

9-2018

The Relationship between Psychotherapist Personality and Therapeutic Alliance

Michael Finlay

Follow this and additional works at: <http://scholarsrepository.llu.edu/etd>

 Part of the [Clinical Psychology Commons](#), and the [Medicine and Health Sciences Commons](#)

Recommended Citation

Finlay, Michael, "The Relationship between Psychotherapist Personality and Therapeutic Alliance" (2018). *Loma Linda University Electronic Theses, Dissertations & Projects*. 519.
<http://scholarsrepository.llu.edu/etd/519>

This Dissertation is brought to you for free and open access by TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works. It has been accepted for inclusion in Loma Linda University Electronic Theses, Dissertations & Projects by an authorized administrator of TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works. For more information, please contact scholarsrepository@llu.edu.

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

The Relationship between Psychotherapist Personality and Therapeutic Alliance

by

Michael Finlay

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Clinical Psychology

September 2018

© 2018

Michael Finlay
All Rights Reserved

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

_____, Chairperson
David Vermeersch, Professor of Psychology

Kenny Boyd, Assistant Professor of Psychology

Colleen Brenner, Professor of Psychology

John Davis, Licensed Clinical Psychologist

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to my wife, Anna Finlay, who supported me throughout my journey and encouraged me to persevere regardless of the challenges I faced. Not only did she provide support and encouragement, but she also endured late nights and frequently served as my audience, editor, and practice partner.

I would like to thank Dr. David Vermeersch, who encouraged me to pursue this research project. Your support, guidance, and trust allowed me to grow as a researcher and to challenge my beliefs in the field of psychology. I would also like to thank my committee for their advice, encouragement, and direction. I would like to thank Dr. Holly Morrel, who supported me throughout the program and provided opportunities to participate in research and teaching. The knowledge imparted by Dr. Morrel allowed me to analyze my data even when the data was not ideal. I would also like to thank Mark Cox for your continued guidance, and for your help in conceptualizing the importance of the therapeutic relationship.

To my family and friends, your love and support through this long endeavor have been essential to my success. A special thank you to Mary Finlay for all your love and support, and Fe and Rey Maestrado for all your help supporting the family, which allowed me to pursue my dream. And finally, I would like to thank God for providing me the undeserved opportunity to study His creation and marvel in its complexity.

CONTENT

Approval Page.....	iii
Acknowledgements.....	iv
List of Figures.....	viii
List of Tables.....	ix
List of Abbreviations.....	x
Abstract.....	xi
Chapter	
1. Introduction.....	1
Expectancy Effects.....	2
Extratherapeutic Factors.....	5
Techniques.....	6
Therapeutic Relationship Factors.....	10
Therapist Characteristics.....	11
Client Characteristics.....	14
Therapist-Client Interactions.....	16
Therapist Personality and Therapeutic Alliance.....	20
Specific Aims and Hypotheses.....	24
Hypothesis 1.....	24
Hypothesis 2.....	25
Hypothesis 3.....	25
Hypothesis 3.....	25
2. Methods and Materials.....	27
Participants and Procedures.....	27
Statistical Methods.....	29
Instruments.....	32
Working Alliance Inventory-Short.....	32
NEO- Five-Factor Inventory.....	33
Outcome Rating Scale.....	33
Therapeutic Alliance Focused Intervention.....	34
3. Results.....	38

4. Discussion	45
Therapeutic Alliance Focused Intervention	56
5. Limitations	59
Conclusions and Future Directions	62
References	63
Appendices	
A. Informed Consent	74
B. Working Alliance Inventory-Short	78
C. Outcome Rating Scale	79

FIGURES

Figures	Page
1. Therapeutic Outcome Factors	2
2. Therapeutic Alliance Factors	18
3. Proposed Multilevel Modeling Analysis	31
4. Distribution of Personality Factors Among Psychotherapists	39
5. Mean Levels of Agreeableness by Alliance Rating	43
6. Mean Levels of Agreeableness by Licensure Track	44
7. Scatter Plots to Test the Assumptions of HLM	44

TABLES

Tables	Page
1. Participant demographics.....	28
2. Frequency analysis of NEO-FFI Factors	37
3. Correlation between NEO variables, working alliance, and outcome measures.....	41
4. One-way ANOVA comparing psychotherapy group by T-score on Agreeableness	42
5. ANOVA Comparisons of Agreeableness by psychotherapist group.....	42
6. One-way ANOVA comparing psychotherapist gender and education by T- score on Agreeableness	43

ABBREVIATIONS

NEO-FFI	NEO- Five Factor Inventory
WAI-S	Working Alliance Inventory-Short
ORS	Outcome Rating Scale
SES	Socioeconomic Status
BDI	Beck Depression Inventory
MMPI	Minnesota Multiphasic Personality Inventory
PTSD	Post-Traumatic Stress Disorder
ROM	Routine Outcome Monitoring
SAMHSA	Substance Abuse and Mental Health Services Association
DHHS	Department of Health and Human Services
SAD	Social Anxiety Disorder
APA	American Psychological Association
MBPI	Myers-Briggs Personality Inventory
FFM	Five Factor Model
MFT	Marriage Family Therapy
CP	Clinical Psychology
SW	Social Work
PCC	Professional Clinical Counselor

ABSTRACT OF THE DISSERTATION

The Relationship between Psychotherapist Personality and Therapeutic Alliance

by

Michael Finlay

Doctor of Philosophy, Graduate Program in Clinical Psychology
Loma Linda University, September 2018
Dr. David Vermeersch, Chairperson

Time-limited effective psychotherapy is a topic that is frequently addressed in clinical therapy research. Though a wide range of therapeutic factors, expectancy effects, techniques, and extratherapeutic have all been demonstrated to be related to outcome, researchers have consistently identified the therapeutic alliance as one of the strongest factors in predicting psychotherapy outcomes. Researchers are beginning to measure the effectiveness of therapy by evaluating improvements in outcome measures, and client reported therapeutic alliance. Researchers have recently began investigating the common personality profiles among psychotherapists, and have hypothesized that there is a relationship between psychotherapist personality and therapeutic alliance. The goal of this research was to determine if the relationship between psychotherapist personality traits and therapeutic alliance existed and whether a therapeutic alliance focused intervention would improve client reported therapeutic alliance. Researchers recruited pre-licensed graduate level psychotherapists from community-based outpatient clinics. A total of 50 psychotherapists participated by completing a NEO-Five Factor Inventory (NEO-FFI). Clients of these therapists were also asked to complete a Working Alliance Inventory-Short Form (WAI-S) and an Outcome Rating Scale (ORS). Results indicated that psychotherapists, in general, have lower levels of Neuroticism, and higher levels of

Openness and Agreeableness, compared to community normative data. The researchers found that Agreeableness played a significant role in client-reported therapeutic alliance. Psychotherapists who had the highest ratings of therapeutic alliance had significantly higher scores on the Agreeableness scale compared to psychotherapists who had the lowest ratings of therapeutic alliance. Researchers were unable to statistically demonstrate that therapeutic alliance focused interventions were related to higher ratings of therapeutic alliance or psychotherapy outcomes. However, reports from participants suggest that additional therapeutic alliance focused interventions are beneficial for individuals providing direct service to clients and for supervisors.

CHAPTER ONE

INTRODUCTION

Effective psychotherapy typically involves a therapist and a client working collaboratively to achieve a goal. The therapist brings experience, knowledge, empathy, and interventions to assist the client in developing effective coping abilities to meet the demands of their environment. For therapy to be effective, the client needs to believe that the therapist is working in their best interest, is competent, and is an individual with whom it is safe to explore painful or embarrassing aspects of their life (Hill, 2009). The therapeutic relationship has been examined in an effort to better understand its components and their relationship to both the process and outcome of psychotherapy. Following an exhaustive review of the literature, Lambert and Barley (2001) described four factors that influence psychotherapy outcome; expectancy effects, extratherapeutic changes, techniques, and therapeutic relationship factors (Figure 1). A large part of the variance in psychotherapy outcome is influenced by factors outside of treatment. However, research has demonstrated that psychotherapy produces better outcomes than no treatment control groups and outcomes that are equal to or better than medication-only treatment groups (Dewan, Steenbarger, & Greenberg, 2004). Though the psychotherapeutic technique is often the focus of research, the therapeutic relationship accounts for the largest percentage of variance in treatment outcomes. It is important to understand the various ways that each factor can contribute to psychotherapy outcome and how this information can be used to improve psychotherapy outcome. Considering the importance of the therapeutic relationship, the current study is aimed at better understanding the variables that influence the therapeutic relationship. Specifically, this

study plans to evaluate the relationship between the psychotherapist personality and client reported therapeutic alliance.

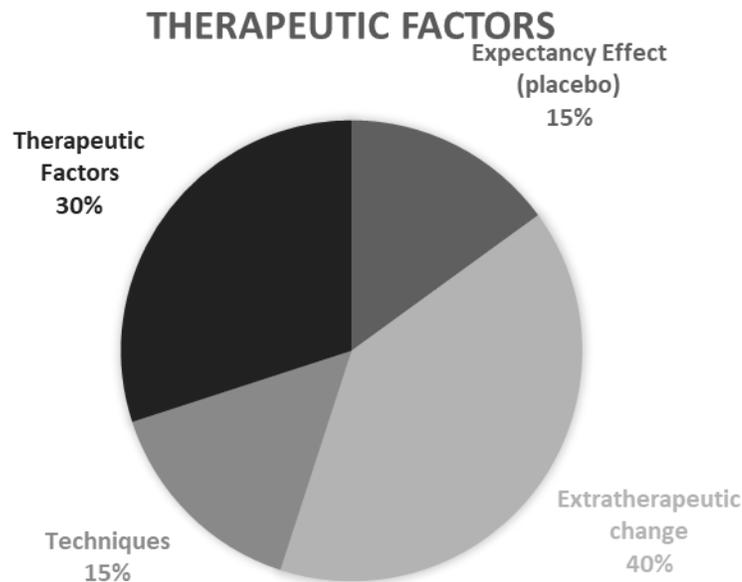


Figure 1. The percentage of change in outcome associated with the four primary factors described by Lambert and Barkey (2001).

Expectancy Effects

The expectancy effect of psychotherapy, also known as the placebo effect, is a widely debated topic in research. A placebo is an inert treatment, such as a sugar pill, that causes no biological changes. The placebo effect is the psychological benefit that occurs from receiving an inert treatment (Jensen and Kelley, 2016). The expectancy effect is the psychological benefit caused by an individual's expectation of receiving benefits from participation in an activity, such as psychotherapy (Lambert and Barley, 2001). Though some researchers have argued that psychotherapy is a placebo effect since it does not

cause any direct biological changes, researchers have found that psychotherapy can lead to long-term neurological changes similar to changes seen with the use of medications (Dewan, et al., 2004). Lamm, Batson, and Decety (2007) found neuroimaging can be used to detect the presence of empathy between a healthcare provider and a patient by identifying increased activity in the limbic system of both parties. These findings suggest that psychotherapy outcome is not the result of an expectancy effect. However, since psychotherapy and placebo effects both operate through psychological mechanisms, it is difficult to agree on a definition for expectancy effects within psychotherapy. The American Psychological Association is currently soliciting research on placebo effects in psychotherapy and on psychotherapy outcome.

Lambert and Barley (2001) defined expectancy effects as non-specific treatments that occur in the psychotherapeutic relationship. Patterson (1985) found three variables that consistently contributed to psychotherapy outcomes that were not specific to any treatment orientation; they are expertness, attractiveness, and trustworthiness. Expertness is the perceived level of knowledge or expertise attributed to a psychotherapist. Attractiveness is the perceived level of similarity between the client and the psychotherapist; that could include socioeconomic status (SES), religion, or race. Trustworthiness is the perceived level of confidence that a psychotherapist is safe before any experience with the therapist. These variables combined to account for approximately 15% of psychotherapy outcome and most occur before any interaction with the therapist. Therapeutic alliance continues to be debated as to whether it is a non-specific treatment (Jensen and Kelley, 2016; Lambert and Barley, 2001; Patterson, 1985). While the therapeutic alliance is not a specific theoretical treatment, all evidence-based treatments

emphasize the importance of establishing a therapeutic alliance before implementing interventions. Since the alliance is something that is developed and intentionally maintained throughout therapy, it does not fit the definition of an inert or non-specific treatment. If the definition of placebo effect or expectancy effect is modified in the future, this research will need to be repeated to determine if the amount of variance is shifted in favor of the placebo effect.

A less common expectancy effect that deserves future research is hope. Several assessment tools, such as the Beck Depression Inventory (BDI) and the Minnesota Multiphasic Personality Inventory (MMPI), measure levels of hopelessness. Hope is not a specific psychotherapy intervention but is often seen as an effect caused by meeting or exceeding expectations. Researchers investigating Post Traumatic Stress Disorder (PTSD) in veterans found that self-reports of hope at the mid-way point of therapy were positively associated with psychotherapy outcomes (Gilman, Schumm, & Chard, 2012).

Placebos and expectancy effects have often been portrayed in research as deceptive, manipulative and harmful. Researchers often aim to eliminate placebo effects to determine the actual effect size of an independent variable. It is possible that expectancies and placebos, such as hope, could be reevaluated and used as a change agent in psychotherapy (Jensen and Kelley, 2016). Expectancy effects explain the same amount of variance in psychotherapy outcomes as the modality used in treatment. It is possible that future research will provide methods that allow psychotherapists to harness the change potential of expectancy effects.

Extratherapeutic Factors

Lambert and Barley (2001) found that events that occur outside of psychotherapy can account for up to 40% of the variance in psychotherapy outcomes. These events range from spontaneous remission, social interactions, community resources, and fortuitous events. Roehrlé and Strouse (2008) conducted a meta-analysis on the effects of social support and social interactions. They found a low effect for social support and social interaction on psychotherapy outcome. Additionally, Roehrlé and Strouse (2008) found that while spontaneous remission accounted for a large percentage of extratherapeutic improvement, it has not frequently been a variable of interest and rarely is statistically analyzed.

Since Lambert and Barley's (2001) study, additional extratherapeutic events have become more prevalent. Psychotherapy continues to become part of mainstream culture and has become more available to a larger population than ever before. The increased population in psychotherapy increases the likelihood of seeing a client in public. Researchers have found that a public encounter with an individual's psychotherapist can have positive and negative effects on the outcome (Cochran, Stewart, Kiklevich, Flentje, & Wong, 2009). The setting of the encounter, progress in treatment, culture and the reaction of the therapist can all have an effect on psychotherapy outcome. Additionally, the explosion of psychotherapy on the internet and social media allows clients to have virtual encounters with psychotherapists (Kolmes, 2012). Future studies will need to evaluate the effects of therapists' websites, blogs, and publically available information on psychotherapy outcomes. The increased use of social media may also play a role in expectancy effects when it comes to perceived expertness and attractiveness.

