics related to the level and development of working alliance in long-term therapy with adults, up to session 120. The authors hypothesized that they would find poorer quality working alliances when patients had more self-reported interpersonal problems, and better alliance when patients had good therapist-rated relationships or a history of better self-reported maternal care. In addition, socioeconomic status, level of education, age, gender, were examined in relation to working alliance, with females hypothesized to have a better quality of alliance. The results of this study showed that better pretreatment global functioning leads to better potential for development of alliance. In addition, higher ratings of maternal care were associated with high ratings of early alliance that continued over time in therapy. Also, good quality of current interpersonal relationships was related to a better start in therapeutic relationship. Client-rated working alliance was not associated with any patient characteristics except gender, in which alliance was rated higher by females in the beginning of therapy, but not as time went on. Therapist ratings of working alliance indicated that older age was related to

better working alliance in the beginning, but that the effects of age diminished over time (Hersoug et al., 2009a).

Similarly, Hersoug, Hoglend, Havik, von der Lippe, and Monsen (2009b) investigated the therapist characteristics that influence the quality of working alliance in long term therapy. The quality of working alliance was rated by clients and therapists at sessions 3, 12, 20, and every 20th successive session. Measures included the mother care subscale of the PBI (Parker, Tupling, & Brown, 1979), a symptom checklist, the Inventory of Interpersonal Problems (IIP-64) (Alden, Wiggins, & Pincus, 1990), the Working Alliance Inventory (Horvath & Greenberg, 1986), a structured diagnostic assessment, and a one hour clinical interview. On average, the therapists' ratings of the working alliance were lower than the patients' ratings, which correspond to the findings of Tryon et al. (2007). Therapist characteristics that impacted the client-rated working alliance were The Inventory of Interpersonal Problems (IIP) cold/detached scores, perceived mother care, and professional training and experience. First, IIP cold/detached scores were associated with lower working alliance ratings later in therapy as compared to earlier sessions. In addition, higher scores on mother care were associated with higher patient-rated alliance scores, and higher rates of therapist training was related to lower quality working alliance, as rated by clients. On the other hand, therapist characteristics of perceived mother care, therapist gender, therapist age, professional training, and professional experience had no significant impact on therapist ratings of working alliance. In sum, therapists' IIP cold/detached scores had the most consistent and most significant impact on the quality of working alliance. This therapist characteristic probably represents a distanced, disconnected, or indifferent attitude towards the client. Findings are consistent with previous research that suggests clients prefer an actively

involved and engaged therapist, rather than a silent, less responsive therapist (Hersoug et al., 2009b).

Another process variable that has been examined in relation to working alliance formation is clients' secret keeping (Kelly & Yuan, 2009). Kelly and Yuan (2009) investigated the relationship between clients keeping relevant secrets in counseling and the development of a strong, positive working alliance from both client and counselor perspective. Participants in this study were 83 clients in an outpatient mental health hospital setting and 22 therapists. Secret keeping was assessed through direct questions about what, if any, secrets the clients were keeping from their counselors, and working alliance was assessed using the WAI (Horvath & Greenberg, 1989). In addition, the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) measured social desirability of client participants. Therapists completed the WAI-S (Tracey & Kokotovic, 1989), and were also asked, "Do you believe that this particular client is keeping any relevant secret(s) from you?" and "To what extent have the complaints or symptoms that brought your client to therapy changed as a result of treatment?" (Kelly & Yuan, 2009, p. 197). Results indicated that, controlling for social desirability, clients who reported keeping a relevant secret scored significantly lower on the Working Alliance Inventory (Horvath & Greenberg, 1986) than clients who were not keeping a secret. In addition, therapists of these clients also reported weaker working alliance ratings, even though they were not informed that their clients were keeping a secret. The results suggest that either secret keeping disrupts the formation of a strong working alliance or a weak working alliance results in clients feeling less comfortable opening up and divulging their secrets (Kelly & Yuan, 2009). Regardless of the direction of the relationship, this study points out the importance of trust when developing a strong working alliance.

Assessing working alliance. Over the years, several measures of working alliance have been developed. Horvath (2001) contrasted five instrument families used most often in the working alliance research. These families are the Helping Alliance (HA; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983), Vanderbilt instruments (VPPS/VTAS; Suh, O'Malley, & Strupp, 1986), Working Alliance Inventory (WAI; Horvath, 1981; Horvath & Greenberg, 1986), Therapeutic Alliance Rating Scale (TARS; Marziali, 1984), and California Psychotherapy Alliance Scale (CALPAS; Gaston & Marmar, 1994). The analysis indicated that the effect sizes found in alliance-outcome research were not significantly different as a result of type of instrument (Horvath, 2001).

Although there are a number of instruments used for measuring working alliance, the WAI (Hatcher & Greenberg, 1986, 1989) is currently the most widely used measure of the alliance across treatment orientations (Samstag et al., 2008). The WAI is based on the highly researched theoretical model and conceptualization developed by Bordin (1979) (Horvath, 1994) and it has been used extensively throughout the research on working alliance. Horvath and Greenberg (1989) examined the development, validity, and reliability of the WAI, and the results of their study indicated adequate reliability and validity. A shortened version of the WAI has also been established and is widely used as a measure of working alliance (WAI-S) (Tracey & Kokotovic, 1989). The WAI-S is a 12-item rating scale that is used to measure working alliance. The format is a 4-point Likert scale, with possible scores ranging from 12 to 48. Busseri and Tyler (2003) examined the interchangeability of the WAI and WAI-S, and found that WAI and WAI-S scores were highly correlated for both subscales and total scores within raters. The results of their study support the use of the WAI-S as a substitute measure for the WAI (Busseri & Tyler, 2003).

Although investigators have widely used the WAI and the WAI-S for a number of years as reliable and valid measures of working alliance, some have raised concern regarding the range of responses on measures of working alliance. In order to investigate this concern, Tryon, Blackwell, and Hammel (2008) examined 63 studies on working alliance in order to examine the claim that therapists and clients tend to rate the working alliance highly. The results of this study indicated that clients and therapists do tend to use a restricted range of responses on working alliance measures, with clients using mainly the top 20% of rating points, and therapists using the top 30% of rating points. These results suggest that the alliance-outcome relationship may be even stronger than it appears in research, as the restricted range of responses may be limiting the effect sizes in many of these studies (Tryon et al., 2008).

Limitations of current working alliance research. As can be seen from the reviewed literature thus far, there is strong empirical support for the relationship between working alliance ratings and treatment outcome. However, research needs to further our understanding of how counselors can be trained to develop better alliances with their clients (Horvath, 2005). While a number of studies have investigated the process variables underlying working alliance formation, there are still many inconsistencies in their findings. In addition, as previously noted, there are developmental considerations in adolescence that suggest it may be inappropriate to generalize adult alliance research to this population (Fitpatrick & Irannejad, 2008). Not only are there developmental considerations, there are also environmental differences that impact the therapeutic process for adolescents in the schools versus adults who go to counseling in clinical or community settings. These environmental and contextual considerations are addressed in the following section.

Counseling Adolescents in the School Setting

Because the present study required adolescent participants who currently receive mandated school-based counseling, it is imperative to not only review the developmental stage of adolescence and the working alliance literature, but also the unique characteristics of the proposed counseling setting. For instance, the typical adolescent client scenario is one in which the client is mandated to attend counseling (DiGiuseppe et al., 1996). This mandate may come from parents or school administration, and is often in strong opposition to the adolescents' own desire or readiness. Additionally, adolescents in counseling often lack a clear understanding of why they are there, because they are referred by parents or by the school, and are not voluntarily seeking help. This can create an environment of uncertainty, hesitance, and discomfort if the process is not clearly and deliberately explained to the adolescent. In addition, parents, therapists, and school personnel often have treatment goals that are different from, or in strong opposition to, the adolescent's goals (DiGiuseppe et al., 1996). Therefore, even if the adolescent understands the purpose of counseling and is ready to address certain issues, this does not mean that those are the issues that the counselor will focus on during the course of treatment. For instance, the school setting often limits the desired outcomes of counseling to academically-related outcomes or classroom behavior outcomes (Fitzpatrick & Irannejad, 2008). In addition, the environment of a school setting often suggests that adults are authority figures, which could affect the comfort level of the adolescent in opening up to the school psychologist (Fitzpatrick & Irannejad, 2008).

Adolescents also differ from adult clients because they are typically unfamiliar with the activities that are expected in counseling, or how these activities relate to the goals of counseling. For instance, adults are much more likely to have friends or family members who have been to

therapy, or to have seen movies or read books that involved the therapeutic process, which leads to a greater understanding of therapeutic expectations. Adolescents, on the other hand, often enter the counseling process blindly, and will be less likely to have accurate expectations regarding the tasks of psychotherapy (DiGiuseppe et al., 1996). Therefore, it has been proposed that therapists or counselors need to provide a much clearer explanation of the techniques that will be used in counseling, and how these techniques relate to the overall goals of counseling. Unfortunately, clear explanation and specification of goals and treatment methodology are often avoided in adolescent counseling because the goals and treatment decisions are being made by someone other than the adolescent (DiGiuseppe et al., 1996).

Another important factor to consider is the treatment methodology used with adolescents. According to Holmbeck et al. (2006), most empirically supported treatments that are applied to adolescents are merely extensions of treatments intended for use with adults. In addition, there are almost twice as many outcome studies published with children than with adolescents, even though adolescents have a higher rate of psychopathology. The authors argue that it is important to consider whether or not these adult treatment approaches or outcome studies with children are at an appropriate developmental level for application with adolescents (Holmbeck et al., 2006).

Finally, the adolescent goes to counseling in a school environment, which allows for more public awareness of the fact that one is going to counseling and in turn increases risk of stigmatization or self-consciousness regarding counseling (Fitzpatrick & Irannejad, 2008). As previously noted, adolescence is a time when classmate support is more predictive of self-esteem than parental support. Due to this, it is very important for adolescents to feel secure in how their classmates view them (Harter, 1990).

Relationship of Adolescent Counseling Scenario to Working Alliance

Taking into account the environmental circumstances that surround counseling in the schools, Fitzpatrick and Irannejad (2008) investigated the relationship between readiness for change and the quality of the working alliance in adolescents ages 14 to 18. Prior to this research, the only published study relating readiness for change to the working alliance was conducted with adults, and showed that higher readiness for change predicted positive working alliances (Derisley & Reynolds, 2000). Fitzpatrick and Irannejad (2008) highlighted the important of their study because most, if not all, adolescents in school counseling are mandated to be there, and therefore are likely to exhibit much lower levels of readiness for change when compared to adults who seek out counseling on their own. The authors used the Stages of Change Scale (McConnaughy, Prochaska, & Velicer, 1983) to measure readiness for change, and the Working Alliance Inventory (Horvath & Greenberg, 1986) to measure working alliance. Results were consistent with the hypotheses, in that participants with higher Stages of Change (SoC) action scored had more positive alliances with their counselors. In particular, these clients showed higher rates of agreement on the goals and tasks of counseling. The authors suggested that adolescents' preoccupation with issues of independence and autonomy may intensify the relationship between readiness for change and the quality of the alliance. Therefore, adolescents who are not ready to accept that change is necessary may be more resentful than adults about any perceived loss of control over the goals or tasks of the counseling process (Fitzpatrick & Irannejad, 2008).

As noted previously, Patterson et al. (2008) examined clients' pretreatment counseling expectations as predictors of the working alliance. The results of their study suggest that the clients' expectations for personal commitment to therapy play a significant role in the

development of a strong working alliance. Based on their findings, the authors suggested that it is important for therapists to address the clients' expectations about the work of therapy and the commitment needed for success (Patterson et al., 2008). This is important to consider for adolescents in the school setting because, as previously mentioned, they often attend counseling for mandated purposes. In addition, they are often sent to work towards goals that are chosen by teacher or parent. Therefore, the level of commitment toward these goals and toward the work involved in therapy may be negatively affected by these circumstances, which will negatively impact the working alliance.

In light of these environmental and contextual differences, further research in the school setting is needed in order to investigate the effects of such environmental conditions on the development and strength of the working alliance.

Pilot Study for the Proposed Dissertation

In order to better understand the nature of the working alliance in adolescent school-based counseling, the researcher conducted the following study during the 2010-2011 school year. This study investigated the relationship between adolescent development and working alliance, along with the process variables that correlated with a strong working alliance in mandated, school-based counseling with adolescents. Based on the reviewed literature, the following hypotheses were made: (a) based on developmental research and previous research on working alliance, adolescents who require more autonomy and independence in their lives would yield lower ratings of working alliance than those who did no exhibit these developmental characteristics; (b) based on the developmental literature and the research on process variables underlying working alliance in the adult population, items on the Current portion of the Current Versus Ideal Counseling Questionnaire would correlate with ratings of working alliance; (c)

adolescents who had large discrepancies between their current and their ideal counseling scenarios would have lower ratings of working alliance with their counselor; and (d) based on developmental characteristics of adolescence, it was hypothesized that the most important process variables related to effective counseling (i.e., working alliance) would be those related to control and decision-making in the counseling process.

Twenty participants, ages 15 through 19 (M = 16.05, SD = 1.35), grades 9 through 12, were solicited from a high school setting in a suburban area. After school administrators gave their permission, parents/guardians of adolescents who receive mandated school-counseling were contacted. When parental consent was received, adolescents were given the opportunity to learn about the study and assent to participation prior to their involvement. Due to lack of assent, one participant withdrew from the study, resulting in a total of 19 participants who completed the study. In total, there were 15 males and 4 females; the majority of participants self-identified as White/Caucasian, while there was one Native American, one Asian American, and two students who identified as "other." All participants spoke English as their primary language, and the number of years receiving school counseling ranged from 2.5 to 10 years. In addition to the school-based counseling, 6 out of the 19 participants were currently seeing a counselor outside of school, and 8 of the 13 who were not currently seeing an outside counselor had done so in the past.

The Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989) was administered to participants in order to measure their perspective of the working alliance with their counselor. This measure is a 12-item questionnaire with a 4-point Likert scale, with possible scores ranging from 12 to 48. The Cognitive Autonomy and Self Evaluation (CASE) Inventory (Beckert, 2007) was used as a measurement of adolescent development. It is a 27-item

rating scale with a 5-point Likert response format. Total scores range from 27 to 135, although the instrument measures five separate factors; Evaluative Thinking, Voicing Opinions, Decision Making, Self Assessing, and Comparative Validation, as components of overall cognitive autonomy and self-evaluation. This measure was used to look at developmental considerations and how these developmental differences between adolescents may relate to differences in working alliance formation. In addition, the Current Versus Ideal Counseling Questionnaire (CVI) was developed by the investigator in order to examine process variables underlying working alliance formation in the schools. It is a 36-item scale broken into two 18-item sections. Two items have a yes-no response format and the other 34 items use a 4-point Likert scale. This measure had its basis in the research on process variables in the adult population, and was based on the hypothesis that adolescent clients would prefer a more autonomy-supportive therapy environment. There are two 18-item sections of this measure. One section (Current) asked clients to rate the occurrence of certain process variables in the counseling that they have experienced thus far, and the other section (Ideal) asked them to rate the hypothetical importance of such occurrences in the ideal counseling situation. The purpose of this measure was to gain further insight into what actually takes place in a school counseling session, and what the adolescents want to experience in an ideal situation. This information was thought to enhance our understanding of the process variables underlying the working alliance ratings on the WAI-S completed by the adolescents.

All participating adolescents were seen by the investigator in small groups (one to three students) during school hours on one of two days. Students were seated in an office with the investigator, and were instructed to sit on opposite sides of the room so that all information was kept confidential. After receiving verbal and written instructions, each participant was given a

packet containing a demographic questionnaire, a WAI-S-client version, a CASE Inventory, and a CVI. They filled out all questionnaires individually and submitted the completed packet to the investigator when finished. All information was kept confidential and no identifying information was written on the questionnaires.

Correlational analysis was conducted between the results of the CASE Inventory and the corresponding WAI-S ratings of the adolescents. It was hypothesized that working alliance and CASE Inventory ratings would be negatively correlated, so that higher ratings of client autonomy would correlate with lower ratings of working alliance. When the CASE Inventory was used in its entirety, there was no significant relationship found between CASE ratings and working alliance ratings (See Appendix A, Table 1). However, when only those items reflecting cognitive autonomy were included (and self-evaluation was removed) results were consistent with the hypothesis; participant ratings on items reflecting adolescent autonomy on the CASE Inventory were negatively correlated with client ratings of working alliance (WAI-S); $r(17) = -.41$, $p < .05$ (See Appendix A, Table 2). Because self-evaluation was not hypothesized to affect working alliance formation, removal of these items allowed the modified CASE inventory to more accurately reflect the intended construct (i.e., autonomy).

A second correlational analysis was conducted between the results of the Current section of the CVI and the clients' ratings of working alliance on the WAI-S. It was hypothesized that the two variables would be positively correlated, demonstrating a positive relationship between the process variables listed on the Current CVI questionnaire and the development of a strong working alliance (WAI-S). Consistent with this hypothesis, the correlation between the Current section of the CVI questionnaire and the WAI-S ratings was positive, $r(17) = .69$, $p < .01$ (See Appendix A, Table 3).

Additionally, the two sections of the CVI were analyzed through a correlational analysis. The purpose of this was to examine whether or not the client ratings of what actually occurs in therapy related to the client ratings of what they would like to experience in an ideal counseling scenario. Although the relationship between the Current counseling on the CVI and the Ideal counseling on the CVI was positive, $r(17) = .26$, this relationship was not statistically significant (See Appendix A, Table 4). This indicates that the qualities that were rated as highly desirable in the Ideal section of the CVI did not strongly correlate with what was actually occurring in counseling, as rated by the Current section of the CVI.

Finally, the discrepancy between Current and Ideal ratings on the CVI was then analyzed with the WAI-S to examine the correlation between discrepancy and working alliance. It was hypothesized that larger discrepancies would correlate with lower ratings of working alliance. Consistent with this hypothesis, working alliance ratings were negatively correlated with CVI discrepancies ($r(17) = -.40$, $p < .05$) (See Appendix A, Table 5).

Overall, the results of this study largely support the aforementioned hypotheses. First, ratings of client autonomy were negatively correlated with working alliance ratings. This finding supports the hypothesis that adolescent clients who developmentally require a greater sense of autonomy and control in their lives will report lower ratings of a working alliance with their counselor. This finding also suggests that a sense of autonomy is an important process variable contributing to working alliance formation with adolescents in the school, and that the current counseling environment experienced by these participants is one that lacks autonomy-support.

Secondly, the Current portion of the CVI questionnaire, which was developed by the examiner based on the reviewed literature on adolescent development and working alliance formation with adults, strongly correlated with ratings of working alliance. This suggests that

the process variables that were included on this measure, and that were hypothesized to underlie working alliance formation, did in fact relate to adolescents' perception of working alliance with their counselor. This finding provides a first step toward understanding the nature of working alliance formation in school-based counseling with adolescents, as there is no published literature reflecting specific process variables that contribute to successful development of a positive working alliance with this population.

A third finding was that there was only a small relationship between the two sections of the CVI. This result indicates that participants were not experiencing the same factors in their counseling relationship that they endorsed as important factors in the ideal counseling relationship. Once again, this may reflect the counselors' lack of knowledge regarding the best methodology for forming a positive working alliance with this population.

Finally, an analysis was also conducted to determine the relationship between the discrepancy of participant ratings on the two parts of the CVI and their subsequent ratings of working alliance. As was predicted, adolescents who perceived larger discrepancies between their current and their ideal counseling scenario endorsed lower ratings of working alliance.

Overall, there were several limitations to this study. First, there was a small sample size with only 19 participants. Secondly, the participants came from one specific school population, and therefore the results may not generalize to the general adolescent population. Also, some of the participants had more than one counseling arrangement (both in and out of school), or had been receiving school counseling services for a number of years (See Appendix A, Table 6 for demographic information). Even though instructed to rate just their current in-school relationship with their counselor, some students' ratings may have been influenced by their private counselors or by previous experiences with other school counselors. However, given

these limitations, the results suggest that further research is certainly warranted in order to more fully understand the process of working alliance formation with adolescents who receive mandated school counseling. In general, it appears that an autonomy-supportive environment is a critical component to working alliance development with this population. Most adolescents prefer a counseling environment that allows for a sense of choice and control, perceived trust in the counselor and the counselor's intentions, as well as clear explanations about the counseling process. Interestingly, many participants also endorsed several "external" factors as being important for an ideal scenario, such as being met with a smile at every session and having a counselor that looks well-groomed and professional. In sum, this study was intended as a first step in understanding the complex mechanisms through which a counselor can establish a positive working alliance with adolescents who are mandated to counseling; however, further research is necessary in order to fully examine this process.

Rationale and Hypotheses

Based on the reviewed literature and the results of the pilot study, it is clear that the formation of a strong, positive working alliance is a critical component in the counseling process. This statement has been supported through extensive research with the adult client population and with children and adolescents in community settings (e.g., Botella et al., 2008; Hawley & Garland, 2008; Hintikka, et al., 2006; Horvath & Symonds, 1991; Samstag et al., 2008; Shirk & Karver, 2003; Tryon et al., 2008). In addition, it is clear that the developmental stage of adolescence is a transitional stage, and that it is considered a critical period in development when one's trajectory can be significantly altered by positive or negative events and interactions (Holmbeck et al., 2006). Therefore, it is crucial that counselors who are working with these individuals approach treatment in a developmentally appropriate way, and build a relationship

that will foster positive future outcomes (Holmbeck et al., 2006). This is only possible if counselors understand how to form a strong working alliance with the adolescent clients in their schools. However, even though much of the treatment of adolescents takes place in their schools, there are no studies to date that fully explore the development and maintenance of the working alliance relationship with adolescent clients in the school setting. The combined information regarding a lack of working alliance research with this adolescent population, the developmental tasks of the stage, and the specific differences in counseling in the schools versus community-based or inpatient settings, highlight the gap in the literature regarding working alliance formation with adolescents who receive school-based counseling.

Purpose

There are several reasons for conducting the proposed study. First, it will extend previous research so that we can begin to explore the relationship between client-rated working alliance and treatment outcome when treatment is mandated school-based counseling. Second, it will determine if there is a relationship between the developmental level of the adolescents and their ratings of working alliance. Third, it will determine which, if any, of the proposed process variables underlie working alliance formation with adolescents in the school setting.

Adolescent participants will be recruited from several diverse high school settings. Level of adolescent development will be measured using selected scales from the Adolescent Autonomy Questionnaire (AAQ; Noom, 1999), a 15-item rating scale with a 5-point Likert response format. This measure was selected for the current study because it focuses on the specific area of adolescent development that is of interest to the researcher; cognitive, emotional, and behavioral autonomy.

Participating adolescents will also be administered the Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989). This will be used as a measure of working alliance between client and counselor. The researcher will not require the counselor to fill out a WAI-S, as client ratings of working alliance are more predictive than counselor ratings and observer ratings (Horvath & Symonds, 1991). In addition, because the relationship between working alliance and treatment outcome does not appear to be a function of type of therapy, length of treatment, number of participants, or whether or not the data was published (Horvath & Symonds, 1991; Horvath & Bedi, 2002), further clarification and explanation of the clients' perspective can eventually help to improve the effectiveness of the counseling process (Bedi, Davis, & Williams, 2005).

Finally, the adolescent will complete a questionnaire that asks about the current counseling situation and an ideal counseling situation from his/her point of view. The Current Versus Ideal Counseling Questionnaire (CVI) was developed by this researcher for examination of process variables underlying working alliance formation in the schools. This measure has its basis in the research on process variables in the adult population, and is based on the hypothesis that adolescent clients will prefer a more autonomy-supportive environment. There are two sections of this measure; one section (Current) will ask clients to rate the occurrence of certain process variables in the school counseling that they have experienced thus far, and the other section (Ideal) will ask them to rate the hypothetical importance of such occurrences in the ideal counseling situation. The purpose of this measure is to gain further insight into what actually takes place in a school counseling session, and what the adolescents want to experience in an ideal situation. This information is thought to enhance our understanding of the process variables underlying the working alliance ratings on the WAI-S completed by the adolescents.

In addition to the adolescent clients, their counselors will also be recruited to participate in the study. Counselors will simply be asked to fill out a brief questionnaire indicating level of client's progress during that school year. This measure will provide information regarding the relationship between client-rated working alliance and treatment outcome in mandated school-based counseling.

Hypotheses

Based on the reviewed literature regarding adolescent development, working alliance formation, and the unique environmental characteristics of mandated school-based counseling, the following hypotheses have been developed.

HO1: It is expected that several demographic variables have the potential to correlate with various major constructs. These variables (e.g., clients' number of years in school counseling; counselors' number of years post-degree experience; counselors' type of degree) will be analyzed and then subsequently controlled for if necessary.

HO2: It is hypothesized that Adolescent Autonomy (AAQ) will be negatively correlated with Working Alliance ratings (WAI-S). In other words, higher levels of self-reported autonomy will be in conflict with working alliance development in a mandated setting, which is typically an environment that does not allow for autonomous behavior.

HO3: It is expected that ratings on the Current section of the CVI will be positively correlated with Working Alliance (WAI-S) ratings. This will demonstrate the proposed relationship between factors included in the CVI and those measured by the Working Alliance Inventory – Short Form.

HO4: It is expected that discrepancies between the Current and Ideal counseling scenarios (CVI Discrepancies) will be negatively correlated with Working Alliance

ratings (WAI-S). (CVI Discrepancy will be calculated by subtracting Ideal total scores from Current total scores.) This will demonstrate the importance of consistency between the client's actual counseling experiences and client's expectations for ideal counseling experiences.

HO5: It is hypothesized that client-rated Working Alliance (WAI-S) will be positively correlated with counselor-rated treatment progress/outcome (COM). This is consistent with the reviewed literature on the relationship between working alliance and treatment outcome.

HO6: It is expected that, controlling for any significant demographic variables, CVI Discrepancy and Adolescent Autonomy (AAQ) will predict, through a regression analysis, WAI-S ratings.

HO7: It is expected that students' working alliance ratings (WAI-S) will predict counselors' outcome ratings (COM) via regression analysis.

HO8: It is expected that students' working alliance ratings as well as demographic variables that correlate significantly with COM will predict counselors' outcome ratings via hierarchical regression analysis.

Note: All hypotheses related to the AAQ will be tested using the AAQ Total Score, as well as AAQ sub-scores. Of particular interest is AAQ-A, as the reviewed literature points to a cognitive change in autonomy during adolescence.

CHAPTER III

Method

This chapter presents the methodology that was used to address the research questions and hypotheses concerning the formation of a working alliance with adolescent clients who receive mandated school-based counseling. First, participant solicitation is described. This is followed by a description of each instrument that was used in the study, as well as a rationale for using these instruments. In addition, the procedures that were used to assess client-rated working alliance, adolescent development, and the process variables associated with a positive working alliance are discussed. Finally, the investigator will present the study's design and methods for data analysis. All methodology presented was approved by the Institutional Review Board of the City University of New York.

Participant Selection and Description

The investigator solicited participation from school administration in several diverse high school settings across Long Island and New York City. The solicitation focused on high school settings because they contained the population of interest (i.e., adolescents receiving mandated school-based counseling). I contacted potential school sites by email and telephone in order to inform them about the nature and the content of the study (see Appendix B). School and district administrators were contacted as an initial recruitment tactic because their permission was necessary before I could enter the schools and recruit adolescent and counselor participants. If administrators were receptive to the initial contact, face-to-face meetings were scheduled in order to provide a more detailed overview of the study, as well as answer any questions. Depending on the particular school district, I met with several different levels of administration, as well as the relevant school faculty in order to obtain full consent to school participation. After

receiving permission to do so, I provided introductory letters describing the study, as well as consent forms to the counselors who provided mandated counseling (e.g., school psychologists and social workers) (see Appendix E). Counselors' consent form indicated that I was the principal investigator of the study and also informed them about the nature of confidentiality (i.e., students' names would not appear on any of the information gathered during the study and all results would be kept strictly confidential in a locked file cabinet). In addition, the letter explained that they had the right to withdraw at any point during the study without penalty. Counselors completed the forms and returned them to the investigator in person. Once school and faculty consent was obtained, students were recruited from the 10 consenting public and non-public (i.e., 7 public and 3 private/independent, non-public) high schools in both suburban and urban regions of New York.

The first step in student recruitment was to inform the parents/guardians about the study and to seek consent for their child's participation. An introductory letter describing the nature of the study and a consent form (see Appendix C) was sent to the parents of those students who receive mandated counseling in each school. In order to protect the confidentiality of students who receive mandated services, each school was given a set of sealed envelopes containing the introductory letter, consent form, and a self-addressed stamped envelope; return-address and postage were included on the sealed envelopes. The investigator was not given the names or addresses of any of the potential participants, and it was up to the school to put the addresses on the sealed envelopes provided. This was a way to protect the rights of the students and their families, and therefore no identifying information was ever given out directly from the school to the investigator. Depending on the administration's preference, the self-addressed envelopes contained either my mailing address or the school's mailing address. Some schools preferred to

collect the returned consent forms themselves, while others chose to have them go directly to me. In addition, some schools preferred to include their own introductory letter on school letterhead. This decision was left to the discretion of the school administration. When this was the preference, the investigator made copies of the school's letter and included it in the sealed envelopes with the consent form and introductory letter.

