8-2009

Informed Consent as a Predictor of Working Alliance and Perception of Counselor/Psychotherapist

Scott E. Kerby
Western Michigan University

Follow this and additional works at: https://scholarworks.wmich.edu/dissertations
Part of the Clinical Psychology Commons, and the Counseling Psychology Commons

Recommended Citation
https://scholarworks.wmich.edu/dissertations/711

This Dissertation-Open Access is brought to you for free and open access by the Graduate College at ScholarWorks at WMU. It has been accepted for inclusion in Dissertations by an authorized administrator of ScholarWorks at WMU. For more information, please contact maira.bundza@wmich.edu.
INFORMED CONSENT AS A PREDICTOR OF WORKING ALLIANCE AND PERCEPTION OF COUNSELOR/PSYCHOTHERAPIST

by

Scott E. Kerby

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Advisor: Patrick Munley, Ph.D.

Western Michigan University
Kalamazoo, Michigan
August 2009
Client informed consent is an important component and ethical dimension of counseling and psychotherapy required by each of the mental health professions. The purpose of this study was to examine the extent to which informed consent in counseling/psychotherapy may relate to client perceptions of the working alliance, measured by the Working Alliance Inventory – Short Version (WAI-S) (Tracey and Kokotovic, 1989), and clients’ general opinion of the counselor/psychotherapist, measured by the short form of Counselor Rating Form (CRF-S) (Corrigan and Schmidt, 1983). In particular, the study investigated: (1) how discussion and understanding of informed consent related to client perceptions of the working alliance and (2) how discussion and understanding of informed consent related to client general opinion of the counselor/psychotherapist.

One-hundred sixty clients receiving counseling/psychotherapy at a Community Mental Health Authority (CMHA) in a rural Midwest county who had completed a minimum of 3 counseling/psychotherapy sessions served as participants. Participants completed a demographic form, an Informed Consent Survey (ICI); the Behavioral and Symptom Identification Scale (Eisen, Dill & Grob, 1994); the WAI-S; and the CRF-S. On the ICI, clients rated the amount of discussion they had with their
counselor/psychotherapist and how well they understood items pertaining to six areas of informed consent. ICI surveys were scored for amount of discussion and understanding across six informed consent areas.

Hierarchical multiple regression analyses were performed to investigate the relationships between ICI Discussion and ICI Understanding and working alliance measured by the WAI-S and client general opinion of the counselor/psychotherapist measured by the CRF-S. In the regression analyses age, gender, number of counseling/psychotherapy sessions, social class, and functionality and severity of psychopathology were entered first in the model, followed alternatively by ICI discussion, ICI understanding and then ICI Discussion and ICI Understanding together. When entered individually in the regression model ICI Discussion and ICI Understanding each made a unique significant contribution to predicting WAI-S and CRF-S. When entered together ICI Understanding emerged as the significant unique predictor.

Results highlight the possible relationship of informed consent to client perception of the counselor/psychotherapist and the working alliance. Findings are discussed and suggestions made for future research.
ACKNOWLEDGMENTS

Having completed this final step in my doctoral studies, I am blessed to have had the support of so many amazing people. I am grateful to my doctoral committee for their incredible support. Dr. Patrick Munley, the chairperson of my doctoral committee, despite the incredible schedule you keep, you always find time to give me patient and wise guidance. Your continual care and attention to all aspects of this project allowed its completion. Dr. Alan Hovestadt, for your kind, thoughtful manner, as well as your scholarly wisdom, you are greatly appreciated. Dr. C. Dennis Simpson, you have been a steadfast supporter, always taking an extra interest in me and willing to give me that push toward success that I needed.

My wife Jessica, I wouldn’t have accomplished this without you. I will always be grateful for your incredible mind, caring heart, and undying encouragement. I can’t count the times where your love and thoughtfulness kept me on track. My son Samuel, I hope only the very best for you and deeply thank you for your understanding as Daddy typed away when he would have loved to be playing Legos with you.

To my parents, Philip and Deborah Kerby, I owe you so much. Dad, your love of education and unwavering belief in me set this entire process in motion and for that I thank you. Mom, you are an amazing listener and so special to me, sainthood awaits you. To my brother, Steve and sister, Emily, thanks for being there.

Last, and certainly not least, thanks be to God!

Scott E. Kerby
# TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................................................................................... ii  
LIST OF TABLES .................................................................................................................. v  

CHAPTER

I. INTRODUCTION .................................................................................................................. 1  
   Nature of the Problem ........................................................................................................ 1  
   Purpose of the Study ......................................................................................................... 4  
   Research Questions .......................................................................................................... 5  
   Definition of Terms .......................................................................................................... 8  
   Importance of the Study ................................................................................................... 9  

II. LITERATURE REVIEW ..................................................................................................... 11  
   Informed Consent ............................................................................................................ 11  
      History and Context of Informed Consent .................................................................... 12  
      Historical Underpinnings .............................................................................................. 12  
      Arguments for and Against Informed Consent ............................................................ 15  
      Content and Process of Informed Consent .................................................................. 19  
      Client Perspective of Informed Consent ...................................................................... 25  
      Counselor/Psychotherapist Perspective of Informed Consent ...................................... 33  
   Working Alliance ............................................................................................................ 39  
      Factors Related to the Working Alliance ..................................................................... 42  
      Client Factors Related to the Working Alliance ........................................................... 42  

iii
# Table of Contents—Continued

## CHAPTER
- Counselor/Psychotherapist Factors Related to the Working Alliance ................................................................. 45
- Measurement of the Working Alliance ........................................... 49
- Working Alliance and Counseling/Psychotherapy Outcome ...... 52
- Client Perception of Counselor/Psychotherapist ......................... 59
- Factors Related to the Client Perception of Counselor/Psychotherapist .......................................................... 61
- Measurement of the Client Perception of Counselor/Psychotherapist .......................................................... 77
- Summary .................................................................................. 82

## III. METHODOLOGY .......................................................... 83
- Sample .................................................................................... 83
- Participant Characteristics .......................................................... 85
- Instruments .............................................................................. 87
- Demographic Form .................................................................. 87
- Informed Consent Instrument ...................................................... 88
- Working Alliance Inventory ......................................................... 89
- Counselor Rating Form .............................................................. 92
- Behavior and Symptom Identification Scale .............................. 94
- Procedure ................................................................................. 95
- Data Analysis ........................................................................... 97

## IV. RESEARCH FINDINGS .................................................. 102
Table of Contents—Continued

CHAPTER

Introduction .................................................................................................................. 102
Descriptive Statistics and Correlations among the Variables .......................... 102
Hypothesis Testing ..................................................................................................... 103
Summary ...................................................................................................................... 113

V. DISCUSSION ........................................................................................................... 115

Introduction ............................................................................................................... 115
Informed Consent and Working Alliance ............................................................. 117
Informed Consent and Client Perception of Counselor/Psychotherapist .......... 125
Implications of the Current Study ........................................................................ 133
Limitations of the Current Study .......................................................................... 136
Summary ...................................................................................................................... 138

REFERENCES ........................................................................................................... 140

APPENDICES

A. Human Subjects Institutional Review Board Approval Letter .................. 157
B. Demographic Form .............................................................................................. 159
C. ICI Form ............................................................................................................... 165
D. Invitation Script ................................................................................................... 172
E. Consent Form ....................................................................................................... 174
<table>
<thead>
<tr>
<th>Table Number</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Correlation Matrix for Criterion and Predictor Variables</td>
<td>104</td>
</tr>
<tr>
<td>2</td>
<td>Hierarchical Multiple Regression for Working Alliance—Model 1</td>
<td>105</td>
</tr>
<tr>
<td>3</td>
<td>Hierarchical Multiple Regression for Working Alliance—Model 2</td>
<td>106</td>
</tr>
<tr>
<td>4</td>
<td>Hierarchical Multiple Regression for Working Alliance—Model 3</td>
<td>107</td>
</tr>
<tr>
<td>5</td>
<td>Hierarchical Multiple Regression for Working Alliance—Model 4</td>
<td>108</td>
</tr>
<tr>
<td>6</td>
<td>Hierarchical Multiple Regression for Client Ratings of Counselor/Psychoterapist Attributes—Model 1</td>
<td>110</td>
</tr>
<tr>
<td>7</td>
<td>Hierarchical Multiple Regression for Client Ratings of Counselor/Psychoterapist Attributes—Model 2</td>
<td>111</td>
</tr>
<tr>
<td>8</td>
<td>Hierarchical Multiple Regression for Client Ratings of Counselor/Psychoterapist Attributes—Model 3</td>
<td>112</td>
</tr>
<tr>
<td>9</td>
<td>Hierarchical Multiple Regression for Client Ratings of Counselor/Psychoterapist Attributes—Model 4</td>
<td>113</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Nature of the Problem

Early counseling/psychotherapy, beginning with the treatment initiation, is arguably the most critical period in a therapeutic relationship. During this time the client and counselor/psychotherapist enter into a professional relationship and may discuss both the goals of treatment as well as how this is to be accomplished through the counseling/psychotherapy process (Thomas, Werner-Wilson, & Murphy, 2005). The opening phase of counseling/psychotherapy may help to set the foundation for the overall counseling/psychotherapy process and the relationship between the client and the counselor/psychotherapist (Blau, 1987).

Understanding the process of counseling/psychotherapy is of great interest to counselors/psychotherapists. Such treatment has been stated to have two distinct and important parts (Gelso & Hayes 1998). First is the technical, which encompasses the more clearly defined aspects of counseling/psychotherapy such as techniques and the prescribed roles taken on by both the client and counselor/psychotherapist (Gelso & Hayes, 1998). The second is that of the relationship, which refers to what happens when the client and counselor/psychotherapist meet and form a connection based upon feelings and attitude (Gelso & Hayes, 1998). Both the technical and relational components have inherent importance. Distinguishing the technical from the relational aspects is helpful for the purposes of conceptualizing counseling/psychotherapy. Understanding the extent to which the technical aspects of counseling/psychotherapy impact the relational aspects
of counseling/psychotherapy may be helpful in understanding the process and outcome of counseling/psychotherapy.

There are many technical aspects of the counseling/psychotherapy process, one being the process of informed consent. Informed consent has been widely recognized as an important component in research, as evidenced by its presence as a part of three international policy statements on medical research: the Nuremberg Code (1947), the Declaration of Helsinki (1964), and the Council for International Organizations of Medical Sciences (CIOMS) guidelines (1982). Each of these guidelines indicated what is both necessary and appropriate behavior within the context of medical research (Bray, Shepherd, & Hays, 1985). Furthermore, each of these codes has, to some degree, played an important part in the development of professional ethical codes for a myriad of professional organizations including the American Psychological Association.

The American Psychological Association (APA) Ethics Code makes several recommendations related to informed consent. The APA code discusses informed consent related to psychological research, assessment, and also provides guidelines related to informed consent in psychotherapy practice. In the context of psychotherapy, the code indicates that informed consent is to be completed in a timely fashion, the general content of what informed consent should cover, and the necessity of allowing clients to process such issues (American Psychological Association, 2002). Furthermore, through a consent process, the APA ethics code seeks to protect clients from treatments that are not established and requires informing a client of a treating counselor/psychotherapists status as a trainee (American Psychological Association, 2002). The code establishes that informed consent information should be communicated
in an understandable fashion meeting the particular needs of individual clients (e.g. age) with appropriate documentation present (American Psychological Association, 2002). The informed consent process allows potential clients both access to information and choice. The process adheres to the general principles set forth by the APA ethics code (Kitchener, 2000) including: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people’s rights and dignity.

Informed consent has been empirically investigated through the lens of the client’s view and the counselor/psychotherapist’s view. Related to the client’s perspective, research has found that clients valued informed consent as a part of mental health treatment (Sullivan, Martin, & Handelsman, 1993) and viewed therapists in a positive fashion when a consent process was utilized (Sullivan et al. 1993; Handelsman, 1990) with specific information provided (Walter & Handelsman, 1996). Informed consent processes/content have not been found to affect clients’ decisions to seek treatment (Gustafson, McNamara, & Jensen, 1994). Related to the counselor/psychotherapists view, research findings have demonstrated differences between mental health practitioners in the importance placed on informed consent and have connected these differences to practitioner characteristics including discipline (Croarkin, Berg, & Spira, 2003) and theoretical orientation (Somberg, Stone, & Claiborn, 1993). Furthermore, there have been findings with regard to what counselors/psychotherapists view as salient content of informed consent. Salient content from the perspective of the counselor/psychotherapist related primarily to confidentiality, cost of treatment, office information, person of the therapist information, process/nature of therapy, and risks/benefits (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud,
1986; Haslam & Harris, 2004; Jensen, McNamara, & Gustafson, 1991; Talbert & Pipes, 1988). Research has revealed variability with respect to what information was actually conveyed within the consent processes (Haslam & Harris, 2004; Talbert & Pipes, 1988) and variability with the actual process of informed consent with some clinicians reportedly preferring verbal or written procedures (Handelsman et al. 1986; Somberg et al. 1993).

As the technical aspects of counseling/psychotherapy have been noted to be many, so too are the relational aspects. Two relational aspects of treatment are the concept of working alliance and the clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness. Working alliance has been the focus of much scholarly attention including examination of its relationship with other factors, development of psychometric measures of working alliance, and exploration of its role in predicting successful counseling/psychotherapy outcome. Client perception of counselor/psychotherapist has focused on the associations with other factors and on development of psychometric measures. Investigating how the technical factors influence relational factors within the counseling/psychotherapy process is an important avenue for empirical research.

Purpose of the Study

Completing an informed consent process may be part of a counselor/psychotherapist’s first attempt to engage a client during the initial period of counseling/psychotherapy. Unfortunately, informed consent may be completed in a manner that means little to a potential counseling/psychotherapy client (Handelsman et
Informed consent may actually represent an integral part of treatment rather than a procedural matter prior to its outset (Haas, 1991). Therefore, if done well it may have the potential to positively affect the working alliance between a counselor/psychotherapist and a client. The purpose of this study was to examine the extent to which the informed consent process relates to client perceptions of the working alliance as measured by the Working Alliance Inventory-S (Tracey and Kokotovic, 1989) and the clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness obtained with the short form of Counselor Rating Form (CRF-S) (Corrigan and Schmidt, 1983). In the study, select demographic and client information was collected to statistically control for the possible effects of age, gender, number of counseling/psychotherapy sessions and social class. Also, to control for the possible effects of functionality and severity of psychopathology, clients were also assessed with the Behavior and Symptom Identification Scale, or BASIS-32 (Eisen, Dill and Grob, 1994). In particular, the present study was aimed at investigating: (1) how discussion and understanding of informed consent may relate to client perceptions of the working alliance as measured by the client form of the WAI-S, and (2) how discussion and understanding of informed consent may relate to client general opinion of the counselor/psychotherapist as measured by the CRF-S.

Research Questions

Research Question One: To what extent do client ratings of thoroughness of informed consent discussion and client understanding of informed consent relate to client
ratings of working alliance on the client form of the Working Alliance Inventory – Short Version (WAI-S)?

**Null Hypothesis 1a:** After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report thoroughness of informed consent discussion will not contribute significant unique variance to predicting working alliance on the client form of the Working Alliance Inventory – Short Version.

**Null Hypothesis 1b:** After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report understanding of informed consent will not contribute significant unique variance to predicting working alliance on the client form of the Working Alliance Inventory – Short Version.

**Null Hypothesis 1c:** After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report thoroughness of informed consent discussion and client understanding of informed consent considered together will not contribute significant unique variance to predicting working alliance on the client form of the Working Alliance Inventory – Short Version.

**Research Question Two:** To what extent do client ratings of thoroughness of informed consent discussion and client understanding of informed consent relate to
clients’ general opinion of the counselor/psychotherapist as measured by ratings of the
counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness
on the short form of the Counselor Rating Form (CRF-S)?

Null Hypothesis 2a: After controlling for the variables of gender, age, social
class, number of counseling/psychotherapy sessions, and client’s degree of
psychopathology (as determined by the BASIS – 32), the degree to which
counseling/psychotherapy clients report thoroughness of informed consent discussion
will not contribute significant unique variance to predicting clients’ general opinion of
the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s
attributes of expertness, trustworthiness, and attractiveness on the short form of
Counselor Rating Form (CRF-S).

Null Hypothesis 2b: After controlling for the variables of gender, age, social
class, number of counseling/psychotherapy sessions, and client’s degree of
psychopathology (as determined by the BASIS – 32), the degree to which
counseling/psychotherapy clients report understanding of informed consent will not
contribute significant unique variance to predicting clients’ general opinion of the
counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s
attributes of expertness, trustworthiness, and attractiveness on the short form of
Counselor Rating Form (CRF-S).

Null Hypothesis 2c: After controlling for the variables of gender, age, social class,
number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as
determined by the BASIS – 32), the degree to which counseling/psychotherapy clients
report thoroughness of informed consent discussion and client understanding of informed
consent considered together will not contribute significant unique variance to predicting clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness on the short form of Counselor Rating Form (CRF-S).

Definition of Terms

**Informed Consent.** Kitchener (2000) defined informed consent as “the legal requirements or administrative regulations that specify how and what psychologists should tell clients or research participants about their participation in treatment or scientific study” (p. 56). In this present study this includes the nature of therapy, treatment alternatives, appointments/scheduling, confidentiality/third party involvement, money/finances, and general/other (e.g. counselor/psychotherapist training level, license, or discipline).

**Working Alliance.** Bordin (1979) characterized the working alliance as being conceptualized through three features; agreement on goals, assignment of tasks, and the development of a bond in counseling/psychotherapy. Agreement of the goals refers to the extent to which the client and counselor/psychotherapist agree on the desired outcome of treatment, while assignment of tasks refers to the extent to which the client and counselor/psychotherapist agree on the process of treatment, and the development of a bond refers to the quality of the professional relationship between the client and counselor/psychotherapist.

**Perception of Counselor/Psychotherapist.** A general sense of the client’s perception of the counselor/psychotherapist along the domains of expertness,
trustworthiness, and attractiveness (Barak and LaCrosse, 1975; Hepner, Kivlighan, & Wampold, 1999).

**Counselors/Psychotherapists.** Mental health professionals providing counseling/psychotherapy to clients including fully licensed doctoral psychologists, psychiatrists, limited licensed psychologists, licensed professional counselors, social workers, and master’s level/doctoral level interns.

**Importance of the Study**

The process of informed consent is clearly an important ethical dimension and component of the counseling/psychotherapy relationship. Informed consent is one of the initial steps that a mental health professional takes to engage a potential client at the outset of treatment. Exploring the various aspects of the informed consent process (such as confidentiality and the risks and benefits of treatment), may impact the professional relationship between counselor/psychotherapist and client, may influence the working alliance between the client and the counselor/psychotherapist and affect how the client perceives the counselor/psychotherapist providing treatment.

The participants for this research study were active counseling/psychotherapy clients whose participation afforded the opportunity to examine and explore how current clients perceive the various aspects of informed consent, working alliance, and the attributes of their counselor/psychotherapist. Furthermore, the study explored the possible importance of the consent process and the relationship informed consent may have to counseling/psychotherapy relationship. To date, to the author's knowledge, there have been no studies that have examined both the working alliance and client perception of counselor/psychotherapist and their relationship to the process of informed consent.
The next chapter will review the literature on informed consent, working alliance, and client perception of counselor/psychotherapist.
CHAPTER II
LITERATURE REVIEW

Informed Consent

Informed consent “pertains to the legal requirements or administrative regulations
that specify how and what psychologists should tell clients or research participants about
their participation in treatment or scientific study” (Kitchener, 2000, p. 56). More
importantly, informed consent “refers to the ethical responsibility to help individuals
make responsible, informed, and autonomous decisions about treatment or research, and
it sometimes refers to the interpersonal process through which both of those goals are
fulfilled” (Kitchener, 2000, p. 56). Informed consent is directly cited in the American
Psychological Association’s code of ethics (American Psychological Association, 2002).
General provisions are noted in section 3.10 and provisions specific to therapy are noted
in section 10.01. Other ethical codes also contain disclosure statements on informed
consent (American Counseling Association, 2005 & National Association of Social
Workers, 1999) indicating the importance placed on this process.

Research has indicated that clients seeking counseling/psychotherapy appreciate
more information rather than less related to their treatment (Haut & Muehleman, 1986).
Therefore, it has been recommended that a counselor/psychotherapist should seek to
inform clients about information in a variety of areas including the nature of therapy,
treatment alternatives, appointments/scheduling, confidentiality/third party involvement,
money/finances, and general/other (Pomerantz & Handelsman, 2004; Claiborn,
Berberoglu, Nerison, & Somberg, 1994).
In order to provide framework for this research, literature related to informed consent will be examined here. This will include attention to the history and context of informed consent, content and process of informed consent, client perspective of informed consent, and counselor/psychotherapist perspective of informed consent.

**History and Context of Informed Consent**

After being established in 1892, the APA went without a formal ethics codes for six decades (Pope & Vetter, 1992). This may be indicative of several things including the fact that developing a code of ethics is a complicated process. In order to provide an explanation of informed consent as it is understood in the field of psychology, both the historical underpinnings and arguments for and against informed consent will be discussed.

- **Historical Underpinnings**

  Informed consent has its foundation in both legal and moral theory (Faden, Beauchamp, & King, 1986). Informed consent’s basis in legal theory, relates to issues such as liability or disclosure requirements (Faden, Beauchamp, & King, 1986) while its basis in moral theory emphasizes the importance of informed consent through such essential principles as respect for autonomy, beneficence and justice (Faden, Beauchamp & King, 1986). Interestingly, it is through the medium of a specific profession that informed consent graduated from theoretical discussion to the applied rigors of the real world. This took place two hundred years ago in the field of medicine (Andrews, 1984; Bray, Shepherd, & Hays, 1985).

  Within medicine, informed consent was crystallized through the lens of litigation. There have been several important instances wherein litigation focused a spotlight on
informed consent, thus changing the ethical landscape. Faden and Beauchamp (1986) cite and discuss several legal cases related to the practice of medicine wherein informed consent was a focal issue. The Slater case of the late eighteenth century, the Mohr case of 1905, and the Scholendorff case of 1914 each set legal precedent within medicine. In such cases, the basic rights of the individual were allegedly not respected by medical professionals such that arguably poor treatment occurred. As a result of such cases, the field of medicine began to recognize the need for doctors to develop a professional relationship with patients (Bray et al., 1985; Gutheil, Bursztajn, & Brodsky, 1984) leading to an important shift in the doctrine of informed consent over time. Prior to this shift, it had been the doctor’s decision as to what information was shared with the patient. This was referred to as the “professional community standard” (Braaten & Handelsman, 1997). This standard was replaced with the “reasonable person doctrine” which involves the patient to a greater degree (Braaten & Handelsman, 1997). This latter doctrine holds that information should be disclosed based upon whether a reasonable person in a similar circumstance may want to be informed of information germane to treatment (Jensen et al., 1991).

Mental health appears to have followed the tracks laid by medicine (Haas, 1991), though the integration of informed consent in psychological practice occurred later. Most likely this occurred through counseling/psychotherapy being viewed as akin to a medical procedure or treatment which was being performed on clients (Beahrs & Gutheil, 2001). As medicine underwent the rigors of litigation, which focused necessary attention upon informed consent, so too did psychology. One example which aptly demonstrates the role of litigation in psychology is the case of Osherhoff versus Chestnut Lodge
wherein a client’s mental illness was treated on an inpatient basis with lengthy psychotherapy with minimum result (Beahrs & Gutheil, 2001; Bray et al., 1985; Malcom, 1986). The client was noted to have departed the facility and was successfully treated elsewhere with psychotropic medication which resolved the mental illness in a relatively short period. It was maintained had this client been aware of the psychotropic medication, medications would have been opted for versus the lengthy inpatient stay. Providing such information during the informed consent process can protect a therapist from legal ramifications in such circumstances.

The practice of informed consent has spread responsibility for knowledgeable decision making to the therapeutic dyad rather than remaining solely the possession of the therapist (Croakin, Berg, & Spira, 2003). Thus, there has been a shift within psychology, as in medicine, from a professional community standard to a reasonable person standard. Fear of litigation is considered an insufficient rationale for adequately informing clients of the myriad of aspects related to treatment (Handelsman et al., 1986) however fear of litigation has been undeniably linked to how informed consent came to exist. Informed consent developed into a mandatory procedure (Braaten, Otto, & Handelsman, 1993; Beahrs & Gutheil, 2001), which functions to help avoid legal difficulties such as civil action, and also to provide clients with desired information (Braaten et al., 1993; Jensen et al., 1991). However, “practitioners still retain considerable latitude in defining what constitutes informed consent for psychotherapy, what is optimal, what is the acceptable range of content, and the processes through which psychotherapists provide information and gain consent” (Beahrs & Gutheil, 2001, p. 5).
Informed consent is now a component of several areas of psychology including therapy, research, and assessment (American Psychological Association, 2002).

**Arguments for and Against Informed Consent**

There have been arguments made both for and against informed consent. Specific to medicine, proponents of informed consent have indicated the practice of informed consent has the potential to be purposeful and serve to enhance a doctor-patient relationship. Furthermore, proponents hold informed consent respects the personhood of the individual, allows for decision making on the part of the patient, protects the patient from treatment that is potentially uninformed or inappropriate, allows for the privacy of the individual, compensates the patient for potentially afflictive care, and protects the dignity of the individual by involving them in the treatment process (Malcom, 1986). These arguments would appear to support the reasonable person standard of informed consent with both moral and legal aspects of informed consent being met.

Critics of informed consent within medicine focus upon the extent to which this process may be unnecessary. Specifically, there is a belief informed consent wastes resources, such as the time of the professional; interrupts the trust between professional and patient as the doctor is to be the treating expert; and informed consent may in fact cause a patient difficulty through such issues as discussion of the risks of treatment (Malcom, 1986). These statements clearly argue against a collaborative professional relationship and appear to propose the doctor as the sole arbiter of treatment. These arguments would appear to support the professional community standard.

There have also been arguments made for and against the practice of informed consent within the field of psychology. Proponents of informed consent in
counseling/psychotherapy argue it upholds the general principles set forth by the APA ethics code (Kitchener, 2000): beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people’s rights and dignity. Beneficence and nonmaleficence each refer to providing a potential client with a valuable experience while also protecting the client from potential harm. “Psychologists strive to benefit those with whom they work and take care to do no harm” (American Psychological Association, 2002, p. 3). The process of informed consent may even protect the individual as it ensures one’s entrance into treatment is voluntary (Kitchener, 2000) and may allow for avoidance of potential harm due to information access (Kitchener, 2000).

