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The Rorschach's (R-PAS) Capacity to Predict Quality of the Working Alliance

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Abstract

The aim of this study was to explore the Rorschach's ability to predict the working alliance by investigating associations between specific Rorschach Performance Assessment System (R-PAS) variables and the Goals, Tasks, and Bonds dimensions of the Working Alliance Inventory (WAI). Specific R-PAS variables were chosen based their theoretical relatedness to the three dimensions of the WAI. The linear multiple regression results trended toward significance within the Goals domain, with the Human Movement Proportion score (M/MC) significantly predicting individual's initial WAI Goals scores, indicating that individuals who possibly have difficulty modulating their emotions and tend to be more reactive in their responses may have a more difficult time creating and maintaining goals in therapy. The minimal significant finding is most likely due to a lack of statistical power due to a small sample size, making it challenging to detect meaningful relationships among variables. Unique to this study was the opportunity to examine a collective sample of Rorschach tests, which provided information regarding individuals' psychological resources and their cognitive, affective, and relational functioning. From these data, a picture emerged of an individual who would likely consent to take a Rorschach and provide their data for research purposes, providing important clinical implications. Future research with a larger sample size will be necessary to thoroughly examine the relationship between the Rorschach and the WAI.

Keywords: Rorschach, R-PAS, Working Alliance Inventory

The Rorschach's (R-PAS) Capacity to Predict Quality of the Working Alliance

Literature Review

Working Alliance is a Critical Factor of Therapeutic Change

The working alliance is a key factor of change in the therapeutic process. According to several meta-analyses, the quality of the working alliance is the strongest predictor of therapeutic outcome across a variety of different treatment models (Horvath, Del Re, Flückiger, & Symonds, 2011; Safran, Muran, & Shaker, 2014). Therefore, establishing and maintaining a robust working alliance is vital to the success of treatment in psychotherapy. The concept of the alliance was mentioned as early as Freud's work (1937/1964) when he wrote about the importance of the "positive, 'unobjectionable' transference that binds the patient to the person of the therapist and helps keeps the patient in treatment despite increased levels of anxiety" (Zilcha-Mano, 2017). The specific term alliance originated with Sterba (1934), who discussed therapists' ability to ally themselves with the patients' capacity for rational observation. Sometime later, Greenson (1965) described the patient's ability to work in the analytic situation, highlighting the collaborative nature of the relationship, which he called the working alliance. The most comprehensive theory of the alliance was created by Bordin (1979). Bordin created a pantheoretical model consisting of three separate parts: (a) the bond between therapist and patient, (b) the goals agreed upon between therapist and patient, and (c) the tasks needed to achieve the goals — which combined created the working alliance. As time passed and the literature developed, several terms were created and used interchangeably to describe the working alliance, which created some confusion in both the literature and clinical practice.

Defining the Working Alliance

A note of distinction should be made between terms such as working alliance, therapeutic alliance, therapeutic relationship, and helping alliance. Much of the research uses the terms interchangeably. Horvath and Luborsky (1993) noted this interchangeability, stating these terms previously had been used to refer to specific aspects of the alliance or as synonyms for the alliance as a whole; however, these terms have not been used consistently throughout the literature. Bordin (1980) described the working alliance as an integrated relationship with three distinct components: (a) tasks, (b) goals, and (c) bonds. Tasks refer to the in-counseling behaviors and cognitions that form the substance of the therapy process. Both parties must agree to these tasks and see them as relevant and efficacious. Goals are mutually agreed upon outcomes of the therapy process. These goals are the target of the interventions that take place during therapy. Finally, bonds refer to the intricate, complex personal attachments between the patient and the therapist, including issues such as mutual trust, acceptance, and confidence (Bordin, 1975, 1979, 1980). The working alliance transcends theoretical orientations, capturing essential components of the therapist relationship. Bordin proposed that all therapeutic approaches require the negotiation of a working alliance between patient and therapist and that different approaches vary in the alliance features they require for successful treatment (Hatcher & Gillaspy, 2006). Bordin (1979) also proposed that the strength of the alliance would greatly influence the outcome of the treatment. A good working alliance, particularly the bond component, may enhance the effects of therapist procedures, and is most likely a central aspect in the long-term change in psychological functioning and interpersonal problems (Hersoug, Høglend, Gabbard, & Lorentzen, 2013). Bordin suggests that different therapies require and

produce different types of alliances, which may be indicated by different levels and patterns of scores on the Working Alliance Inventory dimensions (Hatcher & Gillaspy, 2006).

Development of the Working Alliance Inventory

Using Bordin's (1979, 1980) model of the alliance, Horvath developed a measure of the working alliance called the Working Alliance Inventory (WAI). Horvath sought items that described the patients' feelings and attitudes in therapy that would specifically reference the concepts and qualities related to the goals, tasks, and bonds that Bordin identified in his early theoretical writing (Horvath, 1981). Horvath then initiated an extensive process in which he selected the most appropriate items corresponding to each of the three domains of Bordin's theory. This process consisted of having experts with different theoretical backgrounds screen the items to ensure a wide range of applicability, having specific alliance experts look over the items and narrow down the items to further specify their fit with the three domains, and finally testing the items with practicing clinicians and their patients. The entire process yielded a 36-item questionnaire with 12 items for each theoretical dimension of Bordin's theory (Hatcher & Gillaspy, 2006). After examining the psychometric properties of the original 36-item WAI using confirmatory factor analysis, Tracey and Kokotovic (1989) indicated a need for a revision and thus developed a 12-item short form of the WAI (WAI-S). They chose the four highest loading items on each of the three dimensions determined by the confirmatory factor analysis and examined the psychometric properties of these new items. It was determined that this new WAI-S was a better fit to use clinically and it has been used widely in psychotherapy research (Hatcher & Gillaspy, 2006). Hatcher and Gillaspy sought to streamline the WAI-S even more when they created the revised short version of the WAI (WAI-SR). Hatcher and Gillaspy kept the 12-item form, however they altered the previous 7-point scale to a new 5-point scale, as the

previous 7-point scale was found to be less optimal because patients seem not to discriminate effectively in the lower ends of the scale. The WAI-SR correlated highly with the full WAI and was shown to be an adequate stand-in for the full WAI if desired (Hatcher & Gillaspy, 2006). The WAI-SR also demonstrated greater differentiation between Goal and Task scales compared with the WAI, a problem previously indicated in WAI research (Hatcher & Gillaspy, 2006). It is because of this efficiency and effectiveness of the WAI-SR that it is currently being used in the clinic in which the current study took place.

The Importance of Examining the Working Alliance for Treatment

Research has demonstrated that effective psychotherapy is characterized by a good working alliance between the therapist and the patient (Crits-Christoph, Gibbons, & Mukherjee, 2013; Wampold, 2015). The quality of the working alliance has been consistently correlated with psychotherapy outcomes, with stronger alliances associated with better therapeutic outcomes (Horvath et al., 2011). Due to this finding, many researchers have argued that the alliance is therapeutic in and of itself and therefore designated as an essential factor in the success of treatment. This view coincides with many theoretical conceptualizations which see the alliance as therapeutic, and even as the core factor of change (Safran & Muran, 2000). Since the therapeutic alliance is an active ingredient in bringing about therapeutic change, then the elements that contribute to the creation of the alliance must be examined. Zilcha-Mano (2017) sought to disentangle some of these elements by distinguishing between the "state-like" and "trait-like" components of the alliance that characterize the individual patient, and which of the two make the alliance inherently therapeutic.