In most cases, parents received the envelopes by mail. School staff was told to only mail the packets to those parents whose child met the criteria for participation. Inclusionary criteria for participation were that the student was between 12 and 21 years of age, received mandated counseling in the school setting, and could read at a sixth grade reading level. The parent consent form indicated that I was the principal investigator of the study and also informed them about the nature of confidentiality (i.e., students' names would not appear on any of the information gathered during the study and all results would be kept strictly confidential in a locked file cabinet). In addition, the letter explained that all participants had the right to withdraw at any point during the study without penalty. The investigator accepted a lack of consent if parents returned the consent form and checked off "No" or if they did not return the consent form at all. In these cases, the investigator never met with the student and the student's counselor did not complete questionnaires relating to him or her.

At one of the private school settings, there was an additional form of recruitment done in person at a parent meeting that took place at the school. The school administration and school psychologists felt that recruitment might be more successful if the investigator had the opportunity to speak to parents and answer any questions face-to-face. Therefore, the investigator was invited to a parent night at the school, and was given the opportunity to distribute the letter and consent form at the beginning of the meeting. This meeting was for all

parents at the school, not only those who met the inclusionary criteria. The investigator was not informed of which parents were which, and therefore it was up to the parents to approach the investigator to return the letter or to ask questions. This school also chose to e-mail, rather than use standard mailings, in order to distribute the rest of the forms to parents who met the inclusionary criteria. In this case, parents were given the option of returning the form directly to the school, rather than mailing them to the investigator. After the school received the consent forms, they were handed over to the investigator and the rest of the study proceeded in the same way as it did with the schools who mailed the letters home.

Another caveat to the initial methodology was that two schools that chose to participate were secondary schools serving middle and high school students in the same building or on the same campus. In these cases, because the setting and types of services overlapped, all middle school adolescents who were able to read at the required level were also included in the recruitment process. Those who were considered to have borderline reading levels or who were likely below the required reading level received questions read aloud by the investigator. However, if comprehension remained an issue even with questions read aloud, these participants were not included in the final data analysis.

After parental consent was received, the investigator contacted the particular point person at each school. In some schools a school psychologist was the main contact, while in others it was a social worker or director of special education. This faculty member was given the final list of students who had parental consent, and it was then decided how/when the investigator would meet with each student to provide an assent form (see Appendix D) and collect data. Although the investigator only met with students who had parental consent to participate, all students were

also given the opportunity to hear about the study and decide whether or not to participate. No student participated in the study without providing assent.

Although the investigator was able to make initial contact with over 25 schools in the New York area, only 10 of those schools agreed to participate in the research. The number of parents who were contacted at these schools came to 311. However, there was a low response rate from parents (21%), even when schools allowed for reminders to be sent out, and therefore the number of parents who consented to have their child participate was 65. Of the 65 who had parental consent, three students chose not to provide assent, one student moved out of state, and one was unable to complete the questionnaires at the required reading level, even when questions were read aloud to her. Therefore, the resulting number of student participants was 60. See the following tables (Table 1 and Table 2) for a summary of participant descriptive information.

Table 1

Descriptive Data for Student Participants

School Name	Type of School	# Student Participants	Internalizing Students	Externalizing Students	Int/Ext Combined	# Students Outside Couns	# Students Outside Couns Past
School A	Public	1	1	0	0	0	1
School B	Public	5	3	2	0	1	3
School C	Public	3	1	1	1	0	0
School D	Public	9	6	1	2	2	2
School E	Non- Public	14	6	6	2	5	5
School F	Non- Public	8	7	1	0	0	1
School G	Non- Public	1	1	0	0	1	0
School H	Public	3	1	1	1	2	0
School I	Public	15	10	1	4	6	5
School J	Public	1	1	0	0	0	1
TOTAL PUBLIC	7	37	23	6	8	11	12
TOTAL NON-PUBLIC	3	23	14	7	2	6	6
OVERALL TOTAL	10	60	37	13	10	17	18

Descriptive Data for Student Participants Continued

School Name	Mean Yrs in School Counseling	Mean Sessions w Counselor	Grade Range	Age Range	Gender	Ethnicity	# Students w English First Language
School A	4-6	10 +	12	17	1M	1 H	1
School B	3-5	10 +	9-12	14-17	4M, 1F	5 C	5
School C	2-4	4-6	7-10	13-16	2M, 1F	2 C; 1 H	3
School D	3-5	5-7	9-12	14-18	6M, 3F	5 C; 2 AfA; 2 H	9
School E	3-5	8-10	6-9	12-16	11M, 3 F	9 C; 1 AsA; 3 H; 1 NA	14
School F	5-7	10 +	10-12	15-18	8M	7 C; 1 AfA	8
School G	7-9	10 +	11	16	1M	1 H	1
School H	2-4	10 +	9-11	14-16	3F	2 C; 1 H	3
School I	6-8	5-7	9-12	14-18	7M, 8F	8 C; 6 Other; 1 H	15
School J	1-3	7-9	12	20	1M	1 C	1

Note. M = Male, F = Female; H = Hispanic/Latino, C = Caucasian/White, AfA = African American, AsA = Asian American, NA = Native American

Table 2

Descriptive Data for Counselor Participants

School Name	Type of School	# Counselor Participants	Mean Years P.D. Experience	Gender	Mean Age	Theoretical Orientation	Type of Degree	Job Title
School A	Public	1	0	1 M	24	1 Other	1 SP Intern	1 SP-I
School B	Public	1	34	1 M	56	1 Other	1 Ph.D.	1 SW
School C	Public	1	12	1 F	42	1 CB	1 Master's	1 SW
School D	Public	2	2.25	2 F	-	2 CB	2 Master's	1 SP, 1 SW
School E	Non-Public	7	5	6F, 1M	32	6 CB, 1 Other	5 Master's; 1 Ph.D., 1 Psy.D.	7 SP
School F	Non-Public	2	3	2 F	35	2 CB	1 Master's, 1 Other	1 SP, 1 SP-I
School G	Non-Public	1	7	1 F	30	1 Psych	1 Other (P.D.)	1 SP
School H	Public	1	0	1 F	32	1 CB	1 Master's	1 SP-I
School I	Public	5	19	5F	50	5 CB	5 Master's	4 SW, 1 SP
School J	Public	1	7	1 M	34	1 CB	1 Master's	1 SP
TOTAL PUBLIC	7	12						
TOTAL NON-PUBLIC	3	10						
OVERALL TOTAL	10	22						

Note. M = Male, F = Female; CB = Cognitive Behavioral; SP = School Psychologist, SP-I = School Psych Intern, SW = Social Worker

As can be seen from the tables, there were 60 student participants and 22 counselor participants. Student participants ranged in age from 12 – 20, represented grades 6 through 12, and all spoke English as their first language. Approximately 62% of the student participants came from public school settings, while 38 percent came from non-public settings. In addition, the majority of the students (62%) were considered to be primarily internalizing students, while 22% were considered externalizing and the other 16% presented with combined internalizing/externalizing problems. In addition, 58% of the students saw a counselor outside of the school setting either currently or in the past.

The counselor participants had similar numbers for the public and non-public setting (55% and 45% respectively). Additionally, the majority of the counselors (73%) identified as cognitive-behavioral in theoretical orientation and the majority were female (82%). Twelve of the counselors held the title of school psychologist, three were school psychology interns, and seven were social workers. The counselors' years of post-degree experience ranged from 0 (interns) to 34 and most of them had a Master's degree (73%).

Instruments

The Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989). The WAI-S is a 12-item rating scale that was used to measure working alliance from the client's perspective (See Appendix F). The response format is a 7-point Likert scale, with possible scores ranging from 12 to 48 with higher scores representing better alliances. The 36-item Working Alliance Inventory (WAI) (Horvath & Greenberg, 1986), the long form of the WAI from which the WAI-S was derived, has been the most extensively used alliance measure in the research on working alliance (Tryon et al., 2008). Horvath and Greenberg (1989) examined the development, validity, and reliability of the WAI, and the results of their study indicated

adequate reliability and validity. In addition, the WAI is based on the highly researched working alliance theoretical model developed by Bordin (Horvath, 1994).

Busseri and Tyler (2003) examined the interchangeability of the WAI and WAI-S in order to demonstrate suitable reliability and validity for the WAI-S as an effective alternative to the WAI. In their study, 54 client-therapist pairs responded to the WAI and WAI-S after their fourth therapy session and their final therapy session. Means, standard deviations, and internal consistency estimates (Cronbach's alpha) for subscale and total scores were calculated. For both WAI and WAI-S items, there was a high degree of internal consistency for subscale and total scores at both measurement points. Internal consistency for the WAI-S in the current study is $\alpha = .87$.

In addition, HLM was used to derive regression coefficients for the relationship between corresponding WAI and WAI-S scores. According to Busseri and Tyler (2003), results of this analysis indicated strong agreement between corresponding ratings on full-scale and short-form WAI scales at both measurement points. The intercorrelations among WAI and WAI-S subscales were also examined, and in all cases intercorrelations among subscales were high (client rating intercorrelations ranged from .71 - .92; therapist rating intercorrelations ranged from .66 - .95). These results suggest a high degree of shared variance among subscale scores for both types of ratings (Busseri & Tyler, 2003).

In addition, Busseri and Tyler (2003) correlated WAI and WAI-S total scale scores across rater perspective (client and therapist) in order to compare parallel client and therapist ratings. Standardized coefficients indicated a moderate amount of convergence between client and therapist for full-scale WAI scores and for WAI-S scores (Busseri & Tyler, 2003). Finally, to compare predictive validities, the authors correlated client and therapist fourth-session WAI and

WAI-S total scores with final ratings of therapy effectiveness. According to the authors, results suggested that the predictive validities for the WAI and WAI-S scores were very similar (Busseri & Tyler, 2003). Overall, the results of their study support the use of the WAI-S as a substitute measure for the WAI. Currently, the WAI-S is the second most frequently used alliance measure (Tryon et al., 2008). The WAI-S has been used in alliance studies with adolescents, the most recent of which was done by Marcus, Kashy, Wintersteen, and Diamond (2011). In addition, according to the Flesch-Kincaid Grade Level Test, the WAI-S has a seventh grade reading level, which fits the grade level and reading level for inclusionary criteria of this study.

Adolescent Autonomy Questionnaire (AAQ; Noom, 1999). Although the investigator used the Cognitive Autonomy Self Evaluation (CASE) Inventory (Beckert, 2007) as a measure of autonomy during the pilot study, the measure used for the present study was the Adolescent Autonomy Questionnaire (Noom, 1999). The reason for the change was that the CASE Inventory was not useful in its entirety. When all 20 items are included in the CASE, the instrument measures cognitive autonomy and self-evaluation; this limits the measurement of autonomy to the cognitive domain and also includes a measure of self-evaluation, which was not of interest in the present study. Therefore, the AAQ, which measures attitudinal autonomy (cognitive), emotional autonomy (affective), and functional autonomy (behavioral), was a more suitable measure of adolescent autonomy (See Appendix G) for this study.

The AAQ was developed by Noom (1999) by adapting the pre-existing Adult Autonomy Questionnaire (Bekker, 1991) to meet the developmental considerations of adolescents. The AAQ is a self-report questionnaire consisting of 15 items, with 5 items for each of the three subscales (attitudinal, emotional, and functional). According to Noom, Dekovic, and Meeus (1999), attitudinal autonomy refers to the perception of goals (e.g., “I know what I want”);

emotional autonomy refers to the perception of independence (e.g., "I don't give in to others easily"); and functional autonomy refers to the perception of strategies for self-regulating and self-control (e.g., "I go straight for my goal"). Adolescents rate each statement on a five-point scale ranging from "*a very bad description of me*" to "*a very good description of me*" with possible scores ranging from 15 to 75 with higher scores representing greater autonomy.

According to Noom et al. (1999), there is acceptable internal consistency for each subscale in the AAQ (attitudinal autonomy $\alpha = 0.71$; emotional autonomy $\alpha = .60$; functional autonomy $\alpha = .64$). In the current study, internal consistency for the AAQ Total is .84; attitudinal autonomy $\alpha = 0.79$; emotional autonomy $\alpha = .87$; functional autonomy $\alpha = .87$.

In addition, Noom et al. (2001) conducted a study to investigate the acceptability and value of the proposed three-factor model of adolescent autonomy. This investigation consisted of three steps; a conceptual analysis, a pilot study of potential items, and a confirmatory factor analysis to test the validity of the initial measure. Overall, the conceptual model was empirically tested and confirmed, suggesting that the three-factor model is an appropriate and effective way to conceptualize adolescent autonomy. More specifically, results of the analysis indicated that the three-factor model was significantly better than using one total factor. In addition, there were moderate correlations between the three subscales, indicating that they are separate entities but they also reflect a general concept of autonomy (Noom et al., 2001).

Current Versus Ideal Counseling Questionnaire (CVI). The investigator developed this questionnaire for examination of process variables underlying working alliance formation in the schools. It is a 40-item scale broken into two 20-item sections (see Appendix H). Two items have a yes-no response format and the other 38 items use a 4-point Likert scale. On the Current Section, the scale ranges from *Strongly Disagree* to *Strongly Agree*, and on the Ideal Section the

scale ranges from *Not Important* to *Very Important*. The range of total scores on the Current section is 18 to 72; total scores on the Ideal section range from 20 to 80. Higher scores on the Current section indicate that the student experiences those counseling factors frequently in his or her current school counseling scenario; higher scores on the Ideal section indicate that the student strongly endorses the same counseling factors as important in the ideal counseling scenario. This measure has its basis in the research on process variables in the adult population, as well as the literature on adolescent development. It aims to explore the importance of five proposed categories in working alliance formation: external/visual features; autonomy/control; trust/confidentiality; counselor competence/techniques; and readiness for change/expectations. Each category has four items, and each item is based on the reviewed literature on process variables contributing to working alliance formation with the adult population or the research on adolescent development (See Appendix I).

The *external/visual features* category reflects variables related to the outward appearance of the counselor and/or the counselor's office. Empirical support for the four items in this factor comes from Bedi (2006) and from Zhang and Burkard (2008).