Fidelity and responsibility call for candor and honesty in professional relationships as “psychologists establish relationships of trust with those with whom they work” (American Psychological Association, 2002, p. 3). The process of informed consent gives the counselor/psychotherapist opportunity to discuss a variety of issues related to counseling/psychotherapy including possible risks/benefits, and expectations for the psychotherapeutic process. Communication of these issues may discourage arbitrariness by a counselor/psychotherapist because they are more likely to act in accordance with the expectations of the treatment process as laid out (Beahrs & Gutheil 2001). Further, it may even discourage malpractice from occurring because the clients know the risks from the outset of counseling/psychotherapy (Kitchener, 2000).

Integrity speaks to the need for professional values as psychologists are expected to “promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology” (American Psychological Association, 2002, p. 3). The process of informed consent provides the counselor/psychotherapist an opportunity to speak openly and
honestly with a client about the psychotherapeutic process. Kitchener (2000) suggests that doing so can help build or enhance the professional relationship. Justice, related to integrity, references equality and fairness. “Psychologists recognize that fairness and justice entitle all persons access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists” (American Psychological Association, 2002, p. 3). The process of informed consent can actually improve treatment and enhance a client’s sense of autonomy because it allows clients to make an informed decision about entering the psychotherapeutic process (Beahrs & Gutheil 2001).

The last of these general principles is respect for people’s rights and dignity. “Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self determination” (American Psychological Association, 2002, p. 4). Informing clients about a therapist’s qualifications, risks and benefits of treatment, and other matters may be seen as a responsible, honest, and just action. Such information enables the client to make an informed decision as to whether or not they believe treatment may be helpful.

Critics of informed consent in counseling/psychotherapy have been less likely to question the value of informed consent in theory, but have criticized the manner in which informed consent is carried out in practice. Two primary concerns have been raised by such critics: the intended outcome of the informed consent process (Kitchener & Anderson 2000) and competency to give informed consent (Kitchener & Anderson, 2000; Stanley, Sieber, & Melton, 1987). The issue of the intended outcome of the informed consent process refers to the fact individual counselors/psychotherapists may have
qualitatively different goals in the consent process. As noted by Kitchener & Anderson (2000) the goal of completing informed consent may be to satisfy legal requirements, to satisfy ethical requirements, or an interpersonal process whereby both legal and ethical requirements are met. Thus, a psychologist may actually be attending to any one or all of these goals. One may argue if informed consent is to be accepted as an important part of therapy, then the goal of the consent process should be standard across practitioners. Complicating this issue is the idea the process of counseling/psychotherapy is oftentimes an unfolding and unpredictable process (Beahrs & Gutheil, 2001). Thus, discussion of issues of informed consent may prove detrimental. For example, when discussing the risks and benefits of treatment, expectations for outcome may be artificially lowered when discussing the risks and artificially raised when discussing the benefits with associated impact on important issues such as the working alliance (Beahrs & Gutheil, 2001). Thus, attempting to capture the nature of counseling/psychotherapy through an informed consent process may prove problematic.

Competence refers to a myriad of issues, the most salient being a proportion of persons seeking mental health treatment may be vulnerable populations such as children or individuals with severe mental illness (Kitchener & Anderson, 2000; Stanley, Sieber, & Melton, 1987). Those with severe mental illness may not be able to competently give informed consent as their illness has the potential to prevent understanding (Kitchener & Anderson, 2000). Further, children are unable to give formal consent as the legal system does not recognize them as autonomous individuals, but views them as vulnerable, and unable to make healthcare related decisions (Kitchener & Anderson, 2000). Hence,
certain populations may simply be unable to make an informed and/or competent decision about mental health treatment (Kitchener, 2000; West, 2002).

Complicating the issue of competence is the use of written consent forms. Such forms have been found to be quite problematic (Kitchener & Anderson, 2000). It has been demonstrated much of the language utilized in written informed consent procedures is comparable to that of a professional journal (Kitchener & Anderson, 2000; Handelsman et al., 1986; Handelsman et al., 1995). Hence, it may be these written forms are inaccessible to a proportion of clients. Furthermore, use of such forms may indicate that informed consent occurs only once, at a point in time versus being a process that occurs in conjunction with the individual's ability to understand (Kitchener & Anderson, 2000). With the individual experiencing mental illness, their ability to understand issues germane to informed consent may evolve as their symptoms of mental illness lift. With children, their ability to understand issues germane to informed consent may evolve in connection with developmental growth.

Content and Process of Informed Consent

Within counseling and psychotherapy, there are those that indicate that the content and process of informed consent is unclear with minimal consensus (Goodyear & Sinnett, 1984) while others indicate consensus on this practice is in place (Bennett, Bryant, VanderBos, & Greenwood, 1990; Pope & Vasquez, 1991). In this section both the content of informed consent and its process and procedures will be discussed.

Within psychology, the APA ethics code (American Psychological Association, 2002) gives direction as to what the content of informed consent must be at minimum.
The APA ethics code sets a basic standard the individual practitioner of psychology must adhere to when providing therapy and specifically states the following three guidelines.

First: “When obtaining informed consent to therapy as required in Standard 3.10 psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers” (American Psychological Association, 2002, p. 14).

Second: “When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation” (American Psychological Association, 2002, p. 15).

Third: “When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor” (American Psychological Association, 2002, p. 15).

The APA ethics code has been criticized as being too vague (Braaten & Handelsman, 1997). Yet, constructing a code of ethics that applies universally to all circumstances is seemingly impossible (Widiger & Rorer, 1984). Nonetheless, there have been suggestions as to what may be a more comprehensive approach to an informed consent procedure. These recommendations echo the areas addressed in the APA ethics code, but provide greater detail (Handelsman & Galvin, 1988; Handelsman et al., 1986; Pomerantz & Handelsman, 2004). Specifically, it has been suggested items such as
therapy, alternatives to treatment, appointments, confidentiality, money, insurance, managed care, and general questions be discussed with psychotherapy clients (Handelsman & Galvin, 1988; Handelsman et al., 1986; Pomerantz & Handelsman, 2004). Within each of these areas, there are a number of specific items that may be addressed. For example, in the area of therapy, a client may wish to know (1) the name of the therapist’s type of therapy, (2) how and where the therapist learned to practice this therapy, (3) how the therapist’s therapy compares with other types of therapy, (4) how the therapy works, (5) what risks are involved, (6) how often clients improve and how is this known, (7) how often clients get worse while receiving treatment, (8) how often clients get worse without this therapy, (9) how long treatment takes, (10) what a client should do if they feel treatment is not working, (11) if there are any tests, (12) if this therapy follows a manual or predetermined set of steps, and (13) if therapy is ever done over the phone or internet (Handelsman & Galvin, 1988; Pomerantz & Handelsman, 2004).

Clearly, when counseling/psychotherapy is to take place, the psychologist bears responsibility to inform the client of several important areas germane to treatment. The APA ethics code sets a foundation for this, but the individual practitioner must decide the degree of detail that they will provide. This may lead to a divergence between the letter of the code and the spirit of the code. Kitchener & Anderson (2000) state that the “spirit of consent generally can be understood to include several components, including competence, disclosure, understanding, voluntariness, and authorization” (p. 57). Thus, it is clear that the spirit of informed consent requires a concerted multiphase approach by the psychologist. A therapist could superficially touch on each of the areas specified by the APA without providing enough information to allow the client to make a truly
informed decision. In the end, meeting only the letter of the code may have a serious
impact on the quality of the therapeutic relationship (Braaten et al., 1993).

As has been demonstrated, the APA ethics code provides some guidance as to
what information must be provided as part of an informed consent process. However, the
code does little to guide the process. That is, there is little explanation of how therapists
or researchers ought to provide the information necessary for potential clients to make
choices germane to their mental health treatment. The APA ethics code makes the
following four statements:

First: “When psychologists conduct research or provide assessment, therapy,
counseling, or consulting services in person or via electronic transmission or other forms
of communication, they obtain the informed consent of the individual or individuals
using language that is reasonably understandable to that person or persons except when
conducting such activities without consent is mandated by law or governmental
regulation or as otherwise provided in the ethics code” (American Psychological

Second: “For persons who are legally incapable of giving informed consent,
psychologists nevertheless (1) provide an appropriate explanation, (2) seek the
individual’s assent, (3) consider such persons’ preferences and best interests, and (4)
obtain appropriate permission from a legally authorized person, if substitute consent is
permitted or required by law. When consent by a legally authorized person is not
permitted or required by law, psychologists take reasonable steps to protect the
Third: “When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality before proceeding” (American Psychological Association, 2002, p. 7).


To summarize, whenever possible, consent should be obtained. When a person is incapable of giving consent, assent should be obtained and information still provided. And no matter what is done, the process should be well documented. Still, there is no mandate for how informed consent should take place. The apparent lack of an agreed upon consent process does result in some degree of confusion and different views as to what should be included in such a process (Haslam & Harris, 2004).

The two most obvious means of obtaining consent are through written and verbal means. These means of administration demonstrate what has been termed the event and process model of informed consent (Applebaum, Lidz, & Meisel, 1987; Braaten & Handelsman, 1997). Written consent demonstrates the event model, as it usually takes place at one point in time, prior to the outset of treatment, wherein a written form explains several factors germane to therapy (Braaten & Handelsman, 1997). Verbal consent demonstrates the process model, as it can unfold as a part of treatment throughout the course of the therapeutic relationship (Braaten & Handelsman, 1997).

Utilizing an event model approach through the use of written consent forms can prove quite useful as these forms can potentially provide significant amounts of information germane to counseling/psychotherapy. The client has access to this
information at the outset of treatment and may return to it at any time should questions arise. Furthermore, it allows the client the choice to discontinue before treatment is begun and time is invested. The inherent problems with written consent forms are twofold. First, such written consent forms have been shown to be constructed in ways a client may not understand them (Handelsman et al., 1986). Second, the content of such forms has been questioned and may vary greatly to the extent that important information may not be included (Handelsman et al., 1986; Haslam & Harris, 2004; Talbert & Pipes, 1988).

Utilizing the process model through ongoing verbal consent does have intuitive benefit as it capitalizes on the relationship between the client and therapist in that it may be a continuous process of negotiation and discussion (Dyer & Bloch, 1987). However, verbal consent does appear to have deficits as well. This type of consent may lack in structure, running the risk of inconsistency in application of informed consent. The client may provide oral agreement for treatment and this may be periodically documented through case notes. However, liability issues could arise for the clinician if there is an absence of physical evidence (i.e. the client’s signature on a document) demonstrating that actual consent has been given.

Both the process model (verbal consent) and event model (written consent) have their inherent benefits. However, at a very intuitive level, it would appear appropriate to combine these processes such that the strengths of each are used while the weaknesses are diminished (Braaten & Handelsman, 1997). One means of doing this has been suggested by Handelsman and Galvin (1988). This important work was updated by Pomerantz and Handelsman (2004) to coincide with the revised APA ethics code of 2002.
These authors suggested a client be given a written document that delineates seven important areas that are germane to informed consent. Each of these seven areas has questions listed that a client may or may not opt to ask. The questions may act as a catalyst for discussion. The psychologist bears responsibility to appropriately document this procedure has taken place at the outset of treatment (possibly through client signature) but also as treatment progresses and these issues are addressed again (possibly through case notation). Utilization of such a procedure as suggested by Pomerantz & Handelsman (2004) may positively impact the client-therapist relationship (Handelsman, 1990; Handelsman & Martin, 1992; Sullivan et al. 1993).

Client Perspective of Informed Consent

Within professional peer reviewed journals there has been limited but important empirical work done in relation to the client’s perspective on informed consent in counseling/psychotherapy. Studies that examine this specific area are reviewed in this section. A number of these studies examined aspects of counseling/psychotherapy in addition to informed consent. However, in this section, only the aspects of these studies that related to informed consent are discussed.

Handelsman (1990) reported two studies related to informed consent. The first examined how the presence of written consent forms influenced impressions of a therapist, while the second sought to determine how years of therapist experience influenced the impact of written consent forms. Within the first study, 129 university student participants received a packet containing a random combination of three consent forms. These were the question sheet designed by Handelsman and Galvin (1988), a legal disclosure form published by the Colorado Psychological Association, and a general
brochure which related information germane to the profession of psychology. Participants rated a fictitious psychologist on seven questions related to first impression via a seven point likert scale. The results of the first study indicated the presence of the legal disclosure form and questions sheet had a largely positive effect. However, the inclusion of the general brochure produced somewhat ambiguous results. Within the second study, there were 137 participants. The structure of this study was similar to that utilized in the first, however, years of experience was varied to determine how this affected the impact of the aforementioned written forms. The results indicated that therapists with at least nine years of experience were seen more positively. In summary, the results of both studies were largely supportive of utilizing written consent forms.

Mardirosian, McGuire, Abbott, and Blau (1990) examined how an informed consent procedure within a pro-life pregnancy counseling center may impact ratings of counselor/psychotherapist expertness, trustworthiness and attractiveness as well as client decision about the pregnancy. The study included 60 participants who were seeking services at a pro-life pregnancy counseling center. Participants were assigned to either an enhanced informed consent group or a group where standard clinic procedures took place. The results of this study indicated no differences between groups on the dependent measures. The groups demonstrated equivalent ratings of counselor/psychotherapist expertness, trustworthiness, or attractiveness and both groups were equally likely to terminate the pregnancy. The authors of this study suggested a thorough informed consent procedure may not impact client’s pregnancy related decisions and may not influence how a counselor/psychotherapist is perceived in terms of expertness, trustworthiness, or attractiveness.
Jensen, McNamara, and Gustafson (1991) examined both the views of parents and, to a lesser extent, clinicians related to informed consent. There were 161 parent participants and an unreported number of clinicians. Participants were mothers who were surveyed regarding mental health treatment for their child/children while clinicians were identified as providers of parent and child psychology. Parents were surveyed on five issues. First, they were presented seventeen areas germane to informed consent and asked to rate them (in terms of importance) on a five point likert scale. Results in this area yielded a strong parental desire to know about the limits of confidentiality, fee structuring, and iatrogenic risks. Second, parents were asked to rate these same seventeen items as therapeutic risks or benefits. Results in this area indicated issues having been rated as highly important were also rated as having either a high risk or benefit potential. Third, parents were asked if they preferred information on therapeutic risks or benefits at the outset of treatment or as issues arose. In addition, they were asked in what format such information should be provided (oral, written, or combined). Results indicated parents largely wished to have information prior to the outset of treatment and in oral as well as written format. Fourth, parents were asked to rate (in terms of importance) several factors that may influence a decision to enter a child in therapy. Results here indicated the most important factors were those related to the severity of the child’s behavior and therapist qualification. Fifth, parents completed the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH). Results indicated parents had fairly positive views of psychotherapy. Clinicians surveyed in this study gave responses (of importance) very similar to those noted by parents with one important
difference. Clinicians did not view discussion of consent issues as importantly as did parents.

Braaten, Otto, and Handelsman (1993) attempted to discern exactly what preferences a person may have for knowledge related to psychotherapy. The authors reported an interest in understanding this through the use of an open-ended question. Each of the 108 university student participants was asked the following question: “What is the most important information you would need to know when deciding whether to go into therapy with a psychologist?” Half of the participants received Handelsman & Galvin’s (1988) consent form while the other half did not. Study participants were university students that volunteered and received extra credit points for their participation. Study participants reported having had experience as a client in counseling/psychotherapy. The results of this study indicated participants placed a high value on a variety of information related to therapy. The authors noted the most frequently requested information related to the therapist (experience, credentials, and personal characteristics) and the least emphasis was on issues such as appointments, alternatives, and confidentiality.

Sullivan, Martin, and Handelsman (1993) explored the perspective of 124 study participants related to three areas germane to informed consent. Study participants were students within an introductory psychology course that received extra credit for their participation. Participants were asked to react to a transcript describing a fictitious therapist. Variables related to this therapist were manipulated in three important ways. First, the therapist was presented as using a verbal and written informed consent procedure or none at all. Second, the therapist was described as either a professional or
paraprofessional. Third, the degree of experience of therapist was varied. The results of
this study indicated the therapist was viewed more positively when utilizing a verbal and
written informed consent procedure rather than none at all. Further, it was found
participants viewed only subtle differences between paraprofessionals and professionals.
Lastly, those therapists with more experience were viewed more positively.

Claiborn et al. (1994) sought to explore understanding of several issues germane
to the relatively broad area of counseling/psychotherapy ethics. These included
confidentiality, dual relationships, informed consent and business practices, competence,
sensitivity to differences, and interventions. There were ninety-six participants that
completed a survey questionnaire. Study participants were recruited from several cities
by graduate students in counseling and counseling psychology. Study participants were
random individuals approached by the recruiting graduate students. They were given
instruction not to recruit mental health professionals, clients from mental health agencies,
or members of their own family. They were further instructed to not recruit more than
one person from a given family. Participants included individuals with and without
counseling/psychotherapy experience. The questionnaire required all participants, both
those with and without counseling/psychotherapy experience, to rate the ethical
appropriateness of practices that may occur in counseling/psychotherapy. The
questionnaire also asked only those that had been counseling/psychotherapy clients
answer questions related to the frequency of occurrence related to the aforementioned
practices. Results related to the area of informed consent indicated many practices were
seen as being appropriate and frequently occurring, including provision of fee
information, discussion of how counseling/psychotherapy is helpful, and description of
therapeutic techniques. Some practices were noted to be appropriate but occurred infrequently including discussion of the strengths/weaknesses of testing, the risks of therapy, and the estimated length of therapy. Practices that were rated by study participants as inappropriate included advertising services that were different from those offered, failing to answer client questions about treatment, or testing without explanation. Occurrence of these practices was notably infrequent.

Gustafson, McNamara, and Jensen (1994) examined how informed consent information influenced parents’ decisions regarding psychotherapy for their children. There were 144 participants who were placed within one of six treatment groups. The treatment groups were based upon random assignment to one of two case studies and one of three written informed consent vignettes. The first case study disclosed information about a child who demonstrated behavior indicative of diagnostic criteria for ADHD while the second case study disclosed information about a child that could be characterized as occasionally concerning but not clinically significant. Each of the vignettes described a hypothetical meeting with a psychologist wherein risks and benefits to treatment were discussed. The ratio of risks to benefits varied for each vignette. Participants were asked to read the randomly assigned case study imagining the child to be their own and also read a randomly assigned vignette. Participants then responded to seven-point likert scale questions regarding their decision to seek treatment. The results of this study indicated that risks and benefits as disclosed in the each of the vignettes held a minor impact on decisions to seek treatment for a child. However, the severity of the behavioral difficulty and overall attitude toward psychotherapy did impact decision to seek treatment.
Walter and Handelsman (1996) surveyed 205 college students regarding their perception of a fictitious counselor/psychotherapist as impacted by informed consent. Participants read an informed consent information sheet and one of two written dialogues. The dialogues contained either very specific or general discussion of the informed consent information. Participants rated the fictitious counselor/psychotherapist via the Counselor Rating Form - Short Version. They also completed the Beck Depression Inventory and answered questions assessing how much of the informed consent information and dialogue they recalled. Results indicated participants who received the more specific dialogue saw the fictitious counselor/psychotherapist as much more trustworthy and expert than those whom received the more general dialogue. However, those who received the more general dialogue did recall more informed consent information. There were no significant effects noted that related to depression.

Braaten and Handelsman (1997) surveyed 124 persons regarding their preferences for informed consent information. This study was unique in that of the 124 participants, 35 were current therapy clients, 47 were former therapy clients, and 42 had no therapy experience. This study used six questionnaires: a demographic questionnaire, a twenty-seven item informed consent questionnaire, the Attitudes Toward Seeking Professional Psychology Help Scale (ATSPPH), the Beck Depression Inventory, the Spielberger State-Trait Anxiety Inventory, and the Eating Attitudes Test. Participants, whether they be current therapy clients, former clients, or those with no therapy experience, all placed a high degree of value on informed consent. However, the particular content areas of informed consent did differ to some degree. Current and former therapy clients rated the following issues as most important to be discussed: techniques that are not appropriate
when used in therapy, confidentiality, risks of alternative treatments, how therapy may help with problems that are too serious to cope with alone, and how therapy may provide a supportive environment. Those with no therapy experience rated the following issues as most important: therapist credentials, inappropriate therapeutic techniques, confidentiality, and therapist’s area of specialization.

Wagner, Davis and Handelsman (1998) examined how readability and personalization of an informed consent form may impact a client’s initial impression of a counselor/psychotherapist as well as recall of information contained on the consent document. Participants in this study were 85 students from a variety of psychology courses in a university setting. This study was reported to be a 2x2 factorial design with between subject variables being readability (readable versus less readable) and personalization (personalized versus impersonal). The results of this study indicated more readable forms were associated with the perception of a counselor/psychotherapist as more expert and the form as more helpful while more personalized forms were associated with the perception of a counselor/psychotherapist as more attractive and the form viewed as more relevant and satisfying. Forms that were personalized were also reported to be associated with increased recall of the consent document’s contents.

Though the number of published empirical studies on the client’s perspective of informed consent is few, those cited above have yielded important findings. Research has shown clients valued informed consent as a part of mental health treatment (Sullivan et al. 1993). Further, clients appeared to view therapists in a positive fashion when an informed consent process was utilized (Sullivan et al. 1993; Handelsman, 1990; Wagner, Davis and Handelsman, 1998) especially when specific information was provided
(Walter & Handelsman, 1996). Informed consent processes/content were also not found to affect decisions to seek treatment (Gustafson et al., 1994; Mardirosian et al., 1990). Clients were noted to prefer combined oral and written consent processes and valued having information at the outset of treatment as opposed to a later time (Jensen et al., 1991). When examining the content of informed consent, research findings have suggested issues such as confidentiality, therapist years of experience, risks/benefits to treatment, and costs of treatment were important aspects to the client (Braaten et al., 1993; Braaten & Handelsman, 1997; Handelsman, 1990; Sullivan et al., 1993; Jensen et al., 1991; Claiborn et al., 1994).

Counselor/Psychotherapist Perspective of Informed Consent

Understanding how therapists view informed consent can provide insight into this important area of counseling/psychotherapy as well. Several authors have conducted empirical research in this area. These studies are reviewed in this section.

Handelsman et al. (1986) examined three areas germane to informed consent: use, content, and readability of written consent documents. The authors completed survey research, sending questionnaires to 196 private practitioners of psychology. There was a 53% response rate to their questionnaire. When looking at use, it was found 28% of respondents indicated using written consent documents. Respondent reasons for and against use of consent documents were presented. The primary reasons for use were facilitation of fee collection and the primary reason against use was a preference for verbal procedures. The authors of this study asked participants to return consent documents they used. Nineteen of such forms were returned with the content of the consent documents found to consist of many areas. The most frequently mentioned
issues were financial obligations (payment, fees for missed appointments, etc.) and confidentiality. Most interesting was readability, with the results of this study indicating the reading level of consent documents reviewed were equivalent with that of academically-oriented journal articles.

Talbert and Pipes (1988) sought to explore the degree to which written informed consent documents were being used in various settings as well as their content. To do this, these authors surveyed and requested information from forty sites that included private psychologists, community mental health centers, universities with an enrollment larger than 10,000, and universities with an enrollment under 10,000. The data gathered was compared to a nineteen-item checklist of informed consent content constructed by the authors. The results of this study indicated of the forty sites surveyed; only one had what was considered to be a majority of the nineteen items from the checklist. The issue that was communicated to clients on the most consistent basis was that of confidentiality. Beyond this, the issue most frequently discussed was of financial obligation.

Beeman and Scott (1991) explored how counselor/psychotherapists viewed informed consent with adolescents. In doing so, they conducted a national survey of 250 training agency psychologists. The survey was based on likert scale rating. The authors received a 52% response rate. The general findings of this survey indicated psychologists do attempt to obtain consent from adolescent clients. In addition, the authors examined information provision, reasons for requesting/not requesting adolescent consent, and situations when adolescents were unable or unwilling to provide informed consent. In regard to information provision, the authors found very different information as being important for adolescents than for adults. For example, time and place of sessions was
viewed as more important for adolescents while financial cost was viewed as more important for parents. When examining reasons for requesting/not requesting adolescent consent, several rationales were given by respondents. One rationale for requesting consent was to increase the therapeutic relationship. A rationale for not requesting consent was concern the adolescent would refuse treatment. Lastly, there was little agreement as to course of action when adolescents were unable or unwilling to provide consent.

As a byproduct of their study on parents’ attitudes toward the informed consent content in child psychotherapy, Jensen, McNamara, and Gustafson (1991) sent a questionnaire to child psychology clinicians. This questionnaire asked clinicians to rate seventeen items germane to informed consent via likert scale. Demographic material was also collected and found not to have an impact on clinician ratings in this study. The findings of this study indicated clinicians saw issues such as confidentiality, fee structuring, therapeutic benefits, and iatrogenic risk as most important with scheduling and labeling-stigma risks as less important.

Somberg, Stone, and Claiborn (1993) sought information on use, importance, reasons for not informing clients about consent issues, communication of consent information, methods, and timing in relation to five areas of informed consent (confidentiality, risks of therapy, length of treatment, possible procedures to be used, and alternative to therapy). The authors used a survey instrument and sent it to 324 practicing psychologists. The response rate for this study was 58%. It was found there was variability in the practice of consent administration. When considering therapists’ reasons for not informing clients of one of the areas of consent, therapists suggested they
did so when he or she believed the client had previous knowledge of that particular area. Some consent areas were rated by respondents to be more important than others. Respondents indicated being informed of the limitations of confidentiality was more important than the other consent areas. In relation to methods and timing of the consent process, it was found the method usually used was verbal and the timing was typically at the initial session. Lastly, theoretical orientation was examined and it was found therapists with a cognitive behavioral orientation viewed informed consent as most important.

Croakin, Berg, and Spira (2003) surveyed practitioners of psychotherapy to explore their view of informed consent through the use of a survey instrument. This survey was sent to 231 psychotherapists. This study is unique in that it examined information on psychotherapists from differing training backgrounds (psychiatry, PhD psychologists, licensed clinical social workers, and “other”), degree level (master’s degree, doctoral degree, etc.), age of therapist, and theoretical orientation (interpersonal therapy, cognitive behavioral therapy, and psychodynamic therapy, and “other”). There were six scales on the survey instrument as follows: informed consent (general statements of application of informed consent), therapeutic alliance (questions on how informed consent may influence the therapeutic alliance), the patient (questions of informed consent and how they may benefit the client), self disclosure (questions related to self-disclosure of a counselor/psychotherapist during a consent process), and level of detail (how detailed informed consent discussion was). High scores on scales indicated more positive views. The authors of this study posited opinions and practice of informed consent may vary with the individual characteristics of the counselor/psychotherapist.
There were salient findings related to provider type and modality of the counselor/psychotherapist.

