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Alliance Expectations and Alliance as Predictor of Therapy Engagement and Outcome

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Running Head: EFFECTS OF ALLIANCE EXPECTATIONS IN THERAPY

Alliance Expectations and Alliance as Predictor of
Therapy Engagement and Outcome

by

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DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of
Psychology in the Department of Clinical Psychology of
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Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

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**ALLIANCE EXPECTATIONS AND ALLIANCE AS PREDICTOR OF
THERAPY ENGAGEMENT AND OUTCOME**

presented on February 23, 2015

by

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Abstract

Clients begin psychotherapy with expectations that may or may not be met during treatment. Discrepancies between pretherapy expectations and the therapy experience may influence client response to treatment. This naturalistic observational pilot study investigated whether the discrepancy between initial expectations of the working alliance and the experience of the alliance predicts early client engagement and outcome. Participants were adult therapy clients at a university training clinic. Each participant completed the Expected-Working Alliance Inventory before their first session and a shortened version of the Working Alliance Inventory after. We hypothesized that the difference between expected alliance scores and actual alliance scores would predict level of client engagement and outcome. We found that participants in this study engaged at a higher rate than generally seen among therapy clients, with 82% remaining in treatment after four weeks. Even with this unusually high engagement rate, the results showed that the expected-actual alliance discrepancy predicted client engagement. Most notably, exceeding alliance expectations was associated with greater early therapy engagement. The expected-actual alliance discrepancy did not predict client outcomes. The results showed a pattern of better outcomes when the alliance exceeded expectations, but this finding was not significant, which may be due in part to a small sample size. Overall, this pilot study suggests that while initial client expectations about the therapy relationship are complex, efforts to surpass alliance expectations may lead to greater early therapy engagement. In addition, recommendations for further research and other clinical implications are discussed.

Keywords: therapy alliance, expectations of therapy, therapy outcome, client engagement

Alliance Expectations and Alliance as Predictor of Therapy Engagement and Outcome

Strong Alliances Enhance Therapy Outcomes

The working alliance between the therapist and client is a crucial ingredient in the psychotherapy process (Luborsky et al., 2002; Wampold, 2001). Multiple meta-analyses have shown that the alliance accounts for between 5% and 7% of the variance in client outcomes (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). This relationship between alliance and client outcomes arises quickly, with alliance ratings predicting subsequent outcomes as early as session two (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009).

Strong alliances are also associated with lower rates of attrition. It goes without saying that clients who drop out of therapy are less likely to reap its benefits, yet between 30% and 60% of adults terminate prematurely (Johannson & Eklund, 2006). Pekarik (1992) found that those who dropped out within the first two sessions improved significantly less, even, than those who dropped out after the third or fourth sessions. Several studies have found that positive alliances predict lower drop-out rates, even very early in treatment (Barber et al., 2001; Johannson & Eklund, 2006; Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Negotiation of Therapy Alliance is Multidimensional and Complex

Bordin's (1979) transtheoretical model of the alliance has become widely accepted among researchers and practitioners. Bordin conceptualized the alliance as emerging from mutually agreed upon tasks and goals, along with the affective bond between the client and therapist. This definition of the alliance emphasizes the degree to which therapeutic success depends on the therapist and client collaborating and negotiating shared understandings about their work together. As Safran and Muran (2000) observed, Bordin's definition "highlights the complex, dynamic, and multidimensional nature of the alliance" (p. 12).

Clients Enter Therapy with Expectations

Each client begins therapy with expectations about psychotherapy, including what his or her therapist will be like, and how they will relate to one another (Arnkoff, Glass, & Shapiro, 2002). Clients enter the first therapy session with assumptions about the therapy methods to be encountered, goals to be made, and outcomes to be achieved. A client may be influenced by media representations of psychotherapy (Orchowski, Spickard, & McNamara, 2006), a friend's stories about counseling (Vogel, Wade, Wester, Larson, & Hackler, 2007) or memories of previous therapy experiences (Deane, Skogstad, & Williams, 1999). These factors and myriad others mean that clients arrive at their first session with expectations about what therapy will be like and the kind of relationship they will forge with their therapist.

Expectations Influence Therapy Outcomes

Pretherapy expectations can shape a client's response to therapy, especially early in treatment. As Frank and Frank (1993) posited, the mobilization of hope and positive expectations are critical common factors in therapy. For therapy to be successful, according to the authors, the client must cooperate fully with the tasks of treatment under the belief that those tasks may lead to salutary ends. Lambert (1992) corroborated the importance of client expectations in therapy, suggesting that 15% of the improvements in therapy may owe to expectancy effects. Meanwhile, negative pretherapy expectations deter clients from seeking out therapy or remaining in treatment after the intake (DeFife & Hilsenroth, 2011).

While studies investigating client expectations of the alliance prior to the start of therapy are sparse, research has found that client expectations of therapy roles and outcomes are highly malleable, especially early on in therapy (Dew & Bickman, 2005; Joyce, Ogradniczuk, Piper, & McCallum, 2003). For clients, expectations at the start of the first session and attitudes later on

often differ substantially, likely on the basis of their intervening experiences in treatment (Tambling, 2012). Overall, more evidence needs to be collected to better understand the impact that pretherapy alliance expectations have on the therapy alliance as well as on engagement and outcome.

Deviation Between Alliance Expectations and Alliance May Predict Engagement

In 2007, Baldwin, Wampold, and Imel designed a study to disentangle the various factors that contribute to the alliance-outcome correlation. In the study, clients completed the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996) before every session and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) before session four. Then, the researchers applied multi-level modeling to parcel out the contribution of therapist variability and client variability to the outcome-alliance correlation. Results indicated that therapists who, on average, had the strongest working alliances with clients tended to achieve the best client outcomes. Surprisingly, variations in the strength of their alliances with clients *within their caseloads* (i.e., the particular alliance scores of their individual clients) did not predict outcomes. Instead, Baldwin et al. found that clients assigned to therapists with better alliances, on average, achieved better outcomes than clients assigned to therapists with poorer alliances, *irrespective of their actual individual alliance scores*.

How could it be true that therapists' *average working alliance scores* better predict outcomes than the *individual alliance scores* of their individual clients? It may be that client pretherapy expectations serve as the initial starting point against which the emerging alliance is judged, such that the true meaning of an individual's alliance scores can only be understood in relation to those initial expectations. Measuring the alliance without accounting for pretherapy expectations may be like measuring the distance a runner has run without knowing where the

race began. One implication of this idea is that the “gift” of high performing therapists is in consistently exceeding the alliance expectations of their clients, which would account for the pattern of findings observed in the Baldwin et al. (2007) study.

Illustration of Potential Influence of Pretherapy Alliance Expectations

Consider two clients, Jane and John. Both start therapy on the same day with equivalent levels of psychological distress. After a few sessions, Jane and John are asked to rate the quality of the alliance. At this point, we find that Jane has a higher alliance score than John. What information might we glean from their respective alliance scores? Without prior knowledge of their alliance expectations, we might reasonably predict that Jane will have a better outcome, since her alliance score is higher. This prediction would be consistent with the finding that the early alliance is positively associated with client outcomes.

