

MANDATORY COUNSELING: A MIXED METHODS STUDY OF FACTORS THAT
CONTRIBUTE TO THE DEVELOPMENT OF THE WORKING ALLIANCE

By

Tanya I. Razzhavaikina

A DISSERTATION

Presented to the Faculty of

The Graduate College at the University of Nebraska

In Partial Fulfillment of Requirements

For the Degree of Doctor of Philosophy

Major: Psychological Studies in Education
(Counseling Psychology)

Under the Supervision of Professor Michael J. Scheel

Lincoln, Nebraska

May, 2007

UMI Number: 3321123

INFORMATION TO USERS

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleed-through, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.



UMI Microform 3321123
Copyright 2008 by ProQuest LLC
All rights reserved. This microform edition is protected against
unauthorized copying under Title 17, United States Code.

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

MANDATORY COUNSELING: A MIXED METHODS STUDY OF FACTORS THAT CONTRIBUTE TO THE DEVELOPMENT OF THE WORKING ALLIANCE

Tanya I. Razzhavaikina, Ph.D.

University of Nebraska, 2007

Adviser: Michael J. Scheel

The purpose of this sequential explanatory mixed methods study was to investigate the process of mandatory counseling and factors that are pivotal in this process. Specifically, the goal of this research project was to assess how the working alliance (WA) changes at the early stage of mandatory counseling and to explain why this change occurs, based on: (a) client hope and motivation for treatment; and (b) qualitative interviews with selected clients.

In the first, quantitative phase of the study, data were collected via administration of self-report questionnaires (i.e., WAI, Hope Scale, and Motivation for Treatment Scale) to sixty-three correctional center inmates who were mandated for counseling. Preliminary quantitative analysis revealed the presence of a significant therapist effect at all points of the data collection as well as in all variables under investigation. Latent growth curve modeling analysis (LG) was conducted on the quantitative data. The growth model for WA slope was non-significant. Participants' WA trajectories were categorized into six different groups: accelerating linear, decelerating linear, relatively stable, accelerating quadratic dramatic, accelerating quadratic late onset, decelerating quadratic, and constant. Surprisingly, on average, mandated clients' WA ratings were high when compared with voluntary clients' WA ratings in other studies. The LG analysis of the data also revealed

the presence of significant variance in the WA ratings after the first counseling session.

Client hope and motivation for treatment were found to be non-significant covariates.

In the second, qualitative phase, six participants, one from each group of change in the WA, were interviewed. The participants' responses regarding their therapy experience were grouped into six themes: (1) therapy development, (2) client role, (3) therapist role, (4) client-therapist relationship, (5) therapy process, and (6) therapy outcomes. Overall, three groups of factors were found to be important in the WA development process: client, therapist, and process factors. The qualitative analysis of interviews found that therapist factors are most influential in WA formation in the area of mandated counseling. Based on the findings from both phases of the study, implications and suggestions for practice of mandatory counseling and research are also discussed.

ACKNOWLEDGEMENTS

This dissertation is the result of the assistance, guidance and support of many individuals. I am deeply grateful for the wisdom and patience of everyone who has assisted me in this six-year journey toward a doctoral degree in a new country, new culture and new academic environment. I would like to extend my special thanks and appreciation to the following people and agencies.

First, I am grateful to the women and men who participated in this research project. Thank you for sharing your experiences, thoughts and feelings with me.

I would also like to extend my sincere appreciation to my supervisory committee: Drs. Mike Scheel, John Creswell, Debra Hope and Roger Bruning. Your guidance, suggestions and support allowed the growth and development of this project. More important, you provided me with a number of opportunities to challenge my own abilities as a scientist, practitioner and person.

This project could not have been completed without the support and cooperation of the Nebraska Department of Correctional Services. The enthusiasm and assistance of not only the administration, but also the case managers and case workers greatly facilitated the data collection process and was truly appreciated.

I would like to sincerely thank three counseling clinics where the data for this project were collected: UNL Counseling and School Psychology Clinic, UNL Family Resource Center, and the Voices of Hope (formerly, Rape and Spouse Abuse Crisis Center). Special thanks to trainees and professionals who coordinated the on-site data collection, including Melanie Rudy, Amy Chatelain, Abby Bjornsen, Rebecca Graham,

Dr. Nancy Bowen, as well as all therapists and counselors who agreed to help with the data collection as they worked with clients in therapy.

In addition, I appreciated the ongoing support of my internship supervisors at the UNL Counseling and Psychological Services, Drs. Tricia Besett-Alesch and Robert N. Portnoy. Your willingness to be flexible with my working hours allowed me to finish my internship and this project simultaneously.

I am also grateful to Joy Arbor, who read almost every page of this dissertation and provided me with feedback regarding my writing style. Joy, your editing suggestions helped me to make this project sound more professional. Also, please know that a side effect of our work together on this project is significant improvements in my written English. Thank you very much for helping me to master this new language.

I will be forever indebted to my academic advisor and mentor, Dr. Mike Scheel. With your support, assistance, guidance, motivation and advising, I am not only a better professional, but a better person. Your knowledge and vision helped me conceptualize this study and bring it to the accepted scholarly and professional level. Friendship with you and your wife, Joan, made it easier for me to adjust to a new culture and find a second home in Lincoln. Thank you for helping my dream to come true!

My family and friends have been unwavering in their patience and support. I owe an enormous debt of gratitude to Dr. James Peugh. Your help with statistics allowed me to finish this project with my sanity largely intact. Thank you so much for always being there for me when I needed your help and support! You are an amazing teacher and friend!

I want to express my deep gratitude to my colleague, friend, and role model, Dr. Oksana Yakushko. Your assistance with the qualitative analysis as well as your encouragement, and support meant a lot to me.

I extend my special thanks and appreciation to my husband, Vitali Lapko. Your love, understanding, support and most important your patience with me carried me through the challenges of this project. You put up with my frustrations, shared my joy and were always available to talk to me when I needed that. You also taught me a lot about overcoming difficulties, balancing my personal and professional life and staying hopeful and positive in my outlook on life. I will keep learning from you! Thank you my newborn son Mark! You have helped me to discover a new meaning to my life. You inspire me every day!

Finally, I wish to acknowledge and thank my family in Belarus for their support of my decision to move to the United States and their unconditional love and confidence that I will succeed in pursuing my graduate education here in the USA. I am so proud to have you as my family!

DEDICATION

To my families in Belarus and the United States

Table of Contents

Chapter I—Introduction.....	1
Purpose of the Study	1
Importance of the Study.....	1
Research Questions and Hypotheses	5
Definition of Terms.....	6
Chapter II—Review of the Literature	9
Mandatory Counseling.....	9
Definitions and Types	9
Characteristics of Mandated Clients	10
Ethical Issues around Mandatory Counseling.....	13
Effectiveness of Mandatory Counseling	15
Therapeutic Factors in Voluntary and Mandatory Counseling.....	18
General Overview of Therapeutic Factors	18
Common Factors: Working Alliance	20
Working Alliance in Voluntary Counseling	22
The Development of the Working Alliance.....	25
Conclusions Related to the Current Study	26
Working Alliance in Mandatory Counseling.....	28
Conclusions Related to the Current Study	30
Client Factors: Motivation for Treatment	31
Motivation for Treatment in Voluntary Counseling	31
Conclusions Related to the Current Study	37
Motivation for Treatment in Mandatory Counseling.....	38
Conclusions Related to the Current Study	44
Placebo, Hope and Expectancy Factors: Clients' Hope.....	45
Clients' Hope in Voluntary Counseling.....	46
Conclusions Related to the Current Study	50
Clients' Hope in Mandatory Counseling	52
Literature Review Conclusions: Current Need for a Mixed Methods Study	53

Characteristics of Mixed Methods Design Research	55
Advantages and Limitations of the Sequential Explanatory Design	58
Chapter III—Methodology	59
The Present Study Design.....	59
Mixed Methods Sequential Explanatory Design	59
Implementation	60
Priority	61
Integration	61
Qualitative Research Design.....	61
Connecting Quantitative and Qualitative Data in Mixed Methods Design	63
Role of the Researcher.....	64
Ethical Considerations	64
Participants.....	67
Instrumentation	68
Independent Variables and Measures	68
Client Hope and Adult Dispositional Hope Scale.....	69
Client Motivation for Treatment and CMOTS	70
Dependent Variables and Measures.....	71
Working Alliance and WAI	71
Social Desirability.....	73
Demographic Information.....	74
Data Collection Procedures.....	75
Quantitative Procedures	75
Selection of the Participants.....	75
Quantitative Data Collection.....	76
Qualitative Procedures	77
Selection of the Participants.....	77
Interview Protocol Development	79
Qualitative Data Collection.....	80
Data Analysis	81

Quantitative Data Analysis	81
Consideration of Therapist Effect	82
Qualitative Data Analysis	85
Validation Procedures	88
Chapter IV—Results	91
Quantitative Results	91
Participants Demographic Information	91
Age	91
Gender	91
Ethnicity	91
Past Experiences with Counseling	92
Latent Growth Curve Modeling Analysis Results	92
Examination of Growth Over Time: Unconditional (without Covariates) Model of Working Alliance Growth	93
Examination of the Covariates' Contribution: Conditional Model (with covariates) of Working Alliance Growth	96
Qualitative Results	97
Participants Demographic Information	97
Descriptions of Cases	98
Case Study 1: Michael	98
Case Study 2: Shelby	100
Case Study 3: George	102
Case Study 4: Chris	104
Case Study 5: Joe	106
Case Study 6: Kyle	109
Common Themes and Codes between Cases	111
Issue 1: Therapy Experience	112
Theme 1: Therapy Development	112
Theme 2: Client Role	113
Theme 3: Therapist Role	114
Theme 4: Client-Therapist Relationship	115
Theme 5: Therapy Process	115
Theme 6: Therapy Outcomes	116
Issue 2: Facilitators of WA Development	118
Theme 1: Client Factors	118
Theme 2: Therapist Factors	121
Theme 3: Process Factors	125
Issue 3: Obstacles to WA Development	126
Theme 1: Client Factors	126

Theme 2: Therapist Factors	127
Theme 3: Process Factors	128
Different Themes and Codes between Cases.....	129
Case 1 “Michael”	130
Case 2 “Shelby”	131
Case 3 “George”	133
Case 4 “Chris”	134
Case 5 “Joe”	135
Case 6 “Kyle”	137
Chapter V—Discussion	141
Quantitative Research Questions and Hypotheses.....	141
Research Question 1: What Is The Growth Trajectory Of The Working Alliance In The Early Stage Of Mandatory Counseling?	142
Research Question Two: Can We Explain Variation In The Working Alliance Growth Trajectory According To Levels Of Mandated Clients’ Motivation For Treatment And Hope?	145
Qualitative Research Questions	147
Research Question Three: How Do Mandated Clients Perceive The Development Of The Working Alliance?	147
Differences in Clients’ Perceptions of WA Development.....	147
Similarities in Clients’ Perceptions of WA Development	148
Research Question Four: How Do Mandated Clients’ Motivation and Hope Contribute To Or Impede The Development Of The Working Alliance?	150
The Role of Clients’ Motivation for Treatment in WA Development	150
The Role of Clients’ Hope in WA Development.....	151
Research Question Five: How Can The Statistical Results Obtained In The Quantitative Phase Be Explained?	152
Research Question Six: What Other Factors Contribute to or Impede The Development Of The Working Alliance In Mandatory Counseling?.....	152
Therapist Factors.....	152
Client Factors	155
Process Factors.....	156
Conclusion	157

Integration of Qualitative and Quantitative Findings	157
Research Finding 1: Different Groups of WA Trajectories.....	158
Research Finding 2: Therapist Effect	161
Research Finding 3: Variability in Clients' Ratings of WA after the First Session	162
Limitations of the Study.....	165
Implications and Recommendations	168
Implications for Practice	168
Implications for Research	170
References.....	174
Appendices.....	190

List of Tables

Table 3.1	Instruments' Sample Sizes, Reliability Estimates, and Number of Items	70
Table 3.2	Data Collection Procedures for the Quantitative Phase of the Study	76
Table 3.3	Possible Patterns of Working Alliance Development.....	78
Table 3.4	Data Collection Matrix of Information Sources for Qualitative Phase	80
Table 3.5	Proportion of Variance in Working Alliance Scores that Occurs between Therapists	85
Table 4.1	Descriptive Statistics for Study variables (Dependent and Independent)	93
Table 4.2	Summary of Unconditional and Conditional Growth Models.....	95
Table 4.3	Groups of Working Alliance Trajectories.....	96
Table 4.9	Comparison of Client Working Alliance Inventory Scores from Three Empirical Studies.....	144
Table 5.1	Hierarchy of Therapist Factors that Facilitate Working Alliance Development	154
Table 5.2	Hierarchy of Client Factors that Facilitate Working Alliance Development	156

List of Figures

Figure 2.1	Content Visualization of the Present Study	54
Figure 3.1	Visual Model for Mixed Methods Sequential Explanatory Design Procedures: The Present Study	62
Figure 3.2	Two-factor Latent Growth Model for the Working Alliance	82
Figure 3.3	Visual Model of Multiple Case Study Qualitative Data Analysis.....	86

List of Appendices

Appendix A	Research Approvals	190
	A-1: Institutional Research Board Approval for the Study	
	A-2: Department of Correctional Services Approval for the Study	
	A-3: Approval to Use the Working Alliance Inventory—Client Form	
	A-4: Approval to Use the Client Motivation for Treatment Scale	
Appendix B	Informed Consent Forms	197
	B-1: Informed Consent Form for the Quantitative Phase	
	B-2: Informed Consent Form for the Qualitative Phase	
Appendix C	Participants Recruitment Materials.....	202
	C-1: Invitation to Participate in the Study	
	C-2: “To Case Manager/Worker” Form	
Appendix D	Assessment Instruments.....	205
	D-1: Working Alliance Inventory—Client Form	
	D-2: Client Motivation for Treatment Scale	
	D-3: Adult Dispositional Hope Scale	
	D-4: Demographic Information Questionnaire	
	D-5: Client Contact Information Sheet	
Appendix E	Interview Protocol.....	213
Appendix F	Qualitative Tables	216
	F-1: Table 4.4 Working Alliance Groups and Cases for Qualitative Interviews	
	F-2: Table 4.5 Demographic Information for Participants for the Qualitative Phase of the Study	
	F-3: Table 4.6 Issue 1 “Therapy Experience:” Qualitative Themes, Codes, and Code Frequencies	
	F-4: Table 4.7 Issue 2 “Facilitators of Working Alliance Development:” Qualitative Themes, Codes, and Code Frequencies	
	F-5: Table 4.8 Issue 3 “Obstacles to Working Alliance Development:” Qualitative Themes, Codes, and Code Frequencies	
Appendix G	Figures.....	224
	G-1: Individual Trajectories of Working Alliance, as Rated by Clients	

They come unwillingly, dragging their feet and their spirit, feeling coerced, robbed of their free will by other persons or conditions they oppose. Sometimes they want help, but not the kind that is to be had or not under the conditions required... Because they see the organization and its representative (you) as an immediate danger threat, they plant their heels in the ground, resist in all the myriad ways human beings have learned in which to protect themselves.

Helen Harris Perlman, 1978, pp.114-115

CHAPTER I

INTRODUCTION

Purpose of the Study

The proposed study employed a two-phase sequential explanatory mixed methods design (Creswell, 2003), incorporating quantitative analyses with qualitative interviews of clients who are mandated to seek psychological counseling. The *purpose* of this study was to assess how the working alliance changes at the early stage of mandatory counseling and to explain why this change occurs, based on: (a) client variables of hope and motivation for treatment; and (b) qualitative interviews with selected mandated clients ($n = 6$). In the first phase, quantitative analysis (i.e., latent growth curve modeling) was conducted on the data collected from 63 mandated clients to (1) ascertain patterns of change in the working alliance; (2) analyze the influence of client motivation and hope on the change in working alliance. In the second phase, selected mandated clients ($n = 6$) with different directions of change in the working alliance were interviewed to explore their counseling experiences in more depth.

Importance of the Study

This study is necessary and important for many reasons, the first and most influential being that mandatory counseling is recommended for more and more clients.

In 1989, Schottenfeld noted that legal judgments account for between 40 and 70 percent of all referrals to community alcohol and drug treatment programs. Storch and Lane (1989) estimated that as high as 25 percent of all clients who come for therapy do so at the initiative of some outside person or agency. In 1986, Lehmer stated “the judiciary system is increasingly ordering probation with counseling or psychotherapy for a number of offenses, considering this to be a more viable route to rehabilitation than incarceration” (p. 16). Riordan and Martin assert that “the criminal justice system now uses mandated counseling instead of jail for first-time offenders, for families with histories of domestic violence and neglect” (1993, p. 374). According to the National Survey of Counseling Centers (Zhang & Taylor, 2003), about 40 percent of universities reported providing counseling services to clients who were mandated for counseling. In addition, about 40 percent of American university counseling centers reported an increase in mandated referrals for counseling and assessment (Zhang & Taylor, 2003). Taken together, these reports suggest that mandatory counseling is a reality that should be researched.

The second reason for studying mandated counseling is because referrals to mandated counseling are given with expectation and hope for success and positive outcomes for the clients who have been referred. However, many negative factors may interfere with positive outcomes. For example, many mandated clients can be viewed as reluctant clients (Riordan & Martin, 1993). They often use their reluctance and hostility to convey the message that they do not agree with the mandate (Riordan & Martin, 1993; Willshire & Brodsky, 2001). These factors need to be addressed in order for counseling to be effective. The theoretical framework of therapeutic factors in counseling and

common factors in particular (e.g., motivation, hope), can help to clarify process dynamics in mandatory counseling.

The third reason for studying mandated counseling is that current literature on mandatory counseling includes an exploration of the ethical side of mandatory counseling (e.g., Amanda, 1995; Honea-Boles & Griffin, 2001; Connor, 1996; Geller, 1986; Gilbert & Sheiman, 1995; Wettstein, 1987; Slonim-Nevo, 1996). The nature of mandatory counseling, effects of the mandated referral to the outcome of the therapy, and ethical issues are central in the articles cited above. The major conclusion of these writings is that mandated counseling should be eliminated. In 1985, Larke pointed out an interesting tendency. That is though more individuals were being mandated for counseling, “there were extremely few mental health facilities or private practitioners available” (p.262). Numerous authors have recently pointed out that mandated counseling is a reality and more research as well as conceptual writings are needed to really understand the counseling process and the conditions for effective use of counseling with mandated clients (e.g., Slonim-Nevo, 1996; Sosis et al., 1980; Waldman, 1999; Zhang & Taylor, 2003). Geller reviewed research articles on involuntary outpatient counseling and psychological treatment that were published between 1972 and 1990. He concluded that “studies of involuntary outpatient treatment remain limited” (1990, p.749).

The fourth reason is that researchers and practitioners have emphasized the necessity of the therapeutic relationship between a client and a therapist in mandatory counseling (Honea-Boles & Griffin, 2001; Larke, 1985; Riordan & Martin, 1993; Slonim-Nevo, 1996), providing a handful of ideas about how this relationship can be

enhanced. Common suggestions are that future studies should investigate the relationship between the therapist and the client in mandatory counseling. Slonim-Nevo (1996) suggested using knowledge about the therapeutic relationship in developing models of effective counseling interventions with mandated clients.

The fifth reason is that the literature on factors contributing to the development of the relationship between a client and a therapist acknowledges a connection between the quality of the therapeutic relationship and clients' motivation for counseling and hope (e.g., Cooper et al., 2003; Frank & Frank, 1991; Pelletier et. al., 1997; Truant, 1999) and emphasizes the importance of researching this connection. The current research will examine the contribution of the client's motivation for treatment and hope to the development of the working alliance.

The proposed study adds to the research on the areas previously mentioned, and furthers the understanding of common factors that exist in mandatory counseling. The central practical goal of the current study was to enhance and detail the understanding of the working alliance and factors that influence change in the working alliance in mandated counseling. Combining quantitative and qualitative data provided a more comprehensive and precise understanding of the counseling process with mandated clients and the working alliance specifically. Furthermore, the multiple case study qualitative approach (1) added richness of detail currently missing in the process literature on working alliance in mandatory counseling; (2) helped avoid researcher assumptions or bias about factors that influence development of the working alliance; and (3) helped provide guidance for future mixed methods process studies in this field.

Mental health professionals may use this study's findings to advance the practice of mandated counseling. Effective counseling strategies could help mandated clients remain in counseling and really benefit from the work with therapists (e.g., realize change in their situations; develop coping skills; enhance self-esteem; reduce recidivism rate). The research was also aimed at empowering mandated clients by listening to them, and voicing, and taking their opinions into considerations.

Research Questions and Hypotheses

The following research questions were central for the first, quantitative phase of this study:

1. What is the growth trajectory of the working alliance in the early stage of mandatory counseling?
2. Can we explain variation in the working alliance growth trajectory according to levels of mandated clients' motivation for treatment and hope?

For the second, qualitative phase of the study the overarching research questions were:

3. How do mandated clients perceive the development of the working alliance?
4. How do mandated clients' motivation and hope contribute to or impede the development of the working alliance?
5. How can the statistical results obtained in the quantitative phase be explained?
In other words, how do mandated clients with different trajectories of the working alliance change perceive their counseling experiences?
6. What other factors contribute to or impede the development of the working alliance in mandatory counseling?

The following research hypotheses were explored in the current study:

1. Mandated clients' levels of hope and motivation for treatment will explain significant amounts of variability in the working alliance growth trajectory:
 - a. Clients' motivation for treatment that is more internally regulated and self-determined will be significantly associated with higher working alliance clients ratings, whereas motivation that is less internally regulated will be significantly associated with less favorable alliances.
 - b. Higher levels of clients dispositional hope will be significantly associated with higher working alliance clients ratings, whereas lower levels of hope will be significantly associated with less favorable alliances.

Definition of Terms

A mandated client refers to an adult who has been ordered to psychological counseling by a court or an agency, and who would not have sought counseling without an order and can expect negative consequences if he or she refuses (adopted from Honea-Boles & Griffin, 2001). Inmates of a regional Community Correctional Center who were mandated to receive counseling services comprised the sample for the current study.

Mandatory counseling refers to a therapeutic process that includes a therapist and a client who have been ordered to counseling by a court or an agency.

A working alliance refers to the "attachment that exists to further the work in therapy and contains participants' role expectations regarding the work of therapy" (Gelso & Carter, 1994). The working alliance makes it possible for the client to accept

and follow treatment faithfully (Bordin, 1979). The working alliance includes the following components:

1. Task - the in-counseling behaviors and cognitions that form the substance of the counseling process. Both the client and the counselor need to perceive tasks as relevant and efficacious and accept responsibilities to perform these tasks.
2. Goals - The counselor and the client must mutually endorse and value the goals (outcomes) they have for therapy.
3. Bonds – complex networks of positive personal attachment between the client and the counselor that includes mutual trust, acceptance, and confidence (Bordin, 1979).

Motivation for treatment refers to reasons mandated clients are willing to participate in the therapy by taking a part in the development of the relationship with a therapist (i.e., working alliance) and completing therapy tasks. The types of motivation for treatment are intrinsic, extrinsic, and amotivation (based on Deci & Ryan, 1985). All three types of motivation (intrinsic, extrinsic, and amotivation) are on a continuum from high to low self-determination where intrinsic motivation has the highest level of self-determination and amotivation implies the lowest one (e.g., Pelletier et al., 1997).

Self-determination is an individual's "capacity to choose and to have those choices, rather than reinforcement contingencies, drives, or any other forces or pressures, be determinants of one's actions" (Deci & Ryan, 1985, p. 38). In the current study the terms "self-determined" and "internally regulated" are used interchangeably.

Dispositional Hope is mandated clients' perceptions regarding their capacities to (1) clearly conceptualize goals, (2) develop the specific strategies to reach those goals (pathway thinking), and (3) initiate and sustain the motivation for using those strategies (agency thinking) (Snyder, 1995).

Early stage of mandatory counseling refers to the first five counseling sessions.

CHAPTER II

REVIEW OF LITERATURE

Mandatory Counseling

Definitions and Types

Mandatory counseling includes a therapist and a client who have been ordered to counseling by a court or an agency. There are numerous groups of clients who could be mandated for counseling. The major groups are: persons with severe mental disorders, sex-offenders, substance abusers, DUI offenders, persons who have been released after certain hospital treatments, perpetrators of domestic violence, incarcerated persons, couple who are going through divorce, persons with eating disorders, state ward children and their families, persons with anger management and disciplinary problems. Counseling may be mandated as a necessary treatment by a court (e.g., perpetrators of domestic violence), an agency (e.g., inmates of a correctional center have counseling in their release plan; some university students are mandated by university students judicial affairs to attend anger management group), or an individual (e.g., a person with eating disorder is required to seek counseling by her/his parents). The scope of this study included an investigation of the process of mandatory counseling with inmates of a Community Correctional Center whose plan of release contains counseling as a necessary condition.

For the purpose of clarification, it is important to note that several synonyms of “mandatory counseling” are used in literature in this field: involuntary treatment, coerced treatment, court-ordered treatment, compulsory counseling. All terms are consistent with

the definition of mandatory counseling provided above. In the current investigation we used the terms “mandatory counseling” and “mandated or involuntary clients.”

Characteristics of Mandated Clients

In their valuable article “Resistance in mandated psychotherapy: Its function and management,” Storch & Lane (1989) describe mandated clients in the following way:

At the time when the mandated client appears at the Center, he is generally very upset and agitated. He has likely just had some sort of difficulty which has brought him to the attention of some agency of society – court, probation or parole office, the police, child protection, school, and so forth. Generally the agency has taken a look at the situation and has decided that “treatment” [counseling] would be an effective part of the intervention. On the basis of this decision the person is sent to an agency, center, or clinic of one sort or another. He comes grudgingly, angry at the authority that “remanded” him to the Center, and hardened and reinforced in his anger and defiance. (p.30)

Mandated clients are often characterized as a population lacking motivation to be in counseling (Larke, 1985; Slonim-Nevo, 1996; Riordan & Martin, 1993). However, it would be a mistake to assume that all mandated clients have completely no motivation to work with the therapist.

The nature of mandatory counseling influences clients’ understanding of the therapeutic process and clients’ perceptions of the therapist (Waldman, 1999). Those who attend counseling involuntarily usually show little interest in the process of building therapeutic relationships and working toward personal change (Haley, 1987, 1992 as cited in Waldman, 1999). A handful of authors in the area of mandatory counseling agree that it is challenging and quite problematic to establish relationship with a person who is required to be in counseling (Honea-Boles & Griffin, 2001; Larke, 1985; Waldman, 1999). Often therapists can be seen by the client as agents of the site (e.g., a person

or/and agency) that mandated the counseling (Adams, 1992; Riordan & Martin, 1993; Waldman, 1999; Weakland & Jordan, 1990). It seems clear that the client will resist establishing a therapeutic relationship with the agency that took away his or her right to make independent choices. At the same time, the clinician faces the ethical dilemma of respecting and working with the client to establish therapeutic relationship while complying with the authorities (Honea-Boles & Griffin, 2001). Contrary to mandatory counseling, in volunteer counseling the therapist is an agent of the client. The therapist works alone, collaborates with the client in making decisions, and maintains power in the therapeutic relationship (Riordan & Martin, 1993).

In mandatory counseling the client's engagement in the therapeutic process is limited by his/her resistance to treatment (Storch & Lane, 1989). Riordan and Martin describe possible reactions of mandated clients to counseling as follows: "...anger, hostility, suspicious, overconfidence, or salience – all are trademark elements of forced counseling" (1993, p.374). The authors assert that by appearing reluctant, resistant, or hostile, clients are sending a message that they do not agree with the mandate. Lack of motivation and the ethical limitations of counseling (e.g., limitations of confidentiality) create clients' reluctance and resistance to be in counseling and work on concerns that they were able to identify. Moreover, common stereotypes about counseling add to clients' resistance to treatment. "Only crazy people seek counseling" is one of those stereotypes (Waldman, 1999). The dilemma of mandatory counseling is further complicated when the client believes that they have done nothing that warrants the "punishment" of counseling (Honea-Boles & Griffin, 2001). Evaluating mandated

clients' resistance to treatment, Riordan and Martin state: "The power to resist treatment may be one of the few powers that the client has retained" (1993). Perlman (1978) also makes an attempt to explain clients' resistance to counseling. She states that resistance might be a coping mechanism for being in counseling by somebody's request. She notes that some resistances may be unconsciously "against becoming aware of anxieties, guilt and traumatic memories" (p.27).

Another characteristic of mandated counseling is the limitations of the clients' rights in counseling. After counseling is mandated, it is not an option for a client to decide not to be in counseling. This limitation in human rights and self-determination may create an enormous sense of being powerless in the counseling process (Slonim-Nevo, 1996). Additionally, other people or agencies often assume a role in determining what the person needs to work on and how long it will be for him or her to "recover." When the client's problem is predetermined, the therapist cannot easily ignore it even in a case in which more important problems surface during initial counseling work. Furthermore, a legal authority can interfere with a treatment via its regulations and policies (e.g., length of treatment, its focus) (Riordan & Martin, 1993; Slonim-Nevo, 1996).

Reflecting on clients' rights in mandatory counseling, Slonim-Nevo (1996) makes distinctions between mandated clients with different levels of autonomy. According to the author, an alcoholic employee fearing being fired if the decision to seek treatment is not made can choose a treatment program and a counselor to work with. At the same

time, a person who is required to be in counseling by his/her parole officer may or may not have a choice over the therapist or counseling settings.

Ethical Issues around Mandatory Counseling

There are a number of articles that raise questions about the appropriateness of mandatory counseling (e.g., Amanda, 1995; Connor, 1996; Gilbert & Sheiman, 1995; Wettstein, 1987). The following are examples of *arguments* presented to make a decision on inappropriateness of mandatory counseling: (1) mandatory counseling is a means to influence client's "putative mental illness" and not their disruptive behaviors (Amanda, 1995); (2) mandatory counseling is too often motivated by the naïve notion that the therapy would cure disruptive behaviors (Amanda, 1995); (3) clients are treated as objects to be manipulated and changed (Connor, 1996); (4) mandatory counseling destroys "the cornerstone of psychotherapeutic treatment confidentiality" (Amanda, 1995, p. 37; Gilbert & Sheiman, 1995); (5) mandatory counseling assaults the dignity and rights of individuals (Amanda, 1995); (6) mandatory counseling compromises the major ethical principles of counseling (i.e., beneficence, autonomy, and nonmaleficence) (Wettstein, 1987); (7) mandate makes candor and genuineness exceptionally difficult (Connor, 1996); (8) mandatory counseling is often perceived by clients as a form of punishment that could instill in clients a hatred for therapy resulting in resistance to treatment (Amanda, 1995). The major conclusion of these writings is that mandated counseling is not ethically appropriate and should be eliminated. Limitations of confidentiality in mandatory counseling and their influences on therapeutic relationship are also described in conceptual articles by Bites & Griffin, 2001; Connor, 1996; and

Slonim-Nevo, 1996. The authors see these limitations to be very important arguments against mandatory counseling.

An article by Pollard (1996) is a clear example of another perspective on mandatory counseling. The author provides the readers with numerous arguments for mandatory counseling. To illustrate, he states:

Diversion programs which offer treatment for domestic violence offenders are utilized by courts across the land as appropriate effective means for dealing with batterers. They do so in recognition that while treatment does not offer a guarantee, it does offer the only alternative to continued interpersonal violence because jail and prison sentences for these offenses are time limited. (p.48)

Pollard asserts that mandatory counseling, like any other form of involuntary commitment (e.g., incarceration, expulsion), is a consequence of unacceptable behavior. Among other forms of involuntary commitment, mandatory counseling “has the unique benefit of potential for preventing future victimization” (p.53).

Slonim-Nevo (1996) stresses that in mandatory counseling, clients’ self-determination is limited by an outside institution that requires counseling. The author describes clients’ self-determination to be a highly valued moral principle in clinical practice. This principle supports the client’s right to freely make decisions. Additionally, clients’ self-determination is also perceived as a tool to help achieve therapeutic progress (Slonim-Nevo, 1996). Another dilemma faced by therapists when working with mandated clients is whether the therapists are agents of society, who ought to maintain stability and control deviants, or whether their role is to bring about change. In other words, whose interests should the therapists work for: the society’s or the client’s? (Slonim-Nevo, 1996). The author however asserts that even with these obvious dilemmas, therapists can

develop and implement an effective intervention in mandatory counseling. In his 1986 analysis of several cases of mandated outpatient treatment, Geller concluded that involuntary counseling can be a valuable and effective option with the condition that the limitations to clients' legal rights should be considered and addressed. Moreover, Wettstein (1987) promotes the ideas of following basic ethical principles in mandatory counseling. Even when the client is mandated to be in counseling, he says, the therapist has to do everything possible to provide treatment consistent with ethical principles of beneficence, autonomy and nonmaleficence.

Taken together the conclusions of the researchers and conceptual writers suggest that there is no one agreed upon perspective on mandatory counseling. Authors continue describing all possible “pros” and “cons” to mandatory counseling. While these debates continue to exist and progress in the literature, numerous authors report that significant numbers of involuntary clients are required to receive counseling (e.g., Lehmer, 1992; Riordan and Martin, 1993; Schottenfeld, 1989; Storch and Lane, 1989). The numbers are increasing (e.g., Zhang & Taylor, 2003). In other words, mandatory counseling is a reality that should be seriously addressed not only at the levels of its ethics and appropriateness, but at the levels of practice and inquiry into its processes.

Effectiveness of Mandatory Counseling

According to a 1985 manuscript by Larke, the majority of studies involving mandatory treatment can be found in the alcohol and substance abuse literature. The studies concluded that a little or no difference exists between mandated or voluntary clients in modifying alcohol use (Laudergan et al., 1979 as cited in Larke, 1985).

Moreover, some studies have found recidivism rates to be lower with mandated populations (Ward & Alivise, 1979 as cited in Larke, 1985).

Reflecting on the mandatory counseling outcome studies, Rooney in 1992 concludes: (1) mandated clients' counseling outcomes are comparable to counseling outcomes of voluntary clients, (2) voluntary clients are rarely distinguished from nonvoluntary clients in the conduct of research, and (3) motivational congruence between client and therapist is an important clue toward effective intervention with mandated clients. Rooney (1992) forwards the positive view of mandated counseling and affirms that it can be a valuable experience not only for clients but for therapists too. Likewise, Holser found that while staying in mandated counseling the clients significantly increased their motivation to change (1980 as cited in Larke, 1985). Furthermore, Dunham & Mause (1982) reported that mandated counseling referral resulted in successful treatment outcomes that were even higher than treatment outcomes of voluntary clients (as cited in Larke, 1985).

Other evaluations of mandated treatment programs in different settings have found pre-post treatment changes in measures of self-esteem, locus of control, depression, anger/hostility, jealousy, and preferences for egalitarian gender roles (e.g., Saunders & Hanusa, 1986). Numerous studies have demonstrated success in short-term, cognitive-behavioral group counseling with mandated clients (Deschner & McNeil, 1986; Dutton, 1986; Hershberger, 1988; Edelson et al., 1985; Saunders & Hanusa, 1986, as cited in Pollard, 1996). In their study of outcomes of mandatory counseling for at-risk college students, Schwitzer et al. (1993) conclude that "initial, mandatory experience

with counseling may lead to enhanced voluntary help-seeking later on” (p. 404). They also have found that, as a result of mandatory counseling intervention, research participants demonstrated significant positive change in their GPAs.

The results of the more recent studies and reviews on mandated counseling revealed conclusions similar to ones derived from the studies conducted in 1979-1996. In particular, after reviewing the body of literature on court-mandated outpatient psychiatric treatment, Collins (2005) concluded that the evidence suggests mandated treatment is a helpful strategy for clients with histories of dangerous behavior to receive and accept outpatient treatment as well as to prevent future dangerous behaviors. Miller and Flaherty (2000) came up with similar conclusions regarding mandated addiction treatment programs. The results of their review of a relevant literature confirmed efficacy and cost benefits from mandated addiction treatment. They also found that providing mandated clients with alternatives to mandated treatment (e.g., sentencing for a violation, loss of child for neglect, loss of employment for negligence) “appeared to motivate patients/clients to comply with addiction treatment” (p.14). The recent empirical investigation of the effectiveness of court-mandated batterer interventions (Buttell & Carney, 2006) also revealed the evidence supporting the practice of court-mandated treatment. Specifically, it was found that the court-ordered batterers demonstrated significant positive changes on psychological variables related to domestic violence as a result of participation in a court-mandated treatment program. Overall, the recent studies on the efficacy of mandated treatment for a variety of problems (e.g., Collins, 2005; Buttell & Carney, 2006; Miller & Flaherty, 2000) conclude that coercion can be a

therapeutic step in initiating treatment as well as it can result in improved psychosocial status for clients and reduce costs for criminal, health, and employment consequences. The described research findings suggest that treatment of clients mandated for counseling works. Given this conclusion, Pollard stresses that “it is immoral and unethical *not* to use it [mandatory counseling] to prevent further victimization” (1996, p. 50).

Therapeutic Factors in Voluntary and Mandatory Counseling

General Overview of Therapeutic Factors

The theory of therapeutic factors (Lambert, 1992) based on ideas pioneered by Rosenzweig (1936) and Frank & Frank (1991), forms the basis for the theoretical framework for the present research study.

In 1936, Saul Rosenzweig suggested that the effectiveness of different therapy approaches involves their common elements more than theoretical tenets on which they are based. In particular he argued that one of the most common factors across therapies was the relationship between the client and the therapist (Hubble et al., 1999). Jerome Frank further developed Rosenzweig’s ideas. He and his daughter, Julia Frank, identified major features shared by all effective therapies (1991): (a) “an emotionally charged, confiding relationship with a helping person,” (b) “a healing setting,” (c) “a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient’s symptoms and prescribes ritual or procedure for resolving them,” (d) “a ritual or procedure that requires the active participation of both patient and the therapist and that is believed by both to be the means of restoring the patient’s health” (pp. 40-43).