Related to the provider type, statistically significant differences were found on the informed consent, written consent, and self disclosure scales. On the informed consent scale, the scores of the “other” group (e.g. marriage and family therapists) were significantly higher than those of the psychiatrists. On the written consent scale, the scores of psychologists, licensed clinical social workers, and “others” (e.g. marriage and family therapists) were significantly higher than those of psychiatrists. On the self disclosure scale, the scores of the “other” (e.g. marriage and family therapists) group were significantly higher than those of the psychiatrists. Psychiatrists evidenced significantly lower scores in this comparison on these three scales compared with other provider types. Thus, it is indicated psychiatrists may view the doctrine of informed consent to counseling/psychotherapy less positively than do other counselor/psychotherapists. There were significant findings related to the modality of the therapist on the informed consent, patient, and written consent scales. On the informed consent and patient scales, there were statistically significant differences between interpersonal therapists and psychodynamic/psychoanalytic therapists with the former having a higher opinion of informed consent. On the written consent scale, there was a statistically significant difference between the “other” (e.g. humanistic) category, the interpersonal category, the cognitive behavioral category versus the psychodynamic/psychoanalytic category with the latter evidencing a significantly lower opinion of informed consent. No significant differences were found related to the counselor/psychotherapist age or years of practice. No significant differences were
reported related to counselor/psychotherapist provider type, modality, age, or years of
practice and perception of how informed consent may influence the therapeutic alliance.

Haslam & Harris (2004) examined the content of informed consent documents
being used by therapists in clinical practice with a focus upon family therapists. Three
hundred and thirty-four invitations for participation were sent out to family therapists as
randomly selected from a database of clinical members of the American Association of
Marriage and Family Therapy. They were requested to return informed consent
documents in use. There was a 10% return rate, such that 34 informed consent
documents were analyzed. The authors used a grounded theory analysis to examine the
documents received. They discerned there to be seven conceptual categories common to
the documents that had been gathered. These categories were reported as follows: title of
documents, person-of-the-therapist information, the process or nature of therapy,
confidentiality, issues related to insurance, fee structure, and office
information/emergency procedures. The authors did note a significant amount of
variability in the details of these documents.

After reviewing published empirical research on the counselor/psychotherapist’s
perspective of informed consent, there are several important findings related to
counseling/psychotherapy. These findings include the characteristics of the
counselor/psychotherapist, the content of informed consent, and process of informed
consent. Related to the characteristics of the counselor/psychotherapist, differences were
noted by discipline (Croarkin et al., 2003) and also by theoretical orientation (Somberg et
al., 1993). Related to discipline, research has indicated counseling/psychotherapy
practitioners including psychologists, social workers and those characterized as “other”
(e.g. nurse practitioners) may place greater importance on issues germane to informed consent (Croarkin et al., 2003) while based upon theoretical orientation, those of an interpersonal or cognitive behavioral orientation may place greater importance on informed consent issues (Croarkin et al., 2003; Somberg et al. 1993). Reasons for this may vary greatly, but could relate to issues such as professional training. Related to the content of informed consent, empirical research has indicated counselors/psychotherapists view the salient factors of informed consent to include confidentiality, cost of treatment, office information, person of the therapist information, process/nature of therapy, and risks/benefits (Handelsman et al., 1986; Haslam & Harris, 2004; Jensen et al., 1991; Talbert & Pipes, 1988). The process of informed consent is intriguing as research has indicated a certain degree of variability in whether the procedure is verbal or written (Handelsman et al. 1986; Somberg et al. 1993) as well as with respect to what information is actually conveyed as part of informed consent procedures (Haslam & Harris, 2004; Talbert & Pipes, 1988). In addition, age has been noted as a salient factor in the process of informed consent procedure as those aged 12 or older have been found to be more likely to be included in such procedures (Beeman & Scott, 1991).

Working Alliance

The concept of working alliance originated in the psychoanalytic tradition (Martin, Garske, & Davis, 2000) with Sigmund Freud. Freud reportedly advocated therapist attention to the alliance (Tichenor & Hill, 1989) and recognized it as an important aspect of successful treatment (Saketopoulou, 1999). The working alliance remained an importance aspect of psychoanalysis as evidenced by its reference in the
works of psychoanalytically-trained individuals such as Richard Sterba in 1934 and
Elizabeth Zetzel in 1956 (Saketopoulou, 1999; Tichnor & Hill, 1989). Demonstrating its
recognized importance, working alliance is now accepted as a factor common to many
theoretical orientations and their efficacy (Horvath & Luborsky, 1993; Saketopoulou,
1999).

Bordin is credited with reinventing the concept of working alliance in several of
his works (Horvath & Greenberg, 1989). In 1979 he brought working alliance to the
forefront of psychology arguing that it may be the most salient component within a
counseling/psychotherapy relationship. Furthermore, he suggested that working alliance
may be trans-theoretical, representing a unifying construct within the differing theories of
treatment. He suggested working alliance can best be conceptualized through three
features; agreement on goals, assignment of tasks, and the development of a bond
(Bordin, 1979). Agreement on goals refers to the extent to which the client and
counselor/psychotherapist each agree on the desired outcome of treatment, while
assignment of tasks refers to the extent to which the client and counselor/psychotherapist
agree on the process of treatment, and the development of a bond refers to the quality of
the professional relationship between the client and counselor/psychotherapist (Bordin,
1979).

Since Bordin’s important work, research has demonstrated the quality of the
working alliance may be an important factor in the outcome of counseling/psychotherapy
(Hill & Williams, 2000; Horvath & Symonds, 1991; Martin et al., 2000). The working
alliance, also known as the therapeutic alliance, helping alliance, or simply the alliance
(Hill & Williams, 2000) has received a significant amount of scholarly attention due to its
reported importance within the process of counseling/psychotherapy. A sound working alliance rests largely on collaboration (Gelso & Fretz, 2001). Collaboration is important as it speaks to the necessity of both client and counselor/psychotherapist investing in the therapeutic relationship such that mutuality exists and the work of counseling/psychotherapy can be completed (Gelso & Fretz, 2001). Collaboration is necessary from the very early phase of treatment (Gelso & Fretz, 2001).

The actual timing or phases of the development of the working alliance have not been agreed upon (Hill & Williams, 2000). The suggestion has been made the working alliance grows over time or remains relatively stable after treatment has begun (Hill & Williams, 2000). The working alliance may develop differently for individual persons and there is some indication that critical periods may exist.

Horvath and Luborsky (1993) argue there are two critical periods in the working alliance. The first occurs at the outset of counseling/psychotherapy. At this stage “satisfactory levels of collaboration and trust must be established, the client needs to join the therapist as a participant in the therapeutic journey, agree on what needs to be accomplished, and develop faith in the procedures that provide the framework of therapy” (Horvath & Luborsky, 1993, p. 567). The second occurs when the client is confronted with change. “The client may experience the therapist’s more active interventions as reduction of sympathy and support; this could reactivate the client’s past dysfunctional relational beliefs and behaviors, thus weakening or rupturing the alliance” (Horvath & Luborsky, 1993, p. 567). Thus, the counselor/psychotherapist encourages change through active intervention, but supports the client and maintains the working alliance. Given the breadth of literature that exists in the area of working alliance, the
following areas will be examined: 1) factors in the working alliance, 2) measurement of
the working alliance, and 3) working alliance and counseling/psychotherapy outcome.

Factors Related to the Working Alliance

Working alliance has been explored in the context of several other factors.
Discussion of empirical research on working alliance follows and includes client factors
and counselor/psychotherapist factors. This is meant to provide information about the
diversity and depth of investigation that has been done on working alliance and
counseling/psychotherapy.

Client Factors Related to the Working Alliance

Client factors that have been investigated related to the working alliance include
several areas. Horvath and Luborsky (1993) suggested these issues can be organized
according to three categories; interpersonal issues of the client, intrapersonal issues of the
client, and diagnostic features. Interpersonal factors included “the quality of clients’
social relationships and family relationships, and indices of stressful life events” (p. 567),
the intrapersonal factors dealt with the “clients’ motivation, psychological status, quality
of object relations, and attitudes” (p. 567) and diagnostic features were reported to be
“the severity of the client’s symptoms in the beginning of treatment or to prognostic
indices” (p. 567). Literature related to each of these three categories will be considered
in turn.

Investigation on the interpersonal factors of the client and their impact on working
alliance has included several areas including personality characteristics, quality of
interpersonal relationships, and type of interpersonal problems. Hill and Williams (2000)
indicated research on working alliance and personality characteristics has shown
stereotypically adaptive personality characteristics, such as friendliness, may positively influence working alliance whereas stereotypically maladaptive personality characteristics such as hostility may have a negative impact. Kokotovic and Tracy (1990) reported that working alliance is related to the quality of client relationships and the level of client adjustment as rated by counselor/psychotherapist with no reported relationship between alliance and the presenting concern of the client (Kokotovic & Tracey, 1990). Horvath and Luborsky (1993) stated that research on the quality of interpersonal relationships, such as how individuals interact within friendships, family relationships, work interactions, etc. may serve as an indicator of the capacity of the client to enter into an adaptive relationship with a counselor/psychotherapist as well. Research on the type of interpersonal problems has indicated more benign interpersonal problems were associated with a positive working alliance while more pervasive interpersonal problems were associated with a negative working alliance (Muran, Segal, Samstag, & Crawford, 1994).

Intrapersonal factors explored include factors such as pretreatment factors, commitment to treatment, and early termination. Pretreatment predictions of the working alliance were found to include better motivation, access to coping strategies, greater social support, and secure attachment style (Meier, Donmall, Barrowclough, McElduff, & Heller, 2005). Client’s commitment to counseling/psychotherapy positively impacted the working alliance (Patterson, Uhlin, & Anderson, 2008). Thus, those that entered counseling/psychotherapy with a greater sense of dedication impacted the formation of the working alliance in a positive fashion. Specific negative correlates of the working alliance have been explored and found to include a history of drug abuse/dependence and lower peak social adjustment (Santiago et al. 2002). Early termination of the client and
how this relates to the working alliance has been explored empirically. This has included the extent to which working alliance is associated with client termination from counseling/psychotherapy. Findings in this area suggest working alliance is not associated with client choice to prematurely or unilaterally discontinue treatment (Kokotovic & Tracey, 1990; Tryon & Kane, 1993), but the alliance is related to mutual termination as rated by a counselor/psychotherapist. Interestingly, other research has found the therapeutic relationship, as measured by the working alliance, is important in determining clients at risk for poor treatment outcome (Samstag, Batchelder, Muran, Safran, Winston, 1998).

Attachment has been related to the working alliance (Hill & Williams, 2000; Eames & Roth, 2000) and is commonly defined as “an affectional tie that one person or animal forms between himself and another specific one—a tie that binds them together in space and endures over time” (Ainsworth, Bell, & Stayton, 1991, p. 31). Adult attachment patterns can be conceptualized as being Autonomous-Secure, Insecure-Dismissing, or Insecure-Preoccupied (Steele & Steele, 1994). Studies have found more securely attached clients report better working alliance (Goldman & Anderson, 2007; Hill & William, 2000; Satterfield & Lyddon, 1998), though there is some evidence this relationship decreases over time (Goldman & Anderson 2007). It has also been found there may be gender differences in how men and women of differing attachment styles form a working alliance (Hietanen & Punamki, 2006) and attachment memories such as parental bonds may influence the working alliance (Mallinckrodt, Coble, & Gantt, 1995). It appears attachment style and working alliance have a relationship which will continue to be investigated.
The diagnostic features of the client may impact treatment through its impact on working alliance (Horvath & Luborsky, 1993). Should more significant psychopathology be present, the working alliance may be influenced to a significant degree. McCabe and Priebe (2003) explored how the working alliance is impacted by demographic and clinical factors. This study took place with those considered to be seriously mentally ill with main findings of this study suggesting diagnostic features impacted working alliance. For example, those diagnosed with alcohol dependence rated the working alliance most positively while individuals diagnosed with schizophrenia rated the working alliance most negatively. Taft, Murphy, Musser, and Priebe (2004) had similar findings when exploring factors related to the impact of psychopathology on the formation of working alliance. This study occurred in a population of men receiving cognitive behavioral group therapy for partner violence. Their findings suggested lower levels of psychopathology were indicative of higher working alliance while higher levels of psychopathology were indicative of poorer working alliance. Pavio and Patterson (1999), when exploring the use of emotionally focused therapy on adult survivors of child abuse found that both the severity of abuse, as well as the presence of personality disorders were both related to difficulty in the formation of a working alliance.

Counselor/Psychotherapist Factors Related to the Working Alliance

Hill and Williams (2000) proposed the counselor/psychotherapist factors which influence working alliance can be organized according to therapist characteristics, therapist techniques, and therapist experience level. Horvath and Luborsky (1993) indicated additional issues such as the re-creation of previous interpersonal relations and attachment style of the counselor/psychotherapist are also salient factors.
Personal characteristics of the counselor/psychotherapist highlight the personality idiosyncrasies of the mental health professional as they manifest in the professional relationship with the client. Hill and Williams (2000) suggested more positive working alliance ratings have been linked to personal characteristics that are considered positive or adaptive, such as flexibility amongst others. Personal characteristics may go beyond personality to include issues such as ethnicity, race, age, or gender. Farkhondeh Draghi-Lorenz, and Ellis (2007) examined how ethnic similarity between a counselor/psychotherapist and client may impact working alliance. Their findings suggested matching ethnicity between counselor/psychotherapist and client positively impacted working alliance. However, there were no significant findings related to age or gender and working alliance. Wintersteen, Mensinger, and Diamond (2005) examined how gender and racial differences may impact the working alliance within a counseling/psychotherapy dyad. Their findings suggested client and counselor/psychotherapist matching of gender did positively impact working alliance while racial matching did not impact the working alliance.

Therapist techniques refer to the interventions individual counselors/psychotherapists may utilize in treatment. Reportedly, certain interventions (e.g. attention to nonverbal behavior) have been noted as facilitators of the working alliance and certain interventions (e.g. assessing or exploring) as impediments to the working alliance (Hill & Williams, 2000). Beyond techniques, working alliance has been explored in the context of specific theories of treatment. Specifically, behavioral therapy, cognitive therapy, gestalt therapy, and psychodynamic therapy have all been examined in this context with findings indicating that a strong working alliance appears
to positively impact each of the aforementioned treatment approaches (Horvath & Luborsky; 1993). More recent research in the area of theories of treatment appears to support this finding.

When comparing psychodynamic therapy to cognitive behavioral therapy, findings have suggested the latter resulted in a more efficacious working alliance, while both therapies resulted in positive ratings of working alliance if sessions were viewed as having adequate depth and smoothness (Raue, Goldfried, & Bark, M., 1997). Black, Hardy, Turpin, and Parry (2005) had similar findings in their examination of attachment as well as theories of treatment. Specifically, cognitive behavioral therapists rated the working alliance higher than those with a psychodynamic orientation. When examining how working alliance may function within cognitive therapy, particularly how the working alliance may relate to cognitive change, findings suggested depressive thinking impacted one’s ability to form a working alliance and that agreement on tasks and treatment goals impacted ensuing changes in depressive thinking. The extent to which a quality working alliance was established and the success of cognitive restructuring of depressive thinking were both related to efficacious treatment outcomes (Rector, Zuroff, & Segal, 1999). Research on the development of a working alliance with adult survivors of child abuse being treated with emotionally focused therapy found that despite experiences of abuse, strong early alliances were established. These alliances were reportedly comparable to populations that did not experience abuse. Furthermore, it was found the alliance was noted to grow throughout treatment with strong alliance being associated with post-treatment change (Pavio & Patterson, 1999).
Experience level has been a focus of research on working alliance. Findings in this area appear to be somewhat mixed. Hill and Williams (2000) indicate neither extensive nor limited experience level appear to have impacted working alliance (Hill & Williams, 2000). However, there have been findings indicating moderate support for more experienced counselor/psychotherapists having stronger working alliances (Bein, Anderson, Strupp, Henry, Schacht, Binder, & Butler, 2000; Mallinckrodt & Nelson, 1991). The experience level of the counselor/psychotherapist has been shown to impact other treatment variables, such as tasks of therapy and goals of treatment, which may in turn have some influence on working alliance (Hill & Williams, 2000).

Re-creation of previous interpersonal relations refers to the counselor/psychotherapist being influenced by previous relations in the present (Horvath & Luborsky, 1993). Such influence has obvious implications for either strong or weak working alliance based upon the previous relationship that is represented in the present with client and counselor/psychotherapist.

Attachment style of the counselor/psychotherapist can be seen as an important indicator of working alliance (Horvath & Luborsky, 1993). Much attention is given to the attachment style of the client versus that of the counselor/psychotherapist. This may be due in part to the client being the central focus of the therapeutic relationship. However, it has been suggested counselor/psychotherapists should examine their own attachment style as well to determine how it may impact working alliance and treatment (Gelso & Hayes, 1998). Black et al. (2005) examined counselor/psychotherapist attachment style with findings suggesting a secure attachment style was correlated to good working alliance and alternately anxious attachments being negatively correlated
with good working alliance. Sauer, Lopez, and Gormley (2003) examined how
counselor/psychotherapist attachment style may impact the working alliance over time
with findings suggesting that anxiously attached therapists had a positive impact on the
working alliance after an initial session and a negative impact over time.

Measurement of the Working Alliance

Given the relative significant attention working alliance has received as an
important aspect of successful counseling/psychotherapy, the measurement of the alliance
is a salient factor in need of discussion. Several different measures have been developed
to explore the construct of working alliance in the counseling/psychotherapy relationship.
Horvath and Symonds (1991) cite fourteen different measures used to assess the working
alliance. The four most commonly used measures are discussed here. These are the
California Psychotherapy Alliance Scales (CALPAS), the Penn Helping Alliance Rating
Scale (Penn), the Vanderbilt Therapeutic Alliance Scale (VTAS), and the Working
Alliance Inventory (WAI). Discussion of each measure is not exhaustive, but meant to
provide general information of available measures of the working alliance.

The California Psychotherapy Alliance Scales (CALPAS; Marmar & Gaston, 1988) is a 24-item measurement of working alliance that is grouped into four different
scales. These scales include patient working capacity, patient commitment, patient-therapist agreement on goals and strategies, and therapist understanding and involvement.
Internal consistency estimates for the CALPAS subscales have been reported be .95, .96,
.95, and .97 respectively (Gaston, Marmar, Gallagher, & Thompson, 1991). Items from
the individual scales are likert based. Gaston et al. (1991) report correlations among the
scales ranging from .33 to .83. The CALPAS is based upon the theoretical perspectives
of Freud, Bordin and Roger’s ideologies related to working alliance. This includes the client’s bond with the counselor/psychotherapist, the client’s ego capacity for working alliance, agreement on the tasks and treatment goals, and the counselor/psychotherapist’s role as an empathic listener (Fenton, Cecero, Nich, Frankforter, & Carroll, 2001). There are client, counselor/psychotherapist, and observer rated versions of the CALPAS (Elvins & Green, 2008).

The Penn Helping Alliance Rating Scale (Penn, Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983) is a 10-item measurement of working alliance that is grouped into two primary scales. The first scale measures working alliance as viewed from a psychoanalytic perspective, with a focus upon the client’s bond with the counselor/psychotherapist. The second measures alliance as viewed from Bordin’s view of the alliance, with a focus on the tasks and goals of counseling/psychotherapy. Internal consistency coefficients for the Penn have been found to be .96 (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983) and .93 (Tichenor & Hill, 1989) with interrater reliability of .71 (Tichenor & Hill, 1989). There are client, counselor/psychotherapist, and observer rated versions of the Penn (Elvins & Green, 2008).

The Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983) is a 44-item measurement of working alliance that is grouped into three scales. The scales include the counselor/psychotherapist’s contributions to the alliance, the client’s contributions to the alliance, and the client and counselor/psychotherapist’s mutual contribution to the alliance. The VTAS reportedly represents the perspectives of both dynamic and eclectic principles (Horvath & Luborsky, 1993; Cecero, Fenton,
Frankforter, Nich, & Carroll, 2001). Six factors are assessed through the VTAS including positive climate for treatment, counselor/psychotherapist intrusiveness, client resistance or anxiety, client motivation for treatment, and client responsibility (Cecero et al., 2001). Internal consistency estimates for the VTAS have been reported to be .95 (Hartley and Strupp, 1983), .93 (Tichenor & Hill, 1989) and .87 (Carroll, Nich, & Rounsaville, 1997) and interrater reliability has been computed as .69 (Hartley and Strupp, 1983), .74 (Tichenor & Hill, 1989), and .59 (Carroll et al., 1997). The VTAS is available in an observer rated version only (Elvins & Green, 2008).

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) is a thirty-six item measure of working alliance. This measure is based on Bordin’s view of the working alliance and has three subscales: agreement on the tasks of treatment, agreement on the goals of treatment, and agreement on bond. Items of WAI are likert based. There are four versions of the WAI, a counselor/psychotherapist version, a client version, an observer version, and a short version. Internal consistency estimates for the full version of the WAI reportedly range from .93 to .84 (Adler, 1988; Horvath, 1981, Plotnicov, 1990) while test-retest reliability for the full scale have been reported to be .80 (Plotnicov, 1990) with the test-retest reliability for the subscales ranging from .74 to .66 (Plotnicov, 1990). The three subscales have also been noted to be highly intercorrelated within the range of .60 to .80 (Horvath & Greenberg, 1989).

The existence of these four differing measures of working alliance and their differing theoretical foundations offers researchers variety in how they may wish to explore the construct of working alliance. Each has established psychometric properties as noted. The Working Alliance Inventory appears to be the most commonly used
measure. Busseri and Tyler (2003) observed that the Working Alliance Inventory has been the focus of the vast majority of empirical attention including prediction of working alliance and how working alliance relates to counseling/psychotherapy outcome.

**Working Alliance and Counseling/Psychotherapy Outcome**

Numerous studies have explored the relationship between working alliance and counseling/psychotherapy outcome; and the research in this area is on-going (Horvath, 2006). The meta-analytic studies completed by Horvath and Symonds (1991) and Martin, Garske, & Davis (2000) summarized the empirical work completed on working alliance and counseling/psychotherapy outcome through their respective dates of publication. Horvath and Symonds (1991) examined 24 studies (representing 20 individual data sets) that examined working alliance and counseling/psychotherapy outcome. The authors used five criteria for inclusion in their meta-analytic study: (a) “The relationship construct measured in the study had to be identified by the author(s) as either ‘working,’ ‘helping,’ or ‘therapeutic alliance’; (b) The investigation had to report a quantifiable relationship between the alliance and some indices of outcome measure subsequently; (c) Research included was clinical (as opposed to analog); (d) All the reports analyzed were based on 5 or more subjects; and (e) Only research involving individual treatment (as opposed to group or family therapy) was included in this review” (p 140).

The overall effect size for this study was reported to be .26 which was noted to be moderate but reliable. The effect size was calculated taking into account differing raters of the working alliance and differing measures of the working alliance within each included study. The working alliance was rated singly or in a combination by a client,
therapist, or observer. Measures used by individual studies included the Working Alliance Inventory, Helping Alliance Questionnaire, Helping Alliance Rating, Helping Alliance Counting Signs, Client Involvement Scale, Vanderbilt Therapeutic Alliance Scale, Therapeutic Alliance Scale, Vanderbilt Psychotherapy Process Scale, California Therapeutic Alliance Rating System, California Psychotherapy Alliance Scales, Penn Helping Alliance Rating Scale, Therapeutic Bond Scale, Active Engagement, Minnesota Multiphasic Personality Inventory, and the Therapeutic Alliance Rating Scale. Working alliance was shown to be predictive of counseling/psychotherapy outcome particularly when the outcome was rated by clients, with an average effect size of .21. This is reportedly less true when outcome is rated by counselors/psychotherapists or observers with effect sizes of .17 and .10, respectively. Furthermore, working alliance was most predictive of outcome when the alliance was rated by the client or observer with effect sizes of .27 and .23 respectively. Interestingly, findings indicated working alliance and outcome were not related to the type of counseling/psychotherapy, the duration of treatment, whether research was published or unpublished, or the number of study participants.

Martin, Garske, and Davis (2000) conducted a meta-analysis of working alliance and counseling/psychotherapy outcome to update the findings of Horvath and Symonds (1991). Horvath and Symonds (1991) identified 24 studies that met criteria for inclusion in their meta-analysis whereas Martin, Garske, and Davis (2000) identified 79 studies. As in the study by Horvath and Symonds (1991), the effect size was calculated by taking into account different raters of the working alliance, and different measures of the working alliance within each included study. There was a variety of measures used
singly or in combination. The authors used the same five criteria for inclusion as specified by Horvath and Symonds (1991), yet they extended the criteria such that “the study needed to be presented in English and the study had to be available between January 1, 1977, and January 1, 1997.” This study found an overall alliance outcome correlation of .22 which was characterized as moderate, but reliable. Beyond this, working alliance and outcome were found to be unrelated to “the type of outcome measure used in the study, the type of outcome rater, the time of the alliance assessment, the type of alliance rater, the type of treatment provided, or the publication status of the study” (p. 438).

The results of the meta-analysis by Horvath and Symonds (1991) and Martin, Garske, and Davis (2000) provide two important findings. First, the moderate, but reliable effect size found between working alliance and counseling/psychotherapy outcome is reportedly within the range of expected effect size pertaining to counseling/psychotherapy outcome (Martin, Garske, and Davis 2000) and suggests working alliance is positively related to counseling/psychotherapy outcome. Second, these meta-analyses ruled out several factors as impacting working alliance and outcome in counseling/psychotherapy. Thus, one can be reasonably certain that the effect size found in each of these studies is due to working alliance and not other factors ruled out as relating to the effect size of working alliance and counseling/psychotherapy outcome.

Empirical research on the working alliance and its impact on counseling/psychotherapy outcome continues. Howard, Turner, Olkin, and Mohr (2006) examined how interpersonal problems prior to treatment may impact the working alliance and hence treatment outcome. This study’s participants were individuals diagnosed with
multiple sclerosis that had entered counseling/psychotherapy for treatment of depression. Study participants were treated for their depression with cognitive-behavioral therapy. Interpersonal difficulty was assessed using the Interpersonal Problems-Circumplex, while the working alliance was assessed with the client and therapist versions of the Working Alliance Inventory, and depression was assessed using the Beck Depression Inventory.