When extratherapeutic effects were initially studied, they were thought to be a distractor to psychotherapy and variables that need to be controlled (Lambert and Barley, 2001; Roehrle and Strouse, 2008). Researchers now believe that extratherapeutic effects could be used to supplement traditional psychotherapy. As seen in the substance abuse population, the use of community resources can improve the outcomes of therapy. As previously stated, these effects account for approximately 40% of the variance in psychotherapy outcome. Researchers believe that the extratherapeutic effects may create a synergistic force, where one specific variable may not account for much variance but may lead to the use of other resources outside of therapy (Roehrle and Strouse, 2008). As psychotherapy continues to be more widely culturally accepted, it will be important to continue to monitor the effects of extratherapeutic factors. Additionally, teletherapy and video-therapy provide new areas for researchers to explore the use of community and social support.

Techniques

Lambert and Barley's (2001) model found that treatment modality, or technique, accounted for approximately 15% of the variance in psychotherapy outcome. According to this model, the type of treatment used accounts for approximately the same amount of variance as the expectancy effect. Despite this conclusion, treatment modalities and specific interventions for the treatment of psychological disturbances continues to be one of the most robust areas of study. As the field of clinical psychology has grown, so have the number of theories posited to resolve psychological disturbances (Duncan, Miller, Wampold, & Hubble, 2010). Several major schools of treatment have been developed

including cognitive-behavioral, psychodynamic, experiential, and family systems. All of these schools have produced empirical evidence that demonstrates its effectiveness (Dewan, et al., 2004; Duncan et al., 2010). Each of these approaches to treatment has been empirically proven to be equally as effective as medication alone. None have been able to demonstrate a clear statistically significant difference between the treatment outcomes of each orientation. Division 12 of the American Psychological Association lists over 40 different empirically supported treatments for psychological and substance use disorders.

The expansion of mental health benefits from insurance companies has placed a premium on brief, effective, and repeatable treatment models (Kazdin, 2008). Some researchers aspire to develop a medical treatment model in the field of behavioral health. The prescriptive therapy model would identify the most effective treatment that is administered the same way to every individual; similar to the way antibiotics are administered for infections (Kazdin, 2008). This has led to the growth of manualized treatments and step by step treatment protocols. The administration of treatment is provided in a standard, consistent way that would maximize the treatment effect (Kazdin, 2008; Duncan et al., 2010). Treatment manuals and workbooks for clinicians and clients can be found on the shelves of any bookstore. Manualized treatment minimizes the therapist effect; which is the ability of the therapist to adjust treatment based on intuition and experience. Prescriptive treatment protocols often script every session to ensure that the treatment is administered uniformly (Kazdin, 2008; Miller, Hubble, Chow, Seidel, 2015). When researchers have investigated the effects of adherence to specific treatment protocols, they often find that strict adherence results in decreased benefits from therapy

(Berman & Norton, 1985; Falkenström et al., 2013; Laska, Smith, Wislocki, Manami, & Wampold, 2013; Scaturro, 2001). These findings suggest that there is a role for the effect of the therapist within treatment models, including in manualized treatment protocols.

The effectiveness of manualized treatment should not be completely minimized. Researchers have found manualized treatment to be successful in clinical trials (Scaturro, 2001). Clinical trials generally have strict criteria for participants and are rarely representative of individuals that attend psychotherapy in community mental health settings. Since the late 1990's, researchers have continued to evaluate various approaches to determine what approach provides the best outcome for specific diagnoses. The research has indicated that the majority of treatment modalities are effective in the treatment of psychological conditions and no one treatment has been proven superior (Wampold and Imel, 2015). Strict adherence or the application of general principles of evidenced-based treatments will likely result in the same amount of variance explained in psychotherapy outcome. At a minimum, manualized treatment can serve as a guide in the treatment of common disorders. Treatment protocols are often developed to help the client achieve small goals early in treatment. The ability to achieve goals early in treatment has been demonstrated to be a good predictor of long-term treatment outcomes (Crits-Christoph, et al., 2006a).

Despite the plethora of information regarding various treatment modalities and methods, it is important to remain cognizant of the amount of variance that is explained by treatment factors. Even if researchers are able to develop a medical type model where individuals are prescribed specific treatment regimens for specific conditions, it would only account for 15% of the total variance in psychotherapy outcomes. This suggests that

even if the ideal treatment modality was identified, at best it may have a moderate effect on outcome, but could plausibly only have a small effect on outcome. The largest effect on psychotherapy outcome is attributed to therapeutic factors.

There is a line of research that shares variance with both technique and therapeutic factors. Routine Outcome Monitoring (ROM) is a feedback-informed treatment method intended to improve treatment and monitor therapeutic factors (Lambert et al., 2001; Miller, Duncan, Brown, Sorrell, and Chalk, 2006; Miller, et al., 2015). While feedback-informed treatment is not associated with a specific modality, it is an evidence-based intervention according to the Substance Abuse and Mental Health Services Association (SAMHSA). Miller et al. (2015) suggest that soliciting feedback from the client regarding their improvement and their experience in therapy can inform the psychotherapist about what issues need to be addressed. Miller et al. (2015) state that treatment modality only accounts for a small amount of improvement and the relationship with the psychotherapist accounts for a larger amount of the variance. This intervention provides a bridge between theoretical orientation and therapeutic factors. Researchers have found that psychotherapy outcomes are improved, particularly the therapeutic relationship, when regular feedback is provided to the therapist from the client (Miller et al., 2006). However, research and implementation on ROM have been limited. Many psychotherapists fear that these measures could be used for hiring, firing, selection criteria for inclusion on insurance panels, or other decisions that may impact their careers as psychotherapists. Psychotherapists invest large amounts of time and money in learning new techniques, theories, and interventions to become a more proficient therapist. Clinical supervision and continuing education are often focused on the implementation of

these techniques. However, interventions account for the least amount of variance in psychotherapy outcome, which is paradoxical to the goals of the psychotherapist. As Miller et al. (2015) state, more attention should be given to client experience and the relationship between the psychotherapist and the client.

Therapeutic Relationship Factors

Therapeutic relationship factors are used to describe the experience of therapy. These factors are transtheoretical, meaning that they can be found in every therapeutic interaction regardless of the orientation of the psychotherapist. The U.S. Department of Health and Human Services (DHHS) (2001) reported that the therapeutic relationship significantly predicted outcome, dropout, and evaluation of the therapist, especially among ethnic minority populations. Understanding the therapeutic relationship and its importance to effective treatment is vital to the field of healthcare. The therapeutic relationship includes empathy, understanding, collaborative treatment, and developing a connection with the client (Swift and Callahan, 2010). Several researchers have evaluated the therapeutic relationship when comparing the efficacy of different treatment models on the same disorder. Stangier, Von Consbruch, Schramm, & Heidenreich (2010) found that when treating social anxiety disorder (SAD), there was no significant difference between cognitive therapy and interpersonal psychotherapy. However, they found that the therapeutic relationship was a significant predictor of outcome regardless of the orientation. The effect of the therapeutic relationship was found both between treatment orientations and within treatment orientations. This outcome is consistent with what has been stated in this study, that the therapeutic relationship is more important than the

modality of treatment selected. These treatment effects are also found when working with couples. A positive therapeutic relationship is related to better outcome within each member of the couple (Quirk, Owen, Inch, France, & Bergen, 2014).

Researchers tend to organize the therapeutic relationship factor into three general subscales; therapist characteristics, patient characteristics, and therapist-client interaction. The therapeutic relationship explains approximately 30% of the variance in psychotherapy outcome and is the largest in treatment effect. Researchers postulated as early as the 1980's that the therapeutic relationship may be the most important component to understand in the entire therapeutic process (Garfield, 1985). However, as previously mentioned, research changed focus in the mid-1990's to prescriptive therapy treatments. This shift in focus created a gap in research and literature explaining how the therapeutic relationship influences outcomes. This study proposes to gain a better understanding of the influence of the therapeutic relationship by examining the therapist-client interaction.

Therapist Characteristics

A frequent research question is whether there is a significant difference between effective and ineffective psychotherapists and what contributes to that difference. Researchers have explored whether variables such as gender, level of education, years of experience, caseload, and religious beliefs make some individuals better psychotherapists (Bowman, 1993; Crits-Christoph & Mintz, 1991; Hill, 2009; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins., 2001; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). In the late 1970's through the mid-1980's researchers believe that female

therapists were generally better at treating both males and females (Bowman, 1993). Researchers compared the evaluations of psychotherapist on client psychotherapy outcomes, and the client reported psychotherapy outcome. Researchers found that female psychotherapists rated their client improvement more positively than their male counterparts. Researchers then compared client responses in an attempt to find agreement between the psychotherapist evaluation and the client evaluation. Since female psychotherapists generally identified and scored higher levels of improvement and were similar to client reports, the researchers believed that female psychotherapists were more effective (Bowman, 1993). However, when researchers only consider the report of the client, psychotherapists were equally as effective regardless of gender. This suggests that male psychotherapist may not rate improvement as high as female psychotherapists, but their clients experience a similar amount of change (Bowman, 1993). Advancements in statistical analysis have led researchers to conclude that gender is a poor predictor of psychotherapy outcome.

Religious beliefs and incorporation of religion or spirituality in psychotherapy have long been believed to improve psychotherapy outcomes. Several websites have been developed to assist people in selecting a psychotherapist that identifies with the same religious beliefs. Similarly to gender, early research found that the incorporation of religion significantly improves treatment. Recent studies have found that improvement in both religious and secular-only treatment but no significant differences between the two type of treatment on psychotherapy outcome (Sanders, Richards, McBride, Lea, Hardman, & Barnes, 2015).

The level of education, amount of experience and caseload are frequently identified as potential influences on outcome since they contribute directly to the ability to practice psychotherapy. Psychotherapy is a broad term that includes professional individuals with graduate-level training, and paraprofessionals, individuals with education ranging from a high school diploma to a bachelor's degree. Research has demonstrated that paraprofessionals are as effective as professionals in the treatment of common psychological disturbances (Berman & Norton, 1985). There has been little research on the effectiveness of graduate-level training or experience. Research has demonstrated that some training is better than no training, but there are no significant correlations between length of training or amount of experience and psychotherapy outcomes (O'Brien & Haaga, 2015; Stein & Lambert, 1995). Researchers have demonstrated that paraprofessionals and professionals are better than untrained laypersons at identifying emotional experiences and applying empathy appropriately (O'Brien & Haaga, 2015). There are no studies currently that demonstrate a significant difference in the treatment of commonly occurring disorders. Researchers suspect that graduate-trained psychotherapists are more effective at treating severe psychopathology and providing brief therapy (Berman & Norton, 1985; Stein & Lambert, 1995).

Caseload and severity of cases are associated with changes in psychotherapy outcome and with the ability to form an alliance (Laska et al., 2013; Saxon & Barkham, 2012). Researchers have found that large caseload and higher levels of severity on a caseload are associated with lowered psychotherapy outcomes. Psychotherapists become less effective at identifying emotional themes and applying appropriate interventions when they are feeling overwhelmed by difficult cases, large caseloads, or a combination

of difficult cases and caseload. Researchers have suggested the use of continuing education and modifications to training programs to assist therapists in identifying and resolving issues with caseload (Laska et al., 2013; Saxon & Barkham, 2012). Severe symptoms and large caseloads are contributing factors to compassion fatigue (O'Brien & Haaga, 2015). Compassion fatigue is a term used to describe a loss of the ability to provide empathic responses to an individual often as a result of experiencing stress or traumatic events. Researchers investigating compassion fatigue found that highly empathic individuals were more likely to be traumatized by hearing traumatic stories in all healthcare fields (Figley, 1995). When therapists attempt to manage large caseloads or are experiencing trauma from working with traumatized clients, they experience difficulty maintaining a positive working relationship. Therapists may experience difficulty being present with the client or may be unwilling to explore difficult emotional experiences in fear of their reactivity. Education and training seminars are tools to assist therapists in identifying when they may be experiencing fatigue and its effect on their clients. It is important to understand that compassion fatigue and secondary trauma are experienced by professionals, paraprofessionals, and other healthcare providers. Failure to adequately address caseloads can lead to compassion fatigue and ultimately poor psychotherapy outcomes. As previously stated, many psychotherapists trend towards focusing on interventions despite the evidence that suggests that the therapeutic relationship is a more significant factor.

Client Characteristics

Client characteristics of interests are often race, personality traits, the severity of

symptoms, and previous level of functioning. Research on client characteristics that predict outcome is lacking. Individuals participating in psychotherapy are considered a protected population in research and require extra measures to ensure confidentiality and that no harm will be caused by participation. Researchers have established that, similar to psychotherapist characteristics, the race of the client is a poor predictor of outcome (Jones, 1978). Researchers have found that initially, clients report a desire for a psychotherapist of the same race (Swift & Callahan, 2010). Results from various studies have found that once therapy begins, the race of either the psychotherapist or the client are not significant predictors of outcome (Swift & Callahan, 2010). Researchers have found that specific personality traits are associated with poorer outcomes. Individuals with a negative self-image prior to beginning treatment generally show a lower response to psychotherapy and therefore score lower on outcome measures (Ryum, Vogel, Walderhaug, & Stiles, 2015). Additionally, there is some evidence that the severity of symptoms prior to starting therapy predicts psychotherapy outcomes (Wiltink et al., 2016). Researchers suggest that symptom severity is measured prior to the commencement of therapy to determine the length and appropriateness for treatment. It is difficult to determine whether the effect of symptoms severity is a client factor or a therapist factor. As described above, high risk and increased severity can reduce the effectiveness of psychotherapists. It is possible that the severity of symptoms interferes with the ability for the individual to effectively participate in psychotherapy. Additional research is needed to better understand the mechanisms that cause symptoms severity to reduce psychotherapy outcomes.

Baseline functioning and previous level of functioning play a significant role in the outcome of psychotherapy. These variables bridge the relationship between the client characteristics and the techniques. Individuals with lower baseline functioning generally have poorer outcomes in psychotherapy (Connolly Gibbons, Thompson, Mack, Lee, & Crits-Christoph, 2015). Researchers have found that these individuals generally lack the initial competencies that insight-oriented or cognitive based therapies require. Psychotherapists have the responsibility to select techniques that are appropriate for the level of functioning of the client. The poorer outcomes could reflect the lack of treatment options for lower functioning individuals and the lack of resources for the individual to utilize within the therapeutic relationship.

Therapist-Client Interaction

The relationship between the therapist and client is critical to the success of psychotherapy. The therapeutic alliance, which is also known as the working alliance or treatment alliance, is the relationship that is established from the first encounter. The therapeutic alliance is how the client experiences the relationship with the therapist as helpful or potentially helpful towards achieving their goals. The therapeutic alliance is one variable that has been suggested to act as a change agent within the therapeutic relationship. Duncan et al. (2010) describe the therapeutic alliance as a partnership between the therapist and the client. Therapeutic alliance can be described as the agreement of goals and tasks in therapy and the empathic and positive regard held by the therapist. (Bordin, 1979; Duncan et al., 2010; Falkenström, 2013). The idea of a therapeutic alliance originated from psychoanalytic theory but became transtheoretical in

the 1970's (Bordin, 1979, Falkenström, 2013). Therapeutic alliance has been incorporated into all evidence-based theories and has consistently been used as a predictor of psychotherapy outcome across all orientations (Bachelor & Horvath, 1999). The therapeutic alliance is not exclusive to psychotherapy. All healthcare providers that have contact with individuals form an alliance (Jensen and Kelley, 2016). The therapeutic alliance is not always positive. A weak therapeutic alliance is associated with dropout and weaker psychotherapy outcomes in mental health fields (DHHS, 2001). In the medical field, weak alliances are associated with poor medication compliance and attendance (Bachelor & Horvath, 1999).