The *autonomy/control* category reflects variables related to the adolescents' desire to be autonomous and in control over their own decisions and goals. Empirical support for the four items in this factor come from Blakemore (2009); Bordin (1979); DiGuiseppe et al. (1996); Harter (1990); Hatcher (1999); Holmbeck et al. (2006); McElhaney et al. (2009); Noom et al. (2001); Patall et al. (2008); Ryan and Deci (2000); and Vansteenkiste et al. (2006).

The *trust/confidentiality* categroy reflects items related to the adolescents' level of trust in their counselor and their level of comfort with confidentiality in the counseling process. Empirical support for the four items in this factor come from Bachelor (1995); Bordin (1979);

DiGuiseppe et al. (1996); Fitzpatrick and Irannejad (2008); Harter (1990); Horvath (2001); and Kelly and Yuan (2009).

The *counselor competence/techniques* category reflects items related to the adolescents' perception of their counselor's ability and the counselor's use of specific techniques (e.g., making eye contact). Empirical support for the four items in this factor come from Bachelor (1995); Bedi (2006); Bedi, Davis, and Arvay (2005); Bedi, Davis, and Williams (2005); Horvath (2001); and Watson and Geller (2005).

The *readiness for change/expectations* category reflects items related to the adolescents' readiness to address change during the counseling process and their expectations about the counseling process. Empirical support for the four items in this factor come from DiGuiseppe et al. (1996); Fitzpatrick and Irannejad (2008); Patterson et al. (2008); and Shirk and Karver (2003) (See Appendix J for scale breakdown).

Also, as previously mentioned, the CVI was initially developed for use in the investigator's pilot study. After pilot testing this measure, limitations of the previous format were noted and subsequent changes were made to the wording and formatting of items. For instance, the items on the piloted version of the CVI were not intended to represent specific constructs (e.g., external/visual features; trust/confidentiality; etc.) and therefore it was difficult to interpret participants' ratings on items and on clusters of items. In addition, the items on the Current section did not all have exact counterparts on the Ideal section. This was a limitation when comparing specific items on the two sections, and resulted in some items being removed during analysis of total scores. Therefore, the revisions to the CVI are intended to improve the validity and reliability of the measure, and to improve the practical utility of the measure.

The revised version of CVI has two 20-item sections. One section (Current) asked clients to rate the occurrence of certain process variables in the counseling that they experienced thus far, and the other section (Ideal) asked them to rate the hypothetical importance of such occurrences in the ideal counseling situation. In the present study, internal consistency was measured for each section of the CVI; Current Section $\alpha = .66$; Ideal Section $\alpha = .75$. The purpose of this measure is to gain further insight into what actually takes place in a school counseling session from the adolescents' perspectives, and what the adolescents want to experience in an ideal situation. This information is expected to enhance our understanding of the process variables underlying the working alliance ratings on the WAI-S completed by the adolescents.

Student Demographic Questionnaire. The investigator developed the student demographic questionnaire for this study (see Appendix J). This form allowed me to gain information on adolescent demographic variables, such as ethnicity, gender, age, and other variables related to experience with counseling. For instance, the students were asked how many years they received school counseling, as well as whether or not they receive outside counseling. This helped the researcher to identify, and control for, any influence of the counseling experience on the other variables of interest.

Counselor Demographic Questionnaire. The investigator developed the counselor demographic questionnaire for this study (see Appendix K). This form allowed me to obtain demographic information about the counselor, such as job title, type of degree, age, and gender. This allowed me to identify any influence of the individual counselor characteristics on the other variables of interest.

Counseling Outcome Measure (COM; Gelso & Johnson, 1983). The Counseling Outcome Measure (Gelso & Johnson, 1983) is a 4-item rating scale that assesses client progress based on the counselor's perspective (see Appendix L). This measure has a 7-point Likert response format ranging "*much worse*" to "*much better*" with respect to "degree of improvement or regression at the end of counseling in clients' feelings, behavior, self-understanding, and overall change" (Gelso, Latts, Gomez, & Fassinger, 2002, p. 864). However, because the questionnaire specifically asks about client outcome at the end of counseling, it was adapted to reflect client progress at this point in counseling, rather than after counseling is terminated.

The COM has been used in a number of studies over the years, many of which support the reliability and validity of its use. For instance, in a study by Tracey (1987), the internal consistency of the scale was reported to be .89 (alpha). In addition, Gelso and Johnson (1983) examined test-retest reliability over a three-week period and found reliability estimates ranging from .63 to .81 on individual items. Also, in a study by Gelso et al. (1997), both the client and the counselor version of the COM were used. Gelso et al. found that the coefficient alphas for both ratings were .92 (client) and .89 (counselor). In the present study, the client version of the COM was used, and $\alpha = .93$. Finally, in a study by Gelso and Johnson (1983), the authors examined the correlation between the COM and other outcome ratings based on structured interviews, providing validity support for the measure.

Procedure

As previously mentioned, I obtained permission from school and district administrators as a first step. Then, school faculty who provide mandated counseling were contacted and asked to provide consent for their participation (Appendix E). The investigator then gave or mailed

introductory letters and consent forms to all parents/guardians of students who receive mandated counseling in the participating high schools (Appendix C).

After parental consent was received, students were asked to meet with the investigator during the school day in a private location. All data collection took place in the students' spring semesters between the months of March and May. The exact time of day and location was dependent on the specific school and the administrators' policies, but was never more than one school period (approximately 40 minutes or less). On average, students took 15 to 20 minutes to complete the survey. All students met with the investigator individually or in small groups. The counselors were asked to determine all of the grouping arrangements, as they had the best knowledge of the students and the types of groups that would be most appropriate. However, the investigator never allowed for a group larger than three students at a time so that the students could be monitored while they completed each questionnaire. The investigator also told the counselors that students should only be grouped together if they have knowledge of each other's counseling services (i.e.., they have worked in a counseling group together) and if they read at approximately the same level. This was a precaution taken by the investigator to make sure that students would feel comfortable together in the room and would work at about the same rate.

When students entered the room, they were given verbal and written instructions, and were given the opportunity to ask any questions they had before we began. Each participant was asked to provide assent (Appendix D), and they were told that even after they started they could change their mind and stop at any point. This confirmed their voluntary participation and understanding of the study. After providing assent, each participant was given a packet containing a *WAI-S-client version* (Appendix F), an *Adolescent Autonomy Questionnaire (AAQ)* (Appendix G), a *Current versus Ideal Counseling Questionnaire (CVI)* (Appendix I), and a

demographic questionnaire (Appendix J) in counterbalanced order. They were asked to complete all questionnaires individually and privately, and submit the completed packet to the investigator when finished. Participants were permitted to ask questions and/or seek clarification throughout the session. All information was kept confidential and no identifying information was written on the questionnaires. Each packet was coded with a number so that the counselors' corresponding questionnaires could be matched to the student questionnaires during data analysis.

On a separate occasion, counselors of the participating adolescents were asked to fill out one brief questionnaire containing demographic questions (Appendix K). This questionnaire took no more than 1 minute and only needed to be filled out once by each counselor. Also, counselors were asked to complete the Counseling Outcome Measure (see Appendix L) for each client they had that participated in the study. This questionnaire had 4 items, as well as an additional 2 items that asked how many sessions (estimated) that they have had with each particular client and whether the client presented with internalizing or externalizing issues. This form took no more than 2 minutes to fill out for each student. Again, all information was kept confidential and no identifying information was written on the questionnaires.

Data Analysis

In the first stages of analyses, all variables in the study were analyzed via descriptive statistics. This included demographic information (client and counselor) as well as questionnaire ratings.

The second stage involved correlational analyses. First, demographic variables were examined in correlational analyses. There were no specific hypotheses related to these variables, so all student and counselor demographics were analyzed using a two-tailed correlation with

each major construct. The purpose of this stage was to determine which, if any, variables (client and/or counselor) needed to be controlled for in the regression analysis. If any correlations did exist, they need to be controlled for or added to the regression model so that the model effectively took them into account.

In addition to correlations between demographic variables and the major constructs, several additional correlations were done in order to examine the hypothesized relationships between constructs. For instance, the correlation between adolescent autonomy (AAQ) and working alliance (WAI-S) was analyzed, as well as adolescent autonomy and CVI discrepancy ratings. CVI Discrepancies were calculated by subtracting individual's Ideal total scores from the Current total scores on the CVI. Thus, a negative discrepancy score means that the student's current experience does not meet his ideal counseling scenario. During this analysis, CVI discrepancies and corresponding working alliance ratings were examined, as well as the Current CVI ratings and working alliance. Finally, working alliance ratings were examined with the corresponding Counseling Outcome Measure ratings via correlational analysis. The purpose of each of these correlational analyses was to test hypotheses about the relationships between the constructs.

The third stage of analysis involved regression analysis to determine whether the hypothesized client-rated variables predicted counselor-rated outcome. Three separate regression analyses were run. The first was done with WAI-S as the dependent variable. The aim of this analysis was to determine if adolescent autonomy and CVI discrepancy predicted working alliance ratings, as hypothesized. The second regression analysis examined student-rated working alliance as a predictor of the counseling outcome measure. The third regression examined the relationships of all variables that were hypothesized to predict counselors' ratings

of student progress in counseling. Therefore, the counseling outcome measure was used as the dependent variable, and two steps of independent variables were included. First, demographic variables that were flagged with significant correlations with COM ratings were entered as independent predictors. Then, a second step was entered with working alliance ratings (WAI-S).

CHAPTER IV

Results

The aim of this study was to examine the relationship between student-rated working alliance and counselor-rated outcome/progress in mandated school-based counseling. Another primary goal of the study was to determine which counselor, client, or counseling factors predict a strong working alliance, as rated by the student client. Lastly, the study examined whether or not client autonomy predicted client-rated working alliance, and subsequently whether or not working alliance predicted counselor-rated outcome. This chapter provides results for these hypotheses.

Descriptive Statistics

Demographic information was collected for both student and counselor participants. Student variables include age, grade, ethnicity, gender, language, years in school counseling, number of sessions with current school counselor, whether they attend a private or public school, whether or not they see any counselor outside of the school setting and, if not, whether or not they have ever seen an outside counselor. Likewise, counselor demographic variables include gender, age, job title in the school, type of educational degree, theoretical orientation, and years of post-degree experience. As previously mentioned, a summary of these findings, organized by school, can be found in Table 1 and Table 2 in the Participant Selection and Description section.

Table 3 presents the descriptive statistics for student responses to the Adolescent Autonomy Questionnaire (AAQ) (Total scale and subscales), Current versus Ideal Counseling Questionnaire (Current Section, Ideal Section, and CVI Discrepancies), Working Alliance Inventory – Short Form (WAI-S), and the Counseling Outcome Measure (COM). Because these instruments are not normed, interpretation of the descriptive statistics is limited to a general

overview of the range of scores and relative comparison to scores that as possible on the instruments. For instance, as can be seen from the table, students endorsed an average range of 1.75 to 3.9 on the CVI's 4-point scale, demonstrating relative use of the full range of options. As was previously mentioned, the investigator developed this scale for the current research and therefore there is no previous research for which to compare these ratings. However, results do suggest that the range of options is appropriate for the scale items. In addition, on the WAI-S students endorsed and average range of 1.25 to 4.7 on the questionnaire's 7-point scale, with totals ranging from 16 to 56. According to Tryon et al. (2008) clients and therapists tend to use a restricted range of responses on working alliance measures, with clients using mainly the top 20% of rating points. However, this does not appear to be consistent with the current findings, as the range of possible total scores is 12 to 84, and the students in the present study ranged from 16 to 56. This suggests that there may be a difference in the response tendency of students who are responding to working alliance measures regarding mandated counseling versus clients who are responding to the same questionnaire in a voluntary and/or adult counseling setting. Unfortunately, there is no research of this nature for the AAQ and the COM, and therefore descriptive statistics cannot be interpreted in relation to any documented trends.

Table 3
Descriptive Statistics for All Scales and Subscales

	N	Minimum	Maximum	*M*	*SD*	Coefficient Apha (α)
Current Sum	60.00	52.00	78.00	63.37	6.04	0.66
Ideal Sum	60.00	35.00	70.00	59.05	6.91	0.75
CVI Discrepancy	60.00	-23.00	13.00	-4.32	7.32	
AAQ Sum	60.00	21.00	62.00	48.00	7.45	0.84
AAQ-A	60.00	7.00	22.00	15.75	3.23	0.79
AAQ-E	60.00	9.00	23.00	15.38	3.15	0.87
AAQ-F	60.00	5.00	25.00	16.87	3.88	0.87
WAI-S Sum	60.00	16.00	56.00	42.33	8.02	0.87
COM-Ave	60.00	2.50	7.00	5.04	1.00	0.93

Note. All variables are normally distributed based on the Kolmogorov-Smirnov test of normality

Correlational Analyses

Before reporting correlational statistics, it is important to address the underlying assumption of linear relationships between constructs. Therefore, in order to visually inspect the data related to the assumption of linearity, all correlations between major constructs were analyzed via scatterplots with Lowess lines. The result of this visual inspection was that all major constructs with which significant correlations are reported did pass a visual inspection of linearity. See Appendix for M scatterplots.

Correlations between demographic variables and major constructs. First, demographic variables were examined in correlational analyses with the main study variables. Of particular interest was the correlation between student age and student level of autonomy. The purpose of examining this relationship was to provide support for measuring autonomy, rather than using age as an estimate of level of autonomy. Results indicated that age was not significantly related to AAQ Total scores or AAQ Subcategories (see Table 4). This supports the investigator's interpretation of the research on adolescent development (e.g., Beckert, 2007) that adolescent autonomy will not develop at a standard rate across individuals at certain ages, and therefore

must be directly measured in each individual. Because there were no specific hypotheses or assumptions related to the other demographic variables, all other student and counselor demographics were analyzed using a two-tailed correlation with each major construct.