In 1992, Michael Lambert built on Rosenzweig's and Frank & Frank's thinking about therapy components. Lambert proposed four therapeutic factors accounting for improvement in clients: extratherapeutic, common factors, expectancy or placebo, and techniques. *Extratherapeutic factors* are parts of the client or the client's life circumstances that aid in recovery despite the client's formal participation in therapy. This group of factors includes client's strengths, supportive elements in the environment (e.g., family), client's faith and motivation, etc. Lambert (1992) estimates this group of factors accounts for 40 percent of outcome variance. *Relationships or common factors* refer to the relationship between the client and the therapist and account for 30 percent of successful outcome variance (Lambert, 1992). This includes caring, empathy, warmth, acceptance, mutual affirmation, and encouragement of risk taking, and therapeutic (working) alliance. The contribution of *placebo, hope, and expectancy factors* to successful therapy outcomes is about 15 percent (Lambert, 1992). This group of therapeutic factors refers to the portion of improvement derived from client's knowledge of being treated and assessment of the credibility of the rationale for therapy. Expectancy is comprised of client's and therapist's beliefs in the restorative power of the treatment's procedure and rituals. These factors come from the optimistic and hopeful client's and therapist's expectations of positive counseling outcomes (Hubble et al., 1999). According to Lambert (1992), *techniques* account for 15 percent of improvement in therapy. This group of factors may be regarded as beliefs, procedures, and techniques unique to specific treatments.

The majority of writings on therapeutic factors are found in the area of voluntary counseling. An assumption of the present research study is that the therapeutic factors theory is applicable to mandatory counseling. In other words, therapeutic factors of mandatory counseling also include client variables; placebo, hope and expectancy factors; common factors; and specific techniques. However, it is also recognized that distinct characteristics of mandatory counseling (e.g., limitations of confidentiality, client resistance, client perception of therapist as an agent of an organization that mandated counseling) in one way or another affect all groups of therapeutic factors mentioned above. Currently, no process research has explored the relationship between therapeutic factors and the distinct characteristics of mandatory counseling. In other words, it is not clear how therapeutic factors change, if they change at all, in the context of mandatory counseling.

The main focus of the current research was on the therapeutic relationship or “the working alliance.” Specifically, the contribution of motivation (a client factor), and hope (a placebo, hope, and expectancy factor) to change in the development of the working alliance was considered. The rest of this chapter presents the overview of the literature regarding therapeutic factors that were the focus of the present study.

Common Factors: Working Alliance

The terms therapeutic alliance, working alliance, and helping alliance have been used in the literature to refer to specific aspects of the alliance or the alliance as a whole (Horvath & Luborsky, 1993). All of these terms were used in the present study to refer to the general construct of the working alliance, unless otherwise specified.

The central role of therapeutic relationship in the process of psychotherapy and client change is acknowledged by clinicians and researchers in voluntary (e.g., Bordin, 1979; Frank & Frank, 1991; Horvath and Greenberg, 1985; Lambert, 1992; Rogers, 1957) as well as in mandatory counseling (e.g., Connor, 1996; Honea-Boles, 2001). For instance, in their prominent attempt to define psychotherapy, Frank and Frank (1991) describe it as a process that includes (a) a healing agent, (b) a sufferer who seeks a relief from pain, and (c) a healing relationship. In the other words, the authors see the therapeutic relationship as a process that connects the healer and the sufferer and creates an environment for the healing to take place. Their vision of the therapeutic relationship is consistent with Rogers (1957) ideas that the therapeutic alliance is one of the necessary and sufficient conditions for improvement in any kind of therapy. More recently it has been shown that the therapist-client relationship is the second-best predictor of client change in voluntary therapy (Lambert, 1992), with the first-best predictor being client/extratherapeutic factors. Similarly, in mandatory counseling, the working alliance is seen as one of the essential means and challenges to work effectively with mandated clients (Honea-Boles, 2001).

According to Bordin (1979), the term “therapeutic working alliance” came from psychoanalytic theories. The psychoanalytic writings of Sterba (1934), Meninnger (1958), Zetzel (1956), and Greenson (1967) are considered to be foundations of the working alliance (as cited in Bordin, 1979). Analyzing and synthesizing these contributions, Bordin described three major features of the working alliance: “an agreement on goals, an assignment of task or a series of tasks, and the development of

bonds” (p. 253). Describing “*goals*” as a part of the working alliance, Bordin (1979) notes that even though goals might be different in different therapies, an agreement of goals between the client and the therapist is an important and necessary feature of the working alliance. *Tasks* should be developed based on collaboration and agreement between the client and the therapist in any counseling approach. Bordin (1979) also stresses that only when there is client-therapist agreement on tasks does the working alliance contribute positively to the therapeutic relationship. The goals and tasks set in client-therapist collaboration are linked to the quality of *bond* between participants of the therapy. An agreement on goals and tasks contributes positively to the development of trust in the therapeutic relationship and consequently helps a deeper and stronger client-therapist bond to form (Bordin, 1979). Gelso and Carter (1985) added the new dimension of emotional alignment to Bordin’s definition of the working alliance. They describe the alliance as “an emotional alignment that is both fostered and fed by the emotional bond, agreement on goals, and agreement on tasks” (p.163). Although there are some differences in definitions of the working alliance, there appears to be an agreement in the literature that the alliance involves both collaboration between participants and the capacity for the client and the therapist to negotiate a contract appropriate to the therapy (Bachelor & Horvath, 1999; Sexton & Whiston, 1994).

Working Alliance in Voluntary Counseling

Proposing the concept of the working alliance, Bordin (1979) stated that “the effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance” (p. 253). Since 1979 the quality of the therapeutic relationship between

the therapist and the client has been shown to be a significant determinant of beneficial therapy outcome across diverse approaches such as behavioral, eclectic, and dynamically oriented therapies (e.g., Bachelor & Horvath, 1999; Kivlighan & Shaughnessy, 1995; Kivlighan & Shaughnessy, 2000). Furthermore, the working alliance has been shown to be a significant factor not only in individual but in group therapy and group marital therapy (Bachelor & Horvath, 1999). Two major meta-analyses of relationship between working alliance and therapy outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) revealed the evidence that there is a moderately strong relationship between the two.

What makes for a good working alliance? Gelso and Carter (1985) assert that from the therapist's side of the relationship, professional concern and compassion as well as a willingness to help the client face his or her problems contribute to the alliance between client and therapist. Therapists' empathy, genuineness, and respect are viewed as central in developing the working alliance (Gelso & Carter, 1985). To foster the development of the alliance, the therapist's job is to be consistent and constant in his or her stance toward the client (Gelso & Carter, 1985). From the client's side, he or she needs to possess a capacity to trust so that healthy bonding can occur. The client must be able to form attachments to people and to invest energy and caring in relationships. Therapy tasks and goals should make sense for the client. If the client cannot appreciate or understand what the therapist has to offer, one cannot expect an effective working alliance to develop (Gelso & Carter, 1985). Numerous studies have taken into consideration the idea that it takes both therapist's and client's efforts to develop the

working alliance. For example, in the qualitative study of clients' perceptions of the working alliance conducted by Alexandra Bachelor (1995), the author found and described several client conceptualizations of the alliance: (1) alliance as a client-therapist bond; (2) alliance as improved self-understanding; (3) alliance as client collaboration. These findings suggest that even though goals, tasks, and bonds are essential features of the working alliance (Bordin, 1979), different clients may emphasize different features of the therapeutic relationship and conceptualize the therapeutic alliance based on the most significant one (e.g., insight).

Bedi (2006) emphasizes the point forwarded by Bachelor (1995), Horvath and Symonds (1991) and Wampold (2001) that the clients' perspectives of the alliance seem to be related to therapy outcome more strongly than therapists' or independent observers' ratings. Given this conclusion, in his empirical manuscript on client's perspective on working alliance formation Bedi (2006) strongly emphasizes the lack of research studies on clients' subjective perspectives of the working alliance development. Specifically, he states "there is a conspicuous absence of theorizing and empirical research that represents clients' subjective understandings" (p. 26). Bedi (2006) forwards the view that such investigations of clients' subjective experiences are needed to create an accurate understanding of the working alliance from the clients' perspectives. In the exploratory study he conducted, eleven tentative categories of factors that contributed to a successful alliance development from the client perspective were identified. Among those categories are nonverbal gestures, emotional support and care, presentation and body language, setting, session administration, client's personal responsibility, referrals and

recommended materials, guidance and challenging, education, honesty, and validation (Bedi, 2006).

The development of the working alliance. Hill and Williams (2000) emphasize the existence of a number of conflicting theories and empirical evidence about the “phases” of the working alliance. For instance, one view is that the working alliance increases steadily over time (e.g., Gunderson et al., 1997; Sauer, Lopez, & Gormley, 2003). Another view is that the alliance remains relatively stable over time (e.g., Eaton et al., 1993). Furthermore, Bachelor and Salame conclude that the quality of the working alliance is established early in therapy and does not change significantly overtime (2000). In 1994, reviewing studies of working alliance in the short-term therapy, Gelso & Carter found that for brief therapy it is particularly important to have the working alliance formed at the early stages of therapy. This may be because without a strong working alliance early in brief work, productive outcomes of therapy will not occur. In 1985, Gelso & Carter proposed high-low-high pattern of working alliance development (see also Golden & Robbins, 1990, as cited in Sauer, Lopez, & Gormley, 2003). One of the first studies that looked at clusters of the working alliance patterns was a study conducted by Kivlighan and Shaughnessy (2000). In this empirical investigation based on two samples of participants, researchers have found three types of working alliance patterns: (1) stable alliance, (2) linear growth, and (3) quadratic growth. Further investigations of the patterns of working alliance development found four major types (Stiles et al., 2004): (1) a modestly positive and very slightly negatively accelerated slope with high variability or linear growth pattern, (2) very little slope, with virtually no curve and low

variability or stable alliance pattern, (3) a negative slightly positively accelerated slope with high variability, and (4) a positive slope with negatively accelerated curve and low variability. Of these four patterns, two (linear growth and stable alliance) resembled Kivlighan & Shaughnessy's (2000) patterns, and the other two were new patterns discovered by Stiles and colleagues (2004). A number of studies have clearly established that the early alliance (i.e., the third to the fifth sessions) and alliance strength are significant predictors of final treatment outcomes (e.g., Bachelor & Horvath, 1999; Horvath & Greenberg, 1985; Kivlighan & Shaughnessy, 1995; Kivlighan & Shaughnessy, 2000). In a qualitative study analyzing therapy failure, Strupp (1990) found that failure to form a working alliance early in the therapy resulted in early termination as a consequence of clients feeling misunderstood and insufficiently supported. Taken together, these findings suggest that (1) the controversy exists regarding the impact of time on the working alliance development, and (2) the development of a positive therapist-client relationship is critical from the very beginning of the therapy. Also, these findings emphasize the importance of studying the development of the working alliance as an essential feature of therapy that largely influences treatment outcomes.

Conclusions related to the current study. Described conclusions from the previous research on the working alliance in voluntary counseling have several important implications for the current study:

1. The importance of the development of the working alliance early in therapy (e.g., Bachelor & Horvath, 1999; Gelso & Carter, 1994) determined the choice

of counseling sessions that was investigated in the current research (i.e., 1st, 3rd, and 5th).

2. The development of the working alliance includes changes in client-therapist perspectives toward goals, tasks, and bonds (e.g., Bordin, 1979; Gelso & Carter, 1985). Since the major focus of the current research was placed on client's perceptions of the working alliance, this conclusion was examined in the qualitative phase of the present study by asking the participants about their experiences in counseling that influenced the change in their perspectives on the working alliance.
3. In light of research findings by Bachelor (1995) and Bedi (2006), it was expected that clients' qualitative descriptions of the factors contributing to change in the working alliance will vary depending on the subjective values clients ascribe to particular features of the alliance. This conclusion in turn warranted interviewing at least four people with different directions of change in the working alliance so different responses could be considered.
4. It is important to note that the researcher is aware that both therapist's and client's factors affect the development of the working alliance. However, the quantitative phase of the current study was focused on exploring the contribution of client's factors, specifically, motivation and hope, to the working alliance.

Working Alliance in Mandatory Counseling

A number of authors describe how limitations to mandated clients' confidentiality, therapist's power and other hallmark characteristics of mandatory counseling negatively affect the development of the working alliance (e.g., Honea-Boles & Griffin, 2001). For example, Popiel (1980) states that mandated clients are not free to fully participate in the development of the working alliance if the therapist is not free to respect the client's confidentiality. Slonim-Nevo (1996) asserts that because mandated clients cannot choose their own therapists, define their own presenting problem, freely deny their symptoms or become non-compliant, their relationships with their therapists differ from that of voluntary clients and their practitioners. In addition to highlighting the specificity of client-therapist relationship in mandatory counseling, Slonim-Nevo (1996) emphasizes the importance of the working alliance for the therapy process as well as outcomes. She notes that the working alliance, trust, honesty, and openness should be capitalized in the therapeutic relationship to acquire successful therapy outcomes.

The idea that mandated clients often lack motivation for change is commonly accepted (e.g., Perlman, 1979; Rooney, 1992). Rosenfeld in 1992 highlights the importance of internal motivation in facilitating effective treatment and thus bringing about change. Rosenfeld asserts that when the client has no motivation, both the therapist and the client cannot develop a working alliance. Moreover, if there is no working alliance, a therapist may be tempted to blame the client by labeling him or her resistant or uncooperative.

The ideas of Rosenfeld (1992) forward the view that therapists also significantly contribute to the development of the working alliance. According to Honea-Boles & Griffin (2001), therapists often experience the ethical dilemma of respecting the client while working with mandated population. Often the actual behavior of the mandated client may be hostile, angry, unappreciative, or manipulative and can provide justifications or unconscious motivation for the therapist to discontinue treatment. Larke (1985) and Perlman (1979) stress that in order to work successfully with mandated clients, therapists must combat the tendency to consciously and unconsciously give up on the therapeutic relationship.

Honea-Boles and Griffin (2001) raise the question of whether it is possible and appropriate to form the working alliance with openness, genuineness, respect, cooperation, and empathy when the client is mandated to be in counseling? The literature on this topic presents different opinions. On the one hand, development of the therapeutic relationship between the mandated client and the therapist is considered to be “dehumanizing and dishonest; where dominance and submissive roles are delineated” (Cingolani, 1984) and therefore it is ethically inappropriate for the therapist to pursue the development of a therapeutic relationship. On the other hand, a number of authors strongly support the development of the working alliance in mandatory counseling and assert that it is possible to develop an effective therapeutic relationship (e.g., Honea-Boles & Griffin, 2001; Rooney, 1992; Slonim-Nevo, 1996). Lehmer (1986) states that an effective beginning of a working alliance includes clarifications of role expectations for both the therapist and the client as well as the development of agreed-upon therapy goals.

Given all these findings it becomes clear that establishing the working alliance with mandated clients may be a more extended and complicated process in comparison with voluntary counseling (Lehmer, 1986). In general, the results of this literature review highlight the fact that only a few conceptual articles in the area of mandatory counseling address and position the working alliance as an important component of successful counseling. Moreover, no research studies that investigated the development of the working alliance in mandatory counseling were found.

Conclusions related to the current study.

1. Rosenfeld's (1992) conclusion, "when the client has no motivation, the therapist cannot develop a working alliance," aided the researcher in choosing motivation as a client variable that could influence the development of the working alliance.
2. The literature review revealed several factors specific to mandatory counseling that negatively affect the development of the working alliance: limitations to confidentiality, therapists' alignment with authorities, clients' understanding of the therapeutic process, client's perceptions of therapists. It is important to note that the researcher acknowledges the possible effects of these factors on working alliance development. However, the exploration of each of these factors was beyond the scope of the present research study.
3. In general, the results of the literature review highlighted the need for research inquiries into the specificities of working alliance development in mandatory

counseling. This finding supports the major goal of the present study – to research the development of the working alliance in mandatory counseling.

Client Factors: Motivation for Treatment

Although several research studies reveal that counseling, in general, can be beneficial for many mental illness and adjustment problems, it remains true that not everyone benefits from counseling to a satisfactory degree (Lambert et al., 1994). Often weak therapeutic relationship between a client and a therapist negatively affect the therapy outcomes (e.g., Lambert, 1992). One client factor that has particular relevance to failures in the development of the working alliance is clients' motivation for treatment (Pelletier et al., 1997). A number of authors agree that motivation for treatment is indeed an area of inquiry particularly relevant to the issues of attrition, compliance, and maintenance of change (e.g., Drieschner et. al., 2004; Truant, 1999). According to Lambert (1992), clients' motivation for treatment is included in a category of extratherapeutic (or client) factors. This group of therapeutic factors makes the largest contribution to the results of therapy and by accounting for 40 percent of therapy outcome variance (Lambert, 1992). Therefore, motivation for treatment is an important concept to study.

Motivation for Treatment in Voluntary Counseling

In Rosenbaum and Horowitz's 1983 study of client motivation for therapy, they concluded that in the existing literature there was "conceptual and theoretical confusion" surrounding not only motivation for psychotherapy, but also the concept of motivation in general. From their exploratory factor analysis of factors that appeared to be relevant to

the clients' motivation for treatment, they conclude that motivation is a multidimensional phenomenon that includes: (1) active engagement, (2) psychological-mindedness, (3) incentive-mediated willingness to sacrifice, and (4) positive valuation of therapy (Rosenbaum & Horowitz, 1983). Additionally, they posit the client's treatment motivation to be a concept that is particularly important in choosing therapeutic interventions.

A number of years after the initial attempt to clarify the meaning of treatment motivation (Raskin, 1961, as cited in Drieschner et. al., 2004), Drieschner and colleagues (2004) still concluded that a concept of treatment motivation "is surrounded by conceptual confusion, resulting in miscommunication, ambiguous measures, and contradictory conclusions of research" (p. 1115). In their review of the existing literature regarding treatment motivation, Drieschner and colleagues analyze and criticize existing ideas. Major points of their criticism are (1) divergence in definitions of treatment motivation, (2) conceptual ambiguity of different definitions, (3) confusion and overlap among factors that determine motivation for treatment, and (4) ambiguous and non-comparable measures of treatment motivation. Summarizing the reviewed findings, the authors develop their own conceptualization of treatment motivation. They define treatment motivation as "the patients' motivation to engage in their treatment" (p. 1126). Moreover, they hypothesize that motivation to engage in treatment depends on six cognitive and emotional factors or "internal determinants". Specifically, (1) problem recognition, (2) level of suffering, (3) perceived external pleasure, (4) perceived costs of treatment, (5) perceived suitability of treatment, and (6) outcome expectancy. Even

though their conceptualization has a number of clear strengths (e.g., multidimensional conceptualization of treatment motivation, systemic understanding of the phenomena in the context of its determinants and engagement in treatment), the utility of this model is limited by the availability of measures for its elements. Currently, no measures of “motivation to engage in treatment” are available. This limitation became the major criterion for rejecting Drieschner and colleagues’ (2004) theory of “motivation to engage in treatment” as a theoretical lens for the present study.

One theoretical perspective of human motivation that recently has received a great deal of attention from the researchers is the self-determination theory proposed by Deci and Ryan (1985). Pelletier and his colleagues (1997) described a number of ways in which Deci and Ryan’s theory of motivation and self-determination can be instrumental in understanding clients’ motivation for treatment and change. First, they state that the theory distinguishes between different types of motivation that can have a significant impact on the maintenance and integration of therapeutic change. Second, the theory posits about a variety of therapeutic factors that should facilitate clients’ motivation for therapy. Third, the theory outlines possible consequences (affective, cognitive, and behavioral) of the different types of motivation. And fourth, the authors state that the theory addresses the issue of internalization, “the process by which therapeutic changes that were initially reinforced by external sources (e.g., therapist) becomes integrated within the individual to form a permanent part of his or her character” (Pelletier et al., 1997, p. 415). A brief overview of the major points of Deci and Ryan’s self-determination theory in the context of counseling is useful for this study.

Deci and Ryan (1985) suggested the existence of three basic types of motivation that regulate human behavior: intrinsic, extrinsic, and amotivation. *Intrinsically motivated behaviors* are voluntary, devoid of any external or material rewards or constraints. Deci and Ryan further assert that intrinsically motivated behaviors are internally regulated and thus are more likely to be performed in a consistent manner. This form of motivation is derived from the individuals' need to "feel competent and self-determined" (Deci & Ryan, 1985, p.34). An example of this type of motivation in the context of counseling would be a client who enters therapy purely for the pleasure and satisfaction derived from their performance in therapy (Pelletier, et al., 1997).

Extrinsic motivation is the opposite of intrinsic motivation. In other words, extrinsically motivated behaviors are performed to receive an external reward or to avoid punishment once the behavior has ended (Deci, 1975, as cited in Pelletier et al., 1997). It was proposed that extrinsic motivation has four subtypes that range from the lowest to highest manifestation of self-determination: external regulation, introjection, identification, and integration (e.g., Deci & Ryan, 1985). Specifically, *external regulation* involves the regulation of behavior through external sources such as material rewards and punishment (Deci & Ryan, 1985). An example of external regulation is a client who enters counseling because his wife has given him an ultimatum to deal with his drinking or seek a divorce attorney (Pelletier, et al., 1997). *Introjected regulation* involves former extrinsically motivated behaviors that have been internalized. Internal pressures such as guilt, anxiety, or emotions related to self-esteem have replaced the external forces (Pelletier, et al., 1997). A battered woman with young children who seeks out therapy

because she is overwhelmed with feelings of shame for having done nothing to improve her situation would be considered a client motivated by introjected regulation (Pelletier, et al., 1997). *Identified regulation* refers to behavior that is performed because it is congruent with an individual's values and goals (Deci & Ryan, 1985). This behavior is still performed for extrinsic reasons (e.g., reward), but it is internally regulated and self-determined. An example of a client motivated by identified regulation would be a woman struggling with a difficult marriage who makes the decision to enter counseling because seeking professional help is congruent with her value of trying everything possible to save the marriage (Pelletier, 1997). Finally, *integrated regulation* refers to "behavior that is performed not only because the individual values its significance, but also because it is consistent with other self-schemas the individual possesses; it is consistent with his or her self-identity" (Deci & Ryan, 1985). For example, a woman who had previously completed counseling but now wants to see a therapist to help her maintain the changes she acquired in counseling would be motivated by integrated regulation. A desire to sustain mental health became "an integral aspect" (p. 416) of the woman's life and thus seeking out therapy is entirely consistent with her new identity (Pelletier et al., 1997). In other words, extrinsically motivated behaviors can range from being determined by controls, external rewards, to being determined more by choices based on one's own values and desires. In the latter case, they would be more self-determined (Deci & Ryan, 1985).

Amotivation is the last type of motivation described by Deci and Ryan. They hypothesized that amotivation is consistent with situations when individuals, in addition

to feeling incompetent and powerless, do not perceive a relationship between their actions and the outcomes that follow these actions. Moreover, this type of motivation is characterized by no real sense of purpose or understanding for engaging in a particular activity. The client experiencing a sense of hopelessness who enters therapy believing that therapy is a waste of time is an example of amotivated client (Pelletier et. al., 1997).

Research has shown that six types of motivation (intrinsic, integrated, identified, introjected, external regulation, and amotivation) are on a continuum from high to low self-determination where intrinsic motivation has the highest level of self-determination and amotivation implies the lowest one (e.g., Blais et al., 1990; Deci et al., 1991, as cited in Pelletier et al., 1997). Moreover, according to Deci and Ryan's conceptualizations (1985), human motivation is a "dynamic concept." Applying this idea to the context of counseling, Pelletier and colleagues (1997) posit that a client's motivational type at a particular point in therapy may change depending on situational influences (e.g., therapist's interpersonal style).

Reviewing the literature on clients' motivation for treatment and therapy outcomes, Pelletier and colleagues concluded that the research supports the hypothesized link between motivation type and treatment outcome (Pelletier et. al., 1997; Parker et. al., 1979). According to Pelletier and colleagues (1997), the major common finding of the reviewed studies is that an increase in internally regulated behaviors results in more positive therapy outcomes (e.g., greater interest in therapy, increased life satisfaction, persistence), while less self-determined, extrinsic and amotivational behaviors yield varying degrees of negative therapy outcomes and consequences (e.g., poor maintenance

of changes gained in therapy, weak therapeutic relationship). Furthermore, Strupp & Binder (1986) assert that clients' motivation for therapy affects their use of the relationship with therapists for learning in counseling as well as clients' abilities to build effective therapeutic relationships with their therapists.

Conclusions Related to the Current Study.

1. Motivation for treatment is included in the most influential group of therapeutic factors, client factors, and significantly contributes to the treatment outcome (Lambert, 1992). Furthermore, Strupp and Binder's ideas (1986) regarding the influences of motivation on client's abilities to form working alliances with their therapists. This supported the choice of motivation as a covariate variable for the current research study.
2. A number of authors position motivation as one of the factors that influences the development of the working alliance (e.g., Pelletier et. al., 1997, Truant, 1999).
3. Given all debates regarding the definition of clients' motivation for treatment that exist in the literature, the ideas of Deci and Ryan (1985) were chosen as a theoretical lens for the present study. There were a number of reasons which informed this decision. First, Deci and Ryan's self-determination theory (1985), which informed Pelletier and colleagues' definition of motivation for treatment, is a theory that recently has been supported in a number of research studies. Second, utilizing the major ideas of Deci and Ryan's self-determination theory, Pelletier and colleagues (1997) developed an instrument

(i.e., Client Motivation for Treatment Scale) with sound psychometric properties (see Instruments section) that assesses different types of clients' motivation for treatment.

4. A number of authors assert that the failure of the therapist and the client to build an effective working alliance results in decreasing the chances of therapeutic change (e.g., Bachelor & Horvath, 1999; Bordin, 1979; Horvath & Luborsky, 1993; Lambert, 1992) and increasing the possibility of clients' dropping out of counseling (e.g., Gelso & Carter, 1994; Strupp, 1990, as cited in Sexton & Whiston, 1994). The current study researched the connection between client motivation for therapy and the development of the working alliance between the client and the therapist. Ideas of Pelletier and colleagues (1997) and Strupp and Binder (1986) regarding the relationship between motivation for treatment and therapy outcomes informed an initial hypothesis of the present study. Specifically, it was hypothesized that motivation for therapy that is less self-regulated would negatively affect the development of the working alliance. Moreover, an increase in internally regulated, self-determined behavior would result in stronger therapeutic relationship between the therapist and the client.

Motivation for Treatment in Mandatory Counseling

Motivation for treatment is the pivotal characteristic of involuntary clients.

Literature on mandatory counseling often defines involuntary clients as those who lack motivation for treatment (e.g., Perlman, 1979; Rooney, 1992). Willshire and Brodsky

(2001) state that one of the most difficult tasks facing therapists working with mandated clients who often not motivated to be in therapy is to engage meaningfully with the client and to build effective therapeutic relationships.

A number of conceptual and empirical writings in the area of mandatory counseling address clients' motivation for treatment and change. For example, in the area of substance abuse treatment, De Leon and colleagues (2001) distinguish between two types of clients' motivation, external and internal, that have an impact on recovery from substance abuse. They define *external motivation* as "perceived outside pressures or coercion to change, or to enter or remain in treatment" (p. 145). The sources of coercion can be legal, family, or employment pressures, although health concerns may also qualify. *Internal motivation* refers to the desire to be in treatment and desire for change that arises from within the individual (e.g., negative self-perceptions concerning drug use, desire for better lifestyle). According to De Leon and colleagues (2001), regardless of the initial source of motivation, external or internal, stable recovery appears to depend on the continuing influences of intrinsic motivational factors (e.g., Cunningham et al., 1994 as cited in De Leon et al., 2001). Another perspective on clients' motivation for substance abuse treatment is presented in writings by Simpson and Joe (1993). They view motivation for treatment as a phenomenon that includes several stages – comprising problem recognition, desire for help, and treatment readiness. A different interpretation of motivation for treatment is presented in McGrath's work (1991) on treatment for sexual abusers. The motivation of sexual abusers is often assessed according to the following criteria: (1) the abuser must admit to his or her crime and accept responsibility for own

actions; (2) the person must recognize that his or her behavior is problematic and must be ended; (3) and the person must be willing to follow treatment. The self-determination theory (Deci and Ryan, 1985), as another way to conceptualize motivation for treatment, was utilized in several research studies in the area of mandatory counseling (e.g., Wild et al., 1998; Lauretti, 2002).

Taken together, the preceding descriptions of perspectives on treatment motivation suggest that there is no clear-cut definition of treatment motivation in the area of mandatory counseling. All authors appear to agree that motivation is a multidimensional phenomenon. However, every conceptualization of treatment motivation proposes different dimensions. This situation mirrors an uncertainty in the conceptualization of treatment motivation that exists in the area of voluntary counseling (e.g., Drieschner et. al., 2004; Pelletier et al., 1993; Rosenbaum & Horowitz, 1983).

Reviewing the literature on motivation for substance abuse treatment, De Leon and colleagues (2001) made a number of important conclusions. First, they assert that the research on extrinsic motivation in mandatory treatment includes studies of legal pressure which bear out the importance of external motivation as a predictor of treatment retention and outcomes (De Leon et al., 2001). This conclusion supports the results of earlier studies of motivation and treatment outcomes in mandatory counseling (e.g., Sosis et al., 1980). Second, they posit that client motivation at intake predicts clients' perceptions of counselor competence and support from peers (Broome et al., 1997, as cited in De Leon et a., 2001). Third, motivation for treatment appears to be one of the most significant client-related factors in the substance abuse recovery process thus far identified by the

prediction research (De Leon et al., 2001). Fifth, motivation for treatment alone does not directly result in positive therapy outcomes. Motivation helps the individual engage in therapeutic activities and a relationship with the therapist, which lead to significant therapy change (De Leon et al., 2001). Finally, De Leon and colleagues (2001) acknowledge the need for further clarifications of the motivational construct, specifically distinguishing between two constructs, motivation for treatment and readiness for change.

As a part of their 1997 study of treatment process components that improve retention in drug abuse treatment programs, Simpson and colleagues (1997) analyzed the relationship between clients' pre-treatment motivation and other treatment components (e.g., session attendance, therapeutic relationship, time in treatment, outcomes). They identified the strong influence of clients' motivation on the session attendance, and the subsequent effect of the attendance on the development of the working alliance and treatment outcome. It is important to note that the researchers conceptualized motivation for treatment as a phenomenon with three components: problem recognition, desire for help, and treatment readiness (Simpson et al., 1997). They also distinguished three factors in the therapeutic relationship: rapport, motivation, and self-confidence. In other words, Simpson and colleagues conceptualized motivation and therapeutic relationship differently in comparison with the current study.

Reflecting on the literature on motivation in community-based substance abuse treatment, Hiller and colleagues (2002) conclude that motivation predicts both retention and engagement in the treatment. Moreover, authors assert that higher motivation was found to be associated with improved perceptions of personal progress in treatment and

with stronger intentions to remain in treatment. Also pretreatment levels of motivation have been shown to play an important role in the development of therapeutic relationships between clients and therapists (e.g., Broom et al., 1996, 1997, as cited in Hiller et al., 2002). In their own study of treatment motivation influences on clients' engagement in treatment, Hiller and colleagues (2002) identified a number of important findings. Specifically, they conclude that treatment motivation among clients mandated for substance abuse treatment showed a high degree of variability. For example, some clients appeared to be self-motivated by becoming engaged in the treatment program right from the beginning, while others were not. They also conclude that higher levels of motivation were generally associated with higher levels of personal commitment to the treatment. In a recent study on predicting the early therapeutic alliance in drug addiction treatment (Meier et al., 2005) the investigators found that clients who had better motivation along with other factors were more likely to develop good alliances with their therapists. Generally speaking, Hiller and colleagues (2002) posit that in the area of substance abuse treatment "relatively few studies have looked specifically at the influence of motivation on therapeutic engagement in correctional settings" (p. 59).

Willshire and Brodsky (2001) conceptualize the lack in clients' motivation for treatment as one of the major impediments to mandatory therapy. They assert that little motivation for treatment can be found in a number of different areas including problem definition, negative expectations, power and control issues, and cognitive and personality factors. For example, mandated clients often do not experience the problem for which they were referred to counseling as being a problem for them. Denial is often a

component of low motivation. Some involuntary clients are preoccupied with the perceived injustice of their situation, which can prevent them from recognizing their behaviors as misdeeds (Willshire & Brodsky, 2001). Furthermore, involuntary clients may be fearful or ignorant about the process of therapy and their role in it. They may be pessimistic that therapy can do any good or they may feel powerless, asserting “I can’t change or I’ve tried everything and it made no difference” (Willshire & Brodsky, 2001). Some involuntary clients may have negative attitudes toward counseling because of their past experiences with judgmental therapists. Willshire and Brodsky (2001) state that the inherent power imbalance in the client-therapist relationship is intensified in mandatory counseling. Clients may fear that the therapy will be controlling, and that the therapist will try to dominate them. As a consequence, they often fight against what they perceive as an imposition on their freedom. According to Willshire and Brodsky (2001), long-standing problems, rigid coping styles or interpersonal difficulties may lessen clients’ openness and motivation for therapy. Cultural issues may also impede clients’ motivation for treatment. For example, people from certain cultures are more fearful of authority than others (Willshire & Brodsky, 2001).

Lincourt and colleagues (2004) also identified a number of challenges of mandatory modes of treatment which can negatively affect clients’ motivation for seeking substance abuse treatment. Specifically, (1) difficulty identifying problems related to substance abuse; and (2) greater likelihood that the client feels coerced into treatment.

Conclusions related to the current study.

1. A number of research studies in the area of mandatory counseling use conceptualizations of motivation for treatment that are similar to voluntary counseling. For instance, studies conducted by Wild and colleagues (1998), DeLeon and colleagues (2001), and Lauretti (2002) use ideas similar to the self-determination theory (Deci & Ryan, 1985). The present study employed Deci and Ryan's (1985) theory to conceptualize treatment motivation.
2. Motivation for treatment and motivation for change are two different concepts (e.g., Drapeu et al., 2004; Drieschner et al., 2004). Only *motivation for treatment* is investigated in the present study.
3. A number of studies looked at factors which can impede clients' motivation for treatment (e.g., Lincourt et al., 2004; Willshire & Brodsky, 2001). However, only one process-oriented empirical study of the relationship between motivation for treatment and the development of the working alliance was identified (Simpson et al., 1997). Therefore, it appears important to investigate the link between two variables (motivation and working alliance) that are very essential for the treatment outcomes more thoroughly.
4. The literature on mandatory counseling forwards somewhat contradictory views of the initial treatment motivation of involuntary clients. Some authors suggest that mandated clients lack motivation for treatment (e.g., Riordan & Martin, 1993; Willshire & Brodsky, 2001). Others posit that initial treatment motivation of mandated clients shows a high degree of variability (e.g.,

De Leon et al., 2001; Hiller et al., 2001). This study explored the variability of treatment motivation across mandated clients.

Placebo, Hope and Expectancy Factors: Clients' Hope

“The grand essentials of happiness are: something to do, something to love, and something to hope for.”

Alan K. Chalmers, as cited in Cooper et al. (2003, p. 67)

The importance of hope is relatively new not only in therapy and counseling, but in social science in general. Only in the late-20th century did the social sciences start studying hope (Lopez et al., 2003). Specifically, a number of definitions and measures of hope were developed; scientists made attempts to classify hope as emotion or cognition. In his 2002 empirical comparison of four measures of hope and optimism, Lyndall G. Steed states that “the propensity to view life positively has long been associated with psychological and physical health, but it did not receive serious attention in the scientific literature until Menninger (1959), Frankl (1963), and Stotland (1969) introduced hope to the academic literature” (p. 466). However, researchers and practitioners became actively interested in the concept of hope only in the mid-1970s, as a result of research related to stress, coping, and illness (Snyder et al, 1991). Since then, there has been increasing attention to defining and operationalizing positive constructs such as hope. As a result of reviewing the status of empirical evidence on the efficacy of psychotherapy (Lambert & Bergin, 1986), Lambert (1992) concluded that clients' hope is included in a group of therapeutic factors called “placebo, hope, and expectancy factors.” The contribution of this group to successful therapy outcomes is significant and constitutes about 15 percent (Lambert, 1992).

Clients' Hope in Voluntary Counseling

In 2003, Lopez and colleagues identified 26 different theories and definitions of hope in addition to a handful of validated measures. They classified theories of hope into two categories: (1) theories that conceptualize hope as emotion; and (2) theories that conceptualize hope as cognition. A detailed discussion of these theories is beyond the scope of the present study and can be found elsewhere (e.g., Lopez et al., 2003; Snyder, 1995). More recently, another category of hope theories has begun to emerge. Theories in this third category incorporate cognition as well as emotion into the conceptualization of hope. Snyder and his colleagues (1994) have developed a hope theory that has received considerable attention in the past two decades. The hope theory is a strength-based construct that is a part of the positive psychology field (Snyder et al., 2003).

Reflecting on many definitions of hope (e.g., Beck et al., 1974; Cantril, 1964; Erickson et al., 1975; Farber, 1968/1991; Frank, 1968; Frankl, 1992; Lewin, 1938, as cited in Snyder et al., 1996), Snyder and colleagues concluded that hope refers to the overall perception that one's goals can be met (1991). Analyzing the construct of hope further, Snyder and colleagues (1991) refined the definition and added new dimensions to this concept. They view hope as "individuals' perceptions regarding their capacities to (1) clearly conceptualize goals, (2) develop the specific strategies to reach those goals (pathway thinking), and (3) initiate and sustain the motivation for using those strategies (agency thinking)" (Snyder et al., 2003). In other words, they assert that hope consists of three components including goals, pathways, and agency (Snyder, 2000). *Goals* anchor hope theory by being the targets of person's mental actions. Goals may be short- or long-

term, but they need to be valuable in order to occupy a person's thoughts. Additionally, goals vary in their difficulty of attainment (Snyder, 2000). To reach goals, people need to be able to imagine strategies to accomplish their goals – *pathway thoughts*. According to Snyder (2000), pathway thinking reflects the person's self-perceived ability to generate reasonable alternative ways to achieve goals. *Agency thinking* is a motivational component of the hope theory. Agency reflects the belief that "one can initiate and sustain movement along the imagined pathways to goals" (Snyder, 2000, p. 13). Agentic thinking is especially important when the initial ways to achieve the goals are blocked and the person needs to re-direct his or her motivation (Snyder, 2000). Without both the pathway and the agency for goals, high-hope cognitions are not active; therefore, neither agency nor pathways alone is sufficient to produce high hope (Snyder, 1995). Snyder asserts that "hope is "carried," in part, by an internal dialogue that people have about themselves and their goal pursuit activities" (1995, p. 18). In 1999 Magaletta and Oliver raised the question about the relations between the hope construct and its two essential components "will or pathway thinking" and "ways or agency thinking" (Snyder, 1995) as well as constructs of self-efficacy and optimism. In their empirical investigation of these relations (Magaletta & Oliver, 1999) they found that "will, ways, self-efficacy, and optimism are related but not identical constructs" (p.539).