Now consider how knowledge of John and Jane’s pretherapy alliance expectations might alter our predictions. Imagine that Jane, before arriving for her first session, had extremely high expectations about the alliance she and her therapist would form, whereas John’s alliance expectations were very low (see Table 1 for a depiction of this scenario). If their alliance scores after the first session were the same, we would see that John’s alliance exceeded expectations, whereas Jane’s alliance expectations went unmet. In this scenario, we might predict that John would have a better outcome.

Table 1

Client Outcome and Level of Engagement Based on Expected-Actual Alliance Discrepancy

Client	Pretherapy Alliance Expectations	Alliance Score after Therapy Begins	Discrepancy	Predicted Therapy Response
Jane	40	30	-10	John engages more and has better outcome than Jane, even though their alliance scores are the same.
John	10	30	+20	

Whether an alliance surpasses, meets, or falls short of clients' alliance expectations may be a critical determinant of early engagement and outcome. As Table 2 illustrates, all else being equal, a therapist who typically exceeds alliance expectations (e.g., Therapist 2) will have a higher average alliance score than one who usually meets alliance expectations (e.g., Therapist 1). Perhaps the best therapists consistently beat the expectations of their clients, thereby achieving higher alliance scores on average than their peers (as seen in Baldwin et al., 2007), along with superior outcomes.

Table 2

Expected-Actual Alliance Discrepancies Highlight Therapist Effect

Therapist	Pretherapy Alliance Expectations	Alliance Score after 3 sessions	Discrepancy	Predicted Therapy Response
Therapist 1	15 (Average)	20 (Average)	0 (Average)	
Client A	5	5	0	
Client B	15	15	0	
Client C	25	25	0	All three of therapist 2's clients engage and respond better than therapist 1's
Therapist 2	15 (Average)	30 (Average)	15 (Average)	
Client D	5	15	10	
Client E	15	25	10	
Client F	25	35	10	

Statement of Purpose

The early engagement and treatment response of psychotherapy clients may be influenced by the extent to which their pretherapy alliance expectations are or are not met. The purpose of the proposed research was to test whether the discrepancy between expected and actual alliance scores predicts engagement and outcome. This pilot study aimed to investigate the following hypotheses:

- The deviation between pretherapy expected alliance scores and actual alliance scores will predict the level of client engagement. More specifically, engagement levels will be higher when the alliance exceeds expectations and lower when the alliance falls short of expectations.
- The discrepancy between pretherapy alliance expectations and actual alliance scores will predict client-rated outcomes. More specifically, outcomes will be better when the alliance exceeds expectations and worse when the alliance falls short of expectations.

Literature Review

The introduction established several principles: (a) the working alliance is established early on (Horvath, Fluckiger, Del Re, & Symonds, 2011); (b) measures of the alliance after only a couple of sessions are predictive of responses in psychotherapy, such as the level of client engagement and clinical outcomes (Barber et al., 2009; Horvath, 2001); (c) average alliance scores across therapists' caseloads are more predictive of outcome than the specific alliance scores of individual clients within therapists' caseloads (Baldwin et al., 2007); and, (d) client expectations predict the process and outcome of therapy (Greenberg, Constantino, & Bruce, 2005). Based on these principles, we hypothesized that the discrepancy between clients' expected and actual alliance with their therapists may be a better predictor of early engagement and outcome than early alliance scores alone. In this section, we review in more depth the literature on the influence of pretherapy expectations on the process and outcome of psychotherapy.

Defining and Differentiating Expectations

Expectations are anticipatory beliefs that clients have about therapy (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Noble, Douglas, & Newman, 2001). Preferences are similar to expectations, except preferences refer to treatment characteristics that the client consciously desires (Goates-Jones & Hill, 2008). A client may have strong preferences about the kind of therapy that will be most helpful, without necessarily expecting that those desires will be honored or otherwise come to pass.

Clients start therapy with numerous explicit and implicit expectations, including outcome, treatment, and alliance expectations (Dew & Bickman, 2005). Outcome expectations are "prognostic beliefs about the consequences of engaging in treatment" (Constantino et al.,

2011, p. 185). Outcome expectations can vary drastically from person to person (Arnkoff et al., 2002). One client may expect all problems to be cured through therapy, while another may be skeptical that any benefits will accrue at all.

Treatment expectations are beliefs about “what will transpire during the course of therapy” (Greenberg et al., 2005, p. 666). Clients begin therapy with any number of treatment expectations, including beliefs about the conversations, activities, and emotions they will encounter during therapy. One person may expect to complete weekly homework assignments, while another expects to lie on a couch free associating. One client may anticipate that therapy will be uncomfortable or unpleasant, while another may expect to enjoy the treatment experience.

Treatment expectancies also include beliefs about therapist and client roles, and how they will conduct themselves (Greenberg et al., 2005). Clients begin therapy with particular notions about how collaborative, supportive, advice giving, and directive the therapist will be (Dew & Bickman, 2005). A study by Vogel et al. (2005), for example, found that clients expect to divulge personal information and talk about concrete, distressing problems in therapy. Clients also expect the therapist to be motivated, flexible, and willing to listen (Tinsley, Brown, de St. Aubin, & Lucek, 1984).

Alliance expectations are a type of treatment expectation. They refer to clients’ beliefs about the type of working alliance they expect to develop with their therapist, such as the level of agreement they expect regarding the goals and tasks of therapy, as well as the nature of the emotional bond they expect to develop with the therapist. A client with high alliance expectations might imagine that he or she will form a close, confiding relationship with the therapist, and that the two of them will work in close collaboration to tackle her or his presenting

problems. High alliance expectations for one person might be founded in a history of positive and trusting relationships. For another person, they may originate from the rosy memories of a previous helpful therapy experience.

In contrast, a client with low alliance expectations may expect a more combative or disjointed relationship. This client may doubt her or his ability to adequately communicate treatment preferences to the therapist. She or he may have critical or suspicious preconceptions, acquired second-hand from friends, about “what therapists are like.” She or he may have low expectations due to an impoverished or negative interpersonal history.

Regardless of the underlying contributing factors involved, pretherapy alliance expectations are likely to vary, and the experienced alliance might meet, or under- or over-perform those initial expectations. We contend that the discrepancy—positive and negative—between the expected and actual alliance may predict client engagement and outcomes better than the alliance alone.

The Effects of Disconfirming Expectations: Reviewing the Literature

Most research on expectations has focused on the tendency for clients with higher expectations of improvement to engage more and respond better to treatment than those with lower expectations (Constantino et al., 2011; Noble et al., 2001). Numerous meta-analyses that have explored the relationship between outcome expectations and outcomes have consistently supported a positive, if modest, association (Dew & Bickman, 2005; Noble et al., 2001; Greenberg et al., 2006).

An area of inquiry that has received substantially less attention is the concordance/discordance between pretherapy expectations and actual therapy experience (Arnkoff et al., 2002; Duckro, Beal, & George, 1979). However, the social psychological and

communications literature suggests that further study is merited. For instance, research on Burgoon's (1993) expectancy violations theory suggests that expectancy-disconfirming experiences should heighten attention and arousal. When two people are interacting, according to Burgoon, communication that disconfirms a person's expectations will elicit an amplified complementary response. Consequently, positive expectations that are disconfirmed should cause highly negative reactions, whereas negative expectations that are disconfirmed produce highly positive reactions (Burgoon). Expectancy violations theory has been used to successfully predict a range of phenomena, from breaches in social etiquette norms among Facebook friends (McLaughlin & Vitak, 2011) to the expression of affectionate behavior in platonic adult friendships (Floyd & Voloudakis, 2006).