Table 4

Correlations with Demographic Variables in Support of Hypotheses

Demographic Variables	Major Constructs							
	AAQ-SUM	AAQ-A	AAQ-E	AAQ-F	Working Alliance	CVI Current	CVI Discrepancy	Counseling Outcome
Number of Sessions	.04 (p = .74)	.04 (p = .76)	-.05 (p = .72)	.09 (p = .51)	.21 (p = .11)	.31* (p =.04)	.22 (p = .10)	.35** (p =.006)
Student Age	-.13 (p = .31)	-.09 (p =.48)	-.10 (p =.43)	-.09 (p =.48)	-.11 (p =.38)	.06 (p =.67)	-.21 (p =.11)	.16 (p =.23)
Yrs in Sch Couns	-.17 (p =.18)	-.08 (p = .55)	.02 (p = .87)	-.29* (p = .03)	-.26* (p = .04)	-.32* (p =.01)	-.01 (p =.96)	-.09 ((p =.52)
Counselor's Yrs Exp	-.14 (p = .30)	-.22 (p =.09)	-.06 (p =.66)	-.03 (p =.84)	.31* (p =.02)	.20 (p =.12)	-.20 (p =.14)	.16 (p =.22)

Note. * Significant at the $p < .05$ level. ** Significant at the $p < .01$ level; AAQ-SUM = Adolescent Autonomy Questionnaire – Total Scores; AAQ-A = Adolescent Autonomy Questionnaire – Attitudinal; AAQ-E = Adolescent Autonomy Questionnaire – Emotional; AAQ-F = Adolescent Autonomy Questionnaire – Functional CVI = Current versus Ideal Counseling Questionnaire; CVI = Current versus Ideal Counseling Questionnaire

As can be seen in the table, two demographic variables significantly related to student ratings on the WAI-S. First, number of years in school counseling was negatively correlated with working alliance (r = -.26; p < .05, 95% CI [-.48, -.01]), suggesting that the longer students stayed in school counseling, the lower they rated the working alliance relationship with their current counselor. Also, the counselor's number of years post-degree experience was positively related to working alliance (r = .31; p < .05, 95% CI [.06, .52]), so that counselors with more years experience had higher ratings of working alliance from their students. This makes intuitive sense, and also corresponds with previous literature on working alliance (i.e., Horvath, 2001; Tryon et al., 2007).

Finally, the student's number of sessions with his or her current counselor was positively correlated with counselor ratings on the COM (r = .35; p < .01, 95% CI [.11, .56]). The positive relationship between number of sessions and client outcome indicates that counselors rated higher levels of progress for students with whom they had more sessions. In the current study, the majority of the students (65%) were seen by the current counselor 10 or more times. Another 12% had between 7 and 9 sessions with the current counselor; 8% had 4 to 6 sessions; and 15% had 1 to 3 sessions with their current counselor. See Table 4 for significant correlations between demographic variables and all major constructs.

Correlations between major constructs. As hypothesized, there were also several significant correlations between major constructs of interest. First, results indicated that all three subcategories measured by the AAQ (i.e., AAQ-A, AAQ-E, AAQ-F) were significantly, positively correlated with AAQ Total scores (AAQ Total and AAQ-A r = *.82*, p < .001; AAQ Total and AAQ-E r = .59, p < .001; AAQ Total and AAQ-F r = .77, p < .001). In addition, AAQ-A was significantly correlated with each of the other two sub-categories (AAQ-E r = .30, p

< .05; AAQ-F $r = .50$, $p < .01$). However, as previously discussed, adolescent autonomy was of interest to the investigator because the need for more autonomy is thought to reflect normative cognitive development in adolescence (i.e., Blakemore, 2009; Harter, 1990; Holmbeck et al., 2006; McElhaney et al., 2009). Therefore, AAQ-A (which is the attitudinal, or cognitive subscale) and AAQ Total were used as the primary measures of adolescent autonomy throughout hypothesis testing.

In accordance with this literature and the investigator's hypotheses, adolescent cognitive autonomy (AAQ-Attitudinal) was negatively related to working alliance ($r = -.31$; $p < .01$, 95% CI [-.52, -.06]). This suggests that higher levels of adolescent cognitive autonomy correspond with lower levels of adolescents' ratings of working alliance with their counselor.

Likewise, CVI Discrepancy (i.e., discrepancy between current and ideal ratings of counseling factors) was negatively related to working alliance ratings ($r = -.23$; $p < .05$, 95% CI [-.46, -.02]); indicating that students who have larger discrepancies between their current and ideal counseling scenario have lower perceptions of the working alliance relationship with their counselor.

In addition, student ratings on the Current section of the CVI were positively correlated with the WAI-S ($r = .49$; $p < .01$, 95% CI [.27, .66]). This demonstrates the strong relationship between the counseling factors measured in the CVI and those that contribute to a strong working alliance.

Finally, student ratings of working alliance were positively correlated with counselors' ratings of student outcome/progress in counseling ($r = .43$; $p < .01$, 95% CI [.20, .62]). This particular finding is consistent with hypotheses as well as the literature on working alliance and outcome (e.g., Botella et al., 2008; Castonguay et al., 2006; Greenson, 1967; Hawley & Garland,

2008; Horvath & Symonds, 1991; Horvath et al., 2011; Hintikka et al., 2006; Karver et al., 2008; Shirk & Karver, 2003; Shirk et al., 2011).

An additional finding, which was not hypothesized, was that adolescent autonomy, as a total score, was negatively related to CVI Discrepancies (r = -.24; p < .05, 95% CI [-.47, .01]). It's not clear exactly how to interpret this particular relationship at this time. However, one explanation is that students who function as more autonomous individuals in their everyday lives are more mature and more capable of communicating their needs to their counselors. Therefore, if they are more able to ask for specific things in counseling, they may have less of a discrepancy between their actual counseling scenario and their expectations or ideal counseling scenario. This is just one possible explanation for this finding, and follow up research would be required to more fully explore this relationship. See Table 5 for a summary of these findings.

Table 5
Correlations Between Major Constructs

	AAQ-Sum	AAQ-A	CVI Current	CVI Discrepancy	WAI-S	COM
AAQ-Sum	1	.82*	.10	-.24*	-.11	-.05
AAQ-A	.82*	1	-.12	-.14	-.31**	-.13
CVI Current	.10	-.12	1	-.50**	.49**	.32*
CVI Discrepancy	- .24*	-.14	-.50**	1	-.23*	-.12
WAI-S	- .11	-.31**	.49**	-.23*	1	.43**
COM	-.05	-.13	.32*	-.12	.43**	1

Note. * Significant at the p < .05 level. ** Significant at the p < .01 level; AAQ = Adolescent Autonomy Questionnaire (Sum = total scores; A = Attitudinal Subcategory); CVI = Current Versus Ideal Counseling Questionnaire (Current = Current Counseling Section; Discrepancy = Difference between Current and Ideal); WAI-S = Working Alliance Inventory – Short Form; COM = Counseling Outcome Measure

Regression Analyses

To further examine the relationships that were found between constructs, three different regression analyses were completed. The first was done with WAI-S as the dependent variable. The aim of this analysis was to determine if adolescent cognitive autonomy (AAQ-A) and CVI discrepancy predicted working alliance ratings, as hypothesized. In addition, demographic variables that were significantly correlated with working alliance ratings (i.e., counselor's number of years post-degree experience, and number of years in school counseling) were added to this analysis in order to determine whether or not the relationship between adolescent autonomy, CVI discrepancy, and working alliance changed as a result of controlling for these variables. See Table 6 and Table 7 for a summary of these results.

Table 6

Regression Analysis to Predict Working Alliance: Model Summary

Model	*R*	*R* Square	Adjusted *R* Square	Standard Error of the Estimate	*R* Square Change	*df*1	*df*2	Sig. *F* Change
1[a]	.444	.197	.169	7.32	.197	2	57	.002
2[b]	.556	.309	.259	6.91	.113	2	55	.016

Note a. Predictors: (Constant), Number of Years in School Counseling, Counselor Years Post-Degree Experience

Note b. Predictors: (Constant), Number of Years in School Counseling, Counselor Years Post-Degree Experience, Attitudinal Autonomy (AAQ-A), CVI Discrepancy

Note c. Dependent Variable: WAI-S Sum

Table 7

Model Summary for Regression Analysis Predicting Working Alliance Ratings

		Unstandardized		Standardized	*t*	Sig.
	Model	B	Std. Error	Beta		
1	(Constant)	46.03	2.63		17.51	.000
	Counselor Years Post-Degree Experience	.27	.09	.37	3.03	.004
	Number of Years in School Counseling	-2.20	.82	-.32	-2.68	.010
2	(Constant)	57.89	5.41		10.70	.000
	Counselor Years Post-Degree Experience	.19	.09	.25	2.13	.038
	Number of Years in School Counseling	-2.25	.78	-.33	-2.90	.005
	AAQ-A	-.79	.29	-.31	-2.61	.012
	CVI Discrepancy	-.25	.13	-.22	-1.93	.059

Note. AAQ-A = Adolescent Autonomy Questionnaire-Attitudinal; CVI = Current versus Ideal Counseling Questionnaire; Dependent variable: WAI-S Sum

The results indicate that adolescents' level of cognitive autonomy and their self-rated CVI discrepancies do in fact significantly predict working alliance ratings, as was hypothesized. In addition, results suggest that the added demographic variables (i.e., counselor's number of years post-degree experience, and students' number of years in school counseling) also contribute significantly to the prediction of working alliance ratings. Actually, when these variables were added to the equation, CVI discrepancy was no longer a significant predictor of WAI-S. Therefore, the correlation between CVI discrepancy and WAI-S may be largely attributable to the confounding influence of counselor's number of years experience. Another potential explanation is that the small sample size may be an influencing factor here. Further research is needed in order to further examine this relationship.

The second regression analysis examined adolescent-rated working alliance as a predictor of the counseling outcome measure. As hypothesized, this result was also significant, $F = 15.32$, $p < .01$. See Tables 8 and 9 for an overview of this analysis.

Table 8

Regression Analysis to Predict Counseling Outcome/Progress with Working Alliance

Model 1	Sum of Squares	*Df*	Mean Square	*F*	Sig.
Regression	11.84	1	11.84	15.32	.00
Residual	44.83	58	.77		
Total	56.67	59			

Note: Dependent variable: COM Average; Predictors: (Constant), WAI-S Sum

Table 9

Coefficients for Model 1

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta		
Model 1				*t*	Sig.
(Constant)	2.70	.61		4.39	.00
WAIsum	.06	.01	.433	3.91	.00

Note. Dependent variable: COM Average

The third regression examined the relationships of all variables that were hypothesized to predict counselors' ratings of student progress in counseling via hierarchical regression analysis. Therefore, the Counseling Outcome Measure was used as the dependent variable, and two steps of independent variables were included. First, demographic variables that were flagged with significant correlations with COM were entered as independent predictors. Then, a second step was entered, including working alliance (WAI-S). See Table 10 and Table 11 for a summary of the findings from this regression analysis.

Table 10

Model Summary for Regression Analysis to Predict Outcome with Working Alliance and Demographic Variables

					Change Statistics				
Model	*R*	*R* Square	Adjusted *R* Square	Std. Error of the Estimate	*R* Square Change	*F* Change	*df*1	*df*2	Sig. *F* Change
1 [a]	.37	.14	.12	.97	.14	7.04	1	44	.011
2 [b]	.57	.32	.29	.87	.18	11.68	1	43	.001

Note a. Predictors: (Constant), Number of Sessions w Counselor

Note b. Predictors: (Constant), Number of Sessions w Counselor, WAI-S Sum

Table 11
ANOVA for Total Regression Analysis

Model		Sum of Squares	*df*	Mean Squares	*F*	Sig.
1[a]	Regression	6.63	1	6.63	7.04	.011
	Residual	41.45	44	0.94		
	Total	48.08	45			
2[b]	Regression	15.48	2	7.74	10.21	.000
	Residual	32.60	43	0.76		
	Total	48.08	45			

		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	*t*	Sig.
1	(Constant)	4.08	.39		10.45	.000
	Number of sessions w Counselor	.32	.12	0.37	2.65	.011
2	(Constant)	2.12	.67		3.15	.003
	Number of sessions w Counselor	.24	.11	.28	2.17	.036
	WAI-S Sum	.05	.02	.44	3.42	.001

Note a. Dependent Variable: COM Average
Note b. Predictors: (Constant), Number of Sessions with Counselor, WAI-S Sum

As can be seen from the above tables, both models are significant predictors of counseling progress/outcome, and there is a significant change in the level of prediction when the second model is added. This demonstrates the predictive ability of the number of counseling sessions as well as the working alliance ratings (from the student's perspective) when the dependent variable is the counselor's rating of progress/outcome.

Summary of Findings Related to Study Hypotheses

Table 12 summarizes this study's hypotheses and indicates which hypotheses were supported by the research findings. As can be seen from the table, all 9 hypotheses were either supported or partially supported.

Table 12
Overview of Study Hypotheses

HO Number	Study Hypotheses	Supported / Not Supported
HO1	It is expected that several demographic variables have the potential to correlate with various major constructs. These variables (e.g., clients' number of years in school counseling; counselors' number of years post-degree experience; counselors' type of degree) will be analyzed and then subsequently controlled for if necessary.	Supported
HO2	It is hypothesized that Adolescent Autonomy will be negatively correlated with Working Alliance ratings (WAI-S).	Supported[a]
HO3	It is expected that ratings on the Current section of the CVI will be positively correlated with Working Alliance ratings.	Supported
HO4	It is expected that discrepancies between the Current and Ideal counseling scenarios (CVI Discrepancies) will be negatively correlated with Working Alliance ratings.	Supported
HO5	Client-rated working alliance will be positively correlated with counselor-rated treatment progress/outcome.	Supported
HO6	It is expected that, controlling for any significant demographic variables, CVI Discrepancy and Adolescent Autonomy will predict, through a regression analysis, WAI-S ratings.	Supported[a]
HO7	It is expected that students' working alliance ratings will predict counselors' outcome ratings via regression analysis.	Supported
HO8	It is expected that, students' working alliance ratings as well as demographic variables with significant correlations to COM will predict counselors' outcome ratings via hierarchical regression analysis.	Supported

Note a. Hypotheses related to the AAQ were tested using the AAQ Total Score, as well as AAQ sub-scores. Of particular interest was AAQ-A.

Review of supported hypotheses. HO1 stated that demographic variables would potentially correlate with various major constructs, although the specific variables and the directions of these relationships were not stipulated. HO1 was therefore tested via correlations

between demographic variables and each major construct. Support was demonstrated via the correlation between working alliance (WAI-S) and number of years in school counseling (r = -.26, p < .05), as well as the relationship between WAI-S and counselor's number of years post degree experience (r = .31, p < .05). Finally, HO1 was also supported by the correlation between counselor's number of sessions with client and the Counseling Outcome Measure (r = .35, p < .01).