The effects of the therapeutic alliance have been researched thoroughly. It has repeatedly been found to be a significant predictor of psychotherapy outcome regardless of modality of treatment. Most research indicates that therapeutic alliance explains between 10-20% of the variance in psychotherapy outcome (Bowman, 1993; Crits-Christoph & Mintz, 1991; Hill, 2009; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins., 2001; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). The therapeutic alliance accounts for approximately a third to more than half of the variance explained from the therapeutic relationship. The therapeutic alliance accounts for as much of the variance in psychotherapy outcome as the modality of treatment and expectancy effects. When potential candidates for psychotherapy were asked about the traits they wanted in a therapist, the candidates reported that they wanted a positive relationship, to experience empathy and understanding, and to do the majority of the talking (Swift & Callahan, 2010). The agreement between the task, goals, and the maintenance of the bond lead to positive psychotherapeutic outcomes (Figure 2).

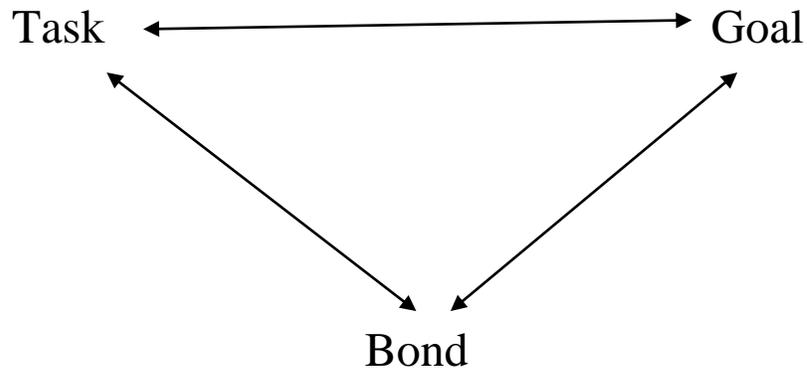


Figure 2. The Bordin (1979) model of the components of therapeutic alliance.

The exact mechanisms that allow therapeutic alliance to influence outcome have frequently been debated in the research literature. Researchers have generally supported two opposite positions; therapeutic alliance is the byproduct of symptom reduction, or therapeutic alliance provides an environment that promotes symptoms reduction (Crits-Christoph et al., 2006a; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Crits-Christoph et al. (2006a) suggest that as symptoms improve, the alliance is likely to improve. When considering the factor model suggested throughout this paper, it is possible that expectancy effects could lead to symptom reduction and a positive view of psychotherapy. Using this hypothesized relationship, the therapeutic alliance should deteriorate as soon as symptom reduction slows in later stages of treatment. Researchers have found that the formation of a positive therapeutic alliance in the early stage of treatment is the best predictor of psychotherapy outcome and a moderate predictor for later alliance ratings (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Baldwin, Wampold, & Imel, 2007). These findings suggest that the therapeutic alliance occurs prior to symptom reduction and lasts longer than the initial reduction. When

conceptualizing the therapeutic alliance through the Bordin (1979) model, one would expect that the bond would strengthen with symptom reduction. Most psychotherapists would agree that the primary goal of an individual attending counseling would be to “feel better” and movement towards that goal would positively affect the therapeutic alliance.

Crits-Christoph et al. (2006a) also suggest that researchers should continue to investigate the factors of the therapeutic alliance that contribute to the outcome. They hypothesized that therapeutic alliance, theoretical orientation, specific interventions are all critical to understanding factors related to therapy outcome. The majority of the variance explained in psychotherapy outcome occurs outside of therapeutic relationship and treatment. While future research can explore methods to utilize expectancy effects and extratherapeutic factors to benefit clients, it is important to consider the variance that can be directly influenced by the therapist. Despite the generally dismissive views of the Crits-Christoph et al. (2006a) article, Crits-Christoph et al. (2006b) conducted a follow-up study to determine if supervision focused on fostering the therapeutic alliance would result in significant improvement in psychotherapy outcomes. The study only used five psychotherapists, and the results were trending towards significance. While the results of the study were not significant, it supports the idea that fostering the therapeutic alliance through supervision could be a tool to improve psychotherapy outcomes in the future. Additional research is needed to determine the mechanisms that lead to the initial formation and maintenance of therapeutic alliance so that education and supervision can be developed.

Problems in establishing and maintaining a strong the therapeutic alliance can significantly and adversely impact both the therapist and the client. As previously

mentioned, a weak alliance is related to higher dropout rates and poorer outcomes. Approximately 20-30% of clients terminate psychotherapy prematurely (Swift, Greenberg, Whipple, & Kominiak, 2012). Six factors have been suggested to contribute to premature termination and suggestions are made to assist in reducing the impact of each factor in the therapeutic relationship. Half of the factors proposed by Swift et al. (2012) are related to therapeutic alliance; incorporating the client's preference, strengthening hope and fostering the therapeutic alliance. Each of these factors has been discussed thoroughly throughout this paper while evaluating the therapeutic relationship. These factors highlight the importance of establishing a collaborative alliance early in therapy and continuing to build the alliance throughout. High dropout rates can affect the financial health of a therapist's practice and lead to increased stress. One of the most consistent concerns mentioned in the *APA Monitor on Psychology* is financial stability in early career psychotherapists. High dropouts and financial concerns can lead to over-committing to large caseloads. Appropriate attention to and fostering of the therapeutic alliance could be a way for novice psychotherapists to balance caseloads, reduce dropouts, improve outcomes and stabilize financial insecurities in private practice.

Therapist Personality and Therapeutic Alliance

Researchers have demonstrated that therapeutic alliance is vital to positive psychotherapy outcomes and have identified variables that can have a negative impact on therapeutic alliance. Research has not been able to identify personality factors that contribute to establishing a therapeutic alliance. Research has proven that psychotherapy is effective and that a positive therapeutic alliance is responsible for some of the

effectiveness. However, less is known regarding the specific components of personality that allow for a therapeutic alliance to be developed. Researchers have found that clients prefer to feel connected to the therapist, experience empathy and understanding and that the client will do the majority of the talking (Swift & Callahan, 2010). This study proposes that one of the mechanisms that may create an environment conducive for the therapeutic alliance to develop is the psychotherapist personality.

Personality traits may have a large role in determining a therapist's ability to establish and maintain an alliance. Conducting effective psychotherapy requires specific skills and temperament that suits some individuals more than others. Keirse (1998) even includes "the counselor" as a temperament when describing the characteristics of the Myers-Briggs Inventory (MBPI). While research has generally dismissed temperament theory, the conceptualization of a counselor fits with the research on therapeutic alliance. The *Counselor archetype* describes the individual as empathic, having abilities to identify others' emotions, and having a desire to help others achieve their goals (Keirse, 1998). Researchers have found that psychotherapist, both professional and paraprofessionals, are more effective in identifying emotional experiences and handling trauma than laypersons even while controlling for education (O'Brien & Haaga, 2015). When comparing a novice versus experienced psychotherapist, the ability to correctly identify emotional experience and handle traumatic information is not statistically significant. Researchers have suggested that individuals that enter the mental health field are more likely to have a specific personality suited to identifying emotional experiences and handling trauma (O'Brien & Haaga, 2015). These findings suggest that there may be a set of personality traits that are conducive to creating an empathic environment and establishing working

alliances with others. Researchers have found that psychotherapists tend to have a similar personality profile, especially when using the Five Factor Model (FFM) (Chapman, Talbot, Tatman, & Britton, 2009; Saarnio, 2010). Since personality traits are thought to be generally stable throughout life, it is likely that individuals drawn to psychotherapy already have some innate ability to be empathic, identify emotions, and create a bond with others.

Chapman et al. (2009) conducted a study on the effects of personality on therapeutic alliance. They used the NEO-Five Factor Inventory (NEO-FFI) to develop a profile for each therapist and compared each of the five factors to the client reported alliance. The NEO-Five Factor Inventory creates a profile that scales the individual's personality traits on five different factors; Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. The NEO-FFI has been standardized to show how individuals vary compared to the general population. Psychotherapists generally fall lower than the general population on Neuroticism and higher than the general population on Openness to experience, Agreeableness, and Conscientiousness. The researchers found that higher levels of Neuroticism, within the psychotherapist population, were associated with better client reported alliance. However, the highest levels of Openness and Agreeableness were associated with lower levels of client reported alliance. The personality profiles were consistent with other studies that have used the NEO-FFI with mental health providers globally (Saarnio, 2010). The stereotypical personality profile of mental health providers is consistent with the expectations of psychotherapists. In general, psychotherapists are expected to have developed effective coping skills, have advanced communication skills, and be more

open and accepting of others. These findings suggest that the stereotypical psychotherapist personality is the most conducive to psychotherapy outcome.

Studies looking at psychotherapists' personality profiles all suggest that, in general, psychotherapists do not conform to the means of the general population. The means for all the scales on the NEO-FFI are 50, with a standard deviation of 10. However, Saarnio (2010) found that the mean for Neuroticism was in the low 40's for psychotherapists and that Openness and Agreeableness means were in the upper 50's. This is an important distinction when looking at research regarding psychotherapists' personality profile on the NEO-FFI because qualitatively a high score on Neuroticism would be anything above 50, but in the general population, we would be looking at scores in the 60's. Likewise, a low Agreeableness score within psychotherapists may be represented by scores below 55; however, in the general population, a low score would be represented by scores in the 40's. The purpose of this study, we compared participants to the means of psychotherapists, not to the means of the general population.

This study planned to evaluate whether specific personality profiles are associated with better client reported therapeutic alliance. Additionally, we plan to investigate whether the relationship between a personality profile and therapeutic alliance can be modified through the use of education. Since the 1950's, Carl Roger has emphasized the importance of empathy and unconditional positive regard. Graduate school programs, continuing education seminars, clinical supervision, and textbooks have all been used to cultivate and strengthen empathic abilities in psychotherapists. We believe that education and supervision can be utilized to improve the therapeutic alliance and the use of personality traits to improve psychotherapy outcomes.

Specific Aims and Hypotheses

The purpose of this study is to fill a gap between research on the importance of therapeutic alliance and the effects of personality traits on the development of the alliance. As evidenced throughout the research presented, therapeutic alliance is an important predictor of outcome and can be influenced by an individual's characteristics. This study builds on previous studies by attempting to influence the effects of personality traits on the therapeutic alliance through education. Crits-Christoph et al. (2006b) conducted a pilot study to determine if the therapeutic alliance could be improved through supervision and education. They hypothesized that the ability to develop and maintain a positive therapeutic alliance could be taught through supervision. The results of the study were trending towards positive despite the study only containing five therapists and three clients per therapist. Crits-Christoph et al. (2006b) used multilevel modeling to analyze the data. Determining power for multilevel modeling cannot be done until after the data is collected, but it is suggested to have a minimum of 300 data points. This study further evaluates the relationship between the psychotherapist's personality and client reported therapeutic alliance.

Hypothesis 1

We hypothesize that there will be a relationship between the psychotherapist's personality profile using the NEO-FFI and client reported therapeutic alliance using the Working Alliance Inventory-Short Form (WAI-S). Specifically, we hypothesize that higher levels of Neuroticism, compared to other mental health professionals, will be associated with higher ratings of therapeutic alliance (Hypothesis 1a). We hypothesize

that $T > 70$ Openness and Agreeableness will be associated with lower levels of client reported therapeutic alliance (Hypothesis 1b). We do not expect to find a relationship between Extraversion or Conscientiousness and client reported therapeutic alliance.

Hypothesis 2

We hypothesize that clients whose therapists received the therapeutic alliance focused intervention will report higher scores on the WAI-S than clients whose therapists did not receive the training. The therapeutic alliance focused intervention provided feedback to the therapists on their individualized personality profile, along with research on the role of therapeutic alliance in outcome, and specific ways to address therapeutic alliance within treatment. We hypothesize that the therapists that received the training would implement the information presented in the seminar, and clients will report a stronger therapeutic alliance.

Hypothesis 3

We hypothesize that therapists with the lowest rated therapeutic alliance scores on the WAI-S will also have $T < 50$ on Openness and Agreeableness on the NEO-FFI. We do not expect to find a significant relationship between Neuroticism, Extraversion, or Conscientiousness.

Hypothesis 4

We hypothesize that $T > 60$ on Openness and Agreeableness will be significantly related to better scores on the WAI-S. Specifically, we hypothesize that therapists with

$T > 60$ on Openness and Agreeableness will have better ratings on the WAI-S. We also hypothesize that therapists with Openness and Agreeableness scores in the high or very high range will have better outcomes than those with Openness or Agreeableness scores in the low range.

This study will focus on early career, graduate level, psychotherapists. Early career is defined as having 1-3 years of psychotherapy experience including practicum and internship experiences. Early career psychotherapists are less likely to have developed compensatory skills to address barriers to building a therapeutic alliance. If the hypotheses are held in this study, this population would be the initial target for future studies and educational courses on factors contributing to the therapeutic alliance. These findings could be used to modify graduate school training and clinical supervision. Even if hypotheses 1a and 1b are not supported, this study can provide data on the usefulness of training on therapeutic alliance.

CHAPTER TWO

METHODS AND MATERIALS

Participants and Procedures

Graduate level psychotherapists were recruited from local outpatient counseling centers (n= 50). Participation was open to all genders, race, age, and ethnicity. Specific demographic information was not collected from participants during the study; however, participants' self-report age during training ranged from early 20's to early 60's. The majority of the participants identified with a primary discipline of Marriage and Family Therapy (MFT) (n= 34), followed by Clinical Psychology (CP) (n= 10), and Social Work (SW) (n= 6). Several participants that identified a primary discipline of MFT also identified pursuing licensure as a Professional Clinical Counselor (PCC). All participants were providing outpatient mental health services to adults throughout the study. Initially, 57 participants volunteered to complete the study. Five participants were removed from the study for failing to complete the NEO-FFI, and two participants were removed because they were not able to have clients complete the WAI-S and ORS. A total of 50 psychotherapists participated in the study.

The therapists completed the NEO-Five Factor Inventory (NEO-FFI) at the beginning of the study. The NEO-FFI provides a personality profile on five personality traits that are considered cross-culturally valid (Costa & McCrae, 1992). Participants were provided with the option to complete the NEO-FFI online through iPARCONNECT, a secure assessment administration system available through PAR inc., or by completing a paper-based version. Therapists were provided with several copies of the WAI-S and the ORS with their participant identification number listed on the survey.