Also stated in hope theory is that emotions follow one's thoughts about achieving goals (Snyder, 2000). Therefore, "emotions are a by-product of goal-directed thought" (p.13). In other words, the perceptions regarding the success of goal pursuits drive subsequent positive and negative emotions (Snyder et al., 1996). Snyder and colleagues

(2003) assert that hope can exist in a relatively stable disposition (i.e., trait) or as a more temporary frame of mind (i.e., state). People have dispositional hope that applies across situations and time, but they also have state hope that reflects particular times and more proximal events (Snyder et al., 1996). It is important to notice that dispositional hope is related to the intensity of state hope by setting a band range within which state hope varies (Snyder et al., 1996).

Another conceptualization of hope by Staats (1989) asserts that hope refers to future-referenced events that are wished for, have positive affect and have some cognitively perceived probability of occurrence. According to this conceptualization, hope includes (1) the difference between expected positive and expected negative affect (emotion); and (2) the interaction between wishes and expectations (cognition) (Staats, 1989).

Richard Erickson and his colleagues were among the first authors who addressed hope empirically in psychotherapy. In their 1975 study of hope as a psychiatric variable, Erickson and colleagues tested Stotland's (1969, as cited in Erickson et. al., 1975) conceptualization of hope as a high expectation about goal attainment by designing and validating the hope scale. A number of conclusions regarding hope in psychotherapy were made as a result of this study. Specifically, it was found that psychopathology is associated with lower estimates of perceived probability of goal attainment (i.e., hope). Also, the researchers found that the lower the perceived probability of goal attainment and the higher the importance of the goal, the more the individual will experience anxiety (Erickson et al., 1975). And finally, Erickson and associates (1975) concluded that

effective treatment helps increase the perceived probability of goal attainment (i.e., hope). Since that time, numerous research initiatives have been undertaken to study the phenomenon of hope.

A number of authors position hope as the cornerstone of effective therapeutic practice and a major catalyst of change within therapy (e.g., Cooper et al., 2003; Darmody, 2003; Lori et al., 2004). For example, as early as in 1968, Frank (Frank & Frank, 1991) asserted that the mobilization of hope is a critical factor in predicting a positive therapeutic outcome. According to Snyder (2000), “the beneficial changes in clients may result because clients are learning more effective agency and pathways goal thoughts” (p. 18). While studying therapy drop-outs, Perley and colleagues (1971, as cited in Staats, 1989) found that persons with higher hope were more likely to initiate activities (e.g., help-seeking) and seemed more likely to persist in such activities once initiated.

Hope has also been theorized and studied in relation to specific client population. For example, hope is viewed as a very important phenomenon in work with suicidal clients. A number of research studies concluded that hopelessness is a key element in determining whether or not a person will commit suicide rather than merely considering it (e.g., Motto et al., 1985; Weisharr & Beck, 1992; Cutcliffe & Barker, 2002).

The study conducted by Snyder and colleagues (Lopez et al., 2003) concluded that high-hopers, who have successfully dealt with stressors and attained desired goals, generally have positive emotions as well as confidence. On the contrary, low hopers have histories of not dealing successfully with stressors along with negative emotions and

flatness. Moreover, summarizing research conclusions on the advantages of elevated hope, Snyder (1995) states that higher-hope individuals, as compared with lower-hope ones, have a greater number of goals, have more difficult goals, have success at achieving their goals, perceive their goals as challenges, have greater happiness and less distress, have superior coping skills, and recover better from physical injury.

Frank and Frank (1991) address a possible connection between clients' levels of hope and the working alliance development in the following statement: "Patients' own world-views or personal attributes predispose them to accept some therapeutic conceptualizations and procedures more readily than others" (p. 167). In the other words, it can be said that clients' general level of dispositional hope (i.e., hope as a trait) pre-defines how receptive the client will be of a therapist, therapy, and the client's own role in establishing therapist-client relationship. Ryan and Cicchetti' (1985) empirical investigation of pre-therapy predictors of early working alliance revealed that hope is among a group of client variables that explain 10% of the variance in client working alliance ratings. Finally, the findings from numerous studies on hope suggest that clients' hope can be enhanced through therapeutic interventions (e.g., Erickson et al., 1975; Klausner et al., 2000, as cited in Snyder, 2000).

Conclusions related to the current study.

1. Taken together, the literature review findings suggest that there is strong relationship between clients' level of hope and treatment outcomes (e.g., Cooper et al., 2003; Darmody, 2003; Frank & Frank, 1991; Lori et al., 2004).
At the same time, researchers have not made significant attempts to

empirically investigate the role hope plays in the therapy process and the working alliance development specifically. In other words, no process studies regarding hope were identified. This finding highlights the need for research inquiries in this area.

2. The present study utilized Snyder and colleagues' (1991) hope theory as a theoretical framework to conceptualize hope. The choice was made based on a number of criteria. Specifically, (1) hope theory has gotten significant research support, (2) hope is conceptualized in this theory as a multidimensional phenomenon with both emotion and cognition present; (3) state and trait hope are distinguished between each other in this theory, and (4) utilizing major ideas of the hope theory Snyder and colleagues (1991) has developed an assessment instrument (i.e., Hope Scale) with sound psychometric properties (see Instruments section).
3. Hope theory helps explain the differences between the construct of hope and the construct of motivation for treatment. Specifically, agency, which is a motivational component in hope, is a concept different from one's motivation for treatment. Agency refers to person's belief that he or she can sustain "movement along the imagined pathways to goals" and achieve them, while motivation for treatment refers to the level of clients' desire to enter therapy and become involved in therapeutic activities (e.g., building the working alliance).

4. The current study assessed hope as a relatively stable personality disposition (i.e., trait). The hypothesis was that higher levels of hope would be associated with stronger working alliance.

Clients' Hope in Mandatory Counseling

Although the significance of hope in voluntary counseling has been recognized by researchers and practitioners, researchers in mandatory counseling have not made a concerted attempt to investigate the hope construct. The review of literature on this topic did not identify any empirical studies or theoretical writings on hope in mandatory counseling.

One reference to hope in mandatory counseling was found in the Cooper, Darmody and Dolan's article (2003). According to Darmody, involuntary clients participate in therapy because doing so constitutes a better alternative than going to jail, losing a significant relationship, or other undesirable outcomes. "The mandated clients harbor a hope to retain their liberty, or to remain in their current relationship" (Cooper et al., 2003, p. 68). Moreover, mandated clients may hope that when they get out of treatment, their life will be better and they will not make the same mistakes. In other words, involuntary clients have hope. As Lopez and colleagues (2003) concluded, hope is a universal construct.

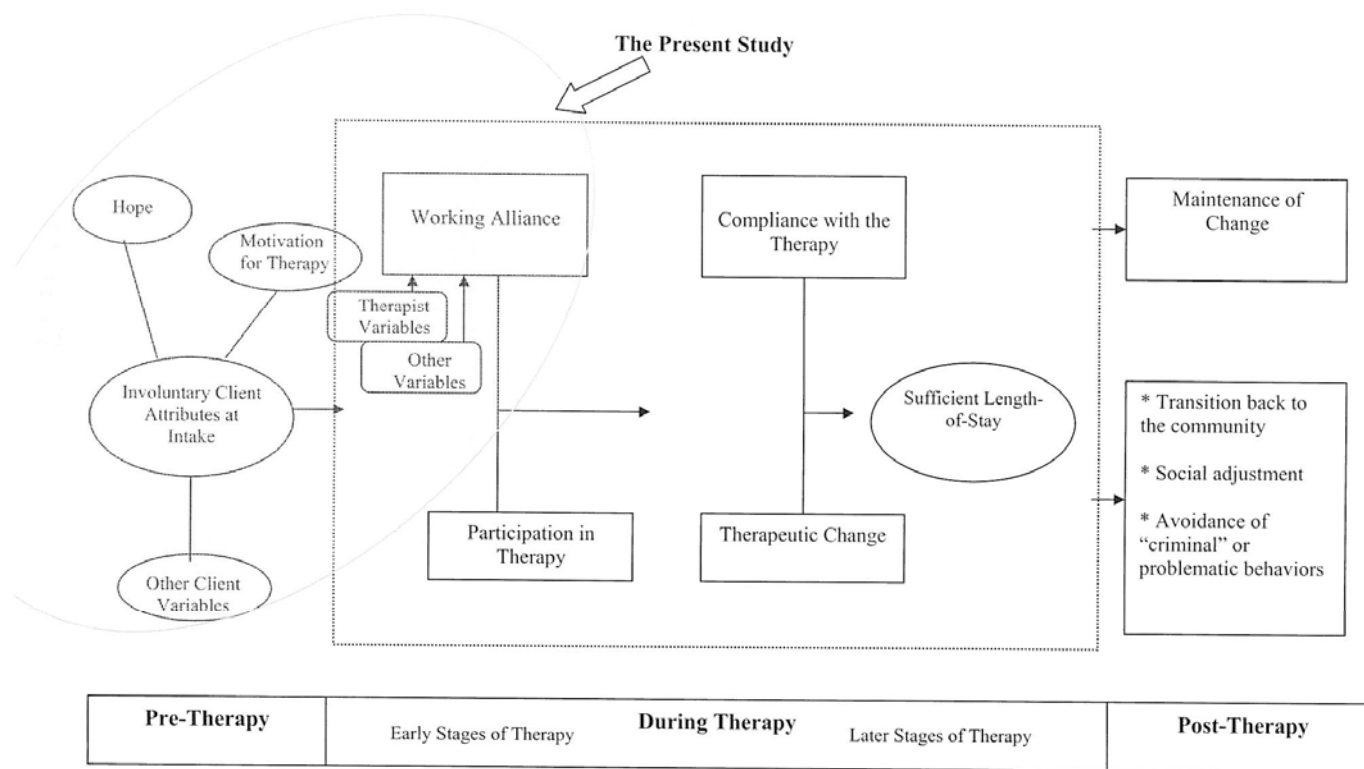
In the present study, the hope of mandated clients was defined similarly to hope of voluntary clients. Specifically, hope includes mandated clients' perceptions regarding their capacities to (1) set goals, (2) develop specific strategies to achieve their goals, and (3) initiate and sustain the motivation for using developed strategies (Snyder et al., 2003).

The fact that literature on mandatory counseling does not address the role of clients' hope in the therapy process highlighted the need to research this phenomenon.

Literature Review Conclusions: Current Need for a Mixed Methods Study

Taking all literature review findings together, the content logic of the current study can be illustrated in a visual graph (Figure 2.1). Through the literature review and work with clients, the researcher became aware that many factors besides motivation for treatment and clients' hope, contribute to the development of the working alliance (e.g., severity of the problem, previous relationship history, therapist variables). However, the current literature on voluntary as well as mandatory counseling positions motivation and hope as critical phenomena in the development of the working alliance. The qualitative portion of the current study investigated other variables that influenced the development of the working alliance in mandatory counseling (e.g., client's perception of therapist variables). Motivation and hope represent two characteristics that clients present at therapy intake. Because these two characteristics are the first elements in the model, it was hypothesized that they influence the entire therapy as well as posttherapy highlighting their importance. Findings for the current study clarified the role of motivation and hope in the development of the working alliance at the early stages of therapy.

To summarize, the review of the literature supported investigating the development of the working alliance in mandatory counseling. Empirical evidence and conceptual ideas have been consistent in implicating motivation for therapy, clients' hope



Note: This figure is a modified version of Texas Christian University Treatment Process Model (Hiller et al., 2002). The shaded area highlights the scope of the present study, including pre-therapy stage and early stages of the therapy. Other stages of therapy (e.g., post-therapy) along with their elements (e.g., social adjustment) are beyond the scope of the present study.

Figure 2.1. Content visualization of the present study.

and the working alliance as important process variables in voluntary as well as mandatory counseling (e.g., Bordin, 1979; Honea-Boles & Griffin, 2001; Lauretti, 2002; Lopez et al., 2003; Pelletier et al., 1997). Moreover, the contradictions in the literature regarding involuntary clients motivation for treatment; research emphasizing the pivotal role of the working alliance in the treatment outcomes (e.g., Sexton & Whiston, 1994); conceptual writings on the relationship between motivation for treatment and the working alliance (Rosenfeld, 1992); and the lack of empirical studies and theoretical writings on involuntary clients' hope, suggested that systematic quantitative as well as qualitative examinations of factors that affect the working alliance development are necessary. Therefore, investigating the role of client motivation for therapy and client hope in the development of the working alliance was a main focus for the present study. This study adds to the developing literature on the process of therapy in mandatory counseling, and the development of the working alliance specifically.

Characteristics of Mixed Methods Design Research

The present study used a mixed methods design (Tashakkori & Teddlie, 2003). The literature on research designs describes mixed methods as a research type where both quantitative and qualitative approaches are implemented (Tashakkori & Teddlie, 1998; see also Creswell, 2002). Both types of data are collected concurrently or sequentially with a priority given to one of them. During the process of a mixed methods research, quantitative and qualitative data are integrated at one or more stages of the research (Creswell et al., 2003).

Mixed method design is a relatively new design in science. In 1959 “multitrait-multi-method matrix” was proposed by Campbell and Fiske (Tashakkori & Teddlie, 1998) as an alternative to the mono-method that dominated in the world of psychology during the past three decades (Tashakkori & Teddlie, 1998). By proposing a new way of doing research – mixed methods - Campbell and Fiske wanted to assure that the variance of the phenomena that is studied is accounted by the phenomena itself and its traits and not by the method (Tashakkori & Teddlie, 1998). Since then there were many terms used to describe a design that incorporates quantitative and qualitative procedures, including multi-method, triangulation, integrated, combined, mixed methodology, qualitative and quantitative methods (Tashakkori & Teddlie, 2003). Nevertheless, the term that recently was chosen to describe this design is “mixed methods” (Creswell, 2002; Tashakkori & Teddlie, 2003).

There are two distinct research parts in a mixed methods design. Each part has its own philosophical roots. In quantitative research an investigator uses postpositivistic claims for developing knowledge, such as cause and effect thinking, reduction to specific variables, hypothesis and questions, use of measurement and observation, and the test of theories (Ivankova, 2004). On the other hand, qualitative research is “an inquiry process of understanding” where the researcher develops a “complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (Creswell, 1998, p. 15). In this approach, the investigator makes knowledge claims based on the constructivist (Creswell, 1998; Lincoln & Guba, 1985) or participatory (Mertens, 2003) perspectives. In a mixed methods methodology, the researcher builds the

knowledge on pragmatic principles (Creswell, 2003), asserting truth is “what works” (Howe, 1988, as cited in Ivankova, 2004). The investigator chooses approaches, as well as variables and units of analysis, which are most appropriate for finding an answer to research questions (Tashakkori & Teddlie, 1998). Pragmatism allows for quantitative and qualitative methods to be compatible (Creswell, 2003).

The popularity of the mixed methods design is growing over time. Counseling psychology is one of the psychology fields that encourages researchers to incorporate advanced mixed methods strategies in their studies’ designs. Examining counseling psychology empirical inquiries, Hanson and colleagues (2005) identified 22 mixed methods studies that were published between 1986 and 2000. The following advantages of mixed methods design could explain why researchers may choose to employ mixed methods design while studying a phenomenon. The mixed methods methodology allows the researcher to: (1) converge or confirm the results of different data sources, (2) examine similarities and differences of different results, and (3) expand the understanding of results of one method by using another one (Creswell, 2002; Tashakkori & Teddlie, 1998). At the same time, mixed methods researchers forward the view that this design encompasses all challenges of doing quantitative and qualitative research plus includes its own challenges (e.g., Creswell, 2002). These challenges might include (1) a requirement for the inquirer to be familiar with quantitative and qualitative procedures, (2) very extensive data collection that requires a lot of resources and time, and (3) a need for special strategies of analyzing both quantitative and qualitative data (Creswell, 2002).

Advantages and Limitations of the Sequential Explanatory Design

The literature widely discusses the strengths and weaknesses of mixed methods designs (e.g., Green & Caracelli, 1997; see also Creswell, 2002; Creswell, 2003; Ivankova, 2004; Morse, 1991). Advantages of the sequential explanatory design that will be utilized in this study include:

1. The design is straightforward and sequentially proceeds from one stage to another.
2. The design is relatively easy to implement for a single researcher, because it has separate stages.
3. The design enables the researcher to explore quantitative results in more detail.
4. The design is particularly useful to explain unexpected results which could arise from the quantitative phase of the study.

The limitations of this design include:

1. As any other mixed methods sequential design, it requires lengthy time to complete.
2. The design requires feasibility of resources to collect and analyze both types of data.

Given the discussed strengths and weaknesses, the current investigation exemplifies how mixed methods methodology is imperative in studies with limited sample size.

CHAPTER III

METHODOLOGY

The Present Study Design

Mixed Methods Sequential Explanatory Design

The present study utilized sequential explanatory mixed methods design. The quantitative phase of this study was designed as a quasi-experiment. The qualitative phase of the study was designed as a multiple case study. A number of reasons guided the choice of a mixed methods design for the present study. The major rationale for utilizing quantitative data collection and analysis was defined by an apparent agreement in the literature that clients' hope and motivation are among the most influential client factors in the development of the working alliance. However, neither literature on voluntary counseling nor theoretical and empirical writings on mandatory counseling provide knowledge about the strength of influence clients' motivation and hope have on the development of the working alliance. The current research was aimed at breeching this gap. Alternatively, the main rationale for employing a qualitative case study approach included the need to understand the nature of the working alliance, and the nature of motivation and hope phenomena within the working alliance. Bachelor (1995) emphasizes that scientists' perceptions of therapy phenomena (e.g., working alliance, motivation, hope) or constructs elicited by researcher's definitions of these phenomena may not be the same as those clients would spontaneously generate. Therefore, qualitative investigation of clients' views of the working alliance, motivation, hope and

other factors contributing to the development of the working alliance seemed warranted to gain understanding of clients' subjective perceptions.

While designing the present mixed methods study, three issues were considered: priority, implementation, and integration (Creswell et al., 2003). Priority refers to which method (qualitative or quantitative) is given more emphasis in the study. Implementation refers to whether the quantitative or qualitative data collection and analysis comes in sequence, in parallel, or concurrently. Integration is the phase in the research process that connects the quantitative and qualitative data.

Implementation

The present study utilized one of the most popular mixed methods designs in counseling (Hanson et al., 2005): two-phase sequential explanatory design, consisting of two distinct phases (Creswell, 2002, Tashakkori & Teddlie, 1998). In the first phase, the quantitative, numeric, data was collected, using self-report questionnaires. Upon collection, the quantitative data was subjected to a latent growth curve analysis with time invariant covariates. The goal of the quantitative phase was to identify the strength of influence clients' motivation and hope have on the development of the working alliance and to allow for the purposeful selection of informants for the second phase. In the second phase, a qualitative multiple case study approach was used to collect text data through individual semi-structured interviews, and observations to help (1) explain and enrich the quantitative findings, (2) explain the differences and similarities in counseling experiences between mandated clients with different trajectories of change in the working

alliance, and (3) gain information concerning other client' and therapist' factors that may influence the development of the working alliance in mandatory counseling.

Priority

The priority in this study was given to the qualitative phase, because it was focused on in-depth explanations of the results obtained in the first, quantitative phase of the study. A multiple case study analysis of six participants representing different trajectories of change in the working alliance was used to study, interpret, and enrich the results from the statistical tests. The data analysis was performed on two levels: individual cases and across cases (Stake, 1995).

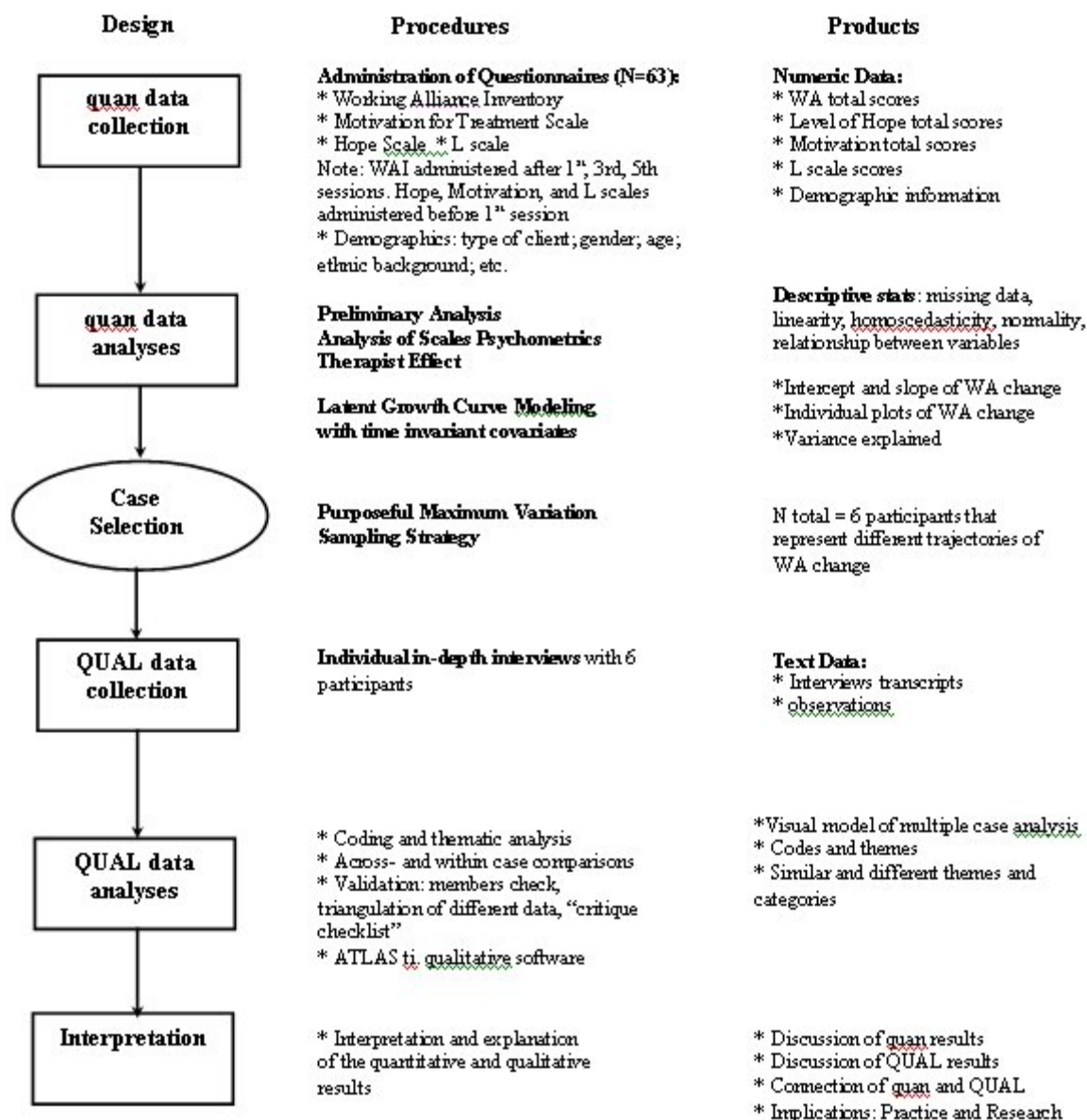
Integration

Integration of quantitative and qualitative data occurred on a number of levels. First, the quantitative and qualitative methods were connected in the intermediate phase of the research process while selecting the participants for the case study analysis. Second, the results of two phases were integrated during the interpretation of the research findings of the entire study. The visual model of the procedures for the mixed methods sequential explanatory design of this study is depicted in Figure 3.1.

Qualitative Research Design

A multiple case study multi-site design (see Stake, 1995; Creswell, 1998) was used for collecting and analyzing the qualitative data. A case study is the study of “particularity and complexity of a single case, coming to understand its activity within important circumstances” (Stake, 1995, p. xi). When more than one case is studied, it is referred to as collective or multiple case study (Stake, 1995; see also Creswell, 1998).

Visual Model for Mixed Methods Sequential Explanatory Design Procedures: The Present Study



The participants for the present study were recruited from different counseling clinics, what makes the design multi-site (Creswell, 1998). Case study design includes detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, researcher's notes) (Creswell, 1998). In this study, the instrumental multiple cases (Stake, 1995) served the purpose of "illuminating a particular issue" (Creswell, 2002, p. 485), such as the development of the working alliance in mandatory counseling. The cases were described and compared to provide insight into the issue (Stake, 1995). The unit of the analysis was a client mandated to receive counseling services selected on a maximum variation principle. Each case study was bounded by one individual client mandated for counseling (case boundary) and by five counseling sessions (time boundary). The data were collected from multiple-sites (place boundary), including university counseling training clinics (i.e., 3 sites), and a community counseling center.

Connecting Quantitative and Qualitative Data in Mixed Methods Design

The qualitative phase of this study was focused on explaining and enriching the results from the statistical tests, obtained in the quantitative phase. In the mixed methods sequential explanatory design, two types of data, quantitative and qualitative, are typically mixed between the two phases while selecting participants for the qualitative follow-up analysis. In other words, participants are selected based on the quantitative results of the first phase (Creswell, 2003). In this study the qualitative and quantitative data were connected during the intermediate phase of the research while selecting the participants for the multiple case study analysis. Furthermore, the results of the two phases were integrated during the interpretation of the research outcomes.

Role of the Researcher

The functions that the principal researcher performed during the current investigation included (a) establishing relationships with data collection sites (i.e., “gate keepers”); (b) collecting the data (quantitative as well as qualitative), (c) analyzing the data, and (d) discussing the data. In the first, quantitative phase of the study the researcher recruited participants and administered the questionnaires. After that, the quantitative data analysis was performed using Latent Growth Curve Modeling technique and the results were interpreted based on statistical conclusions. It bears noting that even though the principal investigator holds a graduate degree in psychology, other therapists were asked to work with mandated clients in counseling. Doing this let the researcher distant herself from the counseling process to make relatively objective conclusions about it. In the second, qualitative phase, the researcher interviewed all participants chosen to take part in the Phase II of the study to ensure the consistency of the interviews.

Ethical Considerations

Ethical issues were addressed at each stage of this study. In compliance with the regulations of the Institutional Review Board (IRB), the Request for Review Form was filed, providing information about the principal investigator, the project title and type, type of review requested, number and type of subjects. Application for research permission contained the description of the project and its significance, methods and procedures, participants, and research status. All assessment instruments and cooperation letters from the data collection sites were appended to the application. The project status was classified as a full-board review because the participants fell into the sensitive

category of participants. The IRB permission for conducting the research was obtained in August 2005 (see Appendix A-1). Moreover, the permission to involve correctional center inmates in the research study was obtained from the Department of Correctional Services (see Appendix A-2). Two separate informed consent forms were developed for Phase I and Phase II of the study (Appendices B-1 and B-2). Only after receiving signed and dated informed consents the questionnaires were administered and interviews conducted. There were several potential ethical issues for the current investigation that had to be addressed while the data was gathered:

1. *Limitation of free choice to participate or not participate in the research.* At the recruiting stage it was emphasized that participants' decision to participate in the research or not would not (a) influence their relationship with their therapist or/and with an agency which mandated counseling; (b) give them any additional privileges (e.g., privileges in the correctional agency, early data of release).
2. *Limitations of confidentiality.* Consent forms clearly specified any possible limits to confidentiality. All direct identifiers (e.g., name, therapist's name) were removed from the data substituted with codes. Code lists were stored separately from the data files. Only the principal investigator had an access to the code lists. While conducting the case studies with the selected participants in Phase II, they were assigned fictitious names for use in reporting results, thus keeping the responses confidential.

3. *Selection of the participants.* The goal of a sample selection phase of this research was to identify persons who are mandated for counseling by an agency. The researcher obtained information regarding which clients were mandated for counseling from a clinic coordinator or a correctional center case manager only after clients agreed to talk to the researcher. All clients mandated for counseling were approached by the case manager in the correctional center or by a therapist in a waiting room and asked if they would like to speak to the researcher. Those who agreed received a packet with a study description and informed consents. Information about a person's decision to participate in the research or not was strictly confidential.
4. *Undue inducement.* A \$6 compensation for participating in the quantitative phase and \$5 for participating in the qualitative phase of the research was given to the participants. This compensation seemed to be reasonable for participation in this research (i.e., filling out 5 questionnaires at three data collection points, and participating in 1-hour interview). Additionally, the Department of Correctional Services as well as IRB approved the compensation amount as appropriate. Therefore, this amount of compensation was not considered to be an undue inducement.
5. *Experimenter expectancies.* To minimize "experimenter expectancies" the therapists who provided counseling were not informed about the phenomena that will be studied (i.e., working alliance, hope, motivation). However, they

were informed that the research would examine the therapy process with mandated clients.

Participants

The target population in this study was clients who were mandated for receiving individual counseling services. Clients were recruited at a number of sites, including university counseling clinics, and a community counseling center. All participants in the current study represented one type of mandated clients, Community Correctional Center inmates whose release plan included counseling as a condition. The next paragraph briefly summarizes the circumstances under which an inmate is required to receive counseling services.

When a person who committed a crime displays appropriate behaviors in prison and is close to a parole date, she or he may be transferred to the Community Correctional Center. All inmates are evaluated by a number of professionals, including a licensed mental health practitioner. A mental health professional may or may not request that an inmate receives counseling services based on the crime committed by this inmate. This requirement does not include a specific number of sessions. It is left up to a counselor to decide when counseling should be terminated. When counseling is mandated, it becomes a part of the inmate's personal plan for release. In a case when individuals do not follow through on their counseling requirement the parole day may be postponed until this requirement is successfully met. To attend individual counseling services, the inmates of this Midwestern community correctional center receive a pass with a permission to attend a psychological clinic. At the end of every session attended by an inmate, a counselor

who works with that inmate signs the pass issued by the correctional center, indicating that the session was attended.

Criteria for selecting the participants included: (1) being mandated to work with a counselor; (2) being mandated for an individual counseling; and (3) being not younger than 19 years old. Sixty-three participants took part in the quantitative phase of the study (Phase I). Six participants were selected for the qualitative phase (Phase II) and interviewed.

The therapists ($N = 29$) that worked with the clients were graduate students in counseling psychology ($n = 15$), graduate students in marriage and family therapy ($n = 12$) and professional counselors ($n = 2$). The therapists came from three different clinics: (1) a counseling psychology training clinic ($n = 15$), (2) a marriage and family counseling training clinic ($n = 12$), and (3) a community counseling clinic ($n = 2$), and varied in the following ways: gender, professional degree, ethnicity and past experiences of working with clients. Five therapists were males (17%) and twenty-four were females (84%). Ethnicity also varied: African-American ($n = 1$; 3%), Asian ($n = 1$; 3%), Hispanic ($n = 1$; 3%); and Caucasian ($n = 26$; 91%). Finally, 6 therapists (21%) held Masters degrees and twenty-three (79%) had Bachelors degrees. The information regarding therapists' theoretical orientation as well as age was not collected because clients were the focus of the study.

Instrumentation

Independent Variables and Measures

The research questions for the current study predetermined a set of variables. Client motivation for treatment and client hope were treated as covariates, because they influenced or affected the dependent variable (i.e., working alliance). Both variables were continuous. These variables were identified through analysis of the literature related to working alliance in voluntary and mandatory counseling outlined in Chapter 2.

Client Hope and Adult Dispositional Hope Scale

Clients' level of dispositional hope was measured by the Adult Dispositional Hope Scale (Snyder et al., 1991). For clients this scale is called Goals Scale (Snyder et al., 1991). The purpose of the Adult Dispositional Hope Scale (*Hope Scale*) is to measure the trait aspect of hope in adolescents and adults ages 15 and higher (Snyder et al., 1991). The Hope Scale consists of 12 items: four are distracters, four measure agency for goals, and four measure pathways thinking in regard to goals. Each subscale is scored on an 8-point continuum that ranges from 1 (*definitely false*), to 8 (*definitely true*). Total scores can range from a low of 8 to a high of 64. Having been used with a wide range of samples, the Hope Scale has demonstrated acceptable and strong (1) internal consistency: a range for agency scores is from .70 to .84; a range for pathways scores is from .63 to .86; and a range for total scores is from .74 to .88; (2) test-retest reliabilities ranging from .85 for three weeks to .82 for ten weeks; (3) concurrent and discriminant validities (Snyder et al., 1991). For the purposes of the current study, the subscales scores (pathways and goals) were combined to calculate a total score. The total score on the

Hope scale represented a level of dispositional hope that an individual possesses. Higher scores on the Hope scale indicated higher levels of dispositional hope. The internal consistency of the Hope Scale for the sample in the current study was estimated to be .72 (see Table 3.1).

Table 3.1

Instruments' Sample Sizes, Reliability Estimates, and Number of Items

Instrument	N	Chronbach's Alpha	N of Items
WAI – Time 1	44	.91	36
WAI – Time 2	39	.94	36
WAI – Time 3	25	.88	36
CMOTS – Time 1	51	.85	24
Hope Scale – Time 1	58	.72	8
Lie-Scale (MMPI-2)	57	.52	15

Note. WAI = Working Alliance Inventory; CMOTS = Client Motivation for Treatment Scale; Time 1 = session 1; Time 2 = session 3; Time 3 = session 5.

Client Motivation for Treatment and CMOTS

Clients' motivation for treatment was assessed by Client Motivation for Treatment Scale (*CMOTS*) (Pelletier et al., 1997). *CMOTS* is a 24-item instrument designed to measure client motivation for therapy. Describing the instrument, Pelletier and colleagues state that practitioners can use *CMOTS* to address the impact of client motivation on psychotherapy effectiveness. The instrument includes 6 subscales: intrinsic motivation, integration, identification, introjection, external regulation, and amotivation, each of which is based on Deci and Ryan's (1985) conceptualization of human

motivation and self-determination. Deci and Ryan postulated that six different types of motivation fall along a continuum of increasing autonomy. The subscales are: intrinsic motivation (items 3, 4, 12, 16); integrated regulation (items 17, 18, 23, 24); identified regulation (items 6, 7, 15, 20); introjected regulation (items 5, 9, 10, 19); external regulation (items 1, 11, 21, 22); and amotivation (items 2, 8, 13, 14). Internal consistency estimates of the six subscale scores, based on initial validation sample of 138 clients, ranged from .70 to .92 (Pelletier et al., 1997). Pelletier and colleagues reported that “correlations among motivation subscales form a simplex pattern that, in general, provides support for the continuum of self-determination” (p. 431). For the purposes of the current study, the subscales scores will be combined to calculate a Relative Autonomy Index. The following formula will be used to compute the Relative Autonomy Index: $(3 \times \text{Intrinsic Motivation}) + (2 \times \text{Integration}) + (\text{Identification}) - (\text{Introjection}) - (2 \times \text{External Regulation}) - (3 \times \text{Amotivation})$ (Pelletier, 2005). The Relative Autonomy Index represents the level of internal regulation and self-determination a client possesses. Higher Relative Autonomy Index indicated client’s motivation and behavior that were more internally regulated and self-determined. The internal consistency of CMOTS for the sample in the current study was estimated to be .85 (see Table 3.1).

Dependent Variables and Measures

Working Alliance and WAI

The therapeutic relationship between a mandated client and a therapist was considered a dependent variable and labeled “working alliance.” It was a quantitative continuous variable. The dependent variable was measured by the *Working Alliance*

Inventory – Client Form (WAI) (Horvath & Greenberg, 1989). There are two WAI forms: client and therapist. Only the Client Form was used in the current study. The inventory was designed to measure the quality of therapeutic alliance between client and therapist. WAI is self-administered self-report measure. WAI-client form consists of 36 questions and includes three subscales: bond, task, and goal, each of which is based on Bordin's (1979) conceptualization of WA. Each WAI subscale is scored on a 7-point descriptively anchored Likert scale ranging from 1 (*never*) to 7 (*always*) and has 12 nonoverlapping items. Subscale scores can range from 12 to 84. Total scores can range from 36 to 252. Higher scores reflected more positive and stronger ratings of the working alliance. Internal consistency estimates of the three subscale scores of the WAI-Client Form, based on initial validation samples of 29 and 25 clients, ranged from .85 to .92 (Horvath & Greenberg, 1989). Internal consistency estimates of the total scores for the WAI-Client Form were .93 (Horvath & Greenberg, 1989). The recent study conducted by Hanson, Curry, and Bandalos (2002) supported previous statistical conclusions regarding WAI-Client Form internal consistency. Specifically, (1) internal consistency estimates of the three subscale scores ranged from .77 to .97, and (2) internal consistency estimates of the total scores ranged from .83 to .97. For the purposes of the current study, the subscales scores (bond, task, and goal) were combined to calculate a total working alliance score. The total score on the WAI represented an overall client's rating of the working alliance. Higher WAI scores indicated a stronger working alliance. The internal consistency of WAI-Client Form for the sample in the current study was estimated to be: .91 (WAI-Time 1), .94 (WAI-Time 2), .88 (WAI-Time 3) (see Table 3.1).

Social Desirability

MMPI-2 *L scale*, a measure of social desirability, was used in the current research to assess for the occurrence of demand characteristics. The presence of demand characteristics was assessed to understand the degree to which social desirability influenced the data. Social desirability scores were not included in the latent growth model analysis. The L scale was utilized as a validity scale for the rest of the research data. The analysis of the L Scale scores revealed that profiles of 88 percent of participants ($n = 52$) were clearly valid. Eleven percents of participants ($n = 7$) had questionably valid profile. One participant (1%) had clearly invalid profile on the L-Scale. Even though there were a number of profiles with moderate score elevations, all data were used in the further Latent Growth Modeling analysis. Butcher and colleagues (2001) suggest that when there is a strong press for presenting oneself in a favorable manner, moderate elevations on L Scale are common and do not necessary indicate an invalid profile. One participant, who had a high score on the L scale was not considered as a candidate for the qualitative phase of the study because of a high probability for “faking good.” Furthermore, this participant’s quantitative data were excluded from the quantitative analysis. Due to the fact that the majority of participants had valid L Scale profiles, it was assumed that no adjustments to the final interpretation of the Latent Growth Curve Modeling results were needed.