A similar theory, decision affect theory, emerged out of research by Mellers, Schwartz, Ho, and Ritov (1997). This theory proposes that the intensity of an emotional response to an outcome depends on whether the outcome was anticipated or not. Unexpected outcomes are more emotionally provocative than expected ones (Meller et al., 1997). Thus, experiences that disconfirm expectations by exceeding them result in a particularly gratifying response, and vice versa.

The aforementioned literature is consistent with the scant extant research on the (dis)confirmation of therapy expectations, which indicates that unmet therapy expectations tend to lead to unfavorable treatment responses (Trambling, 2012). Indeed, a major conclusion of Reis and Brown's (1999) meta-analysis was that unmet expectations are nearly always an underlying factor in premature termination. For instance, in one of the studies included in the meta-analysis (Gunzburger, Henggeler, & Watson, 1985), clients completed questionnaires immediately before and after their first therapy session to assess their treatment and outcome expectations. The

pretherapy expectations of clients that dropped out of therapy were not distinguishable from those of continuers, but after the first session, the dropouts expected counseling to be less helpful and were more reticent about returning than were the continuers.

Disconfirmed treatment expectations are not only associated with treatment dropout, but with lower levels of therapy engagement. For instance, Rosen and Wish (1980) assessed the expectations clients had about how their therapists would behave and the specific topics their therapists would focus on in the first two sessions. Clients also weighted each expected therapist behavior and treatment topic by its importance. The more the responses of therapists deviated from the topics clients expected and valued, the more disappointed and apprehensive clients were about participating in treatment. In another study, Nock and Kazdin (2001) developed a scale to measure a broad range of pretherapy expectations. They found that when expectations about the demands of therapy, the structure of sessions, and treatment credibility deviated from the actual therapy experience, clients had lower rates of therapy attendance.

Joyce and Piper (1998) measured client expectations of a “typical session” of time-limited psychodynamic therapy and found that unrealistically high expectations of session comfort and usefulness were associated with disappointment. While the moderate expectations of most clients were met or surpassed by their actual therapy experience, clients with overly optimistic expectations tended to feel let down once therapy began, since the actual treatment failed to live up to their expectations. These clients experienced therapy to be more difficult and less helpful than they initially thought it would be.

Of the treatment expectation findings, expectations about the duration of therapy are the most robust (Greenberg et al., 2005). Pekarik and Wierzbicki (1986) asked individuals to predict the number of sessions they planned to attend. Of the 148 clients in the study, about 50%

anticipated going to five or fewer sessions. Therapists held very different expectations, with most expecting the number of sessions attended to be greater than 15. In the end, by far the strongest predictor of treatment duration was the pretherapy expectations of the client. In fact, clients typically attended about the same number of sessions as they originally expected. As Mueller and Pekarik (2000) noted, clients who did not experience positive change in their anticipated time frame tended to be less satisfied, and to drop out of treatment “prematurely,” at least in the eyes of their therapists.

While underperforming client expectations (i.e., failing to meet expectations) is associated with less engagement and poorer outcomes, exceeding client expectations may be associated with more engagement and better outcomes (Westra et al., 2010). As Frank and Frank (1993) theorized, clients tend to enter psychotherapy in a demoralized state due to persistent failed efforts at managing their problems. From these failed efforts, they develop an expectation that their difficulties are beyond their control and may persist indefinitely. According to the “remoralization hypothesis,” effective psychotherapy disconfirms the client’s pessimistic mindset, replacing demoralization with hope and higher outcome expectations.

Westra et al. (2010) conducted a systematic qualitative study of expectations in *good-outcome* versus *poor-outcome* therapy cases. All of the clients in the good-outcome group attested to being pleasantly surprised by their experience of therapy, which they described as surpassing their role and process expectations. For instance, good-outcome clients consistently reported feeling an unexpected sense of comfort with their therapist. Conversely, poor-outcome clients reported that treatment generally fell short of their expectations. For example, one poor-outcome client stated that “I thought in the beginning few sessions that I’ll get more out of therapy but that was probably unrealistic anyway” (p. 442).

The bulk of the expectations literature has centered on the modest correlation between expectations and outcome (Constantino et al., 2011), while generally neglecting the discrepancy, or deviation, between therapy expectations and experience (Burgoon, 1993). Nonetheless, the small body of extant research supports the notion that positive discrepancies are associated with enhanced treatment engagement and response, whereas negative discrepancies are associated with diminished treatment engagement and response (Nock & Kazdin, 2001; Reis & Brown, 1999; Westra et al., 2010). This pilot study attempted to enrich this body of research by assessing the discrepancy between initial alliance expectations and the actual alliance as a predictor of client engagement and outcome.

Alliance Expectations: A Key to the Puzzle?

Baldwin et al. (2007) found that clients who worked with the therapists with the highest average alliance ratings tended to respond most favorably to treatment, regardless of that client's specific alliance rating. We speculate that the influence of treatment expectations was a factor in this counterintuitive finding in that the higher performing therapists were probably most likely to surpass (or confirm, in the case of high expectations) client alliance expectations, whereas the lower performing therapists were probably most likely to fall short of (or meet, in the case of low expectations) client expectations.

Much of our evidence comes from the expectancy literature, which shows that clients begin therapy with various types of expectations (Constantino et al., 2011), and that how these expectations compare with the actual treatment experience shapes client attendance, engagement, and treatment response (Tambling, 2012; Westra, 2010). If alliance expectations have similar effects on the process and outcomes of therapy as other types of expectations, they may help explain the Baldwin et al. (2007) results and shed further light on the crucial relationship

between expectations, the working alliance, and outcome in psychotherapy.

Methods

Pilot Study Design

This naturalistic observational process study examined whether the discrepancy between clients' expected and actual early alliance predicts client engagement and outcome. This research design was optimal for two reasons. First, it minimized additional burdens on the clients and clinical personnel. Second, studies such as this are critical to increasing our understanding of therapy as it occurs under naturalistic conditions.

The independent variable of interest in this study was the *expected-actual alliance discrepancy*, as derived from self-report inventories that the clients completed before and after therapy began. The criterion variables were client *early engagement* and *outcome*. Polynomial multiple regression was used to assess whether the discrepancy between the expected and actual alliance impacted early engagement and outcome.

Clinic Setting

This study took place at the Psychological Services Center (PSC) in Keene, New Hampshire. The PSC serves as the training clinic for Antioch University New England's Clinical Psychology Doctoral Program. The PSC serves over 200 Antioch students and residents of the Keene and surrounding communities. The clinicians consist of about ten clinical psychology students. The practicum training, which lasts a full year, provides students with between 700 and 1000 hours of clinical experience.