The results of this study found that interpersonal problems were predictive of working alliance ($\beta = -.494, p<.05$) and working alliance was predictive of post-treatment depression ($\beta = -.672, p<.01$). Furthermore, the results indicated interpersonal problems were significantly predictive of post-treatment depression ($\beta = .527, p \leq .01$), but this relationship was mediated by working alliance ($\beta$ for interpersonal problems $=.276, p \leq .01$ and $\beta$ for working alliance $=.545, p<.05$). Thus, the authors concluded that interpersonal problems prior to treatment may interfere with the formation of a working alliance thus impacting successful treatment outcome.

Psychlic, Laukkanen, Marttunen, and Lehtonen (2006) examined how working alliance and psychotherapy may impact treatment outcome. The particular treatment outcome measured in this study was cognitive performance and psychosocial functioning. Study participants were adolescent psychiatric inpatients that received bi-weekly counseling/psychotherapy that was psychodynamic in nature. The working alliance was measured using the full version of the Working Alliance Inventory. Cognitive performance was assessed using the five subtests of the Wechsler Adult Intelligence Scale-Revised. Psychosocial functioning was assessed using the Global Assessment Scale and the Offer Self-Image Questionnaire was used to assess the self image of participants. Based upon use of the Working Alliance Inventory, study participants were
divided into two groups, good working alliance and poor working alliance. The results of this study indicated working alliance was continuously better in the good alliance group versus the poor alliance group (p < .0005). Cognitive performance was noted to improve in both the good and poor alliance groups during treatment (p = .0001). There was a noted positive tendency toward psychological self-image in the good working alliance group during treatment and improvement in psychological, social and familial self-image was significant in the poor alliance group and entire sample. Regression analysis indicated good working alliance (β = .87, p = .0005) and number of psychotherapy sessions (β = .34, p = .008) were predictive of positive changes in cognitive performance at discharge.

Hawley and Garland (2008) examined the working alliance in the context of outpatient treatment for adolescents and how the alliance relates to counseling/psychotherapy outcome. Participants in the present study were adolescents, their parents, and counselors/psychotherapists providing outpatient treatment. All participants completed a short version of the Working Alliance Inventory and several outcome measures. Youth symptom severity was assessed using the Youth Self Report and Child Behavior Checklist, youth self esteem was assessed using the Rosenberg Self Esteem Scale, youth functioning was assessed using the Vanderbilt Functioning Inventory, family relationship functioning was assessed using the Family Relationship Index, youth/parent social support was assessed using the Social Support Questionnaire, and youth/parent satisfaction with counseling/psychotherapy was assessed using Multidimensional Adolescent Satisfaction Scale.
Major findings of this study indicated adolescent-rated working alliance was significantly associated with several outcome measures as follows: decreased total (p<.001) and externalizing (p<.001) symptoms on the Youth Self Report and Child Behavior Checklist; decreased internalizing symptoms on the Youth Self Report (p<.05); improved family functioning on the youth (p<.001) and parent (p<.01) scales of the Family Relationship Index; increased youth self-esteem on youth-completed Rosenberg Self Esteem Scale (p<.01); greater perceived social support on the youth (p<.001) and parent (p<.05) versions of the Social Support Questionnaire; and both youth and parent satisfaction with counseling/psychotherapy as rated by the Multidimensional Adolescent Satisfaction Scale (p<.001) and the Consumer Satisfaction Questionnaire (p<.05).

Parent-rated working alliance and therapist-rated working alliance also showed significant associations with outcome measures, though these associations were fewer in number and tended to be within subject. That is, parent-rated working alliance was significantly associated with the parent-rated measures of outcome and the therapist-rated working alliance was associated with the therapist-rated measures of outcome. Thus, it was found that working alliance is a salient factor when working with adolescents as it was related to several aspects of counseling/psychotherapy outcome.

Dundon et al. (2008) conducted a study examining how the working alliance impacts treatment outcome for individuals receiving treatment for alcohol dependence. Participants in this study were individuals receiving treatment for alcohol dependence at an outpatient treatment and research center. Study participants were randomly assigned to a naltrexone or placebo group, with subsequent assignment to one of three interventions. These interventions were medication clinic only, medication clinic plus
BRENDA (a biopsychosocial evaluation), and medication clinic with cognitive behavioral therapy. The working alliance was assessed in this study through use of the Working Alliance Inventory. The outcome measures in this study were percent of days abstinent and percent of therapy sessions attended. Major findings of this study follow. Within the medication clinic only condition, alliance as assessed by counselors/psychotherapists, was marginally related to percent of visits attended (p=.057) with no relationship to percent of days abstinent. In the medication clinic plus BRENDA counselor/psychotherapist ratings of alliance were positively correlated with percent of days abstinent (p=.013) but not percent of visits attended. There were no significant findings in the medication clinic with cognitive behavioral therapy related to either of the outcome measures. The authors of this study did not report findings related to the placebo versus the naltrexone groups. Surprisingly, no significant relationships were found between the alliance as assessed by study participants in the differing treatment groups and outcome. Thus, the authors of this study called for more investigation in this area to allow for greater understanding of what role working alliance plays in successful treatment outcome for individuals in treatment for alcohol dependence.

The studies completed by both Horvath and Symonds (1991), Martin, Garske, and Davis (2000), and subsequent authors reflect the ongoing empirical research on working alliance and its relationship to counseling/psychotherapy outcome. The meta-analytic work shows a moderate but reliable relationship between working alliance and efficacious counseling/psychotherapy outcomes. Furthermore, the more recent studies reviewed suggest that working alliance has a positive impact on the outpatient treatment of adolescents (Hawley & Garland, 2008), and may impact outcomes of alcohol
dependency treatment (Dundon et al., 2008). Research has also illuminated other factors that are associated with working alliance and treatment outcomes such as interpersonal problems prior to treatment (Howard et al., 2006), cognitive performance and psychosocial functioning (Psychlic et al., 2006). Working alliance is clearly an important aspect of counseling/psychotherapy and will likely continue to be a focal point of scholarly inquiry.

Client Perception of Counselor/Psychotherapist

The client’s perception of a counselor/psychotherapist has been stated to be a “crucial issue in counseling practice and research” (Ponterotto & Furlong, 1985, p. 597) and has reportedly been the focus of significant scholarly attention (Arbuckle, 1956). This is the case as the client’s perception of the counselor/psychotherapist is likely to impact how the treating clinician is able to facilitate the client in making adaptive change (Henderson & Lyddon, 1997). Luborsky (1952) reported common personality characteristics of counselors/psychotherapists include being sensitive to others, being an independent thinker, being subdued in expressions of warmth, being quiet or reserved, being able to appropriately express themselves, and being conventionally adjusted. Cottle (1953) also discussed personality characteristics of counselor/psychotherapists when reviewing several differing studies. The personality characteristics of counselors/psychotherapists were reported to include being understanding, having a compassionate attitude, being friendly, being stable or secure, having a sense of endurance or patience, having common sense, and being objective. Arbuckle (1956) indicated desirable counselor/psychotherapist personality attributes may include a sense
of general confidence, being experienced by others as normal, and having an interest in areas of social science and research.

As noted, the client’s perception of a counselor/psychotherapist’s attributes may represent a salient factor related to a client’s ability to make adaptive life change. In his 1968 work Stanley Strong discussed how social psychology principles may apply to counseling/psychotherapy. He took the social influence process of opinion change and operationalized it within the therapeutic context. Strong pointed out the goal when seeking to change an opinion is to influence an audience in a predetermined direction whereas the goal in counseling/psychotherapy is to influence the client to attain the goals of treatment. The process of opinion change reported by Strong may occur as a result of five factors: communication discrepancy, perception of communicator expertness, perception of communicator trustworthiness, perception of communicator attractiveness, and involvement. Note that in the context of opinion change, the recipient is the message receiver and the communicator is the message transmitter.

Communication discrepancy occurs when there is a dissonance between the recipient’s cognitions and the content of the communicator’s message. Strong (1968) stated that the communicator will change their cognitions only when “other means of dissonance reduction are controlled” (p. 216). Perception of the communicator as an expert was reported to be based upon objective evidence such as displayed educational degrees or licenses, the actions of a communicator including overall verbal/nonverbal presentation, and reputation as being skilled (Strong, 1968). Strong suggested that perception of communicator as trustworthy occurred when the communicator had a reputation of honesty, presented self as a professional, was seen by recipients as being
genuine, open, and altruistic (Strong, 1968). Perception of the communicator as attractive is reported to be related to similarity and compatibility between recipient and communicator (Strong, 1968). Similarity and compatibility can be influenced by a variety of factors, such as overall background or general opinions (Strong, 1968). The last issue, that of involvement, relates to the extent of importance a recipient places on an issue. Those issues with more intrinsic value may have the effect of engaging or involving the client. Thus, the communicator, may impact involvement by assessing and influencing the recipient’s opinion as well as the amount of physical and/or psychological effort necessary to effect change (Strong, 1968).

Strong (1968) applied these concepts to the counseling/psychotherapy relationship through a two-phase model of treatment. In the first phase, the counselor/psychotherapist attempts to establish credibility through purveying expertness, trustworthiness and attractiveness. In the second phase, based upon the credibility established in the first phase, the counselor/psychotherapist is able to influence the client to move toward adaptive change. Hence, based on this theory, adaptive change is most likely to occur when the counselor/psychotherapist can establish themselves as expert, trustworthy, and attractive, and utilize the perceived credibility to influence the client toward achievement of the goals of treatment.

Factors Related to the Client Perception of Counselor/Psychotherapist

examined social influence research in an effort to suggest future avenues of empirical study and to consider three questions. First, whether counselor/psychotherapists influence clients; second, what cues clients may use to determine expertness, trustworthiness, and the attractiveness of their counselor/psychotherapist; and third, whether the consideration of counseling/psychotherapy as a social influence process is useful. Similarly, Heppner and Dixon (1981) examined how counselor/psychotherapists influence clients through review of existent research on client perception of expertness, trustworthiness, and attractiveness as well as the extent to which these counselor/psychotherapist characteristics may influence clients in their thinking and behaviors with suggestions made for future research. Heppner and Claiborn (1989) reviewed studies that explored research on the social influence process of counseling/psychotherapy since 1981 with particular attention to factors that may impact how a counselor/psychotherapist may be perceived as expert, trustworthy, or attractive as well the process whereby the client’s perception of the counselor/psychotherapist as expert, trustworthy, and attractive may influence the client toward change.

Heppner and Claiborn (1989) reported the research on the factors that impact how counselor/psychotherapists are perceived fell into four categories: counselor variables in analogue studies, counselor variables in field studies, client variables, and client-counselor similarity studies. Studies summarized by Heppner and Claiborn (1989) related to counselor variables in analogue studies resulted in interesting findings. In this area, studies were separated by the specific area of counselor rating examined (expertness, trustworthiness, or attractiveness).
Studies of expertness included exploration of several different variables including evidence of training, prestigious cues, counselor/psychotherapist behaviors, and personal characteristics. Studies examining evidence of training and prestigious cues were reported to consistently have a positive impact on client perception of counselor/psychotherapist (Angle & Goodyear, 1984; Berstein & Figioli, 1983, Littrell, Caffrey, & Hopper, 1987; McCarthy, 1982; Paradise, Conway, & Zweig, 1986). Counselor/psychotherapist behaviors included both verbal and nonverbal behaviors. Findings suggested nonverbal behaviors (e.g. physical touch or gestures) by the professional produce a positive view related to expertness (Barak, Patkin, & Dell, 1982; Hackman & Claiborn, 1982; Hubble, Noble, & Robinson, 1981; Roll, Crowley, & Rappl, 1985; Seigel, 1980; Strohmer & Biggs, 1983; Tyson & Wall, 1983). Furthermore, there have been indications nonverbal cues are more important in determining perceptions of expertness versus other cues such counselor/psychotherapist attire (Barak et al. 1982; Lee, Uhlemann, & Haase, 1985; Robbins & Haase, 1985; Tyson & Wall, 1983). Investigation of verbal behaviors of the counselor/psychotherapist has indicated use of narrative analogies, empathic responses (Suit & Paradise, 1985) and positive self involving statements (Anderson & Anderson, 1985) had a positive impact on client view of expertness. Investigation of the personal characteristics of the counselor/psychotherapist and client perception of expertness found that the following factors had a positive impact: Black counselor/psychotherapist as indicated by White study participants (Paurohit, Dowd, & Cottingham, 1982); egalitarian sex role orientation (Atkinson & Alpert, 1981; Banikiotes & Merluzzi, 1981); counselor/psychotherapist with an obvious physical disability as indicated by able-bodied study participants.
(Mallinckrodt & Helms, 1986); counselor/psychotherapist with a Gay sexual preference as indicated by Gay clients (Atkinson, Brady, & Casas, 1981); and informal attire (Roll & Roll, 1984).

Studies on trustworthiness examined cues and behaviors of counselor/psychotherapists. Cues examined that had a positive impact on trustworthiness included prestigious cues such as credible introductions (Berstein & Figioli, 1983; Littrell et al., 1987) and advanced experience level (McCarthy, 1982; McKee & Smouse, 1983). Behaviors of the counselor/psychotherapist that were reported to positively impact trustworthiness included congruity of roles (Ruppel & Kaul, 1982), responsive nonverbal behavior (Hackman & Claiborn, 1982), behaviors associated with confidentiality (LaFromboise & Dixon, 1981; Merluzzi & Brischetto, 1983) and self involving statements that were positive (Anderson & Anderson, 1985). Other findings that had a positive impact on trustworthiness related to personal characteristics of the counselor/psychotherapist included an egalitarian sex role orientation of the professional (Atkinson & Alpert, 1981; Banikotes & Merluzzi, 1981), counselor/psychotherapist with a Gay sexual preference as indicated by Gay clients (Atkinson et al., 1981), informal attire (Roll & Roll, 1984), Black counselor/psychotherapist as indicated by White study participants (Paurohit et al., 1982), counselor/psychotherapist with an obvious physical disability as indicated by able-bodied study participants (Mallinckrodt & Helms, 1986).

Studies on attractiveness also examined cues and behaviors of the counselor/psychotherapist. Cues that positively impacted perception of counselor/psychotherapist attractiveness included evidence of training through introduction (Angle & Goodyear, 1984; Berstein & Figioli, 1983; Paradise et al., 1986),

64
positive cues as to reputation (Littrell et al., 1987) and status related to advanced
experience (McCarthy, 1982). A positive relationship was reported between responsive
nonverbal behavior and perception of counselor/psychotherapist attractiveness (Barak et
al., 1982; Hackman & Claiborn, 1982; Strohmer & Biggs, 1983). Verbal behaviors that
were found to relate to perception of counselor/psychotherapist attractiveness included
self disclosure and self-involving statements (Anderson & Anderson, 1985; Curran &
Loganbill, 1983; Dowd & Boroto, 1982; Remer, Roffey & Buckholtz, 1983).

Counselor variables examined through field study were surprisingly minimal.
Heppner and Claiborn (1989) noted four studies in which perception of a
counselor/psychotherapist was investigated in a real world setting. Findings from these
studies indicated that counselor/psychotherapists were perceived quite positively by their
clients overall. Other findings related to the changing of client perception of
counselor/psychotherapist over time and experience level. There were mixed findings in
this area, yet the perception of the counselor/psychotherapist appeared to vary, possibly
positively increasing, through the course of the relationship (Heppner & Heesacker,
1982; LaCrosse, 1980). Findings related to counselor/psychotherapist experience level
were decidedly minimal with one study (Zamostny, Corrigan & Eggert, 1981) supporting
a more positive view of a more experienced counselor/psychotherapist.

Studies on client variables included gender, sex role orientation, cognitive
complexity, field dependence, marital status, and self concept. A significant relationship
was found only for gender. Findings on client gender were somewhat mixed as several
studies indicated an impact on the counseling/psychotherapy relationship. However, the
direction of the relationship appeared to vary (Bankikiotes & Merluzzi, 1981; Bernstein
Studies on client-counselor similarity related to group similarity and how this may influence counselor/psychotherapist perception. The idea that client-counselor similarity impacts perception of the counselor/psychotherapist was supported. Heppner and Claiborn (1989) noted eight studies which supported this idea. More specific support for client-counselor matching on specific factors included sexual preference (Atkinson et al., 1981), sexual attitude similarity (Holland, Atkinson, & Johnson, 1987), hearing impairment (Freeman & Conoley, 1986), and cultural sensitivity (Pomales, Claiborn, & LaFromboise, 1986). Similarity between client-counselor in each of these areas was reported to positively impact the client’s perception of the counselor/psychotherapist.

Research on the influence process within Strong’s (1968) model was very limited at the time of Heppner and Claiborn’s (1989) review and they reported on available research studies that explored the influence process in the context of therapeutic outcomes, attitude change, or symptom change. The theory holds that if a counselor/psychotherapist successfully influences change in a client, one or more of these areas will be impacted. Heppner and Claiborn (1989) examined research on the influence process and identified five categories of studies; counselor variables in analogue studies, counselor variables in field studies, client variable studies, message variable studies and studies that examined the interactions among counselor, client, and message variables.

Studies summarized by Heppner and Claiborn (1989) that examined counselor variables in analogue studies yielded several interesting findings. Results suggested clients were more willing to work with a professional that did not use profanity (Paradise,
Cohl, & Zweig, 1980). There was reported to be a likelihood a client would work with a
counselor/psychotherapist that used positive self-involving statements (Anderson &
Anderson, 1985) and had a positive reputation (Litrell et. al, 1987). Other findings
indicated a willingness to work with a counselor/psychotherapist that was congruent in
verbal as well as nonverbal behavior (Tyson & Wall, 1983) and additionally used
interpretations versus summary statements during treatment (Dowd & Boroto, 1982).
There were no reported findings related to different types of interpretative statements
utilized (Milne & Dowd, 1983) nor counselor attire (Roll & Roll, 1984),

Additional research in this area related to a client’s belief that a
counselor/psychotherapist may be able to help with a specific problem area based upon
certain characteristics of the treatment professional. One study examined both race and
attractiveness of the treatment professional with findings suggesting that Black versus
White counselor/psychotherapists were viewed as likely to be able to help (Green,
Cunningham, & Yanico, 1986). This was reportedly true of attractive treatment
professionals and furthermore, Black but not White study participants indicated attractive
treatment professionals as being more helpful versus unattractive treatment professionals
(Green et al., 1986). There were similar findings related to similarity of sexual attitude,
as clients that viewed their counselor/psychotherapist as having a similar attitude
believed they could be more helpful (Holland et al., 1987).

With respect to the influence process and gender, high school subjects were
reported to prefer a female counselor/psychotherapist for parenting issues while
alternately preferring a male professional when issues were of a vocational nature (Lee et
al., 1980). Furthermore, female undergraduate students indicated a greater likelihood to
disclose to a female counselor/psychotherapist who utilized an egalitarian sex role orientation (Banikiotes & Merluzzi, 1981) while undergraduate students appeared to respond more effectively to a counselor/psychotherapist that utilized more positive self-involving statements (Remer et al., 1983). Other findings related to attitude change with findings suggesting that trustworthiness and congruence in power base impacted clients’ intention to follow career planning suggestions (Ruppel & Kaul, 1982) and use of the Attributional Model of Attractiveness and Influence was supported (Hackman & Claiborn, 1982).

Heppner and Claiborn (1989) reported on several studies which examined the counselor/psychotherapist variables that affect the influence process through a field design. These related to the client perception of counselor/psychotherapist and treatment outcomes, client perception of counselor/psychotherapist ability to impact change, and initial perception of expertness. Counseling outcome was noted to be the measure of counselor/psychotherapist influence and included general satisfaction with treatment, changes in client presenting problem, and goal attainment. Findings supported a relationship between positive view of a counselor/psychotherapist and satisfaction with treatment outcome (Heppner & Heesacker, 1983; McNeill, May, & Lee, 1987; Zamostny et al., 1981; Dorn & Day, 1985; LaCrosse, 1980). Counselor/psychotherapists that were able to impact change in a client were perceived more positively by clients (Heppner & Heesacker, 1982). Another study found that initial perception of counselor/psychotherapist expertness was predictive of positive treatment outcome (LaCrosse, 1980). Also, perception of counselor/psychotherapist has been associated with premature termination, with findings suggesting that clients who perceived their
counselor/psychotherapist less positively were more likely to prematurely terminate treatment (McNeill et al., 1987; Kokotovic & Tracy, 1987).

Since Heppner and Claiborn's (1989) review, client perception of counselor/psychotherapist has continued to be explored. Several studies have examined how various issues or areas may impact a client’s perception of a counselor/psychotherapist. Such factors include power base, client’s psychological reactance, multicultural issues, religiosity, disability status, recovery status, use of counseling/psychotherapy techniques or strategies, working alliance, early termination, and gender issues. Discussion of empirical research on each of the noted areas follows.

Guinee and Tracy (1994) explored client preference for the “power base” of their counselor/psychotherapist. Drawing from Strong’s (1968) social influence theory, the counselor/psychotherapist’s power base could be categorized as expert, referent, and/or legitimate (Guinee & Tracey, 1994). Expert power refers to the knowledge and skills of a counselor/psychotherapist, referent power reflects interpersonal attraction, and legitimate power is associated with trustworthiness. Client preferences for the type of power base did not differ as a result of the experience level of the counselor/psychotherapist but client preferences did change as a function of client problem. Specifically, clients with career related problems were noted to prefer expert more than the legitimate power base while clients with depression/suicidality preferred the legitimate power more than the expert (Guinee & Tracy, 1994).

Psychological reactance is a tendency to react emotionally to perceived threats to behavioral freedom. Dissertation research has examined how client psychological reactance relates to social influence (Reitenbach, 2000). Findings in this area suggested
psychological reactance mediated the client’s perception of the counselor/psychotherapist related to social influence. Specifically, low reactant clients were found to have a higher perception of the social influence power of the counselor/psychotherapist versus those that were high reactant. In another dissertation, Courchaine (1994) found low reactance clients perceived their counselor/psychotherapist positively on the social influence variables of expertness, trustworthiness and attractiveness.

Multicultural issues have been examined in the context of client perception of counselor/psychotherapist. Richardson and Helms (1994) explored how racial identity attitudes of Black men impact client perception of counselor/psychotherapist, particularly in parallel counseling dyads. Parallel counseling dyads were reported to occur when both client and counselor/psychotherapist “share similar racial attitudes about Blacks and Whites as well as about themselves as members of their ascribed group” (p. 172). The results of this study suggested effective counseling/psychotherapy with black men is partly related to racial identity attitudes of both client and counselor/psychotherapist. Also, it was noted it may be important for counselors/psychotherapists to be able to accurately bring racial identity into the context of the therapeutic relationship and to use interventions which are sensitive to these issues. Furthermore, this study provided evidence that racial identity is a salient factor in how Black men may perceive counselors/psychotherapists.

Fraga (2003) investigated the potential relationship among client and counselor/psychotherapist ethnic similarity, Hispanic cultural value similarity, and social influence. The findings of this study suggested cultural value similarity was predictive of the client’s evaluation of the counseling/psychotherapy process as measured by client
ratings of the working alliance and counseling/psychotherapy outcome as measured by client satisfaction with the counselor/psychotherapist. The author suggests a positive predictive relationship with these variables is supportive of the social influence process in counseling/psychotherapy. Bhagwat (2001) examined Asian Americans as counseling/psychotherapy clients, comparing them to Caucasian American clients. Findings of this research suggested Asian American clients viewed counselor/psychotherapists more negatively. Specifically, such clients rated counselor/psychotherapists as less expert, trustworthy as well as less attractive and even less credible when compared to Caucasian Americans clients.

Guinee and Tracey (1997) explored the extent to which religiosity and problem type may impact how a client perceives a counselor/psychotherapist. Religiosity in the context of this study referred to degree of investment in Christian religious beliefs while problem area was categorized as either personal/social or educational/vocational in nature. Results of this study indicated the religiosity of the participant was significantly related to both perception of counselor/psychotherapist and willingness to seek help. When participants were dichotomized into high and low religiosity, there were no differences in how they viewed a secular or moderately religious counselor/psychotherapist, yet those with high religiosity viewed a highly religious counselor/psychotherapist more positively. An interaction was found between religiosity and problem type. A match on high religiosity between the participant and counselor/psychotherapist had a positive impact on the perception of the counselor/psychotherapist when the problem type was personal/social, but this was not found for educational/vocational problems. Likewise, a mismatch between participant
and counselor/psychotherapist (low participant religiosity and high
counselor/psychotherapist religiosity) had a negative impact on the perception of the
counselor/psychotherapist when the problem type was personal/social problems, but this
was not found for educational/vocational problems. Randall (1999) examined perceived
expertness in the context of mental health treatment. Particularly, whether, clergy would
be perceived as more expert when compared to Christian counselors. Results of this
study suggested that clients did perceive clergy as more expert when compared to other
mental health practitioners, such as psychologists or psychiatrists. The degree of
religiosity by the client was reported to not be a moderator.

Leierer, Strohmer, Leclere, Cornwell, and Whitten (1996) explored the effects of
counselor disability, attending behavior, and client problem on
counseling/psychotherapy. Findings of this study indicated there was minimal support
for a client viewing a similarly disabled counselor/psychotherapist more positively than
an able-bodied counselor/psychotherapist. There were no significant findings related to
the importance of the counselor/psychotherapist disability status when the topic of
treatment was germane to a shared disability. Counselors/psychotherapists that used
attending behavior were perceived more positively by clients with disabilities. Disabled
counselor/psychotherapists using attending behavior were viewed as more attractive than
able-bodied counselor/psychotherapist using attending behavior.

Leierer et al. (1998) explored whether disability status or reputation impacts how
a disabled client perceives the counselor/psychotherapist. Findings of this study
indicated disabled clients gave higher ratings of social influence, expertness,
trustworthiness, and attractiveness to counselors/psychotherapists that were able-bodied.
There was no noted relationship between a client’s ratings of a counselor/psychotherapist based upon reputation. Miller (1993) examined how disability status and perceived level of training may influence client perception of counselor/psychotherapist. Findings of this study indicated no differences in perception of expertness, trustworthiness, or attractiveness based on the disability status or level of training.

Priester, Azen, Speight, and Vera (2007) explored how the recovery status of a counselor/psychotherapist may impact how a recovering alcoholic client perceives them in the three areas of social influence: expertness, trustworthiness, and attractiveness. The results of this study suggested clients in recovery from alcoholism viewed counselors/psychotherapists who were similar in recovery status more positively. This suggests that similarity between counselor/psychotherapist and the client related to recovery status may impact the social influence process in treatment.