The L scale is a measure of the tendency of some individuals to distort their responses by claiming that they are excessively virtuous (Butcher & Williams, 1992). The scale consists of 15 true or false items. This scale, when elevated (i.e., T scores

greater than 65), reflects naïve or obvious attempts by a person to put oneself in a favorable light, to look unusually virtuous, overly conscientious, and above moral reproach (Friedman et al., 2001). The mean score for both males and females (contemporary normative sample) on the L scale is 3.5 (T score of 50) (Friedman et al., 2001). It has been shown that moderator variables (e.g., SES, education, and occupation) can greatly affect scores on this scale (Friedman et al., 2001). For example, college educated individuals and those with higher SES infrequently obtain scores above 50. Individuals of lower SES with less education tend to earn higher scores on the L scale because the items reflect a more obvious form of test taking defensiveness (Dahlstrom & Tellegen, 1993, as cited in Friedman et al., 2001). It has been suggested that a raw score of 4 or 5 (T scores of 52 and 56 accordingly) can be considered a moderate score for individuals in a lower SES or for persons who work as laborers (Groth-Marnat, 1990). The test-retest reliability coefficients on the L scale over 1-week interval are estimated to be .77 (for men) and .81 (for women) (Friedman et al., 2001). The internal consistency of the L scale for the sample in the current study was estimated to be .52 (see Table 3.1).

Demographic Information

Demographic Information Questionnaire was administered for the purposes of (a) describing the participants of the study, (b) conducting the preliminary data analysis, and (b) judging the generalizability of the results of the study. The following demographic information was collected: participants' age, gender, ethnic background, previous experiences with individual counseling, and an agency which mandated counseling.

Data Collection Procedures

Two types of data were collected: quantitative and qualitative. Quantitative data were collected first (Phase I), and qualitative data were collected second (Phase II).

Quantitative Procedures

Selection of the Participants

For the purpose of the first, quantitative phase of the study a convenience sample was selected. The sample included 63 community correctional center inmates who were mandated to receive individual counseling services (see Results section for demographic characteristics of the sample). Mandated clients' names were obtained through a number of sources, including (a) university clinic assistants; (b) correctional center case managers, and (c) community clinic assistants. All identified mandated clients were approached before the first session (e.g., in the waiting room, in the correctional center) and offered an opportunity to participate in the research. An informed consent with detailed descriptions of the purposes and procedures of the research was given to participants to read and sign. In addition to study description, the informed consent stated that (a) 7-8 responding individuals would be contacted for a follow-up interview; (b) six dollars would be offered to participants to provide an incentive to complete the questionnaires (two dollars for each wave of data collection) and another five dollars would be given to those participants who complete the interviews. Only those participants, who read and signed the informed consent, were asked to fill out the questionnaires and participate in the interviews.

Quantitative Data Collection

For the first, quantitative phase the longitudinal design with multiple substantive posttests was utilized. This included the data collection at several time points. For reliable and accurate latent growth model parameter estimation a minimum of 3 data points are required (Singer & Willett, 2003). Therefore, the quantitative data collection for the present study had three waves (see Table 3.2). Wave 1 included (1) administration of CMOTS, Hope Scale, Demographic Information, and Lie scale right before the intake session, and (2) administration of WAI right after the intake session. Wave 2 included administration of WAI right after 3rd session. Wave 3 included administration of WAI right after 5th session. The participants received a small monetary incentive of \$2 cash after they completed each wave of the assessment (i.e., total of six dollars).

Table 3.2

Data Collection Procedures for the Quantitative Phase of the Study

	Session 1(Intake)	Session 3	Session 5
Before the session	* CMOTS * Hope Scale * Demographics * Lie Scale		
After the session	* WAI	* WAI	* WAI

Note. CMOTS = Client Motivation for Treatment Scale; WAI = Working Alliance Inventory.


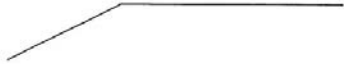




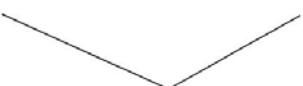
Qualitative Procedures

Selection of the Participants (cases)

Case selection is a first connecting point between the quantitative and qualitative phases of the study in the mixed methods sequential explanatory design (Hanson, Creswell, Plano Clark & Petska, 2005). Due to the explanatory nature of the second phase of this mixed methods study, the researcher decided to focus on the participants with different working alliance growth trajectories. In other words, to select participants for the second phase of the study, maximum variation sampling strategy (Creswell, 2002) was utilized. The major goal of this sampling strategy was to develop multiple perspectives on the phenomenon under scrutiny (i.e., working alliance) (Creswell, 2002). This procedure involved, first, identifying a specific characteristic, (i.e., a trajectory of the working alliance development), and then selecting the participants displaying different dimensions of this characteristic. The literature on the working alliance aided the researcher in development of possible patterns of the working alliance change (see Table 3.3). Seven possible WA patterns were identified: accelerating linear, decelerating linear, relatively stable, accelerating quadratic dramatic, accelerating quadratic late onset, decelerating quadratic, and constant. All WA identified patterns, except one (relatively stable pattern), were found in the present study. Eight participants representing different WA patterns were selected for the qualitative phase of the study (see Table 4.4 in Attachment F-1 for specific cases). Only six participants agreed to be interviewed. Two participants were transferred back to prison and were unreachable for the interview. A total of six participants (1 female and 6 males), representing five WA groups were

Table 3.3

Possible Patterns of Working Alliance Development

#	Graphical Picture of a Pattern	Description of a Growth Pattern
1		<p>Accelerating Linear growth pattern: increases steadily over time</p> <p>Kivlighan et al., 1995 Kivlighan & Shaughnessy, 2000 Stiles et al., 2004</p>
2		<p>Relatively stable pattern: increase by the third session and no significant changes over time</p> <ul style="list-style-type: none"> ▪ Eaton et al., 1993 ▪ Bachelor & Salame, 2000
3		<p>Decelerating Quadratic or "Low-High-Low" growth pattern</p> <ul style="list-style-type: none"> ▪ Gelso & Carter, 1994 ▪ Golden & Robbins, 1990
4		<p>Decelerating Linear growth pattern: decreases steadily over time</p> <ul style="list-style-type: none"> ▪ Stiles et al., 2004
5		<p>Accelerating Quadratic Late Onset or "Low-high" pattern: relatively stable between the 1st and 3rd session, with increase by the 5th session</p> <ul style="list-style-type: none"> ▪ Hypothetical pattern
6		<p>Constant or Stable growth pattern: no significant change over time</p> <ul style="list-style-type: none"> ▪ Kivlighan & Shaughnessy, 2000 ▪ Stiles et al., 2004
7		<p>Accelerating Quadratic Dramatic growth pattern</p> <ul style="list-style-type: none"> ▪ Kivlighan & Shaughnessy, 2000

interviewed (see Table 4.5 in Attachment F-2). Each case description that precedes the discussion of the qualitative results provides more detailed demographic information (see Qualitative Results section). As an incentive, all six participants who completed the second phase of the study received a small monetary gift (\$5 cash).

Interview Protocol Development

The aim of the interview protocol (Appendix B) was to investigate in depth, enrich, and elaborate on the results of the first, quantitative phase. Due to the nature of the mixed methods sequential explanatory design, the content of the interview questions was partially grounded in the results of the first, quantitative phase of the study (Creswell, Plano Clark, Gutmann, & Hanson, 2003). The protocol consisted of 12 open-ended questions (see Appendix A). The first question asked participants to talk about themselves, their education, culture, family, previous experiences with counseling, and reasons to be mandated for counseling. The aim of this question was two-fold: (1) to serve as an ice breaker, and (2) to obtain details of the case. Two questions (i.e., 2-3) explored participants' reason to be in counseling. Three questions (i.e., 4-6) were focused on exploring participants' experiences with counseling. Question 7 asked about clients' motivation for coming to counseling. A few questions (i.e., 8-9) explored clients' levels of hope. Two additional questions (i.e., 10-11) were related to clients' perceptions of their relationship with therapists. A number of probing questions were added to open-ended questions to ensure that all aspects of the complex phenomena were discussed. The last question in the protocol asked participants for any information they believed may have affected the development of their relationship with a therapist. The content of the

interview protocol and its correspondence with the research questions were examined by two independent readers. No adjustments to the protocol were needed.

Qualitative Data Collection

The primary data collection techniques included one hour in-depth semi-structured individual interviews with 6 purposefully selected participants. All interviews were tape recorded. Interviews were scheduled according to participants' availability and conducted at the location that (a) was convenient for participants, and (b) had necessary conditions to protect participants' confidentiality. Immediately after each interview, the researcher wrote down (1) reflections on what has been learned from the interview, and (2) observations of the participant. Table 3.4 represents the information sources that were used for the qualitative case study analysis. Triangulation of different data sources is essential for case study analysis, providing richness and depth to the case study description (see Stake, 1995; Creswell, 1998).

Table 3.4

Data Collection Matrix of Information Sources for Qualitative Phase

Variable/Information	Individual Interviews	Researcher's notes
Working Alliance	yes	yes
Motivation	yes	yes
Hope	yes	yes
Other Variables	yes	yes

Data Analysis

Quantitative Data Analysis

First, a preliminary correlational data analysis was conducted. The relationships between independent as well as dependent variables were examined. Second, changes in the working alliance ratings by clients over the three time-point measures were assessed through a Latent Growth Curve Modeling (LG; Singer & Willett, 2003) via the mixed command in SPSS version 14 (e.g., Peugh & Enders, 2004a). In the present study two levels of change were examined: (1) the within-client level, and (2) the between-client level. Also, two models of LG were performed: (1) unconditional or basic model without any covariates added (Model 1); and (2) conditional model with covariates of hope and motivation added to the equation (Model 2). In Model 1 (basic unconditional model without covariates) the presence of change in the working alliance across five therapy sessions (i.e., three data points: time 1, 2, 3) was assessed. The basic unconditional LG model was comprised of two factors (intercept and slope) with the repeated measures of the construct (i.e. working alliance) as the indicators (see Figure 3.2). The first latent factor defined the *intercept* of the growth curve in which the factor loadings of the repeated measures was set to 1. This represented the starting point of the WA growth curve as Time 1 (i.e., the intake session). The second latent factor defined the *slope* of the WA growth curve, and represented change in alliance scores over time. The factor loading of the repeated measures was set to 0, 1, and 2 to represent change over time. The means of these intercept and slope factors represented the *group* growth parameters, and were the overall measures of the intercept and slope for all subjects in the model. Finally,

the variance of the latent factors reflected the variation of each individual subject around the overall group growth parameters. This variance defined a *random coefficients* model. In Model 2 (conditional model) two covariates, client motivation and hope, were included to explain variation in WA intercept and slope latent factor variability.

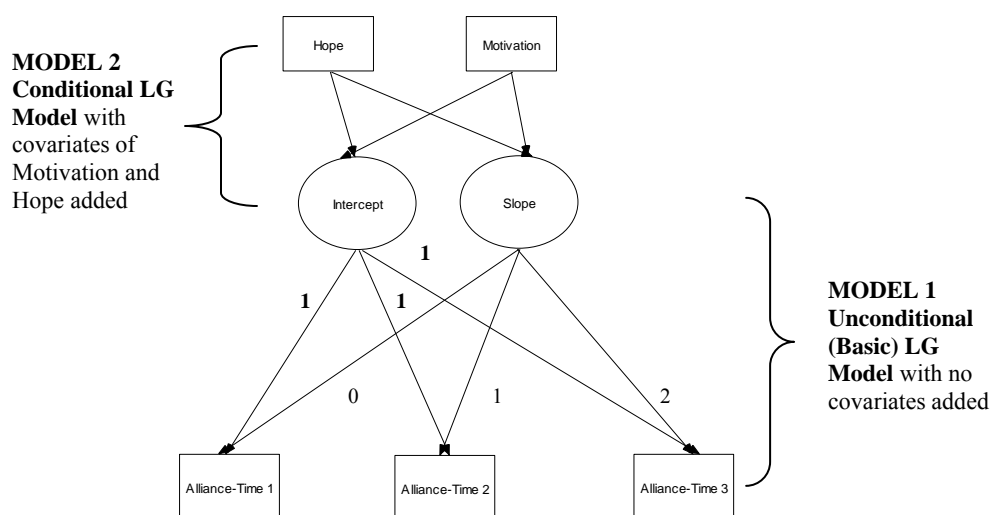


Figure 3.2. Two-factor Latent Growth Model for the Working Alliance

Consideration of Therapist Effect

Therapist effect can bias the estimation of WA, increasing the probability of Type I error (Burlingame, Kircher, & Taylor, 1994). In the current study sample participants did not have the same therapist. Specifically, 29 therapists worked with clients. Therefore, clients with the same therapist had working alliance, hope, and motivation scores that were correlated. As such, two sources of variability existed in this study: variability in outcome and covariate scores (1) within clients, and variability in outcome and covariate scores (2) between therapists. Because the research questions under investigation involved changes in alliance scores, and variability in these change

trajectories explained by the covariates at the client level (i.e., motivation and hope), variability in alliance scores that occurs between therapists was considered “nuisance” variability. However, biased parameter estimates and negatively biased parameter estimate standard errors could occur if therapist-level variability is uncorrected (e.g., Julian, 2001; see also Muthen & Satorra, 1995) in Growth Curve analyses. Therefore, to assess the “true” effects of clients’ motivation and hope on the trajectory of working alliance change any influence due to therapist effect must be tested and accounted for. In the present study therapist effect was estimated by calculating the intraclass correlation (ICC). The following formula was used to calculate ICC: $ICC = \tau_{00} / (\tau_{00} + \sigma^2)$, τ_{00} represents the proportion of variance in the outcome variables (i.e., working alliance scores, motivation scores, and hope scores) that occurs between therapists, and σ^2 represents proportion of variance in the outcome variables that occurs between clients. To quantify the therapist effect, an unconditional linear growth model was analyzed to compute the proportion of variability in response variable scores (i.e., working alliance, hope, and motivation) that occurred between therapists. An unconditional linear growth model is identical to a repeated measures ANOVA model with random effects, as demonstrated below:

$$\text{Level-1: } Y_{ij} = \pi_{0i} + \pi_{1i}(TIME_{ij}) + r_{ij} \quad (1)$$

$$\text{Level-2: } \pi_{0i} = \beta_{00} + u_{0i} \quad (2)$$

$$\text{Level-2: } \pi_{1i} = \beta_{10} \quad (3)$$

$$\text{Combined: } Y_{ij} = \beta_{00} + \beta_{10}(TIME_{ij}) + u_{0i} + r_{ij} \quad (4)$$

The level-1 model (equation 1) describes the growth trajectory for the repeated measures.

Specifically, individual i ’s response variable score at assessment j is a function of the

intercept (i.e., initial status, π_{0i}), the slope (i.e., the growth rate, π_{1i}), and a time-specific residual term (r_{ij}) that captures the deviation between an individual's observed data points and their estimated linear trajectory. In turn, Equation 2 describes the individual intercepts as a function of the mean initial status (β_{00}) plus an individual deviation (u_{0i}) from this mean. Individual growth rates are expressed as a function of the mean growth rate (β_{10}) only; slopes were not allowed to vary. The combined model is obtained by substituting the level-2 equations into the level-1 equation. As shown in equation 4, there were two random effects in this model, individual response variable score deviations from their respective therapist's means, and response variable repeated measures deviated about the individual's mean (i.e., $u_{0i} + r_{ij}$). These random effects are estimated as variance components, τ_{00} and σ^2 , respectively, that are necessary for the calculation of the ICC that quantifies the proportion of variability in response variable scores (i.e., working alliance, hope, and motivation) that occurred between therapists. Intraclass correlation coefficients, as well as test statistics and p -values are presented in Table 3.5 (see below). The criterion for therapist effect significance was set at $p < .01$. It can be seen that therapist effect was found to be significant in the dependent as well as both independent variables. Therefore, in order to proceed with the Latent Growth Curve Modeling, therapist effect had to be statistically eliminated. Group mean centering procedure was utilized to control for therapist effect. Specifically, therapists' mean scores were subtracted from each of the mean scores of their clients.

Table 3.5

Proportion of Variance in Working Alliance Scores that Occurs between Therapists

Variables	σ^2	τ_{00}	ICC %	ICC Test Statistics
Working Alliance	459	232	33.6	2.01**
Motivation	369	409	52.6	3.22***
Hope	35	50	59.2	3.86***

Note. σ^2 = Proportion of variance in the outcome variables (i.e., working alliance, motivation, and hope) that occurs between clients. τ_{00} = Proportion of variance in the outcome variables (i.e., working alliance, motivation, and hope) that occurs between therapists. ICC = Intraclass correlation. ** $p < .01$. *** $p < .001$.

Qualitative Data Analysis

In the qualitative analysis, data collection and analysis proceed simultaneously (Creswell, 1998). Each interview was audiotaped and transcribed verbatim. The transcriptions were checked for accuracy by listening to the audio and comparing it with the transcribed text. The open-coding and analysis of the text data was performed using the ATLAS.ti qualitative data analysis software program. Figure 3.3 represents the visual model of qualitative analysis for this study (adopted from Creswell, 2002). To analyze the qualitative data, the following steps were undertaken (adopted from Ivankova, 2004):

1. Preliminary exploration of the data by reading through the transcripts of each case, acquiring a general sense of the information, and writing memos.
Specifically, the following questions were reflected upon during this step: (a) what general ideas are participants stating? (b) what is the general impression of the overall depth, credibility, and use of the information? (Creswell, 2002).

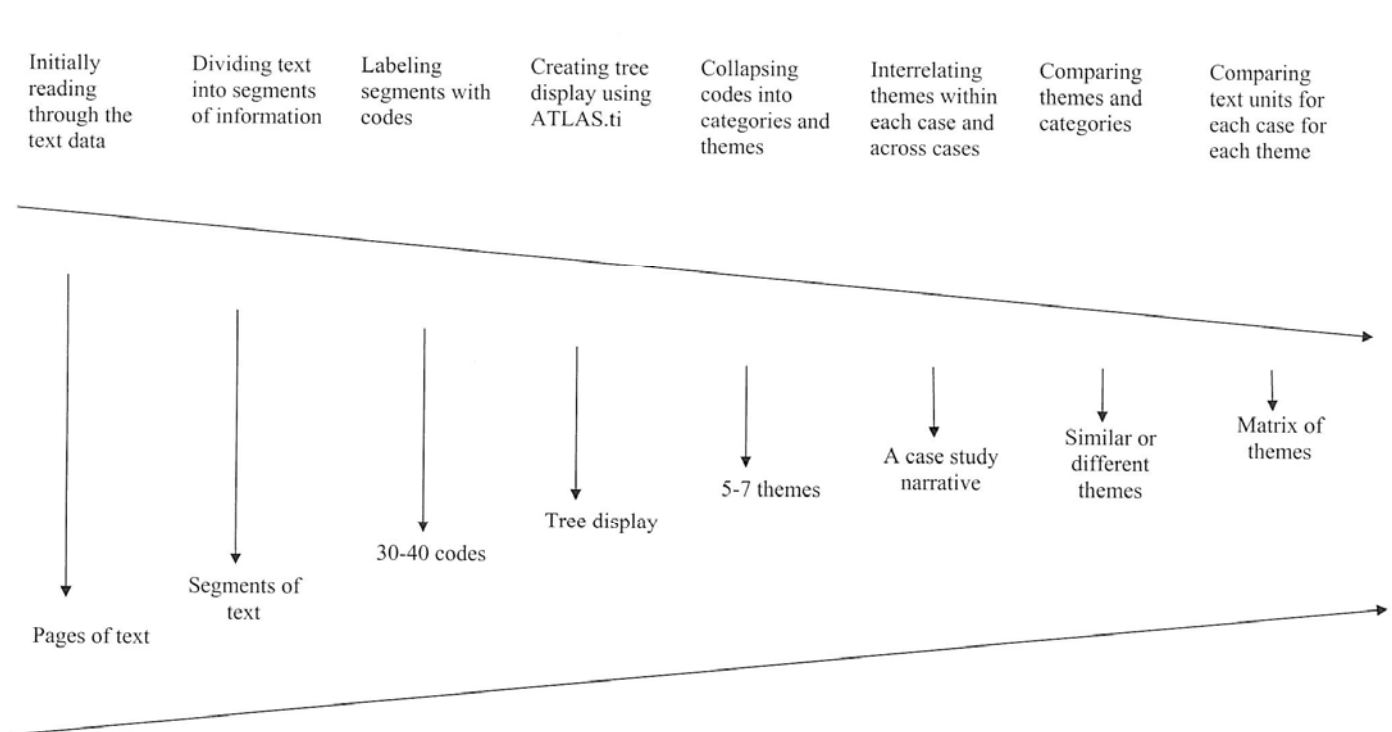


Figure 3.3. Visual model of multiple case study qualitative data analysis.

2. Coding the data by segmenting and labeling the text (Creswell, 2002). Coding implies organizing the material into “chunks” before bringing meaning to those chunks” (Creswell, 2002). During this step, the segments of text were labeled with a term; often terms were based in the actual language of the participant (*in vivo* term).
3. Using codes to develop a small number of themes by aggregating similar codes together (Creswell, 2002). The themes were developed for each individual case. Each theme was supported by diverse quotations.
4. Connecting and interrelating themes (Creswell, 2002). The researcher established patterns of themes and looked for correspondence between themes (Stake, 1995) within the same individual case.
5. Constructing a case study narrative composed of descriptions and themes for each individual case. Case narrative included naturalistic generalizations (see Stake, 1995, Creswell, 1998), interpretations of a case that a researcher constructed to make the case understandable.
6. Cross-case thematic analysis (see Stake, 1995; Creswell, 1998). During this step the researcher examined themes across cases to delineate themes that are common or different to all cases.
7. Interpreting the meaning of cases and reporting the “lessons learned” (Lincoln & Guba, 1985). These lessons were the researcher’s personal interpretations, based on her own culture, history, and experiences. Moreover, the lessons included a comparison of the findings with information gained from the

literature review. Finally, new questions raised by the data were included in this section (Creswell, 2002).

Validation Procedures

The criteria for judging the rigor and validity of a qualitative study differ from quantitative research. In qualitative research, a researcher seeks believability, based on insight, coherence, and instrumental utility (Eisner, 1991), as well as credibility, dependability and trustworthiness (Lincoln & Guba, 1985) of the inquiry through the process of validation, rather than through traditional validity and reliability measures. Describing validation procedures for qualitative research design, Lincoln and Guba (1985) propose techniques that help researchers establish study credibility, including prolonged engagement in the field, and triangulation of research methods and data sources. Thick descriptions of the phenomena studied are necessary to ensure that the findings of the research are transferable between the researcher and participants (Creswell, 1998). The uniqueness of the qualitative study within a specific context precludes it being exactly replicated in another context (Ivankova, 2004). However, the study assumptions – statements about a researcher’s position, the selection of participants, the biases and values of the researcher – all enhance a study’s credibility and trustworthiness (Creswell, 2003).

In this study, eight primary validation procedures were used to determine the credibility of information and whether it matches the reality:

1. Using triangulation of methods – converging different methods of collecting data (Lincoln & Guba, 1985). The results of the first, quantitative phase of the

study regarding the role of clients' motivation and hope in the development of the working alliance were compared with the qualitative data. Furthermore, the qualitative data were used to explain and enrich the quantitative results.

2. Clarifying the researcher's bias from the outset of the study (Merriam, 1988) helped understand the researcher's position and any biases or assumptions that could have impacted the inquiry (see section Role of the Researcher).
3. Using triangulation of data – converging different sources of information (see Stake, 1995; Creswell, 1998). Researcher's notes and observations augmented the information obtained from the interviews.
4. Using member checking – getting feedback from the participants on the accuracy of the identified categories and themes in the qualitative analysis (see Lincoln & Guba, 1985; Creswell, 1998).
5. Establishing inter-coder agreement (Creswell, 2007; Miles & Huberman, 1994). Inter-coder agreement involved two phases. During the first phase, two researchers independently coded and analyzed three interview transcripts for codes and themes. After coding, the researchers met and compared the codes, their names, and the text segments that they coded for consensus. The researchers felt it was more important to agree on the text segments they assigned codes to than to have the exact same passage coded. They looked at the passages they both coded and asked themselves whether they had assigned the same code word to the passage. The decision was either a “yes” or “no” decision, so they calculated the percentage of agreement between them. The

percentage of inter-coder agreement on codes was 90%, which was consistent with the minimum of 80%, recommended by Miles and Huberman (1994). During the second phase, the researchers collapsed the codes into broader themes. They then compared themes and to see if the codes comprising a particular theme are the same. The percentage of inter-coder agreement on themes was 90%. The primary researcher then coded the rest of the transcripts consistently with the codes and the themes that emerged during the inter-coder agreement procedure.

6. Providing rich, thick descriptions to convey research findings (see Stake, 1995; Creswell & Miller, 2002). Providing details of what the clients experience while receiving mandatory counseling helped “transport the reader to the setting” (Creswell, 2003, p. 196).
7. Providing disconfirming evidence (Miles & Huberman, 1994). This process involved establishing the preliminary themes and then searching through the text data for evidence that confirmed or disconfirmed the identified themes.
8. Auditing (Creswell & Miller, 2002). The researcher’s academic adviser conducted a constant and careful auditing on all research procedures and data analysis in the study.

CHAPTER IV

RESULTS

Quantitative Results

Participants Demographic Information

The following demographic data were gathered of participants for descriptive purposes: age, gender, ethnicity, past experiences with counseling, and the level of satisfaction with the counseling outcomes.

Age

Sixty-three inmates from a Midwestern Community Correctional Center participated in the quantitative phase of this study. All the participants, except two, reported their age ($n = 61$). Age ranged from 20 to 56 years-old with a median age of 34, and a mean age of 35.6 ($SD = 9.9$). Pedhazur (1997) suggests that skewness and kurtosis less than $|2.0|$ are indicative of normal distributions. In the present study, skewness (.35) and kurtosis (-.79) statistics showed that the age data are normally distributed.

Gender

All participants reported their gender ($N = 63$). There were more males ($n = 38$; 60.3%), than females ($n = 25$; 39.7%) in the study. Skewness (.43) and kurtosis (-1.88) statistics indicated that the gender data are normally distributed.

Ethnicity

All participants, except two, reported their ethnicity ($n = 61$). Participants were of African-American ($n = 16$; 26.2%), Caucasian ($n = 37$; 60.7%), Native-American ($n = 4$;

6.6%), Hispanic/Latino(a) ($n = 2$; 3.3%), and other ($n = 2$; 3.3%) ethnicity. Skewness (.25) and kurtosis (.54) statistics showed ethnicity data to be normally distributed.

Past Experiences with Counseling

Fifty-five percent of the participants ($n = 34$) reported having past experiences with counseling. All participants who had histories of previous counseling, except two, reported their level of satisfaction with counseling ($n = 32$). Specifically, 63 % of participants reported being satisfied with their counseling outcomes. Skewness (.2) and kurtosis (-2.03) statistics demonstrated a normal distribution for past counseling experience.

Latent Growth Curve Modeling Analysis Results

Table 4.1 presents the means, medians, and standard deviations for the two covariates (Motivation and Hope) and the dependent variable (Working Alliance). The mean level of the working alliance shows an increasing trajectory over time. As expected, moderate correlation was found between measures of the working alliance (WA) at different data points (WA at time 1 and WA at time 2: $r = .53, p < .01$; WA at time 2 and WA at time 3: $r = .62, p < .01$). Finally, none of the study variables (Working Alliance, Hope and Motivation) reflected significant departure from normality (e.g., no measure of these constructs exceeded a skewness of 1.0 at any time point). Thus, no power transformations of the data were required to proceed with further analyses.

Table 4.1

Descriptive Statistics for Study variables (Dependent and Independent)

Variable	<i>M</i>	<i>Mdn</i>	<i>SD</i>
Working Alliance – Time 1	205	210	28
Working Alliance – Time 2	212	222	27
Working Alliance – Time 3	218	219	21
Motivation – Time 1	141	143	27
Hope – Time 1	46	46.5	9

Note. *N* = 63. Time 1 = session 1. Time 2 = session 3. Time 3 = session 5.

Examination of Growth Over Time: Unconditional (without Covariates) Model of Working Alliance Growth

Growth trajectory statistics were obtained via the mixed command in SPSS version 14 (e.g., Peugh & Enders, 2004a). Since SPSS uses the maximum likelihood algorithm for parameter estimation, missing data was appropriately handled by default. (e.g., Peugh & Enders, 2004b).

Research Question One: What Is The Growth Trajectory Of The Working Alliance In The Early Stage Of Mandatory Counseling?

Latent Growth Curve Modeling (LG) was used to estimate the growth trajectory of the working alliance (WA) as well as changes in the WA clients' ratings over the first five therapy sessions (Singer & Willett, 2003). All models were estimated using SPSS for Windows, Version 14 (SPSS, 2006). The first step in LG analysis involved estimating the growth trajectory parameters (i.e., intercept and slope) of an unconditional growth model

(i.e., no covariates; Model 1) to show how working alliance scores change over the three time points (i.e., 1st, 3rd, and 5th sessions), and to test for the presence of significant intercept and slope variance that would indicate the need to add covariates to the growth model. A statistically significant unconditional model is displayed in Table 4.2. As it can be seen, the Model 1 of LG analysis was able to detect the presence of the significant variance in the WA intercept. Therefore, since a significant difference in the WA intercept is present, it warrants exploration of the reasons for this significance by entering covariates (i.e., motivation and hope) into the equation (see “Conditional Model” below). Table 4.2 also shows that on average, clients’ WA scores begin .50 above the mean WA score, and consistently increase by 1 point above the mean at each assessment period (i.e., sessions 1, 3, and 5), creating a positive slope. However, the growth model for slope was non-significant. Furthermore, due to a relatively small sample size ($N = 63$) it was not possible to estimate variance in the WA slope. Consequently, since at this point there is no information regarding the variance in WA slope, it does not make sense to examine the impact of covariates to the WA slope.

Unconditional growth model (Model 1) also yielded graphs of trajectories of change in the working alliance for each participant (see Figure 4.1). Even though due to the insufficient data it was not possible to estimate variance in the working alliance slope, visual analysis of the individual trajectories allowed the conclusion that the shapes of the trajectories varied (e.g., accelerating quadratic, decelerating liner etc.). The following process was used to organize WA trajectories into groups. First, 37 individuals (59%) had

Table 4.2

Summary of Unconditional and Conditional Growth Models

Model	Fixed Effects			Covariance Parameters		
	Intercept	Time (Slope)	Covariates	$\sigma^2 - L 1$	$\sigma^2 - L 2$	σ^2 change
Unconditional (Model 1)	.50	1.09		113.19**	150.33**	
Conditional (Model 2a): Hope	.33	1.07	.17	117.98	165.33	
Conditional (Model 2b): Motivation	.92	1.34	-.02	104.66	180.74	7.54 %

Note: Unconditional (Model 1) = First model of Latent Growth Modeling with no covariates added. Conditional (Model 2a) = Second model of Latent Growth Modeling with Hope as a covariate. Conditional (Model 2b) = Second model of Latent Growth Modeling with Motivation as a covariate. $\sigma^2 - L 1$ = Proportion of variance in the outcome variables (i.e., working alliance, motivation, and hope) that occurs in between clients' repeated responses at three different times. $\sigma^2 - L 2$ = Proportion of variance in the outcome variables (i.e., working alliance, motivation, and hope) that occurs across clients. ** $p < .01$.

one or more missing data points, and therefore, a decision was made to not classify these graphs. Second, the rest of the trajectories ($n = 26$; 41%) were classified, based on visual analysis of their shapes (see Figure 4.1) as well as individual working alliance scores.

The trajectories were organized into six groups: accelerating quadratic (dramatic) ($n = 3$), accelerating quadratic (late onset) ($n = 2$), accelerating linear ($n = 9$), decelerating linear ($n = 1$), decelerating quadratic ($n = 8$), constant ($n = 3$). The groups were formed based on either increasing or decreasing patterns of WA. For example, trajectories that increased steadily over time (e.g., cases 6, 10, 13 etc.) were placed into the accelerating linear group. Table 4.3 shows six groups of working alliance trajectories and individual cases that were included in each group.

Table 4.3

Groups of Working Alliance Trajectories

#	WA Trajectory Group	# of Individual Cases
1	Accelerating quadratic (dramatic)	3; 7; 52
2	Accelerating quadratic (late onset)	4; 26
3	Accelerating linear	6; 10; 13; 15; 16; 17; 30; 34; 60
4	Decelerating linear	42
5	Decelerating quadratic	1; 8; 23; 32; 33; 35; 36; 55
6	Constant	23; 24; 28
Missing Data		2; 5; 9; 11; 12; 14; 18; 19; 20; 21; 22; 25; 27; 29; 31; 37; 38; 39; 40; 41; 43; 44; 45; 47; 48; 49; 50; 51; 53; 54; 56; 57; 58; 59; 61; 62; 63

Note. WA = working Alliance

Examination of the Covariates' Contribution: Conditional Model (with covariates) of Working Alliance Growth

Research Question 2: Can We Explain Variation In The Working Alliance Growth

Trajectory According To Levels Of Mandated Clients' Motivation For Treatment And Hope?

Conditional modeling of WA growth (Model 2) of the Latent Growth Curve was used to estimate the impact the two covariates (i.e., motivation and hope) have on the variance in the WA intercept. First, through the analysis, the significance of the two covariates (one by one) was examined. Second, the analysis yielded a percentage of variance that each covariate explained (see Table 4.2, p. 85). As it can be seen in the Table 4.2, when the covariates of hope and motivation were included, conditional models

were non-significant. In other words, motivation and hope were found to be non-significant as covariates. Neither of the covariates explained significant amount of the WA intercept variance.

The results of the quantitative analysis were used to determine which participants should be interviewed during the second, qualitative phase of the study. Specifically, one participant that represented each group of WA patterns was invited for an interview. In the next section the results of the qualitative data analysis will be presented.

Qualitative Results

Participants Demographic Information

Based on the literature review as well as results of the quantitative analysis, participants' working alliance trajectories were clustered into six different groups: accelerating linear, decelerating linear, relatively stable, accelerating quadratic dramatic, accelerating quadratic late onset, decelerating quadratic, and constant (see section "Quantitative Results" p. for the details regarding group formation). Consequently, eight participants were selected for the qualitative phase of the study (see Table 4.4 in Attachment F-1 for specific cases). Two out of eight participants were transferred back to prison and were unreachable for the interview. As a result, a total of six participants, representing five WA groups were interviewed (see Table 4.5 in Attachment F-2 for demographic information). Each case description below provides more detailed demographic information.

Descriptions of Cases

Case Study 1: Michael

Obviously, I didn't want to do it [counseling]. In the beginning I was only here because I had to be but I think over time - once I got to know her [the therapist] and everything - then I felt more comfortable. Then it was all right. (From the interview with Michael)

At the time of the interview, Michael was a divorced 29 year old man with no children. He described his ethnicity as "white with a French background". At the time of the interview he was completing his sentence at the Community Correctional Center. Information about the reason for his incarceration was not available to the researcher. His parole date was reportedly sometime in April 2006. According to Michael, the main reason for him being in counseling, at least initially, was because counseling was a part of his release plan; he needed to work with a therapist in order to be eligible for release in April. As he stated in the interview: "I was hoping that she [the therapist] would give me letter that I could take back [to the correctional center] and say I was done [with counseling]."

Michael's therapist was an Asian female doctoral student in counseling psychology with two and a half years of work with clients. Michael came to 12 therapy sessions and then counseling was terminated by the mutual agreement of him and his therapist. Michael said he, as well as his therapist, felt that he achieved the goals he set for this counseling experience. Michael was one of the clients who did not have any previous experience with counseling and did not know what to expect from therapy. While talking to the researcher, Michael shared that being in counseling has helped him understand possible benefits he can gain from this experiences. Moreover, he concluded

that his overall impression of being in counseling was positive. He stated that at some point after his 3rd or 4th session his attitude toward counseling changed. In particular, he started coming to sessions not only because he needed to, but because he wanted to be in therapy and work on his issues.

During the interview, Michael described himself as a person who had a hard time opening up to a stranger. He needed some time to get to know his conversation partner to “like” the person first and then open up. Even during this interview, Michael appeared somewhat reserved at the beginning and then somewhere in the middle of the interview gradually he started giving more detailed answers and required less prompts to answer the researcher’s questions. Generally speaking, during the interview he was very cooperative and willing to share his experiences in counseling.

According to the pattern of Working Alliance Inventory (WAI) scores, Michael’s perception of relationship development with his therapist represents an *accelerating quadratic dramatic growth pattern* (Kivlighan & Shaghnessy, 2000); in other words, Michael represents a group of clients whose initial perception of the working alliance was relatively high, then it significantly decreased, and then it started increasing slowly. When presented with the results of his WAI, Michael confirmed the accuracy of the results and offered his explanation of the pattern (see below).

It is also important to note that Michael’s T-score on the social desirability scale (Lie-scale) was low (i.e., 48). This indicates that his answers on other scales as well as during the interview can be considered valid; in other words, his score on the Lie-scale

suggests that Michael was not trying to present himself in either an overly-positive or overly-negative light.

Case Study 2: Shelby

I had already been told that I have to come here [for counseling]. I was already told that I have to do 18 months out there [in prison]. I have been told enough. So, when you are being forced to come to counseling, the last thing you want to be told once you get here is what you have to do. I did not get that from here. I got a lot more interaction, a lot more discussion and together we [the therapist and I] identified these and areas to work on. (From the interview with Shelby)

At the time of the interview Shelby was a married, 34 year old woman with two children. She described her ethnicity as Caucasian. She stated that she has been incarcerated for about a year and a half, and it was her first time being in prison. Describing the reason for incarceration, she said: “My corrections were the result of embezzlement from my job...” The major driving force for Shelby’s decision to start counseling was, reportedly, the fact that the Community Correctional Center required her to complete a course of therapy. However, the second part of her motivation to be in counseling was her personal desire to change some things about her to cope with problems and stress. In the interview she stated: “One [reason to be in counseling] is because they [correctional center officials] want me to and the other one is that I really do need to be prepared so that I don’t fall into any of the traps that I found myself in before.” Shelby described herself as a person for whom developing strong friendship ties with anyone was difficult, even before she was incarcerated. She also reported that before counseling she tended to keep all her emotions and stress inside and did not share anything with other people, including her husband, a few friends, and her parents. Her major strategy to cope with stress was, reportedly, binge eating. Further, Shelby

described herself as a very goal-oriented person who likes having a clear picture in mind of the steps she needs to take to accomplish her goals. She also stated that she experienced a lot of stress from being in the very rigid prison environment. At the same time, she noted that incarceration as well as counseling have helped her to learn to appreciate and value her family of her husband and two children.