Participants

The PSC routinely collects and provides feedback to clinicians on the outcome and process of therapy in order to improve clinical practice and serve as a basis for applied research

projects. Clients who use PSC services sign a consent form indicating whether or not they wish to make their routine data available for research. Since this study involved a measure not typically administered to PSC clients, a specific informed consent protocol was developed for the study.

We recruit all patients 18 years of age and older who initiated individual psychotherapy during the study period, with no other inclusion or exclusion criteria. The data contained no personally identifying information. Instead, each participant was de-identified through the provision of an ID number to ensure confidentiality. Informed Consent forms, which contained both participant code numbers and their names, were stored in a locked file cabinet within the PSC, separate from study data.

In total, this study captured a sample size of 34 participants. Most of the participants were women (62%) with men making up 34% of the sample and one participant identifying as transgender. The median age of the participants was 25 years old. Close to half of the participants (44%) were university students, while the rest came from the surrounding community. All of the participants were Caucasian except for one person, who identified as Asian.

Measures

Working alliance. The PSC used the client-rated Working Alliance Inventory short form (WAI-SR; Hatcher and Gillespy, 2006). The original Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was designed to measure the quality of the working alliance as articulated by Bordin (1979). The WAI-SR was created as a revision to the original Working Alliance Inventory. The WAI-SR assesses the extent of therapist and client agreement on tasks

and goals and the quality of the therapeutic bond. The global alliance score is an aggregate of the scores for all three subscales on the WAI-SR.

The WAI-SR holds several advantages over the WAI, according to Hatcher and Gillaspay (2006). First, it is shorter and easier to fill out. The WAI-SR consists of 12 items and takes only about one minute to complete. Second, the WAI-SR uses a 5-point rather than a 7-point Likert item response scale; clients reportedly experienced difficulty differentiating among the anchors with the original 7-point scale. Third, the WAI-SR is better able to discriminate between the Goal and Task subscales than the standard WAI.

The WAI-SR has solid psychometric properties. Hatcher and Gillaspay (2006) employed a confirmatory factor analysis and demonstrated that a three-factor structure corresponded to the hypothesized three subscales. Hatcher and Gillaspay found that the WAI-SR had excellent reliability, with a total coefficient alpha score of .92. The coefficient alpha scores for the three subscales were also good, ranging between .85 and .90. Compared to the standard WAI and an earlier brief version of the WAI, the WAI-SR showed superior model invariance, which signifies that the meaning of the Task, Goal, and Bond subscales remain stable across contexts (Hatcher & Gillaspay).

Client ratings of the alliance are particularly important because they are more robust predictors of ultimate treatment outcome than therapist or observer ratings (Bohart & Tallman, 2009). The composite client-rated WAI-SR score, when administered after the third therapy session, is predictive of treatment outcome (Horvath & Greenberg, 1989). PSC clients routinely complete the WAI-SR electronically at the beginning of every even numbered session, starting with Session 2. Participants for this pilot study completed a WAI-SR after Session 1 as well as before Session 2 in order to minimize the loss of data from early dropouts.

Pretherapy alliance expectations. The Expected-Working Alliance Inventory (E-WAI) was designed for this study to measure clients' pretherapy alliance expectations. Clients completed this measure prior to the start of the first session. The E-WAI was adapted from the WAI-SR to assess expectations of the impending alliance instead of perceptions of the actual alliance. The E-WAI directions instruct clients to describe the alliances they expect to have, and the E-WAI statements were changed to the future tense.

Expected-actual alliance discrepancy. To capture the expected-actual alliance discrepancy, we used polynomial regression analysis. Polynomial regression analysis is a more reliable technique for showing the difference between participant expectations and experience than calculating simple difference scores (Edwards, 2001).

Outcome. The Outcome Questionnaire-45 (OQ-45) is a 45-item client-rated psychotherapy outcome scale that measures client functioning in three domains: psychological well-being, interpersonal distress, and social role performance (Lambert, Hanson, & Finch, 2001). A five-point Likert scale was provided for each item on the OQ-45. On average, the measure takes five minutes to complete. As part of standard PSC procedures, clients at the PSC already completed this measure electronically before every odd numbered session, starting with session one. Client outcome was operationalized in this study as the OQ-45 score at Session 5. When Session 5 OQ-45 scores were unavailable, Session 3 or Session 6 scores were used.

The OQ-45 is a psychometrically sound instrument, with strong evidence of reliability and validity (Lambert, Okiishi, Finch, & Johnson, 1998). It has test-retest coefficients of .84, with internal consistency (alpha coefficient) of .93 and higher (Lambert, 2007). The OQ-45 has demonstrated concurrent validity with other common psychotherapy outcome measures such as the Beck Depression Inventory, Inventory of Interpersonal Problems, and Social Adjustment

Rating Scale (Lambert et al., 2001). The OQ-45 has also proven sensitive to client change over time, a particularly crucial characteristic for a psychotherapy outcome measure (Lambert et al., 2001). As a result of its sound psychometric properties, the OQ-45 enjoys widespread use as both a research and clinical tool (Lambert, 2007).

Early client engagement. Early engagement represents a commitment to and full participation in therapy, and it is associated with greater satisfaction and better outcomes (Dearing, Barrick, Dermen, & Walitzer, 2005).¹ Consistent with research by Smith-Hansen (2010), we operationalized client engagement using three criteria (see below). Clients received a rating between one and four for each criterion, with higher scores reflecting stronger engagement in therapy. The sum of scores across the criteria constituted the measure of early client engagement.

Number of sessions attended in first four weeks. The score that a client received in this subscale corresponded to the number of appointments he or she attended in the first four weeks, irrespective of how many sessions the client was scheduled to attend. Clients who attend a greater number of sessions early on were viewed as engaging more fully in therapy. Thus, a client received 1 point for attending one session, 2 for attending two sessions, 3 for attending three sessions, and 4 for attending four sessions.

Treatment status at end of first four weeks. Scores were allocated based on whether clients stay in therapy or how successfully and collaboratively they reach termination. Dropping out unilaterally without informing the therapist resulted in a rating of 1. Dropping out unilaterally lead to a rating of 2 if the client notified the therapist in person or by phone, or if

¹ Historically, dropout rates have often been used as a measure of client engagement. However, differentiating between clients who dropout prematurely due to dissatisfaction with treatment and clients who terminate because they have achieved a desired outcome is inherently difficult (Pekarik, 1993; Stiles, Barkham, Connell, & Mello-Clark, 2008).

they informed the front office staff about their plans to end treatment. A rating of 1 was still given if a client notified the therapist of plans to terminate only after the therapist made efforts to contact them about a recent no-show. Mutually agreed upon terminations resulted in a rating of 3 if the termination was due to (a) a mismatch (e.g., the client preferred a therapist of the opposite gender) or (b) a referral to another provider (e.g., the therapist referred the client to a substance abuse specialist). A rating of 4 was allotted when future sessions were scheduled after the first four weeks of therapy or mutual termination was reached due to no need for further treatment.

Rate of attendance in first four weeks. Scores were allotted according to the proportion of sessions a client attends, which takes into account differences in the frequency of scheduled sessions among clients (e.g., a client is scheduled for biweekly sessions or is away on vacation for a week). An attendance rate between 0% and 25% resulted in 1 point, an attendance rate between 25% and 50% resulted in 2 points, an attendance rate between 50% and 75% resulted in a rating of 3, and an attendance rate above 75% resulted in a rating of 4.