How the use of counseling/psychotherapy techniques or strategies may impact how the client perceives a counselor/psychotherapist has also been explored empirically. Morran, Kurpius, Brack, and Rozecki (1994) examined how a counselor/psychotherapist’s ability to formulate hypotheses related to the client’s perception of the counselor/psychotherapist. Findings of this study indicated clients tended to perceive counselors/psychotherapists in a positive fashion and this was particularly true when there was greater skill in hypothesis formation evidenced by the counselor/psychotherapist. Skill in hypothesis formation was assessed through the use of a measure designed for use in this study which examined several areas germane to the formation of hypotheses such as the number and dimensions of hypotheses, the number and dimensions of supportive information, and the overall quality of hypotheses.
Blankenship, Eells, Carolozzi, Perry, and Barnes (1998) examined how adolescent clients perceived counselors/psychotherapists when reframing or symptom prescription techniques were used. The results of this study indicated level of resistance should be assessed prior to use of particular techniques, particularly paradoxical techniques. The authors reported use of reframing resulted in more positive perception of a counselor/psychotherapist rather than use of symptom prescription. Miller (1992) examined how note-taking by a counselor/psychotherapist may impact client perception of the mental health professional. Findings of this study indicated note-taking did not influence client perception of the counselor/psychotherapist as expert, trustworthy or attractive. However, there was a noted preference in participants to see a counselor/psychotherapist who did not note-take.

Very little research has been done on the relationship of working alliance and client perception of the social influence variables of expertness, trustworthiness and attractiveness. In fact, only one dissertation (Lukin, 1997) was found which examined this relationship in the context of the counseling/psychotherapy relationship. In this research, Lukin hypothesized that participants indicating a higher perception of their counselor/psychotherapist as expert, trustworthy, and attractive would also have a higher working alliance. The Counselor Rating Form and Working Alliance Inventory were used and a significant correlation between these measures was found ($r=.837$, $p=.000$). Lukin suggests this relationship is an area for future inquiry, specifically what the relationship between these two variables may be. Other research has examined both working alliance and client perception of the social influence variables in the context of other factors. Helwig, (1995) conducted dissertation research examining the development
of working alliance and social influence in counseling/psychotherapy. Findings of this study suggested both working alliance and social influence were positively related to counselor/psychotherapist experience, client symptomatology, attachment style, and beliefs of social support.

Client perception of counselor/psychotherapist has also been examined in the context of termination. Martin, McNair, and Hight (1988) examined how termination may relate to how a client perceives their counselor/psychotherapist in terms of expertness, trustworthiness, and attractiveness and degree to which they believed themselves to be understood. The results of this study indicated clients did not tend to terminate counseling/psychotherapy prematurely due to treating professionals not being expert, trustworthy, or attractive nor due to a failure of the treating professional to understand their client. Rather, the results indicated study participants terminated prematurely because they lacked time for treatment, no longer required treatment, or forgot appointments. This finding conflicts with research reported by McNeil et al. (1987) which indicated clients that terminated treatment early perceived their counselor/psychotherapist less positively (McNeill et al., 1987). Harari and Waehler (1999) examined how discussion of termination at an initial appointment may impact perception of a counselor/psychotherapist. The results of this study indicated such discussion of termination at an initial appointment did not impact participant view of a counselor/psychotherapist as being expert, trustworthy, or attractive.

Gender issues in the context of client perception of counselor/psychotherapist have been explored by several authors. Glidden-Tracey and Wagner (1995) explored how clients may perceive counselors/psychotherapists in the context of gender
exploration. The results of this study demonstrated counselors/psychotherapists who indicated that gender was highly salient were viewed more positively as gender typical interactions increased. By contrast, counselors/psychotherapists who rated gender as less salient were viewed less positively, as gender typical interactions increased. Participants were assessed for the interaction type (positive or negative) with own sex. Results indicated participants who had a negative or unfavorable interaction with their own sex indicated increased willingness to meet with a counselor/psychotherapist who rated gender as highly salient and decreased willingness to meet with a counselor/psychotherapist who indicated gender as less salient.

Ametrano and Pappas (1996) explored how clients viewed counselor/psychotherapists in training, with a focus on the effects of sex and gender role orientation. The results of this study indicated sex or gender role orientation alone did not impact how clients perceived their counselor/psychotherapist along the lines of expertness, trustworthiness and attractiveness. However, there was an effect on the study participants’ willingness to refer a friend to their counselor/psychotherapist. Participants were less likely to refer a friend to male counselor/psychotherapist with undifferentiated gender than to male and female counselor/psychotherapists identified as androgynous, feminine female, and undifferentiated female.

Henderson and Lyddon (1997) examined the impact of client gender role attitudes on client’s perceptions of their counselor/psychotherapist. Findings suggested female participants rated the counselor/psychotherapist much higher than males. Additionally, it was found that clients’ perception of female counselor/psychotherapists was positively related to gender role attitude. Specifically, clients with a more positive gender role
attitude viewed a female counselor/psychotherapist as more expert, trustworthy, and attractive. The authors posit this suggests study participants had a less stereotypical and more liberal view of women’s roles.

Feldman, Kluwin, and McCrone (2006) examined how signing skill, gender, and therapy type impacted perceptions of deaf clients receiving counseling/psychotherapy. The results of this study indicated sex of the counselor/psychotherapist, the match between the counselor/psychotherapist’s gender and client’s gender, and mode of communication did not have a statistically significant impact on client perception of the treating professional related to expertness, trustworthiness, and attractiveness.

Measurement of the Client Perception of Counselor/Psychotherapist

Several different measures have been developed to explore client perceptions of counselor/psychotherapist. Ponterotto and Furlong (1985) discuss several measures by which a client can rate a counselor/psychotherapist including the Barrett-Lenard Relationship Inventory (BLRI), the Counselor Evaluation Inventory (CEI), the Counselor Effectiveness Scale (CES), the Counselor Effectiveness Rating Scale (CERS) and the Counselor Rating Form (CRF). These measures are discussed below. Discussion of each measure is not exhaustive, but meant to provide general information of available measures.

The Barrett-Lenard Relationship Inventory (BLRI; Barret-Lennard, 1962) is an 85 item measure of client perception of counselor/psychotherapist which is based upon the views of client centered therapy. Items of the BLRI are likert based. There are five subscales to this measure and results can be presented by subscale or total score. Subscale inter-correlations were reported to be .04 to .85 (excluding total score) and .04
to .92 (including total score) while split-half reliability ranged from .82 to .93 (Ponterotto & Furlong, 1985). Test-retest reliability coefficients were found to range from .78 to .90 (Ponterotto & Furlong, 1985). The validity of this measure was reported to be based upon expert ratings and predictive validity of counseling/psychotherapy outcome (Ponterotto & Furlong, 1985). There are client, and counselor/psychotherapist versions of the BLRI (Elvins & Green, 2008).

The Counselor Evaluation Inventory (CEI; Linden, Stone & Shertzer, 1965) is a 21 item measurement of client perception of counselor/psychotherapist which is based upon client perceived rapport. Items of the CEI are likert based. There are three subscales to this measure and results can be presented by subscale or total score. Subscale inter-correlations were reported to be .36 to .50 (excluding total score) and .36 to .70 (including total score) while test-retest reliability was reported to range from .63 to .83 (Ponterotto & Furlong, 1985). The validity of this measure was reported to be based upon limited discriminative validity ($r = .32$) (Ponterotto & Furlong, 1985).

The Counselor Effectiveness Scale (CES; Ivey, 1971) is a 25 item, parallel form which measures the client perception of counselor/psychotherapist. The items of the CES are reported to be “7-point semantic differential” (Ponterotto & Furlong, 1985, p. 602). This measure results in a total score only. Reliability was examined by use of two parallel forms of the CES and was found to be .98 (coefficient of equivalence). Discriminative validity was examined through having undergraduate students rate the effectiveness of videotaped sessions of two counselors/psychotherapists with one predetermined as ineffective and the other predetermined as effective. Scores on the CES
were found to be significantly different through use of t-test (p<.001) (Ponterotto & Furlong, 1985).

The Counselor Effectiveness Rating Scale (CERS; Atkinson & Carskaddon, 1975) is a 10 item measure of client perception of counselor/psychotherapist. It is based upon the social influence model. The items of the CERS are reported to be “7-point semantic differential” (Ponterotto & Furlong, 1985, p. 602). There are three subscales to this measure and results can be presented as subscale or total score (Ponterotto & Furlong, 1985). Subscale inter-correlations were reported to be .54 to .76 while Crobach’s alpha was reported to range from .75 to .90 by scale (Ponterotto & Furlong, 1985). Concurrent validity (r=.80) was reported with the Counselor Rating Form (Ponterotto & Furlong, 1985).

The Counselor Rating Form (CRF; Barak & LaCrosse, 1975) is a 36 item measure of client perception of counselor/psychotherapist. This measure is also based upon the social influence model. The items of the CRF are reported to be “7-point bipolar” (Ponterrotto & Furlong, 1985, p. 602). There are two versions of the CRF, a full and short version. The CRF has three subscales and results can be presented by subscale or total score. Subscale inter-correlation have been reported to range from .53 to .79 (Atkinson & Wampold, 1982) while split-half reliability was found to range from .85 to .91 by scale (Ponterrotto & Furlong, 1985). Construct validity has been examined through factor analysis in two separate studies (Barak & LaCrosse, 1975; LaCrosse & Barak, 1976). In both studies undergraduate students were asked to rate the counseling behaviors of Rogers, Perls, and Ellis after watching videotaped sessions. These studies showed the three-factor structure (expertness, trustworthiness, and attractiveness) of the
CRF to hold up reasonably well, though high inter-scale correlations were still present (.53 to .88). There is some support for predictive validity of the CRF as it has been found to predict treatment outcomes in drug rehabilitation treatment (LaCrosse, 1980). There is a client version of the CRF only (Elvins & Green, 1998).

The measures discussed are used in empirical research to capture the client’s perception of the treating professional. The Counselor Rating Form appears to be the measurement used most widely for this purpose. Ponterotto and Furlong (1985) reported that from 1974 until 1984, the Counselor Rating Form (CRF) was used 70 times within published studies while the Barrett-Lenard Relationship Inventory (BLRI) was used 45 times, the Counselor Evaluation Inventory (CEI) was used 20 times, the Counselor Effectiveness Scale (CES) was used 9 times, and the Counselor Effectiveness Rating Scale (CERS) was used 8 times. Beyond this evident historical use, the Counselor Rating Form remains a measure that is reviewed in the context of assessing the counseling/psychotherapy relationship (Elvins & Green, 2008). In sum, the Counselor Rating Form, which examines the client’s perception of the dimensions of counselor/psychotherapist expertness, trustworthiness and attractiveness, appears to have been widely used empirically and remains a recognized assessment of the counseling/psychotherapy relationship.

The client’s perception of the counselor/psychotherapist represents an important aspect of counseling/psychotherapy research (Corrigan et al., 1980; Heppner & Dixon, 1981; Ponterotto & Furlong, 1985; Heppner & Claiborn, 1989; Wilson & Yager, 1990). The seminal work of Stanley Strong (1968) and subsequent investigators focused attention on client perception of counselor/psychotherapist expertness, trustworthiness
and attractiveness as an important area of inquiry for understanding the social influence process in counseling/psychotherapy. Heppner and Claiborn (1989) reviewed research findings in this area which indicated a number of different variables that relate to a counselor/psychotherapist being viewed by a client as expert, trustworthy and attractive. These have included evidence of training, prestigious cues, counselor/psychotherapist behaviors, and personal characteristics. More recently, research findings have expanded the influencing factors to include such areas as power base, client psychological reactance, multicultural issues, religiosity, disability status, recovery status, use of counseling/psychotherapy techniques or strategies, early termination, and gender issues. Each of these areas has been reported to hold a significant relationship to the client’s perception of a counselor/psychotherapist. Only very limited research has explored the relationship between client perception of counselor/psychotherapist expertness, trustworthiness and attractiveness and working alliance. One dissertation study by Helwig (1996) has examined how several factors correlated with both the social influence variables and working alliance in counseling/psychotherapy. Findings of this study suggested both working alliance and social influence were positively related to counselor/psychotherapist experience, client symptomatology, attachment style, and beliefs of social support. In another dissertation study Lukin (1996) examined working alliance and social influence and reported that a positive perception of client’s counselor/psychotherapist as expert, trustworthy, and attractive was found to be correlated with a higher working alliance (Lukin, 1996). The possible relationship between clients’ perception of their counselor/psychotherapist and informed consent remains an area in need of further study.
Summary

The empirical research completed on informed consent, working alliance and client perception of counselor/psychotherapist highlights the importance of each of these areas within the field of mental health. Empirical findings in each area have acted to guide training, research and practice. In this Chapter, informed consent was explored both conceptually and empirically through both the perspective of the client as well as the perspective of the counselor/psychotherapist. Working alliance was also discussed and explored in the context of several important factors including its relationship to counseling/psychotherapy outcome. Research on clients’ perception of counselor/psychotherapist was also reviewed and discussed. The possible relationship of informed consent to working alliance and client perception of their counselor/psychotherapists appears to be a potentially important area of inquiry for counseling/psychotherapy practice research that is investigated in this study.
CHAPTER III

METHODOLOGY

Sample

The participants for this study (approved by the Human Subjects Institutional Review Board; see Appendix A) were clients actively receiving counseling/psychotherapy at a Community Mental Health Authority (CMHA) located in a rural Midwest county. Active clients were defined as those persons who had been seen by direct service professional staff for counseling/psychotherapy and who had received a minimum of three counseling/psychotherapy sessions. Active clients of the CMHA resided within the county where the agency provided services. As a CMHA, the agency provides outpatient mental health services to those considered to be seriously mentally ill. At the time of the study, the majority of clients serviced by the agency had no insurance coverage or were insured through state funding. The present study took place at a single CMHA site. Participants were recruited with the assistance of direct service professional staff of the CMHA. The professional staff was provided with information about the purpose of this study and the procedures that would be involved. They were requested to assist in inviting mental health clients to participate in the study. Direct service professional staff were defined as professionals providing counseling/psychotherapy to the clientele of the agency. These professionals included fully licensed doctoral psychologists, limited licensed psychologists, licensed professional counselors, social workers, and master’s level/doctoral level interns. Direct service professional staff invited active CMHA clients to participate. Clients under the age of eighteen and those with diagnoses of active psychosis or developmental disorder were not invited to
participate in the study. Only those clients capable of giving consent were approached and invited to participate.

At the agency where the data for the present study were gathered, the typical informed consent procedure begins when the client is first seen for intake assessment. The initial informed consent process involves the use of a written consent document that guides the initial discussion and informed consent information that must be verbally reviewed with the client by the intake professional before the intake interview begins. At the time of the intake assessment, the informed consent process is initiated by service professional staff (e.g. a psychologist or social worker) and issues such as clinic appointment procedures, fees, insurance, the nature of counseling/psychotherapy and confidentiality are discussed and reviewed. After verbally discussing the informed consent information initially presented at the beginning of the intake interview, the client is asked to sign the consent document indicating that the issues noted were verbally discussed and processed. Upon completion of the intake assessment, the client may continue to work with the professional staff who conducted the intake interview or may be assigned to another clinician. If the client is assigned to another professional staff member after the intake interview common practice within the agency was for the assigned counselor/psychotherapist to review with newly assigned clients informed consent information before the process of counseling/psychotherapy actually begins. All counselors and therapists are expected to review and discuss informed consent issues as may be appropriate during the ongoing process of counseling/psychotherapy.

A total of 223 survey packets were distributed to potential participants who were clients of the CMHA. Of these, 160 survey packets were returned and used in the study.
There were 63 survey packets that could not be used because they were 1) not returned, 2) returned blank, indicating that the client did not consent to participate or, 3) they were incomplete and could not be used in the study.

**Participant Characteristics**

Demographic information collected included the following: gender, age, current marital/relationship status, educational level, race/ethnicity, employment status, social class, and religious affiliation. In conjunction with demographic information, the number of counseling/psychotherapy sessions attended by participants was reported.

Of the 160 participants in the present study, 52 (32.5 percent) were male while 108 (67.5 percent were female). Participants ranged in age from 18 to 71 years, with a mean age of 38.98 years (SD= 12.73). The current marital/relationship status of the study participants at the time of the study included 50 (31.2 percent) identified as married, 47 (29.4 percent) identified as single, 33 (20.6 percent) identified as divorced, 13 (8.1 percent) identified as partnered, 12 (7.5 percent) identified as married/separated, 2 (1.2 percent) identified as partnered/separated, 2 (1.2 percent) identified as widowed, and 1 (.6 percent) identified as Other.

Highest attained educational level reported by study participants was as follows: 59 (36.9 percent) reported graduating high school, 48 (30 percent) indicated partial college or specialized training, 22 (13.8 percent) reported partial high school, 16 (10 percent) indicated college or university graduation, 8 (5 percent) reported completing junior high school, 5 (3.1 percent) reported some graduate professional training, and 1 (.6 percent) indicated less than a seventh grade education. One participant (.6 percent) did not indicate educational level.
The race/ethnicity of the study participants was as follows: 144 (90.0 percent) reported being White, not of Hispanic Origin, 5 (3.1 percent) reported being Hispanic, 4 (2.5 percent) reported being Bi-Racial/Multi-Racial, 3 (1.9 percent) reported being American Indian or Alaskan Native, and 3 (1.9 percent) indicated being Other. Forty-six (28.8 percent) study participants reported being employed while 113 (70.6 percent) reported being unemployed. One study participant did not provide information on employment status.

Social class was determined by Hollingshead’s (1975) Four Factor Index of Social Status. This is computed through determining the education level, occupation, sex, and marital status of participants. In the present study, 29 (18.13 percent) of study participants were identified in the unskilled laborer, menial service worker level of social strata, 53 (33.13 percent) of study participants were identified in the machine operator, semiskilled worker level of social strata, 42 (26.25 percent) of study participants were identified in the skilled craftsmen, clerical, sales worker level of social strata, 32 (20 percent) of study participants were identified in the medium business, minor professional, technical level of social strata, and 3 (1.88 percent) were identified in the major business and professional level of social strata. One study participant did not provide information and social class could not be determined.

Study participants reported the following religious affiliation: 121 (75.6 percent) reported being Christian, 20 (12.5 percent) indicated Other as their religious preference, 4 (2.5 percent) reported being Agnostic, 4 (2.5 percent) reported being Atheist, and 1 (.6 percent) reported being a Sikh. Ten study participants did not provide information on religious affiliation.
The number of counseling/psychotherapy sessions reported by study participants ranged from 4 to 288, with a mean of 26.69 (SD= 34.44) and a median of 14.

The Behavioral and Symptom Identification Scale (BASIS-32) was included as a measure to assess the degree of functionality and psychopathology reported by participants. Items on this scale are rated on a five-point likert scale with 0-no difficulty, 1-a little difficulty, 2-moderate difficulty, 3, quite a bit of difficulty, 4-extreme difficulty. The mean average response total score by participants in the present study was 1.50 (SD=.80) indicating little to moderate difficulty with regard to mental health status. These results were consistent with those reported by Eisen, Wilcox, Leff, Schaefer, and Culhane (1999) where 399 outpatient mental health clients completed this measure with a mean response of 1.50 (SD=.80).

Instruments

In the present study, each survey packet contained five instruments. The instruments included the demographic form, the Informed Consent Instrument (ICI), Working Alliance Inventory – Short Version (WAI-S), short form of the Counselor Rating Form (CRF-S), and the Behavioral and Symptom Identification Scale (BASIS-32). Each of these instruments and their associated psychometric properties is discussed below.

Demographic Form

The demographic form collected information in the following areas: gender, age, current marital/relationship status, educational level, race/ethnicity, social class, religious affiliation, and number of counseling/therapy sessions. Social class was assessed through the use of Hollingshead’s (1975) Four Factor Index of Social Status. This is computed by
taking into account the participant's education level, occupation, sex, and marital status. Point values are assigned within these factors and then totaled to result in a score ranging from 8-66. Higher scores indicate higher social class. Using their social class scores, participants can be classified into one of five categories as follows: unskilled laborers, menial service workers (scores ranging from 8 to 19), machine operators, semiskilled workers (scores ranging from 20 to 29), skilled craftsmen, clerical sales worker (scores ranging from 30 to 39), medium business, minor professional, technical (scores ranging from 40 to 54), and major business and professional (scores ranging from 55 to 66). The demographic information form is presented in Appendix B.

Informed Consent Instrument

The present study utilized a survey instrument developed by the investigator. This instrument is titled the Informed Consent Instrument (ICI) and is presented in Appendix C. The developed survey instrument was based upon a consideration of information provided in three sources: the APA Code of Ethics (American Psychological Association (2002), Claiborn et al. (1994); and Pomerantz and Handelsman (2004). The APA Code of Ethics provides guidelines for both the process and content of informed consent. Claiborn et al. (1994) cited several areas as germane to informed consent which they utilized to assess client's perception of informed consent, and Pomerantz and Handelsman (2004) cited several areas they considered germane to informed consent to be utilized as part of a consent process with a counseling/psychotherapy client.

The ICI survey questionnaire consists of twenty-six statements. Survey questions fall in six differing categories. These are the nature of therapy, treatment alternatives, appointments/scheduling, confidentiality/third party involvement, money/finances, and
general/other. For each item, survey respondents are asked to do two things. First, they are asked to rate the amount of discussion they have had with their counselor/psychotherapist in each content area of informed consent. Second, they are asked to rate how well they understand each content area of informed consent. Ratings are made on two seven point Likert scales with discussion rated from 1=Minimal Discussion, 4=Moderate Discussion, 7=Thorough Discussion; and understanding rated from 1=Minimal Understanding, 4=Moderate Understanding, 7=Complete Understanding.

There are two main scales to the ICI, ICI Discussion and ICI Understanding. The ICI Discussion scale indicates how thoroughly clients believe the informed consent content area has been discussed while the ICI Understanding scale indicates how well clients feel they understand the informed consent content area. ICI Discussion is computed by taking an average of the client’s scores across all 26 items pertaining to the client’s perception of how thoroughly each content area of informed consent was discussed. ICI Understanding is computed by taking an average of the client’s scores across all 26 items pertaining to the client’s understanding of each area of informed consent. Cronbach’s alpha coefficients were computed for both scales of the ICI. The Cronbach’s alpha coefficient for the ICI Discussion scale was found to be .943 while the ICI Understanding scale was found to be .939.

Working Alliance Inventory

The Working Alliance Inventory (WAI) was developed by Horvath and Greenberg and first published in professional literature in 1986 (Horvath & Greenberg, 1989). This instrument can be used to explore the perspective of both the client and
clinician. It is used frequently in counseling/psychotherapy research as it is a self-report measure, applies across theoretical orientations, and can be used early in the therapeutic relationship (Tracey & Kokotovic, 1989). There are three forms of the WAI as follows: a client form, a counselor/psychotherapist form and an observer form. Each form of the WAI consists of thirty-six items. Each item is a statement regarding the counseling/psychotherapy relationship. Respondents are asked to rate statements on a seven point likert scale (1=Never, 7=Always).

The WAI reportedly has internal consistency that ranges from .88 to .91 for each of the three subscales (Tracey & Kokotovic, 1989). The three subscales are counselor-client agreement on task, counselor-client agreement on goals, and establishment of a bond between client and counselor. Predictive and concurrent validity are evident as WAI scores have been significantly correlated with counseling/psychotherapy outcome measures (Horvath & Greenberg, 1989). The Working Alliance Inventory can be scored by subscale and/or scored as a total score.

The abridged version of the WAI proposed by Tracey and Kokotovic (1989) was used in the present study. The Working Alliance Inventory Short Form, client (WAI-S client) consists of twelve items (Tracey & Kokotovic, 1989). The abridged twelve item short form was developed as a result of examination with confirmatory factor analysis and the factor structure is reportedly similar to that of the unabridged WAI (Tracey & Kokotovic, 1989). The psychometric properties of the unabridged WAI have been well established (Cecero et al., 2001; Fenton et al., 2001; Hatcher & Barends, 1996; Horvath & Greenberg, 1989; Safran & Wallner, 1991; Tracey & Kokotovic, 1989). Busseri and Tyler (2003) indicated that there is strong support for the interchangeability of the WAI.
and the WAI-S. Internal consistency estimates for the three subscales of the WAI-S client range from .90 to .92 while internal consistency for the total score was reported to be .98 (Tracey & Kokotovic, 1989). Given the reported interchangeability of the WAI and WAI-S, validity information on the full version of the WAI is also expected to apply to the WAI-S. In support of the validity for the full version of the WAI, significant correlations have been found between the WAI and other instruments assessing similar constructs (Hatcher & Barends, 1996; Horvath & Greenberg, 1989; Safran & Wallner, 1991). The WAI shows association with measures assessing other aspects of the nature/process of psychotherapy (convergent validity). However, these correlations are modest, suggesting that the WAI is measuring a unique construct (discriminant validity) (Horvath & Greenberg, 1989). There is also evidence of the predictive validity of the WAI as it has been found to predict therapy outcome as discussed in the literature review of the present study.

In the present study, the total score was used as an indication of the working alliance between counselor/psychotherapist and client. The total score was found by averaging all twelve items of the WAI-S client. The total score can range from 1 to 7, with higher numbers indicating a greater working alliance. Use of the average total score has been a common practice in empirical studies using the WAI-S client (see Hawley & Garland, 2008; Knaevelsrud & Maercker, 2006; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Santiago et al. 2002) and has the advantage of affording a frame of reference in terms of the scale anchor points.
**Counselor Rating Form**

The Counselor Rating Form (CRF) was developed by Barak and LaCrosse (1975). The CRF is widely used in counseling/psychotherapy research and gives a general sense of the client’s perception of the counselor/psychotherapist (Heppner, Kivlighan, & Wampold, 1999). This instrument was used in the present investigation to provide a measure of the client perception of the counselor/psychotherapist. Specifically, the instrument examines the client’s assessment of the counselor/psychotherapist in regards to the following attributes: expertness, trustworthiness, and attractiveness.

The full version of the instrument consists of thirty-six items. Each item on the instrument consists of a single adjective. Respondents are instructed to rate the extent to which the counselor/psychotherapist embodies the given adjective on a seven point likert scale (1=not very, 7=very). Internal consistency for the full version of the CRF has been found to range from .77 to .93 and from .63 to .89 for the abridged version (Epperson & Pecnik, 1985). Factor analysis has reportedly confirmed the existence of the three counselor/psychotherapist characteristics (Heppner & Claiborn, 1989). However, due to correlations among the characteristics, it has been speculated that each of the three characteristics is giving indication of one construct which has simply been called the client’s “general opinion of the counselor” (Hepner et al., 1999, p. 294).