De-identified data was provided to the researchers in electronic form with the value for each response, with the original document being placed in the client’s chart. Therapists were encouraged to provide the WAI-S as early in treatment as possible, and they were encouraged to provide the measure to as many willing participants as possible during the collection phase of the study. The majority of practicum students reported working approximately 15 hours per week and managed a caseload of 7-12 individuals seen in weekly or bi-weekly settings. Psychotherapists were instructed not to provide the WAI-S or ORS to individuals from group therapy unless they also provided the individual with one-on-one therapy.

Table 1. Participant demographics

	<i>N</i>	<i>Min</i>	<i>Max</i>
<i>Discipline:</i>			
MFT	33		
LCSW	7		
Clinical Psych	10		
Average Age	34	24	61
Average Years of Practice	1.9	.5	4
<i>Gender:</i>			
Female	38		
Male	12		

Therapists were randomly assigned to one of two group; a training first group or a control group. Table 1 contains the general demographics of participants. Two outpatient counseling centers were randomly selected to participate in the training first condition.

Ideally, therapists would be randomly assigned regardless of work setting; however, the researchers were concerned about the possibility of the training or topic to be addressed with individuals assigned to the control condition. Additionally, grouping the clinicians by their assigned clinic allowed for a supervisor from each clinic to attend the training. The supervisors reported that they intended to incorporate therapeutic alliance into supervision after attending the training. The remaining participants were invited to attend the same training after the data collection phase was completed. The training was open to a clinical supervisor from each site. A total of 235 surveys were returned for an average of approximately five surveys completed per therapist.

Statistical Methods

Hierarchical Linear Modeling (HLM) is a statistical analysis that accounts for predictors that occur at a higher level than the outcome measures. Hierarchical Linear Modeling can be conducted in a single analysis or longitudinally. This study proposes to use a single data collection method to determine the role of personality on the therapeutic alliance. In this study, the therapeutic alliance reported by clients are the outcome variable and are placed at level one. The ORS collected from the clients will be the level, one predictor. As previously stated, researchers have hypothesized that outcomes may affect the therapeutic alliance. The ORS will measure the client's perception of change prior to the measurement of the therapeutic alliance. The personality of the therapists is a higher order predictor variable. Additional higher order predictors will include participation in the educational seminar and level of education. Each therapist had several clients reporting their evaluation of the alliance. Some of the variances between the

personality of the therapist and the client reported alliance is likely to be shared. HLM accounts for this shared variance by estimating slopes for each level. Regression coefficients are produced in the analysis for interpretation (Woltman, Feldstain, MacKay, Rocchi, 2012). Prior to analysis, researchers ensured that all the assumptions of HLM were met.

Since HLM is used to analyze data that occurs on multiple levels, it is difficult to accurately predict power or sample size prior to the collection of data. The majority of statistical analyses rely on effect size and alpha level to determine power starting a study. This informs the researchers on how many participants are required to find a significant finding. However, the power level of HLM is determined by effect size, sample size, and the covariance structure (Fang, 2006). The covariance structure can only be determined once the data is collected. For the current study, the researchers were aiming to collect data from 100 therapists (level two) and for each therapist to collect at least 5 WAI-S and ORS during the collection time. Optimal Design is a new program similar to G*power that attempts to estimate power and the number of participants required for multilevel modeling. This program is new in development and is currently collecting empirical support to determine its usefulness. Using the data from this study, Optimal Design estimates that approximately 47 therapists with 5 clients each will likely detect a moderate effect. The proposed model is illustrated in Figure 3.

To determine the effects of specific personality traits on therapeutic alliance and psychotherapy outcome, psychotherapists were divided into sub-groups based on T-scores on specific NEO-FFI scales, by total score on WAI-S scales, and by overall functioning score measured on the ORS. One-way ANOVAs were run using the selected

groups of individuals to determine significant differences between groups. Researchers ensured that all the assumptions of ANOVA were met prior to analyzing the data.

Psychotherapists were divided into subgroups by their NEO-FFI score and the scoring profile associated with the measure. Categories consisted of Low ($T= 35-44$), Average ($T= 45-55$), High ($T= 56-65$), and very high ($T > 65$).

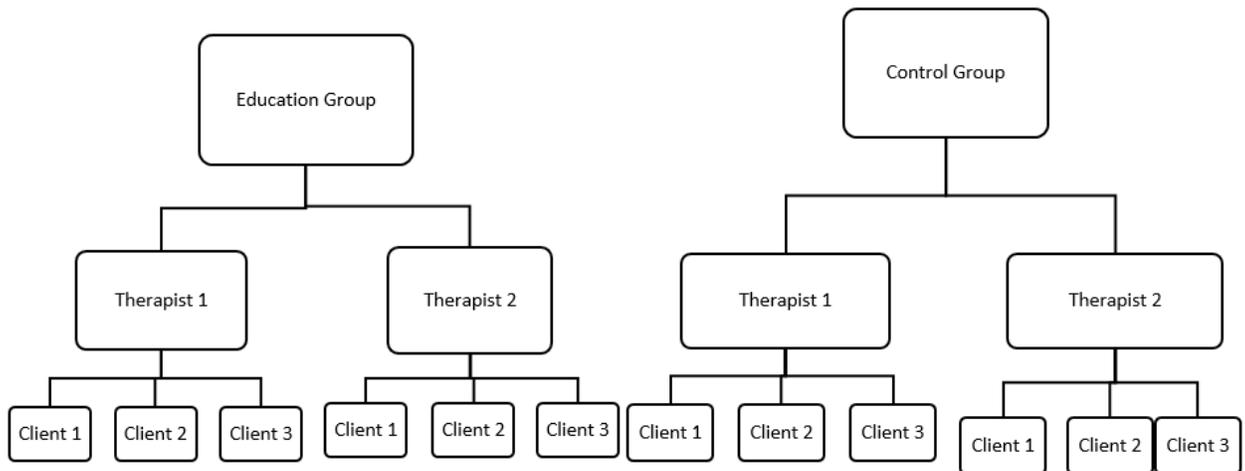


Figure 3. The proposed multilevel model of statistical analysis. Each psychotherapist will be assigned to the education or control group. Clients will be nested under their psychotherapist.

As an additional strategy to measure hypothesis four, which suggested that higher levels of Openness and Agreeableness would be associated with higher scores on the WAI-S, psychotherapists were divided in the top ten based on WAI-S scores and lowest ten based on WAI scores. The remaining psychotherapists were grouped together to serve as a comparison group. As previously mentioned, researchers suspected that there might be personality differences that may impact the therapeutic alliance. By comparing the highest rated psychotherapists with the lowest rated psychotherapists, the researchers

were able to identify the existence of any personality differences. To sort the psychotherapists into groups the average WAI-S was calculated, then to break any ties the researchers used the number of WAI-S returned (high numbers rated higher), number of WAI-S that contained ratings of all 7's, average ORS overall rating, number of ratings below 7 on the WAI-S, and finally the lowest WAI-S. The ranking order allowed the ten highest rated therapist and the ten lowest rated therapist to be group.

Instruments

Working Alliance Inventory-Short

The Working Alliance Inventory-Short was developed as a repeatable tool within therapy based on the longer Working Alliance Inventory (Tracey & Kokotovic, 1989). The WAI-S is a 12 question Likert scale that measures the client's or therapist's views on the task, bond, and goals of therapy. Factor analysis on the WAI-S has produced these three subcategories. However, researchers have found that the subcategories are highly correlated and difficult to interpret (Horvath & Greenberg, 1989). The WAI-S has consistently shown high reliability ($\alpha = .85-.90$) and high correlations with outcome measures such as the OQ-45.2 (Busseri, & Tyler, 2003). This study plans to use the total score of the WAI-S, which ranges between 12 and 84 with a higher score meaning a stronger alliance. Two items on the WAI-S were reverse scored, question four and question ten because the items imply that the therapist and client disagree on tasks and goals.

NEO-Five Factor Inventory

The NEO Five-Factor Inventory (NEO-FFI) is a 60-item questionnaire that uses a Likert scale between one and four to describe the individual completing the assessment. The NEO-FFI is a shorter version of the NEO Personality Inventory that maintains high reliability with the longer form. The NEO-FFI can be administered electronically or using a paper-based method. The results provide a scaled score on five factors; Neuroticism, Extraversion, Openness to Experiences, Agreeableness, and Conscientiousness. Each factor can be evaluated for subcategories to assist in understanding the functioning of the personality further. For this study, the five primary factors will be used as predictors for therapeutic alliance.

Outcome Rating Scale

The Outcome Rating Scale is a measure of overall being that is broken down into four subscales; individual well-being, interpersonal well-being, social well-being, and overall well-being. (Miller & Duncan, 2000). The ORS has shown similar predictive properties as the OQ-45, which is often used to track improvements throughout treatment (Seidel, Andrews, Owen, Miller, & Buccino, 2017). Researchers have found that the ORS has increased sensitivity to subjective distress; however, test-retest reliability and validity measures have shown that responses are predictive of improvement in therapy. The ORS contains four total subscales, and the measure can repeatedly be administered throughout treatment to track improvements over time. For the purpose of this study, the ORS was administered at the beginning of therapy appointments to capture the client's overall functioning. The ORS has high reliability ($\alpha = .93$) and high correlations with other

outcome measures such as the OQ-45.2 ($r = .6$) (Miller, et al., 2003). The high ratings of validity and reliability are significant considering that the ORS consists of 4 questions compared to the OQ-45's 45 questions. Researchers have found the measures to be equivalent in the predictability of outcome, and the ORS scores moderately correlate with OQ-45 sensitivity scores. While specific information can be extracted from the OQ-45, the ORS provides an alternative to measuring general functioning quickly. Additionally, when comparing scores on the ORS and OQ-45 administered in a repeated measures fashion, researchers have found a moderate correlation between the measures ($r = .53$) (Miller, et al., 2003). These results suggest that the ORS can repeatedly be administered across treatment, and can accurately measure and predict therapeutic outcomes.

Therapeutic Alliance Focused Intervention

Therapeutic Alliance Focused Intervention (TAFI) was developed by the researchers specifically for the study. The goal of the intervention for this study was to provide a transtheoretical approach to incorporating therapeutic alliance skills into treatment. Therapeutic alliance skills were defined as interventions specifically used to develop, maintain, repair, and provide feedback on the therapeutic alliance. The intervention was designed to be interactive to allow participants to practice skills introduced during the training and receive feedback from the facilitators. The training was categorized into three general topic areas: an overview on current literature regarding therapeutic alliance and outcomes; specific skills used to build, maintain, repair, and measure alliance; and the interaction between personality traits and therapeutic alliance. During the training, participants received feedback on their personal NEO-FFI profile.

The training lasted approximately 6 hours and was conducted in a conference room with a combination of PowerPoint slides, videos, and activities. Questions were answered throughout training, and feedback was provided during practical exercises. Training began by reviewing the current literature on psychotherapy outcomes and therapeutic alliance. Facilitators reviewed factors that contribute to positive and negative outcomes in therapy. Information was provided about the medical model for the treatment of psychiatric conditions, as well as the development of common factors. Facilitators emphasized research that included multiple therapeutic approaches to ensure that participants understood that the training was applicable regardless of theoretical orientation within treatment, and was effective even when incorporated in manualized treatment methods. Participants were provided examples from research that demonstrated the lack of significant difference between treatment approaches. Additional information was provided about the role of therapeutic alliance within supervision for the supervisors that attended the training. This portion of training concluded with a discussion on the high degree of emphasis placed by graduate training programs on empirically supported treatments relative to the therapeutic alliance, despite the evidence suggesting that many factors other than therapeutic technique influence outcome more strongly. Evidence was provided to support the idea that therapeutic alliance can be incorporated into any Evidenced Supported Treatment, and that majority of theoretical orientations now emphasize the importance of the therapeutic relationship. Motivational Interviewing has recently split autonomy, a component of the spirit of Motivational Interviewing, into empathy and support. This change reflects the growing emphasis of therapeutic alliance within Evidence Supported Treatments.

A specific goal of the intervention was to ensure that participants learned skills that could be applied in therapy after completing the training. Researchers have not developed interventions with the specific goal of building therapeutic alliance, and many of the prominent researchers in the field of therapeutic alliance disagree on the specific ingredients that make up the alliance. For this training, the facilitators identified specific communication strategies from Client-Centered Therapy and Motivational Interviewing. Motivational Interviewing was identified because it is considered an evidence-supported intervention, and is a way of communicating with clients while emphasizing respect and collaboration. Many of the factors mentioned previously that contribute to therapeutic alliance involve effective communication, both listening and reflecting, as well as a collaborative relationship (Rollnick, Miller, & Butler, 2008). Motivational Interviewing was also applicable because it is not considered a theoretical orientation, but instead a skill to be used to identify the client's motivations and goals for treatment. These skills align with the factors that contribute to the working alliance, which consist of agreement on task and goals, and an underlying bond of trust and respect (Swift & Callahan, 2010). The participants practiced skills in establishing an alliance, maintaining an alliance, and repairing a rupture in the alliance. Facilitators also reviewed common methods to measure the therapeutic alliance including the WAI-S, the OQ-45.2 TA, and the FIT system developed by Dr. Scott Miller. Participants were provided examples of each measurement tool and were provided examples of how feedback would be addressed from each measure.

The final component of the training consisted of information on the role of personality traits, and traits of psychotherapists on outcome. Participants were provided

with information on their personality profile, as well as information on how research has demonstrated common traits among psychotherapists globally. Facilitators reviewed the effectiveness of training on therapeutic alliance on improving therapeutic alliance (Crits-Christoph, et al., 2006a; Muran, Safran, Eubanks, & Gorman, 2018). Participants were encouraged to reflect on their interactions with clients and identify personality traits that may be beneficial and traits that may harm the therapeutic alliance. Facilitators also reviewed the normal development of novice therapists and the common anxiety associated with making a mistake in therapy. Facilitators consistently emphasized the importance of the relationship, regardless of experience, to improve psychotherapy outcomes. Finally, participants were encouraged to identify their own internal motivations to incorporate the skills learned in training. The goal of this final exercise was to encourage participants to use the skills after training. Researchers have found that newly acquired skills are not always implemented if there is low motivation, or low perceived reward for implementing those skills (Schumacher, Madson, & Nilsen, 2014). Additionally, facilitators reviewed the role of supervisors in encouraging, developing, measuring, and demonstrating therapeutic alliance within the supervisory relationship.

CHAPTER THREE

RESULTS

The results of the NEO-FFI were consistent with previous research that found mental health professionals demonstrate higher levels of Extroversion ($M= 57, SD= 8.01$), Openness ($M= 61, SD= 6.13$), and Agreeableness ($M= 57, SD= 8.32$) than the general population. Psychotherapists generally scored lower than the general population on Neuroticism ($M= 48, SD= 7.68$), with the less than 10% of the psychotherapists placed in the High range ($T > 55$). Table 2 shows the means for each of the Five Factors and Figure 4 shows the distribution of the profiles on each factor. There were no identifiable distinct relationships between psychotherapist personality profile and their level of education or the professional license they are pursuing. Additionally, there were no relationships between the gender of the psychotherapist and their personality profile.