State-like components of the alliance. State-like components of the alliance are the changes in the alliance that happen during the treatment that can predict changes in outcome

(Zilcha-Mano, 2017). This component is "an active ingredient sufficient in itself to bring about therapeutic change" (Zilcha-Mano, 2017, p. 312). Research has shown that state-like changes in the alliance across a treatment period can predict outcome, apart from the patient's trait-like components, supporting the ability of the alliance to actively bring about changes in outcomes (Falkenström, Granström, & Holmqvist, 2013; Zilcha-Mano & Errázuriz, 2015; Zilcha-Mano et al., 2015).

Trait-like components of the alliance. Some elements of the alliance that are associated with therapeutic outcomes are the result of the patients' trait-like components which are "their general ability to form satisfactory relationships with others, their internal representations of self and others, and expectations from interpersonal relationships" (Zilcha-Mano, 2017, p. 312). This ability may affect the patient's capacity to form a satisfactory relationship with the therapist and may also influence the patient's capacity to benefit from treatment (Zilcha-Mano, 2017). Trait-like components of the alliance already exist when the patient enters therapy, and are not the result of therapeutic interactions with the therapist and can be thought of as the level of alliance early in treatment. Patients have a predisposed capacity to form an alliance with the therapist (DeRubeis, Brotman, & Gibbons, 2005). Zilcha-Mano et al. (2015) found that the percentage of the alliance explained by trait-like components of the alliance, or pretreatment representations of others, was 32% to 54%. Because these trait-like components are at least partly due to existing traits of the patients, they are not the components that make the alliance therapeutic in itself (Zilcha-Mano, 2017). However, trait-like components of the alliance are important for understanding the alliance–outcome association. Because trait-like components of the alliance are predisposed prior to the formation of the alliance, some individuals are more capable of forming a strong and satisfying relationship with others (Zilcha-Mano, 2017). These

patients are more likely to have a better chance of forming a strong alliance with their therapist, and may benefit from better treatment outcomes (Zilcha-Mano, 2017). While the trait-like components of the alliance are not enough to sufficiently induce change on their own, they can enable the use of other aspects of treatment that may create change, such as effective therapeutic techniques (Zilcha-Mano, 2017). Trait-like components become valuable in the later stages of treatment after the state-like components have brought about specific changes in the patient, allowing a deeper process of change in the patients' trait-like components of the alliance to occur (Zilcha-Mano, 2017). This process allows many therapists to focus on the patient's internal representations, as they appear in the here and now of the therapeutic relationship, which may bring about a general change in how the patient perceives the self and others (Zilcha-Mano, 2017).

The importance of differentiating between trait-like and state-like components. It is important to differentiate between the trait-like and state-like components of the alliance for several reasons. Each component may serve a different function within treatment and therefore can have implications for clinical practice (Curran & Bauer, 2011). In order to create change within the patient utilizing the alliance, the therapist must be able to differentiate between the components of the alliance that are more difficult or less capable to change (i.e., the trait-like components), and the state-like components which have the potential to change throughout the course of therapy (Zilcha-Mano, 2017). Trait-like components are useful in psychotherapy because they can be used to "moderate treatment outcome by determining which type of treatment works best for each subgroup of patients" (Zilcha-Mano, 2017, p. 320). Trait-like components may also be useful in providing insight into a patient's capacity to make progress in psychotherapy and any difficulties that may arise in the beginning phases of treatment

(Zilcha-Mano, 2017). If we have the ability to recognize an individual's trait-like components we could gain insight into their capacity to form a therapeutic relationship, make progress in psychotherapy, and potentially catch problems in treatment before they arise. The clinician could tailor their treatment to fit the individual patient and develop state-like components that foster deeper change. The Rorschach would provide the clinician with information that coincides with trait-like components of the alliance, such as an individual's internal representation of self and others, and expectations of interpersonal relationships. The Rorschach may provide information about aspects of individuals' psychological functioning which they are not able to communicate or which may be overlooked by therapists (Bihlar & Carlsson, 2000).

<center>**Using the Rorschach to Inform the Therapeutic Relationship**</center>

A Brief Overview of the Rorschach

The Rorschach Inkblot Test is a well-known psychodiagnostic test which yields comprehensive information regarding "both psychological resources and specific problem areas of cognitive, affective, relational, and self-defining character" (Bihlar & Carlsson, 2000, p. 198). Hermann Rorschach first published his carefully selected and artistically enriched set of 10 inkblots in 1921 (Rorschach, 1942), which have come to be known as "the Rorschach," and have been in continuous clinical use since their publication. The Rorschach is used frequently in large part because it (a) is portable, (b) can be administered in a reasonably brief amount of time in a variety of clinical settings, and (c) assesses psychological and behavioral aspects of an individual (Meyer & Eblin, 2012). "The stimuli are complex and they are structured to provide multiple suggestive, but incomplete or imperfect, perceptual likeness that form competing visual images" (Meyer & Eblin, 2012, p. 107). When administering the Rorschach, the respondent examines the stimuli (card) and answers the question, "What might this be?" The respondent's answer

provides the examiner with "both a visual attribution to the stimulus, as well as a verbal

explanation or elaboration" (Meyer & Eblin, 2012, p. 107). Due to the nature of the task, the

Rorschach provides the examiner with a standardized, *in vivo* sample of the respondent's

problem-solving behavior (Meyer & Eblin, 2012). This in vivo experience gives the examiner

access to direct observation of how the respondent handles a given task, analysis of the thematic

content, imagery, and progression of responses, in addition to the ability to compare the

respondent's performance with normative data and expectations (Meyer & Eblin, 2012). The

interpreted data and behavioral observations generalize to the individual's mental, verbal, and

perceptual behaviors in their daily lives (Mihura, Meyer, Dumitrascu, & Bombel, 2013). For

these reasons, the Rorschach is best thought of as a performance-based assessment tool (Foster &

Cone, 1995; Meyer & Kurtz, 2006; Viglione & Rivera, 2003).

Facilitated by its visual nature, the Rorschach assesses personality characteristics that are

based on an individual's interactions with the test and it has the ability to access implicit

characteristics that an individual may not be consciously aware of or willing to endorse

(Bornstein, 2002, 2012; Slabbinck, De Houwer, & Van Kenhove, 2011). This type of assessment

complements self-report instruments such as the Minnesota Multiphasic Personality Inventory-2

(MMPI; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 2001) and the Personality

Assessment Inventory (PAI; Morey, 1991), as the examiner is able to gain access to implicit

information. Where the Rorschach goes beyond self-report instruments is in its ability to assess

in vivo reality testing and interpersonal behavior—the way in which an individual processes

information and problem solves, their unique coping style, their representations of self and

others, and their method of interactions (Meyer & Eblin, 2012).

Evolution of Scoring Systems

Since the initial publication of the test in 1921, the overall understanding of the

Rorschach has continued to be similar to what Hermann Rorschach intended. However, as

research developed, so have the ways that clinicians approach the task of administering, scoring,

and interpreting the Rorschach (Meyer & Eblin, 2012). Beginning in the early 1940s, there were

five Rorschach scoring systems commonly used (Beck, 1944, 1945; Hertz, 1951; Klopfer &

Kelley, 1942; Piotrowski, 1957; Rapaport, Gill, & Schafer, 1946, 1968). Each system was unique

in its guidelines for administration, scoring, and interpretation of the test (Meyer & Eblin, 2012).