The abridged version of the CRF proposed by Corrigan and Schmidt (1983) was used in the present study. The abridged version of the Counselor Rating Form (CRF-S) consists of twelve questions. The CRF-S has demonstrated reliability and validity that is reportedly comparable to that of the unabridged CRF (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985). Subscale inter-correlations have been reported to range from
.27 to .90 while inter-item reliability has been reported to be .90 (expertness), .87 (trustworthiness), and .91 (attractiveness) (Epperson & Pecnik, 1985). Construct validity was reported to be established through confirmatory factor analysis (Corrigan & Schmidt, 1983).

The CRF-S can be scored by subscale and/or total score. There is lack of agreement among empirical studies as to which scoring procedure should be used, with some studies using only the subscales (Amertrano & Pappas, 1996; Feldman, Kluwin, & McCrone, 2005/2006; Guinee & Tracey, 1994; Leier et al., 1996; Leier et al., 1998; Martin, McNair, & Hight, 1988; Richardson & Helms, 1994; Suit & Paradise, 1985; Kelly & Shilo, 1991; Schneider, 1985), others using the total score (Kokotovic & Tracey, 1987; Harari & Waehler, 1999; Guinee & Tracey, 1997; Lawsen & Gaushell, 1995; Morran & Kurpius, 1994; Priester, Azen, Speight, & Vera, 2007), and still others using both (Glidden-Tracey & Wagner, 1995; Morran et al. 1994; Walter & Handelsman, 1996).

There is psychometric rationale for use of the total score alone as Tracey, Glidden and Kokotovic (1988) report that the factor structure of the overall CRF-S was stronger than the factor structure of any of the three subscales. Furthermore, inter-correlations between subscales have been found (Corrigan & Schmidt, 1983; Harari & Waehler, 1999). Therefore in this present study, the CRF-S was not scored by subscale and the total score was used. Tracey et al. (1988) described the total score as being a reflection of the client’s overall view of the counselor/psychotherapist. Typical scoring procedures for the CRF-S are to sum the items to achieve the total score. However, in the present study, a decision was made to use the total score obtained by summing and then averaging the
total score across the 12 individual items. Therefore in the present study total scores on the CRF-S can range from 1 to 7, with higher scores indicating a more positive opinion of the counselor/psychotherapist. An averaged total score was used for purposes of scoring consistency with other instruments utilized in the present study and to allow total score interpretation in the context of the scale anchor points.

Behavior and Symptom Identification Scale

The Behavior and Symptom Identification Scale, or BASIS-32, was developed by Eisen, Dill and Grob (1994). It was developed to assess the degree of functionality and psychopathology in respondents (Klinkenberg, Cho, & Vieweg, 1998). Particularly, it was designed for use with those persons receiving inpatient psychiatric treatment, but has been assessed for treatment on outpatient populations as well (Eisen, Wilcox, Leff, Schaefer, & Culhand, 1999).

The BASIS – 32 consists of thirty-two items that ask a counseling/psychotherapy client to give their perception of how they are doing in their life in five areas: relation to self/others, daily living/role functioning, depression/anxiety, impulsive/addictive behavior, and psychosis. Respondents rate each item on a five point likert scale with 0=No Difficulty, 1= A Little Difficulty, 2=Moderate Difficulty, 3= Quit a Bit of Difficulty, and 4=Extreme Difficulty. Results of the BASIS – 32 yield both subscale and total scores. Only total scores were used in the present study. High scores on the BASIS – 32 are indicative of greater difficulty in terms of mental health status. The BASIS-32 total score was computed by averaging across all items. Internal consistency for the full scale of the BASIS – 32 has been reported to be .95 (Klinkenberg et al., 1998; Eisen et al., 1999). Construct validity has been well established via both concurrent and discriminant
validity analysis (Klinkenberg et al., 1998; Eisen et al., 1999). The BASIS-32 has been found to be correlated as expected with the Hopkins Symptom checklist ($r = .86$) and with the Short Form Health Status Profile ($r = -.69$) (Klinkenberg et al., 1998; Eisen et al., 1999) demonstrating concurrent validity. Discriminant validity revealed that the BASIS-32 effectively differentiated clinical populations (Klinkenberg et al., 1998; Eisen et al., 1999). The BASIS-32 was used in this study to control for functionality and psychopathology on the part of the client.

Procedure

Prior to use in the present investigation, a pilot project was completed to obtain feedback on the preliminary version of the demographic form, the initial version of the Informed Consent Instrument and the overall packet of research materials. The participants for the pilot project were graduate students in counseling programs at a mid-west university who had been counseling/psychotherapy clients in the past. Survey packets containing the demographic form, the Informed Consent Instrument, Working Alliance Inventory – Short Version (WAI-S), short form of the Counselor Rating Form (CRF-S), and the BASIS-32 were distributed to students in several counseling graduate courses. It was explained that the students were eligible to participate if they had been a counseling/psychotherapy client within the past two years and were seen for a minimum of three sessions. Students who met these criteria and who were willing to participate were asked to complete the survey packet on their own time and return it anonymously through inter-campus mail. If students had not been clients in counseling/psychotherapy in the past two years or were not interested in participating, they were asked to return blank copies of the survey packets anonymously through intercampus mail. This allowed
research participants to maintain anonymity and privacy. Based upon their completion of each instrument in the research packet, the graduate students were invited to give comments, suggestions and feedback on the measures. Specific feedback on the Demographic Form and ICI were sought to make alterations as appropriate.

A total of 109 survey packets were distributed in graduate counseling classes and 14 completed packets were returned by graduate students who had been in counseling/psychotherapy within the prior two years and been seen for a minimum of three sessions. Participant feedback from the pilot project was received on both the Demographic form and the ICI. Feedback included suggestions for clarifying items on the Demographic form related to relationship status, gender, and race. Feedback on the ICI included comments related to wording, length and suggestions for clarifying the instrument. Following the pilot project the Demographic form and ICI were revised and finalized based upon the feedback received.

Subsequent to the pilot project, active clients of the CMHA were invited to participate in the present study by direct professional service staff of the CMHA. Professional service staff were provided a script inviting participation in the study. The script provided information about the purpose of the study, expectation of participation, participant rights, and confidentiality. The invitation script is presented in Appendix D. Active clients were invited to participate only after a minimum of three counseling/psychotherapy sessions had taken place. After the script was read, clients were supplied with a research packet. Contained in the packet were: the informed consent letter, which described the study and client participation (presented in Appendix E); the demographic form; the Informed Consent Instrument (ICI); Working Alliance
Inventory – Short Version (WAI-S); short form of the Counselor Rating Form (CRF-S),
and the BASIS-32. Clients were informed that they had the option to not participate and
to withdraw from participation at any time. Furthermore, all research materials were
completed anonymously and clients were asked not to place any identifying information
about themselves or others on any of the study materials.

Clients were advised that if they wished to participate they should complete the
research packet before leaving the CMHA and place completed materials in a clearly
marked receptacle that was made available. If clients were not interested in participating
they were asked to place the incomplete or blank survey packet in the same receptacle.

Data Analysis

The present study can best be characterized as a correlational field study. First,
the study investigated how thoroughly clients perceived that their
counselor/psychotherapist had been in discussing various content areas of informed
consent, how well clients reported understanding various content areas of informed
consent, and how these variables related to client perceptions of working alliance.
Second, the study examined how thoroughly clients perceived their
counselor/psychotherapist had been in discussing various content areas of informed
consent, how well clients reported understanding various content areas of informed
consent and how these variables related to client ratings of the working alliance and
counselor/psychotherapist attributes of expertness, trustworthiness, and attractiveness.
Ratings of discussion and understanding of informed consent areas were examined using
the survey instrument developed for this study: the Informed Consent Instrument (ICI).
Working alliance was measured using the Working Alliance Inventory – Short Version
(WAI-S) (Tracey & Kokotovic, 1989). The client version of the WAI-S was used in this study. Ratings of counselor/psychotherapist attributes were measured using the short form of the Counselor Rating Form (CRF-S) (Corrigan & Schmidt, 1983). The criterion variables were scores on Working Alliance Inventory – Short Version (WAI-S) and scores on the short form of the Counselor Rating Form (CRF-S), while the predictor variables were ratings on the ICI and demographic variables.

SPSS statistical software was used to perform the statistical analyses. Descriptive statistics, correlation analyses and multiple regression analyses were used to analyze the data and to examine the research questions. Assumptions of linearity, homoscedasticity, and multicollinearity were examined and were found to be met and the data were considered appropriate for multiple regression. Predictor variables included gender, age, educational level, social class, number of counseling/therapy sessions, client psychopathology (as assessed by the BASIS-32), client ratings of thoroughness of discussion of informed consent areas (as measured by the ICI- Discussion scale), and client ratings of understanding of informed consent areas (as measured by the ICI- Understanding scale). Two separate criterion variables were client ratings of the working alliance as measured by the Working Alliance Inventory – Short Version (WAI-S) and client ratings of general opinion of the counselor/therapist as measured by the short form of the Counselor Rating Form (CRF-S).

Descriptive statistics were calculated for each of the variables. Pearson r correlations between the variables were calculated to examine the single order correlations among the variables in the study. Hierarchical multiple regression was performed to examine each of the research questions and to test the null hypotheses. The
multiple regression analysis was performed separately for each criterion variable. In the first model of the regression analysis the demographic variables of age, gender, social class, along with the variables of number of counseling/psychotherapy sessions and client’s degree of psychopathology as measured by the BASIS – 32 were entered together as a block of variables. In the second model of the analysis ICI Discussion was added to the regression model and tested for significance in accounting for unique variance in the criterion variable after controlling for the variables entered in the first model. In the third model of the analysis ICI Discussion was taken out of the model and ICI Understanding was entered into the regression model and tested for significance in accounting for unique variance in the criterion variable after controlling for the variables entered in the first model. Finally, in the fourth model, ICI Discussion and ICI Understanding were added together as a block of variables and their contributions as a block of variables in predicting the criterion variables were examined and tested for significance.

To examine the first research question, “To what extent do client ratings of thoroughness of informed consent discussion and client understanding of informed consent relate to client ratings of working alliance on the client form of the Working Alliance Inventory – Short Version (WAI-S)?” a hierarchical multiple regression analysis was performed. In this analysis the criterion variable was the total score on the WAI-S client. To control for age, gender, social class, number of counseling/psychotherapy sessions and client psychopathology, these predictor variables were entered together as a block in the first model of the analysis. The variable of ICI Discussion was entered in the second model. The F test for significant difference in variance accounted for in working alliance, as measured by the WAIS-S client, was calculated and used to test null
hypothesis 1a. To test hypothesis 1b, in the third model of the analysis ICI Discussion was removed from the model and ICI Understanding was entered into the model. The F test for significant difference in variance accounted for in working alliance between the variables entered in model 1 and model 3 was calculated and used to test null hypothesis 1b. To test hypothesis 1c, ICI Discussion and ICI Understanding were added together as a block of variables in the fourth model. The F test for significant difference in variance accounted for in working alliance between the variables entered in model 1 and model 4 was calculated and used to test null hypothesis 1c.

To examine the second research question, “To what extent do client ratings of thoroughness of informed consent discussion and client understanding of informed consent relate to clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness on the short form of the Counselor Rating Form (CRF-S)?” a hierarchical multiple regression analysis was performed. The criterion variable was the total score on the short form of the CRF-S. To control for age, gender, social class, number of counseling/psychotherapy sessions and client psychopathology, these predictor variables were entered together as a block in the first model of the analysis. The variable of ICI Discussion was entered in the second model. The F test for significant difference in variance accounted for in clients’ general opinion of the counselor/psychotherapist, as measured by the CRF-S, was calculated and used to test null hypothesis 2a. To test hypothesis 2b, in the third model of the analysis ICI Discussion was removed from the model and ICI Understanding was entered into the model. The F test for significant difference in variance accounted for in clients’ general opinion of the
counselor/psychotherapist between the variables entered in model 1 and model 3 was calculated and used to test null hypothesis 2b. To test hypothesis 2c, ICI Discussion and ICI Understanding were added together as a block of variables in the fourth model. The F test for significant difference in variance accounted for in clients’ general opinion of the counselor/psychotherapist between the variables entered in model 1 and model 4 was calculated and used to test null hypothesis 2c.
CHAPTER IV
RESEARCH FINDINGS

Introduction

Chapter IV presents the research findings of this study. Descriptive statistics and correlations among the study variables will be presented first. This will be followed by the main analysis for each research question.

Descriptive Statistics and Correlations among the Variables

The means, standard deviations, and Pearson r correlations were calculated. Scores on the ICI are separated into two main scales, ICI Discussion and ICI Understanding. Scores on the ICI Discussion scale ranged from 1.58 to 7 with a mean of 5.09 (SD=1.33, N=160). Scores on the ICI Understanding scale ranged from 1.65 to 7 with a mean of 5.39 (SD=1.20, N=160). Scores on the WAI-S client resulted in a total score which acts as a measure for the working alliance between counselor/psychotherapist and client. Scores on the WAI-S client ranged from 2.50 to 7 with a mean total score of 5.82 (SD=.97, N=160). Scores on the CRF-S resulted in a total score which gives indication of the client’s general opinion about the counselor/psychotherapist (which includes perceptions of trustworthiness, expertness, and attractiveness). Scores on the CRF-S ranged from 3 to 7 with a mean total of 6.45 (SD=.82, N=160). Scores on the BASIS-32 ranged from 0 to 3.25 with a mean total of 1.50 (SD=.80, N=160). Scores Hollingshead’s (1975) Four Factor Index of Social Status ranged from 8 to 58 with a mean of 30.14 (SD=11.08, N=159).

Table 1 shows correlation coefficients computed between participant age, number of counseling/psychotherapy sessions, social class as assessed by the Hollingshead’s
(1975) Four Factor Index of Social Status, Basis-32 total score, WAI-S total score, CRF-S total score, ICI Discussion, and ICI Understanding.

As can be seen in Table 1, WAI-S was significantly correlated with ICI Discussion (p = .00001) and ICI Understanding (p = .00001). CRF-S was significantly correlated with ICI Discussion (p < .01) and ICI Understanding (p < .00001). WAI-S and CRF-S were significantly correlated with one another p < .00001. ICI Discussion and ICI Understanding were significantly correlated with one another (p = .00001). Other significant correlations include participant age and gender (p = .01), participant age and number of counseling/psychotherapy sessions (p = .01), participant age and social class (p = .01), participant age and WAI-S (p = .05), participant age and ICI Understanding (p = .05), participant gender and SES Hollingshead (p = .0001), participant gender and WAI-S (p = .05), number of counseling/psychotherapy sessions and WAI-S (p = .05), number of counseling/psychotherapy sessions and ICI Discussion (p = .05), and number of counseling/psychotherapy sessions and ICI Understanding (p = .01). Note that gender was coded with 1 = male and 2 = female, so female participants tended to be older, have higher SES, and higher WAI-S ratings than male participants.

**Hypotheses Testing**

**Research Question One:** To what extent do client ratings of thoroughness of informed consent discussion and client understanding of informed consent relate to client ratings of working alliance on the short client version of the Working Alliance Inventory (WAI-S)?
Table 1: Correlation Matrix for Criterion and Predictor Variables

<table>
<thead>
<tr>
<th></th>
<th>Participant Age</th>
<th>Participant Gender</th>
<th>Number of Counseling / Psychotherapy Sessions</th>
<th>SES Hollingshead</th>
<th>Basis-32</th>
<th>WAI-S</th>
<th>CRF-S</th>
<th>ICI Discussion</th>
<th>ICI Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Age</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Gender</td>
<td>.229**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td>.220**</td>
<td>0.145</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>.221**</td>
<td>.295***</td>
<td>0.057</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basis-32</td>
<td>0.075</td>
<td>0.042</td>
<td>0.082</td>
<td>-0.038</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAI-S</td>
<td>.184*</td>
<td>.198*</td>
<td>.181*</td>
<td>0.132</td>
<td>-0.08</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRF-S</td>
<td>0.151</td>
<td>0.035</td>
<td>0.143</td>
<td>0.024</td>
<td>-0.048</td>
<td>.492****</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICI Discussion</td>
<td>0.11</td>
<td>0.039</td>
<td>.165*</td>
<td>0.037</td>
<td>0.052</td>
<td>.399****</td>
<td>.248**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ICI Understanding</td>
<td>.185*</td>
<td>0.05</td>
<td>.208**</td>
<td>0.063</td>
<td>0.043</td>
<td>.559****</td>
<td>.357****</td>
<td>.787****</td>
<td>1</td>
</tr>
</tbody>
</table>

*Correlation is significant at the .05 level (two tailed)
**Correlation is significant at the .01 level (two tailed)
***Correlation is significant at the .001 level (two tailed)
****Correlation is significant at the .00001 level (two tailed)
Null Hypothesis 1a: After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report thoroughness of informed consent discussion will not contribute significant unique variance to predicting working alliance on the short client version of the Working Alliance Inventory (WAI-S).

To consider the first research question and to test null hypotheses 1a, 1b and 1c, a hierarchical multiple regression analysis was conducted and the results are presented in Tables 2, 3, 4 and 5. In the first model, the participant variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS-32) were entered as a block of variables. The findings of the first model are presented in Table 2. As may be seen in Table 2 these variables together accounted for 9.1% of the variance in working alliance (Multiple $R = .301; R^2 = .091; \text{Adj. } R^2 = .061; R^2 \text{ change } = .091, F (5, 153) = 3.056$, and $p = .012$). While the overall test of this model was significant, none of the variables entered in this first model emerged as significant unique predictors of working alliance.

Table 2: Hierarchical Multiple Regression for Working Alliance—Model 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>4.919</td>
<td>0.366</td>
<td></td>
<td>13.447</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td>0.009</td>
<td>0.006</td>
<td>0.121</td>
<td>1.474</td>
<td>0.143</td>
</tr>
<tr>
<td>Participant Gender</td>
<td>0.293</td>
<td>0.17</td>
<td>0.142</td>
<td>1.728</td>
<td>0.086</td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td>0.004</td>
<td>0.002</td>
<td>0.138</td>
<td>1.736</td>
<td>0.085</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>0.004</td>
<td>0.007</td>
<td>0.051</td>
<td>0.625</td>
<td>0.533</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.127</td>
<td>0.094</td>
<td>-0.104</td>
<td>-1.345</td>
<td>0.181</td>
</tr>
</tbody>
</table>

Model 1: Multiple $R = .301; R^2 = .091; \text{Adj. } R^2 = .061; R^2 \text{ change } = .091, F (5, 153) = 3.056, p = .012$
To test null hypothesis 1a, ICI Discussion was added to the analysis in the second model which is presented in Table 3. ICI-Discussion was found to account for an additional 13.7% of the variance in working alliance (Multiple R=.478; R²=.228; Adj. R²=.198; R² change = .137, F (6, 152) = 7.487, and p=.0000005). Again, as in the first model none of the variables entered initially in model 1 emerged as significant unique predictors of working alliance in model 2. ICI-Discussion was the one significant unique predictor (t=5.2, p=.0000006) in model 2. Therefore, null hypothesis 1a was rejected.

Table 3: Hierarchical Multiple Regression for Working Alliance—Model 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2 (Constant)</td>
<td>3.672</td>
<td>0.415</td>
<td>0.095</td>
<td>8.855</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td>0.007</td>
<td>0.006</td>
<td>0.095</td>
<td>1.248</td>
<td>0.214</td>
</tr>
<tr>
<td>Participant Gender</td>
<td>0.300</td>
<td>0.157</td>
<td>0.145</td>
<td>1.911</td>
<td>0.058</td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td>0.002</td>
<td>0.002</td>
<td>0.082</td>
<td>1.098</td>
<td>0.274</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>0.004</td>
<td>0.007</td>
<td>0.045</td>
<td>0.592</td>
<td>0.555</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.143</td>
<td>0.087</td>
<td>-0.118</td>
<td>-1.637</td>
<td>0.104</td>
</tr>
<tr>
<td>ICI Discussion</td>
<td>0.275</td>
<td>0.053</td>
<td>0.377</td>
<td>5.2</td>
<td>0.0000006</td>
</tr>
</tbody>
</table>

Note. Model 1: Multiple R=.301; R²=.091; Adj. R²=.061; R² Change=.091; F (5, 153) =3.056; p=.012. Model 2: Multiple R=.478; R²=.228; Adj. R²=.198; R² Change=.137; F (6,152) =7.487; p=.0000005.

Null Hypothesis 1b: After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report understanding of informed consent will not contribute significant unique variance to predicting working alliance on the short client version of the Working Alliance Inventory (WAI-S).
To test null hypothesis 1b, ICI Discussion was removed from the model and ICI Understanding was added in model 3. As may be seen in Table 4, ICI Understanding accounted for 27.5% of the variance in working alliance above and beyond the variables entered in model 1 (Multiple R=.605; R${^2}=.366$; Adj R${^2}=.341$; R${^2}$ change = .275, F(6, 152)= 14.622, and p< .0000001). ICI Understanding served as a significant unique predictor ( t= 8.122, p< .0000001). In this model gender also acted as a significant unique predictor of working alliance (t= 2.221, p=.028), such that female gender of participant predicted greater working alliance. Null hypothesis 1b was rejected.

Table 4: Hierarchical Multiple Regression for Working Alliance—Model 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>2.870</td>
<td>0.397</td>
<td>0.004</td>
<td>7.230</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td>0.004</td>
<td>0.005</td>
<td>0.046</td>
<td>0.667</td>
<td>0.506</td>
</tr>
<tr>
<td>Participant Gender</td>
<td>0.316</td>
<td>0.142</td>
<td>0.153</td>
<td>2.221</td>
<td>0.028</td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td>0.001</td>
<td>0.002</td>
<td>0.040</td>
<td>0.587</td>
<td>0.558</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>0.003</td>
<td>0.006</td>
<td>0.036</td>
<td>0.518</td>
<td>0.605</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.139</td>
<td>0.079</td>
<td>-0.115</td>
<td>-1.762</td>
<td>0.080</td>
</tr>
<tr>
<td>ICI Understanding</td>
<td>0.440</td>
<td>0.054</td>
<td>0.542</td>
<td>8.122</td>
<td>&lt;.0000001</td>
</tr>
</tbody>
</table>

Note. Model 1: Multiple R=.301; R${^2}=.091$; Adj. R${^2}=.061$; R${^2}$ Change=.091; F (5, 153)=3.056; p=.012. Model 3: Multiple R=.605; R${^2}=.366$; Adj. R${^2}=.341$; R${^2}$ Change = .275; F (6,152) =14.622; p< .0000001.

Null Hypothesis 1c.: After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report thoroughness of informed consent discussion and client understanding of informed consent considered together will not contribute
significant unique variance to predicting working alliance on the short client version of the Working Alliance Inventory (WAI-S).

To test null hypothesis lc, in the fourth model, both ICI Discussion and ICI Understanding were entered into the model as a block of variables. As may be seen in Table 5, ICI Discussion and ICI Understanding as a block of variables accounted for 27.9% of additional variance in working alliance above and beyond the variance accounted for by the variables entered in model 1 (Multiple R=.608; R²=.370; Adj R²=.340; R² change = .279, F(7, 151)= 12.643, and p< .0000001). In model 4 only ICI Understanding (t=5.819, p<.0000001) and gender (t=2.23, p=.027) were identified as significant unique predictors of working alliance. In this model ICI Discussion was not identified as a significant unique predictor of working alliance when entered in the model with ICI-Understanding. Since the block of variables consisting of ICI Discussion and ICI Understanding together contributed additional unique variance to the prediction of working alliance null hypothesis lc was rejected.

Table 5: Hierarchical Multiple Regression for Working Alliance—Model 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 4</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td></td>
<td>2.901</td>
<td>0.399</td>
<td>0.042</td>
<td>7.279</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td></td>
<td>0.003</td>
<td>0.005</td>
<td>0.040</td>
<td>0.611</td>
<td>0.542</td>
</tr>
<tr>
<td>Participant Gender</td>
<td></td>
<td>0.318</td>
<td>0.142</td>
<td>0.154</td>
<td>2.230</td>
<td>0.027</td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td></td>
<td>0.001</td>
<td>0.002</td>
<td>0.040</td>
<td>0.596</td>
<td>0.552</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td></td>
<td>0.003</td>
<td>0.006</td>
<td>0.035</td>
<td>0.509</td>
<td>0.611</td>
</tr>
<tr>
<td>BASIS-32</td>
<td></td>
<td>-0.137</td>
<td>0.079</td>
<td>-0.113</td>
<td>-1.730</td>
<td>0.086</td>
</tr>
<tr>
<td>ICI Discussion</td>
<td></td>
<td>-0.070</td>
<td>0.076</td>
<td>-0.097</td>
<td>-0.923</td>
<td>0.357</td>
</tr>
<tr>
<td>ICI Understanding</td>
<td></td>
<td>0.502</td>
<td>0.086</td>
<td>0.619</td>
<td>5.819</td>
<td>&lt;.0000001</td>
</tr>
</tbody>
</table>

Note. Model 1: Multiple R=.301; R²=.091; Adj. R²=.061; R² Change=.091; F (5, 153) =3.056; p=.012. Model 4: Multiple R=.608; R²=.370; Adj. R²=.340; R² Change =.279; F (7,151) =12.643; p<.0000001.
Research Question Two: To what extent do client ratings of thoroughness of informed consent discussion and client understanding of informed consent relate to clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness on the short form of Counselor Rating Form (CRF-S)?

Null Hypothesis 2a: After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report thoroughness of informed consent discussion will not contribute significant unique variance to predicting clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor’s/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness on the short form of Counselor Rating Form (CRF-S).