Shelby's therapist was a Caucasian female masters student in marriage and family therapy with two years of work with clients. At the time of the interview, Shelby had gone to six counseling sessions. She said that after the sixth session she and her therapist decided to meet on a monthly basis because Shelby was achieving her goals and wanted to come once a month for a check-in.

Shelby stated that she did not have any counseling experience prior to the current one. Moreover, she noted that her expectations of counseling, which were based primarily on the images she has seen on TV, were negative and unclear. During the six sessions she attended, her vision of counseling evolved from uncertain and vague to detailed and understandable. She was able to feel comfortable in her "client" role as well as to recognize the benefits counseling could provide. In the interview she described counseling as an experience that helped her build the foundation for the future.

During the interview Shelby appeared to be very open and cooperative. She was willing to provide very detailed answers to the researcher's questions without any additional prompting. Her speech was well paced and emotionally expressive.

According to the Working Alliance Inventory (WAI), Shelby's perception of relationship development with her therapist represents an *accelerating linear growth*

pattern (Kivlighan et al., 1995; Kivlighan & Shaghnessy, 2000; Stiles et al., 2004); in other words, Shelby represents a group of clients whose perception of the working alliance increases steadily over time. When presented with the results of her WAI, Shelby confirmed their accuracy and offered her explanation of the pattern (see below).

Shelby's T-score on the social desirability scale (Lie-scale) was low (i.e., 52). This indicates that her answers on other scales as well as during the interview can be considered valid; in other words, her score on the Lie-scale suggests that Shelby was not trying to present herself in either an overly-positive or overly-negative way.

Case Study 3: George

I went home and I seen my family and everything, it changed a lot, you know. That kind of boosted me up to come back to the next meeting [fourth counseling session] and just put my heart into it. (From the interview with George)

At the time of the interview, George was a single 40 year-old Caucasian man with three children. He stated that he had currently served eight years out of his nineteen-year sentence in prison. Information about the reason for his incarceration was not available to the researcher. His parole date was, reportedly, sometime in 2007. George said that his prior counseling experience, which was in a group setting, was negative. He noted that it was very difficult for him to open up in front of other people. While describing his personality, George said that he is "a person with a real bad temper." He reported that he used to have a very low self-esteem. His self-esteem especially decreased after his incarceration, when the majority of his friends abandoned him.

Similar to Michael and Shelby, the main reason for George to begin counseling was because counseling was a part of his release plan. He said that after his third

counseling session, however, his motivation changed from extrinsic to intrinsic. As he stated in the interview: “The third [counseling] meeting when I came in... I think that was the first time I went home and my son stopped by. I think that was the first time that it really clicked in my head that I wanted to better myself and I better try [work hard in counseling]...”

George’s therapist was a Caucasian female master student in counseling psychology with six months experience working with clients. George attended ten counseling sessions and then counseling was terminated by mutual agreement between his therapist and him. Even though initially George had negative expectations of counseling, in time he started enjoying coming to sessions. He stated that it was very important to him that in his session he and his therapist talked about his children, identified issues George was facing and generated specific solutions to resolve those issues. According to George, counseling has helped him significantly increase his self-esteem.

At the beginning of the interview, George appeared to be somewhat reluctant to answer the researcher’s questions. He needed a lot of prompting at first. It appeared that George needed some time to establish trust in the researcher. He seemed to become more open after the researcher clarified the purpose of the interview. Gradually, his answers became more detailed and his attitude more cooperative.

According to the pattern of the Working Alliance Inventories (WAI), George’s perception of relationship development with his therapist represents an *accelerating linear growth pattern* (Kivlighan et al., 1995; Kivlighan & Shaghnessy, 2000; Stiles et

al., 2004). George's first impression of the relationship development with his therapist was significantly lower than Shelby's. However, similar to Shelby, in the third and fifth sessions his WAI scores steadily increased.

George received a relatively low T-score on the social desirability scale (i.e., 56). This score indicates that his answers on other scales as well as during the interview can be considered valid; in other words, his score on the Lie-scale suggests that Michael was not trying to present himself in either an overly-positive or overly-negative light.

Case Study 4: Chris

As the session would go on and then I'd kind of open up in session and I kind of enjoyed the session myself too because I was saying things that I knew was [*sic*] true about myself. You know, the more you talk about yourself, the better you feel about yourself. (From the interview with Chris)

At the time of the interview, Chris was a 55 year old unmarried man with three children. He described his ethnicity as "Black." Chris, similar to other participants of the study, was serving his sentence in the correctional system. Information about the reason for his incarceration was not available to the researcher. He reported that his parole day would be in December, 2006. Chris portrayed himself as a shy person for whom it was somewhat difficult to disclose personal information to strangers. Reflecting on his life before the prison, he said that he had been experiencing a lot of stresses; excessive spending of money was a coping strategy he had developed over time. He noted that even though that coping strategy did bring him some relief, he also understood and experienced its negative effects. At the time of the interview, Chris had a job and was very satisfied with the way it was going. He reported that lately he has been trying to

implement his new coping strategy, which was to avoid relationships with negative people and to get back to society as healthy as he could.

Chris reported having no counseling experience prior to the current one. He said that he decided to come to counseling not only because it was required by his release plan, but because he wanted to change things in his life: “[I came to counseling] Because I saw that if I didn’t try to get somebody to help me figure out what was wrong with me, I would end up in the same place that I am now.”

In counseling, Chris worked with a Caucasian female masters student in marriage and family therapy with two years experience working with clients. Chris came for five sessions after which counseling was terminated by mutual agreement between his therapist and him. Chris said he, as well as his therapist, felt that he achieved the goals he set for this counseling experience. Chris stated that he did not have any expectations about counseling prior to coming to the university counseling clinic. He added that he had some negative attitudes toward his therapist before coming to the first session because he assumed that the therapist would be telling him what he needs to do to “fix” his life. Specifically, he said: “I think before I came here [to counseling], I had a negative attitude about people telling me what I should and what they think I should do.” However, with time, he stated, counseling helped him to understand himself more by learning characteristics of his own personality as well as developing helpful coping strategies for the future. He noted that gradually he developed a positive perception of counseling and would continue therapy in the future.

During the interview, Chris appeared to be very cooperative. His speech was somewhat slow paced and often times very soft. Throughout the interview, Chris mentioned how thankful he was to the researcher because she wanted to interview him. It appeared that he was very excited to share his impressions of counseling and help the researcher to understand his subjective perspective.

Based on the pattern of the Working Alliance Inventories (WAI), Chris's perception of relationship development with his therapist was a *constant growth pattern* (Kivlighan & Shaghnessy, 2000; Stiles et al., 2004); in other words, Chris represents a group of clients whose initial perception of the working alliance did not significantly change over time and was relatively high at all three measuring points. When presented with the results of his WAI, Chris confirmed the accuracy of the results and offered his explanation of the pattern (see below).

Chris's T-score on the social desirability scale (Lie-scale) was relatively low (i.e., 56), which indicates that his answers on other scales as well as during the interview can be considered valid.

Case Study 5: Joe

It [counseling] was something that I need to [do] so and once I started doing it [counseling], I started finding things that was helpful and even learned stuff about myself. (From the interview with Joe)

At the time of the interview, Joe was an unmarried 48 year old African American male with four children. He reported that his parole hearing would take place in August of 2007, and his actual release day was set for April of 2009. Further, the interviewee stated that he had already spent seven months in the Correctional Center. Information

about the reason for his incarceration was not available to the researcher. While talking about his life at the Center, Joe shared his disappointment about not being able to get a work release. However, he also expressed hope that soon he would receive a release and find a job.

Joe said that he was raised in a big Midwestern city and came from a family of eleven children (seven brothers and four sisters), in which he was the youngest. He noted that he had close relationships with his siblings and his mother. Joe added that he cared about his family members a great deal, especially now, that some of them have serious medical conditions (e.g., cancer, Alzheimer). The interviewee said that his oldest son was accidentally killed a few months ago. He reported that he was still mourning his death.

In the interview, Joe described himself as a very hard-working person who puts a lot of time and energy into achieving his goals. He also portrayed himself as a very “private person” who “does not like to say personal things.” He stated that he usually needs time to get to know and develop trust in a person before he opens up.

Joe started individual counseling because it was a part of his release plan. By the fifth session, however, his motivation became more intrinsic; he started enjoying attending sessions and talking to his therapist. Joe reported having previous counseling experience in a group setting. He stated that that experience was positive. He emphasized, however, that he often felt uncomfortable in the group. He said: “It’s hard to sit in a group session sometimes. You are more involved with other people’s issues and problems instead of just directly focusing on what’s going on with yours.” Joe stressed how important individual attention was to him. He mentioned that he liked his individual

sessions specifically because his therapist and he were focusing on his issues each session.

In counseling Joe worked with a Caucasian female masters student in marriage and family therapy with two years experience working with clients. Joe's counseling was terminated after five sessions by his and his therapist's mutual agreement. Describing the major gains of this counseling experience, Joe said that with help of his therapist he developed a decision-making system based on his values and beliefs. He stated that he will be using this system as a tool to help with his decisions in the future. According to Joe, counseling ended up being an important and useful experience for him.

Right from the beginning of the interview, Joe appeared to be open, sincere, and willing to share his thoughts regarding his experiences in counseling. He stated that he agreed to be interviewed because he wanted to "contribute to the study and feel useful." His answers and comments were detailed and, yet at the same time, somewhat disorganized. He used very long sentences to express his ideas with one sentence often transitioning into another without ending. His speech was soft and slowly paced.

According to the Working Alliance Inventory (WAI), Joe's perception of relationship development with his therapist represents an *accelerating quadratic late onset growth pattern*. His WAI scores were relatively stable between the first and third sessions, and then significantly increased by the fifth session. When presented with the results of his WAI, Joe confirmed the accuracy of the results and stated that the pattern of increase in his WAI scores would continue if he were to complete more WAI assessments.

Joe received a low T-score on the social desirability scale (i.e., 48). This score indicates that his answers on other scales as well as during the interview can be considered valid; in other words, his score on the Lie-scale suggests that Joe was not trying to present himself in either an overly-positive or overly-negative light.

Case Study 6: Kyle

When I talk, she [the therapist] seems interested and trying to help me find the things I have a problem with and trying to come up with answers (...). Sometimes I just can't wait for next week to come so we can get back on that topic I was talking about with her. (From the interview with Kyle)

Kyle is a 27 year old Caucasian unmarried man with one child. He stated that he served seven years in a prison and was transferred to the community correctional center a few months ago. Information about the reason for his incarceration was not available to the researcher. Currently Kyle is on a work release. He stated that his adaptation to life outside of the correctional center (i.e., while he is working or coming to counseling) is going well. He described being in prison as the “worst experience” of his life because he was separated from his family and his son. When asked about his family, Kyle said that he has two brothers on his father's side and two sisters and one brother on his mother's side. His parents split up during the first years of Kyle's life.

According to Kyle, after his previous individual counseling experience, which was negative, he developed a negative attitude toward counseling in general. Kyle said that he preferred individual therapy sessions to group ones. He said that he felt embarrassed at times when he had to speak about his issues in front of a group. Similar to other interviewees, Kyle started his current individual counseling because it was required of him. He openly stated that he did not expect to get anything out of it. Furthermore, he

thought that “it would be bullshit.” When asked about changes in his perception of counseling, Kyle said that by the end of his first session he started becoming more interested in the therapy process. By the fifth meeting with the therapist his motivation gradually evolved into intrinsic; he started enjoying coming to every session. Kyle stated that in his sessions he was able to open up and tell his therapist things he would never tell anyone else.

Kyle worked with an Asian female therapist, who was a graduate student in counseling psychology and had two years experience working with clients. Kyle specifically stated that he was glad to see his therapist was a woman. He noted that “men do not understand” him. At the time of the interview, Kyle had attended six therapy sessions and was planning on continuing to come to therapy.

Kyle described himself as a shy person who does not like to talk a lot. His behavior during the interview mirrored his self-description. It appeared that initially it was very difficult for him to talk, as evidenced by his very simple short answers, the many prompts he needed to respond to a question, his soft voice and slowly paced speech. In order to bring some clarity to the interview process and start to establish a trusting relationship, the researcher had to clarify the purpose of the study and things Kyle should expect from the interview. Gradually the interviewee’s answers became more spontaneous and detailed, and his speech became more rapid.

According to the pattern derived from the Working Alliance Inventory (WAI) scores, Kyle’s perception of relationship development with his therapist represents a *decelerating quadratic growth pattern* (Gelso & Carter, 1994; Golden & Robbins, 1990).

His WAI score was relatively low after his first session, significantly increased after the third, and then significantly decreased after the fifth session. When presented with the results of his WAI, Kyle confirmed the accuracy of the results and explained the pattern. He also stated that if he were to complete the WAI several more times, his profile would look like “a rollercoaster” with a number of increases and decreases.

Kyle received a low T-score on the social desirability scale (i.e., 48). This score indicates that his answers on other scales as well as during the interview can be considered valid.

Common Themes and Codes between Cases

Qualitative findings addressed three issues: (1) therapy experience, (2) facilitators of WA development, and (3) obstacles to WA development. The analysis of all qualitative data (i.e., interviews, researcher’s notes and observations) resulted in a number of themes regarding each issue. Specifically, the participants’ responses regarding their therapy experience were grouped into six themes: (1) therapy development, (2) client role, (3) therapist role, (4) client-therapist relationship, (5) therapy process, and (6) therapy outcomes. Three themes described the participants’ perceptions of factors that facilitate the WA development: (1) client factors, (2) therapist factors, and (3) process factors. Finally, three themes describe participants’ visions of obstacles to WA development: (1) client factors, (2) therapist factors, and (3) process factors. Tables 4.5, 4.6, and 4.7 (see Attachment G) show themes, codes that constituted each theme, and codes frequencies that were derived for each issue under investigation.

Issue 1: Therapy Experience

Theme 1: Therapy development. This theme addressed clients' perception of how the process of therapy was developing. The theme consists of four codes: (1) "It started slow," (2) "Boring and tedious at the beginning," (3) "More personal at the end," and (4) "From mandate to volunteer." According to participants' perceptions, the beginning of counseling appeared to be "boring and tedious" for them. Specifically, counseling was viewed as something that resembled prison, because everything seemed to be predetermined: intake paperwork, standard questions about background information, etc. For example, Michael commented: "It [counseling] was not necessary going anywhere... It was because she [therapist] asked me a list of questions so she could ask even more questions later. So, to me, I was just being bored to death." Interestingly, all participants talked about the transformation of their work with therapists from "boring and tedious at the beginning" to "more personal" at the end. In other words, once trust between a client and a therapist was established and clients felt more comfortable, they saw therapy as something they might benefit from. Shelby described this idea thusly:

Once that [trust] was developed, and that bond was there, then we [client and therapist] were able to get to the things that truly have benefited me. Those didn't come until later....until I felt more comfortable and was able to truly open up to her [the therapist].

Additionally, perhaps after the intake process was completed, therapists were able to relate to mandated clients at an interpersonal level. Overall, all respondents saw counseling as a process that started slowly and required three or four sessions for establishing trust, which, in turn, allowed clients to begin opening up. Furthermore, the idea "from mandate to volunteer" was mentioned in every interview. Participants stated

that initially they started counseling because it was mandated. However, at some point each of them noticed that they continued coming back to sessions not because they were required to do so, but because they became personally invested in the process. Chris illustrated this point very well: “After I was here [in counseling] like two to three weeks, when I started to get to know my counselor a little bit, I started lettin’ my walls down because I was really going to try to make this work this time.”

Theme 2: Client role. As interviewees talked about the way they experienced therapy, it became clear that they saw their role as “clients” to be an important part of the therapy process. The client role is viewed as an active role in which clients have certain responsibilities. The prominent code included in this theme is “Mandated client has freedom in counseling.” All participants talked about this idea at least once in their interviews. For instance, Shelby stated:

I had already been told that I have to come here [to the counseling clinic]. I was already told that I have to do 18 months out there [in prison]. I have been told enough. So, when you are being forced to come to counseling, the last thing you want to be told once you get here is what you have to do. I did not get that from here [counseling]. I got a lot more interaction, a lot more discussion and together we identified these and areas to work on...I have enough people telling me what to do. I don’t need one more person. At no point in time did I ever get that from her.

This quote emphasizes the point that was portrayed in all interviews: there are numerous opportunities for clients to make choices and assume an active rather than passive role, even in mandated counseling. George talked about how his therapist helped him assume an active role in his own therapy:

I think when she [the therapist] had me to sort of sum up my whole counseling sessions and put it in a letter and instead of me just writing out paragraphs, I wrote out what we worked on and she had me just talk about it. Sort of like an essay. I still read it now.

Another important concept participants discussed with regards to the client role in therapy was client responsibility. It was interesting to listen to participants talk about contributions to therapy they could and should make to be sure that the outcomes are successful. Michael stated:

Now I think of it [counseling] as life. Up to a point, it is basically what you make of it. I mean there is always determining factors. Maybe you just never connected with your counselor or things like that. But, up to a point, it is basically on you.

In other words participants see counseling being effective only when a client also assumes an active role by making certain decisions as well as taking some responsibility for things in therapy. As Kyle illustrated, “It was probably just my stubbornness and reluctance to want to be here [in counseling] was probably the biggest obstacle to building a relationship.”

Theme 3: Therapist role. In addition to the client role, all participants, except one (Kyle), said that they see the therapist’s role as an active role. It appears to be important for mandated clients to feel that that they are “not the only one[s] talking for the whole hour” (from interview with Michael). As reported by all participants, except one, this feeling helps to increase clients’ willingness to open up in therapy. Furthermore, the respondents talked about the importance of experiencing a therapist as a confident person who takes an active role in the healing process. As said by George,

I looked at it [therapy] like this, that she [therapist] knew exactly where she wanted to start with me and what I needed to do in order to benefit from these sessions with her because each session was ... and I think that is where the beginning started as far as trying to make sure that I worked on the issue we had planned. To me that was the beginning.

It appears that by being active in counseling, therapists could model this role for clients as well as encourage them to be active in their own healing process.

Theme 4: Client-Therapist relationship. Three out of six participants talked about characteristics of client-therapist relationships as parts of their perceptions of therapy. Trust in the client-therapist relationship was the code used most often. For example, Shelby commented about this issue: “At some point in time ...I am not exactly sure when or how or what triggered it. But, at some point in time, I was able to trust her and I think that made all the difference in the world.” Trust in the client-therapist relationship was also viewed by participants as one of the major process factors that facilitates working alliance development (see Issue 2, p. 112, for more detail).

Theme 5: Therapy process. The participants used a number of ways to describe characteristics of the therapy process itself. Overall, they depicted it as an interesting process where clients have opportunities to talk about their everyday problems. For instance, Michael was one of the respondents who emphasized this idea:

Now she [therapist] can ask questions about specific situations and it becomes more interesting than just asking questions like where did you grow up and what did you do? Now, it is “Why did you want to do this?” and things like that which makes it [counseling] a lot more interesting.

Moreover, interviewees saw the therapy as an ongoing process that does not stop when clients stop coming to counseling. For those clients who took part in interviews, counseling appears to be a “foundation for the future.” For example, Shelby stated:

I do know when I go home [from prison], I will continue counseling because I am going to have a whole new set of issues and other stressors in my marriage and everything else that we are going to have to work out when I get home.

In other words, participants appeared to have strong intentions of utilizing insights and conclusions they made in counseling to make their decisions in the future. Furthermore, an additional important role of counseling that emerged from interviews is that therapy can help clients transition into society and be ready for productive and independent functioning. This point could be illustrated by a quote from the interview with Shelby:

I think it [therapy] is like the foundation. It is laying a good, solid foundation for the future ... because I am basically having to restart my entire life over and working with my counselor has really helped prepare myself for that. So, if anything, I think it was just helping prepare me for those.

It is also important to note that the code “Counseling is a foundation for future” was used a number of times by each participant, except one, Chris (Note: Chris saw the therapy as an environment that helps solve present problems). Furthermore, it was the most often used code under this theme.

Theme 6: Therapy outcomes. Even though the participants were not specifically asked about counseling outcomes, this theme strongly emerged as interviews were analyzed. Furthermore, codes included in this theme were used more often than codes of any other theme under Issue 1 (i.e., 55 times). As Table 4.6 shows, overall participants talked about seven different outcomes they received as a result of counseling: (1) reflection on past experiences, (2) generation of solutions, (3) accomplishments of goals, (4) identification of needs, (5) increased hope, (6) understanding self, and (7) increased self-esteem. Interviewees especially emphasized two outcomes: therapy as a means of reflecting upon past experiences and generating solutions to problems. To illustrate, Michael noted:

It [therapy] has made me think about some past relationships and present that maybe I do or maybe I wasn't doing something or I being the same way and doing the same things to two different people when the one way worked for one person and it wasn't working for the other person.

With regards to these two outcomes, participants stated that as therapy progressed from mandated to volunteer, they were able to openly and honestly talk about their present concerns as well as past experiences (successes and mistakes). This, in turn, helped them to develop insights regarding ways in which their past, present, and future may be connected. Furthermore, participants' reflections on past experiences and generation of solutions resulted in identification of their needs and accomplishment of their goals. A quote from the interview with Shelby supports the idea that accomplishing certain goals in counseling may be an important motivator for mandated clients as they think about their past, present and the future. She said: "Years and years in meetings and you don't accomplish anything. So, it is nice to be able to come out and actually feel like you have accomplished something."

A quote from the interview with Shelby may be instrumental in understanding how counseling can increase hope:

Then the counseling not only is helping me feel hopeful about my time when I go home and I know what I am going to be looking forward to and I know what the career and I know what the family and the marriage and things like that. She [therapist] has helped identify those things and work with those. But, it has really given me a little bit of peace around here [correctional center].

In other words, through talking about participants' past experiences, their present concerns and needs, as well as through helping them to generate solutions, counseling increases clients' hope about their future.

Finally, reflecting on therapy outcomes, participants talked about their increased self-awareness as persons. This point can be illustrated by a quote from the interview with Chris: “I feel relieved. I feel better about myself than I did when I came here [to therapy] and I still keep in mind what she [therapist] told me.” Apparently, counseling that is strength-oriented can bring mandated clients some relief as well as increased self-esteem.

Issue 2: Facilitators of WA Development

As participants talked about factors that from their perspectives facilitated the development of the working alliance, their responses clustered into three groups creating three themes: (1) client factors, (2) therapist factors, and (3) process factors.

Theme 1: Client factors. Study participants who were interviewed discussed multiple client factors that significantly contributed to the development of client-therapist relationships in therapy (see Table 4.6). These factors included: (1) knowing your therapist, (2) liking your therapist, (2) need and ability to trust, (3) assuming an active role in therapy, (4) opening up, (5) clients’ desire to be in counseling, (6) clients’ “free will”, and (7) clients’ hopefulness.

Emerging from the interviews with three out of six participants, mandated clients often would like to know at least some information about their therapists to be able to trust them and continue working with them. For instance, Kyle stated:

I guess just getting to know each other and ... I don’t know too much about her [therapist]. I know she answered my questions but I mean she knows about me and she knows a lot about me. So, I feel like I know her, I guess.

As illustrated by this quote, knowing some things about a therapist aids clients in developing trust in their therapist as well as in a therapy process as a whole. Another important client factor related to client desires to know their therapists is “liking your therapist.” Michael stated: “You are not going to build trust with somebody you don’t like. I mean, if I didn’t like her [therapist] or get along with her, then I am not going to trust her.” Michael specified that he liked his therapist because she presented herself as a person, and not like a “machine” right from the beginning of therapy. Specifically, instead of asking question by question from her list of “things to ask,” the therapist smiled and made some jokes during therapy sessions.

Two respondents discussed clients’ need as well as their ability to trust their therapist as an important factor that helps the client-therapist relationship develop. For example, Shelby noted: “In large part I am sure it was the trust...at some point in time, I was able to trust her and I think that made all the difference in the world.” This code appears to be related to another idea emphasized by the majority of interviewees - “client is active in therapy.” George illustrated this factor by stating:

I would always, even when I was working, I would be thinking about the things I wanted to talk about before I came to class [session] or during the whole week and you know how sometimes, you can think and think and think and then when you get to class, you choke up and forget what you were thinking about. But, that didn’t happen to me. I was kind of proud of myself for being like that.

It is important to note that a number of participants reported having initial difficulties trusting therapists due to previous experiences with betrayal of their trust.

It appears that taking an active role became one of the factors that made counseling an environment that is different from a correctional center. In particular,

mandated clients seemed to realize that they have choices about what they decide to talk about as well as what they want to get out of their sessions and this facilitates working alliance development.

Clients' willingness to open up became another significant client characteristic that facilitates WA development. Chris described this idea thusly: "I really threw everything I had into it [counseling] this time." Furthermore, analysis of the qualitative data related to this theme revealed that clients' willingness to open up helped the client-therapist relationship to develop and the counseling to become appealing for clients.

The concept of "free will" was discussed by four interviewees. For instance, Michael said:

It makes it easier when you come to the point that now you don't have to be here [in therapy]. You are here of your own free will which makes you want to do it more because somebody is not telling you that you have to do it.

It became clear from the interviews that client-therapist relationships would not have developed and survived unless clients were willing to accept counseling as something that they wanted to attend on their own rather than because they were mandated to do so. This code also demonstrates the importance of clients' motivation for counseling in WA development. Furthermore, the code "free will" emphasizes the idea that mandated clients value the fact that they may make choices in counseling even though the counseling was mandated to them. Overall, the participants talked about a number of reasons that helped them start wanting to build a productive relationships with their therapists. As stated by Chris, his family was the major reason for him. He stated: "I went home and I seen my family and everything, it changed a lot, you know. That kind of

boosted me up to come back to the next meeting [therapy session] and just put my heart into it [therapy].” Other reasons included: a desire to have a better future, worries about children’s future, a determination to change one’s own life for the better.

Clients’ hopefulness that their lives will be better some day became another imperative factor contributing to WA development. As Michael stated, “I mean I always had hope. I never felt like everything was just going downhill or anything like that. I mean generally everything was all right before counseling.” As it emerged from the interview with Michael, as well as with George, Joe and Kyle, clients’ levels of hope before coming to counseling also make a noteworthy contribution to the development of client-therapist relationships. Therefore, it is important that therapists assess mandated clients’ pre-existing sources of hope, utilize clients’ existing levels of hope and focus on further instillation of hope.

Theme 2: Therapist factors. “Therapist factors” became a major theme that explained interviewees’ perceptions of factors that contribute to WA development. Twelve codes that comprised this theme were mentioned 79 times by participants. No other theme was as popular as this one. This may signify the importance of the therapist factors in developing client-therapist relationships. As Table 4.6 shows, interviewees talked about characteristics of a therapist as a person as well as a professional.

Reflecting on imperative characteristics of a therapist as a person, the participants talked about being non-judgmental, comforting, respectful, and sincere. Kyle was one of five participants who stressed the role of therapist being comforting. Specifically, he stated:

She [therapist] made the comfort level and she is really easy to get along with and I don't feel like she is going to force me to say this or say that...So, she is a comfort. She makes me feel comfortable enough to go ahead and let her in. That is what makes the relationship.

While Kyle focused on how the therapist made him feel comfortable, Shelby, in turn, emphasized the importance of the therapist being non-judgmental:

From the minute I got here at no point in time did [my therapist] make me feel like I was a criminal....We [inmates] came in and there was no instant stigma identified because I was a felon...That was one of the biggest things was that if she had put out in any point in time the first five minutes I was here if I would have ever felt that I was instantly being labeled as a felon from the Correctional Center, I would not have been able to open up and communicate or I probably would not have continued because I'm just that type of person.

Shelby also talked about specific things her therapist did to help Shelby feel that she was not judged by that therapist. In particular, Shelby noted that her therapist has never called her "a criminal." Furthermore, the therapist did not make assumptions about Shelby's life situation and reasons for incarceration; she simply asked Shelby to disclose only that information she felt comfortable sharing. It appears that feeling of not being judged plays a crucial role in developing client-therapist relationships in mandated counseling.

Overall, the interviews suggest that mandated clients prefer to work with a therapist who acts "like a person" (from the interview with Michael). Michael's statement illustrates this point very well:

Acting like a person, I guess. Not like a machine. Well, not necessarily like a machine but like just sitting there, asking questions and blah, blah, blah - but unemotionally. I mean something as simple as laughing or smiling will make anybody feel more comfortable.

As illustrated by this quote, mandated clients would like to work with a therapist who is approachable and demonstrates emotions.

Interviewees also expressed appreciation of therapists' sincerity in expressing their interest in a client as a person. A quote from the interview with Joe exemplifies this idea:

I think the biggest thing, too, was instead of looking at us [clients] so much like a job or something like that but more so of actually seeing a person that needs some help. Having that kind of feeling of wanting to help somebody.

On the whole, analysis of the interviews revealed that for mandated clients it is especially important to see their therapists as sincere because they do not feel that they are being treated as persons the majority of time while they are in prison.

Mandated clients who were interviewed talked about a number of professional qualities of therapists that seem to significantly contribute to the WA development. This group of qualities included therapists being knowledgeable and consistent in their approach to clients, being able to ask interesting questions and understand clients' backgrounds, offering choices to clients, and assuming an active role in therapy.

As participants reflected on essential professional attributes of their therapists, they talked about therapists' educational background. Michael, for instance, said: "It feels more like you are talking to someone who knows more...more than going to someone on the street and having to tell them your life story." Michael was one of those participants who appreciate therapists' knowledge of their field and her ability to demonstrate that to clients. It seems that ways therapists present themselves and their knowledge in sessions may help clients to be more confident that their time in counseling will be worthwhile.

Therapists' consistency in ways they relate to clients during therapy became another important characteristic of an effective professional. Three interviewees talked

about this idea. Joe commented: “There was nothing ever different. Each session was the same. It was presented the same. We started and ended the same... And I would say that everything was professional as far as the actual session.” Kyle described the importance of this characteristic in a slightly different way: “She [therapist] don’t treat me no different - like the next session, cause I told her about my life and she didn’t treat me no different in the session after that. She treats me the same.” These quotes emphasize that therapists’ consistency is one of the major factors that helped some mandated clients to feel comfortable in a counseling room and to start opening up.

A quote from the interview with Michael highlights the weight that interviewees placed on therapists’ professional skills of asking interesting questions and understanding clients’ backgrounds.

After the third or fourth session, when she [therapist] had a general understanding of what my life is, then it was not just machine questions. It was more personal and, I guess, more interesting than just me saying things that I have done.

In other words, seeking answers to questions appears to help therapists to understand the background of their clients better as well as to demonstrate their understanding to the clients. At the same time mandated clients appear to perceive these questions as helping them to open up in therapy as well as to develop working relationships with therapists.

Comments about therapists giving choices to clients and therapists assuming an active role in counseling became two codes that were used most often when interviewees talked about therapists’ professional qualities. As George said,

The way she [therapist] asked the questions was pretty nice. You know, you get ordered around you know and it is hard. When she [therapist] got to the point to ask the question, it just came out nice and when I answered the questions, she agreed with what I was saying and then she [therapist] gave me my options.

Another example of this perspective is a quote from the interview with Chris:

She [therapist] was giving me options... She would try to explain - “Don’t do it this way.” So, you know, that was what I really liked. Having the options available in my mind. Usually I don’t think before I react. But now, I think.

These quotes demonstrate a special role mandated clients see in having opportunities to choose rather than being told what to do in their own therapy.

Therapists’ tendencies to ask questions and give choices appear to be related to therapists’ overall active role in the counseling process. All participants, except Kyle who emphasized the need for therapists to be respectful, talked about the importance of this factor in developing working alliance. For instance, Chris stated: “You know, before I got here [therapy] I was wondering what she’s [therapist] got planned for me today and what are we going to talk about today other than what we had discussed last time we were there.” Chris’s statement exemplifies that for mandated clients it is important to feel that they are being genuinely cared about and their therapists take time to prepare for sessions and talk about their thoughts during sessions.

Theme 3: Process factors. Four out of six interviewees discussed a few process factors that contribute to WA development (see Table 4.6). Two codes, “trusting relationships” and “confidentiality” were common topics for those four participants. For instance, Michael emphasized the role of trust in the client-therapist relationship by saying: “And it also I think a big part [in development of our relationship] was that by that time [4th session] I had learned to trust her [therapist], I guess.” Kyle made a connection between “trust” and “confidentiality”:

So, the counseling sessions, I feel like I can trust her [therapist]. I don't think that she would go and tell nobody else all these things [personal information]. Like, he did this or he did that... I think that's the biggest change and I guess it has just gotta be something that keeps me coming. The comfort level is higher and higher and higher.

Taken together, these two quotes demonstrate the significance of confidentiality and trust in mandated counseling and their pivotal role in building productive client-therapist relationships.

Three other codes included in this theme (see Table 4.6) will be discussed in a section "Different themes and codes between cases" (p. 120) because each of them was used by only one interviewee.

Issue 3: Obstacles to WA Development

As study participants talked about factors that impede development of client-therapist relationships, three themes emerged: (1) client factors, (2) therapist factors, and (3) process factors.

Theme 1: Client factors. Analysis of the qualitative data revealed three codes describing client characteristics that may negatively influence WA development (see Table 4.8): (1) clients' uncertainty about expectations of counseling, (2) clients' reluctance to enter therapy and start developing therapeutic relationship, and (3) clients' difficulties with opening up to their therapists.

With regards to clients' pre-counseling expectations, Shelby stated:

I really didn't know what to expect when I started counseling because I really don't have any background in it at all. And, so the only foundation that I have in counseling is what you see on TV, you know movies and things along that line. So, I was not really unprepared. I was unsure of what to expect.

As demonstrated by this quote, clients' ideas of counseling as it is portrayed by media could be disruptive to the WA development.

The interviewees also talked about their reluctance to enter therapy and actively participate in developing of working relationships with their therapists. George described this factor thusly: "She [therapist] asked me a bunch of questions and I really didn't want to come out and say anything right away because I didn't know how I was going to react to being there [in therapy]." In other words, it appears that mandated clients require an extended period of time to adjust to a new environment of therapy and to get to know their therapists.

Finally, the interviewees highlighted the idea that often clients' difficulties to open up to their therapists prevent client-therapist relationships from developing. To illustrate this point Shelby stated:

For me, I am not exactly the most open person and am not able to share a lot about myself. Not with my spouse, not with my family and not with anyone... And it did not help my relationship with her [therapist].

Shelby's statement addresses "difficulty to open up" as a personality characteristic. This characteristic could develop as a mechanism helping a mandated client cope with a reality of a correctional center where disclosed information could be used against a person.

Theme 2: Therapist factors. Only one therapist characteristic - lack of therapist's directiveness - was mentioned as interviewees talked about obstacles to WA development (see Table 4.8). Furthermore, only two participants (Michael and Shelby) talked about this characteristic. As it emerged from these two interviews, sometimes mandated clients

would like their therapists to be more directive and specific in their interactions with clients. For instance, sometimes therapists should let clients know if their ideas are not “productive.” The two respondents also pointed out that they would like to see therapists directing the therapy process in a way that would result in practical outcomes.

Additionally, Shelby and Michael noted the importance of therapy being future- rather than past-oriented. They expect the therapist to assure that this direction is being taken.

Theme 3: Process factors. Three codes were common as respondents described process factors that impede working alliance development. The one used by every interviewee was “counseling is mandated.” Furthermore, no other code comprising Issue 3 was used more often than this one. For example, Michael stated: “I guess I didn’t care in the beginning if it [counseling] did anything or made me feel more hopeful or made me feel better or anything like that because I was only here [in counseling] because I had to be.” In many ways, Michael’s statement exemplifies other respondents’ perspectives. In particular, mandated clients appear to have a minimum amount of hope and motivation for counseling due to the fact that it is mandated. It became apparent from the interviews that, initially, clients wanted to complete the mandate as soon as they could without getting personally invested in the process of therapy.

Three out of six interviewees saw therapy as “boring and tedious” at the beginning (from the interview with Michael). Chris described his perception of the beginning of his therapy thusly:

It [therapy] was not necessarily going anywhere - well, it was because she [therapist] asked me a list of questions so she could ask even more questions later. So, to me I was just being bored to death.

The analysis of the data revealed that initially therapy for some clients may have resembled prison. Specifically, everything in therapy may be perceived to be predetermined (e.g., standard set of questions, paperwork), boring, impersonal, and directed by the therapist resulting in less control for the mandated client.

Finally, two respondents, Joe and Kyle, pointed out that training features of a counseling clinic (e.g., taping of counseling sessions) became another factor impeding WA development. As Joe said,

I didn't allow it [taping] to distract me as far as my participation or even the reason why I am here was not totally volunteering. I did know that anyway. Just sometime I wanted to say "Can I see the video?" I like to watch videos. Watch it and replay it.

Three other codes included in this theme (i.e., client-therapist misunderstandings, difficult topic, and homework not helpful) will be discussed in the next section (i.e., "Different themes and coded between cases," p. 120) because each of them was used by only one interviewee.

Different Themes and Codes between Cases

Analysis of codes and themes that are different between cases is pivotal for the case study research (e.g., Creswell, 1998; Stake, 1995). As a result of examining the differences between the cases, a number of results emerged. First, the qualitative analysis revealed that no single theme was absolutely unique to any specific case. Second, it was found that there were a number of codes that were specific to a particular case (see Tables 4.6, 4.7, 4.8). Third, participants who were interviewed also differed in amounts of value they placed on each theme and code. Fifth, interviewees' explanations of their WA graphs also varied. All named differences created descriptions that make each case

unique and explained the specificity of each participant's perception of a therapy experience.