In 1974, John Exner published the Comprehensive System (CS), and as its name implies, it

synthesized the existing scoring systems into one integrated system that encompasses the most

valid Rorschach administration, coding, and interpretive practices (Meyer & Eblin, 2012). The

CS quickly became the most widely used system (Ritzler & Alter, 1986).

In 1997, Exner created the Rorschach Research Council (RRC) to advance and synthesize

the research basis of the CS (Meyer & Eblin, 2012). Around the same time as the RRC was

founded, several studies were published criticizing the psychometric foundations of the CS (e.g.,

Lilienfeld, Wood, & Garb, 2000; Wood, Garb, Lilienfeld, & Nezworski, 2002; Wood, Lilienfeld,

Garb, & Nezworski, 2000). Many of these criticisms were unfounded, such as the suggestion that

coding reliability may be no better than chance agreement (Wood, Nezworski, & Stejskal, 1996).

Some studies raised appropriate concerns that were revealed by additional research, particularly

with variations across examiners and training sites, administration and coding errors, inaccurate

and overpathologizing normative reference data, and overreliance on negative or clinically

unhealthy interpretations of variables, and several others (Gacono & Evans, 2008; Meyer &

Eblin, 2012). The RRC began to address some of these concerns until John Exner's death in

2006. Exner did not legally designate the RRC or any individual with the task of updating or modifying the CS (Meyer & Eblin, 2012). Exner's heirs contemplated making changes to the CS based on the established RRC guidelines; however, they ultimately ended up leaving the CS as it was in 2006 (Meyer & Eblin, 2012). Four former members of the RRC went on to further the Rorschach as a research-based assessment using emerging research and some previous RRC initiatives. These researchers built on the CS and the research endeavors of the RRC and created a new evidence-focused, internationally oriented approach to using the Rorschach called the Rorschach Performance Assessment System (R-PAS; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011).

The Rorschach Performance Assessment System. Meyer and Eblin (2012) describe the new system's mission:

> R-PAS seeks to take advantage of the Rorschach's unique strengths as a highly portable complex behavioral assessment measure that provides a means of systematically observing and measuring what might be referred to as the "personality in action." R-PAS aims to enhance the psychometric foundation of the Rorschach method, while allowing examiners to interpret the rich communication, imagery, and interpersonal behavior within a stronger, evolving psychometric foundation. (p. 108)

The R-PAS built on the existing CS system and incorporated the latest available research to create a new, empirically based, psychometrically stronger system.

R-PAS improves upon the CS. Using the most recent research, R-PAS improves the use of the Rorschach as an assessment tool. Meyer and Eblin (2012) concisely outlined how the R-PAS enhances the utility of the Rorschach in the following ways:

- Selecting and highlighting those variables with the strongest empirical, clinical, and response process or behavioral representational support, while eliminating those with insufficient support;

- Developing new and revised indices by applying contemporary statistical and computational approaches;

- Providing a simplified, uniform, and logical system of terminology, symbols, calculations, and data presentation, in order to reduce redundancy and increase parsimony;

- Describing the empirical basis and psychological rationale for each score that is to be interpreted;

- Providing a statistical procedure to adjust for the overall complexity of the record and a graphical illustration of its impact on each variable;

- Optimizing the number of responses to the task in order to ensure an interpretable and meaningful protocol, while drastically reducing both the number of times the task needs to be re-administered because of too few responses and the likelihood of inordinately long and taxing administration because of too many responses;

- Comparing test takers' scores to a large internationally collected reference sample, using a graphic array of percentiles and standard score equivalents;

- Offering access to a scoring program on a secure, encrypted web-platform from any device that can interface with the Internet (e.g., PC, Notebook, iPad). (p. 108–109).

The R-PAS streamlines the administration, coding, and interpretive procedures of the Rorschach, allowing for a more systematic, valid, reliable result (Meyer, Hsiao, Viglione, Mihura, & Abraham, 2013).

Theoretical and Empirical Underpinnings of R-PAS Variables

Bonds. There are several scores in the R-PAS that have been shown to predict personal attributes related to bond formation in therapy. They are the (a) Cooperative Movement variable, (b) Mutual Autonomy of Health, (c) Oral Dependency Language, (d) Whole Human Content, and (e)Vigilance Composite score.

Cooperative Movement (COP). COP is a thematic code involving humans or animals engaged in cooperative activity. COP responses involve attributing cooperative, collaborative, synchronized, teamwork, pleasant, benevolent, or helpful qualities to interactions (Meyer et al., 2011). The propensity to do so suggests a person who has a generally positive template for envisioning relationships, seeing such characteristics as natural components of interactions (Meyer et al., 2011). Research shows support for COP as an indicator of the capacity to perceive or consider positive interpersonal interactions (Meyer et al., 2011). COP is easily generalized thematically to an active interest in cooperative or collaborative relations with other people (Meyer et al., 2011).

Mutual Autonomy of Health (MAH). MAH responses indicate that a person has envisioned a positive, mutually enhancing relationship in connection with the inkblot image (Meyer et al., 2011). This suggests attention to, and an ability to envision, such relationships in one's environment, and thus a healthy and productive understanding of relationships (Meyer et al., 2011). Theoretically, MAH is an expression of healthy and positive object relations, interpersonal schemas, or attachment models (Meyer et al., 2011). Similarly to the way some Special Scores are categorized into Level 1 and Level 2, with Level 2 indicating more severe instances of dissociated, illogical, or circumstantial thinking, MAH can in some ways be considered a "Level 2" COP score, as MAH requires more mutuality and a more consistently

healthy view of relatedness than COP (Meyer et al., 2011). MAH is a thematic code based on the

proportion of Mutuality of Autonomy (MA) Health responses to all MA responses (Pathology

and Health responses; Meyer et al., 2011). MAH is derived from the Mutuality of Autonomy

score (Urist, 1977), which has strong support in the literature as summarized in a validity

meta-analysis by Graceffo, Mihura, and Meyer (2011). Historically, the MA scale was coded on

a 7-point continuum, with researchers using a variety of methods to compute a final score (e.g.,

best score, worst score, mean score, sum of the three most pathological scores; Meyer et al.,

2011). Graceffo et al. found that the most valid method of computing MA were based on

aggregated measures, not scores using one data point (e.g., best or worse score). Bombel,

Mihura, and Meyer (2009) found that the most valid index was formed by contrasting the

opposite ends of the continuum to create a relative difference score where the number of

pathological representations of power imbalance (Urist's Level 5, 6, and 7) were subtracted from

the healthiest representations (Level 1) and then divided by the total number of MA responses.

Clinicians have reported that one of the main reasons they do not regularly use the MA is the

complexity of its scoring, given that one has to decide which of the original seven levels should

be coded on each response (Meyer et al., 2011). This problem was addressed by Meyer et al.

(2011) when they reduced the number of levels from seven to two. Being based on the quality of

human and other object representations as demonstrated in the response imagery, the MAH

Proportion also makes sense in terms of response process as an index of interpersonal schemas

(Meyer et al., 2011). In the surveys conducted by Meyer et al. (2011), clinicians who used the

MA scale found it to be among the more valid scales.