HO2 through HO5 were tested through correlations between specific demographic variables and/or measures of major constructs. HO2 stated that adolescent autonomy would be negatively correlated with working alliance ratings (WAI-S). A correlation of -.31 significant at the p < .01 level was found between AAQ-A and WAI-S, supporting this hypothesis and suggesting that, as expected from the literature, cognitive autonomy is of particular interest in the counseling environment. HO3 asserted that the items on the Current section of the CVI and the factors measured on the WAI-S would be positively correlated. This hypothesis was supported with a correlation of .49 significant at the p < .01 level. HO4 noted that CVI Discrepancies (difference between Current and Ideal ratings on the CVI) would be negatively correlated with WAI-S ratings. This was supported by a correlation of -.23 significant at the p < 0.5 level. This finding suggests that students who have larger discrepancies between their current and ideal counseling arrangements rate the working alliance with their counselor lower than those who have similar current and ideal counseling scenarios. Finally, in accordance with the reviewed working alliance literature, HO5 asserted that working alliance ratings (WAI-S) would be positively correlated with counseling outcome/progress (COM). This hypothesis was supported with a positive correlation of .43 significant at the p < .01 level.

HO6 through HO8 were tested using regression analyses. HO6 noted that, controlling for significant demographic variables, CVI Discrepancy and adolescent cognitive autonomy (AAQ-A) would predict working alliance ratings (WAI-S). This hypothesis was supported by results of a multiple regression analysis, $F = 6.16$, $p = .001$. HO7 stated that students' working alliance ratings would predict counselors' measures of student outcome (COM), and this was also supported via regression analysis, $t = 3.91$, $p = .01$.

Finally, HO8 noted that working alliance ratings, as well as any demographic variables with significant correlations to COM, would predict counseling outcome/progress via hierarchical regression. This hypothesis was supported by the results of the hierarchical regression analysis, $F = 10.21$, $p = .01$.

CHAPTER V

Discussion

This chapter describes the central findings obtained from the statistical analyses in the present study. It also presents the educational implications of these findings, limitations of the research, and suggestions for future research related to this area of study.

Key Findings

The overall goal of this study was to extend previous research and determine whether or not the literature on working alliance applied to the setting of mandated school-based counseling with adolescents. More specifically, the aim was to examine the relationship between student-rated working alliance and counselor-rated outcome/progress in mandated school-based counseling, as well as to examine which counselor, client, or counseling factors predict a strong working alliance, as rated by the student client. Finally, the study sought to determine whether or not client autonomy was predictive of client-rated working alliance, and subsequently, whether or not working alliance was predictive of counselor-rated outcome.

Key findings pertaining to major constructs. Overall, the study revealed that there is in fact a positive relationship between client-rated working alliance and counselor-rated progress/outcome in mandated, school-based counseling with adolescents. This positive relationship is consistent with the literature previously reviewed on working alliance and treatment outcome (e.g., Auerbach et al., 2008; Botella et al., 2008; Castonguay et al., 2006; Hawley & Garland, 2008; Hintikka et al., 2006; Horvath et al., 2011; Horvath & Symonds, 1991; Karver et al., 2008; Samstag et al., 2008; Shirk & Karver, 2003; Shirk et al., 2011). Thus, results indicate that even when counseling is mandated, a good working alliance is related to a good outcome.

In addition, another variable that was significantly related to counselors' ratings of student outcome/progress was number of sessions with the student. Results indicated that counselors rated higher levels of progress or outcome for students with which they had more sessions. The results are in keeping with findings by Draper, Jennings, Baron, Erdur, and Shankar (2002) who found a positive relationship between number of sessions attended by a large, nationwide sample of college students and outcome. One plausible explanation for this is that counselors feel they have had more time to make an impact and see change in students when they have had more contact with that student over time. However, it is important to note that the progress rating in the current study is from the counselor's perspective, and it may or may not be consistent with the student's perspective of progress in counseling. In the Draper et al. study, college students rated their own outcome, but this was not the case in the current study.

Key findings regarding process variables underlying working alliance. As previously mentioned, research to this point has not clearly identified which process variables relate to working alliance, and certainly has not done so for the alliance in mandated counseling. However, based on the limited research that does exist in this general area (e.g., Bachelor, 1995; Bedi, 2006; Bedi et al., 2005; Bordin, 1979; Fitzpatrick & Irannejad, 2008; Horvath, 2001; Kelly & Yuan, 2009; Zhang & Burkard, 2008) and the investigator's own hypotheses from her clinical work, a number of variables were analyzed to try to determine which factors predict a strong working alliance in this setting. Results of these analyses indicated that numerous variables were predictors of client-rated working alliance with this sample. First, two demographic variables related to working alliance ratings: student's number of years in school counseling and counselor's number of years post-degree experience. Student's number of years in school counseling was negatively related to their ratings of working alliance with the current counselor.

Although the years in school counseling were not necessarily all with the same counselor (in fact, it is likely that they were not all with the same counselor), it appears as though the general length of time in mandated counseling within the schools may result in a lowered perception of the relationship with counselors over time. It may be that students who are in counseling for years are somewhat discouraged about the length of time it has taken to address their problems and this affects their view of the alliance. It is also possible that students who are in counseling for longer periods with different counselors judge their working alliances with each in comparison to their alliances with prior counselors. Tryon et al. (2007) found that counselors usually indicate a lower working alliance than do their clients. These authors believed that one reason for counselors' lower alliance ratings is because they have experience with several clients, and thus, have developed a more realistic picture of the alliance than their clients. Clients, on the other hand, who do not generally have extensive experiences with different counselors, may rate the alliance relative to other standards (e.g., their relationship with medical doctors). Following this line of reasoning, one would expect that the more experience clients have with different counselors, the lower their alliance ratings would be.

On the other hand, counselor's number of years post-degree experience was positively related to student ratings of working alliance. This is also in line with previous research conducted by Horvath (2001), suggesting that counselor experience may be an important factor to consider when developing this therapeutic relationship. There are a number of possible explanations for this finding. For example, one explanation is that counselors with more experience are better at building rapport and developing a strong working alliance with their clients. This may be due to practice, training, etc. Another explanation is that clients have more faith and trust in a counselor whom they perceive as experienced, and therefore this higher level

of trust leads to a greater sense of alliance with the counselor. Further research would be necessary in order to understand the underlying cause of this relationship. However, it is important to note that, in general, more experienced counselors may have an easier time developing a strong working alliance in this particular counseling setting.

In addition to these demographic variables, there were two other constructs, in accordance with the hypotheses, that were related to working alliance ratings: level of adolescent cognitive autonomy and CVI discrepancy (i.e., the difference between student ratings of their current and ideal counseling environment). The preliminary analysis of these variables indicated a significant, and negative relationship between each of these individual variables and working alliance ratings. This suggests that, in general, higher levels of self-rated cognitive autonomy relate to lower levels of client-rated working alliance in mandated school-based counseling. This is in line with the investigator's hypotheses, and suggests that adolescents' need for an autonomy-supportive environment may be in conflict with the setting created by typical mandated counseling scenarios in schools (e.g., DiGuiseppe et al., 1996; Fitzpatrick & Irannejad, 2008). It also suggests that an evaluation of students' level of autonomy may be an important step in the early stages of the counseling process, so that counselors can accurately account for this individual characteristic in each of their clients.

In addition, the negative relationship between CVI discrepancies and working alliance ratings indicates that it is important for students' actual counseling scenarios to be in line with what they expect or desire out of the counseling process. If the "ideal" and the "current" do not line up, there may be a negative impact on working alliance between that student and his/her counselor. This finding is related to the previously discussed research on the effects of client expectations in counseling (i.e., Patterson et al., 2008).

Key findings of the regression analyses. A secondary analysis was conducted in order to examine whether or not the aforementioned variables maintained their predictive strength when taken together in a regression analysis. The results indicated that adolescent cognitive autonomy and CVI discrepancies, when taken together, were significant predictors of working alliance ratings. Also, the additional information gained from including student's number of years in school counseling and counselor's number of years post-degree experience suggested that these factors also add significantly to the prediction of working alliance ratings. The results of this analysis suggest that working alliance ratings can be predicted by examining adolescents' level of cognitive autonomy, the consistency between their current and ideal counseling scenario (i.e., expectations of counseling), their number of years in school counseling, and the counselor's level of experience.

A final regression analysis indicated that the student's number of sessions with the current counselor and the student's ratings of working alliance could be used together to predict counseling progress or outcome, as rated by the counselor.

Implications for School Psychologists

While many researchers have noted the critical role of the working alliance relationship in treatment outcome (e.g., Botella et al., 2008; Hawley & Garland, 2008; Hintikka, et al., 2006; Horvath & Symonds, 1991; Samstag et al., 2008; Shirk & Karver, 2003; Tryon et al., 2008), there is no published research to date that explores the development of this relationship in mandated school counseling. This lack of research is to the detriment of school psychologists who provide this service on a daily basis.

Without any empirical support, there was no way to know if the working alliance relationship carried the same weight with the school population as it did with the adult

population (i.e., whether working alliance is in fact related to treatment progress/outcomes with this population). This was a crucial question to answer, as it determines whether or not there is a need for future research on the development and maintenance of such a relationship. The information obtained through this study provides school psychologists with the first step towards understanding the role of this relationship with their adolescent clients.

In addition, information obtained through this study provides empirical evidence as to whether or not the working alliance relationship can be developed in the same way with adolescents that it can be with adults, and whether school psychologists are using the correct strategies to form a positive and effective relationship with their adolescent clients. Likewise, information obtained through the analysis of adolescent autonomy informs school psychologists about the developmental considerations that need to be acknowledged when developing a working alliance with adolescents at different stages.

Therefore, based on the findings, there are a number of specific implications for school psychologists and other counseling professionals in the school setting.

First, this research provides evidence for the relationship between client-rated working alliance and counselor-rated progress/outcome within the school setting. Therefore, counselors need to make sure that they spend time and effort developing rapport and maintaining a relationship with their clients if they want to have a positive treatment outcome. While some professionals may focus on the specifics of the intervention strategies, it is important not to overlook the importance of developing a trusting, open, supportive relationship with the client. In addition, because alliance formation carries such great weight in the counseling environment, graduate training programs and internship supervisors may want to place more emphasis on this aspect of the school psychologist training program so that it is a more focused part of the

counseling curriculum.

Additionally, the negative relationship between adolescent cognitive autonomy and working alliance in mandated school-based counseling with adolescents also has important implications for school psychologists. This finding suggests that the working alliance, which predicts treatment outcome, is largely dependent on whether or not the counseling environment is autonomy-supportive. In other words, students who perceive higher levels of their own cognitive autonomy require more perceived control, decision-making power, and autonomy in the counseling environment. As previously noted, these are not the typical characteristics of the mandated counseling environment within the schools (DiGuiseppe et al., 1996). Therefore, the first major implication of this is the need for counselors to assess the level of autonomy in their adolescent clients. As was noted by the statistical relationship between client age and client level of cognitive autonomy, age is not a sufficient indicator of autonomous behavior. Therefore, counselors must employ specific measures for assessing the level of autonomy-support that their adolescent clients will need. This suggests that further research may also be necessary to develop a measure that is most useful and valid for this purpose. The AAQ, which was used in this study, is probably not an appropriate measure to use in the clinical setting. Students' autonomy would need to be assessed in a less formal, and more clinically appropriate manner so that they do not enter the counseling setting and immediately begin taking formal written questionnaires. It is more likely that interview questions for the student or for caregivers (parents/teachers) regarding the student's behavior would be more valuable and a more appropriate way to examine autonomy. For instance, questions regarding daily living skills and independence, finances/allowances, and ability to travel within one's own community alone could provide the counselor with important information about the student's level of autonomy in

other settings. The key issue is that regardless of the types of questions, autonomy should be assessed when working with adolescents in this setting.

Then, a further implication is that counselors must deliberately choose to alter the typical counseling environment when working with adolescents who are seeking greater autonomy. There are a number of ways that that counselors may need to change the environment, such as differences in the goal-setting process, the type of intervention being used, the type of rapport-building techniques that are used in the beginning of the counseling process, etc. However, further research is needed to determine which aspects of the counseling environment are most in conflict with the clients' need for autonomy.

Another interesting finding with important implications is that CVI discrepancy (i.e., difference between a client's current and ideal counseling scenario) is negatively related to the students' working alliance ratings. This highlights the importance of finding out what the client expects and what the client feels is important in an effective counseling environment. This can be accomplished via a simple conversation, interview, or questionnaire about client's expectations and needs. In turn, this type of conversation can reveal important information to the counselor about how to proceed or about client misconceptions that need to be addressed prior to treatment. Depending on the length of treatment, this may also need to be an ongoing conversation that gets addressed at varying points within the course of the counseling process. For instance, as the client becomes more knowledgeable and aware of the specific tasks involved in the counseling process, his or her expectations may shift and subsequently the counselor may need to adapt the environment to meet those needs. Overall, it is important that counselors are doing their best to minimize the discrepancy between the client's current counseling environment and their ideal counseling environment, as this is predictive of the client's working alliance

ratings.

Another finding with important implications is that counselors' number of years post-degree experience is positively correlated with student ratings of working alliance. This implies that students perceive a stronger working alliance relationship with counselors who they see as more experienced. There are a number of possible reasons for this. First, students may put more trust in a counselor who they perceive as more highly qualified, therefore creating a stronger sense of alliance. Alternatively, the more experienced counselors may actually be better at developing rapport and using effective strategies to create a good working relationship with their clients. Either way, the implications of this finding are that counselors with few years post degree experience may need to spend more time developing a relationship with their student clients. They need to ensure that the students see them as qualified professionals, and that they use effective strategies for developing a strong working alliance. In addition, if it is in fact a result of inexperience, school administration may want to consider a supervision arrangement in which new school psychologists or school counselors are supervised and mentored by more experienced counselors in the school. This would allow the inexperienced counselor to receive feedback on the strategies they are implementing during the relationship-building portion of counseling.

Finally, because number of years in school counseling was negatively correlated with working alliance, this has implications for how school psychologists and school administration make decisions about mandating counseling for a particular student year after year. For instance, it may be important to give students very clear, short-term goals in counseling so that there are objectives for each semester. This would allow the student to feel success more frequently, and it would allow for a restructuring of the counseling goals more regularly. Subsequently,

counseling would not just be one long ongoing process with no end in sight; it would take on new directions and new characteristics at various points throughout the year(s). In addition, it would be useful if there were further research to determine at which point students' ratings of working alliance begin to decrease. If there is a trend in the students' perceptions, such that alliance tends to decline after a certain amount of time in mandated counseling, then there may be implications regarding the length of time that schools decide to maintain such a mandate. As an alternative, if alliance is going to decline after a certain number of years, schools may opt to refer the student to an outside professional or to change the type of counseling intervention being used within the school.

Overall, the results of this study provide school psychologists with the information that is necessary to begin to understand the development of a strong, positive working alliance with adolescents who receive mandated school-based counseling. This type of treatment is different than the types of treatment explored in previous research due to its environmental, contextual, and developmental specifications. Therefore, it is imperative that school psychologists approach this type of treatment using empirical evidence that is directly relevant to this population.