Our purpose for including the *rate of attendance* criterion was to avoid the possibility of “penalizing” clients who scheduled bi-weekly sessions or went out of town for a week. For example, a client who goes on frequent work trips might schedule therapy sessions less frequently than every week, in spite of having a strong commitment to treatment. This criterion prevents these clients from being unduly categorized as unengaged.

Procedure

Adult clients received an Informed Consent form upon arriving for their initial psychotherapy appointments at the PSC. Participants who chose to participate completed the E-WAI and OQ-45 prior to their first session of psychotherapy. Before the start of every odd numbered session (i.e., at the start of sessions three, five, seven, etc.), clients completed the

OQ-45 as per routine clinic procedures. Clients filled out the WAI-SR after the first session and prior to every even session. In sum, the only extra requirement for study participants will be signing the consent form and completing the E-WAI.

Results

Reliability

The internal consistency of the primary instruments was assessed using Cronbach's alpha coefficient. The coefficient alpha score for both the E-WAI and the WAI-SR was .92, which is excellent and nearly identical to that found by Hatcher and Gillaspay (2006).

We calculated Pearson correlation coefficients to explore the relationships among the primary variables (see Table 3). The results indicated a statistically significant correlation between E-WAI and WAI-SR scores, which was expected since the E-WAI is a modified version of the WAI. No other statistically significant correlations were found between the study variables.

Table 3

Pearson Correlation Coefficients Among Average Expected Alliance, Alliance, Engagement and Outcome

	E-WAI (N = 34)	WAI-SR (N = 34)	Engagement (N = 34)	OQ-45 (N = 29)
E-WAI	1.00			
WAI-SR	.58*	1.00		
Engagement	-.19	-.093	1.00	
OQ-45	.17	.09	.09	1.00

Note. Pearson correlation coefficients below the diagonal show correlations between expected alliance, alliance, engagement, and outcome. E-WAI = Expected-Working Alliance Inventory; WAI-SR = Working Alliance Inventory-Short Revised; OQ-45 = Outcome Questionnaire-45; N = sample size.

* $p < .01$.

Data Analysis

We predicted that the discrepancy between participants' expected and working alliance would predict our criterion variables, engagement and early outcome. To test these hypotheses, we used polynomial multiple regression with a response surface analysis. Polynomial regression is the recommended analytic approach for testing whether the fit or discrepancy between two independent variables predicts a criterion variable (Edwards, 2001).

Polynomial regression models and tests for the statistical significance of various types of interactions between two predictor variables (i.e., E-WAI and WAI-SR scores) and a criterion variable (in this case, engagement or outcome). Response surface analysis displays, in three-dimensional space, how a pair of predictor variables interacts in relation to an outcome. We will use response surface analysis to display how the degree of discrepancy between E-WAI and WAI-SR scores relates to early engagement and outcome (Shanock, Baran, Gentry, Pattison, & Heggstad, 2010).

Table 4

Average Expected Alliance, Alliance, Engagement and Outcome Scores by Discrepancy Group

Discrepancy Groups	%	E-WAI		WAI-SR		Engagement		OQ-45 Change (Post – Pre)	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD
E-WAI < WAI	32.35	44.37	5.99	52.09	6.27	11.27	1.35	-10.33	15.05
No significant discrepancy	55.88	47.95	6.84	48.53	6.79	10.37	2.65	-7.33	16.77
E-WAI > WAI	11.76	51.50	7.33	37.50	14.53	11	1.15	-7.50	15.59
Total	100.00	47.21	6.82	48.38	8.67	10.74	2.16	-6.79	15.28

Note. SD = Standard deviation; E-WAI = Expected-Working Alliance Inventory; WAI-SR = Working Alliance Inventory-Short Revised; OQ-45 = Outcome Questionnaire-45; E-WAI < WAI = E-WAI score at least .5 SD less than WAI-SR score; E-WAI > WAI = E-WAI score at least .5 SD greater than WAI-SR score.

We followed the statistical analysis approach suggested by Shanock et al. (2010). First, we looked at the base rates of the discrepancies between the E-WAI and Session 1 WAI-SR scores. To do this, we standardized the scores for E-WAI and Session 1 WAI-SR. Any individual with a standardized E-WAI score that was half a standard deviation above or below the standardized WAI-SR score was determined to have shown a response discrepancy. The frequency of discrepant responses for the two measures is shown in Table 4. As the table illustrates, discrepancies between E-WAI and WAI-SR scores were common (44% of respondents).

The next step was to perform a polynomial regression analysis (Shanock et al., 2010). This required centering the E-WAI and WAI-SR variables in order to reduce the risk of multicollinearity and to make interpretation easier. We then computed three new variables using SPSS (version 22): (i) the square of the centered E-WAI variable, (ii) the square of the centered WAI-SR variable, (iii) and the cross-product of the two variables, allowing us to test for nonlinear relationships between the predictor and criterion variables.

Instead of interpreting the regression coefficients as is typically done in a regression analysis, we examined the results of the polynomial regression via four surface test values a_1 , a_2 , a_3 , and a_4 (Shanock et al., 2010). These values are represented visually in the three-dimensional response surface chart (See Figure 2). We calculated the first surface test value, a_1 , to test for the presence of a linear slope between the predictors and the criterion along the line of congruence, as represented by the line $X = Y$ in Figures 1 and 2. The line of congruence reflects the relationship between the predictors (i.e., E-WAI and WAI-SR scores) and the criterion (i.e., early engagement or early outcomes scores) when the predictors are equal. In other words, a_1 is a test of whether clients' early engagement and outcome increase in a linear manner along the continuum from low matching scores (e.g., E-WAI and WAI-SR = -2) to high matching scores (e.g., E-WAI and WAI-SR = 2) on the predictors. To visualize the line of congruence, imagine a line running from the front right (i.e., where WAI-SR and E-WAI = -2) to the back left (i.e., where WAI-SR and E-WAI = 2) of the graph. The line of congruence is also displayed as the dashed line in Tables 4 and 6.

The second surface test value, a_2 , tests for the presence of a nonlinear (e.g., quadratic) relationship between the predictors and the criterion variable along the line of congruence ($X = Y$). A significant a_2 indicates that the slope along the line of congruence between E-WAI and WAI-SR is non-linear. For instance, a significant and positive value for a_2 would appear on the graph as an upward curve along the line of congruence.

The third surface test value, a_3 , tests for the presence of a linear slope between the predictors and criterion along the line of discrepancy, as shown by the line $X = -Y$ in Figures 1 and 2. The line of discrepancy marks the relationship between the predictors and the criterion when the predictors—E-WAI and WAI-SR scores—are at different points along the discrepancy

continuum. Imagine a line running from the front left to the back right of the graph—that's the line of discrepancy. Testing a_3 lets us examine whether early engagement and outcome change in a linear fashion along the discrepancy continuum (i.e., ranging from E-WAI = -2/WAI-SR = 2 to E-WAI = 2/WAI-SR = -2).