To consider the second research question and to test null hypotheses 2a, 2b and 2c a hierarchical multiple regression analysis was conducted with CRF-S as the criterion variable. The results are presented in Tables 6, 7, 8, and 9. In the first model of this analysis, the participant variables of gender, age, social class, number of counseling/psychotherapy sessions, client’s degree of psychopathology (as determined by the BASIS-32) were entered as a block of variables. The findings of the first model are presented in Table 6. As may be seen in Table 6 these variables entered together in model 1 did not account for a significant proportion of variance in client ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness as measured by the short form of Counselor Rating Form (CRF-S).
Table 6: Hierarchical Multiple Regression for Client Ratings of Counselor/Psychotherapist Attributes—Model 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>6.194</td>
<td>0.317</td>
<td></td>
<td>19.516</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td>0.008</td>
<td>0.005</td>
<td>0.131</td>
<td>1.553</td>
<td>0.123</td>
</tr>
<tr>
<td>Participant Gender</td>
<td>-0.014</td>
<td>0.147</td>
<td>-0.008</td>
<td>-0.097</td>
<td>0.923</td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td>0.003</td>
<td>0.002</td>
<td>0.124</td>
<td>1.513</td>
<td>0.132</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>-0.001</td>
<td>0.006</td>
<td>-0.012</td>
<td>-0.143</td>
<td>0.887</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.071</td>
<td>0.082</td>
<td>-0.069</td>
<td>-0.864</td>
<td>0.389</td>
</tr>
</tbody>
</table>

Model 1: Multiple R=.201; R^2=.040; Adj. R^2=.009; R^2 Change = .040; F (5,153) = 1.282; p=.274.

To test null hypothesis 2a, ICI Discussion was added to the analysis in the second model which is presented in table 7. As may be seen in Table 7, ICI Discussion was found to account for an additional 4.8% of the variance in client ratings of the counselor/psychotherapist’s attributes beyond the variance accounted for by variables entered in model 1 (Multiple R=.296; R^2=.088; Adj. R^2=.052; R^2 change = .048, F (6,152) = 2.437 and p=.028). None of the variables entered in model 1 emerged as significant unique predictors of client ratings of counselor/psychotherapist attributes in this second model. ICI Discussion was the only significant unique predictor (t=2.841, p=.006). Therefore, null hypothesis 2a was rejected.

**Null Hypothesis 2b:** After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report understanding of informed consent will not contribute significant unique variance to predicting clients’ general opinion of the counselor/psychotherapist as measured by ratings of the counselor/psychotherapist’s...
attributes of expertness, trustworthiness, and attractiveness on the short form of Counselor Rating Form (CRF-S).

Table 7: Hierarchical Multiple Regression for Client Ratings of Counselor/Psychotherapist Attributes—Model 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>5.574</td>
<td>0.381</td>
<td>0.115</td>
<td>14.643</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td>0.007</td>
<td>0.005</td>
<td>0.011</td>
<td>1.398</td>
<td>0.164</td>
</tr>
<tr>
<td>Participant Gender</td>
<td>-0.011</td>
<td>0.144</td>
<td>-0.006</td>
<td>-0.077</td>
<td>0.939</td>
</tr>
<tr>
<td>Number of Counseling/Psychoterapy Sessions</td>
<td>0.002</td>
<td>0.002</td>
<td>0.091</td>
<td>1.119</td>
<td>0.265</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>-0.001</td>
<td>0.006</td>
<td>-0.016</td>
<td>-0.192</td>
<td>0.848</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.078</td>
<td>0.080</td>
<td>-0.077</td>
<td>-0.982</td>
<td>0.328</td>
</tr>
<tr>
<td>ICI Discussion</td>
<td>0.137</td>
<td>0.049</td>
<td>0.222</td>
<td>2.841</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Note. Model 1: Multiple \( R^2 = .040; \) \( R^2 = .009; \) \( R^2 \) Change = .040; \( F (5, 153) = 1.282; \) \( p = .274. \)

Model 2: Multiple \( R^2 = .088; \) \( R^2 = .052; \) \( R^2 \) Change = .048; \( F (6, 152) = 2.437; \) \( p = .028. \)

To test null hypothesis 2b, ICI Discussion was removed from the model and ICI Understanding was added in model 3. As may be seen in Table 8, ICI Understanding accounted for an additional 10.2% of the variance in client ratings of counselor/psychotherapist attributes above and beyond the variables entered in model 1 (Multiple \( R^2 = .377; \) \( R^2 = .142; \) \( R^2 \) Change = .102, \( F (6, 152) = 4.199; \) \( p = .001. \)). ICI Understanding was the only significant unique predictor of counselor/psychotherapist ratings in this third model (\( t = 4.251, \) \( p = .00004. \)). Therefore, null hypothesis 2b was rejected.

Null Hypothesis 2c: After controlling for the variables of gender, age, social class, number of counseling/psychotherapy sessions, and client’s degree of psychopathology (as determined by the BASIS – 32), the degree to which counseling/psychotherapy clients report thoroughness of informed consent discussion and client understanding of informed consent considered together will not contribute significant unique variance to predicting
clients' general opinion of the counselor/psychotherapist as measured by ratings of the 
counselor/psychotherapist's attributes of expertness, trustworthiness, and attractiveness 
on the short form of Counselor Rating Form (CRF-S).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 3</th>
<th>(Constant)</th>
<th>5.140</th>
<th>0.390</th>
<th>13.184</th>
<th>0.000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Age</td>
<td>0.005</td>
<td>0.005</td>
<td>0.085</td>
<td>1.059</td>
<td>0.291</td>
<td></td>
</tr>
<tr>
<td>Participant Gender</td>
<td>-0.003</td>
<td>0.140</td>
<td>-0.002</td>
<td>-0.019</td>
<td>0.985</td>
<td></td>
</tr>
<tr>
<td>Number of Counseling/</td>
<td>0.002</td>
<td>0.002</td>
<td>0.064</td>
<td>0.810</td>
<td>0.419</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>-0.002</td>
<td>0.006</td>
<td>-0.022</td>
<td>-0.270</td>
<td>0.788</td>
<td></td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.077</td>
<td>0.077</td>
<td>-0.075</td>
<td>-0.993</td>
<td>0.322</td>
<td></td>
</tr>
<tr>
<td>ICI Understanding</td>
<td>0.226</td>
<td>0.053</td>
<td>0.330</td>
<td>4.251</td>
<td>0.00004</td>
<td></td>
</tr>
</tbody>
</table>

Note. Model 1: Multiple R=.201; R²=.040; Adj. R²=.009; R² Change=.040; F (5,153) = 1.282; p=.274.
Model 3: Multiple R=.377; R²=.142; Adj. R²=.108; R² Change=.102; F (6,152) =4.199; p=.001.

To test null hypothesis 2c, in the fourth model, both ICI Discussion and ICI Understanding were entered into the model as a block of variables. As may be seen in Table 9, ICI Discussion and ICI Understanding together accounted for 10.5% of the variance in client ratings of counselor/psychotherapist attributes beyond the variance accounted for by the variables entered in model 1 (Multiple R=.380; R²=.145; Adj. R²=.105; R² change=.105, F (7, 151) = 3.645, p=.001). In this fourth model only ICI Understanding emerged as a significant unique predictor of counselor/psychotherapist rating. Null hypothesis 2c was rejected.
Table 9: Hierarchical Multiple Regression for Client Ratings of Counselor/Psychotherapist Attributes—Model 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Error</th>
<th>Beta</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>5.162</td>
<td>0.392</td>
<td>0.082</td>
<td>13.166</td>
<td>0.000</td>
</tr>
<tr>
<td>Participant Age</td>
<td>0.005</td>
<td>0.005</td>
<td>0.013</td>
<td>1.017</td>
<td>0.311</td>
</tr>
<tr>
<td>Participant Gender</td>
<td>-0.002</td>
<td>0.140</td>
<td>-0.011</td>
<td>-0.012</td>
<td>0.991</td>
</tr>
<tr>
<td>Number of Counseling/Psychotherapy Sessions</td>
<td>0.002</td>
<td>0.002</td>
<td>0.064</td>
<td>0.815</td>
<td>0.416</td>
</tr>
<tr>
<td>SES Hollingshead</td>
<td>-0.002</td>
<td>0.006</td>
<td>-0.022</td>
<td>-0.275</td>
<td>0.784</td>
</tr>
<tr>
<td>BASIS-32</td>
<td>-0.075</td>
<td>0.078</td>
<td>-0.074</td>
<td>-0.970</td>
<td>0.334</td>
</tr>
<tr>
<td>ICI Discussion</td>
<td>-0.048</td>
<td>0.075</td>
<td>-0.078</td>
<td>-0.643</td>
<td>0.521</td>
</tr>
<tr>
<td>ICI Understanding</td>
<td>0.269</td>
<td>0.085</td>
<td>0.392</td>
<td>3.166</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Note. Model 1: Multiple R=.201; R²=.040; Adj. R²=.009; R² Change=.040; F (5,153) = 1.282; p=.274.
Model 4: Multiple R=.380; R²=.145; Adj. R²=.105; R² Change=.105; F (7,151) =3.645; p=.001.

Summary

When entered individually, both discussion of informed consent and understanding of informed consent emerged as significant unique predictors of client ratings of working alliance. When considered together in model 4, only understanding of informed consent uniquely predicted working alliance. In addition, gender emerged as a unique predictor of working alliance when considered with understanding of informed consent and when considered with both discussion and understanding of informed consent with female participants tending to report higher working alliance scores.

When entered individually, both discussion of informed consent and understanding of informed consent acted as significant predictors of clients' general opinion of the counselor/psychotherapist. However, when discussion and understanding of informed consent were considered together, only understanding of informed consent
emerged as a significant unique predictor of the clients' general opinion of the counselor/psychotherapist.
CHAPTER V
DISCUSSION

Introduction

Chapter V is a discussion of the findings of the present study. Included in this discussion are the following five areas: (1) Informed Consent and Working Alliance; (2) Informed Consent and Client Perception of Counselor/Psychotherapist; (3) Implications of the Current Study; (4) Limitations of the Current Study; and (5) Summary. Each of these areas will be discussed considering the findings of the present study.

The main purpose of the present study was to examine the extent to which the informed consent process may relate to the counseling/psychotherapy relationship. Previous research has explored informed consent conceptually and empirically. Through the latter, informed consent has been examined both through the perspective of the client and the counselor/psychotherapist. Research findings in each area have been interesting with implications for counselor/psychotherapist training as well as practice. For example, research on the client’s view of informed consent has suggested clients value informed consent as a part of mental health treatment (Sullivan, Martin, & Handelsman, 1993) and viewed counselors/psychotherapists in a positive fashion when a consent process was utilized (Sullivan et al. 1993; Handelsman, 1990) with specific information provided (Walter & Handelsman, 1996); while research on the counselor/psychotherapist’s view of informed consent demonstrates differences between mental health practitioners in the relative importance placed on informed consent with these differences being connected to practitioner characteristics including discipline
(Croarkin, Berg, & Spira, 2003) and theoretical orientation (Somberg, Stone, & Claiborn, 1993).

Previous research does not appear to have examined how the working alliance and client perception of counselor/psychotherapist may relate to and be influenced by the process of informed consent. Both working alliance and client perception of counselor/psychotherapist are salient factors in understanding the counseling/psychotherapy relationship (Hill & Williams, 2000; Horvath & Symonds, 1991; Martin et al., 2000; Ponterotto & Furlong, 1985; Arbuckle, 1956). Research has demonstrated the quality of the working alliance may be an important factor in the outcome of counseling/psychotherapy (Hill & Williams, 2000; Horvath & Symonds, 1991; Martin et al., 2000). Furthermore, the client’s perception of the counselor/psychotherapist is likely to impact how the treating clinician is able to facilitate the client in making adaptive change (Henderson & Lyddon, 1997). Given the potential importance of these two counseling/psychotherapy variables in understanding counseling/psychotherapy process and outcome, investigation of their possible relationship to informed consent seems to be an important area of inquiry.

Two main research questions were investigated in the present study. The first research question explored the extent to which client ratings of thoroughness of informed consent discussion and client understanding of informed consent related to working alliance as measured by the client form of the Working Alliance Inventory – Short Version (WAI-S) (Tracey & Kokotovic, 1989). The second research question explored the extent to which client ratings of thoroughness of informed consent discussion and client understanding of informed consent related to clients’ general opinion of the
counselor/psychotherapist as reflected by ratings of the counselor/psychotherapist’s attributes of expertness, trustworthiness, and attractiveness as measured by the short form of the Counselor Rating Form (CRF-S) (Corrigan & Schmidt, 1983). Each research question was considered after gender, age, social class, number of counseling/psychotherapy sessions and client’s degree of functionality and severity of psychopathology were controlled for in the analyses.

Informed Consent and Working Alliance

In testing the hypotheses associated with the first research question both ICI Discussion and ICI Understanding contributed significant additional unique variance in predicting working alliance when entered individually after the variables of age, gender, social class, number of counseling/psychotherapy sessions and client’s degree of functionality and severity of psychopathology were entered into the regression model. These findings indicate that both ICI Discussion and ICI Understanding contributed unique variance to predicting working alliance when entered alone in the model after client age, gender, social class, number of counseling/psychotherapy sessions and client’s degree of functionality and severity of psychopathology were entered. When ICI Discussion and ICI Understanding were entered together as a block of variables in the regression model, only ICI Understanding emerged as a significant unique predictor of working alliance. This finding appears to relate to the fact that ICI Discussion and ICI Understanding correlated highly with each other (r = .787) and ICI Understanding had a higher correlation with the WAI-S in comparison to ICI Discussion (r = .559 versus r = .399). Thus, ICI Understanding emerged as the significant unique predictor when these
two variables were entered together in the model and as the most important predictor in
the full model.

Previous research on informed consent has examined several differing areas such
as preferences for the format of informed consent (Jensen et al., 1991; Sullivan et al.,
1993) and preferences for informed consent content (Gustafson, 1994; Jensen et al.,
1991; Walter & Handelsman, 1996; Braaten & Handelsman, 1997). However, a link to
working alliance may be found in how counseling/psychotherapy clients’ feel about
informed consent procedures. It appears as though counseling/psychotherapy clients
value informed consent as a part of mental health treatment (Sullivan et al. 1993).
Further, clients appear to view counselor/psychotherapists in a positive fashion when an
informed consent process was utilized (Sullivan et al. 1993; Handelsman, 1990; Wagner
& Handelsman, 1998). This has been found to be especially true when specific
information was provided (Walter & Handelsman, 1996). Such empirical research on
informed consent and its positive impact on how a counselor/psychotherapist is viewed
has implications for the formation of a working alliance. Clients may feel better about
entering into and committing to counseling/psychotherapy when fully informed through a
consent process. This may help the client more easily enter into a working alliance with
the counselor/psychotherapist.

Bordin (1979) defined the working alliance as consisting of agreement on goals,
assignment of tasks, and the development of a bond within the context of the
counseling/psychotherapy relationship. Agreement on goals relates to the client and
counselor/psychotherapist agreeing on the desired outcome of treatment, while
assignment of tasks refers to the extent to which the client and counselor/psychotherapist
agree on the process of treatment, and the development of a bond refers to the quality of the professional relationship (Bordin, 1979). Gelso and Fretz (2001) discussed the idea that a sound working alliance has roots in a collaborative relationship between client and counselor/psychotherapist. Collaboration is important as it speaks to the necessity of both the client and counselor/psychotherapist to invest in the therapeutic relationship to the extent that a sense of mutuality exists such that the work of counseling/psychotherapy can be completed (Gelso & Fretz, 2001). Collaboration is reported to be necessary from a very early phase of treatment (Gelso & Fretz, 2001). Considering the nature and characteristics attributed to a good working alliance by professionals in the field (Bordin, 1989; Horvath & Luborsky, 1993; Gelso & Fretz, 2001) the positive relationship found in the present study between the extent of discussion of informed consent issues and client understanding of informed consent with working alliance appears understandable and consistent with the framework of the working alliance construct. This relationship indicates more discussion of informed consent issues and a better understanding by clients was positively associated with a good working alliance. There are probably several facets and aspects of the informed consent process and the working alliance that may relate to this finding.

First, the informed consent process itself may support and lead to a better working alliance between the client and counselor/psychotherapist. Second, certain counselors/therapists who establish a good and effective working alliance with a client may be more attentive and effective in facilitating and establishing a relationship in which the client has a more in-depth understanding of issues relevant to informed consent during the counseling/psychotherapy process. Third, there may be client variables that
relate to both informed consent and working alliance, contributing to a positive
association between them. Each of these possible factors will be discussed in turn.

Within an informed consent process, there may be discussion of issues such as the
nature of therapy, treatment alternatives, appointments/scheduling, confidentiality/third
party involvement, money/finances, and general/other. Open discussion of the various
areas of informed consent may not only provide the client with important information,
but may also serve to engage the client as an active participant and equal partner rather
than a passive recipient of treatment. Croakin, Berg, and Spira (2003) noted the practice
of informed consent has spread responsibility for knowledgeable decision making to the
therapeutic dyad rather than remaining solely the possession of the
counselor/psychotherapist. The first two areas Bordin indicated as components of the
working alliance, agreement on goals and the assignment of tasks, may be addressed by a
counselor/psychotherapist processing the informed consent issue of the nature of therapy.
In processing the nature of therapy, the following issues may be discussed: use of
treatment plans, use of testing or assessment procedures, the therapeutic approach of the
counselor/psychotherapist, and how therapy may work. An exchange of ideas related to
treatment plans clearly references the desired goals or outcome of treatment, while
processing the therapeutic approach may give insight into the tasks necessary to initiate
desired change. Conceptually, a thoroughly discussed and understood consent process
which covers a variety of areas germane to treatment may invite and invest the client in
treatment. Thus, the informed consent process may allow the counselor/psychotherapist
and the client to begin discussing the goals and tasks for counseling/psychotherapy which
may ultimately lead to agreement in these areas and therefore, contribute to establishing a working alliance.

Furthermore, some of the content areas of informed consent—namely, discussion of confidentiality and person of the therapist information—may help foster a bond between the client and the counselor/psychotherapist, which is the last of the three components of the working alliance suggested by Bordin. The client may feel reassured in knowing that the information provided to the counselor/psychotherapist will be kept confidential. This may help the client begin to feel safe with the counselor/psychotherapist. Previous research has suggested behaviors associated with confidentiality relate to client perception of trustworthiness (LaFromboise & Dixon, 1981; Merluzzi & Brischetto, 1983) which is intuitively linked to the formation of a bond. Provision of information about the person of the therapist may help the client feel more connected to the counselor/psychotherapist and more able to enter into a relationship with him/her. Research on informed consent has indicated personalized consent documents do result in a positive view of a counselor/psychotherapist (Walter & Handelsman, 1998).

Similarly, the very nature of the informed consent process may help the client to feel bonded to the counselor/psychotherapist. The process may function to assist the client in feeling more at ease as he/she discovers what the expectations for counseling/psychotherapy will be. This may help the client begin to feel comfortable enough to enter into a relationship with the counselor/psychotherapist. Additionally, simply by giving attention to informed consent, the counselor/psychotherapist may be subtly indicating that they value the client. Even if the client does not remember the
specifics of the informed consent discussion, he/she may walk away from the process with positive feelings towards the counselor/psychotherapist and the therapeutic process which can contribute to the development of a working alliance.

The relationship between informed consent and working alliance may also be due in part to the characteristics of the counselor/psychotherapist. Counselors/psychotherapists who are more effective in establishing relationships and good working alliances with their clients may be more attentive and sensitive to a client’s informed consent needs, questions, and issues within the therapeutic relationship. Accordingly, they may spend more time discussing and processing informed consent issues with their clients. Increased sensitivity on the part of counselor/psychotherapists to the importance of clients understanding the nature of the counseling/psychotherapy process may contribute to the establishment of an effective working alliance with the client.

There may be additional counselor/psychotherapist variables that are correlated with both informed consent and working alliance which may, therefore, help explain the relationship between these two variables. This may include several of the factors which have been previously explored in connection with informed consent and/or working alliance including counselor/psychotherapist characteristics, techniques, experience level (Hill & Williams, 2000), re-creation of previous interpersonal relations, and attachment style of the counselor/psychotherapist (Horvath & Luborsky, 1993). The most germane factor explored in relation to working alliance relates to therapist characteristics. Research in this area has examined issues such as personality characteristics, race, age, or gender. Other areas that also seem to fall in this category include differences by
discipline (Croarkin et al., 2003) and by theoretical orientation (Somberg et al., 1993). Related to discipline, research has indicated that counseling/psychotherapy practitioners including psychologists, social workers and those characterized as “other” (e.g. nurse practitioners) may place greater importance on issues germane to informed consent as compared to psychiatrists (Croarkin et al., 2003). Based upon theoretical orientation, those counselors/psychotherapists identified as interpersonal, cognitive behavioral, and “other” (e.g. humanistic) appeared to value informed consent more so than those identifying themselves as psychodynamic/psychoanalytic in their theoretical orientation (Croarkin et al., 2003).

The finding there is variability in the relative importance placed upon informed consent based upon theoretical orientations has possible implications for considering current findings. It is possible the mental health professionals who see informed consent as more important may also be more effective facilitators of the working alliance. Croakin et al. (2003) reported interesting findings when asking counselor/psychotherapists to rate whether written informed consent benefitted the working alliance. Their findings suggested those of a psychodynamic orientation rated this relationship as much less significant versus those of a cognitive behavioral, interpersonal and the “other” (e.g. humanistic) orientation. Empirical findings have suggested those of a cognitive behavioral orientation both place greater value upon working alliance (Black, Hardy, Turpin, & Parry, 2005) and also facilitate the development of a more efficacious working alliance (Raue, Goldfried, & Bark, M., 1997). The same may be true of interpersonal and humanistic therapists, who also place high value on informed consent (Croarkin et al., 2003). One might conjecture
interpersonal and humanistic therapists might also be effective facilitators of working alliance and informed consent due to the continual attention to the counseling/psychotherapy relationship that is inherent in these approaches. If this is the case, the high correlation between informed consent and working alliance in this present study may in part relate to the orientation of the counselor/psychotherapist. That is, the clients who rated both informed consent and working alliance highly may have worked with a mental health professional from one of the theoretical orientations which place greater value on informed consent and who were also more effective at developing a working alliance. Since the theoretical orientations of the counselor/psychotherapist were not assessed in the present study, this is an area for future investigation.

There are a number of client variables that may also relate to both informed consent and working alliance. Empirical work on client factors related to informed consent have focused on the value clients may place on informed consent, how they may view a counselor/psychotherapist who utilized an informed consent procedure, preferences for the method of informed content, and preferences for the content of a consent process (Braaten Otto, & Handelsman, 1993; Jensen et al., 1991; Sullivan et al., 1993; Wagner, Davis & Handelsman, 1998; Gustafson, 1994; Jensen et al., 1991; Walter & Handelsman, 1996; Braaten & Handelsman; 1997). Empirical work on client factors and the working alliance have included interpersonal issues of the client, intrapersonal issues of the client, and diagnostic features. Considering research in each area, one may infer that the interpersonal issues of the client may be salient (Hill & Williams, 2000; Horvath & Luborsky, 1993; Kokotovic & Tracy, 1990; Muran, Segal, Samstag, & Crawford, 1994). Empirical work on the interpersonal issues of the client includes
personality characteristics, quality of interpersonal relationships, and type of interpersonal problems (Horvath & Luborsky, 1993). Research has shown clients with more engaging personality characteristics and quality relationships may be predisposed to the development of working alliance (Hill & Williams, 2000). These same client characteristics may also help the clients engage in the informed consent process, therefore resulting in greater understanding of the informed consent content areas. Thus, it may be that some clients who are more likely to establish an effective working alliance due to interpersonal factors are also predisposed to more involvement in the informed consent process and therefore have a better understanding of informed consent issues.

Informed Consent and Client Perception of Counselor/Psychotherapist

In testing the hypotheses associated with the second research question both ICI Discussion and ICI Understanding contributed significant additional unique variance in predicting clients’ general opinion of the counselor/psychotherapist when added individually after the variables of age, gender, social class, number of counseling/psychotherapy sessions and client’s degree of functionality and severity of psychopathology were entered into the regression model. These findings indicate both ICI Discussion and ICI Understanding contributed unique variance to predicting clients’ general opinion of their counselor/psychotherapist when entered alone in the model after the variables that were being controlled for in the model were entered. When ICI Discussion and ICI Understanding were entered together as a block of variables in the regression model, only ICI Understanding emerged as a significant unique predictor of clients’ general opinion of the counselor/psychotherapist. This finding appears to relate to the fact ICI Discussion and ICI Understanding correlated highly with each other ($r =$
.787) and ICI Understanding had a higher correlation with the CRF-S in comparison to ICI Discussion (r = .357 versus r = .248). Thus, ICI Understanding emerged as the significant unique predictor when these two variables were entered together in the model and as the most important predictor in the full model. Examination of previous research on informed consent and client perception of counselor/psychotherapist may be helpful in considering the current findings.

Findings in this study appear consistent with several previous empirical research studies on informed consent and client perception of the counselor/psychotherapist. In essence, research findings suggest clients may perceive counselor/psychotherapists in a positive fashion when informed consent procedures take place. Research in this area has also examined the following: how the means informed consent is provided (written or verbal) influences perception of counselor/psychotherapist (Handelsman, 1990; Walter & Handelsman, 1996), whether readability influences perception of counselor/psychotherapist (Wagner, Davis, & Handelsman, 1998), whether an informed consent process influences perception of counselor/psychotherapist and medically-related decisions, (Mardirosian, McGuire, Abbott, & Blau, 1990), and whether characteristics of the counselor/psychotherapist influence how a counselor/psychotherapist is viewed (Handelsman, 1990; Sullivan, Martin, & Handelsman, 1993; Wagner, Davis & Handelsman, 1998).

Several counseling/psychotherapy analogue studies have suggested a relationship between informed consent or aspects of the informed consent process and a positive perception of the counselor/psychotherapist. Research findings have indicated the provision of informed consent information relates to research participants viewing a
counselor/psychotherapist as expert and trustworthy (Sullivan, Martin, & Handelsman, 1993; Walter & Handelsman, 1996). Positive perception of a counselor/psychotherapist has been found when the format for informed consent was a written consent form (Handelsman, 1990) as well as when written and verbal consent methods were used concurrently (Sullivan, Martin, & Handelsman, 1993). In the case of written consent forms, findings suggest that counselors/psychotherapists were viewed as more expert when the consent form was more readable (Wagner, Davis & Handelsman, 1998). A personalized informed consent process has been found to be associated with perception of a counselor/psychotherapist as attractive (Wagner, Davis, & Handelsman, 1998) and personalized consent forms have been found to improve client recall of the consent information (Wagner, Davis, & Handelsman, 1998). In addition, more years of counseling/psychotherapy experience did translate to more positive view of counselor/psychotherapist (Handelsman, 1990; Sullivan, Martin, & Handelsman, 1993). However, it should be noted these studies were counseling/psychotherapy analogue research studies in which research participants rated materials, information and fictionalized therapists in studies designed to simulate informed consent information provided in actual counseling/psychotherapy (Handelsman, 1990; Sullivan, Martin, & Handelsman, 1993; Wagner, Davis & Handelsman, 1998; Walter & Handelsman, 1996). In one study, conducted in an actual clinical setting, a pro-life pregnancy counseling center pregnancy, Mardirosian et al. (1990) found no differences in perceptions of counselor/psychotherapist expertness, trustworthiness or attractiveness for client’s receiving enhanced informed consent versus standard informed consent procedures. In the current research study, participants were actual counseling/psychotherapy clients who
rated the thoroughness of discussion and their understanding of informed consent information and rated their counselor/psychotherapists in an actual mental health clinical setting. Thus, current findings seem to support analogue findings which have suggested a relationship between informed consent and more positive perceptions of counselor/psychotherapists and appear to support generalization to actual counseling/psychotherapy settings.