Limitations of the Present Study and Suggestions for Future Research

There are several limitations to the current study. The first limitation was the number of participants. While the sample did contain students and counselors from a range of educational settings in New York, it was difficult to get consistently large numbers of students to participate in each setting. Therefore, although the investigator was initially in contact with more than 25 schools, only 10 of those schools agreed to participate in the research. In addition, there was a low response rate from parents (21%), and therefore the number of parents who consented to have their child participate was only 65. Of the 65 who had parental consent, three students

chose not to provide assent, one student moved out of state, and one was unable to complete the questionnaires at the required reading level, even when questions were read aloud to her. Therefore, the resulting number of student participants was 60. While this sample provided sufficient information for a first step in this line of research, there is a need for a much broader sample and larger numbers of participants in order to verify these findings.

A second limitation was that counselors did not rate alliance and students did not rate outcome. Although there was research to support the use of client ratings over counselor ratings of working alliance (e.g., Hawley & Garland, 2008; Horvath & Symonds, 1991), it would be useful to compare the two types of ratings and analyze any differences that arise. In addition, it would also be beneficial to determine whether or not student ratings of their own progress are in line with the counselors' ratings. This information would allow for an examination of whether or not the same process variables are consistently predictive of outcome regardless of whether it is a student rating or a counselor rating. Similarly, a third party rating of outcome would be useful, such as a teacher or parent rating. This information would help to clarify the relationship between alliance and real change/student progress.

A third limitation is that students did not provide information about how many different counselors they had over the course of treatment within the schools. This piece of information would have been useful; particularly because number of years in school counseling was predictive of alliance ratings.

All of these limitations can be addressed in future research pertaining to working alliance in the school setting. In addition, future research may also want to include an examination of the relationship between attachment and alliance in this counseling setting. Some researchers consider working alliance to be a specialized type of attachment bond (Mallinckrodt, 1991). In

addition, a number of researchers have suggested that an important determinant of the client's ability to form a productive working alliance relationship is their early experiences of attachment and bonding with their parents (Mallinckrodt, 1991). Although theorists tend to speculate about this connection, there is not an abundance of empirical research to support or deny these hypotheses. In particular, there is no research to support these claims as they pertain to the specific population of interest in this current study.

For instance, in order to examine the relationship between attachment and alliance with adults, Mallinckrodt (1991) conducted a study analyzing adult clients' early memories of their parents' emotional responsiveness and how they affect ratings of working alliance. The author hypothesized that parental bonds would be positively related to working alliance. Results indicated that this was only true of counselor ratings of working alliance; client attachment/bond with parent was not related to client ratings of working alliance. However, clients who revealed emotionally expressive, warm, nurturing father bonds were associated with higher counselor ratings of alliance. Overall, the results of this study indicated that parental bonds (in a hierarchical regression) did not account for any variance in working alliance as rated by the client, but counselor ratings were related.

In addition to early attachment with parents, adult attachment style has also been examined in relation to working alliance. "A growing number of studies have investigated the link between clients' adult attachment and quality of working alliance" (Mallinckrodt, Porter, & Kiviligham, 2005, p. 88). However, Mallinckrodt et al. (2005) makes the distinction between adult attachment and adult working alliance by specifying that secure attachment involves explicitly feeling persuaded to explore uncomfortable events in therapy, while working alliance (as defined by the subscales measured on the WAI) does not explicitly measure this concept of

inner exploration.

In order to assess the psychotherapy relationship from the attachment theory perspective Mallinckrodt, Gantt, and Coble (1995) developed the *Client Attachment to Therapist Scale (CATS)*. However, further research in this area is necessary in order to tease out the differences between attachment to therapist and working alliance relationship with therapist. In addition, all of this research should be extended to the child/adolescent population, and to the school setting involving mandated counseling.

Conclusions

The purpose of this study was to extend previous research and determine whether or not the literature on working alliance applied to the setting of mandated school-based counseling with adolescents. Due to the extensive amount of literature on the relationship between alliance and outcome in other counseling settings, it was critical to determine if this relationship held the same weight with the adolescent population in the school setting who receive mandated counseling. This was an important question to answer because of the number of adolescents who receive these types of services in school, and because of the aforementioned risk factors associated with adolescence (e.g., Alonso et al., 2005; Bava & Tapert, 2010; Davey et al., 2008; Kerig & Wenar, 2006).

Based on adolescent development literature, as well as the literature on working alliance formation in other settings, hypotheses were made regarding the nature of this relationship and the types of variables that would contribute to the development of a strong working alliance in the school setting. Results of the study were largely in support of these hypotheses, indicating that variables such as level of adolescent cognitive autonomy and the amount of discrepancy between adolescent's current and ideal counseling scenario were predictive of student working

alliance ratings with their counselors. In addition, this student rating of working alliance strongly predicted counselor ratings of student progress or outcome in counseling.

As was previously discussed, these findings have important implications for school psychologists and other professionals who provide counseling within the schools. Counselors need to account for the developmental tasks of adolescence by creating a more autonomy-supportive environment for those clients. In addition, they need to create a counseling setting that is in line with student expectations, or help to restructure those expectations, so that the ideal is in line with the actual counseling environment. If counselors do not address these important variables, working alliance may suffer, subsequently diminishing the effects of the counseling intervention being implemented.

Appendix A

Data from Pilot Study

Table 1

Correlation between Working Alliance Ratings and Full CASE Inventory

	WAI-S	CASE Inventory
Pearson Correlation	1	.256
Sig. (1-tailed)		.153
N	18	18

Table 2

Correlation between Working Alliance Ratings and CASE Inventory (Selected Items)

	WAI-S	CASE Inventory – Selected Items
Pearson Correlation	1	-.406*
Sig. (1-tailed)		.047
N	18	18

*Note: Correlation is significant at the $p < 0.05$ level.

Table 3

Correlation between Working Alliance Ratings and Current Counseling Ratings on CVI

	WAI-S	CVI – Current Section
Pearson Correlation	1	.693*
Sig. (2-tailed)		.003
N	19	19

*Note: Correlation is significant at the $p < 0.01$ level.

Table 4

Correlation between Current and Ideal Sections of the CVI

	CVI – Current Section	CVI – Ideal Section
Pearson Correlation	1	.262
Sig. (2-tailed)		.279
N	19	19

Table 5

Correlation between CVI Discrepancies and Working Alliance Ratings

	WAI-S	CVI Discrepancies
Pearson Correlation	1	-.400*
Sig. (1-tailed)		.050
N	18	18

*Note: Correlation is significant at the $p < 0.05$ level.

Table 6

Participant Demographic Information

Mean Age	Mean Grade	Gender		Mean # Years in School Counseling	% Currently Seeing Private Counselor	% Previously Saw Private Counselor
		% Male	% Female			
16.05	10.53	78.95	21.05	4.63	31.58	61.54

*Note: *% Previously Saw Private Counselor* excludes those who are currently seeing a private counselor.

Appendix B

School Administration Script

My name is Amanda Cenerelli and I am a student in the Ph.D. Program in Educational Psychology at The Graduate Center of the City University of New York (CUNY). I am interested in completing my dissertation this year and am seeking high schools to allow me to contact parents/guardians of their students who receive mandated school-based counseling in order to request participation. In addition, I am seeking participation of faculty members who provide mandated counseling services. The purpose of my study is to examine the development and maintenance of a strong, positive working alliance in mandated school-based counseling with adolescents (high school students).

Background Information about the Study: The term working alliance refers to the extent to which client and counselor work collaboratively and purposefully, and connect emotionally. Extensive research with clients outside of the school setting has shown that regardless of the type of treatment, clients who feel that there is a strong working alliance have better treatment outcomes. There has also been extensive research with adults to try to determine what variables underlie the development of a strong working alliance during the counseling process. This information is very helpful for counselors because it allows them to choose strategies/tools that will foster the development and maintenance of the working alliance relationship, and in turn produce greater treatment effects for their clients. But, there is no research to date that examines the development of this relationship in the school setting. So, counselors in the schools are working without research to guide them on how to develop this very important relationship.

With the school's permission, I would like to contact parents with a letter and explain the study, seeking parental consent for their child's participation. If students are able to participate, I will provide them with several questionnaires at the school's convenience, and the process should take no more than one school period (45 minutes). If counselors agree to participate as well, they will be asked to answer one questionnaire that will take no more than 2 minutes per counseled student.

None of the questionnaires will ask any details about why the students are in counseling or what is discussed, and everything will be kept anonymous and confidential (no names or identifying information on anything). The questions will pertain to how students' feel about the counseling process, as well as some demographic questions. Names of schools, counselors, students, etc. will not be included, so there will be no identifying information at any level.

Appendix C

PARENT/GUARDIAN PERMISSION FORM

My name is Amanda Cenerelli and I am a student in the Ph.D. Program in Educational Psychology at The Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project, entitled "An Investigation of Working Alliance in School-based Counseling with Adolescents." This is a research study of adolescents' relationships with their counselors in school, and the factors that lead to a positive working relationship between client and counselor. At this time, your son/daughter's school administration has agreed to participate in this study, pending parental permission for each individual.

I would like permission to ask your son/daughter about his/her experiences in counseling by filling out written questionnaires that ask general questions about your child's experience with his/her counselor in school and some of his or her own personality characteristics. None of the questionnaires will ask about what is actually discussed in counseling or about the specific details of the counseling sessions. In total, the questionnaires should take no longer than 45 minutes to complete.

Refusal to participate by yourself or your child will not result in any penalties, nor jeopardize your child's relationship with the school or their counselor. All information gathered will be kept strictly confidential, and will be stored in a locked file cabinet, to which only I will have access.

The risks involved in this study are no more than encountered in everyday life. The benefit of participation is that your child will provide crucial information on how to most effectively form a positive working relationship with adolescents who receive school-based mandated counseling.

I may publish results of the study, but names of people, schools, or any identifying characteristics will not be used in any of the publications. If you would like a copy of the study, please provide me with your address and I will send you a copy in the future.

The study described above has been explained to me. I understand that I may contact Amanda Cenerelli at (631) 513-8452 or acenerelli@gc.cuny.edu if I have any future questions about the project. I may also contact her faculty advisor, Georgiana Tryon at 212-817-8293 or gtryon@gc.cuny.edu. If I have any questions about my child's rights as a participant, I may contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York at (212) 817-7525 or kpowell@gc.cuny.edu. I understand I may keep a copy of this form.

____ Yes, I give permission for my child's participation in this study.
____ No, I do not give permission for my child's participation in this study.

_____
Child's name

_____ _____ _____ _____
Parent's signature Date Investigator's signature Date

Appendix D

STUDENT INTRODUCTORY LETTER AND ASSENT

My name is Amanda Cenerelli and I am a student in the Educational Psychology Ph.D. Program at The Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project, entitled "An Investigation of Working Alliance in School-based Counseling with Adolescents." This is a research study of adolescents' relationships with their counselors in school, and the factors that lead to a positive working relationship between client and counselor. You are being contacted because your school's administration and your parent or guardian has agreed to let you participate in this study.

If you agree to participate, you would be required to fill out several questionnaires about your experiences with your school counselor, as well as some general personality characteristics. None of the questions will ask about what is actually discussed in counseling or about the specific details of the counseling sessions. In total, the questionnaires should take no longer than 45 minutes.

If you refuse to participate, it will not result in any penalties, nor jeopardize your relationship with the school or your counselor. All information gathered will be kept strictly confidential, and will be stored in a locked file cabinet, to which only I will have access.

The risks involved in this study are no more than encountered in everyday life. The benefits of participation is that you will add to the generalized knowledge of how to most effectively counsel individuals like yourself, and on how counselors can form a positive relationship with their adolescent clients in the schools.

I may publish results of the study, but names of people, schools, or any identifying characteristics will not be used in any of the publications. If you would like a copy of the study, please provide me with your address and I will send you a copy in the future.

The study described above has been explained to me. I understand that I may contact Amanda Cenerelli at (631) 513-8452 or acenerelli@gc.cuny.edu if I have any future questions about the project. I may also contact her faculty advisor, Georgiana Tryon at 212-817-8293 or gtryon@gc.cuny.edu. If I have any questions about my rights as a participant, I may contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York at (212) 817-7525 or kpowell@gc.cuny.edu. I understand I may keep a copy of this form.

____ Yes, I consent to participate in this study.
____ No, I do not consent to participate in this study.

_____	_____	_____	_____
Participant's signature	Date	Investigator's signature	Date

Appendix E

COUNSELOR INTRODUCTORY LETTER AND ASSENT

My name is Amanda Cenerelli and I am a student in the Ph.D. Program in Educational Psychology at The Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project, entitled "An Investigation of Working Alliance in School-based Counseling with Adolescents." This is a research study of adolescents' relationships with their counselors in school, and the factors that lead to a positive working relationship between client and counselor. I would like permission to ask you questions about your clients' treatment progress thus far.

In total, the questionnaires should take no longer than 2 minutes per participating client. All information gathered will be kept strictly confidential, and will be stored in a locked file cabinet, to which only I will have access. At any time you can refuse to answer any questions or remove yourself from participation without penalty.

The risks involved in this study are no more than encountered in everyday life. The benefits of your participation is that hopefully you will add to the generalized knowledge of how to most effectively counsel individuals like yourself, and on how counselors can form a positive relationship with their adolescent clients in the schools.

I may publish results of the study, but names of people, schools, or any identifying characteristics, will not be used in any of the publications. If you would like a copy of the study, please provide me with your address and I will send you a copy in the future.

The study described above has been explained to me. I understand that I may contact Amanda Cenerelli at (631) 513-8452 or acenerelli@gc.cuny.edu if I have any future questions about the project. I may also contact her faculty advisor, Georgiana Tryon at 212-817-8293 or gtryon@gc.cuny.edu. If I have any questions about my rights as a participant, I may contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York at (212) 817-7525 or kpowell@gc.cuny.edu. I understand I may keep a copy of this form.

____ Yes, I consent to participate in this study.
____ No, I do not consent to participate in this study.

_____	_____	_____	_____
Participant's signature	Date	Investigator's signature	Date

Appendix F

Working Alliance Inventory – Short Form (Tracey & Kokotovic, 1989)

Directions: For each of the 12 items, please circle the number that best describes the counseling sessions you have had IN SCHOOL THIS YEAR.