Oral Dependency Language (ODL). ODL codes the words that suggest or images that

convey themes of nurturance, needed support of help, oral activity, food and eating, or birth and

fragility (Meyer et al., 2011). The emphasis with this code is on the implicit linguistic

manifestations of these themes, which might be present even when the overt image does not

suggest it (e.g., "*praying* mantis*" or "jelly*fish;*"* Meyer et al., 2011). An elevated frequency of

these terms or images identifies respondents who are implicitly motivated by dependent needs,

related to an underlying dependent trait or state (Meyer et al., 2011). ODL calculates the

percentage of responses involving language associated with orality or dependency (Meyer et al.,

2011). ODL is established both by research and by imagery and linguistic associations as a

strong performance measure of dependency and an implicit personality feature (Bornstein, 1996,

1999; Meyer, 2004). The surveys conducted by Meyer et al. (2011) found ODL to be among the

most valid variables.

     Whole Human Content . Whole Human Content (H) is often referred to as Pure H.

Compared to other Human Content subtypes, regularly seeing whole, realistically portrayed

humans involves a more accurate, integrated, and complete view of people (Meyer et al., 2011).

Doing so is more cognitively sophisticated than a propensity to see human parts (e.g., legs, head)

and more realistic and objective than a propensity to identify fantasized or distorted characters

(e.g., robots, cartoon people; Meyer et al., 2011). Also, because whole people are more likely to

interact meaningfully with their environment than parts of people, most human content responses

involving meaningful synthesis with a broader context will involve whole humans rather than

human details (Meyer et al., 2011). Thus, most human content responses involving juxtaposition

to other objects, movement, intentionality, distinguishing characteristics, narrative implications,

and allusions to the passage of time and relationships will involve whole human responses

(Meyer et al., 2011). In turn, these entail more elaborated and informed schemas for

understanding people. Overall, H responses suggest the potential for a cognitively sophisticated

and realistic view of oneself and others (Meyer et al., 2011). The research literature demonstrates

that H is associated with healthy interpersonal functioning (Meyer et al., 2011). From a response

process perspective, seeing whole, realistic humans suggests an interest in others and a capacity

to view people in a balanced and realistic way (Meyer et al., 2011).

     Vigilance Composite (V-Comp). As a measure of vigilance, V-Comp, is understood as

assessing guardedness, effortful and focused cognition, sensitivity to cues of danger, and

interpersonal wariness and distancing (Meyer et al., 2011). V-Comp elevations can be associated

with vigilantly scanning the environment for threats, but elevations are not specific to paranoid

conditions because the index captures more of a cognitive style than an expectation of

malevolence from others and fearfulness (Meyer et al., 2011). The V-Comp is derived from the

Location, Space, and Object Complexity (LSO) subcomponent of the Complexity score, Space

Reversal (SR), Space Integration (SI), Texture (T), Sum of all Human Content codes (SumH),

Parenthesized Content, Whole to Partial Content, and Clothing content (Cg; $V - Comp = -0.631$

$\times (\sqrt{T}) + 0.065 \times$ ([Sum of Responses with W or SI or Sy]) $+ 0.699 \times$ (LSO/R) $+ 0.224 \times$

(AnyS) $+ 0.652 \times (\sqrt{SumH}) + 0.388 \times (\sqrt{((H) + (A) + (Hd) + (Ad)))} - 2.340 \times$ ([H + (H) + A +

(A)] / [H + (H) + A + (A) + Hd + (Hd) + Ad + (Ad)]) $+ 0.278 \times (\sqrt{Cg}) + 0.332$; Meyer et

al.,2011). Some of the variables in the V-Comp are negatively correlated, such as T and SumH,

desire for closeness and interest in people, creating a protective factor against or at least

inversely related to vigilance. The V-Comp is a more reliable dimensional version of the CS's

bifurcated Hypervigilance Index (HVI; Viglione, Giromini, Gustafson, & Meyer, 2012). The

HVI required an absence of Texture scores, which is not required in the V-Comp (Meyer et al.,

2011). In the validation sample of Viglione et al., validation sample HVI and V-Comp correlated

at .86. V-Comp is interpreted as a sign of chronic activation and attentiveness to protect oneself

from potential threats. The response process for the components of this index is consistent with its interpretation (Meyer et al., 2011).

Goals. There are several scores in the R-PAS that have been shown to predict goal–setting behavior. They are the Complexity composite variable and the Human Movement Proportion score.

Complexity. Meyer et al. (2011) noted that Complexity is a composite variable that quantifies the amount of differentiation and integration involved with location and object qualities, use of multiple determinants, and use of multiple contents. The complexity composite is an overall index of complexity of processing in that it measures differentiation, integration, and productivity at the response level. It has been associated with age, education, intelligence, and adaptation. Responding to the test with a high Complexity score means that the person has brought a considerable amount of psychological activity and effort to bear in coping with the demands of the test. Similarly, in real life, complexity should be associated with more success and flexibility in coping, and a preference for more cognitive activity and energy when responding to challenges. The Complexity composite is derived from the sophistication of Location, Space, and Object Qualities; and the density of Determinants and Contents. As a single variable in its present form, it has little direct validity research with psychological complexity, flexibility, and adaptive capacity (Meyer et al., 2011).

Dumitrascu, Mihura, and Meyer (2011) found a strong relationship ($r = .44$) between Complexity and level of education, but most of its empirical support lies in the considerable amount of indirect research connections in its subcomponents to age, education, intelligence, adaptation, and various other relevant criteria (Mihura et al., 2013; Viglione, 1999). Complexity has a very high correlation with the first factor among Rorschach scores so that it represents a

relatively easily understandable marker for it (Meyer & Viglione, 2006). To illustrate this

concept, Meyer and Viglione completed a principal components analysis in the normative

reference sample ($N = 640$) using sums of all of the individually assigned codes rather than

percentages or composite scores (e.g., for location codes W, D, and Dd were used, but not WD,

W%, Dd%, or Location Complexity) and extracted the first component. The correlation between

the first factor and Complexity was .95 (Meyer & Viglione, 2006). Because Complexity appears

to act as a moderator for other variables (e.g., Dean, Viglione, Perry, & Meyer, 2007, 2008;

Meyer et al., 2000), Complexity Adjusted standard scores are presented as part of the standard R-

PAS interpretive output. Clinically speaking, the ability to adjust for the complexity of a record

should also address concerns that arise when records are either very high or low in complexity

due to factors assumed to be minimally related to other individual Rorschach variables (e.g.,

constriction due to anxiety, situational demands, and natural variations in cognitive abilities;

Meyer et al., 2011).

　　　Human Movement Proportion score. The Human Movement Proportion score

(M/[M+WSumC]) assesses the degree to which decisions and actions are impacted by thoughtful

deliberation (M) versus reactivity, vitality, and emotional expressiveness (WSumC; Meyer et al.,

2011). Some research suggests that the relative strength of M is the more important component

of these variables (Meyer et al., 2011). In addition, before making inferences about strong

emotional reactivity or impulsivity, there are many other factors that should be assessed as

contributors—such as a high level of stress, thought disturbance, or substance use (Meyer et al.,

2011).