The fourth surface test, a_4 , tests for the presence of a nonlinear relationship between the predictors and criterion variables along the line of discrepancy ($X = -Y$). A significant a_4 would appear on the graph as a curved slope along the line of discrepancy. For instance, a significant and negative a_4 would appear as a downward curving slope on the graphs, indicating that as E-WAI and WAI-SR ratings become more discrepant (e.g., E-WAI = 2, WAI-SR = -2 and E-WAI = -2, WAI-SR = 2), the outcome variable decreases in an exponential or other nonlinear fashion.

Hypothesis 1: Discrepancy between pretherapy alliance expectations and alliance predicts client engagement. We hypothesized that the discrepancy between participants' expected and actual working alliance would predict client engagement early in therapy. Specifically, we expected early engagement scores would be higher the more that WAI-SR scores exceeded E-WAI scores, and vice versa. This hypothesis would be supported by the lack of a linear or nonlinear relationship along the line of congruence (i.e., the a_1 and a_2 surface tests, respectively), and a statistically significant linear and/or nonlinear relationship along the line of discrepancy (i.e., the a_3 and/or a_4 surface tests, respectively), with engagement scores increasing the more that WAI-SR scores surpassed E-WAI scores. The response surface tests appear in Table 5 and 7 and the response surface graphs can be seen in Figure 1 and 2.

In line with our hypotheses, the tests of response surfaces a_1 and a_2 , which assessed for a linear ($a_1 = .06, p = .71$) and nonlinear ($a_2 = .00, p = 0.81$) relationship along the line of

congruence, respectively, were not statistically significant. When E-WAI and WAI-SR scores were congruent (i.e., the same), there was no significant relationship between them and early engagement scores.

The tests of response surfaces a_3 and a_4 supported our hypotheses. While the third surface test did not find a statistically significant linear relationship between E-WAI and WAI-SR scores along the line of discrepancy ($a_3 = -.26, p = 0.31$), the fourth surface test found a statistically significant nonlinear relationship between E-WAI and WAI-SR scores along the line of discrepancy ($a_4 = 0.04; p = .01$). As Figure 1 shows, the slope along the line of discrepancy was negative, but followed a mild U-shaped curve, with engagement levels rising upward as WAI-SR surpassed E-WAI scores by greater amounts.

Table 5

Expected-actual alliance discrepancy as predictor of client engagement

Variable	<i>B</i>	SE	<i>p</i> -value
Constant	10.22	1.03	
Expected working alliance	-0.10	0.17	
Working alliance	0.16	0.12	
Expected working alliance squared	0.01	0.01	
Working alliance squared	0.01	0.00	
Expected working alliance X working alliance	-0.02	0.01	
R ²	0.14	2.18	
Surface tests			
<i>a</i> ₁	0.06	0.15	0.71
<i>a</i> ₂	0.00	0.02	0.81
<i>a</i> ₃	-0.26	0.25	0.31
<i>a</i> ₄	0.04	0.01	*0.01

Note. *B* = unstandardized regression coefficient; SE = standard error; R² = coefficient of determination; *a*₁ = first surface test; *a*₂ = second surface test ; *a*₃ = third surface test; *a*₄ = fourth surface test.

* *p* < .01.

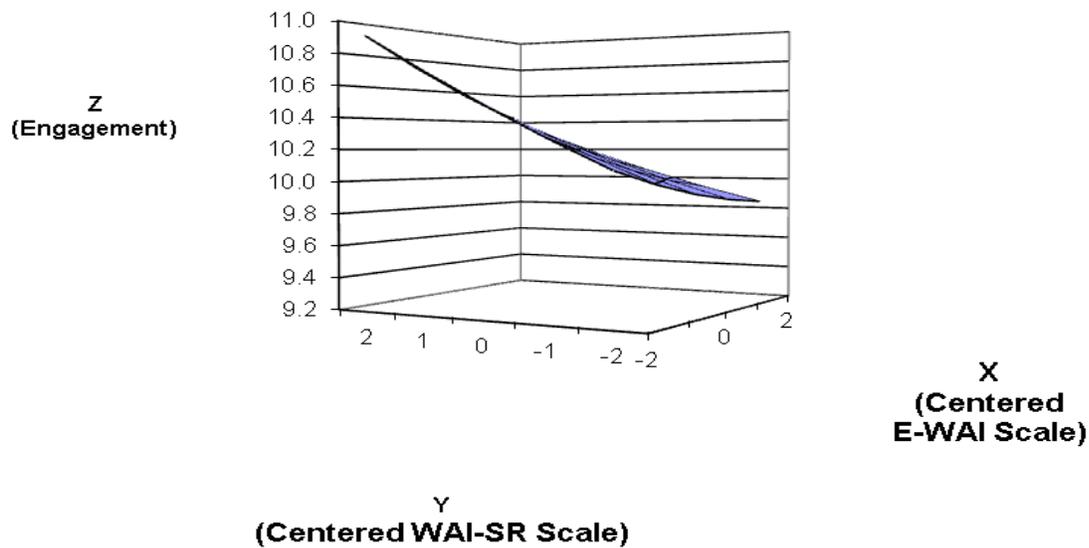
Table 6

Engagement as predicted by each combination of the centered E-WAI and WAI-SR scores

		E-WAI				
		-2	-1	0	1	2
WAI-SR	2	10.90	10.72	10.57	10.43	10.32
	1	10.67	10.52	10.38	10.27	10.18
	0	10.46	10.33	10.22	10.12	10.05
	-1	10.27	10.16	10.06	9.99	9.94
	-2	10.09	9.99	9.92	9.87	9.84

Note. Dashed diagonal line represents the line of congruence; below line, WAI-SR < E-WAI; Above line, E-WAI < WAI-SR.

Figure 1. Engagement as Predicted by Expected Working Alliance-Actual Working Alliance Discrepancy



Hypothesis 2: Discrepancy between pretherapy alliance expectations and alliance predicts early outcome. Our second hypothesis was that the discrepancy between the expected and actual alliance would predict early outcome. Specifically, we expected outcome scores to improve (i.e., decrease) as WAI-SR scores surpassed E-WAI scores by greater amounts, and vice versa. This hypothesis would be supported by: (a) the absence of either a linear (i.e., the a_1 surface test) or nonlinear (i.e., the a_2 surface test) relationship along the line of congruence; and, (b) a statistically significant linear (i.e., the a_3 surface test) or nonlinear (i.e., the a_4 surface test) relationship along the line of discrepancy, with outcome increasing the more that WAI-SR scores surpassed E-WAI scores.

The criterion variable, outcome, was obtained by regressing the Session 5 OQ-45 (or session 3 OQ-45 scores when necessary) scores onto Session 1 OQ-45 scores, in order to control for participants' baseline OQ-45 scores. We then regressed those early outcome scores onto the following predictor variables: centered E-WAI and WAI-SR scores, the product of the centered E-WAI and WAI scores, and each of the centered E-WAI and WAI-SR squared variables.

In accordance with our hypotheses, the response surface tests of a_1 and a_2 , which assessed for a linear ($a_1 = .69, p = .52$) and nonlinear ($a_2 = -.02, p = 0.52$) relationship along the line of congruence, were not statistically significant. When E-WAI and WAI-SR scores were congruent, there was no significant relationship between them and client outcomes.