In the present study, client perception of counselor/psychotherapists was measured by the short version of the Counselor Rating Form (CRF-S) which has its origins in the social influence model of counseling/psychotherapy (Strong, 1968) and in the measurement of counselor expertness, trustworthiness and attractiveness. The total score of the short version of the Counselor Rating Form (CRF-S) was used in the present study and may be considered a reflection of the client's overall view of the counselor/psychotherapist (Tracey et al., 1988). Although subscale scores for the CRF-S were not used in the present study, the CRF-S is composed of items from the full version of the CRF. Consideration of the current findings in the context of the research on counselor expertness, trustworthiness and attractiveness may still be helpful in interpreting these findings. However, it is important to keep in mind the CRF-S total score is a reflection of client ratings across counselor expertness, trustworthiness and attractiveness scored together and research findings from one specific area of variables relating to counselor expertness, trustworthiness and attractiveness may be suggestive of why ICI Discussion and ICI Understanding positively related to CRF-S scores.

Current findings suggest client exposure to the content areas of informed consent and to the informed consent process over the course of counseling/psychotherapy may
relate to perception of a counselor/psychotherapist as expert, trustworthy, and attractive. As has been noted, there were six differing areas of informed consent that were assessed by the ICI measure used in the present study including the nature of therapy, treatment alternatives, appointments/scheduling, confidentiality/third party involvement, money/finances, and general/other. Both more thorough discussion of these issues by a counselor/psychotherapist and more understanding of these issues by a client may directly relate to perceptions of the counselor/psychotherapist as more expert, trustworthy, and attractive.

According to Strong (1968), perception of the counselor/psychotherapist as an expert may be based upon objective evidence, such as displayed educational degrees. Existent research on expertness has suggested several other factors also play a role, such as evidence of training, prestigious cues, counselor/psychotherapist behaviors, and personal characteristics. Each of these areas may be germane to the present study. Previous research has indicated that clients perceive a counselor/psychotherapist as more expert when evidence of training and prestigious cues were present (Angle & Goodyear, 1984; Berstein & Figioli, 1983, Littrell, Caffrey, & Hopper, 1987; McCarthy, 1982; Paradise, Conway, & Zweig, 1986). Some of these very factors are likely be addressed at some point during the informed consent process. For example, the counselor/psychotherapist may share about his/her training and experience, about his/her professional discipline, what license he/she holds, and the theoretical approach to counseling/psychotherapy he/she employs. The communication of such information may function to demonstrate training and potentially prestige to the client.
Research on the behaviors of counselor/psychotherapists has suggested nonverbal behaviors (e.g. physical touch or gestures) by the professional relate to perception of expertness (Barak, Patkin, & Dell; Hackman & Claiborn, 1982; Hubble, Noble, & Robinson, 1981; Roll, Crowley, & Rapp, 1985; Seigel, 1980; Strohmer & Biggs, 1983; Tyson & Wall, 1983). Investigation of verbal behaviors of the counselor/psychotherapist has indicated use of narrative analogies, empathic responses (Suit & Paradise, 1985) and positive self involving statements (Anderson & Anderson, 1985) have a positive impact on client view of expertness. In the present study, the actual behaviors associated with an informed consent procedure, may in and of themselves impact perceived expertness. In effect, expertness may be perceived through the counselor/psychotherapist addressing issues germane to informed consent, through verbal behaviors, such as the actual explanation and discussion of informed consent issues including the nature of therapy, treatment alternatives, confidentiality etc.

Research on perceptions of counselor/psychotherapist as trustworthy relates to a counselor/psychotherapist being perceived as honest or professional. Existent research on trustworthiness has examined cues, behaviors of counselor/psychotherapists, and personal characteristics. Cues examined that have had a positive impact on trustworthiness included prestigious cues such as credible introductions (Berstein & Figioli, 1983; Littrell et al., 1987) and advanced experience level (McCarthy, 1982; McKee & Smouse, 1983). Similar to perception of expertness, it may be that through a credible introduction and evidence of advanced experience level, the client feels a greater sense of trust. Discussion of informed consent issues such as the training and experience of the counselor/psychotherapist, the license of the counselor/psychotherapist, and the
professional discipline of the counselor/psychotherapist appear to be indicators of credibility and experience. Presentation of such information may contribute to the client seeing the counselor/psychotherapist as trustworthy.

Behaviors of the counselor/psychotherapist that have been reported to positively impact trustworthiness have included congruity of roles (Ruppel & Kaul, 1982), responsive nonverbal behavior (Hackman & Claiborn, 1982), behaviors associated with confidentiality (LaFromboise & Dixon, 1981; Merluzzi & Brischetto, 1983) and self involving statements that were positive (Anderson & Anderson, 1985). The issue of confidentiality appears very relevant to the present study as it represents one of the most well known aspects of informed consent. Discussion of when a counselor/psychotherapist would be allowed to tell others about the issues discussed or whether they would discuss a client’s treatment with family, friends or others (e.g. doctor) may be quite significant to a client. Assurance the actual content of the counseling/psychotherapy is privileged information may provide significant comfort and result in a perception of trustworthiness. With two previous studies (LaFromboise & Dixon, 1981; Merluzzi & Brischetto, 1983) suggesting a positive relationship between behaviors associated with confidentiality and client perceived trustworthiness, this idea is particularly relevant.

Perception of the counselor/psychotherapist as attractive is reported to be related to similarity and compatibility between client and counselor/psychotherapist. Studies on attractiveness have also examined the role of cues and behaviors of the counselor/psychotherapist. Cues positively impacting perception of counselor/psychotherapist attractiveness included evidence of training through introduction (Angle & Goodyear, 1984; Berstein & Figioli, 1983; Paradise et al., 1986),
positive cues as to reputation (Littrell et al., 1987) and status related to advanced experience (McCarthy, 1982). Again, as was noted with perception of expertness and trustworthiness, a credible introduction and evidence of advanced experience level, may relate to a client feeling a greater sense of attraction. It may be during the informed consent process the client begins to believe that the counselor/psychotherapist has the ability to understand them. Discussion of informed consent issues such as the training and experience of the counselor/psychotherapist, the license of the counselor/psychotherapist, and the discipline of the counselor/psychotherapist appear to be indicators of credibility and attractiveness. Thus, through greater discussion and understanding of the areas of informed consent, the client may feel a greater attraction to the counselor/psychotherapist due to the belief that they will be implicitly understood.

Verbal behaviors that have been found to relate to perception of counselor/psychotherapist attractiveness have included self-disclosure and self-involving statements (Anderson & Anderson, 1985; Curran & Loganbill, 1983; Dowd & Boroto, 1982; Remer, Roffey & Buckholtz, 1983). This existent research on self-disclosure and self-involving statements and their relationship to counselor perceived attractiveness appear interesting and possibly relevant to current findings on informed consent and client perception of counselor/psychotherapist. Through informed consent procedures, counselors/psychotherapists may reveal information about themselves, through discussion of their professional credentials, training, licensure, and the nature of counseling/psychotherapy. Interestingly, one can conjecture that through discussion of informed consent issues such as the nature of counseling/psychotherapy, a treating professional is providing information about themselves and how they perceive the
process of change to take place and thus are sharing important aspects of themselves which may enhance their perceived attractiveness.

Implications of the Current Study

The current study found discussion of informed consent and client understanding of issues germane to informed consent both related to a more positive working alliance and a more positive perception of the counselor/psychotherapist as expert, trustworthy, and attractive. These findings seem important in highlighting the possible relationship of informed consent to client perception of the counselor/psychotherapist and the working alliance. These findings are significant in the context of research on the social influence process in counseling (Corrigan, Dell, Lewis, & Schmidt, 1980; Heppner and Claiborn, 1989; Heppner & Dixon, 1981) and research on the working alliance, especially the relationship between working alliance and counseling/psychotherapy outcome (Hill & Williams, 2000; Horvath & Symonds, 1991; Martin et al., 2000).

Research has found there is a relationship between the working alliance and counseling/psychotherapy outcome when outcome is rated by clients (Horvath & Symonds, 1991). One implication of the relationships found between client ratings of discussion and understanding of informed consent, client perception of the counseling/psychotherapist, and client rated working alliance is these findings further highlight informed consent as a crucial aspect of the counseling/psychotherapy process. These findings also appear to suggest client involvement in informed consent discussion and understanding of informed consent issues may be one important benchmark of the working alliance as counseling/psychotherapy proceeds. Given the emphasis on the collaborative nature of the working alliance (Gelso & Fretz, 2001), current findings
seem consistent with the idea that a collaborative relationship built on mutual respect may serve as the foundation for a good working alliance and may be related to more thorough and effective attention to informed consent.

The findings of this study have possible implications for counseling/psychotherapy training, practice, and research. With respect to training and the actual practice of counseling/psychotherapy it seems very important for both students in training and for practitioners to be aware of and to appreciate the relationship between informed consent and client perception of the counselor/psychotherapist and the working alliance. While there may be a preference on the part of some professionals to view or conceptualize informed consent as an event (Applebaum, Lidz, & Meisel, 1987), the relationship of informed consent to working alliance found in the present study seems to support the process view since the working alliance is an ongoing part of the counseling/psychotherapy relationship. These findings suggest it may be beneficial for counseling/psychotherapy practitioners to view informed consent as less of an event and more of a process. When an informed consent procedure is viewed as an event, there may be the potential for informed consent to be considered as a formality, distinct and separate from the process of counseling/psychotherapy. With an informed consent process that is ongoing, the counselor/psychotherapist may be able to capitalize on the relationship and create a continuous process of negotiation and discussion (Dyer & Bloch, 1987). Through the process of discussion, the client may become more involved in treatment as part of a collaborative relationship and this in turn may enhance the client's perception of the counselor/psychotherapist and the working alliance relationship.

The current findings also indicated client rated understanding of informed consent
topics was the most important predictor of client perception of counselor/psychotherapist and the working alliance. This finding highlights the importance of counseling/psychotherapy practitioners communicating informed consent information, whether written or verbal, in a manner that is understandable to the client. Although thoroughness of discussion of informed consent was a significant predictor, client understanding had a stronger relationship to both client perception of the counselor/psychotherapist and working alliance. One of the implications of this may be that client understanding of informed consent is the central variable and is more important than method, format, or amount of discussion given to informed consent topics when considered in the context of the client and counselor/psychotherapist relationship.

The present study suggests several possible directions for future research. First, there is a need to replicate the findings of the current study. Since this is one of the first investigations simultaneously examining informed consent, client perception of the counselor/psychotherapist, and working alliance, replication of the findings is needed. Second, additional research on the measure of informed consent (ICI) used in the present study may be beneficial. The ICI was developed specifically for use in this study and additional research on the measure would be helpful to establish the reliability and validity of this instrument. Third, future research can be done to investigate client perception and understanding of informed consent at several points in time across the course of counseling/psychotherapy. Current findings are based on a single assessment at one point in time. Longitudinal research can help to illuminate how clients’ perceptions change over time. Fourth, research specifically focused on the issue of client and counselor/psychotherapist perspective of informed consent as a single event or as an
ongoing process overtime would be interesting. Fifth, further investigation on the nature
of the relationship between working alliance and client perception of the
counselor/psychotherapist is needed. A great deal of the empirical research on working
alliance has operationalized this construct along the lines suggested by Bordin (1979).
However, others (Elvins & Green, 2008) have viewed working alliance to include other
variables such as the social influence variables suggested by Strong (1968). Elvins and
Green (2008) included the social influence variables as an alliance concept stating that it
"implicitly tests Bordin's conception of the bond in alliance" (p. 1170). Others have
treated working alliance and counselor rating as separate constructs. There have been
very few investigations of the relationship between these two variables. At least one other
study (Lukin, 1996) has investigated these two variables and found that the social
influence variables of expertness, trustworthiness, and attractiveness were strongly
related to working alliance. However, researchers may wish to further examine the
relationship between these two variables.

Limitations of the Current Study

Limitations of the study include the study design, measurement limitations, the
client focus of the study, and procedures within the setting in which the research was
conducted. With respect to study design, since the research design employed was a
correlational field study, current findings do not establish any causal relationships among
the variables studied. Rather, the results of this study are suggestive of relationships
between and among the variables and caution is indicated when interpreting the results.
Also, data was collected and analyzed from one point in time. Future studies might
include longitudinal designs that might examine relationships among the variables over
time. An additional design limitation is that study participants were all volunteers from a single clinical setting.

Another limitation is the instrumentation used and the reliance on client self-report. The informed consent measure used in this study was developed specifically for use in the study to assess client perception of both the discussion and understanding of informed consent issues. All the measures used in the study relied on client self-report. Different measures of some of the same variables might yield different findings. In particular, it may be interesting to examine ratings made by observers and/or counselor/psychotherapists. The study was also limited by not including information about the counselor/psychotherapist. Hence, counselor/psychotherapist variables could not be taken into account in the analysis. Finally, as has been noted, in the clinical setting in which the study was conducted; clients were involved in the initial informed consent process at intake assessment. This process was guided by a consent document with client signature obtained at the conclusion of the intake assessment process. Upon completion of the intake assessment, clients may have continued to work with the professional staff who conducted the intake interview or may have been assigned to another clinician. If the client was assigned to another professional staff member after the intake interview, common practice within the agency was for the assigned counselor/psychotherapist to review informed consent information with the newly assigned clients before the process of counseling/psychotherapy actually began. All counselor/psychotherapists were expected to review and discuss informed consent issues as appropriate during the ongoing process of counseling/psychotherapy. However, a similar study in a setting in which all
clients saw the same clinical professional for intake and for all of their counseling/psychotherapy sessions may be more desirable.

Summary

The current study found that discussion of informed consent and client understanding of issues germane to informed consent both related to a more positive working alliance and a more positive perception of the counselor/psychotherapist as expert, trustworthy, and attractive. These findings seem important in highlighting the possible relationship of informed consent to client perception of the counselor/psychotherapist and the working alliance. Discussion focused on several possible factors that may be involved in the relationships between informed consent and working alliance and between informed consent and client perception of the counselor/psychotherapist. With respect to informed consent and the working alliance, three factors were discussed: (1) aspects of the informed consent process itself may support and lead to a better working alliance between the client and counselor/psychotherapist; (2) counselors/psychotherapists may share certain characteristics that may relate to establishing an effective working alliance with a client that includes being more attentive and effective in establishing a relationship in which the client develops a more in-depth understanding of informed consent issues; and (3) there may be client characteristics that relate to both informed consent and working alliance, contributing to a positive association between them. The relationship between informed consent and client perception of counselor/psychotherapist may relate to aspects of the informed consent process relating to perceptions of the counselor/psychotherapist as more expert, trustworthy, and attractive. Current findings appear to highlight the
importance of informed consent as an essential aspect of the process of counseling/psychotherapy. Possible research implications and directions were noted and discussed. Research on the relationship between informed consent and the process of counseling/psychotherapy appears to be a potentially fruitful area for future research.
REFERENCES


Hollingshead, A. G. (1975). *Four factor index of social status*. New Haven, Conn: Yale University, Department of Sociology.


Appendix A

Human Subjects Institutional Review Board Approval Letter
Date: December 23, 2009

To: Patricia M. Kennedy, Ph.D., Chair

From: Marc C. Tyrany, Ph.D., Vice Chair

Subject: Project Number: 08-0049

I am writing to confirm that your research proposal entitled "Eating Habits and Nutritional Knowledge" has been approved under the approval form of the Human Subjects Research Committee. The protocol and anticipated procedures have been approved by the Human Subjects Research Committee. You must comply with all the procedures described in the protocol.

Please note that you must ensure that the research methods in the form have been approved. You must contact the chair of the committee for any changes in the project. You must also ensure that the study is conducted in accordance with the approved protocol. Any violation of the protocol may result in the project being discontinued. If you have any questions or concerns regarding the procedures, you should immediately contact the chair of the committee.

The Board wishes you success in your research.

Approval Date: December 23, 2009
Appendix B

Demographic Form
Demographic Form

Instructions: Please answer the following questions by filling in the blank or circling the choice that best describes you. Please read each question carefully.

1. Age: _______

2. Gender (Please Circle): Male Female

3. Current Marital/Relationship Status (Please Circle):
   - Divorced
   - Partnered/Separated
   - Married
   - Single
   - Partnered
   - Widowed
   - Married/Separated
   - Other - Specify _______

4. Occupational status: Employed Unemployed

5. Please indicate your most recent occupational title (for example, postal carrier or cashier).

6. If you are married or partnered, please indicate the present occupational title of your spouse or partner. If you are not married or partnered, please write “not applicable”:

7. If you are divorced or separated and receiving financial support, please indicate the present occupational title of your former spouse/partner. If you are not divorced or separated and receiving financial support, please write “not applicable”:

8. If you are widowed and living on the income from a deceased spouse/partner, please indicate the occupational title of your former spouse/partner. If you are not widowed, please write “not applicable”:

160
9. Please circle the appropriate level of education you have completed:

- less than seventh grade
- junior high school (9th grade)
- partial high school (10th or 11th grade)
- high school graduate
- partial college (at least one year) or specialized training
- standard college or university graduation
- graduate professional training (graduate degree)

10. If you are married or partnered, please circle the appropriate level of education your spouse/partner completed:

- not applicable
- less than seventh grade
- junior high school (9th grade)
- partial high school (10th or 11th grade)
- high school graduate
- partial college (at least one year) or specialized training
- standard college or university graduation
- graduate professional training (graduate degree)
11. If you are divorced or separated and receiving financial support, please circle the appropriate level of education your former spouse/partner completed:

not applicable

less than seventh grade

junior high school (9th grade)

partial high school (10th or 11th grade)

high school graduate

partial college (at least one year) or specialized training

standard college or university graduation

graduate professional training (graduate degree)

12. If you are widowed and living on the income from a deceased spouse/partner, please circle the appropriate level of education your spouse/partner completed:

not applicable

less than seventh grade

junior high school (9th grade)

partial high school (10th or 11th grade)

high school graduate

partial college (at least one year) or specialized training

standard college or university graduation

graduate professional training (graduate degree)
13. Race/ethnicity (Please Circle):

- African-American/Black – not of Hispanic Origin
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or Pacific Islander
- White, not of Hispanic Origin
- Hispanic
- Bi-Racial/Multi-racial
- Other – Specify ________

14. Religious Affiliation (Please Circle):

- Agnosticism
- Atheism
- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism
- Other – Specify ________
15. Please circle the number of counseling/therapy session you have had with your therapist

1  2  3  4  5  6  7  8  9  10  11  12
13  14  15  16  17  18  19  20  21  22  23  24
25  26  27  28  29  30  31  32  33  34  35  36
37  38  39  40  41  42  43  44  45  46  47  48
49  50

If you have received more than 50 sessions please write in the number of sessions you have had with your therapist. ______

If you are not sure of the exact number of sessions you have had with your therapist please estimate the number of sessions to the best of your ability.
Appendix C

ICI Form
ICI FORM

Instructions: On the following pages are several statements that relate to information that therapists sometimes discuss with their clients during the course of counseling/therapy.

First, carefully read each statement. Decide how much discussion you and your therapist have had about the topic. Circle the number that best reflects the amount of discussion you feel took place between you and your therapist. For example, if you decide you and your therapist have had thorough discussion of the topic, you would circle the number seven.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often my therapist and I will meet.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>How often my therapist and I will meet.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Minimal Understanding</td>
<td>Moderate Understanding</td>
<td>Thorough Understanding</td>
<td></td>
</tr>
<tr>
<td>Minimal Understanding</td>
<td>Moderate Understanding</td>
<td>Thorough Understanding</td>
<td></td>
</tr>
</tbody>
</table>

1. The kind of counseling/therapy that my therapist practices.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

2. How the counseling/therapy that my therapist practices works.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
3. The possible risks and benefits of the counseling/therapy that my therapist practices.

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Minimal</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Thorough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

4. How long my therapist believes counseling/therapy will last.

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Minimal</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Thorough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

5. Whether there are any kinds of tests or assessments involved with my counseling/therapy.

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Minimal</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Thorough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

6. What my treatment plan is and how it affects my counseling/therapy.

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Minimal</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Thorough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

7. What other types of counseling/therapy there are besides the kind that my therapist practices.

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Minimal</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Thorough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
8. How my therapist's type of counseling/therapy is different from others.

<table>
<thead>
<tr>
<th></th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minimal Understanding</th>
<th>Moderate Understanding</th>
<th>Thorough Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

9. What treatments are available, other than counseling/therapy with my therapist.

<table>
<thead>
<tr>
<th></th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minimal Understanding</th>
<th>Moderate Understanding</th>
<th>Thorough Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

10. What other services community mental health offers beyond counseling/therapy.

<table>
<thead>
<tr>
<th></th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minimal Understanding</th>
<th>Moderate Understanding</th>
<th>Thorough Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

11. When community mental health is open and closed.

<table>
<thead>
<tr>
<th></th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minimal Understanding</th>
<th>Moderate Understanding</th>
<th>Thorough Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

12. How appointments with my therapist are scheduled.

<table>
<thead>
<tr>
<th></th>
<th>Minimal Discussion</th>
<th>Moderate Discussion</th>
<th>Thorough Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minimal Understanding</th>
<th>Moderate Understanding</th>
<th>Thorough Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
13. How long appointments with my therapist are.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Discussion</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. How I can reach my therapist in an emergency.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Discussion</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. If my therapist is not available, who else may be contacted.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Discussion</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. What confidentiality means in my counseling/therapy.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Discussion</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. When my therapist would be allowed to tell others about the things we discuss.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Discussion</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. Whether my therapist would discuss my counseling/therapy with my family, friends, or others (doctor, insurance company, etc.).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. What kind of records my therapist keeps.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. How much counseling/therapy sessions with my therapist cost.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Whether my fee can be adjusted.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. Arrangements for payment for sessions with my therapist.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

170
23. Whether I have to pay for missed sessions with my therapist.

1 Minimal Discussion
2 moderation
3 discussion
4 thorough
5 discussion
6 discussion
7 discussion

24. What my therapist’s training and experience is.

1 Minimal Discussion
2 moderation
3 discussion
4 thorough
5 discussion
6 discussion
7 discussion

25. What my therapist’s license is.

1 Minimal Discussion
2 moderation
3 discussion
4 thorough
5 discussion
6 discussion
7 discussion

26. Whether my therapist is a psychologist, counselor, social worker, intern, family therapist, or other.

1 Minimal Discussion
2 moderation
3 discussion
4 thorough
5 discussion
6 discussion
7 discussion
Appendix D

Invitation Script
Invitation Script

"I would like to invite you to participate in a study that aims to learn more about ‘Client Perception of Counseling and Psychotherapy’. This study examines how perceptions and understanding of aspects of counseling and psychotherapy may relate to the work completed with one’s counselor or therapist. This study may help professionals develop further understanding of and improve the therapeutic relationship. This study is being completed by Scott E. Kerby, M.A. and supervised by Patrick Munley, Ph.D.

I’m giving you a packet containing a consent document and five questionnaires which will take approximately thirty minutes to complete. Please take this packet to the waiting area and read the consent document which provides more information on the study. Whether you participate or not, your services through CMHA will not be affected. You are under no obligation to participate. I will not be made aware of whether you choose to participate or not.

If you choose to participate please carefully read and complete the enclosed materials. When you are finished, place all materials back in the survey packet and return them to the receptacle in the waiting area marked ‘Survey on Perceptions of Counseling and Psychotherapy.’ No identifying information is asked of you. Your responses are completely anonymous. If you are not interested after reading the consent document, you may discard the survey packet or place it in the same receptacle. Whether you choose to participate or not, please do not place any identifying information about yourself or others on any of the questionnaires.

"Thank you for considering participating.” [Provide client with a survey packet.]
Appendix E

Consent Form
Western Michigan University
Department of Counselor Education and Counseling Psychology
Client Perception of Counseling and Psychotherapy
Student Investigator: Scott E. Kerby, M.A.
Principle Investigator: Patrick Munley, Ph.D.

You are invited to participate in a study titled “Client Perception of Counseling and Psychotherapy”. Your perspective as a client is of important value. This study is being conducted through the Department of Counselor Education and Counseling Psychology at Western Michigan University by doctoral student, Scott E. Kerby, M.A., under the supervision of Patrick Munley, Ph.D. This study proposes to investigate the relationship between a client’s understanding of issues related to counseling/psychotherapy and the therapeutic relationship.

The present study consists of five questionnaires, which will take approximately 30 minutes to complete. The questionnaires request information about the following: demographic information, your perception of and understanding of several aspects of counseling/psychotherapy, how you perceive your counselor/therapist and your work together, and how you are doing in your life at this time.

The potential benefits of this study relate to possible greater understanding of the process of counseling/psychotherapy. Also, participants may benefit from both the reflection of one’s experience of counseling/psychotherapy as facilitated by the survey packet and the knowledge that one is contributing to the body of research and literature in the area of the present study. There appears to be little risk or discomfort involved in the present study beyond the time involved in completing the questionnaires. Your responses to this study are completely anonymous. Do not place any identifying information about yourself or others on any of the study materials (name, date of birth, social security number, etc.).

Participation in this study is completely voluntary and will not in any way affect your services through this agency. Your counselor/therapist will not be aware of whether or not you choose to participate. Should you decide to participate in this study, please thoroughly read and complete the materials enclosed in the survey packet. When finished, place them back into the survey packet and return them to the receptacle marked “Survey on Perceptions of Counseling and Psychotherapy.” You may discontinue your participation at any time. Should you choose not to participate, you may discard the materials or place them in the same receptacle.

Returning the completed materials indicates your consent for their use in this study. If you have any questions, you may contact Scott E. Kerby at 269-342-4118 or Dr. Patrick Munley at 269-387-5100. You may also contact the Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298. This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old. Please keep this consent form for your own records.