　　　Hermann Rorschach (1942) originated the idea that people who produced relatively more

M responses than Color responses in their records (introversive subtype) were prone to think

carefully before making decisions and taking actions, whereas those with a predominance of Color responses over M responses (extratensive subtype) were more spontaneous and reactive to internal impulses and to the environment. Based on observation, Rorschach also believed that many people with a more evenly balanced ratio of Human Movement to Color (ambient subtype) were likely to be more flexible in their decision making (Meyer et al., 2011). These observations make sense from a response–process standpoint, given that M requires internal elaboration of the stimulus, where Color involves reactivity to immediately salient perceptual features of the stimulus (Meyer et al., 2011). Every Rorschach system since has maintained a focus on the balance between Human Movement and Color, albeit some systems (e.g., the CS) have treated ambients as having ineffective or incompletely developed problem-solving styles involving inconsistency and vacillation (Exner, 2003).

These observations lead to the expectation that M and WSumC would be inversely correlated among nonpatients (Meyer et al., 2011). However, in the normative sample used by Meyer et al. (2011), the correlation between the two is only .17. Notwithstanding the CS claim that the distribution is bimodal (Exner, 2003), research does not support this claim. For example, the normative sample of Meyer et al. (2011) reveals skew = .55 and kurtosis = 2.80. Thus, rather than being bimodal, the M/M+WSumC distribution is peaked at the middle (leptokurtic) so that it is typical to fall near the midpoint (i.e., to be ambient; Meyer et al., 2011). The main R-PAS research support for this variable comes from early Erlenbnistypus (EB) research, although it possible that M alone accounts for these EB findings (Bieri & Blacker, 1956; Blatt & Feirstein, 1977; Singer & Herman, 1954; Singer & Spohn, 1954). Consistent with the available data, R-PAS uses a proportion score to interpret this variable dimensionally instead of using the traditional three-category introversive, extratensive, and ambient subtyping (Meyer et al., 2011).

Low MC sums (M and WSumC near zero) are mathematically more likely to produce the

ambietent style with M being approximately equal to WSumC (Meyer et al., 2011). In this

situation, problems in adaptation are attributed to the low MC sum rather than the ambitent style

as described in the CS (Meyer et al., 2011). In the case of records with reasonably high sums for

MC, when the M/(M+WSumC) proportion is near the midpoint of 0.5, the problem-solving style

is interpreted consistent with the evidence and along the lines proposed by Rorschach rather than

Exner (i.e., there is a balanced approach to problem-solving and decision-making that is likely

adaptive and flexible; Meyer et al., 2011).

Tasks. There are several scores in the R-PAS that have been shown to predict behaviors

associated with the creation and completion of tasks in therapy. They are (a) the Ego Impairment

Index-3, (b) Human Movement variable, and (c) the Human Movement and Weighted Color to

Potentially Problematic Determinants index.

Ego Impairment Index-3. The Ego Impairment Index (EII-3) is a broadband measure of

thinking disturbance and severity of psychopathology (Meyer et al., 2011). Its components

include reality testing (FQ), thought disturbance (Cognitive Codes), crude and disturbing thought

content (Critical Content scores), and measures of interpersonal misunderstanding and

disturbance (M-, GHR and PHR; Meyer et al., 2011). The EII-3 is similar to the Thought and

Perception Composite (TP-Comp) but it also includes crude and disturbing thought content

related to self- and other-representations (Meyer et al., 2011). Therefore, if the EII-3 is high and

the TP-Comp is average or low, the EII-3 elevation may be due to crude and disturbing thought

content or impaired object-representations (Meyer et al., 2011). If so, one should consider

inferences about general personality dysfunction or the contribution of trauma rather than

psychotic-type disturbances (Meyer et al., 2011).

Research on previous versions of the Ego Impairment Index empirically established it as a strong, dimensional measure of the severity of psychopathology and thought disturbance (Meyer et al., 2011; Nygren, 2004). Although earlier versions were not rated highly in the clinical survey, a meta-analysis by Diener, Hilsenroth, Shaffer, and Sexton (2011) found a stable medium effect size relationship ($r = .29$) for them in association with various measure of psychiatric severity. The EII-3, an R-PAS revision, includes: (a) the new distribution of R that accompanies R-Opt administration and (b) the fact the Food content is not included in R-PAS (Meyer et al., 2011). By design, the EII-3 is more normally distributed than the EII or EII-2, and it has demonstrated strong reliability and validity, comparable with the previous versions (Viglione, Perry, Giromini, & Meyer, 2011). The components the EII-3 measures (i.e., reality testing, thought disturbances, and measure of interpersonal misunderstanding) are essential to the tasks domain, which examines the in-session behaviors and cognitions of the patient. The EII-3 components can provide the therapist with information regarding how to best structure the therapy sessions.

Human Movement (M). Human movement (M) is defined by the respondent envisioning human action or experience. It requires the ability to use one's imagination to envision these experiences or activities (Meyer et al., 2011). M is therefore a type of mentalization that contributes to the capacity for identification with others and empathy (Meyer et al., 2011). The cognitive abilities associated with giving an M response include the ability to imagine and to envision action or emotion, some capacity to reflect on life experience, and a degree of developmental maturity (Meyer et al., 2011). Based on the implicit identification of the self with human action and experience, M (relative to animal movement and inanimate movement) may

involve more awareness, agency, deliberation, and purposefulness, thus seeing the self as the

agent or the initiator of the experience (Meyer et al., 2011).

Research generally supports M as a measure of ideation and cognitive resources through

its relationship to such variables as intelligence and cognitive development, and the significantly

lower levels of M found in patients known to have cognitive or neurological difficulties (e.g.,

ADHD, Alzheimer's, Autism Spectrum Disorders, closed head injury, and with aging; Meyer et

al., 2011). Emerging neurophysiological research associates M with mirror neuron activity and

ideation about other people (Giromini, Porcelli, Viglione, Parolin, & Pineda, 2010; Pineda,

Giromini, Porcelli, Parolin, & Viglione, 2011). Given these findings and its negative association

with high functioning Autism Spectrum Disorders, M may indicate an important component for

the development of empathy (Meyer et al., 2011). Because the response process presumably

involves an implicit identification with a figure engaged in human activity and a fantasy

elaboration of the percept (since the inkblots themselves do not move), M is associated with

imagination, empathy, and mentalization of one's own and others' experiences and actions

(Meyer et al., 2011). Meyer et al. (2011) found M to be among the variables considered most

clinically valid in their clinical studies. The M variable is important when examining tasks in

therapy because it captures the patient's ability to understand the human experience, empathize,

and process the therapeutic relationship, allowing the patient to engage more fully in therapy.

Human Movement and Weighted Color to Potentially Problematic Determinants

(MC-PPD). Meyer et al. (2011) noted that the index of Human Movement and Weighted Color

(MC) to Potentially Problematic Determinants (PPD) is a measure of likely coping effectiveness.

It is obtained by contrasting codes that suggest resources associated with ideational elaboration

(movement) and lively responsiveness to the world (chromatic color; MC) to codes that suggest

potentially taxing anxiousness (noticing the nuances and subtleties of shading that indicate a sort

of an uncomfortable vigilance), disruptive ideation (inanimate or animal movement, which are

more primitive types of movement), and dysphoria (darkening their experience with achromatic

color and shading; PD). The interpretation of this index should consider the quality of the

variables that go into MC and PPD (Meyer et al., 2011). MC may not indicate healthy resources

if it is accompanied by FQ-, Cognitive Codes, and Pure C.