The tests of response surfaces a_3 and a_4 , however, did not support our hypothesis. The response surface tests did not reflect a statistically significant linear ($a_3 = 0.93, p = 0.58$) or nonlinear ($a_4 = -0.07; p = .62$) relationship between E-WAI and WAI-SR scores and improved OQ-45 change scores along the line of discrepancy.

Table 7

Expected-actual alliance discrepancy as predictor of client outcome

Variable	<i>B</i>	SE	<i>p</i> -value
Constant	-3.24	7.00	
Expected working alliance	0.81	1.12	
Working alliance	-0.12	0.81	
Expected working alliance squared	-0.03	0.07	
Working alliance squared	-0.02	0.03	
Expected working alliance X working alliance	0.02	0.08	
R ²	0.05	13.78	
Surface tests			
<i>a</i> ₁	0.69	1.04	0.52
<i>a</i> ₂	-0.02	0.03	0.52
<i>a</i> ₃	0.93	1.65	0.58
<i>a</i> ₄	-0.07	0.13	0.62

Note. *B* = unstandardized regression coefficient; SE = standard error; R² = coefficient of determination; *a*₁ = first surface test; *a*₂ = second surface test ; *a*₃ = third surface test; *a*₄ = fourth surface test.

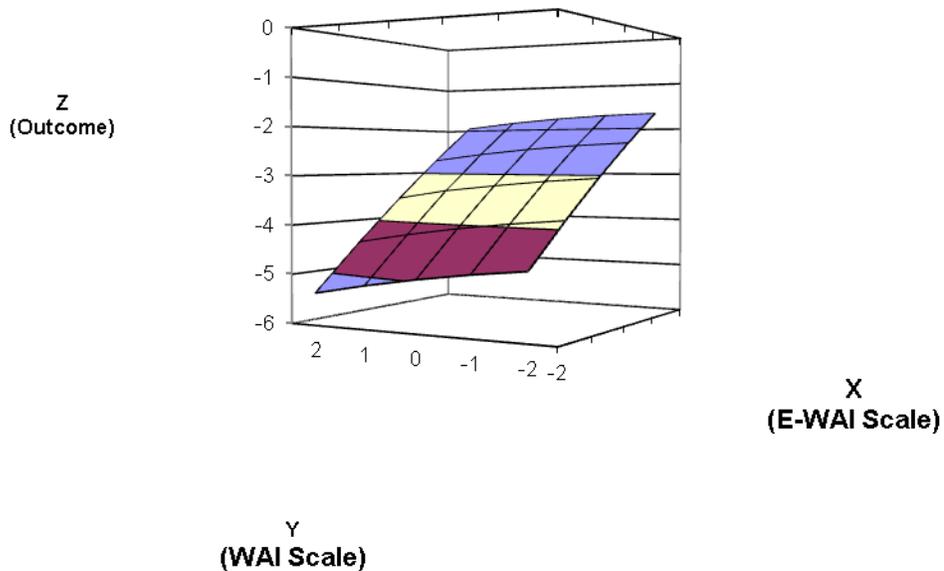
Table 8

Outcome as predicted by each combination of the centered E-WAI and WAI-SR scores

		E-WAI				
		-2	-1	0	1	2
WAI-SR	2	-5.35	-4.41	-3.54	-2.71	-1.95
	1	-5.14	-4.23	-3.36	-2.57	-1.83
	0	-4.96	-4.07	-3.24	-2.46	-1.74
	-1	-4.81	-3.94	-3.13	-2.38	-1.68
	-2	-4.69	-3.84	-3.06	-2.32	-1.65

Note. Dashed diagonal line represents the line of congruence; Below line, WAI-SR < E-WAI; Above line, E-WAI < WAI-SR.

Figure 2. Outcome as Predicted by Expected Working Alliance-Actual Working Alliance Discrepancy



Discussion

This pilot study explored how the discrepancy between clients' expected and actual working alliance related to early therapy engagement and outcome. A substantial portion of the participants in this study, about 44%, rated their working alliance as significantly discrepant from their expectations, with most of those rating the alliance as having exceeded their expectations, in line with previous findings (Joyce & Piper, 1998). In all, the alliance significantly surpassed expectations for eleven clients and fell short of expectations for only four. Clearly, the experience of the alliance diverges from expectations for a sizable minority of clients, even after just one session.

Clients in this study engaged in therapy at fairly high levels across the board, with 28 of the 34 participants remaining in therapy after four weeks of treatment. This finding would seem to be at odds with other findings in the therapy attrition literature. Reis and Brown (1999), for instance, cited evidence that between 20 and 57% of clients attend only one session. High attrition is especially problematic in training clinics. In one study, Callahan, Aubuchon-Endsley, Borja, and Swift (2009) found a 22% higher premature termination rate at a clinical psychology training clinic (77% dropout rate) than at nearby community outpatient centers (45%).

Recently implemented procedures at the PSC to better assess the motivation and readiness of new clients during the screening process, by using a set of simple rating scales about therapy readiness, client expectations, treatment barriers, and initial feelings about the PSC, may have contributed to these high engagement and low attrition. One potential consequence of this new procedure might have been to nudge clients, and possibly therapists, to more carefully consider and shape in some important way, their expectations of treatment *before the first session*. Arming clinicians with even rudimentary information about treatment progress helps

improve therapy effectiveness (Lambert, 2007). Perhaps the new screening questions served a similar function in terms of engagement early in therapy.

Another reason for the high degree of engagement among participants may be that the most motivated therapists and clients may have been most likely to volunteer to be in the study. Since therapists and clients were free to participate or not, less motivated therapists and clients may have declined to participate, filtering out many of the highest dropout risks from the research.

Correlational analyses indicated that the working alliance was not associated with level of client engagement, which is inconsistent with a large body of research showing an “unequivocal” tendency for stronger alliances to be linked with higher early attendance rates and fewer premature terminations (Reis & Brown, 1999, p. 129). There was also no significant association between the working alliance and client outcomes, even though a positive relationship has been documented many times in the psychotherapy literature (Horvath & Bedi, 2002; Martin et al., 2000). The absence of a significant association between alliance and either early engagement or outcome might be due to the fairly small sample size in this study.

Similarly, the results do not show a relationship between clients’ alliance expectations and their level of engagement or outcome. We did note that clients with unmet alliance expectations began therapy with the highest average initial expectations, and vice versa. This suggests that even though higher outcome expectations tend to predict better outcomes (Constantino, 2012), the same may not be true for alliance expectations.

Our first primary analysis examined the relationship between the expected-actual alliance discrepancy and client engagement. In accordance with our hypothesis, engagement levels were predicted by the discrepancy between expected alliance and alliance scores. Specifically,

exceeding alliance expectations was associated with improved engagement, despite the restricted range of engagement in this study. Most clients enter therapy with some degree of ambivalence about participating in treatment, and a better-than-anticipated alliance seems to enhance their engagement and commitment to therapy. There may also be a portion of clients highly committed to therapy, however, that will stay with it regardless of whether the therapist meets or exceeds their alliance expectations. These committed clients might give treatment a “grace period” during which they engage fully in treatment, even if the alliance does not live up to their hopes or expectations. For this group of clients, meeting or falling short of alliance expectations would not be associated with their engagement levels.