Table 2. Frequency analysis of NEO-FFI Factors

	<i>Mean</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>
Neuroticism	48.16	7.68	35	71
Extraversion	57.02	8.08	37	74
Openness	61.46	6.13	43	72
Agreeableness	56.92	8.32	38	72
Conscientiousness	55.08	8.52	40	71

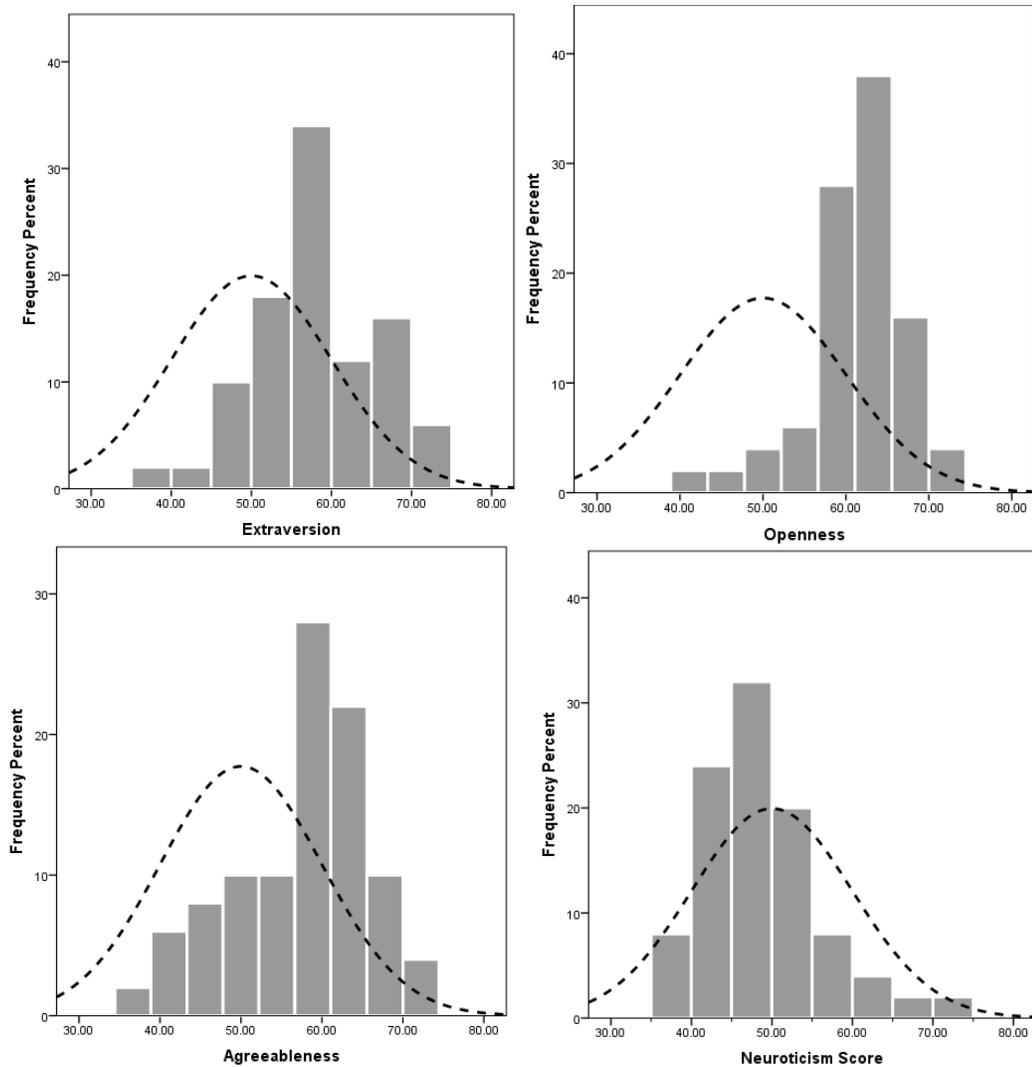


Figure 4. The frequency of scores on selected scales of NEO-FFI. Psychotherapists generally scored lower on Neuroticism, and higher on Extraversion, Openness, and Agreeableness. The dotted line represents the standard curve for the NEO-FFI.

The WAI-S and the ORS surveys were completed by clients following a session. Of the 242 surveys returned, 188 of them contained scores of all sevens on the WAI-S. The remaining 54 surveys contained no scores lower than a five and had an average score of above 6.5. The average rating across all conditions for the WAI-S was 83.62. The ORS results found an average rated score of overall well-being was 77mm across both

conditions. The lack of variance due to a ceiling effect on the WAI-S eliminated the possibility of conducting a multilevel model. A new variable was created to measure the number of non-perfect WAI-S's completed per therapist. The assumption of linearity was met using this new variable as the residuals were generally randomly scattered on the plot. The assumptions that the residuals are normally distributed was also met. Figure 7 contains scatter plots of the residuals necessary for the multilevel modeling. The model violated the assumption of homogeneity of variance ($p < .01$). The violation of this assumption eliminated the possibility of creating a multilevel model using the newly created variable. A similar process was completed by creating a new variable using the two lowest scores on the WAI-S. Similarly, the new variable met the assumptions of linearity and normal distribution of residuals but violated the assumption of homogeneity of variance.

A correlation matrix was analyzed, and a relationship between Agreeableness and the frequency of non-perfect WAI-S was found (Table 3). To better understand the role of Agreeableness, we divided the psychotherapists into groups of highest rating, average rated, and low rated therapeutic alliance based on the number of non-perfect alliance ratings. When comparing the highest rated therapists to the lowest rated therapists, there were some differences in the WAI-S scores. The ten highest rated therapists had an average of six clients complete the WAI-S and ORS compared to the four clients for the lowest rated psychotherapists. Additionally, all ten of the lowest rated psychotherapists had at least two WAI-S returned with at least one score of a six. All ten of the highest rated psychotherapists scored all sevens on all returned copies of the WAI-S. The top ten psychotherapists group was comprised of four Clinical Psychology interns, five Marriage

and Family Therapy interns, and one Clinical Social Worker intern. The group of lowest rated psychotherapists was comprised of eight Marriage and Family Therapy interns and two Clinical Social Worker interns.

Table 3. Correlation between NEO variables, working alliance, and outcome measures

	1	2	3	4	5	6	7	8
1. Non-Perfect Scores	1							
2. Surveys Completed	-.38**	1						
3. Neuroticism	.17	-.14	1					
4. Extraversion	-.11	.07	-.33*	1				
5. Openness	-.21	.28*	-.22	.23	1			
6. Agreeableness	-.65**	.39**	-.30*	.16	.01	1		
7. Conscientiousness	.06	.07	-.10	-.02	.05	.11	1	
8. ORS Average	.02	-.23	.23	-.08	-.03	-.20	.03	1
9. Training Group	-.13	-.14	-.19	.08	.19	-.01	-.01	-.004

Note: * denotes $p < .05$, ** denotes $p < .01$

There was an overall, significant main effect of psychotherapy group on the personality factor Agreeableness in the one-way ANOVA, $F(2, 39) = 7.09, p < .001$ (Table 4). There was significant between the highest rated psychotherapist group and the lowest rated psychotherapist group ($p < .01$) and a significant difference between the lowest rated psychotherapists group and the psychotherapists rated in between the two groups ($p < .05$) (Table 5). However, there was no significant difference between the highest rated group of psychotherapists and the psychotherapists rated between the two groups ($p > .25$). Figure 5 displays the mean scores on the Agreeableness scale by

psychotherapist group. Table 4 contains the between group means, standard deviations, and significance of the difference between group. There was no significant group difference on the personality factors of Extraversion ($p > .6$) or Openness ($p > .1$).

Table 4. One-way ANOVA comparing psychotherapy group by T-score on Agreeableness

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Between Groups	786.01	2	393.01	7.09	.002
Within Groups	2603.67	47	55.40		
Total	3389.68	49			

Table 5. ANOVA Comparisons of Agreeableness by psychotherapist group

Group	<i>n</i>	Mean	<i>SD</i>	Tukey's HSD Comparisons		
				High	Low	Control
High Rated	10	61.9	3.5			
Low Rated	10	49.7	7.7	.002*		
Control	30	57.7	8.2	< .24	.014*	

* denotes $p < .05$

There was no significant effect of psychotherapy group on the ORS overall rating scores ($p > .6$). There was no significant difference between psychotherapists with high scores on Openness and Agreeableness and psychotherapists with elevations on only one of the scales ($p > .6$). Additionally, there was no significant difference in ORS or any of the five personality factors by education (Table 6). There were no significant differences

between the type of license pursued and level of Agreeableness ($p > .05$). Figure 6 shows the levels of Agreeableness for each type of license pursued.

Table 6. One-way ANOVA comparing psychotherapist gender and education by T-score on Agreeableness

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	<i>Eta</i> ²
Discipline	377.04	2	188.50	2.99	.06	.120
Gender	184.30	1	184.30	2.92	.094	.062
Discipline x Gender	284.72	2	142.36	2.26	.117	.093

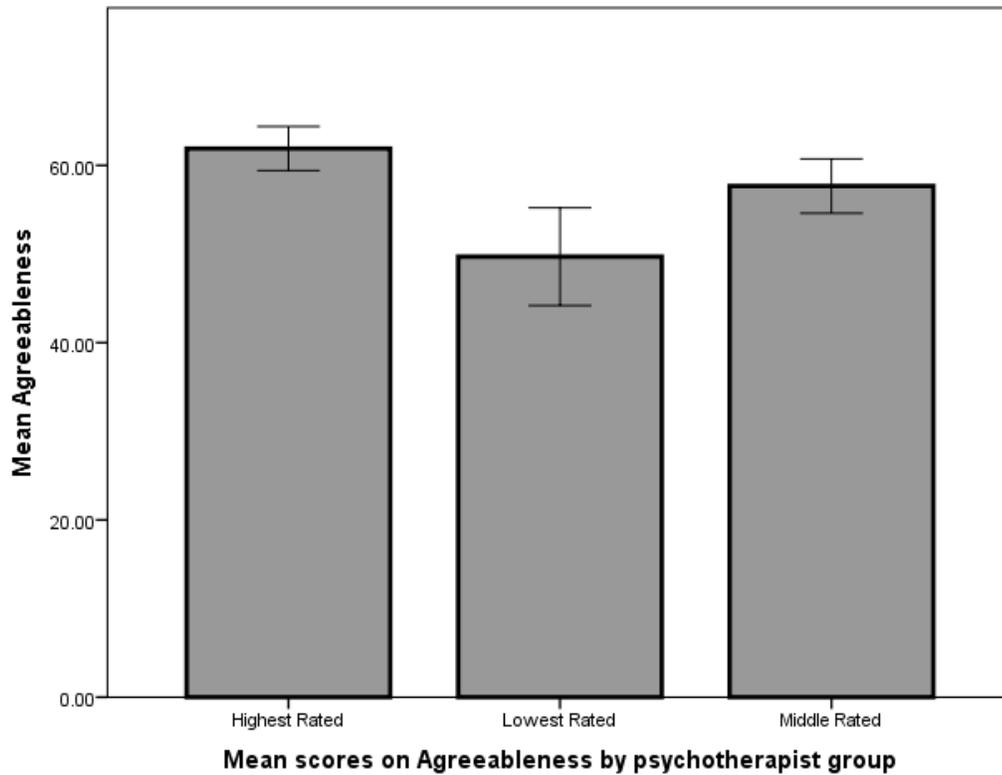


Figure 5. The means of scores on the Agreeableness scale of NEO-FFI. Psychotherapists were divided into three groups: highest rated therapeutic alliance, lowest rated therapeutic alliance, and middle rated. The lowest rated therapeutic alliance psychotherapists had significantly lower scores on Agreeableness compared to the highest rated group and the middle group.

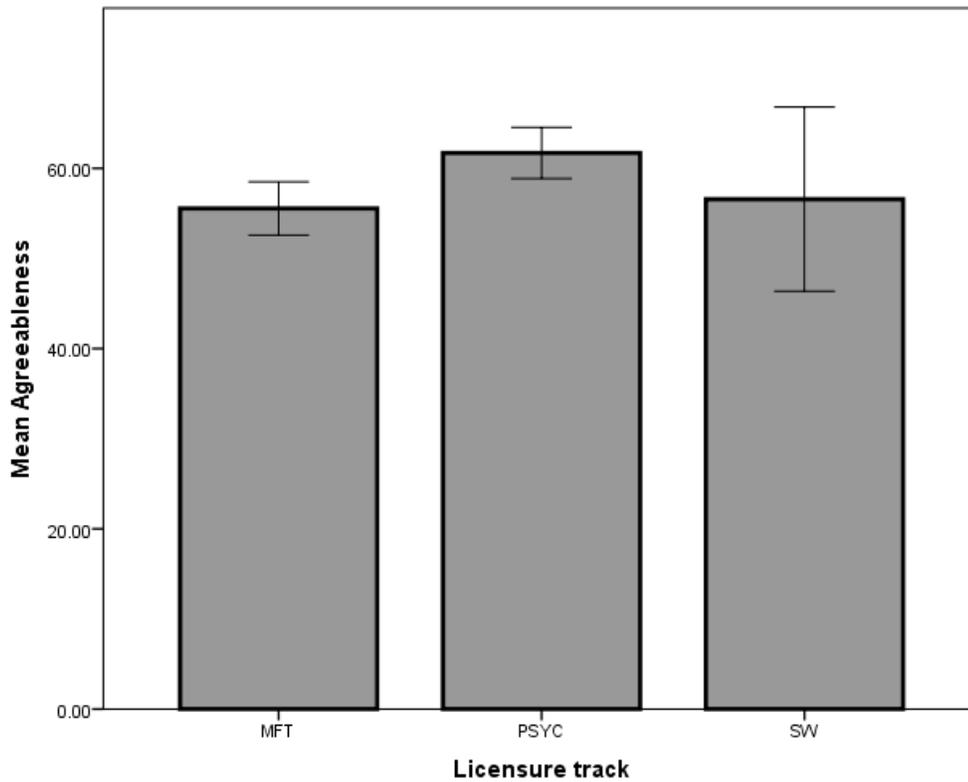


Figure 6. The means of scores on the Agreeableness scale of NEO-FFI. Psychotherapists were divided into three groups by the license they were pursuing. There was no significant difference between groups on scores of Agreeableness.