Case 1 "Michael"

In comparison to other cases, Michael emphasized the importance of the client-therapist relationship (55.6%) more than other participants did as he discussed his perception of the therapy process. He also placed more emphasis on the value of client factors as facilitators of WA development (30.6%). Specifically, Michael discussed the significance of client motivation for counseling. He stressed that even though counseling was mandated for him, he started it with a high internal motivation to make use of it.

While talking about obstacles to WA development, Michael gave a special value to therapist factors (75%) and process factors (34.3%), which was higher than the emphasis other participants placed on the same factors. In particular, Michael discussed his desire to have a therapist who is willing to give suggestions and be more directive in the therapy. For Michael, the fact that counseling was mandated became a major obstacle to WA formation in comparison with other interviewees. He talked about this obstacle eight times, more than any other participant did.

Overall, Michael talked equally about therapy process (Issue 1) and facilitators of WA (Issue 2). He mentioned each issue 39 times (see (see Tables 4.6, 4.7, 4.8). He talked less about obstacles to WA development (18 mentions). Furthermore, Michael mentioned a number of ideas that nobody else talked about. Specifically, he discussed the fact that counseling did not increase his general level of hope. He noted that he was hopeful even before he started the counseling:

I always had hope that things would be all right. I don't necessarily think that it [counseling] gave me hope. It [counseling] gave me a new - I guess a better way would be of getting new ideas and perspectives to think on and to think about things.

In other words, for Michael, increased hope was not a part of his therapy experience.

He also mentioned that "client-therapist misunderstandings" became an obstacle to WA development for him. Michael noted that when he came for his third session, he asked his therapist for a letter confirming his attendance. Apparently, initially the therapist responded negatively to this request, which made Michael upset:

She [therapist] said that she couldn't give that [letter] to me and she didn't really understand what it was. So I got upset because I didn't want to end up having to come here for the next six months and to not get the letter. It wasn't high on my pleasurable things to do necessarily.

Michael's rating of WA after that third session (153) was significantly lower than his rating after the first session (197) (see Figure 4.1, case 3). However, during the fourth session Michael and his therapist discussed the conflict situation. The therapist agreed to write the letter, and Michael agreed to continue counseling. As a result of this discussion, Michael's rating of the WA after fifth session became more positive (164).

Case 2 "Shelby"

In comparison to other participants, "Therapy Process" was the major theme for Shelby (36.2%, see Table 4.9). She specifically talked about the importance of the therapy for the future: "I think it [counseling] is like the foundation. It is laying a good, solid foundation for the future." Furthermore, Shelby's comments regarding her vision of therapy as a foundation for the future suggested that she would consider returning to counseling in the future if it is needed.

While reflecting upon obstacles to WA development, Shelby especially emphasized the value of client factors. In particular, she talked about clients' negative expectations of counseling as well as clients' difficulties to open up in therapy. Shelby noted that if clients expect counseling to be a "waste of time," they would use this attitude to evaluate their initial counseling experience. Moreover, clients' reluctance to open up in sessions and be willing to take risks to do that prevents productive client-therapist relationships from developing.

Among the original ideas Shelby talked about were: (1) "equality between therapist and client," and (2) "appropriate timing for counseling." Shelby was the only interviewee who brought up her need to feel equal to her therapist as one of the important conditions for WA to develop:

I like the fact that they [therapists] are in jeans and sweaters and they are not wearing a three piece suit because I would have been in the suit and someone in a suit across from me I want to be on equal ground and equal footing and I would have wanted to be in a suit too. It is one of those important things. A little bit of equality. So part of it [relationship development] is the atmosphere. There is no big desk where somebody is stuck behind and the atmosphere was a big part of it.

She also mentioned that the fact that her counseling mandate came around the time close to her parole made the therapy relevant and more useful for her. It also helped facilitate the formation of client-therapist relationship because Shelby could see the practical meaning of the counseling process.

Another original idea Shelby used was "hopelessness." Shelby described herself as "hopeless" as she talked about her pre-therapy level of hope. She explained that characteristic as an obstacle to WA development:

You don't put too much stock into your future. You don't put up all your stock into being hopeful. We [inmates] live such a day-to-day life with literally everything constantly changing and so you really don't [hope].

Overall, Shelby spent more time talking about her perception of the therapy experience (Issue 1) than any other issue. She discussed this issue on 45 different occasions (see Table 4.7).

When Shelby looked at a graph that represented her WA ratings (i.e., accelerating linear), she agreed that the pattern was an accurate portrait of her subjective perception of client-therapist relationship. She acknowledged that the gradual increase in WA scores mirrored her gradual process of building trust in therapist and feeling more confident to open up in session. Specifically, Shelby noted: "She [therapist] hadn't done anything to offend me but then after the more times [sessions] we met the more your confidence grows and your trust grows and so that [the accelerating increase] makes complete sense." In other words, for Shelby major factors that participated in the formation of the client-therapist relationship were time and therapist factors (e.g., trustworthiness, respect).

Case 3 "George"

When compared to other participants, George emphasized ideas about therapy outcomes more than others did. He especially stressed the significance of "self-understanding" and "accomplishing goals":

She [therapist] made sure that what we discussed towards my plans for staying out of jail and what we had laid out for me to work on, she made sure that it was always instilled in my head that that was what I need to do.

In other words, George greatly appreciated the fact that counseling was very practical for him. There were a number of themes that George did not talk about. In particular, (1) process factors as obstacles to WA, (2) client-therapist relationship, (3) and therapist factors as obstacles to WA (see (see Tables 4.6, 4.7, 4.8).

Another unique feature of the interview with George was that he, more than others, emphasized the therapist role in the therapy process. On five different occasions he highlighted the importance of a therapist being active in counseling. Similarly to Shelby, George spent more time talking about his vision of the therapy process (36 mentions), and less time reflecting on obstacles to WA development (9 mentions).

When George looked a graph that represented his WA ratings (i.e., accelerating linear), he agreed that the pattern was an accurate portrait of his subjective perception of the status of his relationship with his therapist. In particular, George noted: “I agreed [with the WA graph] because that is the way I felt in our sessions. It wasn’t me just puttin’ somethin’ down there [questionnaires]. That was just the way I felt.” George also pointed out that if he were asked to rate WA in future sessions, the scores would be similarly high.

Case 4 “Chris”

In his interview Chris focused on therapist factors as the major facilitators of WA. He talked about this theme on twelve different occasions. Chris emphasized the significance of therapists giving choices to mandated clients and therapists being comforting as they work with clients. He said:

When she [therapist] got to the point to ask the question, it just came out nice. And when I answered the questions, she agreed with what I was saying and then she gave me my options ...try this or whatever. I just liked that.

In other words, Chris's statements regarding therapist qualities highlight both professional and personal characteristics of therapists.

Similarly to the interview with George, there were a number of themes that Chris did not talk about. In particular, (1) process factors as obstacles to WA, (2) client-therapist relationship, (3) and therapist factors as obstacles to WA (see (see Tables 4.6, 4.7, 4.8).

Overall, Chris gave relatively equal attention to the therapy process (Issue 1) and facilitators of WA (Issue 2; 23 and 20 mentions respectively). He spent significantly less time talking about specific obstacles to WA formation (7 mentions).

When plotted, Chris's ratings of the working alliance created a constant pattern. When presented with the graph of his WA scores, Chris stated: "I don't think it [the graph] is accurate. The beginning [first session] and the middle [third session] is accurate but it [line] should have went up a little bit more [at the fifth session]... Overall, I think it [line] would have kept going straight up." In other words, Chris noted that the WA rating after the fifth session should have been higher than it was on the graph. Chris's comment emphasizes the point that it takes mandated clients longer to develop trusting and productive relationship with their therapists as well as it takes clients longer to start changing their original perception of a therapist and counseling relationship.

Case 5 “Joe”

In comparison to other participants, Joe emphasized the importance of process factors (38.9%) more as he discussed his perceptions of facilitators of WA development. Moreover, Joe also mentioned two ideas that no other interviewees presented. In particular, he talked about “individual attention” as one of the most significant factors that facilitates WA formation. He stated: “The focus [of therapy] was mainly on my issues and it helped me actually just to develop [a] personal decision making system...[it was important to] basically having a total focus on me. Cause I like attention.” Apparently, positive attention from the therapist has helped Joe to overcome his reluctance to be in counseling due to the fact that it was mandated. Furthermore, it allowed him to become open to building a genuine relationship with his therapist.

Clients’ positive expectations of counseling became another important facilitator of WA formation for Joe. While talking about the origin of his own positive expectation of counseling, Joe noted: “I went through the program of mental health counseling earlier and became educated about its format, and different stages of that and levels like thinking, the behaviors, and things like that.” Joe noted that his first experience with “mental health counseling” has helped him to make a number of positive changes in his lifestyle. He also emphasized, that his previous experience has helped him to know what format of counseling he prefers as well as what goals he could set for the counseling.

Another aspect of the interview with Joe was the fact that along with the same themes that were not discussed by George and Chris (i.e., client-therapist relationship and therapist factors as obstacles to WA), he did not talk about client factors as obstacles to

WA development. In other words, when reflecting on the obstacles to WA, Joe emphasized process factors only (e.g., counseling is mandated; recording equipment).

Similar to Chris, while talking about all three issues, Joe placed the major emphasis on therapist factors as facilitators of WA. Specifically he noted that for therapists working with mandated clients it is imperative to be sincere and understanding as well as to assume an active position in counseling. Like Chris, Joe equally emphasized the issues of therapy experience (Issue 1) and facilitators of WA development (Issue 2; 27 and 30 mentions respectively). He spent significantly less time talking about obstacles to WA development (Issue 3; 5 mentions).

When Joe looked at a graph that represented his WA ratings (i.e., accelerating quadratic late onset), he agreed that the pattern was an accurate portrait of his subjective perception of his relationship with his therapist. Specifically, Joe said: “It [his WA pattern] could be because at some point [in therapy], I stopped be a stranger in certain areas and then after you allow a person to get to know you it develops into a more likable circumstance.” In other words, for Joe major factors that determined the formation of the client-therapist relationship were time, client factors (e.g., ability to trust, readiness to open up), and therapist factors (e.g., therapist asking questions).

Case 6 “Kyle”

Similar to Chris, Kyle focused on therapist factors as the major force that facilitates WA development among all qualitative themes. However, in contrast to Chris, Kyle stated that the therapist quality most important to him was respect toward clients. He stated: “She [therapist] don’t treat me no different - like the next session, cause I told

her about my life and she didn't treat me no different in the session after that. She treats me the same. She is respectful." Kyle's quote points out to the difficulties mandated clients may have with disclosing their personal background information to therapists. At the same time the quote emphasizes the importance of therapists' consistency in ways they treat mandated clients regardless of the type of information they learned about those clients.

Furthermore, Kyle mentioned four ideas that nobody else talked about: (1) therapist gender, (2) negative expectations, (3) difficult topics that are discussed in therapy, and (4) homework not helpful. From the interview with Kyle it became clear that therapist gender did matter to him. He stated: "So, for me it is a lot easier to talk to a woman than it is to a guy. Most of the time when I was talking to a man for a counselor, I would just say whatever to get them off my back." In other words, for Kyle his therapist's gender appears to be an important facilitator of WA development.

While discussing his thoughts about obstacles to WA development further, Kyle brought up the idea of clients' negative expectations of counseling. This idea complemented Joe's idea about clients' positive expectations being a facilitator of WA. Kyle reflected upon the origin of his own negative expectation of counseling to illustrate how this factor may significantly impede the development of a productive client-therapist relationship. He said:

For the past seven years in prison, you don't have one-on-one counseling. They call it mental health therapy. You're in a group sitting in a circle and just talk about problems you have... and it's uncomfortable. It's embarrassing at times. So, it's not something I like to do. I figured that being here would be the same. I didn't know it would be one-on-one and I didn't know it...I just figured it [counseling] would be bullshit.

Kyle's preconceived notions of counseling provide specific examples of negative expectations that negatively interfere with client-therapist relationships as therapy begins.

Finally, Kyle commented on the effectiveness of the assignments his therapist asked him to do:

She [therapist] gives me like every week she will give me an assignment or something she wants me to do... I said, "It's just something it's not - I mean, I didn't go to school because homework was just something that I would rather do other things. I mean if I did it, maybe it would be helpful but I guess it's something I don't like doing."

Kyle acknowledged the fact that counseling homework may be helpful, but not for him.

Similar to George, Chris, and Joe, Kyle did not mention any therapist factors that could be considered obstacles to WA development. Overall, the topic of facilitators of WA development appeared to be more important for Kyle than other issues. He talked about the WA facilitators on 26 different occasions. Consistently with all previous participants, he talked noticeably less about WA obstacles (11 mentions).

When plotted, Kyle's ratings of the working alliance created a decelerating linear pattern. When presented with the graph of his WA scores, Kyle acknowledged its accuracy and explained:

Well, the first one [1st session] was hard to answer the questions and didn't really have answers. But, I felt that some of them were kind of weird questions and then the third session I remember I had a good time and I don't remember exactly what it was. But, I remember feeling that most of my answers were definite and things definitely were going well. But then, in that session [before 5th session], I remember I had a bad night. I was kind of depressed. I mean it was the topic we talked about and it wasn't that she [therapist] did anything wrong. It was the way I was feeling. So, some of the answers bothered me, too.

In other words, Kyle strongly stressed the importance of both client and therapist factors in the formation of the working alliance. In his comment he noted that questions the

therapist asked were one of the major factors that influenced Kyle's perception of counseling. Furthermore, Kyle's emotional reactions to those questions (e.g., feeling depressed) became another imperative component of his overall perception of therapy sessions as well as a factor that significantly influenced the WA development.

The results of the quantitative and qualitative phases of the present study will be discussed in the chapter 5 "Discussion." This chapter will also include the discussion of implications of the study results for practice and research in the area of mandated counseling.

CHAPTER V

DISCUSSION

The present sequential explanatory mixed methods study sought to address six overarching research questions: two quantitative and four qualitative. The first question was about the trajectory of the working alliance in the early stages of mandatory counseling. To address the second research question, the influence of clients' motivation and hope on their ratings of the working alliance was examined. Finally, questions three through five required the exploration of the qualitative similarities and differences in the perception of working alliance development as well as therapy in general by clients with different trajectories of the working alliance growth.

Quantitative Research Questions and Hypotheses

As stated earlier, preliminary analysis revealed the presence of a significant therapist effect at all points of the data collection as well as in all variables under investigation (i.e., working alliance, motivation and hope). Through a preliminary analysis, this finding appears to be important on its own. This finding represents a statistical confirmation of the fact that the present study as well as current literature on mandatory counseling (e.g., Honea-Boles & Griffin, 2001; Storch & Lane, 1989; Waldman, 1999) may have underestimated the importance of therapist factors in forming the working alliance between a mandated client and a therapist. In other words, therapist qualities appear to have a determining role in therapy with mandated clients. Perhaps mandated clients prefer a particular profile of therapist qualities. For example, therapists who do not pre-judge clients based on their crime could be more able to form a working

alliance with mandated clients. Investigation of this profile is beyond the scope of the current study. It is important to note, however, that this finding was also supported by the qualitative results. Refer to the section “Qualitative Results” for specific therapist qualities that were uncovered by the qualitative investigation. The therapist effect was statistically accounted for when the data were analyzed (see p. 75 for more details).

***Research Question One: What Is The Growth Trajectory Of The
Working Alliance In The Early Stage Of Mandatory Counseling?***

The first quantitative research question focused on the trajectory of the working alliance development in the early stage of mandatory counseling. The growth model for WA slope was non-significant. However, the fixed effects (means) estimated by the LG Model 1 suggested that the slope of the working alliance trajectory is positive. In other words, mandated clients on average perceive that the alliance between them and their therapists slightly improves every session during the course of the first five sessions. It is important to note that the calculated change in variance¹ (see Table 4.2) revealed that the WA slope is positive not due to chance, but due to the small sample size, which in turn allows to talk about this result as a research finding. This finding supports results that were previously found in studies of therapist-client relationship in volunteer counseling by Gunderson and colleagues (1997) and Sauer, Lopez, and Gormley (2003) and highlights the idea that the working alliance increases steadily over time. Additionally, the finding about the increasing working alliance growth trajectory provides some evidence that regardless of limitations to mandated clients’ confidentiality and freedom,

¹ “Change in variance” in LG terms has the same meaning as “effect size.”

the client-therapist relationships in mandated counseling still can have a positive influence on clients. This finding appears to be consistent with ideas that are forwarded in conceptual writings of scientists advocating for the importance, necessity, and feasibility of the working alliance development in mandatory counseling (e.g., Honea-Boles & Griffin, 2001; Lehmer, 1986; Rooney, 1992; Slonim-Nevo, 1996). Moreover, this finding is also a promising indicator of possible productive outcomes of mandatory counseling. However, since the present study did not investigate the relationship between working alliance and therapy outcomes, the latter conclusion may be made only tentatively. Therefore, further investigations may be instrumental in clarifying the relationships between working alliance and therapy outcomes in mandated counseling.

Another important finding sheds some light on how mandated clients see their relationships with their therapists after the first session. Similar to findings of Kivlighan and Shaughnessy (1995) and Sauer, Lopez & Gormley (2003), on average, clients' working alliance ratings were high (see Table 4.9). This was a surprising conclusion due to the fact that participants of the studies by Kivlighan and Shaughnessy (1995) and Sauer, Lopez & Gormley (2003) were volunteer clients. In other words, mandated clients' ratings of WA were either similarly high or even higher than ratings of WA by volunteer clients. This finding was somewhat unexpected because of the nature of mandated counseling. A number of conceptual and empirical writings in the area of mandated counseling forward the view that in general mandated clients perceive counseling as something negative even after their initial meeting with their therapists.

Table 4.9

Comparison of Client Working Alliance Inventory Scores from Three Empirical Studies

Empirical Study	Session					
	1		2		3	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Present Study (<i>N</i> =63, mandated clients)	205	28	212	27	218	21
Study 1 (<i>N</i> =28, volunteer clients)	199	31				
Study 2: Sample 1 (<i>N</i> =41, volunteer clients)	204	23	214	25		
Study 2: Sample 2 (<i>N</i> =38, volunteer clients)	185	42	185	46		

Note. ¹ Working Alliance scores can range from 36 to 252 (higher scores indicate stronger WA). Study 1 = Sauer, Lopez & Gormley, 2003. Study 2 = Kivlighan & Shaughnessy, 1995

Clients may see counseling settings as well as therapists as an extension of an agency that made the mandate (e.g., Adams, 1992; Riordan & Martin, 1993; Waldman, 1999; Weakland & Jordan, 1990). Therefore, the clients' evaluations of their relationships with their therapists would be expected to be relatively low after the first session in comparison with volunteer clients.

This study's finding points to the possibility that after mandated clients meet their therapists for the first time they may start seeing a value in the relationship with these therapists, which, in turn, may improve their overall perception of the therapy. It also points to the importance of therapist qualities in establishing client-therapist relationships. It is important to note that the results of the social desirability scale (L-Scale, see p. 65) that was administered to all mandated clients in the current study

suggest that participants were truthful in their responses on the questionnaires and in the interviews. Perhaps, an alternative explanation for the high WA scores for mandated clients who participated in the current study could be that there are different types of mandated clients. In particular, the participants of the present study came from the work release center, and may have been more receptive to the idea of counseling, since they would soon be out of prison. In addition, the therapists who provided counseling to the study participants may have been less authoritarian in presentation than some other counselors that are mandated by the courts in certain situations.

Furthermore, this study found that mandated clients' initial WA ratings are significantly different from each other. The analysis of the data revealed the presence of significant variance in the WA ratings after the first counseling session. This finding is important because it implies that there are some unknown reasons for this variability. In other words, there are certain variables that may explain the differences in clients' WA scores after the first session.

Research Question Two: Can We Explain Variation In The Working

Alliance Growth Trajectory According To Levels Of Mandated

Clients' Motivation For Treatment And Hope?

The second quantitative research question investigated the amount of variance in the working alliance trajectories that could be explained by clients' levels of motivation and hope. Based on the reviewed literature on volunteer counseling, the researcher hypothesized that mandated clients' levels hope and motivation explains significant amounts of variability in the working alliance growth over first five therapy sessions.

Moreover, the study hypotheses suggested that (a) clients' motivation for treatment that is more internally regulated is significantly associated with higher working alliance ratings; and (b) higher levels of clients' dispositional hope is significantly associated with higher working alliance ratings. Even though the original research hypotheses were not confirmed by the statistical analysis, some important implications and summaries still can be drawn from the statistical results.

Since none of the chosen client variables (i.e., motivation and hope) were found to be significant in explaining the variance in WA ratings after the first session, other client, therapist, or therapy process variables may explain this variance better. Furthermore, it is possible that it is not client but therapist characteristics that have more influence on WA in mandatory counseling than originally hypothesized. Moreover, it is possible that contrary to the conceptual and empirical writings on the importance of clients' hope and motivation in volunteer counseling (e.g., Cooper et. al., 2003; Darmody, 2003; Erickson, et. al., 1975; Lambert, 1992; Pelletier et al., 1997), these variables may not be as influential when counseling is mandated. The qualitative phase of the current study resulted in a number of findings about therapist, client, and therapy process factors that may have a potential to be more influential in WA formation than client motivation and hope. Refer to the Qualitative Results and Qualitative Discussion sections for more details.

Qualitative Research Questions

Research Question Three: How Do Mandated Clients

Perceive The Development Of The Working Alliance?

Differences in Clients' Perceptions of WA Development

The third research question focused on qualitative exploration of mandated clients' perceptions of the development of their client-therapist relationships. Qualitative analysis revealed that mandated clients with different WA trajectories place emphasis on different factors as they discuss their perceptions of the WA. For instance, while three out of six interviewees (i.e., Michael, Shelby, Joe) discussed client-therapist relationship as they described their perception of therapy, three did not. Michael and Shelby placed more emphasis on therapist factors that impede WA development. Specifically, these two participants wanted to see the therapist be more directive in therapy. Furthermore, clients' opinions about the role of process factors as facilitators of WA were also different. Two interviewees (George and Chris) did not mention those factors at all. Because only one client from the selected WA patterns was interviewed, it is difficult to form generalized conclusions about differences between all individuals representing those WA patterns. Nevertheless, the current study allows the researcher to identify a few specific areas of difference such as (a) specific factors that were seen as impediments to WA development by different participants, (b) pre-existing levels of clients' motivation and hopes, as well as (c) pre-therapy expectations of counseling (refer to the section "Different themes and codes between cases" p.120 for further details). In order to form more definite conclusions about differences between patterns of WA trajectories, it is important in

future research replicate the study and interview several clients representing the same WA trajectory group.

Similarities in Clients' Perceptions of WA Development

At the same time, the qualitative analysis describes a number of common ways in which clients with different WA trajectories see the formation of the client-therapist relationship. First, all interviewed participants concluded that the fact that counseling is mandated significantly interferes with WA formation. For example, Michael stated:

I didn't care about if she [therapist] liked me or anything like that. I came in [for counseling] because I had to and just kind of answered her [therapist's] questions and things like that and hoped I could get out as soon as I could.

Other participants' statements were similar to ideas expressed by Michael. At the same time all interviewees highlighted the importance and usefulness of their individual therapy outcomes despite the fact that therapy was mandated. For instance, Chris noted: "I feel relieved. I feel better about myself than I did when I came here [counseling] and I still keep in mind what she [therapist] told me." In other words, all mandated clients who were interviewed agreed that therapy was beneficial for them. This unexpected qualitative finding is very promising as we think about the usefulness of mandated counseling practice. In other words, this finding offers an argument for mandated counseling and empirically supports scholars who advocate for it (e.g., Pollard, 1996; Rooney, 1992).

Second, all participants talked about therapist factors (e.g., knowledge, consistency, respectfulness, sincerity; see Table 4.6 for more factors) being important facilitators of WA development. To illustrate, Joe said: "Once I did discuss things that

were going on in my life, she [therapist] became aware of them. She [therapist] was not judgmental about things I told her [therapist]. Those are the things that make people comfortable.” This qualitative finding stresses the importance of future empirical explorations of therapist influences on WA formation. Furthermore, the qualitative analysis of participants’ description of their therapists also provides specific ideas of therapist factors that could potentially be very influential in facilitating the WA development (see Table 4.6).

Third, respondents also similarly reported that client factors (e.g., knowing your therapist, client need and ability to trust a therapist, client active role in counseling; see Table 4.6 for more factors) are very influential in WA development. For instance, Michael commented on the importance of client being active in counseling thusly:

Sure, it [therapy] can be helpful... I think of it [counseling] as life. Up to a point, it [counseling] is basically what you make of it. I mean there is always determining factors. Maybe you just never connected with your counselor or things like that. But, up to a point, it is basically on you.

It is important to note that the research finding of the importance of client factors in mandated counseling is consistent with findings regarding the role of client factors for therapy outcomes and WA formation in voluntary counseling (e.g., Lambert, 1992).

Finally, all interviewed clients noted that with time mandated counseling gradually transformed into being more voluntary. In other words, for the types of clients represented by participants of the current study clients’ motivation to be in counseling became more intrinsic overtime.

Research Question Four: How Do Mandated Clients' Motivation and Hope

Contribute To Or Impede The Development Of The Working Alliance?

The Role of Clients' Motivation for Treatment in WA Development

The fourth research question focused on the influence of mandated clients' motivation and hope on working alliance development. As mentioned earlier (p. 138), mandated clients concluded that the fact that counseling was mandated significantly interfered with WA development at the beginning of the counseling. In motivational terms, all interviewees acknowledged that extrinsic motivation for counseling (i.e., counseling is mandated) negatively interferes with WA development. As reported in the interviews, at the beginning of counseling mandated clients tended to see it as an extension of the agency that made the mandate. Furthermore, clients talked about feeling reluctant to actively engage in the therapeutic process when the therapy began. This qualitative finding is similar to findings from previous research investigations that studied the role of client motivation in mandated treatment (e.g., Lincourt et al., 2004; Simpson et al., 1994; Willshire & Brodsky, 2001).

Another interesting idea the current study uncovered was the finding about changes in mandated clients' motivation as the therapy unfolded. Specifically, clients' initial extrinsic motivation gradually became more intrinsic. During interviews, clients also discussed that as counseling transitioned from mandated to volunteer, their ratings of WA also increased. The finding that motivation is a "dynamic" (Deci & Ryan, 1985) and changing concept supports the idea forwarded in writings by Pelletier et al. (1997). In

particular, Pelletier and colleagues assert that client motivation at a particular point in therapy may change depending on situational influences.

Finally, as mandated clients discussed major client factors that facilitate WA development, “free will” (i.e., clients desire to be in counseling) became the factor that was discussed more than other factors (see Table 5.2). This highlights the importance of client motivation in the formation of the client-therapist relationship in mandated counseling. Furthermore, this qualitative finding is consistent with ideas of scientists who posit that client motivation as a pivotal characteristic of involuntary clients and mandated treatment (e.g., De Leon et al., 2001; Perlman, 1979; Rooney, 1992; Willshire & Brodsky, 2001).

The Role of Clients’ Hope in WA Development

Participants’ perceptions of the role hope plays in the WA development were not as consistent as when interviewees discussed the role of motivation. Specifically, while talking about facilitators of WA development, five out of six interviewees (i.e., Michael, Shelby, George, Joe and Kyle) talked about the important role client hope plays in the WA formation. For instance, one participant (Shelby) stressed that she did not have a lot of hope about her future when therapy started. This interfered with client-therapist relationship development formation. Overall, despite that not all interviewees discussed the role of clients’ hopefulness about their future and that counseling could be helpful to them, it became the third most used client factor as they talked about facilitators of WA development (see Table 5.2). Taken together, qualitative findings provide some evidence that supports the importance of client hope in facilitating the WA development.

Research Question Five: How Can The Statistical Results

Obtained In The Quantitative Phase Be Explained?

The fifth research question focused on ways in which qualitative findings could explain quantitative conclusions. This research question is addressed in the section “Integration of Qualitative and Quantitative Findings” (pp.146-155).

Research Question Six: What Other Factors Contribute to or Impede

The Development Of The Working Alliance In Mandatory Counseling?

The sixth and final research question inquired about other factors that contribute to or impede the development of the working alliance. The qualitative part of the current study describes a number of factors other than client hope and motivation that facilitate the development of the working alliance in mandated counseling. Three groups of factors were revealed: therapist, client, and process factors.

Therapist Factors

The findings of the current study regarding facilitators and obstacles to WA formation confirmed conclusions of two major qualitative studies (i.e., Bedi, 2006; Bachelor, 1995) of WA in voluntary counseling. Both previous investigations of WA in voluntary counseling found that clients value therapists who are respectful, emotionally supportive, caring, validating, guiding, listening, friendly, congruent, (Bedi, 2006; Bachelor, 1995) and honest (Bedi, 2006). Mandated clients interviewed for the current study identified a number of therapist qualities that are similar to perceptions of voluntary clients (see Table 4.6). Specifically, mandated clients talked about the importance of therapists being consistent, understanding, non judgmental, sincere, comforting,

respectful, and “acting like a person.” The discussed findings of previous studies regarding therapists’ personal characteristics as well as the present investigation support a well-known theoretical concept of “therapist as a person” forwarded by Carl Rogers (1957) in his writings on necessary and sufficient conditions for therapeutic personality change.

Furthermore, Bedi (2006) and Bachelor (1995) also found a number of professional qualities voluntary clients valued in therapists. Both studies identified therapist education as one of the important therapist characteristics that play an important role in the WA development. Additionally, Bedi (2006) described therapist abilities to provide guidance and challenge as another essential professional quality of therapists. The participants of the present study also talked about the instrumental role therapist competency plays in the WA formation. For instance, Michael described the importance of therapist competency thusly: “It feels more like you [a client] are talking to someone [a therapist] who knows more... more than going to someone on the street and having to tell them your life story.”

In addition to providing evidence that confirmed the findings of the previous studies, the current study revealed a number of new therapist factors such as therapist consistency, therapist ability to ask interesting questions, therapist willingness to give choices to mandated clients, and therapist willingness to be active in counseling (see Table 4.6). Table 5.1 presents therapist factors ranked in accordance with the number of times each of them was used. Overall, based on this study’s results about therapist

Table 5.1

Hierarchy of Therapist Factors that Facilitate Working Alliance Development

Rank	Therapist factors	# of times factor was mentioned
1	Therapist is active in counseling	12
2	Therapist asks "interesting questions"	10
2	Therapist gave me choices	10
2	Therapist is respectful	10
3	Therapist is sincere	9
4	Therapist was comforting	8
5	Therapist is not judgmental	7
6	Therapist understands my background	6
7	Therapist consistency	3
8	Therapist is knowledgeable	2
9	"Therapist acting like a person"	1
9	Therapist's gender	1

qualities it appears that one major difference between mandated and volunteer clients' perceptions of WA facilitators is that mandated clients strongly emphasize the importance of the therapist giving options to clients in sessions. Perhaps, mandated clients appreciate this therapist factor because they may not be given choices when they interact with professionals in a correctional system which in turn may feel disempowering. That is why therapists' willingness to give some control over sessions to inmates themselves may be very empowering for them (inmates).

Client Factors

The previous research by Bachelor (1995) and Bedi (2006) identified client factors that aid WA development. Those were client readiness to open up, client honesty, client personal responsibility, client ability to trust therapist, client responsibility in therapy (Bedi, 2006; Bachelor, 1995). While the present study identified clients' characteristics that were consistent with previous research (i.e., client need and ability to trust a therapist, client choice to take an active role in therapy, client willingness to open up to a therapist), the study also produced new client factors that go beyond findings from previous research. The three new client factors for mandated clients that are facilitative of a WA revealed through this investigation are client (a) free will, (b) hopefulness, and (c) positive expectations. Table 5.2 shows client factors revealed in the present study that are ranked in accordance with the number of time each of them was used. As can be seen in Table 5.2, the factor "free will" was one of the most popular codes used by interviewees.

The present study's qualitative analysis of statements related to client characteristics impeding WA formation revealed that a number of clients talked about their reluctance to open up to other people to protect themselves from being hurt by others. This finding supports ideas forwarded by Riordan and Martin (1993) and Storch and Lane (1989) regarding protective mechanisms mandated clients develop while being incarcerated. These protective mechanisms may play out in therapy and will need to be taken into consideration by clinicians who work with mandated clients.

Table 5.2

Hierarchy of Client Factors that Facilitate Working Alliance Development

Rank	Client factors	# of times factor was mentioned
1	"Free will"	16
2	Client opened up	11
3	Hopefulness	10
4	Need and ability to trust	7
4	Client is active in counseling	7
5	Knowing your therapist	5
6	Liking your therapist	4
7	Positive expectation	2

Process Factors

While in their studies Bachelor (1995) and Bedi (2006) did not describe process factors as a separate group, they still concluded that trust and equality in the client-therapist relationship are important requirements for WA to develop. Mandated clients who took part in the qualitative phase of the present investigation also talked about the pivotal role trust and equality play in formation of the WA. For instance, when talking about trust in client-therapist relationship, Shelby noted:

We took it [relationship development] very slowly, very easy and I am not exactly sure when or how or what triggered it [the relationship development]. I am not sure. But, at some point in time, I was able to trust her [therapist] and I think that made all the difference in the world.

In other words, Shelby's statement exemplifies the idea that for mandated clients trust is a necessary condition for their willingness to work on the development of the client-

therapist relationships. Perhaps mandated clients place special value on these qualities (i.e., equality and trust) in their relationships with therapists because those factors are not parts of their experiences as inmates.

Conclusion

To conclude, all participants interviewed in the present study seem to emphasize the importance of therapist factors in the formation of the WA (79 mentions; see Tables 4.5, 4.6, 4.7). Client factors became the second most talked about theme (62 mentions; see Tables 4.5, 4.6, 4.7). Overall, interviewees talked less about obstacles to WA development than its facilitators. It appears that the major obstacle to WA development from the perspective of interviewed mandated clients is that counseling is mandated. On the whole, it is interesting to see that many client, therapist, and process factors were found to be the same or similar to facilitators of WA in voluntary counseling. Moreover, the findings of the current and previous studies (e.g., Bedi, 2006; Bachelor, 1995) suggest that when compared, voluntary and mandated counseling appear to have more similarities than differences.

Integration of Qualitative and Quantitative Findings

The fifth research question focused on using qualitative results to explain quantitative findings. More specifically, the purpose of this research question and this section is to connect quantitative and qualitative results with the goal to gain a deeper understanding of issues under investigation (i.e., WA, motivation, hope). Three major findings were revealed by the quantitative analysis. First, the variability within the shapes of WA trajectories based on the graphs was confirmed. Second, therapist effect was

found to have significant influence on all variables chosen for the study: WA, motivation and hope. Third, significant variability in the mandated clients' ratings of WA after the first session was discovered. During the qualitative phase, data was gathered to clarify and explain the quantitative findings.

Research Finding 1: Different Groups of WA Trajectories

Even though we were unable to statistically estimate the presence of variability in the working alliance slope, the visual analysis of individual working alliance trajectories as well as the results of the qualitative data suggest at least six qualitatively different groups of WA patterns: accelerating quadratic (dramatic), accelerating quadratic (late onset), accelerating linear, decelerating linear, decelerating quadratic, constant. Overall, this study's findings regarding working alliance patterns appear to be consistent with the results previously found in the empirical investigations of the working alliance development in voluntary counseling. Specifically, *accelerating linear pattern* was identified in studies by Kivlighan and colleagues (1995), Kivlighan and Shaughnessy (2000), and Stiles and colleagues (2004). They named this pattern a "linear growth pattern." Based on the qualitative findings of the current study, the specificity of the accelerating linear pattern in comparison with others included (see cases of Shelby and George): (1) clients pre-existing low level of hope, (2) the fact that mandated clients attended counseling shortly before their release from prison, (3) clients' need for equality in client-therapist relationships, and (4) the fact that mandated clients especially valued therapy outcomes (e.g., self-understanding, identifying problems and solutions, increase self-esteem etc.).

The present study, consistent with an empirical investigation by Kivlighan and Shaughnessy (2000), also found an *accelerating quadratic dramatic pattern* of the working alliance. Kivlighan and Shaughnessy named this pattern a “quadratic growth pattern.” The qualitative analysis of the interview with Michael revealed the following attributes of this WA pattern: (1) the client’s pre-existing internal motivation for counseling, (2) the client’s pre-existing high level of hope, (3) misunderstandings between client and therapist regarding the purpose and formal outcomes of mandated counseling (e.g., Michael initially assumed that his therapist will write him a letter of successful completion of therapy based on session attendance) as major obstacles to WA.

Furthermore, similar to studies by Kivlighan and Shaughnessy (2000), and Stiles and colleagues (2004), the current empirical investigation identified the *constant growth pattern* (or “low-high” in previous studies). Based on the results of the qualitative phase of the current study, clients’ needs for prolonged times to establish productive relationships with therapists became a major characteristic of this WA pattern.

As mentioned earlier, the present study detected another WA pattern, *decelerating linear growth trajectory*, previously identified in an investigation by Stiles and colleagues (2004). Based on the qualitative findings of the current study, the specificity of the decelerating linear growth pattern in comparison with others included (see case of Kyle): (1) the client’s pre-existing negative expectations of counseling, (2) difficult topics discussed in sessions, resulting in the client’s negative personal reactions.

Finally, the *decelerating quadratic growth pattern* identified by this study was previously found in two other empirical investigations (Gelso & Carter, 1994; and

Golden & Robbins, 1990) and called “low-high-low” trajectory. Because study participants that represented this WA pattern were not available for interviews, this particular pattern was not further explored in the qualitative phase of this research.

While consistencies exist between the findings in the current study and past investigations, discrepancies also should be noted. In particular, “the relatively stable WA pattern” (i.e., increase by the third session and no significant changes over time) found and described by Eaton and colleagues (1993) and Bachelor and Salame (2000) was not detected through the present study. Finally, the current study identified one pattern that was not found in studies before. The *accelerating quadratic (late onset) pattern* of working alliance growth, which is described as relatively low and stable growth between the first and third sessions, and increasing more drastically by the fifth session was not identified in previous studies.

This growth trajectory may be unique to mandated counseling. Mandated clients may need additional time to develop trust and agreement on tasks and goals with their therapists. It will be interesting to see whether or not this finding will be confirmed in future studies. The results of the qualitative analysis of the interview with Joe suggested that the accelerating quadratic (late onset) WA pattern could be described by: (1) the client’s pre-existing positive expectations of counseling, (2) the client’s need for individual attention, and (3) the client’s need for a prolonged time for the relationship to be established.