For PPD, the ability to identify shading in achromatic color, and dimensionality within

shading, can be a resource rather than a liability when accompanied by other indicators of

psychological health both within and outside of the Rorschach protocol. MC-PPD compares the

psychological resources and adaptive capacity associated with the MC score with the potentially

stressful or disturbing impact of demands associated with the PPD score. In the CS these

components have the abbreviations Experience Actual (Sum M + WsumC; EA) and Experienced

Stimulation (es), respectively, and this comparison of components is made by using the D score

(in which this difference score is represented as an integral, derived from a truncated

difference-score calculation where raw differences of -2.5 to +2.5 are converted to 0 on he D

scale and more extreme raw score difference increments of |2.5| are converted to one-point

increments on the D scale; Meyer et al., 2011). The psychometric advantage of a simple

difference score over a truncated difference score is that it maximizes the available variability

and information (Meyer et al., 2011).

Research supports the relationship between the MC–PPD variable and the tendency for

internal or external stresses to strain or overmatch one's coping ability (e.g., PTSD, sexual abuse

involving genital contact, or parenting a child with Autism, compared to controls; Meyer et al.,

2011). However, research support is stronger for MC as a measure of the internal capacity to

cope with the day-to-day events of life than it is for PPD as a tax or drain on resources.

Therefore, it is possible that coping capacity may be accounted for by MC alone (Meyer et al.,

2011). The MC-PPD index is important when examining the tasks of therapy because it

measures an individual's coping resources, which can have an effect on their behaviors and

cognitions in the therapy process. It can also provide the therapist with vital knowledge

regarding the patient's capacity to cope and how to best tailor their interventions around coping

resources.

Using the Rorschach to Predict Outcomes

The Rorschach has been used to predict a variety of different phenomena ranging from

treatment outcome in child psychiatric populations (Stokes et al., 2003), to degrees of lethality in

suicide attempts in an adult-hospitalized population (Fowler, Piers, Hilsenroth, Holdwick, &

Padawer, 2001). It has demonstrated better predictability to therapy outcomes than other

personality measures. For instance, in a study of 178 patients (97 who had prematurely

terminated psychotherapy and 81 who participated in individual psychotherapy for at least 6

months and 24 sessions), it was found that compared to the MMPI-2, the Rorschach was able to

determine several variables that predicted early termination in psychotherapy, whereas the

MMPI-2 was unable to detect any significant factors (Hilsenroth, Handler, Toman & Padawer,

1995).

Rorschach variables have demonstrated incremental validity and utility in the prediction

of treatment outcome (Viglione, 1999; Gibby, Stotsky, Hiler, & Miller, 1954). One particular

study used the Ego Impairment Index (EII) of the Rorschach to predict outcome with

antidepressant medication among patients with major depressive disorder, beyond the variance

accounted for by the initial level of self-reported depressive symptoms on two self-report

depression scales (Perry & Viglione, 1991). Specific Rorschach CS variables such as cooperative and aggressive movement scores, textures responses, and morbid content scores were associated with early termination of psychotherapy (Hilsenroth et al., 1995). The Rorschach provides researchers and clinicians with vital information regarding their patient's personality traits, interpersonal behavior, and a variety of potential outcomes. It can be useful tool in illuminating the strengths, weaknesses, and problem-solving styles that may not be evident in a standard interview with a patient (Quirk, Erdberg, Crosier, & Steinfeld, 2007).

While the findings in the aforementioned studies are modest, they do shed light on the use of the Rorschach in aiding therapeutic treatment. Therefore, clinicians can use information gained from the Rorschach to help strengthen the working alliance. An extensive literature exists that supports the importance of understanding patient personality characteristics in developing an effective therapeutic alliance (Norcross, 2002). The Rorschach, specifically the R-PAS, can be a crucial tool in understanding those personality characteristics that the patient may not even be able to articulate themselves.

Research gap. All of the aforementioned studies used the CS to predict various outcomes in psychotherapy. Research using the R-PAS to predict outcome is sparse and, to date, no studies have been published on the R-PAS's ability to predict the working alliance. The current study aimed to address the gap in the literature when the researcher explored the R-PAS's capacity to predict the working alliance as measured by the WAI-SR.

Present study. The Rorschach has the ability to assess unique information about the personality that is most likely to emerge spontaneously over time and be expressed in situations in which individuals must rely on themselves for direction—which can add incrementally and meaningfully to self-reported or introspectively-assessed information. The Rorschach provides

insight into psychological and behavioral aspects of an individual in a standardized in vivo

sample and has the ability to predict some elements related to treatment outcome. Therefore, the

current study explored the Rorschach's capacity to predict the tasks, goals, and bonds

dimensions of the working alliance utilizing specific R-PAS variables.

Research Questions

For my doctoral research, I investigated the following question: *To what extent can*

specific dimensional, proportional, and composite scores on the Rorschach Performance

Assessment System (R-PAS) predict individual dimensions of the working alliance (Goals, Tasks,

and Bond)?

Hypotheses

Bonds. I hypothesized that the Vigilance composite score, the Cooperative Movement

(COP), Mutuality of Autonomy-Health (MAH), Oral Dependency Language (ODL), and Whole

Human Content (H) dimensional variables would predict early bonds on the Working Alliance

Inventory-Short Revised.

Goals. I hypothesized that the Complexity score index and the Human Movement

Proportion score (M/MC) would predict early goals formation on the Working Alliance

Inventory-Short Revised.

Tasks. I hypothesized that the Ego Impairment Index-3 (EII-3) composite score, the

proportion score Weighted Color to Potentially Problematic Determinants index (MC-PPD), and

the dimensional variable Human Movement (M) would predict early task formation on the

Working Alliance Inventory-Short Revised.

Additional exploratory analyses. In addition, I conducted various exploratory analyses to examine any unanticipated correlations between the R-PAS and the WAI-SR. Other measures that were collected in addition to the WAI-SR and the Rorschach were also explored.

Method

The current study utilized a correlational design that explored the relationship between R-PAS scores derived at the outset of therapy, and scores on the Working Alliance Inventory. A multiple linear regression was used to predict scores on the Working Alliance Inventory based on specific Rorschach (R-PAS) variables.

Participants

Antioch University IRB approval was obtained to conduct the current archival study. The study utilized an already existing data set that was comprised of data collected by Antioch University New England's Psychology Services Center (PSC). Archival data were gathered from individuals 18 and over who were receiving psychotherapy at the time of the data collection or who received psychotherapy in the past. The patients agreed to take a Rorschach when they began treatment as a part of their intake procedure. The data were collected as a part of a clinic procedure and not for the purpose of this study. Participants agreed in their general consent form to allow their information to be archived to be potentially used for research in the future; patients have the option to either opt-in or opt-out of having their archival information used for research purposes (Appendix A). Participants were excluded from the current study if they did not consent to have their data available for research purposes. From the existing data set, only patients who were seen in psychotherapy and were administered the research measures were included in the study.

Research Instruments

Rorschach Performance Assessment System. The Rorschach Inkblot test was administered and scored by the PSC clinicians according to the R-PAS procedures. The quality and accuracy of the scoring was checked by several advanced assessment teaching assistants, the clinic director, and additionally some protocols were brought into a group-coding process that occurred during group supervision with the clinicians at the clinic. The Rorschach test consists of 10 same-sized and numbered inkblots. Each inkblot features a unique distinctive design, of which five are in black and white, two are in black and red, and three are in color (Cariola, 2014). The present study focused on the following variables:

- Complexity composite variable

- Cooperative Movement (COP) Thematic Code

- Ego Impairment Index, third version (EII-3)

- Human Movement and Weighted Color to Potentially Problematic Determinants index (MC-PPD)

- Human Movement determinant (M)

- Human Movement Proportion (M/MC)

- Mutuality of Autonomy-Health (MAH) Thematic Code

- Oral Dependency Language (ODL) Thematic Code

- Vigilance Composite (V-Comp)

- Whole Human content (H)

Other variables were examined for exploratory purposes. These are presented in the Results section and can be seen in Tables 3–5.