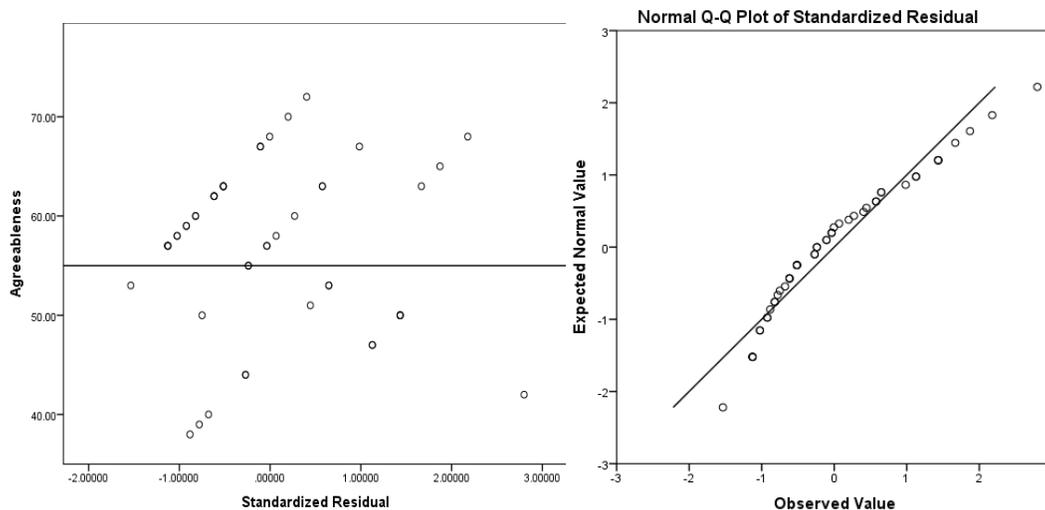


Figure 7. Scatter plots of the residuals to determine if the variables meet the assumptions of linearity and normal distribution of residuals. There is randomness to the residuals compared to the predictor, and the residuals generally fit along the predicted line.

CHAPTER FOUR

DISCUSSION

Overall, the results of the current study were consistent with major components of previous research and partially consistent with the fourth hypothesis. Overall, higher levels of Agreeableness were associated with higher ratings of therapeutic alliance, as well as the highest level of participation in the study. The results did not indicate any curvilinear relationships. Therefore, there was no support for the hypothesis that the highest levels of Openness and Agreeableness were associated with poorer outcomes. Additionally, we did not find any relationship between Neuroticism and therapeutic alliance. When looking at the personality profiles of the psychotherapists that participated in this study, the majority of the factors had a limited range of distribution. While the means of each personality factor is consistent with previous research on psychotherapists, it is possible that a larger sample or a wider geographical sampling may identify other personality factors that contribute to therapeutic alliance and outcomes.

While there is no way to determine the numerous factors that contributed to the number of WAI-S collected by each therapist, it is worth noting that the psychotherapists rated the highest in terms of alliance collected between six and seven WAI-S, while the lowest rated therapists only collected between three and four surveys. High levels of Agreeableness on the NEO are associated with higher levels of empathy, warmth, kindness, and collaborative according to the interpretive manual. When evaluating the questions measuring the scale, it is easy to see how these traits would be beneficial in treatment (Swift and Callahan, 2010). Low scores on Agreeableness are associated with poor interactions with individuals, more frequent critical responses, rigid adherence to

opinions, and frequent confrontations when challenged by others. These traits are frequently cited in the literature as being damaging to the therapeutic alliance. It is important to remember that the psychotherapists who scored lower on the Agreeableness factor generally scored within the average range compared to the general population. These psychotherapists are not likely to be brash and confrontational in general but instead, are balanced between the two descriptions. When looking at specific items that the lowest rated psychotherapists received a score of less than seven, many were items that evaluated whether the client felt like the therapist liked them, whether the therapist appreciated them, and if the client believed that the therapist was addressing the problems that the client wanted to address. Based on this description, it is reasonable to suggest that psychotherapists who score lower on Agreeableness, compared to other psychotherapists, may be more likely to use confrontation, may not communicate as much empathy through verbal and non-verbal language, and may be more likely to emphasize the importance of working on goals that are more important to the psychotherapist rather than the client. The current study was not designed to identify specific behaviors that may account for lower ratings of therapeutic alliance. Additional research is needed to determine if there are specific observable differences between psychotherapists with varying scores on the Agreeableness factor.

The current study was also consistent with previous research in that education, license designation, and gender were not significant predictors of therapeutic alliance rating or psychotherapy outcome. One factor to consider in light of the current study design is that all the participants were pre-licensed clinicians. The ten Clinical Psychology interns were in the process of completing the requirements for their doctorate

degree, and their clinical experiences were primarily acquired through practica. The Clinical Psychology interns had likely only completed one to two additional years of classes at the time of the study. Their exposure to clinical classes, and ability to work in multiple areas across the scope of their practice was likely limited. However, researchers have found no significant difference between doctorate level and master's level licensed clinicians in outpatient settings. The results of the null finding in this study imply that doctorate level clinicians are no more prepared than master's level clinicians to establish and maintain a therapeutic alliance in outpatient psychotherapy. These results are also consistent with other studies in which therapeutic alliance measures completed on licensed clinicians indicate that licensed clinicians do not demonstrate better alliance rating than therapists in training. The overall results suggest that mechanisms other than level of education can predict therapeutic alliance and psychotherapy outcome differences.

One finding that was not consistent with previous literature was that Openness was not significantly associated with therapeutic alliance ratings. The mean and range of scores on the Openness scale in the current study were in the high average range and lacked the amount of variance identified in the Agreeableness factor. High levels of Openness were associated with the therapist's interests in developing new experiences and having increased awareness of their emotions and the emotions of others. Being aware of one's own emotions and the client's emotional experience is likely an important part of the therapeutic alliance. However, there was not a significant difference between the highest rated psychotherapists and the lowest rated psychotherapists in the current study. One possible explanation for his finding is that Agreeableness may explain a larger

amount of the variance in therapeutic alliance ratings. Many psychotherapists scored higher on levels of Openness than they did on Agreeableness. In fact, one of the ten lowest rated psychotherapists had Openness scores in the high average range, but their Agreeableness score was in the low range. It is possible that Openness scores may predict the therapeutic alliance in populations where the psychotherapists' Agreeableness scores do not differ significantly.

While the original intent of the study was to identify traits associated with higher therapeutic alliance and better psychotherapy outcomes, it is important to note that traits associated with lower alliance and poorer outcomes are equally important. Okiishi et al. (2003) attempted to identify traits and behaviors used by the most effective psychotherapists. They found that there is a wide variety of traits that are associated with effective psychotherapists, and they had difficulty predicting what traits would make the best psychotherapists. However, identifying similarities between the least effective therapists are equally important. If traits can be identified as less beneficial to therapeutic alliance and psychotherapy outcomes, such as lower levels of Agreeableness, then targeted interventions could be developed to improve psychotherapy outcomes for a wide range of clients.

Researchers have consistently identified the therapeutic alliance as a significant factor in psychotherapy outcomes (Bowman, 1993; Crits-Christoph & Mintz, 1991; Hill, 2009; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins., 2001; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). Researchers are beginning to measure the effectiveness of therapy by evaluating improvements in outcome measures, and client reported therapeutic alliance. Researchers have also examined the personality profiles of

therapists to hypothesize the interaction between therapeutic alliance and therapist personality (Chapman et al., 2009; Saarnio, 2010). While researchers are beginning to establish a relationship between psychotherapist personality traits and therapeutic alliance, they have not investigated what can be done to educate clinicians on the relationship. The goal of this research was to determine if the relationship between psychotherapist personality traits and therapeutic alliance existed, and whether targeted training to build, maintain, measure, and understand therapeutic alliance would improve client reported therapeutic alliance.

In the current study, clients rated the therapeutic alliance and outcomes highly across all participating therapists. There are several possibilities that may have contributed to the elevated ratings of the therapeutic alliance. Individuals who volunteered to participate in this study likely had an interest in the therapeutic alliance, an interest in improving the relationship, or a desire to develop skills to increase the efficacy of psychotherapy. There were no monetary or educational rewards offered for participating in the study. Therefore it is safe to assume that the participants likely had a genuine interest in the topic. All the participants in this study were aware of the purpose of the study prior to the administration of any of the instruments, including the NEO-FFI and the WAI-S. It is possible that participants of this study were inadvertently paying attention to the therapeutic alliance, and in doing so created a strong working alliance with their clients. The average time from completion of the consent to participate in the study, and to the collection of WAI-S and ORS data was approximately 4 weeks. Therapists may have researched the measures and gained a greater awareness of the relationship between therapeutic alliance and psychotherapy outcomes. This would

explain why there was some variance in the personality profiles of psychotherapists, but no variance in the ratings of the therapeutic alliance.

Researchers have consistently demonstrated that therapy is effective. Psychotherapy in clinical and managed care practices are reaching treatment effectiveness levels comparable to clinical trials (Stiles, Barkham, Mellor-Clark, & Connell, 2008). The estimated effect size for the treatment of mental health issues is approaching .80 in clinical studies. Despite the success of treatment, dropout rates continue to range between 20%-30% (Swift, Greenberg, Whipple, & Kominiak, 2012). While some researchers continue to look for better treatment approaches to reduce dropouts and decrease treatment time, research comparing treatment approaches have found that most treatment approaches are equally effective (Wampold, & Imel, 2015). The results of these studies suggest that psychotherapists and their role in establishing, monitoring, repairing, and ultimately measuring the relationship can significantly influence outcomes. This is further confirmed by comparing the results of studies that evaluate treatment fidelity in treatment models that have been proven effective in randomized clinical trials. Strict adherence to the treatment protocol produces worse outcomes than a moderate adherence to the treatment protocol (Berman & Norton, 1985; Falkenström et al., 2013; Laska, Smith, Wislocki, Manami, & Wampold, 2013; Scaturro, 2001). While findings suggest that increasing the awareness that better therapeutic alliance improves outcomes would be meaningful, previous research suggests that this is not likely the case. Researchers have found that psychotherapists often overestimate their therapeutic skills, including the ability to build and maintain a therapeutic alliance (Mullin, Saver, Savageau, Forsberg, & Forsberg, 2016). Additionally, Okiishi et al.

(2003) found that therapists that score the lowest on measures of working alliance, actually see symptoms increase in their clients. Similarly, Wampold and Brown (2005) found that psychotherapists with poorly rated therapeutic alliance only see improvements in approximately 20% of their clients. In both of these studies, the psychotherapists were aware that information on therapeutic alliance was being collected, yet the therapeutic alliance between some psychotherapists and the clients were rated poorly.

One of the goals of the current study was to create a design which translated to general outpatient clinics. The current research utilized multiple outpatient clinics, and psychotherapists with a variety of educational and training backgrounds, which is consistent with most mental health clinics. To maximize participation from psychotherapists and clients, there were no requirements on when the WAI-S and ORS were to be collected in the process of therapy. Kivlighan, & Shaughnessy (1995) found that when measuring the therapeutic alliance over the course of treatment, a ceiling effect is reached shortly after the third session. They also found that therapeutic alliance does not demonstrate a predictable curvilinear relationship as psychotherapy progress. Given that the number of session completed prior to completing the WAI-S was not collected as part of this study, it is possible that many, if not most of the therapeutic alliances had reached their ceiling. While the ceiling effect limits the ability to conduct traditional statistical analyses, any changes in scores on the WAI-S or any score below the ceiling can provide valuable clinical information to the psychotherapist. That is supported by the findings of significant differences in scores on Agreeableness between the highest rated therapists and the lowest rated therapist, despite the ceiling effect limiting the ability to analyze the WAI-S statistically. This finding suggests that once the therapeutic alliance is

established, after approximately four regularly attended sessions, any score below the client's ceiling could be explored and used to improve the therapeutic alliance and ultimately the outcome of psychotherapy. Changes in scores on the WAI-S, even a change from a seven to a six, could provide valuable information about an individual's likelihood of dropping out of therapy or no-showing to future appointments. Additional research is needed to determine if changes in WAI-S scores are predictive of no-shows or dropout.

Assuming that the psychotherapists represent a normative sample of psychotherapists, then it is possible that the lack of variance in the reported therapeutic alliance could be attributed to the clients. One factor that may have contributed to the inflated values is careless responding. Clients were provided with the WAI-S and the ORS at the completion of a psychotherapy appointment with the goal of measuring the working alliance shortly after interacting with the therapist. However, clients may not have planned for the extra time necessary to complete the survey or may have been multitasking while completing the survey. Multitasking, or splitting attention between multiple demands, could negatively impact the ability for the client to reflect on the session and respond honestly (Carrier, Cheever, Rosen, Benitez, & Chang, 2009). After completing a psychotherapy appointment, clients may be distracted by scheduling a future appointment, checking phones, engaging in social media, or simply preparing to leave (finding car keys, using the restroom, etc.). Given all the possible demands for attention as a person is leaving, it is possible that they were unable or unwilling to give appropriate attention to the measures. Future studies could look at potentially emailing the WAI-S to clients after the session, requesting that they are completed within 24 hours,

or time could be dedicated at the end of the session to complete measures prior to ending the session. Additionally, conducting the study in one large multidisciplinary clinic where measures are provided as part of a weekly routine may foster an expectation that would allow clients to focus on the measures of therapeutic alliance and outcomes completely.

Another potential factor that could have contributed to the non-discriminate rating by clients is the lack of contact with researchers. Johnson (2005) found that there are several factors that inhibit the ability to obtain “clean” data. One factor was infrequent contact with the investigators. Johnson (2005) suggests that individuals may not be invested in participating in the research if they are not informed or frequently engaged. A limitation of the current study was that the researchers had no contact with the clients. This lack of contact was intentional to protect the confidentiality of the client and to allow participants the ability to practice measuring alliance within a psychotherapy setting. However, clients may not have understood the importance of their responses because of the lack of information on the study. Additionally, their responses were kept anonymous for the study to protect the client from any harm of rating a therapist poorly and to reassure participants that the information would not be provided to employers or supervisors. The combination of anonymity, lack of information about the purpose of the surveys, and potential self-selection from the therapist on who to administer surveys to may have contributed to the results. Future studies could allow for contact between investigators and clients to inform them of the importance of their responses.

A potentially more complete solution would be to use a large scale practice that incorporates the systematic measuring of therapeutic alliance and psychotherapy outcome. Systems similar to Scott Miller’s FIT performance system, or the OQ-45.2 TA

that measure alliance and outcome, and include frequent feedback from the therapist to the client would encourage clients to respond honestly, and accurately. Additionally, by receiving feedback, the clients would be invested in completing the measure at each appointment. This design would allow for psychotherapists that frequently receive lower ratings and psychotherapists that frequently receive higher ratings to be compared using personality measures such as the NEO-FFI.

One final factor worth considering is the type of setting that the data is collected from, and the vulnerabilities of the populations served. The current study focused on pre-licensed graduate level mental health professionals. The psychotherapists are not capable of accepting insurance, and often provide services for little to no-cost to underserved populations. Since there are not many providers available at little to no-fee, clients may fear losing services if they rate their therapists poorly. Additionally, clients from this population may experience greater benefits from expectancy effects (Lambert and Barley, 2001). The ability to receive services and the expectation that services will improve their functioning may influence clients from this population to rate the alliance significantly higher. Special considerations should be given to future research within underserved populations.