Overall, because only one client from each group of the identified WA trajectories was interviewed, it is difficult to form definite conclusions about patterns of differences

between those groups. In future studies researchers should consider interviewing several participants from the same group to describe essential characteristics of each WA pattern.

Research Finding 2: Therapist Effect

Both quantitative and qualitative findings confirmed the importance of therapist characteristics in the development of the working alliance. In particular, quantitative analysis detected a significant therapist effect that influenced participants' evaluations of the WA, motivation and hope. The qualitative phase, in turn, revealed thirteen specific therapist characteristics that may facilitate or interfere with WA formation processes (see Tables 4.7 and 5.2). Furthermore, "therapist factors" became a major qualitative theme that explained interviewees' perceptions of factors that contribute to WA development. This finding suggests that there are specific therapist qualities perceived by mandated clients that facilitate or interfering with the WA development. In general, all therapist factors identified by the study participants as facilitators of WA development are consistent with the dimensions of social influence described in the social influence theory (Strong, 2000): expertness, attractiveness, and trustworthiness. For instance, mandated clients talked about the importance of therapists to be knowledgeable which is consistent with the "expertness" part of the social influence theory. Strong's concept of attractiveness can be illustrated by a number of ideas forwarded by the study participants, such as: therapist acts like a person, therapist understands my background, therapist is comforting, therapist gave me choices and others (see Table 4.8). Finally, in the frame of the current study the "trustworthiness" can be illustrated with "therapist is sincere," and "trusting relationships."

Therapist attitudes toward mandated therapy and mandated clients may be another important characteristic that significantly impacts WA development in mandated counseling. In their writings, Frank and Frank (1991) drew attention to this particular therapist characteristic by discussing therapists' attitudes toward therapy (e.g., short-term vs. long-term) and its effectiveness as well as toward clients (e.g., age, gender, problem) and how these attitudes may be transferred to the client intentionally or unintentionally. It appears that in mandated counseling this characteristic (i.e., therapist attitudes) becomes especially important due to the specificity and nature of this type of counseling. The qualitative findings of the current study support the importance of this factor to some extent. Specifically, the study revealed that the way therapists relate to clients in therapy (e.g., respect, non-judgmental, equality) matters to mandated clients. Overall, the quantitative and qualitative results of the current study suggest that therapist factors may account for more variability in mandated clients' ratings of WA than client motivation and hope.

Research Finding 3: Variability in Clients' Ratings of WA after the First Session

The quantitative results of the study show significant variability for mandated clients' ratings of the working alliance after the first session. In other words, this finding demonstrates that participants of the study differed at a statistically significant level in their initial perceptions of the client-therapist relationship. The qualitative portion of the current study resulted in a number of findings that may account for the variability in the initial clients' ratings of WA.

First, the qualitative analysis of the interviews revealed that initial levels of mandated clients' motivation for counseling varied. It appeared that those clients whose motivation combined external (i.e., mandate) and internal motivators (i.e., desire to achieve some personal goals) rated WA higher after the first session. The qualitative findings also suggest that those clients' whose initial motivation was primarily extrinsic rated WA lower in comparison with those whose motivation was more internally regulated (intrinsic).

Second, according to the qualitative analysis, the pre-therapy level of hope was another client characteristic that varied between clients as they started therapy. For example, Michael described his pre-therapy level of hope thusly: "I always had hope. I never felt like everything was just going downhill or anything like that." Whereas, Shelby stated: "You don't put too much stock into your future. You don't put up all your stock into being hopeful. We [inmates] live such a day to day with literally everything constantly changing and so you really don't." In other words, Michael's level of hope was higher than Shelby's. Furthermore, those clients who were more hopeful about counseling being helpful for them as well as those who were hopeful that their life in the future would be better (e.g., Michael), talked about their initial inclinations to rate WA high after the first session. At the same time, the initial ratings of WA by mandated clients with low levels of hope for therapy and the future (e.g., Shelby) life were relatively low. To illustrate, while explaining her ratings of WA, Shelby stated: "I would have to say it [therapy] probably started pretty slow and was never frustrating or anything

along those lines.” In other words, for Shelby needed more time to understand possible benefits of counseling and gradually feel comfortable to open up to her therapist.

Third, clients’ perspectives on timing in the counseling process also varied from client to client. The qualitative findings suggest that those clients who received counseling close to their release from the correctional system found therapy more applicable and rated WA higher in comparison with those who still had a long way to go before the release. For instance, Shelby counseling experience took place within a few months of her release from the correctional center. In the interview she noted:

“[I perceived this counseling experience more positively because of] the time that I am coming here: I am getting closer to when I am going home in March... I have just a few months before I go home and the things she is working with me on are very useful. I don’t know if I am absorbing more of it or being more open to it because I know that the end is coming and it is coming quickly.”

It becomes clear that she greatly benefited from counseling being close to her release because it was able to provide her with specific ideas she could implement in her life outside of the corrections.

Fourth, the qualitative analysis revealed that clients’ pre-existing positive expectations of counseling aided client-therapist relationship formation. Moreover, clients who expected counseling to be a helpful and positive experience rated WA after the first session higher than those whose expectations were negative. Finally, therapist factors could also explain variance in the ratings of WA after the first session. For instance, a particular client may have rated WA lower or higher based on pre-existing gender preferences. Refer to the section “Qualitative Results” (p.108) or Table 4.8 for more information about other specific therapist factors (e.g., therapist is knowledgeable,

therapist asks interesting questions) that may impact clients' perceptions of the WA after the first session.

Limitations of the Study

Several limitations of the current study became evident as data collection and analysis progressed. First, the relatively small sample size ($N = 63$) made it impossible to draw inferences from the data about variability in the WA slope. When the data from 63 participants were collected and necessary mean values were computed, a power analysis was conducted. According to the power analysis, the data from about 200 participants is required to make estimations of the variance in the WA slope given the number of data points and the number of covariates that were used in the present study (Muthen & Muthen, 1998-2006). The initial decision about the original sample size was made based on previous studies that utilized Linear Growth Modeling analysis (e.g., Sauer, Lopez & Gormley, 2003; Willett, 1988). For example, a participant population in the study by Sauer and colleagues (2003) consisted of 28 clients. The study also had one independent and one dependent variable.

Second, study generalizability became limited by (a) the convenience sample, (b) the locations of data collection (i.e. university counseling centers, a community counseling center), (c) the format of examined counseling (i.e., individual), and (d) the source of counseling mandate (e.g., community correctional center). For instance, the results of the current study likely cannot not be translated to long-term therapy with mandated clients who demonstrate severe and chronic psychological disorders and who participate in group counseling. In addition, the results of this study cannot be

generalized to clients mandated for counseling based on reasons other than those of study participants (e.g., correctional center inmates who needed to complete counseling as a requirement for their release).

Third, another limitation was due to the nature of the data collected. All of the assessment instruments used in the study were based on clients' self-report. Consequently, results could be influenced to some degree by the response bias. The researcher chose to be dependent on clients' reports of the working alliance, motivation and hope, because it was impossible to directly assess these constructs. However, in an attempt to compensate for this limitation, the MMPI-2 Lie-scale was used to assess the level of social desirability in clients' answers.

Fourth, the current study investigated the early stage of counseling (e.g., the first five sessions). At this point, it is not clear whether the study findings could be applied to sessions beyond the fifth. Different variables may contribute to the development of the working alliance during the later phase of therapy.

Fifth, this research did not take into consideration individual counselors' theoretical orientations as well as specific treatment models they utilized. This has the potential to be a plausible threat to construct validity of the study. However, in an attempt to address the possibility of therapist variables confounding the estimations of the working alliance trajectory and amount of variance explained, therapist effect was taken into consideration and accounted for in the statistical analyses (see section Therapist Effect, p. 74).

Sixth, the construct of participants' hope was assessed via the Dispositional Hope Scale. This scale was developed to assess general levels of persons' hope not specific to counseling process. As of the time of this study, no valid and reliable scale that measures clients' levels of hope in regard to therapy (i.e., how hopeful they are that counseling will be helpful) was developed and available for use. Therefore, the decision was made to utilize the Dispositional Hope Scale that assesses clients' general levels of hope (i.e., how hopeful they are that their life will be better). The use of this scale has the potential to be a threat to the construct validity of the current study. It is possible that the scale was not able to account for levels of clients' hope specifically in a counseling content.

Seventh, due to the nature of a correctional center life as well as the length of the data collection process, the first three qualitative interviews were conducted simultaneously with the quantitative data collection. Specifically, after the first six months of the quantitative data collection, the researcher made a decision to conduct a preliminary quantitative analysis to select cases for qualitative interviews. This decision was an attempt to avoid situations when selected mandated clients were not available for interviews due to their release from the correctional center or their transfer back to prison. Given this specificity of the qualitative data collection, some final results of the quantitative phase (e.g., insignificance of client hope and motivation, WA intercept variability) may not have been explored in a detailed way in the first three interviews.

Finally, not all participants selected for the second qualitative phase were available to be interviewed. A number of participants were either transferred back to prison or refused to be interviewed. The result was that one pattern of working alliance

change (decelerating linear growth trajectory) was not represented in the qualitative data. Also, the participants who agreed to be interviewed had one characteristic in common – their final perception of counseling was positive. Therefore, the opinions of participants whose perceptions of counseling may have stayed, or changed to, negative were not considered.

Implications and Recommendations

Implications for Practice

First, therapists who work with mandated clients should be aware of therapists' professional and personal qualities that mandated clients find imperative in WA formation. For example, participants noted that it was important for them to see their therapists being “real people,” expressing their emotions in sessions (e.g., making jokes, smiling). Therefore, it appears to be important for clinicians to use their personalities, and not just professional skills, to build the client-therapist relationship. Specifically, this study revealed that confidentiality appears to be an essential facilitator of WA formation from mandated clients' perspectives. Thus, it seems crucial to talk about confidentiality in detail with mandated clients at the beginning of the therapy. Furthermore, it is important for therapists to demonstrate to mandated clients that they took time to prepare for sessions and thought about clients outside of sessions. Table 5.2 presents therapist factors based on their importance to mandated clients who were interviewed in this study. Practicing clinicians may find the use of this table as a helpful guide to therapist factors that are facilitative of WA formation.

Second, the current study revealed that at least five sessions may be needed for some mandated clients to establish productive working relationships with their therapists. Consequently, it may not be practical to mandate less than five sessions of counseling. Furthermore, because mandated clients may require an extended period of time to adjust to the new environment of therapy and to get to know their therapists, they may feel reluctant answering therapists' questions early on in therapy. Therefore, therapists need to be patient with mandated clients, anticipating that they may need extra time to develop trust and feel comfortable in counseling settings. Additionally, this study suggests that it is imperative for therapists to avoid assumptions that all mandated clients have similar perceptions of client-therapist relationships. This study's finding regarding different WA trajectories highlights the faultiness of such an assumption.

Third, this investigation demonstrates that mandated clients' pre-existing negative expectations of counseling significantly interfere with WA development. For that reason, clinicians should consider exploring clients' preconceived notions at the beginning of therapy. This allows therapists to address those negative expectations right at the onset of counseling.

Fourth, a number of qualitative codes forwarded the idea that the formalities of the initial counseling intake process (e.g., standard questions, paperwork) may delay or hinder WA development. It is essential therefore to place a special value on building relationship and not just collecting background information during the first session with mandated clients.

Fifth, clinicians should be aware that despite the fact that mandated clients' initial motivation for counseling usually is driven by external factors (i.e., the mandate), external motivation often gradually transforms into internal motivation (e.g., as they achieve personal goals) as therapy unfolds. This awareness may help therapists to be more optimistic about potential therapy outcomes for mandated clients.

Overall, the findings of the current as well as previous empirical studies (e.g., Bedi, 2006; Bachelor, 1995) suggest that voluntary and mandated counseling have more similarities than differences. This comparison points out an important implication for the practice of mandated counseling: basic counseling skills and therapist qualities are transferable to mandated counseling. Finally, the current study indicated the real possibility of mandated clients forming a working alliance in therapy, which does not seem to differ from therapy with voluntary clients. This finding has the potential to help clinicians believe in the process, usefulness, and appropriateness of mandated therapy.

Implications for Research

As the only study of working alliance development in mandatory counseling, this study leaves a number of questions unanswered, leaving the door open for the future research on factors that contribute to the development of the working alliance in mandatory counseling. Among the unanswered questions are the following: Would the study results be different if

- a) a random sampling instead of convenience sampling procedure were used?
- b) study participants represented other groups of mandated clients, such as college students mandated for counseling, or court-mandated clients?

- c) the majority of the data was collected in different clinical settings (e.g., community counseling centers)?
- d) different stages of counseling process were researched (e.g, middle and late)?
- e) therapists' perspectives on WA formation were researched?

This study's findings suggest that therapist's factors may be significant contributors to the working alliance in mandatory counseling. Therefore, future studies focusing on therapists' characteristics are warranted and needed. Subsequent investigations in this area may shed some light on certain therapist characteristics that are more important than others for mandated clients.

Furthermore, even though data for similar studies could be difficult to collect, it is still important to replicate the study with a larger sample size. According to results of the power analysis that was performed, the data from about 200 participants is required to make estimations of the variance in the working alliance slope (Muthen & Muthen, 1998-2006). Collaborative efforts in data collection between different sites could result in a larger data set.

Future studies could consider employing methods of assessing the working alliance, motivation, and hope (e.g, therapists' report, observation of external evaluators) other than self-report, to enhance both internal and construct validity of the study. Some creative efforts have recently been demonstrated in the empirical literature. For instance, in their study of building the working alliance in early stages of therapy, Sexton and colleagues (2005) developed a rating system that was used by anonymous raters to

evaluate the connection between clients and therapists every 20 seconds of therapy sessions.

Another study that appears to be important and needed is the development of a valid and reliable scale that assesses clients' levels of hope specific to therapy. In other words, an instrument is needed to answer the question of how hopeful clients are about therapy in general and its benefits for their future.

Moreover, it may be very interesting, important, and rewarding to conduct qualitative interviews with mandated clients who have less favorable perceptions of working alliance development as well as counseling in general. Such investigation has the potential to significantly contribute to our knowledge about factors that make counseling a negative experience for some mandated clients.

The results of the visual analysis of plotted WA scores support the need for further replications of this study to confirm or refute the existence of different patterns of WA trajectories. Additionally, it could be important and informative to empirically explore the relationship between WA and outcomes of mandatory counseling. Such a study would aid in evaluating the role of the client-therapist relationship in mandatory counseling. In other words, it would help to clarify whether or not the working alliance is as essential and necessary in mandatory counseling as it is in a voluntary counseling.

Finally, the current study revealed that trust in client-therapist relationships appears to be a core relationship quality important to all interviewed participants. Therefore, an important empirical question is: what helps mandated clients build trust in their therapists and the therapy process?

These examples of future studies as well as other potential investigations may provide further insight into the problem of developing therapeutic relationships between therapists and mandated clients. The results would be productive and beneficial for mandated clients, agencies that issue the mandate, and society in general.

REFERENCES

- Amanda, G. (1995). Mandatory psychotherapy: A commentary on “Mandatory counseling of university students: An oxymoron?” and “Anger and aggression groups: Expanding the scope of college mental health provider services”. *Journal of College Student Psychotherapy*, 9(4), 33-44.
- Asay, T.P., & Lambert, M.J. (1999). The empirical case for the common factors in therapy. In Hubble, M.A., Duncan, B.L., & Miller, S.D. (Eds.), *The heart and soul of change* (pp. 23-55). Washington, DC: American Psychological Association.
- Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology*, 24, 1-8.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In Hubble, M.A., Duncan, B.L., & Miller, S.D. (Eds.), *The heart and soul of change* (pp. 133-178). Washington, DC: American Psychological Association.
- Bachelor, A., & Salame, R. (2000). Participants' perceptions of dimensions of the therapeutic alliance over the course of therapy. *Journal of Psychotherapy Practice Research*, 9, 39-53.
- Bedi, R.P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology*, 53(1), 26-35.
- Bergin, A.E., & Garfield, S.L. (Eds.). (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York: John Wiley & Sons.

- Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, Practice*, 16, 252-38.
- Brackney, B.E., & Westman, A.S. (1992). Relationships among hope, psychosocial development, and locus of control. *Psychological Reports*, 70, 864-866.
- Burlingame, G.M., Kircher, J.C. & Taylor, S. (1994). Methodological considerations in group therapy research: Past, present, and future practices. In A. Fuhrman & G. M. Burlingame (Eds.), *Handbook of group psychotherapy: An empirical and clinical synthesis* (pp. 41-80). New York: Wiley.
- Butcher, J.N., & Williams, C.L. (1992). Essentials of MMPI-2 and MMPI-A interpretation. Minneapolis, MN: The University of Minnesota Press.
- Buttell, F.P. & Carney, M.M. (2006). A large sample evaluation of a court-mandated batterer intervention program: Investigating differential program effect for African American and Caucasian men. *Research on Social Work Practice*, 16(2), 121-131.
- Cingolani, J. (1984). Social conflict perspective on work with involuntary clients. *Social Work*, 29, 442-446.
- Collins, G. (2005). Editorial: Court-mandated psychiatric outpatient treatment in New York: Doesn't this process invoke more care than controversy? *Criminal Behavior and Mental Health*, 15(4), 214-220.
- Connor, T.A. (1996). Ethical and clinical issues in involuntary psychotherapy. *Psychotherapy*, 33, 587-592.

- Cooper, S., Darmody, M. & Dolan, Y. (2003). Impressions of hope and its influence in the process of change: An international e-mail trialogue. *Journal of Systemic Therapies*, 22(3), 67-78.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: Sage Publications.
- Creswell, J.W. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative approaches to research*. Upper Saddle River, NJ: Merrill/Pearson Education.
- Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks: Sage Publications.
- Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five traditions* (2nd ed.). Thousand Oaks: Sage Publications.
- Creswell, J.W., & Miller, D. (2002). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-130.
- Creswell, J.W., Plano Clark, V.L., Gutmann, M.L., & Hanson, W.E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209-240). Thousand Oaks, CA: Sage.
- Curran, P.J., Harford, T.C., & Muthen, B.O. (1996, July). The relation between heavy alcohol use and bar patronage: A latent growth model. *Journal of Studies on Alcohol*, 410-418.

- Cutcliffe, J.R., & Barker, P. (2002). Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations'. *Journal of Psychiatric and Mental Health Nursing*, 9, 611-621.
- Deci, E.L., & Ryan, R.M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum Press.
- DeLeon, G., Melnick, G., & Tims, F.M. (2001). The role of motivation and readiness in treatment and recovery. In F.M. Tims, C.G. Leukefeld, & J.J. Platt (Eds.), *Relapse and recovery in addictions* (pp. 143-171). New Haven: Yale University Press.
- Drapeau, M., Korner, C.A., Brunet, L., & Granger, L. (2004). Treatment at La Macaza Clinic: A qualitative study of the sexual offenders perspective. *Canadian Journal of Criminology and Criminal Justice*, 46(1), 27-44.
- Drieschner, K.H., Lammers, S.M.M., van der Staak, C.P.F. (2004). Treatment motivation: An attempt for clarification of an ambiguous concept. *Clinical Psychology Review*, 23, 1115-1137.
- Eaton, T.T., Abeles, N., & Gutfreund, M.J. (1993). Negative indicators, therapeutic alliance, and therapy outcome. *Psychotherapy Research*, 3, 115-123.
- Eisner, E.W. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. New York: Macmillan.
- Erickson, R.C., Post, R.D., & Paige, A. (1975). Hope as a psychiatric variable. *Journal of Clinical Psychology*, 31(2), 324-330.
- Frank, J.D., & Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins.

- Friedman, A.F., Lewak, R., Nochols, D.S., & Webb, J.T. (2001). Psychological assessment with the MMPI-2. New Jersey: Lawrence Erlbaum Associates, Inc..
- Geller, J.L. (1986). Rights, wrongs, and the dilemma of coerced community treatment. *American Journal of Psychiatry*, 143(10), 1259-1264.
- Geller, J.L. (1990). Clinical guidelines for the use of involuntary outpatient treatment. *Hospital and Community Psychiatry*, 41(7), 749-755.
- Gelso, C.J., & Carter, J.A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist*, 13, 155-243.
- Gelso, C.J., & Carter, J.A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology*, 41, 296-306.
- Gilbert, S.P., & Sheiman, J.A. (1995). Mandatory counseling of university students: An oxymoron? *Journal of College Student Psychotherapy*, 9(4), 3-21.
- Golden, B.R., & Robbins, S.B. (1990). The working alliance within time-limited therapy: A case analysis. *Professional Psychology: Research and Practice*, 21, 476-481.
- Green, J.C., & Caracelli, V.J. (Eds.). (1997). *Advances in mixed methods evaluation: The challenges and benefits of integrating diverse programs* (Vol. 74). San Francisco: Jossey-Bass.
- Groth-Marnat, G. (1990). *Handbook of psychological assessment* (2nd ed.). New York: John Wiley & Sons.

- Gunderson, J.G., Najavits, L.M., Leonhard, C., Sullivan, C.N., & Sabo, A.N. (1997).
Ontogeny of the therapeutic alliance in borderline patients. *Psychotherapy
Research*, 7, 301-309.
- Hanson, W.E., Creswell, J.W., Plano Clark, V.L., & Petska, K.S. (2005). Mixed methods
research in counseling psychology. *Journal of Counseling Psychology*, 52 (2),
224-235.
- Hanson, W.E., Curry, K.T., & Bandalos, D.L. . (2002). Reliability generalization of
working alliance inventory scale scores. *Educational and Psychological
Measurement*, 62(4), 659-673.
- Hill, C.E., & Williams, E.N. (2000). The process of individual therapy. In S.D. Brown, &
R.L. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 670-710). New
York: John Wiley & Sons.
- Hiller, M.L., Knight, K., Leukefeld, C., & Simpson, D.D. (2002). Motivation as a
predictor of therapeutic engagement in mandated residential substance abuse
treatment. *Criminal Justice and Behavior*, 29(1), 56-75.
- Honea-Boles, P. (2001). The court-mandated client: Does limiting confidentiality
preclude a therapeutic encounter? *TCA Journal*, 29(2), 149-160.
- Horvath, A.O., & Greenberg, L. (1985). The development of the working alliance
inventory. In L. Greenberg, & W. Pinsoff (Eds.), *The psychotherapeutic process:
A research handbook*. New York: Guilford.
- Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the working
alliance inventory. *Journal of Counseling Psychology*, 36(2), 223-233.

- Horvath, A.O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.
- Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.
- Hubble, M.A., Duncan, B.L., & Miller, S.D. (Eds.). (1999). *The heart and soul of change*. Washington, DC: American Psychological Association.
- Irving, L.M., Snyder, C.R., Cheavens, J., Gravel, L., Hanke, J., Hilberg, P., & Nelson, N. (2004). The relationship between hope and outcomes at the pretreatment, beginning, and later phases of psychotherapy. *Journal of Psychotherapy Integration, 14*(4), 419-443.
- Ivankova, N.V. (2004). *Students' persistence in the University of Nebraska - Lincoln distributed doctoral program in educational leadership in higher education: A mixed methods study*. Unpublished doctoral dissertation, University of Nebraska - Lincoln.
- Julian, M.W. (2001). The consequences of ignoring multilevel data structures in nonhierarchical covariance modeling . *Structural Equation Modeling, 8*, 325-352.
- Kivlighan, D.M., & Shaughnessy, P. (1995). Analysis of the development of the working alliance using hierarchical linear modeling. *Journal of Counseling Psychology, 42*(3), 338-349.

- Kivlighan, D.M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology*, 47(3), 362-371.
- Kolde, G.G., Howard, K.I., & Maling, M.S. (1994). The counseling relationship and treatment outcome. *The Counseling Psychologist*, 22, 82-89.
- Lambert, M.J. (1992). Implications of outcome research for psychotherapy integration. In J.C. Norcross & M.R. Goldstein (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.
- Lambert, M.J., & Bergin, A.E. (1994). The effectiveness of psychotherapy. In Bergin, A.E., & Garfield, S.L. (Eds.), *Handbook of psychotherapy and behavioral change* (pp. 143-189). New York: John Wiley & Sons.
- Larke, J. (1985). Compulsory treatment: Some practical methods of treating the mandated client. *Psychotherapy*, 22, 262-268.
- Lehmer, M. (1986). Court ordered therapy: Making it work. *American Journal of Forensic Psychology*, 4(4), 16-24.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage Publications.
- Lincourt, P., Kuettel, T.J., & Bombardier, C.H. (2002). Motivational interviewing in a group setting with mandated clients: A pilot study. *Addictive Behaviors*, 27, 381-391.

- Lopez, S.J., Snyder, C.R., & Pedrotti, J.T. (2003). Hope: Many definitions, many measures. In S.J. Lopez, & C.R. Snyder (Eds.), *Positive Psychological Assessment* (pp. 91-107). Washington, DC: American Psychological Association.
- Luretti, J.M. (2002). *A study of the therapeutic working alliance, client motivation for treatment and subsequent self-reported changes in abusive behavior among a sample of male batterers from the Abuse Ceases Today Program*. Unpublished doctoral dissertation, Seaton Hall University.
- Magaletta, P.R. & Oliver, J.M. (1999). The hope construct, will, and ways: Their relationships with self-efficacy, optimism, and general well-being. *Journal of Clinical Psychology*, 55(5), 539-551.
- Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68(3), 438-450.
- McGrath, R.J. (1991). Sex offender risk assessment and dispositional planning: A review of empirical and clinical findings. *International Journal of Offender Therapy and Comparative Criminology*, 35, 328-349.
- Meier, P.S., Donmall, M.C., Barrowclough, C., McElduff, P., & Heller, R.F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction*, 100(4), 500-511.
- Merriam, S.B. (1998). *Qualitative research and case study applications in education: Revised and expanded from case study research in education*. San Francisco, CA: Jossey-Bass Publishers.

- Mertens, D.M. (2003). Mixed methods and the politics of human research: The transformative-emancipatory perspective. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in the behavioral sciences*. Thousand Oaks, CA: Sage Publications.
- Miles, M.B., & Huberman, A.M. . (1994). *Qualitative data analysis: A source book of new methods*. Thousand Oaks, CA: Sage Publications.
- Miller , N.S. & Flaherty, J.A. (2000). Effectiveness of coerced treatment (alternative consequences): A review of the clinical research. *Journal of Substance Abuse Treatment, 18*, 9-16.
- Morse, J.M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research, 40*, 120-123.
- Motto, J.A., Hiilbron, D.C., & Juster, R.P. (1985). Development of a clinical instrument to estimate suicide risk. *American Journal of Psychiatry, 142*, 680-686.
- Muthen, B.O., & Satorra, A. (1995). Complex sample data in structural equation modeling. In P.V. Marsden (Ed.), *Sociological methodology* (pp. 267-316). Oxford: Blackwell.
- Muthen, L.M., & Muthen, B.O. (1998-2004). *Mplus user's guide* (3rd ed.). Los Angeles.
- Pedhazur, I.R. (1997). *Multiple regression in behavioral research (3rd Ed.)* Fort Worth, TX: Harcourt, Brace & Company
- Pelletier, L.G., Tuson, K.M., & Haddad, N. (1997). Client motivation for therapy scale: A measure of intrinsic motivation, extrinsic motivation, and amotivation fro therapy. *Journal of Personality Assessment, 68*(2), 414-435.

- Perlman, H.H. (1978). *The heart of helping people*. Chicago: Chicago University Press.
- Peugh, J.L., & Enders, C.K. (2004a). Using the SPSS Mixed procedure to fit cross-sectional and longitudinal multilevel models. *Educational and Psychological Measurement, 65*, 714-741.
- Peugh, J.L., & Enders, C.K. (2004b). Missing data in educational research: A review of reporting practices and suggestions for improvement. *Review of Educational Research, 74*, 525-556.
- Pollard, J.W. (1995). Involuntary treatment: Counseling or consequence? *Journal of College Student Psychotherapy, 9*(4), 45-55.
- Popiel, D.J. (1980). Confidentiality in the context of court referrals to mental health professionals. *American Journal of Orthopsychiatry, 50*, 678-685.
- Riordan, R.J., & Martin, M.H. (1993). Mental health counseling and the mandated client. *Journal of Mental Health Counseling, 15*(4), 373-383.
- Roberts, M.F. (1993). Day in "Court". *Journal of Systemic Therapies, 12*(2), 55-67.
- Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.
- Rooney, R.H. (1992). *Strategies for work with involuntary clients*. New York: Columbia University Press.
- Rosenbaum, R.L., & Horowitz, M.J. (1983). Motivation for psychotherapy: A factorial and conceptual analysis. *Psychotherapy: Theory, Research and Practice, 20*(3), 346-354.

- Rosenfeld, B.D. (1992). Court-ordered treatment of spouse abuse. *Clinical Psychology Review, 12*, 205-226.
- Ryan, E.R. & Cicchetti, D.V. (1985). Predicting quality of alliance in the initial psychotherapy interview. *Journal of Nervous and Mental Disease, 173*(12), 717-725.
- Saunders, D., & Hanusa, D. (1986). Cognitive-behavioral treatment of men who batter: The short-term effects of group therapy. *Journal of Family Violence, 1*, 357-372.
- Schottenfeld, R.S. (1989). Involuntary treatment of substance abuse disorders: Impediments to success. *Psychiatry, 52*, 164-176.
- Schwitzer, A.M., Grogan, K., Kaddoura, K., & Ochoa, L. (1993). Effects of brief mandatory counseling on help-seeking and academic success among at-risk college students. *Journal of College Student Development, 34*, 401-405.
- Sexton, H., Littauer, H., Sexton, A. & Tommeras, E. (2005). Building an alliance: Early therapy process and the client-therapist connection. *Psychotherapy Research, 15*(1-2), 103-116.
- Sexton, T.L., & Whiston, S.C. (1994). The status of counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*, 6-78.
- Simpson, D.D., Joe, G., Rowan-Szal, G.A., & Greener, J.M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment, 14*(6), 565-572.

- Singer, J.D., & Willet, J.B. (2003). *Applied longitudinal data analysis*. New York: Oxford University Press.
- Slonim-Nevo, V. (1996). Clinical practice: Treating the non-voluntary client. *International Social Work, 39*, 117-129.
- Snyder, C.R. (1994). *The psychology of hope: You can get there from here*. New York: Free Press.
- Snyder, C.R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling and Development, 73*, 355-360.
- Snyder, C.R. (2000). The past and possibilities of hope. *Journal of Social and Clinical Psychology, 19*(1), 11-28.
- Snyder, C.R., Michael, S.T., & Cheavens, J.S. (1999). Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies. In Hubble, M.A., Duncan, B.L., & Miller, S.D. (Eds.), *The Heart and Soul of change* (pp. 179-200). Washington, DC: American.
- Snyder, C.R., Simpson, S.C., Ybasco, F.C., Borders, T.F., Babyak, M.A., & Higgins, R.L. (1996). Development and validation of the state hope scale. *Journal of Personality and Social Psychology, 70*(2), 321-335.
- Snyder, S.R., Harris, C., Anderson, J.A., Holleran, S.A., Irving, L.M., Sigmon, S.T., Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*(4), 570-585.

- Sosis, R.H., Karoly, P., & Ruehlman, L. (1980). Perceive treatment success with involuntary clients: An exploratory study. *Psychological Reports, 46*, 907-910.
- Staats, S. (1989). Hope: A comparison of two self-report measures for adults. *Journal of Personality Assessment, 53*(2), 366-375.
- Steed, L.G. (2002). A psychometric comparison of four measures of hope and optimism. *Educational and Psychological Measurement, 62*(3), 466-482.
- Stiles, W.B., Glick, M.J., Osatuke, K., Hardy, G.E., Shapiro, D.A., Agnew-Davies, R., Rees, A., & Barkham, M. (2004). Patterns of alliance development and rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology, 51*(1), 81-92.
- Storch, R.S., & Lane, R.C. (1989). Resistance in mandated psychotherapy: Its function and management. *Journal of Contemporary Psychotherapy, 19*(1), 2538.
- Strong, S.R. (2000). Social influence theory. In A. E. Kazdin (Ed.), *Encyclopedia of Psychology, Vol.7*, pp. 343-346.
- Strupp, H.H. (1990). The case of Helen R: A therapeutic failure? *Psychotherapy, 27*, 644-656.
- Strupp, H.H., & Binder, J.L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy*. New York: Basic Books.
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches* (Vol. 46). Thousand Oaks: Sage Publications.
- Tashakkori, A., & Teddlie, C. (2003). *Handbook of mixed methods in the behavioral and social sciences*. Thousand Oaks, CA: Sage Publications.

- Tracey, T.J.G., Lichtenberg, J.W., Goodyear, R.K., Claiborn, C.D., & Wampold, B.E. (2003). Concept mapping of therapeutic common factors. *Psychotherapy Research, 13*(4), 401-413.
- Truant, G.S. (1999). Assessment of suitability for psychotherapy. *American Journal of Psychotherapy, 53*(1), 17-34.
- Waldman, F. (1999). Violence or discipline? Working with multicultural court-ordered clients. *Journal of Marital and Family Therapy, 25*(4), 503-515.
- Wampold, B.E. (2001). General Effects: The alliance as a case in point. In B.E. Wampold, *The Great Psychotherapy Debate: Models, Methods, and Findings* (pp.149-158). New Jersey: Lawrence Erlbaum Associates.
- Weisharr, M.E., & Beck, A. (1992). Hopelessness and suicide. *International Review of Psychiatry, 4*, 177-184.
- Wettstein, R.M. (1987). Ethics and involuntary treatment. *Administration in Mental Health, 15*(2), 110-119.
- Wild, T.C., Cunningham, J., & Hobdon, K. (1998). Why do people believe that alcohol treatment is effective? The importance of perceives client and therapist motivation. *Psychology of Addictive Behaviors, 12*(2), 93-100.
- Willett, J.B. (1988). Questions and answers in the measurement of change. In E. Rothkopf (Ed.), *Review of Research in Education (1988-1989)*. Washington DC: American Educational Research Association.
- Willshire, D., & Brodsky, S.L. (2001). Toward a taxonomy of unwillingness: Initial steps in engaging the unwilling client. *Psychiatry, Psychology and Law, 8*(2), 154-160.

Zhang, B., & Taylor, R. (2003). *National Survey of Counseling Center Directors*.

(Available from International Association of Counseling Services, Inc., 101 South Whiting Street, Suite 211, Alexandria, VA 22304)

APPENDIX A
Research Approvals



A-1

RESEARCH COMPLIANCE SERVICES
Institutional Review Board

August 23, 2005

Tanya Razzhavaikina
Michael Scheel
114 TEAC
(0345)

IRB# 2005-05-339 FB

TITLE OF PROJECT: **Mandatory Counseling: A Mixed Methods Study of Factors that Contribute to the Development of the Working Alliance**

Dear Tanya:

This letter is to officially notify you of the approval of your project by the Institutional Review Board (IRB) for the Protection of Human Subjects. It is the Board's opinion that you have provided adequate safeguards for the rights and welfare of the participants in this study. Your proposal seems to be in compliance with this institution's Federal Wide Assurance 00002258 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Date of EP Review: **07/28/05**

You are authorized to implement this study as of the Date of Final Approval: 08/23/05


This approval is Valid Until: 07/27/06

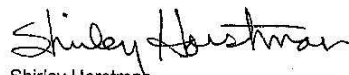
1. Enclosed is the IRB approved Informed Consent Form for this project. Please use this form when making copies to distribute to your participants. If it is necessary to create a new Informed Consent Form, please send us your original so that we may approve and stamp it before it is distributed to participants.

We wish to remind you that the principal investigator is responsible for keeping this Board informed of any changes involved with the procedures or methodology in this study. You should report any unanticipated problems involving risks to the participants or others to the Board. For projects which continue beyond one year from the starting date, the IRB will request continuing review and update of the research project. Your study will be due for continuing review as indicated above. The investigator must also advise the Board when this study is finished or discontinued by completing the enclosed Protocol Final Report form and returning it to the Institutional Review Board.

If you have any questions, please contact Shirley Horstman, IRB Administrator, at 472-9417 or email shorstman1@unl.edu.

Sincerely,


Dan R. Hoyt, Chair
for the IRB


Shirley Horstman
IRB Administrator



A-1

HUMAN RESEARCH PROTECTIONS
Institutional Review Board

May 25, 2006

Tanya Razzhavaikina
Dr. Michael Scheel
114 TEAC
(0345)

IRB# 2005-05-339 FB

TITLE OF PROJECT: **Mandatory Counseling: A Mixed Merthods Study of Factors that Contribute to the Development of the Working Alliance**

Dear Tanya:

This is to officially notify you of the approval of your project's Continuing Review by the Institutional Review Board for the Protection of Human Subjects. It is the committee's opinion that you have provided adequate safeguards for the rights and welfare of the subjects in this study. Your proposal seems to be in compliance with DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Date of FB Review: 5/24/06

1. Enclosed are the IRB approved Informed Consent forms for this project. Please use these forms when making copies to distribute to your participants. If it is necessary to create a new informed consent form, please send us your original so that we may approve and stamp it before it is distributed to participants.

We wish to remind you that the principal investigator is responsible for reporting to this Board any of the following events within 48 hours of the event:

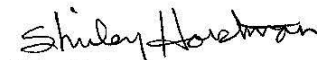
- Any serious event (including on-site and off-site adverse events, injuries, side effects, deaths, or other problems) which in the opinion of the local investigator was unanticipated, involved risk to subjects or others, and was possibly related to the research procedures;
- Any serious accidental or unintentional change to the IRB-approved protocol that involves risk or has the potential to recur;
- Any publication in the literature, safety monitoring report, interim result or other finding that indicates an unexpected change to the risk/benefit ratio of the research;
- Any breach in confidentiality or compromise in data privacy related to the subject or others; or
- Any complaint of a subject that indicates an unanticipated risk or that cannot be resolved by the research staff.

It is the responsibility of the principal investigator to provide the Board with a review and update of the research project each year the project is in effect. This approval is valid until **July 27, 2007**.