Working alliance inventory-short revised. In 2006, Hatcher and Gillaspy refined The Working Alliance Inventory-Short (WAI-S) to create the Working Alliance Inventory-Short Revised (WAI-SR). The WAI-SR measures aspects of the therapeutic alliance and was used to assess and operationalize the working alliance. The WAI-SR is a 12-item self-report measure of the working alliance (Hatcher & Gillaspy, 2006). It is comprised of three subscales: (a) Goals, (b) Tasks, and (c) Bond, each of which is based on Bordin's (1975) multidimensional theoretical conceptualization of the working alliance. The WAI-SR asks the patient to rate the therapeutic relationship in terms of the therapeutic tasks, therapeutic goals, and the therapeutic bond. The respondents rate 12 questions based on a 5-point Likert scale, with 1 = *Seldom* and 5 = *Always*. A total score out of 60 is computed with a high score indicating a stronger alliance. The total score is comprised of three subcategories (Tasks, Goals, and Bond), each with a maximum score of 20. In comparison to the WAI and a previous short version of the WAI (WAI-S; Tracey & Kokotovic, 1989), the WAI-SR demonstrated a clearer representation of the alliance dimensions and an improved model fit in confirmatory factor analysis (CFA) by excluding negatively worded items (Munder, Wilmers, Leonhart, Linster, & Barth, 2010). Overall, the WAI-SR has been shown to demonstrate good internal consistency reliability ($\alpha > 0.80$) and convergent validity with the Helping Alliance Questionnaire ($r > 0.64$; Hatcher & Gillaspy, 2006; Munder et al., 2010). It has also been shown to demonstrate very good internal consistency (Munder et al., 2010).

Procedure

The study utilized archival data that was collected at the PSC. The data were collected as part of independent, ongoing research and were not collected for the sole purpose of this study—but parallel and independent to the inception of my study. The Rorschach was offered to patients

as an optional part of the intake process and part of standard care and treatment planning. Once

the assessments were completed, they were de-identified according to the Safe Harbor Method

by the clinic Administrative Director and teaching assistant and placed in the data set (U.S.

Department of Health and Human Services, 2012). The WAI-SR was administered by the

clinician biweekly and it was also de-identified according to the Safe Harbor Method by the

clinic Administrative Director and placed in the data set. The archival data included (a) research

numbers for tracking,; (b) demographic characteristics including age, sex, race, ethnicity,

diagnosis,; (c) WAI-SR scores; and (d) Rorschach protocol data. Individuals' Rorschach data

were examined in addition to scores on the WAI-SR.

Analysis

Specific Rorschach variables were correlated with the subcategories of the WAI-SR.

Demographic variables were explored after the primary predictors were examined to explore

potential moderator or mediator variables, as well as any trends or relationships between the

Rorschach responses and the WAI-SR and the individual's demographics (i.e., race, ethnicity,

gender, age, etc.). The study first examined potential correlations between Rorschach variables

and initial WAI scores, and then potential correlations between the Rorschach variables and the

changed scores in the final WAI. A contact density variable was created to account for the

variation in frequency of treatment over a particular length of time.

Bonds. A linear multiple regression was conducted using the Vigilance Composite score

(V-Comp), and the dimensional variables Cooperative Movement (COP), Mutuality of

Autonomy-Health (MAH), Oral Dependency Language (ODL), and Whole Human Content (H)

as predictor variables for the Bonds domain of the WAI-SR.

Goals. A linear multiple regression was conducted using the Complexity score index and

the Human Movement Proportion score (M/MC) as predictor variables for the Goals domain of

the WAI-SR.

Tasks. A linear multiple regression was conducted using the composite score Ego

Impairment Index-3 (EII-3), the proportion score Weighted Color to Potentially Problematic

Determinants index (MC-PPD), and the dimensional variable Human Movement (M) as

predictor variables for the Tasks domain of the WAI-SR.

Results

Three individuals were excluded from the data set due to being under age 18 and not

having WAI-SR data. The remaining 13 individuals' data were examined and they ranged from

age 18 to 67, with the majority of individuals falling between 18 and 35 years old. The sample

was over 70% female and 100% Caucasian. It was expected that specific Rorschach variables

would predict the three dimensions of the Working Alliance Inventory (Bonds, Tasks, and

Goals). Correlations and multiple linear regressions were conducted to predict the different

domains of the WAI-SR using various Rorschach variables. Table 1 shows the results of the

multiple linear regression for all of the WAI-SR domains with the selected Rorschach variables.

Bonds

A multiple linear regression was conducted to examine the relationship between the

Bonds domain of the WAI-SR and the Vigilance Composite score (V-Comp), the dimensional

variables Cooperative Movement (COP), Mutuality of Autonomy-Health (MAH), Oral

Dependency Language (ODL), and Whole Human Content (H). The results (see Table 1)

indicated that the Vigilance Composite score (V-Comp), Mutuality of Autonomy-Heath (MAH),

Oral Dependency Language (ODL), and Whole Human Content (H) did not significantly predict

the Bonds dimension of the WAI-SR (R^2 = .60, $F(5, 7)$ = 2.10, p = .18)—meaning, I could not

significantly predict the Bonds dimension of the WAI-SR with the given Rorschach variables. At

first glance, it did appear that Cooperative Movement (COP) significantly predicted the Bonds

dimension of the WAI-SR (β = -1.14, p = .02). Further analyses were conducted. Because the

sample was skewed and not normally distributed, a median split was conducted and a Chi square

was run. No significant relationship between Cooperative Movement (COP) and the Bonds

dimension of the WAI-SR X^2 (1, N = 13) = .08, p = .78) was found. The skewed distribution was

most likely due to the low sample size, which also makes it difficult to see a relationship between

these variables.

Goals

A linear multiple regression analysis was conducted to examine the relationship between

the Goals domain of the WAI-SR and the Complexity score index and the Human Movement

Proportion score (M/MC). As can be seen in Table 1, the results of the regression trended toward

significance (R^2 = .44, $F(2, 9)$ = 3.53, p = .074). These results indicate that the Human

Movement Proportion score (M/MC) and the Complexity score index explained almost half of

the variance in the Goals domain of the WAI-SR. The results cannot be generalized to the larger

population because of the lower p value, however, with a larger sample size this may change.

The analysis showed that the Complexity score index did not significantly predict the Goals

domain of the WAI-SR. The Human Movement Proportion score (M/MC) did significantly

predict the Goals domain of the WAI-SR, indicating that individuals with a lower Human

Movement Proportion score had higher scores on the Goals dimension of the WAI-SR (β = -.67,

p = .03). This finding suggests that individuals who potentially have difficulty modulating their

emotions and may be more reactive in their responses would have a more difficult time creating and maintaining goals in therapy.