A significant component of this study was to determine if additional training on therapeutic alliance would yield better psychotherapy outcomes. Mental health professionals are more effective than lay people in the treatment of mental health concerns (O'Brien & Haaga, 2015). The current culture of time-limited, evidence-based treatment has placed a premium on effective psychotherapy. Researchers have found that psychotherapy can provide superior outcomes compared to placebo and medication-alone

treatment approaches to psychological disorders. However, researchers have also found there is not a significant difference between the various approaches to the treatment of psychological disorders (Wampold, & Imel, 2015). Research has consistently demonstrated that the therapeutic alliance plays a significant role in psychotherapy outcome, but research on effective psychotherapists are limited (Buetler, Moleiro, & Talebi, 2002; Swift, Greenberg, Whipple, & Kominiak, 2012; Wampold, & Imel, 2007). However, there is little research currently on what components of formal education are necessary to produce effective psychotherapists. Accrediting bodies have continued to require more training in evidence-based practices, with little research to support better therapy outcomes (Duncan et al., 2009). As previously mentioned, most research has found that “general therapy” (non-manualized therapy) is as effective as “diagnosis-specific treatment.” The focus of the current study has emphasized the importance of common factors, but few universities offers specific training in therapeutic alliance. Additionally, when reviewing course listings from APA accredited universities, no university offers a course that specifically focuses on psychometric measures of alliance, or psychotherapy outcome. The limited amount of research available suggests that most psychotherapists fail to measure therapeutic alliance. Research also suggests that measuring psychotherapy outcome using psychometrically sound measures is still not considered a standard of practice. There may be an opportunity to increase the use of feedback informed care through the process of supervision. Falender and Shafranske (2004) have found that many supervisors focus on administrative tasks, and spend limited time on clinical issues. Their research suggests that if supervisors do not measure therapeutic alliance or are unaware of the relationship between therapeutic alliance and

outcome, then they are not likely incorporating the fostering of therapeutic alliance in their supervisees.

Therapeutic Alliance Focused Intervention

While the current study was unable to statistically demonstrate that the therapeutic alliance focused intervention resulted in stronger client ratings of the therapeutic alliance, the interest from the participants and their supervisors suggest that psychotherapists believe that additional training is important. Several participants reached out to the facilitators with questions about the training even prior to the training. Additionally, several supervisors were interested in attending the training and spoke with the facilitators about the intent of the study and the literature in depth prior to agreeing to allow individuals to participate.

During the training, several participants shared that they had not had any focused training on therapeutic alliance, and were unaware of how to measure therapeutic alliance from clients. Participants were engaged in the activities during the training and were eager to reflect on their own experiences with clients and therapeutic alliance. Across the training group, there were several themes of questions that were brought up by the participants. These included a lack of training on the therapeutic alliance, but a heavy emphasis of manualized treatment approaches. Participants were unsure of how to incorporate therapeutic alliance into a manualized treatment, and if manualized treatments were the best approach to treatment. Another theme that was frequent in training was how to incorporate feedback within sessions with clients. Clinicians reported feeling anxious addressing potential ruptures in therapeutic alliance or changes in the

client's level of motivation towards treatment. Another relevant theme that occurred was how to address concerns about the therapeutic alliance with supervisors. Participants pointed to their status as interns under supervision and noted that there are times that they feel pressured to incorporate a treatment intervention or approach by their supervisor.

The facilitator discussed each theme with the participants and with the supervisors. Researchers provided information on the importance of continued education and for research such as the one being conducted. The training included information about manualized treatment and the use of therapeutic alliance skills to enhance manualized treatment. The training contained practical exercises on measuring and providing feedback to clients. The topic of supervision was one area that additional emphasis could be placed in the future. The researchers emphasized the importance of competent and collaborative clinical supervision. While there is a hierarchical dynamic to the relationship, research has demonstrated that having a positive supervisory alliance is associated with better communication and supervisory experiences (Falender, & Shafranske, 2004).

The supervisors who attended the training were interested in learning more about how to facilitate supervisees focus on therapeutic alliance. The researchers emphasized the importance of spending time focusing on clinical work, and observing live therapy or reviewing audio or video recording to provide feedback consistent with the recommendations of Falender, & Shafranske (2004). Supervisors were also excited to emphasize the importance of focusing on the therapeutic alliance and discussing the training in group supervision as well. Supervisors were interested in additional training for licensed staff in the future.

Contrary to the current study, Rieck, Callahan, & Watkins, (2015) found that lower levels of Agreeableness in supervisors were associated with improved client outcomes. However, supervisors often do not have direct contact with clients, and the relationship mediated through the supervisee may not be clear. Researchers suggest that supervision needs to include a combination of direct and critical feedback, as well as support and empathy. They also found that none of the personality factors significantly predicted supervisory alliance. The researchers of the current study hypothesized that the relationship between supervisor Agreeableness and client outcomes might actually be mediated by supervisee stress. As previously mentioned, burnout and high stress negatively impact therapeutic alliance. Based on the findings of the current study, the researchers believe that Agreeableness may be essential in establishing a supervisory alliance, and may then be less essential once the relationship is established. Managing supervisee stress, providing feedback on live or recorded sessions, and modeling the measuring and development of therapeutic alliance are recommendations that were provided to supervisors during the training.

CHAPTER FIVE

LIMITATION

The researchers for this study took as many steps as possible to limit interference from outside variables. However, not all factors can be controlled in a field environment. For example, the WAI-S and ORS have a limited range of responses, and in the case of the current study, a ceiling effect was found. Since the study was conducted in a field environment instead of a highly controlled environment, the number of sessions at the time of measurement of the therapeutic alliance was not controlled. Future studies could attempt to measure therapeutic alliance at the beginning of treatment, and every subsequent session. The WAI-S and ORS can repeatedly be administered, and it would establish completing the measures as a standard occurrence at each session. Additionally, clients may have felt pressured to score their therapist highly in order to secure future sessions or as a measure of hope for the future. Participants were provided the WAI-S and an envelope for the client to place the WAI-S after completing them.

Psychotherapists were requested to inform clients that the client's information would be protected to prevent the psychotherapist from being able to identify the client. However, clients may not have felt comfortable providing honest feedback or may have been concerned that the psychotherapist would eventually ask clients if they received any lower scores. A potential remedy for this issue is for psychotherapists to discuss therapeutic alliance within treatment regularly. By avoiding the topic, clients may feel uncomfortable sharing their concerns. However, if psychotherapists regularly discuss the therapeutic relationship, then clients may be more likely to share their concerns, and consider it a normal activity in treatment.

A limiting factor in the current study was the consistently high scores given by the clients when rating the therapeutic alliance. Kivlighan, & Shaughnessy (1995) also found that the ceiling effect is often reached within four sessions of therapy. This presents an issue since most manualized treatment last between 11 and 15 sessions, and many insurance companies allow for more than 15 psychotherapy appointments per calendar year. As previously mentioned, psychotherapists can monitor for any changes in the client reported therapeutic alliance to ensure that changes in scores are addressed (Miller, Hubble, Chow, & Seidel, 2015). This method may allow individual therapists to monitor the therapeutic alliance with clients, but it limits the ability of the profession to conduct research using these measures of therapeutic alliance. Future research could focus on developing measures of therapeutic alliance that are less face valid than current measures. The items on the WAI-S and similar measures are often worded in a way that places blame on the therapist if the client does not provide a high score (e.g., I believe my therapist appreciates me). However, an instrument that could measure congruence on tasks, goals, and bond without attributing the cause directly to the therapist may allow clients to feel more comfortable with lower ratings. A less face valid measure may also reduce the likelihood of experiencing a ceiling effect early in treatment. Ideally, the measure would assist in conceptualizing how the therapeutic alliance changes gradually across the phases of therapy.

A longitudinal study would be beneficial to model the changes in therapeutic alliance, improvement in outcome, and the effect of the therapist over time. A study of this magnitude would require additional motivation for the therapist's continued participation. With the increase in the use of electronic charting and email

communications with clients, it may be possible in the future to send clients an electronic WAI-S and ORS that could be completed between sessions. This would reduce the time requirements and level of participation from therapists to collect data. Additionally, clients may feel more comfortable completing the WAI-S and ORS away from the therapeutic environment. A longitudinal study would also allow researchers to focus on WAI-S scores that are different than the ceiling, and develop a targeted intervention at individuals that have lower ratings of therapeutic alliance over time. As mentioned above, psychotherapy outcomes can be improved by identifying traits associated with therapists that have poorer outcomes, instead of only focusing on the traits that are associated with positive outcomes.

One final limitation to future studies is understanding the difficulty of implementing changes. While individuals who participated in the training expressed interest in implementing the skills learned from the training, research has shown that maintaining change is difficult. As previously stated, psychotherapists often overestimate their ability to foster empathy and a working alliance with clients. Without continued support, many psychotherapists will likely return to their previous approach to therapy, while simultaneously believing that they are incorporating their training into their practice. Many factors such as motivation to change, work environment, and perceived benefits may reduce the benefits of education and training in therapeutic alliance (Schumacher, Madson, & Nilsen, 2014). A potential direction for further training would be to develop a supervision specific curriculum that focuses on fostering therapeutic alliance in supervisees. Training could also include methods to increase both internal and external motivation to implement newly formed skills for supervisees. Falender and

Shafranske (2008) recommend the incorporation of live observation or reviewing recordings of sessions to improve skills and provide useful feedback.

Conclusion and Future Directions

In conclusion, the results of the current study are consistent with the results of previous literature emphasizing the importance of psychotherapists to display warmth, empathy, and trustworthiness in the therapeutic relationship. However, the current study was not able to predict therapy outcomes based on therapeutic alliance due to a ceiling effect on the WAI-S. Researchers were able to identify that psychotherapists with higher scores on the Agreeableness scale were rated higher by clients than psychotherapists with lower scores. The current study also found that mental health professionals are eager to learn more about the relationship between therapeutic alliance and therapy outcome. However, additional research is necessary to determine if personality traits can predict therapeutic alliance, and if training can be used to increase client reported therapeutic alliance scores. Future studies will need to account for the ceiling effect on current measures of therapeutic alliance, as well as the lack of variance in many of the personality factors within the psychotherapy population. Development of new measures of therapeutic alliance that are less face valid, along with longitudinal studies may be successful in identifying the role of psychotherapists personality factors, therapeutic alliance, and psychotherapy outcomes.

REFERENCES

- Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, 38, 4–23. doi:10.1007/s10488-010-0327-7
- Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., & ... Rainer, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations for the Division 29 Task Force. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 495-497. doi:10.1037/0033-3204.38.4.495
- Bachelor, A., & Horvath, A. (1999) The therapeutic relationship. *The heart and soul of change: What works in therapy* (133-178). Washington, DC: American Psychological Association
- Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007) Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, 75, 842-852.
- Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2009). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Personality Disorders: Theory, Research, And Treatment*, S(1), 80-89. doi:10.1037/1949-2715.S.1.80
- Barber, J. P., Gallop, R., Crits-Christoph, P., Frank, A., Thase, M. E., Weiss, R. D., & Gibbons, M. B. (2006). The role of therapist adherence, therapist competence, and therapist alliance in predicting outcomes in individual drug counseling: Results

- from the National Institute Drug Abuse Collaborative Cocaine Treatment Study. *Psychotherapy Research*, 16, 229–240. doi:10.1080/10503300500288951
- Berman, J., & Norton, N. (1985). Does professional training make a therapist more effective. *Psychological Bulletin*, 98 (2), 401-407.
- Beulter, L. E., Moleiro, C. M., & Talebi, H. (2002) *Psychotherapy relationships that work*. New York, NY: Oxford University Press.
- Bowman, D. O. (1993). Effects of therapist sex on the outcome of therapy. *Psychotherapy: Theory, Research, Practice, Training*, 30(4), 678-684. doi:10.1037/0033-3204.30.4.678
- Busseri, M. A., & Tyler, J. D. (2003). Interchangeability of the Working Alliance Inventory and Working Alliance Inventory, Short Form. *Psychological Assessment*, 15, 193–197. 10.1037/1040-3590.15.2.193
- Campbell, B., Guydish, J., Le, T., Wells, E., & McCarty, D. (2015). The relationship of therapeutic alliance and treatment delivery fidelity with treatment retention in a multisite trial of twelve step facilitation. *Psychology of Addictive Behaviors*, 29 (1), 106-113. doi: <http://dx.doi.org/10.1037/adb0000008>
- Carrier, L. M., Cheever, N. A., Rosen, L. D., Benitez, S., & Chang, J. (2009). Multitasking across generations: Multitasking choices and difficulty ratings in three generations of Americans. *Computers in Human Behavior*, 25, 483–489. doi:10.1016/j.chb.2008.10.012
- Carroll, K. M., Nich, C., & Rounsaville, B. J. (1997). Contribution of the therapeutic alliance to outcome in active versus control psychotherapies. *Journal of*

Consulting And Clinical Psychology, 65(3), 510-514. doi:10.1037/0022-006X.65.3.510

Castelloe, J. M., & O'Brien, R. G. (2000). *Power and sample size determination for linear models*. SUGI Proceedings. Cary, NC: SAS Institute Inc..

Chapman, B., Talbot, N., Tatman, A., & Britton, P. (2009). Personality traits and working alliance in psychotherapy trainees: An organizing role for the five factor model. *Journal of Social and Clinical Psychology*, 28 (5), 577-596.