1. My counselor and I agree about the things I will need to do in counseling to help improve my situation						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
2. What I am doing in counseling gives me new ways of looking at my problems.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
3. I believe my counselor likes me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
4. My counselor does not understand what I am trying to accomplish in counseling.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
5. I am confident in my counselor's ability to help me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
6. My counselor and I are working towards mutually agreed upon goals.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
7. I feel that my counselor appreciates me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
8. We agree on what is important for me to work on.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
9. My counselor and I trust one another.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
10. My counselor and I have different ideas on what my problems are.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
11. We have established a good understanding of the kind of changes that would be good for me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
12. I believe the way we are working with my problem is correct.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Appendix G

Adolescent Autonomy Questionnaire (Noom, 1999)

1 = “a very bad description of me”
2
3
4
5 = “a very good description of me.”

1. I find it difficult to decide what I want.	1	2	3	4	5
2. I can make a choice easily.	1	2	3	4	5
3. I often don't know what to think.	1	2	3	4	5
4. When people ask me what I want, I immediately know the answer.	1	2	3	4	5
5. I often hesitate about what to do.	1	2	3	4	5
1. When I act against the will of others, I usually get nervous.	1	2	3	4	5
2. I have a strong tendency to comply with the wishes of others.	1	2	3	4	5
3. When I disagree with others, I tell them.	1	2	3	4	5
4. I often agree with others, even if I'm not sure.	1	2	3	4	5
5. I often change my mind after listening to others.	1	2	3	4	5
1. I go straight for my goal.	1	2	3	4	5
2. I find it difficult to start a new activity on my own.	1	2	3	4	5
3. I can easily begin with new undertakings on my own.	1	2	3	4	5
4. I am an adventurous person.	1	2	3	4	5
5. I quickly feel at ease in a new situation.	1	2	3	4	5

Appendix H

Current versus Ideal Counseling Questionnaire (CVI)

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

Characteristics of my current counselor/counseling sessions in school…

1. My current counselor is the same gender as me. **YES NO**
2. My current counselor is the same race/ethnicity as me. **YES NO**
3. My counselor is always well-groomed and looks professional. **1 2 3 4**
4. My counselor's office area is organized and looks professional. **1 2 3 4**
5. My counselor wants me to work on goals that I set for myself in counseling, not ones that others have set for me. **1 2 3 4**
6. The issues that we discuss in counseling are those that are most important to me. **1 2 3 4**
7. I feel that I have control over the decisions we make in counseling. **1 2 3 4**
8. My counselor takes on much of the responsibility of deciding what problems we work on and the goals that we set. **1 2 3 4**
9. I am confident that I can trust my counselor. **1 2 3 4**
10. I am confident that my counselor always has my best interest at heart. **1 2 3 4**
11. My counselor was very clear when he/she explained what would be kept between us and what he/she would have to tell to others. **1 2 3 4**
12. I do not always feel comfortable going to my counselor because I am worried about what others will think. **1 2 3 4**
13. My counselor appears to be very qualified and good at his/her job. **1 2 3 4**
14. My counselor makes eye contact while listening to me. **1 2 3 4**
15. My counselor congratulates me when I do things to help myself. **1 2 3 4**
16. My counselor remembers and repeats back to me things that I said in previous sessions. **1 2 3 4**
17. When I began going to counseling I felt ready to work on the problems that we spoke about. **1 2 3 4**
18. When we began, my counselor explained to me how counseling would work and what is expected of me. **1 2 3 4**
19. Counseling is just like I expected it to be. **1 2 3 4**
20. I feel that counseling is something that I need at this point in my life. **1 2 3 4**

(1) Not Important (2) Little Importance (3) Important (4) Very Important

In order for counseling to be most effective for me…

1. it is important for my counselor to be the same gender as me. **1 2 3 4**
2. it is important for my counselor to be the same race/ethnicity as me. **1 2 3 4**
3. it is important that my counselor is always well-groomed and looks professional. **1 2 3 4**
4. it is important that my counselor's office area is organized and looks professional. **1 2 3 4**
5. it is important that my counselor wants me to work on goals that I set for myself in counseling, not ones that others have set for me. **1 2 3 4**
6. it is important that the issues that we discuss in counseling are those that are most important to me. **1 2 3 4**
7. it is important that I feel in control over the decisions we make in counseling. **1 2 3 4**
8. it is important that my counselor takes on much of the responsibility of deciding what problems we work on and the goals that we set. **1 2 3 4**
9. it is important that I can trust my counselor. **1 2 3 4**
10.it is important that my counselor always has my best interest at heart. **1 2 3 4**
11.it is important that my counselor is very clear when explaining what will be kept between us and what will be shared with others. **1 2 3 4**
12.it is important that I feel comfortable going to my counselor without worrying about what others will think. **1 2 3 4**
13.it is important that my counselor appears to be very qualified and good at his/her job. **1 2 3 4**
14.it is important that my counselor makes eye contact while listening to me. **1 2 3 4**
15.it is important that my counselor congratulates me when I do things to help myself. **1 2 3 4**
16.it is important that my counselor remembers and repeats back to me things that I said in previous sessions. **1 2 3 4**
17. it is important that I feel ready to work on my problems when I begin going to counseling. **1 2 3 4**
18. it is important for my counselor to explain how counseling will work and what is expected of me before we begin. **1 2 3 4**
19. it is important for counseling to be just like I expected it to be. **1 2 3 4**
20. it is important that I feel that counseling is something that I need at this point in my life. **1 2 3 4**

Appendix I

CVI Proposed Categorical Breakdown with Citations

External/Visual Features

1. My current counselor is the same gender as me (Bedi, 2006).
2. My current counselor is the same race/ethnicity as me (Zhang & Burkard, 2008).
3. My counselor is always well-groomed and looks professional (Bedi, 2006).
4. My counselor's office area is organized and looks professional (Bedi, 2006).

Autonomy/Control (Blakemore, 2009; DiGuiseppe et al., 1996; Harter, 1990; Holmbeck et al., 2006; McElhaney et al., 2009; Noom et al., 2001; Patall et al., 2008, Ryan & Deci, 2000, Vansteenkiste et al., 2006)

5. My counselor wants me to work on goals that I set for myself in counseling, not ones that others have set for me (Bordin, 1979).
6. The issues that we discuss in counseling are those that are most important to me.
7. I feel that I have control over the decisions we make in counseling.
8. My counselor takes on much of the responsibility of deciding what problems we work on and the goals that we set (Hatcher, 1999).

Trust/Confidentiality

9. I am confident that I can trust my counselor (Bachelor, 1995; Bordin, 1979; Fitzpatrick & Irannejad, 2008; Horvath, 2001; Kelly & Yuan, 2009).
10. I am confident that my counselor always has my best interest at heart (DiGuiseppe et al., 1996; Fitzpatrick & Irannejad, 2008).
11. My counselor was very detailed when he/she explained confidentiality to me (i.e. what would be kept between us and what he/she would have to tell to others) (DiGuiseppe et al., 1996).
12. I do not always feel comfortable going to my counselor because I am worried about what others will think (Harter, 1990).

Competence/Techniques

13. My counselor appears to be very qualified and good at his/her job (Horvath, 2001).
14. My counselor makes eye contact while listening to me (Bachelor, 1995; Bedi, 2006; Bedi, Davis, & Williams, 2005; Horvath, 2001).
15. My counselor congratulates me when I do things to help myself (Bedi, Davis, & Arvay, 2005; Watson & Geller, 2005).
16. My counselor remembers and repeats back to me things that I said in previous sessions (Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005).

Readiness for Change/Expectations

17. When I began going to counseling I felt ready to work on the problems that we spoke about (Fitzpatrick & Irannejad, 2008; Shirk & Karver, 2003).
18. When we began, my counselor explained to me how counseling would work and what is expected of me (DiGuiseppe et al., 1996; Patterson et al., 2008).
19. Counseling is just like I expected it to be (DiGuiseppe et al., 1996).
20. I feel that counseling is something that I need at this point in my life (Shirk & Karver, 2003).

Appendix J

Student Demographic Questionnaire

1. **How old are you? (Please Circle One)**
   14 15 16 17 18 19

2. **What grade are you in? (Please Circle One)**
   9 10 11 12

3. **Gender (Please Circle One):**
   Male Female

4. **How would you classify yourself? (Please Circle One):**

Asian American	Hispanic/Latino
Black/African American	Native American
Caucasian/White	Other :_____
Hawaiian or Pacific Islander	

5. **Is English your primary language? (Please Circle One):**
   Yes No
   - If no, what is your primary language? _____

6. **How many years have you been receiving counseling <u>in school</u>? (Please Circle One)**
   (This is my first year) (1 – 3 years) (4 – 6 years) (7 – 9 years) (10 years or more)

7. **Do you currently see any other counselor <u>outside of school</u>? (Please Circle One)**
   Yes No

   - **<u>If you answered yes to question #8</u>, how many years have you been seeing a counselor outside of school? (Please Circle One)**
     (This is my first year) (1 – 3 years) (4 – 6 years) (7 – 9 years) (10 years or more)

   - **<u>If you answered no to question #8</u>, *have you ever* seen any other counselor outside of school? (Please Circle One)**
     Yes No

Appendix K

Counselor Demographic Questionnaire

1. What is your gender (Circle One): Male Female

2. What is your age: _____

3. Please indicate your current title in the school: (Please Circle One)
a. School psychologist
b. School Psychology Intern
c. Social Worker
d. Guidance Counselor
e. Other: _____

4. What type of degree do you have?
a. Ph.D.
b. Psy.D.
c. Master's
d. Other _____

6. What is your theoretical orientation?
a. psychodynamic
b. behavioral
c. cognitive-behavioral
d. humanistic
e. Other _____

7. How many years of post-degree experience do you have? _____

Appendix L

How many counseling sessions have you had with this student? (Please Circle One)
(1 – 3 sessions) (4 – 6 sessions) (7 – 9 sessions) (10 or more sessions)

How would you classify the student's primary presenting problem? (Please Circle One)
(Internalizing) (Externalizing)

Counseling Outcome Measure

COMPARED TO WHEN HE/SHE FIRST CAME TO COUNSELING WITH YOU
(circle the number that best reflects your response):

1. How does this student seem to feel at this point in counseling?

1	2	3	4	5	6	7
Much Worse	Moderately Worse	Slightly Worse	About the Same	Slightly Better	Moderately Better	Much Better

2. To what extent does this student seem to show change in behavior at this point in counseling?

1	2	3	4	5	6	7
Much Worse	Moderately Worse	Slightly Worse	About the Same	Slightly Better	Moderately Better	Much Better

3. To what extent does this student seem to understand him/herself at this point in counseling?

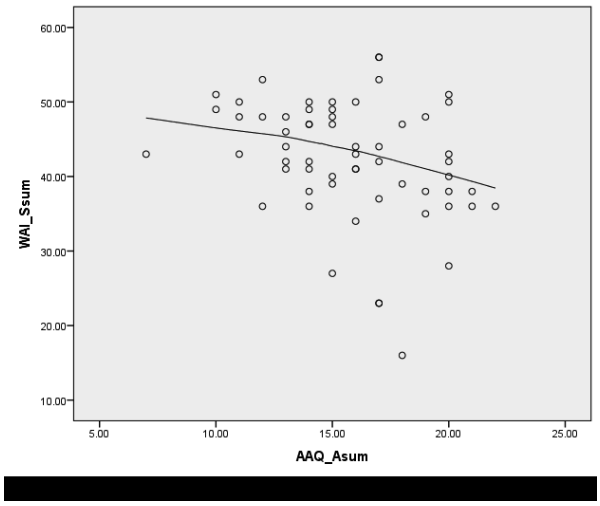
1	2	3	4	5	6	7
Much Worse	Moderately Worse	Slightly Worse	About the Same	Slightly Better	Moderately Better	Much Better

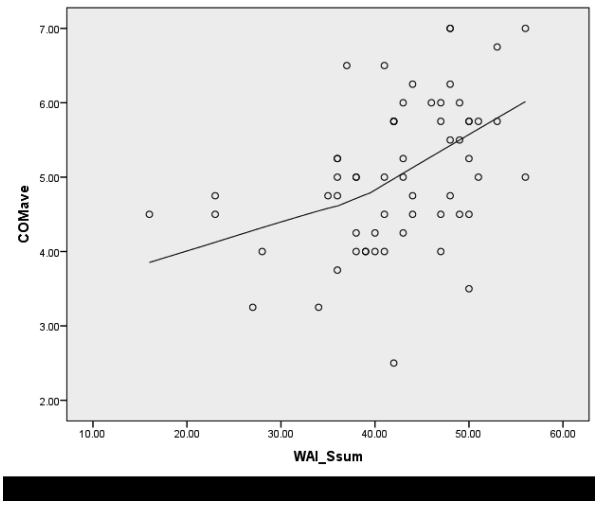
4. Rate the student's overall change in counseling.

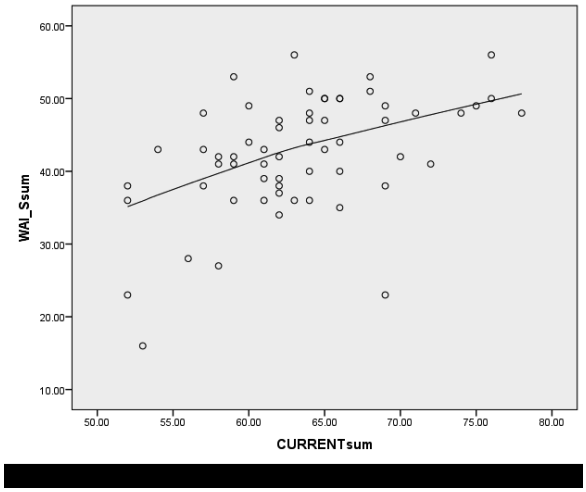
1	2	3	4	5	6	7
Much Worse	Moderately Worse	Slightly Worse	About the Same	Slightly Better	Moderately Better	Much Better

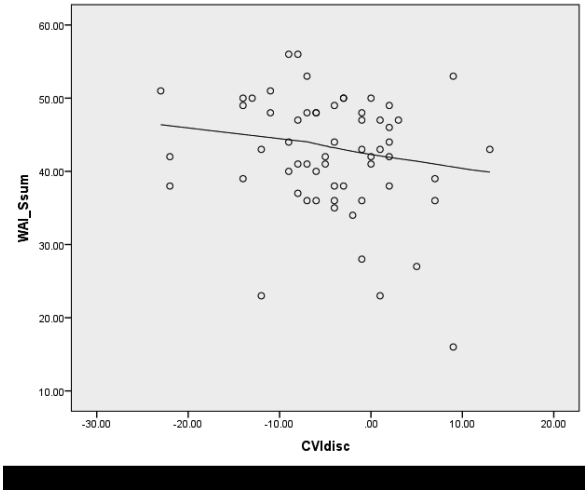
Appendix M

Scatterplots of Correlations









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