Our second hypothesis, that the discrepancy between expected and actual alliance scores would predict early outcomes, was not supported. Although the observed pattern of outcomes was consistent with the hypothesis, the small sample size and considerable variability in outcomes contributed to the lack of significant findings. In addition, measuring the alliance after only one session, as we did in this study, may have led to less reliable and/or valid results than measuring later alliance scores, especially for clients who viewed the first session as a preliminary consultation and thus different from later sessions. Previous research indicates that while the alliance develops quickly, the later it is assessed the better it predicts outcome (Horvath et al., 2011).

Measuring outcome at Session 5 may have also contributed to the absence of statistically significant results. We assessed outcome at Session 5 to minimize data loss and because we believed the expected-actual alliance discrepancy would influence outcome more early in treatment. However, it is possible that obtaining outcome at a later point (e.g., at termination)

might have given more time for a statistically significant association between expected-actual alliance discrepancy and outcome to develop.

A very recent study by Barber et al. (2014) also explored the discrepancy between expected alliance and alliance in relation to outcomes, using two different expected-actual alliance measures. They found that exceeding alliance expectations actually predicted a worsening of depressive symptoms for individuals in a supportive-expressive dynamic psychotherapy group treatment condition for one of the measures, but not in medication or placebo conditions or for the other measure. The Barber et al. results, taken together with our findings, suggest that whether an alliance meets, exceeds, or falls short of a client's alliance expectations may not be connected to therapy outcomes, or at least not in any simple way. Many clients may not arrive in treatment with a clear vision about what kind of relationship they will have with the therapist. Perhaps loosely held expectations such as these may be of little consequence in light of clients' actual experience with the therapist.

In addition, some clients might respond better in therapy relationships that fit with their own interpersonal schemas, even if those schemas are negative. Ahmed and Westra (2008) observed that anxious clients with high outcome expectations had good outcomes only when the treatment rationale came from an eager and caring therapist, while clients with low outcome expectations only improved when the therapy rationale was delivered by a cold, cheerless therapist (as cited in Constantino, 2012). The authors posited that initially matching a client's level of optimism verifies the client's perception of the therapist as credible. It is conceivable that quickly developing a warm therapy relationship actually leads to poorer outcomes for certain clients if a client experiences the relationship as being at odds with his or her own self-perception

and interpersonal history. As Constantino noted, mirroring a client's self-evaluation—even when it takes the form of therapist coldness or uncertainty—can be beneficial to the client.

Limitations

The small sample size undermined statistical power, thereby attenuating our ability to detect a significant relationship between the expected-actual alliance discrepancy and client outcome. Small sample size may also have contributed to the uniformly high levels of engagement observed in this study. In addition, the study took place in a university-based training clinic, where all the therapists were doctoral students enrolled in a single APA-accredited doctoral program. The lack of diversity among the participants and clinicians in this pilot study places a cap on our ability to generalize these findings to different clinical settings.

We measured the expected-actual alliance discrepancy by comparing E-WAI scores filled out just before the first session and WAI-SR scores completed immediately following the first session. While alliance ratings collected very early in treatment are strong predictors of future alliance ratings (Barber et al., 2009), one session nevertheless leaves clients little time to form an initial impression of their working alliance. Finally, the validity of the Expected-Working Alliance Inventory is unknown. It is possible that the small changes in adapting the WAI-SR to create the E-WAI led to unexpected changes in meaning and reliability of items in the measure.

Directions for Future Research

Future research would benefit from more frequently taking clients' initial beliefs, attitudes, and feelings into account when evaluating therapy process and outcome. Repeatedly, studies have demonstrated that various types of expectations effect how clients respond in treatment (Tambling, 2012; Westra, Constantino, Arkowitz, & Dozois, 2011). In spite of this

evidence, studies have often ignored initial expectations (Weinberger & Eig, 1999), and to our knowledge, only this study and Barber et al. (2014) have attempted to understand the working alliance in light of initial alliance expectations. The results of these studies indicate that if alliance expectations influence the treatment process, they do so in complex ways that are not yet well understood.

Exploring the interaction between clients' initial beliefs and relational factors in therapy is not new, but it may be gaining momentum. As one example, Westra, Constantino, and Aviram (2011) looked at the effects of alliance ruptures on outcome expectations. They found that ruptures caused much greater damage to a client's belief in the capacity of treatment to be helpful when the client started therapy with low outcome expectations. Studies such as this typify what Safran, Muran, and Eubanks-Carter (2011) called "a 'second generation' of alliance research" that highlights factors driving the formation and maintenance of a productive therapy relationship (p. 80). A similar approach may also be important in the study of expectations.

We also recommend further research to see how preparing clients for treatment impacts alliance development. Inquiring about expectations and explicitly educating clients about the treatment process can promote stronger alliances and greater engagement (Ahmed & Westra, 2009; Hilsenroth, Cromer, & Ackerman, 2012). Even the PSC's simple practice of assessing client expectations up front may have contributed to the high levels of engagement observed in this study, and this area is ripe for additional study.

Further research will be needed to gain a better understanding of the impact of different types of alliance expectations on the therapy process. For example, some clients enter therapy with very clear treatment preferences (i.e., a graduate student seeking a psychoanalytically-informed therapist) while others will have only a vague sense of what they

want from therapy and their therapist. Also, many clients may begin with a complex mixture of expectations about the alliance, such as an expectation of feeling close to the therapist but doubt that the therapy process will help. Carefully examining the particulars of a client's alliance expectations may help improve our knowledge in this important domain.

Clinical Implications

Our findings suggest that exceeding alliance expectations is associated with improved early client engagement. While therapists should of course strive to foster a positive working relationship with clients, the alliance is not an activity in itself so much as it is an emergent property of the mutual engagement of therapist and client. Assessing clients' alliance expectations may help pave the way for more fruitful collaboration. There are numerous measures that clinicians can use before treatment starts to assess clients' expectations generally, such as the Credibility/Expectancy Questionnaire (Devilly & Borkovec, 2000) and the Milwaukee Psychotherapy Expectations Questionnaire (Norberg et al., 2011). As Constantino (2012) has argued, restructuring expectations lies at the heart of the therapy process across virtually every type of therapy modality. Accordingly, therapists should aim to balance positivity that the therapy relationship can be helpful (i.e., raising outcome and alliance expectations) with mirroring clients' desire for self-verification (i.e., matching the convictions and self-affirmations of the client, even if negative).

In sum, this pilot study sought to explain Baldwin et al.'s (2007) finding that clients seen by therapists with generally strong alliances had better outcomes than clients assigned to therapists with generally poor average alliances, regardless of the individual alliance rating of the client. We posited that the best therapists might routinely surpass their clients' alliance expectations. We tested this theory by exploring the discrepancy between the alliance clients

expect to form and the alliance that actually forms once treatment begins. The pattern of results indicated that the deviation between alliance expectations and alliance predicted client engagement but not outcomes, raising further questions about the potentially complex relationship between alliance expectations, actual alliance, and outcomes.

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