If you have any questions, please contact Shirley Horstman, IRB Administrator, at 472-9417 or email at shorstman1@unl.edu.

Sincerely,


Dan R. Hoyt, Chair
For the IRB


Shirley Horstman
IRB Administrator



A-1

HUMAN RESEARCH PROTECTIONS
Institutional Review Board

February 20, 2006

Tanya Razzhavaikina
Dr. Michael Scheel
114 TEAC
(0345)

IRB#2005-05-339 FB

TITLE OF PROJECT: **Mandatory Counseling: A Mixed Methods Study of Factors
that Contribute to the Development of the Working Alliance**

Dear Tanya:

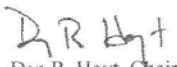
The Institutional Review Board for the Protection of Human Subjects has completed its review of the Request for Change in Protocol submitted to the IRB.

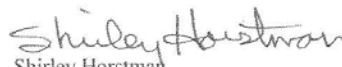
1. It has been approved to add the Rape/Spouse Abuse Crisis Center as a study site.

This letter constitutes official notification of the approval of the protocol change. You are therefore authorized to implement this change accordingly.

If you have any questions, please contact Shirley Horstman, IRB Administrator, at 472-9417 or email shorstman1@unl.edu.

Sincerely,


Dan R. Hoyt, Chair
for the IRB


Shirley Horstman
IRB Administrator

cc: Faculty Advisor

STATE OF NEBRASKA
Dave Heineman, Governor

DEPARTMENT OF CORRECTIONAL SERVICES
Robert P. Houston, Director

P. O. Box 94661 Lincoln, Nebraska 68509-4661 (402) 471-2654



A-2

June 1, 2005

Tanya Razzhavaikina
University of Nebraska – Lincoln
114 Teachers College Hall
P.O. Box 880345
Lincoln, NE 68588-0345

Dear Ms. Razzhavaikina:

RE: "Mandatory Counseling: A Mixed Methods Study of Factors that Contribute to the Development of the Working Alliance"

Your research proposal was reviewed by Superintendent Rex Richard (CCC-L) and Asst. Director Larry Wayne (Community Services). Final review and disposition was made by Director Robert P. Houston, who has approved the Department's involvement in your research project with the following conditions:

- Start your research within 60 days.
- Forward a copy of your IRB approval number and application to me before conducting research.
- Obtain proper identification card or security clearance before conducting research within the institution.
- Remain mindful of the issues and regulations concerning confidentiality and human subject protection issues.
- Forward a copy of your final report to the Department's Planning & Research Section and CCC-L **before dissemination or publication**.

Please coordinate the arrangements to conduct your research through the following individuals:

Rex Richard - Superintendent
402-471-0740

The Department looks forward to receiving copies of your findings. Best wishes on the successful completion of your project. If I can be of further assistance, please contact me at (402) 479-5697.

Sincerely,

Brian M. Finn
Planning, Research & Accreditation

pc: Robert P. Houston - Director
Rex Richard - Superintendent

A-3

SIMON FRASER UNIVERSITY



Burnaby British Columbia, Canada V5A 1S6

Ms. Tanya Razzhavaikina
 University of Nebraska
 Lincoln
 114 Teacher College Hall, P.O. box 880345
 Lincoln NE
 68588-0345
 U.S.

May 4, 2005

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 200545.318

Dear Ms. Razzhavaikina

You have permission to use the Working Alliance Inventory (WAI) for the investigation: "Mandatory Counseling: a mixed methods study of factors that contribute to the development of the working alliance."

This limited copyright release extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact me.

Sincerely,

Dr. Adam O. Horvath
 Professor
 Faculty of Education and
 Department of Psychology

Ph# (604) 291-3624
 Fax: (604) 291-3203
 e-mail: Horvath@sfu.ca
 Internet: <http://www.educ.sfu.ca/alliance/allianceA>

From : Luc G. Pelletier <social@uottawa.ca>
Sent : Thursday, September 9, 2004 7:40 AM
To : "Tanya Razzhavaikina" <tanya_razzhavaikina@hotmail.com>
Subject : RE: Your motivation scale

 Attachment : **CMOTS-short-WP.wpd** (0.01 MB)

Tanya,
Here is the CMOTS.
With my best regards.

Luc G. Pelletier, Ph.D.
Ecole de Psychologie / School of Psychology
Universit  d'Ottawa / University of Ottawa
125 Universit  / 125 University St.
Pavillon Montpetit, 418A / Monpetit Hall, 418A
C.P. 450, succ. A / P.O Box 450, Stn. A
Ottawa, Ontario K1N 6N5 Canada
(613) 562-5800 (4201), Fax (613) 562-5740
Courriel/Email: social@uottawa.ca

APPENDIX B

Informed Consent Forms



B-1

IRB#2005-05-339 FB
Date Approved: 8/23/05
Valid Until: 7/27/06

Participant Informed Consent: UNL

COLLEGE OF EDUCATION AND HUMAN SCIENCES

Educational Psychology

Project Title: Mandatory Counseling
Phase I: Quantitative

Purpose of the Research: This research project is intended to explore mandated clients' perspectives on individual counseling. You must be 19 years of age or older to participate in this study. Also, you must be mandated to receive individual counseling services.

Procedures: As a part of this study you will be asked to complete five short questionnaires that ask about your experiences in counseling in addition to two personal information questionnaires (e.g., gender, age). You will be asked to complete these questionnaires 3 times: (1) before and after your first counseling session, (2) after your third session, and (3) after your fifth session. It will take approximately 65-95 minutes of your time to complete all questionnaires of the study. Also, you may be selected to participate in 1-hour interview. If you are selected I will contact you to explain the detail of the interview.

Risks and/or Discomforts: There are no known risks that may result from your participation in this study. In the event of problems resulting from participation in the study, psychological help is available at the Counseling and School Psychology Clinic, telephone (402) 472- 1152, UNL Counseling and School Psychology Clinic, (402) 472-1152, UNL Family Resource Clinic (402) 472-5035, and UNL Psychological Consultation Clinic (402) 472-2351. All listed clinics have sliding fee policy. In a case if psychological help is needed, you will be responsible for covering services fees.

Benefits: There are no direct benefits from participation in this study. Your participation in this study will NOT give you any additional privileges such as a decrease in duration of academic probation. However, your participation will contribute to the collection of scientific knowledge about effective methods for working with clients who are mandated to receive individual counseling services.

Confidentiality: Any personal information obtained during this study which could identify you will be kept strictly confidential. The questionnaires completed for this study will not identify you by name. All identifiable data (i.e., contact information) will be stored in a locked cabinet in the principle investigator's office at the University of Nebraska - Lincoln and will only be seen by the investigator during the study. Please, know that your therapists will NOT see your responses to the questionnaires. The informed consent will be stored separately from the questionnaires - there will be no way to associate your name with the questionnaires. Questionnaires will be coded. No information collected in this study will be released to an agency that required you to be in counseling.

Moreover, contact information sheets will be destroyed as soon the data for the study are collected and analyzed. The information obtained in this study may be published in scientific journals or presented at scientific meetings but the data will be reported in a way that preserves anonymity.

____ Please, put your initials here, indicating that you have read and understood this page

114 Teachers College Hall / P.O. Box 880345 / Lincoln, NE 68588-0345

B-1

IRB#2005-05-339 FB Date Approved: 8/23/05 Valid Until: 7/27/06

Compensation: As a compensation for participation in this study you will receive \$2 cash each time you complete questioners (\$6 total).

Opportunity to Ask Questions: You may ask any questions concerning this research and have those questions answered by the investigator before agreeing to participate or at any time during the study. If you have any questions about your rights as a research participant that have not been answered by the investigator, or to report any concerns about the study, you may contact the Institutional Review Board at (402) 472-6965.

Freedom to Withdraw: You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigator, or with the University of Nebraska. Your decision will not result in any loss of benefits to which you are otherwise entitled.

Consent, Right to Receive a Copy: You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

Signature of Research Participant:

Signature of Participant

Date

Name and phone number of the principal investigator: Tanya I. Razzhavaikina MA.
Phone: (402) 472-2223

Name and phone number of the research supervisor: Michael J. Scheel, Ph.D.
Phone: (402) 472-0573



B-2

IRB#2005-05-339 FB Date Approved: 8/23/05 Valid Until: 7/27/06

 Participant Informed Consent: CCC COLLEGE OF EDUCATION AND HUMAN SCIENCES

Educational Psychology

Project Title: Mandatory Counseling
Phase II: Qualitative

Purpose of the Research: This research project is intended to explore mandated clients' perspectives on individual counseling. You are selected to participate in this phase of the study because: (1) the results of the questionnaires you filled out earlier in the study are unique (2) you are mandated to receive individual counseling services, and (3) you are 19 years of age or older.

Procedures: As a part of this phase of the study you will be asked to participate in an open-ended individual interview lasting about 1 hour. The interview will be audio taped and all tapes will be transcribed. After the interview is transcribed, I will send you the transcription via mail. I will ask you to check it for accuracy and to make sure that no important statements were missed during the transcription. I will ask you to e-mail or mail your comments back to me.

Risks and/or Discomforts: There are no known risks that may result from your participation in this study. In the event of problems resulting from participation in the study, you can submit a request for mental health interview to your CCCL caseworker/case manager. Additionally, psychological help is also available at the UNL Counseling and School Psychology Clinic, (402) 472-1152, UNL Family Resource Clinic (402) 472-5035, and UNL Psychological Consultation Clinic (402) 472-2351. All listed clinics have sliding fee policy. In a case if psychological help is needed, you will be responsible for covering services fees.

Benefits: There are no direct benefits from participation in this study. Your participation in this study will NOT give you any additional privileges. However, your participation will contribute to the collection of scientific knowledge about effective methods for working with clients who are mandated to receive individual counseling services.

Confidentiality: Any personal information obtained during this study which could identify you will be kept strictly confidential. All identifiable data (i.e., audio tapes, contact information) will be stored in a locked cabinet in the principle investigator's office at the University of Nebraska - Lincoln and will only be seen by the investigator during the study. Please, know that your therapists will NOT see your interview transcripts. The audiotapes will be erased after transcription. The informed consent will be stored separately from the transcripts - there will be no way to associate your name with the transcripts. Transcripts will be coded. No information collected in this study will be released to an agency that required you to be in counseling.

Moreover, contact information sheets will be destroyed as soon the data for the study are collected and analyzed. The information obtained in this study may be published in scientific journals or presented at scientific meetings but the data will be reported in a way that preserves anonymity.

Compensation: As a compensation for participation in this phase of the study you will receive \$5 cash upon completion of the interview.

____ Please, put your initials here, indicating that you have read and understood this page

IRB#2005-05-339 FB Date Approved: 8/23/05 Valid Until: 7/27/06

B-2

Opportunity to Ask Questions: You may ask any questions concerning this research and have those questions answered by the investigator before agreeing to participate or at any time during the study. If you have any questions about your rights as a research participant that have not been answered by the investigator, or to report any concerns about the study, you may contact the Institutional Review Board at (402) 472-6965. To do this, you can submit a phone conversation request to your case worker/manager. Your request will be processed as soon as possible.

Freedom to Withdraw: You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigator, with the University of Nebraska, or with the Nebraska Department of Correctional Services. Your decision will not result in any loss of benefits to which you are otherwise entitled. Your decision to participate will not affect your parole eligibility or any decisions regarding it.

Consent, Right to Receive a Copy: You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

Signature of Research Participant:

Signature of Participant

Date

Name and phone number of the principal investigator: Tanya I. Razzhavaikina MA.
Phone: (402) 472-2223

Name and phone number of the research supervisor: Michael J. Scheel, Ph.D.
Phone: (402) 472-0573

APPENDIX C

Participants Recruitment Materials

INVITATION

If you were mandated to receive counseling services, here is an opportunity for you to participate in the research study and receive a **compensation** for your participation....

My name is Tanya Razzhavaikina. I am a graduate student in counseling psychology. I would like to invite you to participate in my study. Here is some information about the study:

This study explores mandated clients' perspectives on individual counseling.

As a part of the study you will be asked to complete several questionnaires at different points of your counseling experience. I will be asking you to complete the questionnaires 3 times. Each time you fill out the questionnaires you will get a small incentive (**\$2 cash**) as a **compensation for participating in this study (\$6 total)**.

Your answers will be kept strictly confidential. I will not disclose any information you provide me with neither to your counselor nor to the agency that mandated you to be in counseling.

Remember, that your decision to participate in this study is voluntary. You are free to decide not to participate in this study or to withdraw at any time. Your decision will NOT affect your relationship with your counselor, or with UNL/Community Correctional Center.

If you would like to participate in this study here is what you need to do BEFORE YOU COME TO YOUR FIRST COUNSELING SESSION:

1. Read and sign both copies of Participant Informed Consent (attached). One copy is for you to keep.
2. Fill out all 5 questionnaires that are attached (i.e., Contact Information Sheet, Demographic Information, Questionnaire, Why are you presently involved in therapy?, Goals Scale)
Note: It should take you 10-15 min. to fill out all questionnaires
3. You MUST bring signed informed consent and completed questionnaires to your first counseling session and give them to your counselor.
Note: To receive compensation (\$2 for the first session) you will be asked to fill out one more questionnaire after your first counseling session.
4. You MUST inform your caseworker/manager that you chose to participate in the research study: Fill out a sheet **"To Case manager/worker"** and give it to your case manager/worker as soon as you complete it (You MUST inform your case manager/worker before you come to your first counseling session)

If you chose not to participate in the study, please return the envelop to your case worker/manager!

Thank you for your help!

Sincerely,
Tanya Razzhavaikina, MA

To Case Worker/Manager:*To an inmate:*

If you decided to participate in the research study, fill out this form and turn it in to your case manager/worker right after you complete it.

Thank you for your participation!

Today's Date: _____

My name is (First, Last): _____

My case manager name is: _____

I would like to participate in the research study conducted by Tanya Razzhavaikina and give my permission to disclose my name and contact information to her.

My first counseling session is scheduled for (date and time):

Note: if you do not know when is your first session scheduled, leave this line blank

I will be receiving counseling at (circle the appropriate clinic):

Note: if you do not know the clinic name – do not circle anything

Counseling and School
Psychology Clinic
(402) 472 – 1152
14 & Vine

Family Resource Clinic
(402) 472-5035
East Campus (East
Campus Loop & 35th
street)

Psychological Consultation
Clinic (402) 472-2351
City Campus 325 Burnett
Hall

Rape and Spouse Abuse
Crisis Center
(402) 476-2110
2545 N. Str.

To Case worker/manager:

Please submit this form to Mr. XXX right after you receive it.

Thank you for your help!

Tanya Razzhavaikina

APPENDIX D

Assessment Instruments

Working Alliance Inventory

Instructions: On the following pages are the sentences that describe some of the different ways a person might think or feel about his or her therapist (counselor). As you read the sentences mentally insert the name of your therapist (counselor) in place of _____ in the text. To the right of each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you ***always*** feel (or think) check the number 7; if it ***never*** applies to you check the number 1. Use the numbers in between to describe the variations between these extremes.

1. I feel uncomfortable with_____.
2. _____ and I agree about the steps to be taken to Improve his/her situation.
3. I have some concerns about the outcome of these sessions.
4. My client and I both feel confident about the usefulness of our current activity in therapy.
5. I feel I really understand _____.
6. _____ and I have a common perception of her/his goals.
7. _____ finds what we are doing in therapy confusing.
8. I believe _____ likes me.
9. I sense the need to clarify the purpose of our sessions for _____.
10. I have some disagreements with ____ about the goals of these sessions.
11. I believe the time _____ and I are spending together is not spent efficiently.
12. I have doubts about what we are trying to accomplish in therapy.
13. I am clear and explicit about what _____' s responsibilities are in therapy.
14. The current goals of these sessions are Important for _____.
15. I find what _____ and I are doing in therapy is unrelated to his/her current concerns.
16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.
17. I am genuinely concerned for _____'s welfare.
18. I am clear as to what I expect _____ to do in these sessions.
19. _____ and I respect each other.
20. I feel that I am not totally honest about my feelings toward _____.

21. I am confident in my ability to help _____.
22. We are working towards mutually agreed upon goals.
23. I appreciate _____ as a person
24. We agree on what is important for _____ to work on.
25. As a result of these sessions _____ is clearer as to how he/she might be able to change.
26. _____ and I have built a mutual trust.
27. _____ and I have different ideas on what his/her problems are.
28. Our relationship is important to _____.
29. _____ has some fears that if she/he says or does the wrong things, I will stop working with her/him.
30. _____ and I collaborate on setting goals for these sessions.
31. _____ is frustrated by what i am asking him/her to do in therapy.
32. We have established a good understanding between us of the kind of changes that would be good for _____.
33. The things that we are doing in therapy don't make much sense to _____.
34. _____ does not know what to expect as the result of therapy.
35. _____ believes the way we are working with her/his problem is correct.
36. I respect _____ even when he/she does things that I do not approve of.

Your name (first, last):		Today's Date:		
(this information will be erased and substituted to a code)		Participant Code:		
		Therapist:		
<p>WHY ARE YOU PRESENTLY INVOLVED IN THERAPY ?</p> <p>Using the scale below, please indicate to what extent each of the following items corresponds to the reasons why you are presently involved in therapy by checking the appropriate box to the right of each item. We realize that the reasons why you are in therapy at this moment may differ from the reasons that you initially began therapy. However, we are interested to know why you are in therapy at the present moment.</p>		<p>For Office Use Only</p> <p>IM IR1 IR2 IR3 ER A</p>		
1	Because other people think that it's a good idea for me to be in therapy.	Does not correspond at all	Corresponds Exactly	
2	Honestly, I really don't understand what I can get from therapy.	1	2	3
3	For the pleasure I experience when I feel completely absorbed in a therapy session.	4	5	6
4	For the satisfaction I have when I try to achieve my personal goals in the course of therapy.	7		
5	Because I would feel guilty if I was not doing anything about my problem.			
6	Because I would like to make changes to my current situation.			
7	Because I believe that eventually it will allow me to feel better.			
8	I once had good reasons for going to therapy, however, now I wonder whether I should quit.			
9	Because I would feel bad about myself if I didn't continue my therapy.			
10	Because I should have a better understanding of myself.			
11	Because my friends think I should be in therapy.			
12	Because I experience pleasure and satisfaction when I learn new things about myself that I			
13	I wonder what I'm doing in therapy; actually, I find it boring.			
14	I don't know. I never really thought about it before.			
15	Because I believe that therapy will allow me to deal with things better.			
16	For the interest I have in understanding more about myself.			
17	Because through therapy I've come to see a way that I can continue to approach different			
18	Because through therapy I feel that I can now take responsibility for making changes in my life.			
19	Because it is important for clients to remain in therapy until it's finished.			
20	Because I believe it's a good thing to do to find solutions to my problem.			
21	To satisfy people close to me who want me to get help for my current situation.			
22	Because I don't want to upset people close to me who want me to be in therapy.			
23	Because I feel that changes that are taking place through therapy are becoming part of me.			
24	Because I value the way therapy allows me to make changes in my life.			

Adult Dispositional Hope Scale “Goals Scale”

Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1=definitely false 2=mostly false 3=mostly true 4=definitely true

1. I can think of many ways to get out of a jam.
2. I energetically pursue my goals.
3. I feel tired most of the time.
4. There are lots of ways around any problem.
5. I am easily downed in an argument.
6. I can think of many ways to get the things in life that are most important to me.
7. I worry about my health.
8. Even when others get discouraged, I know I can find a way to solve the problem.
9. My past experiences have prepared me well for my future.
10. I've been pretty successful in life.
11. I usually find myself worrying about something.
12. I meet the goals that I set for myself.

Pathways scale: 1, 4, 6, 8 Agency scale: 2, 9, 10, 12 Distracters: 3, 5, 7, 11

Your name (first, last):

(this information will be erased and substituted to a code)

Demographic Information

Please, answer the following questions:

Participant Code:

Therapist:

1 What is your age? _____

2 What is your ethnicity? (please circle)

1= African-American

2= Asian-American

3= Caucasian

4= Native American

5= Hispanic/Latino(a)

6= Other (specify) _____

3 What is your gender? (please circle)

1= Male

2= Female

4 Counseling was mandated from which agency? (please circle)

1= University Judicial Affairs

2= Court

3= Correctional Center

4= Housing Authority

5= Probation

6= Other (specify) _____

5 Have you been in individual counseling before? (please circle)

1= Yes

2= No

**For office
use only**

1

2

3

4

5

6 If you put “yes” in #5, were you satisfied with the outcome of the counseling? (please circle)

1= Yes

2= No

3= Not Applicable



6

Participant Code:	
	Therapist:

Contact Information Sheet

IMPORTANT: The researcher collects this information with the purpose to use it to contact you if you are selected to participate in an individual interview. Only the principle investigator will see this information. This form will be stored in the locked cabinet in the principle investigator's office (at the University of Nebraska - Lincoln) separate from other questioners and interview – tapes. This form "Contact Information" will be destroyed (i.e., shredded) as soon as data collection procedures end.

Please, respond to the following questions:

Your Name (first, last) _____

Specify the best way to reach you _____

Write your contact information (e.g., phone number, e-mail, mailing address, contact person and his/her information):

Please, circle the Clinic where you receive counseling services now:

Counseling and School Psychology Clinic (402) 472 – 1152 14 & Vine	Family Resource Clinic (402) 472-5035 East Campus (East Campus Loop & 35 th street)	Psychological Consultation Clinic (402) 472-2351 City Campus 325 Burnett Hall	Rape and Spouse Abuse Crisis Center (402) 476-2110 2545 N. Str.
-----------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	--------------------------------------------------------------------------

You may or may not be selected to participate in an individual interview. If you are selected, you will be contacted by the principle investigator.

Thank you for your participation in this study!

APPENDIX E

Interview Protocol

MANDATORY COUNSELING: A MIXED METHODS STUDY OF FACTORS THAT CONTRIBUTE
TO THE DEVELOPMENT OF THE WORKING ALLIANCE

Interview Protocol

Interview #:
Interviewee:
Date:
Time:
Length of Interview:
Place:

Demographic information:

Gender: male female
Age:
Ethnicity:
Previous experiences with counseling:

Introduction: Review confidentiality and emphasize that nobody (e.g., therapist, case worker, etc.) but this researcher will know what this particular interviewee disclose in the interview.

1. Please tell me about yourself
 - Age
 - education
 - ethnicity
 - family
 - previous experiences with counseling
 - what agency mandated counseling
2. What is your purpose for being in counseling?
3. How has your perspective toward counseling changed since entering counseling?
4. What I would like you to do is to describe as fully as possible in your own words your experiences in counseling.
5. When you reflect on your experiences in counseling, what stands out as meaningful?
6. How would your life be different (if at all) without this counseling experience?

7. Please describe in your own words your motivation for counseling?
8. How does counseling help you to be more hopeful about things in your life improving?
9. How hopeful are you that counseling will be helpful?
10. Please describe in your own words your relationship with your therapist?
 - How did it start?
 - How did it change?
 - (Here I may ask a question that is specific to a particular client's trajectory of WA change. For example, what do you think caused this change in your relationship with your therapist?)
11. When you reflect on how your relationship with your therapist develops, what are some factors that influence your relationship?
 - What was helpful in the development of relationship with your therapist?
 - What was **not** helpful?
 - What was helpful at the beginning of the therapy?
 - What are some things you wish were or could become part of therapy to help you develop better relationship with your therapist?
12. What else would you like to tell me about your counseling experience and relationship with your counselor? Are there any documents or written materials that could help me understand your experiences in counseling (e.g., homework, diary, reflection)?

APPENDIX F

Qualitative Tables

Table 4.4

Working Alliance Groups and Cases Selected for Qualitative Interviews

Case #	Accelerating Quadratic Dramatic	Accelerating Linear	Decelerating Quadratic	Constant	Accelerating Quadratic Late Onset	Decelerating Linear
3	- selected - interviewed "Michael"					
15		- selected - interviewed "George"				
17		- selected - interviewed "Shelby"				
24				- selected - interviewed "Chris"		
26					- selected - interviewed "Joe"	
35			- selected - interviewed "Kyle"			
48						- selected - not available for interview
52	- selected - not available for interview					

Table 4.5

Demographic Information for Participants Interviewed for the Qualitative Phase of the Study

Participants (original case number)	Gender	Age	Ethnicity	# of sessions completed	Previous counseling experience	Impression of previous counseling
Case 1 (3) "Michael"	Male	29	Caucasian with French Background	12	no	
Case 2 (17) "Shelby"	Female	34	Caucasian	6	no	
Case 3 (15) "George"	Male	40	Caucasian	10	yes	negative
Case 4 (24) "Chris"	Male	55	African-American	5	no	
Case 5 (26) "Joe"	Male	48	African-American	5	yes	positive
Case 6 (35) "Kyle"	Male	27	Caucasian	7	yes	negative

Table 4.6

Issue 1 "Therapy Experience": Qualitative Themes, Codes, and Code Frequencies

Themes	Codes	Cases						Total
		1 "Michael"	2 "Shelby"	3 "George"	4 "Chris"	5 "Joe"	6 "Kyle"	
1. Therapy Development	"It started slow"	0	3	0	0	0	1	4
	"Boring and tedious at the beginning"	2	1	0	1	0	0	4
	"More personal" at the end	2	2	4	2	1	1	12
	From mandate to volunteer	5	3	0	5	2	7	22
	Count	9	9	4	8	3	9	41
	Row Percent	21.1	21.1	9.8	19.5	7.4	21.1	100.0
Column Percent		23.1	20.0	11.1	34.8	11.1	47.4	
2. Client Role	Client responsibility	1	0	0	0	1	1	3
	Client is active in counseling	2	1	4	0	0	0	7
	Mandated client has freedom in counseling	4	2	1	3	3	1	14
	Count	7	3	5	3	4	2	24
	Row Percent	29.2	12.5	20.8	12.5	16.7	8.3	100.0
	Column Percent	17.9	6.7	13.9	13	14.8	10.5	
3. Therapist Role	Therapist is active in counseling	1	1	5	2	3	0	12
	Count	1	1	5	2	3	0	12
	Row Percent	8.3	8.3	41.7	16.7	25.0	0.0	100.0
	Column Percent	2.6	2.2	13.9	8.7	11.1	0.0	
4. Client-Therapist Relationship	Trusting relationships	3	1	0	0	0	2	6
	Client-therapist misunderstandings	2	0	0	0	0	0	2
	Equality between client and therapist	0	1	0	0	0	0	1
	Count	5	2	0	0	0	2	9
	Row Percent	55.6	22.2	0.0	0.0	0.0	22.2	100.0
	Column Percent	12.8	4.4	0.0	0.0	0.0	10.5	3

Table 4.6 (continued). *Issue 1 “Therapy Experience”: Qualitative Themes, Codes, and Code Frequencies*

Themes	Codes	Cases						Total
		1 “Michael”	2 “Shelby”	3 “George”	4 “Chris”	5 “Joe”	6 “Kyle”	
5. Therapy Process	Counseling is interesting	6	0	1	0	0	0	7
	Talking about everyday problems	1	1	0	1	0	1	4
	Counseling is ongoing process	0	4	2	0	0	0	6
	Counseling is a foundation for future	2	12	3	0	4	2	23
	Individual attention	0	0	0	0	7	0	7
	Count	9	17	6	1	11	3	47
	Row Percent	19.2	36.2	12.7	2.1	23.4	6.4	100.0
	Column Percent	23.1	37.8	16.7	4.4	40.8	15.8	
6. Therapy Outcomes	Reflecting on past experiences	6	2	3	1	0	1	13
	Generating solutions	1	4	1	5	3	1	15
	“Counseling did not give me more hope”	1	0	0	0	0	0	1
	Accomplishing goals	0	2	3	0	0	0	5
	Identifying my needs	0	2	1	1	2	0	6
	Counseling increased my hope	0	2	2	0	0	1	5
	“Understanding myself”	0	1	4	0	1	0	6
	Increased self-esteem	0	0	2	2	0	0	4
	Count	8	13	16	9	6	3	55
	Row	14.5	23.6	29.1	16.4	10.9	5.5	100.0
	Percent	20.5	28.9	44.4	39.1	22.2	15.8	
	Column Percent							
	Total	39	45	36	23	27	19	
		100.0	100.0	100.0	100.0	100.0	100.0	

Table 4.7

Issue 2 “Facilitators of Working Alliance Development”: Qualitative Themes, Codes, and Code Frequencies

Themes	Codes	Cases						Total
		1 “Michael”	2 “Shelby”	3 “George”	4 “Chris”	5 “Joe”	6 “Kyle”	
1. Client Factors	Knowing your therapist	2	1	0	0	0	2	5
	Need and ability to trust	5	2	0	0	0	0	7
	Liking your therapist	1	0	0	0	2	1	4
	Client is active in counseling	2	1	4	0	0	0	7
	Client opened up	2	1	2	4	0	2	11
	"Free will"	5	2	5	4	0	0	16
	Hopefulness	2	0	2	0	4	2	10
	Positive expectation	0	0	0	0	2	0	2
	Count	19	7	13	8	8	7	62
	Row Percent	30.6	11.2	21.0	13.0	13.0	11.2	100.0
	Column Percent	48.7	35.0	54.2	40.0	26.7	27.0	
2. Therapist Factors	Therapist is knowledgeable	1	0	0	0	1	0	2
	“Therapist acting like a person”	1	0	0	0	0	0	1
	Therapist consistency	1	0	0	0	1	1	3
	Therapist asks "interesting questions"	7	1	0	1	0	1	10
	Therapist understands my background	1	1	0	0	3	1	6
	Therapist is not judgmental	0	2	0	1	1	3	7
	Therapist gave me choices	1	3	2	4	0	0	10
	Therapist was comforting	0	1	1	3	1	2	8
	Therapist is respectful	0	0	2	1	1	6	10
	Therapist is sincere	3	0	1	0	4	1	9
	Therapist is active in counseling	1	1	5	2	3	0	12
	Therapist's gender	0	0	0	0	0	1	1
	Count	16	9	11	12	15	16	79
	Row Percent	20.3	11.4	13.9	15.2	18.9	20.3	100.0
	Column Percent	41.0	45.0	45.8	60.0	50.0	61.5	

Themes	Codes	Cases						Total
		1 "Michael"	2 "Shelby"	3 "George"	4 "Chris"	5 "Joe"	6 "Kyle"	
3. Process Factors	Trusting relationships	3	1	0	0	0	2	6
	Confidentiality	1	0	0	0	0	1	2
	Appropriate timing for counseling	0	2	0	0	0	0	2
	Equality between client and therapist	0	1	0	0	0	0	1
	Individual attention	0	0	0	0	7	0	7
	Count	4	4	0	0	7	3	18
	Row Percent	22.2	22.2	0.0	0.0	38.9	16.7	100.0
	Column Percent	10.3	20.0	0.0	0.0	23.3	11.5	
	Total	39	20	24	20	30	26	
		100.0	100.0	100.0	100.0	100.0	100.0	

F-4

Table 4.8

Issue 3 “Obstacles to Working Alliance Development”: Qualitative Themes, Codes, and Code Frequencies

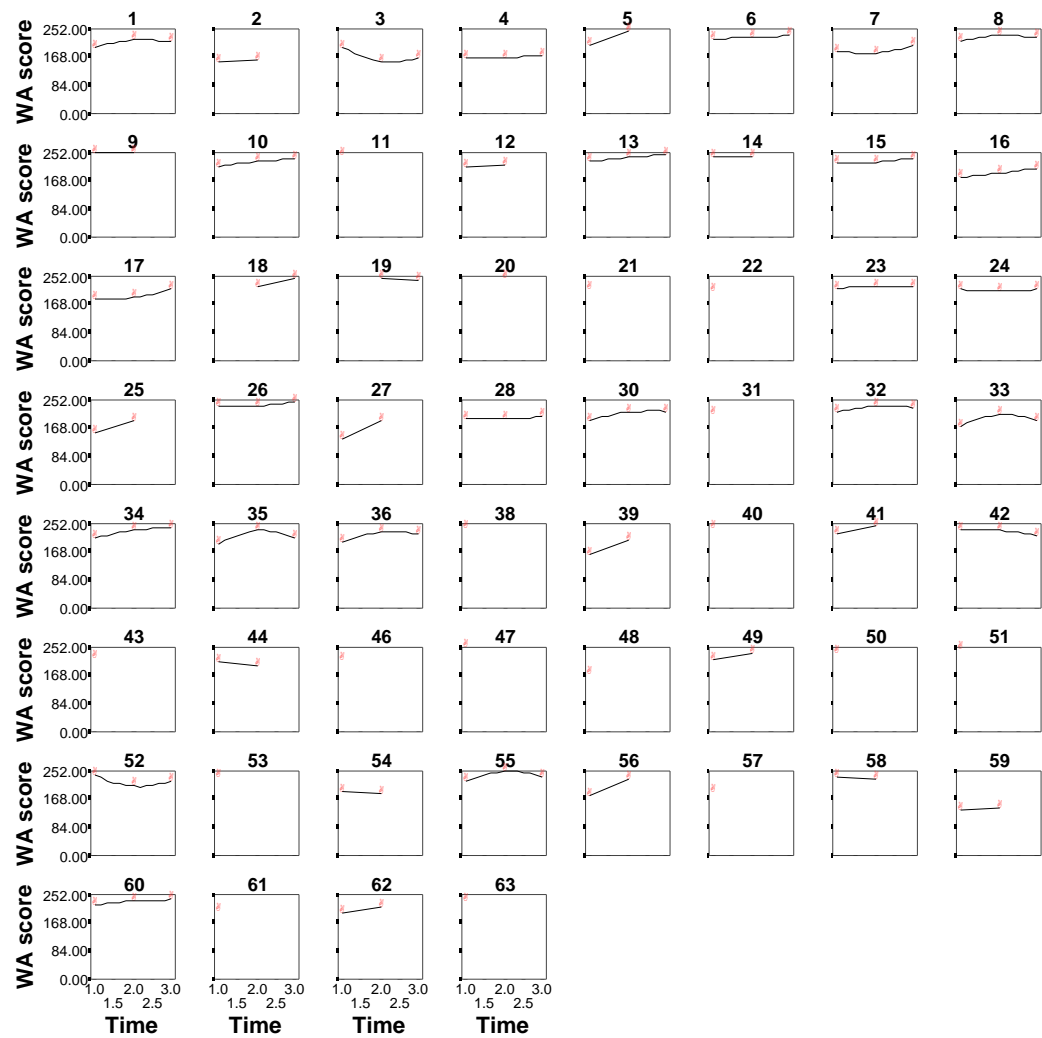
Themes	Codes	Cases						Total
		1 “Michael”	2 “Shelby”	3 “George”	4 “Chris”	5 “Joe”	6 “Kyle”	
1. Client Factors	Negative expectations	0	0	0	0	0	2	2
	Hopelessness	0	1	0	0	0	0	1
	"I was unsure of what to expect"	0	3	1	1	0	0	5
	Client reluctance	1	0	4	2	0	2	9
	Opening up is difficult	2	3	0	0	0	0	5
	Count	3	7	5	3	0	4	22
2. Therapist Factors	Row Percent	13.6	31.8	22.8	13.6	0.0	18.2	100.0
	Column Percent	16.7	50.0	83.3	42.9	0.0	36.4	
	Therapist needs to be more directive	3	1	0	0	0	0	4
	Count	3	1	0	0	0	0	4
	Row Percent	75.0	25.0	0.0	0.0	0.0	0.0	100.0
	Column Percent	16.7	7.1	0.0	0.0	0.0	0.0	
3. Process Factors	Client-therapist misunderstandings	2	0	0	0	0	0	2
	Counseling is mandated	8	5	1	3	3	3	23
	"Boring and tedious at the beginning"	2	1	0	1	0	0	4
	Recording equipment	0	0	0	0	2	1	3
	"Difficult topic"	0	0	0	0	0	2	2
	"Homework not helpful"	0	0	0	0	0	1	1
	Count	12	6	1	4	5	7	35
	Row Percent	34.3	17.1	2.9	11.4	14.3	20.0	100.0
	Column Percent	66.6	42.9	16.7	57.4	100.0	63.6	
	Total	18	14	6	7	5	11	
		100.0	100.0	100.0	100.0	100.0	100.0	

APPENDIX G

Figures

Figure Caption

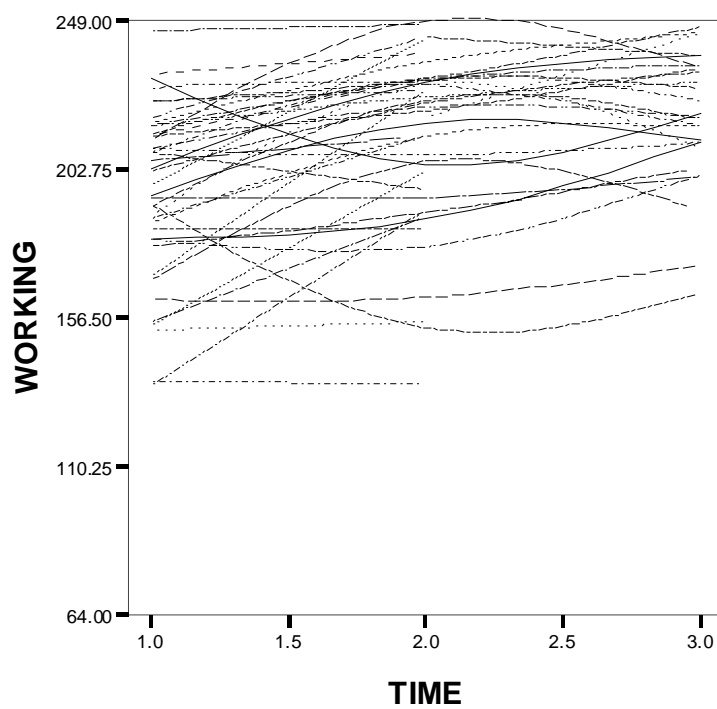
Figure 4.1. Individual Trajectories of Working Alliance, as Rated by Clients.



Note. WA score = Working Alliance Score. Time 1.0 = Session 1, Time 2.0 = Session 3, and Time 3.0 = Session 5.

Figure Caption

Figure 4.2. Trajectories of Working Alliance, as Rated by Clients



Note. Working = Working Alliance Score. Time 1.0 = Session 1, Time 2.0 = Session 3, and Time 3.0 = Session 5.