Cochran, B. N., Stewart, A. J., Kiklevich, A. M., Flentje, A., & Wong, C. C. (2009). The impact of extratherapeutic encounters: Individual reactions to both hypothetical and actual incidental contact with the therapist. *Professional Psychology: Research And Practice*, 40(5), 510-517. doi:10.1037/a0016146

Connolly Gibbons, M. B., Thompson, S. M., Mack, R. A., Lee, J. K., & Crits-Christoph, P. (2015). The Relation of Baseline Skills to Psychotherapy Outcome Across Diverse Psychotherapies. *Journal Of Clinical Psychology*, 71(6), 491-499. doi:10.1002/jclp.22165

Crits-Christoph, P., Gibbons, M. C., & Hearon, B. (2006a). Does the alliance cause good outcome? Recommendations for future research on the alliance. *Psychotherapy: Theory, Research, Practice, Training*, 43(3), 280-285. doi:10.1037/0033-3204.43.3.280

Crits-Christoph, P., Gibbons, M. C., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006b). Can therapists be trained to improve their alliances? A pilot study of Alliance-Fostering Therapy. *Psychotherapy Research*, 16(3), 268-281. doi: 10.1080/10503300500268557

- Davis, T. A., Ancis, J. R., & Ashby, J. S. (2015). Therapist effects, working alliance, and African American women substance users. *Cultural Diversity And Ethnic Minority Psychology, 21*(1), 126-135. doi:10.1037/a0036944
- DeGeorge, J., Constantino, M., Greenberg, R., Swift, J., & Smith-Hansen, L. (2012). Sex differences in college students' preferences for an ideal psychotherapist. *Professional Psychology: Research and Practice*, doi: 10.1037/a0029299
- Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M.A. (2010) *The heart and soul of change: Delivering what works in therapy*, Washington, DC: American Psychological Association
- Falender, C., & Shafranske, E. (2004) *Clinical Supervision: A competency-based approach*, Washington, D.C.: American Psychological Association.
- Falkenström, F., Granström, F., & Holmqvist, R. (2013) Therapeutic alliance predicts symptomatic improvements session by session. *Journal of Counseling Psychology, 60* (3), 317-328. doi: 10.1037/a0032258
- Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner/Mazel.
- Garfield, S. (1997). The therapist as a neglected variable in psychotherapy research. *Clinical Psychology: Science and Practice, 4*, 40–43. 10.1111/j.1468-2850.1997.tb00097.x
- Gilman, R., Schumm, J. A., & Chard, K. M. (2012). Hope as a change mechanism in the treatment of posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, And Policy, 4*(3), 270-277. doi:10.1037/a0024252

- Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66*, 803–810. doi: 10.1037/0022-006X.66.5.803
- Hill, C. E. (2009) *Helping skills: Facilitating exploration, insight, and action*. Washington, DC: American Psychological Association
- 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.
- Johnson, J. A. (2005). Ascertaining the validity of individual protocols from web-based personality inventories. *Journal of Research in Personality, 39*, 103–129.
doi:10.1016/j.jrp.2004.09.009
- Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research & Practice, 15*(3), 226-236. doi:10.1037/h0086004
- Kazdin, A. E. (2008). Evidence based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63*, 146–159. doi:10.1037/0003-066X.63.3.146
- Keirsey, D. (1998) *Please Understand Me II: Temperament, Character, Intelligence*. Del Mar, CA: Prometheus Nemesis Book Company

- 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. doi:10.1037/0022-0167.42.3.338
- Kolmes, K. (2012). Social media in the future of professional psychology. *Professional Psychology: Research And Practice*, 43(6), 606-612. doi:10.1037/a0028678
- Koo, K. H., Tiet, Q. Q., & Rosen, C. S. (2016). Relationships between racial/ethnic minority status, therapeutic alliance, and treatment expectancies among veterans with PTSD. *Psychological Services*, 13(3), 317-321. doi:10.1037/ser0000029
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38, 357–361. 10.1037/0033-3204.38.4.357
- Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11, 49–68.
- Lamm, C., Batson, C. D., & Decety, J. (2007). The neural substrate of human empathy: Effects of perspective-taking and cognitive appraisal. *Journal of Cognitive Neuroscience*, 19, 42–58. 10.1162/jocn.2007.19.1.42
- Laska, K., Smith, T., Wislocki, A., Manami, T., & Wampold, B. (2013). Uniformity of evidence-based treatments in practice? Therapist effects in the delivery of cognitive processing therapy for PTSD. *Journal of Counseling Psychology*, 60(1), 31-41. doi: 10.1037/a0031294

- Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal Of Counseling Psychology, 54*(1), 32-39. doi:10.1037/0022-0167.54.1.32
- 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*, 438–450.
- Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. *Psychotherapy, 52*(4), 449-457. doi:10.1037/pst0000031
- Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M.B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy, 5*(1), 5-21.
- O'Brien, J. L., & Haaga, D. F. (2015). Empathic accuracy and compassion fatigue among therapist trainees. *Professional Psychology: Research And Practice, 46*(6), 414-420. doi:10.1037/pro0000037
- Okiishi, J., Lambert, M. J., Eggett, D., Nielsen, S. L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*, 1157–1172.
- Okiishi, J., Lambert, M.J., Nielsen, S. L., & Ogles, B. M. (2003) Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*, 361-373.

- Patterson, C. H. (1985). What is the placebo in psychotherapy?. *Psychotherapy: Theory, Research, Practice, Training*, 22(2), 163-169. doi:10.1037/h0085489
- Pearson, M., O'Brien, P., & Bulsara, C. (2015). A multiple intelligence approach to counseling: Enhancing alliance with a focus on strengths. *Journal of Psychotherapy Integration*, 25 (2), 128-142. doi:
<http://dx.doi.org/10.1037/a0038881>
- Rieck, T., Callahan, J. L., & Watkins, C. J. (2015). Clinical supervision: An exploration of possible mechanisms of action. *Training And Education In Professional Psychology*, 9(2), 187-194. doi:10.1037/tep0000080
- Roehrle, B., & Strouse, J. (2008). Influence of social support on success of therapeutic interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 45(4), 464-476. doi:10.1037/a0014333
- Rollnick, S., Miller, W. R., & Butler, C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press.
- Ryum, T., Vogel, P. A., Walderhaug, E. P., & Stiles, T. C. (2015). The role of self-image as a predictor of psychotherapy outcome. *Scandinavian Journal Of Psychology*, 56(1), 62-68. doi:10.1111/sjop.12167
- Quirk, K., Owen, J., Inch, L., France, T., & Bergen, C. (2014) The alliance in relationship education programs. *Journal of Marital & Family Therapy*, 40 (2), 178-192.
- Saarnio, P. (2010). Big five personality traits and interpersonal functioning in female and male substance abuse therapists. *Substance Use and Misuse*, 45, 1463-1473. doi:
10.3109/10826081003749963

- Sanders, P. W., Richards, P. S., McBride, J. A., Lea, T., Hardman, R. K., & Barnes, D. V. (2015). Processes and outcomes of theistic spiritually oriented psychotherapy: A practice-based evidence investigation. *Spirituality In Clinical Practice*, 2(3), 180-190. doi:10.1037/scp0000083
- Saxon, D., & Barkham, M. (2012). Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk. *Journal of Consulting and Clinical Psychology*, 80 (4), 535-546. doi: 10.1037/a0028898
- Scaturo, D. (2001). The evolution of psychotherapy and the concept of manualization: an integrative perspective. *Professional Psychology: Research and Practice*, 32 (5), 522-530. doi: 10.1037//0735-7028.32.5.522
- Seidel, J. A., Andrews, W. P., Owen, J., Miller, S. D., & Buccino, D. L. (2017). Preliminary validation of the Rating of Outcome Scale and equivalence of ultra-brief measures of well-being. *Psychological Assessment*, 29(1), 65-75. doi:10.1037/pas0000311
- Stangier, U., Von Consbruch, K., Schramm, E., & Heidenreich T. (2010) Common factors of cognitive therapy and interpersonal psychotherapy in the treatment of social phobia. *Anxiety, Stress, & Coping*, 23 (3), 289-301.
- Stein, D. M., & Lambert, M. J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced?. *Journal Of Consulting And Clinical Psychology*, 63(2), 182-196. doi:10.1037/0022-006X.63.2.182
- Swift, J., & Callahan, J. (2010) A comparison of client references for intervention empirical support versus common therapy variables. *Journal of Clinical Psychology*, 66, 1217-1231.

- Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the alliance Inventory. *Psychological Assessment, 1*, 207-210.
- U.S. Department of Health and Human Services (DHHS). (2001). *Mental health: Culture, race and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*, 878–885. 10.1037/0003-066X.62.8.878
- Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M., & Okiishi, J. C. (2004). Outcome Questionnaire: Is it sensitive to changes in counseling center clients? *Journal of Counseling Psychology, 51*, 38–49.
- Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*, 857-873.
- Wampold, B. E., & Brown, G. (2005). Estimating therapist variability in outcomes attributable to therapists: A naturalistic study of the outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*, 914-923.
- Wampold, B. E., & Imel, Z. E. (2015). *The great **psychotherapy** debate: The evidence for what makes **psychotherapy** work*. New York, NY: Routledge.
- Wiltink, J., Hoyer, J., Beutel, M. E., Ruckes, C., Herpertz, S., Joraschky, P., & ... Leichsenring, F. (2016). Do Patient Characteristics Predict Outcome of Psychodynamic Psychotherapy for Social Anxiety Disorder?. *Plos ONE, 11*(1), 1-17. doi:10.1371/journal.pone.0147165

Woltman, H., Feldstain, A., MacKay, J. C., Rocchi, M. (2012). An introduction to hierarchical linear modeling. *Tutorials in Quantitative Methods for Psychology*, 8(1), 52-69. doi: 10.20982/tqmp.08.1.p052.

APPENDIX A

INFORMED CONSENT FOR THERAPIST

TITLE: THE RELATIONSHIP BETWEEN PSYCHOTHERAPIST PERSONALITY AND CLIENT REPORTED THERAPEUTIC ALLIANCE

PRINCIPAL INVESTIGATOR: David Vermeersch, PhD.
Department of Psychology
11130 Anderson Street, Suite 106
Loma Linda, CA 92350
(909) 558-7116

INVESTIGATORS: Michael Finlay, MS
Amanda Mendez, MA
Department of Psychology
11130 Anderson Street, Suite 106
Loma Linda, CA 92350

1. WHY IS THIS STUDY BEING DONE?

The purpose of the study is to identify if there is a relationship between psychotherapist personality and client reported therapeutic alliance.

You are invited to participate in this research study because you represent the population of psychotherapist that are currently in training either as a trainee or an intern.

2. HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

Approximately 100 subjects will participate in this study various counseling centers in Southern California.

3. HOW LONG WILL THE STUDY GO ON?

Your participation in this study may last up to 4 months. There will be various phases of the study where you will not be required to take any action. Majority of the study will be the collection of surveys from your clients and making them available for pick-up by the researchers. You will be required to complete a survey that will take approximately 1-2 hours and attend a workshop that will last for approximately 8 hours.

4. HOW WILL I BE INVOLVED?

You must meet the following requirements to be in the study:

Inclusion Requirements

You can participate in this study if you are a psychotherapy trainee or intern, currently providing therapy to outpatient adults with mild to moderate mental illness. You must be under the supervision of a licensed mental health professional while providing psychotherapy. You must be willing to provide de-identified copies of the Working Alliance Inventory (WAI) and the Outcome Rating Scale (ORS) that were collected during the specified window. While not a requirement, we request you provide a WAI and ORS for between 7 and 10 clients. You must have the ability to attend a seminar that will be offered during the study. There will be between 2 and 4 seminars that will be available, you are required to attend one.

If you meet the screening requirements and you choose to take part in the study, then the following procedures will take place: You will complete an NEO Five Factor Personality Inventory. You will be provided the Working Alliance Inventory (WAI) to be given to your client to fill out.

Participation in this study involves the following:

Phase 1: All psychotherapist will complete a FFI. The FFI will take approximately 1 hour to complete. The FFI consist of 150 questions that the participant will rate on a 5 point scale ranging from strongly disagree to strongly agree.

Phase 2: All psychotherapist will be randomly assigned to complete a training seminar. The training seminars will be identical and will provide feedback on the FFI, research on the effects of therapeutic alliance on outcome, and techniques to improve therapeutic alliance.

Phase 3: Psychotherapist will administer the WAI and the Outcome Rating Scale (ORS) to their clients as part of normal clinical practice. The psychotherapist will only write their unique ID, session number, and gender of the client on the WAI and ORS. There will be a collection period where the clients that complete the therapist will provide the researchers a copy of the WAI and ORS prior to recording any identifying information regarding the client on the survey. Once the copy has been made, the therapist can record the identifying information regarding the client and place it in the client's chart per normal operating procedures for the center.

If you agree to participate, you will be responsible for completing the NEO FFI, administering, collecting, and returning the WAI to the investigator.

5. WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?

Psychological discomforts: Some of the questions the researchers ask you may be upsetting or make you uncomfortable. If you do not wish to answer a question, you can skip it and go to the next question. If you do not wish to continue to participate you can stop with no penalty. For many of the activities, tests and questionnaires we are evaluating, there is no right or wrong answers. You may experience negative feelings

about your FFI profile. Remember that there are no good or bad profiles and difference combinations can be beneficial in different settings.

6. WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

Although you may not benefit from this study, the scientific information we learn from the study may help us improve training on therapeutic alliances.

The possible benefits you may experience from the procedures described in this study include learning factors that contribute to therapeutic alliance. This may increase your effectiveness in establishing a strong therapeutic alliance.

7. WHAT ARE MY RIGHTS AS A SUBJECT?

Participation in this study is voluntary. Your decision whether or not to participate or withdraw at any time from the study will not involve any penalty or loss of benefits to which you are otherwise entitled.

8. WHAT HAPPENS IF I WANT TO STOP TAKING PART IN THIS STUDY?

- You are free to withdraw from this study at any time.

9. HOW WILL INFORMATION ABOUT ME BE KEPT CONFIDENTIAL?

Efforts will be made to keep your personal information confidential. Documents will be coded and the key will be maintained in a double locked filing cabinet in the psychology department. Documents that contain the participant ID code and the corresponding name will be maintained on a printed document within the filing cabinet. No names will be entered into any computers or data processing software. You will not be identified by name in any publications describing the results of this study.

10. WHAT COSTS ARE INVOLVED?

- There is no cost to you for participating in this study.

11. WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

You will not be paid to participate in this research study.

12. WHO DO I CALL IF I HAVE QUESTIONS?

If you wish to contact a party from this study regarding any questions about your rights or to report a complaint you may have about the study, you may contact Dr. David

Vermeersch, phone (909) 558-7116, email dvermeersch@llu.edu. You may also contact Michael Finlay, phone (951) 444-0596, mfinlay@llu.edu.

If you wish to contact an impartial third party not associated with this study regarding any questions about your rights or to report a complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647, e-mail patientrelations@llu.edu for information and assistance.

13. SUBJECT’S STATEMENT OF CONSENT

- I have read the contents of the consent form and have addressed any questions or concerns with the investigators.
- My questions concerning this study have been answered to my satisfaction.
- Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities.
- I hereby give voluntary consent to participate in this study.

I understand I will be given a copy of this consent form after signing it.

Signature of Subject

Printed Name of Subject

Date

14. INVESTIGATOR’S STATEMENT

I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator

Printed Name of Investigator

Date

APPENDIX B

WORKING ALLIANCE INVENTORY-SHORT

1. _____ and I agree about the things I will need to do in counseling to help improve my situation.

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

2. What I am doing in counseling gives me new ways of looking at my problem.

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

3. I believe _____ likes me.

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

4. _____ does not understand what I am trying to accomplish in counseling.

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

5. I am confident in _____'s ability to help me.

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

6. _____ and I are working towards mutually agreed upon goals.

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

7. I feel that _____ appreciates me.

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

8. We agree on what is important for me to work on.

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

9. _____ and I trust one another.

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

10. _____ and I have different ideas on what my problems are.

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

11. We have established a good understanding of the kind of changes that would be good for me.

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

12. I believe the way we are working with my problem is correct.

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

APPENDIX C
OUTCOME RATING SCALE

Outcome Rating Scale (ORS)

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

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

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

Individually
(Personal well-being)

I-----I

Interpersonally
(Family, close relationships)

I-----I

Socially
(Work, school, friendships)

I-----I

Overall
(General sense of well-being)

I-----I

International Center for Clinical Excellence

www.scottdmiller.com

© 2000, Scott D. Miller and Barry L. Duncan

Licensed for personal use only