Tasks

Multiple regression analysis was conducted to examine the relationship between the Tasks domain of the WAI-SR and the composite score Ego Impairment Index-3 (EII-3), the proportion score Weighted Color to Potentially Problematic Determinants index (MC-PPD), and the dimensional variable Human Movement (M). As can be seen in Table 1, the results revealed no significant association between these variables ($R^2 = .44$, $F(3, 9) = 0.58$, $p = .64$) which shows that there was no detectable relationship between the selected Rorschach variables and the Tasks dimension of the WAI-SR.

Exploratory Analyses

Exploratory analyses were conducted with the sample data. Descriptive statistics for each variable, including additional variables collected with the data set, are presented in Table 2. Number of participants, the range of each variable (minimum and maximum), means, and standard deviations are recorded. One of the measures included in the data set is the Outcome Questionnaire (OQ-45), which measures an individual's mental health functioning and was designed to access common symptoms across a wide range of adult mental disorders and syndromes, including stress-related illnesses (Lambert, Gregersen, & Burlingame, 2004). The OQ-45 scores range from 0 to 100, with higher total scores indicating that the individual endorsed high levels of distress, mainly anxiety, depression, somatic problems and stress, as well as interpersonal difficulties (Lambert et al., 1996). The cutoff score is 63, meaning when an individual's score falls above 63 it indicates clinically significant levels of distress (Lambert et al., 1996). The WAI-SR has a range of scores from 0 to 60, with each subcategory having a

maximum of 20. Information for R-PAS variables is presented in Table 2 as well. R-PAS

converts the raw scores to percentiles and the percentiles are converted to the standard score

equivalent that would be observed on a normal distribution (Meyer et al., 2011). Thus, these are

normalized scores that have been equated onto a common metric for interpretation regardless of

each variable's initial distribution. As a general matter, this means that about 68% of the

reference sample has standard scores between 85 and 115 and about 95% of the reference sample

has standard scores between 70 and 130 (Meyer et al., 2011). I conducted correlations to

examine any potential relationships between variables. Correlations between the Bonds

dimension of the WAI-SR and the Vigilance Composite score (V-Comp), the Cooperative

Movement (COP), Mutuality of Autonomy-Heath (MAH), Oral Dependency Language (ODL),

and Whole Human Content (H) variables can be found in Table 3. A significant correlation was

found between the MAH and COP, $r = .62, p < .05$. This result supports previous findings that

show similar results, as we understand MAH as a "Level 2" COP score (Meyer et al., 2011).

Correlations between the Goals dimension of the WAI-SR and the Complexity score index and

the Human Movement Proportion score (M/MC) are seen in Table 4. There was a significant

negative correlation between the Initial WAI-SR Goals scores and the M/MC, $r = -.66, p < .05$.

Indicating that as an individual's M/MC score decreases, their Initial WAI-SR Goals score

increases. Lower M/MC scores tend to reflect individuals with the ability to modulate one's

emotions with emotional maturity, potentially being better able to set therapy goals

collaboratively with their therapists. Initial WAI-SR Goals and Final WAI-SR Goals were

significantly correlated, $r = .85, p < .01$, indicating that an individual's initial agreed upon goals

in therapy are positively related to their final agreed upon goals in therapy. Upon further

exploration, it appears that the data were skewed, such that the majority of individuals reported

having a high agreement with their therapist on the goals of therapy, both initially and at the end

of therapy. Correlations for the Tasks dimension of the WAI-SR and the composite score Ego

Impairment Index-3 (EII-3), the proportion score Weighted Color to Potentially Problematic

Determinants index (MC-PPD), and the dimensional variable Human Movement (M) can be

found in Table 5. Similar to the Goals results, Initial WAI-SR Tasks and Final WAI-SR Tasks

were significantly correlated, $r = .67$, $p < .05$. This indicates that individuals are relatively

consistent in how they rate the tasks of therapy at the beginning of treatment and upon

termination.

Discussion

The purpose of this study was to assess the Rorschach's (R-PAS) capacity to predict the

Tasks, Goals, and Bonds dimensions of the working alliance using the Working Alliance

Inventory (WAI-SR). It was hypothesized that if a person scored within the normal range on

their Vigilance composite score, their Cooperative Movement (COP), Mutual of Autonomy-

Health (MAH), Oral Dependency Language (ODL), and Whole Human Content (H) dimensional

variables, they would score higher on the bonds dimension of their initial WAI-SR, indicating

that the individual was more likely to form a stable bond with their therapist. I hypothesized that

participants who had normal range scores on their Complexity score index and the Human

Movement Proportion score (M/MC) would also score higher on the goals dimension of their

initial WAI-SR, indicating that the participant was more likely to form mutually agreed upon

outcomes of the therapy process and better able to co-construct interventions that take place

during therapy. Furthermore, it was also hypothesized that the participants that scored in the

normal range on the Ego Impairment Index-3 (EII-3) composite score, the proportion score

Weighted Color to Potentially Problematic Determinants index (MC-PPD), and the dimensional

variable Human Movement (M), would also have higher scores on their initial tasks dimension of the WAI-SR, indicating that the participant would have greater capacity to perform the in-counseling behaviors and cognitions that form the substance of the therapy process.

It appears that there was not enough statistical power due to a small sample size to generalize the results to the larger population. The small sample size did not allow for a normal distribution of the data, which made seeing statistically significant results difficult. Particularly for the Bonds analysis, the small sample size most likely created saturation given the number of predictor variables being large. Several of the multiple linear regressions had large effect sizes, meaning that large parts of the variability in the WAI-SR domains were explained by the Rorschach variables. These results cannot be generalized to the larger population due to the lack of statistical significance. However, if the results were statistically significant and these results were seen, it would mean that the Rorschach variables would explain a large portion of the variance in the WAI-SR domains.

While it is difficult to draw any firm conclusions from the statistical results of this study, the data offer a unique opportunity to examine a collective sample of individual Rorschach tests from which we can potentially infer information about the sample's psychological resources, and their cognitive, affective, and relational functioning. Collectively, this sample of individuals agreed for their data to be used for research purposes. From their Rorschach scores, we may be able to draw conclusions as to what characteristics an individual may have that would indicate they would provide their data for research purposes or seek therapy at Antioch University New England's Psychological Services Center.

Personality Characteristics of the Sample Population

It is important to examine the sample as a whole through the lens of the Rorschach to provide insight into the individuals who chose to complete a Rorschach to help inform treatment and provide their data for research purposes. This may offer some explanatory value in understanding those who have the potential to be receptive to utilizing the Rorschach for treatment planning and developing insight. Conversely, and not tested here, is the willingness of clinicians to utilize the Rorschach; however, because there was no direct focus on clinicians in this study, this discussion is limited to the patients.

Together, the sample of participants appeared to be fairly homogenous in gender and WAI-SR scores, which may indicate certain characteristics of the participants that informed their decision to agree to a Rorschach and consent for their data to be used. Although the sample is homogenous in some ways, it also has variability with a wide dispersion of scores that include bimodal distributions in some variables. In general, the sample distress levels appeared to fall below clinically significant levels as described by the OQ-45 when entering therapy and upon termination. They were able to form strong working alliances with their clinicians, on average, at the beginning of therapy and upon termination. Overall, they had strong bond formation initially and at the end of treatment. Their ability to engage in tasks of therapy was good initially and improved over time with their final scores. Additionally, they were able to set and follow appropriate treatment goals initially and continued to do so upon termination.

Engagement and cognitive processing. The majority of the sample appeared to be experiencing anxiety in some capacity, and a large portion of the participants had likely experienced some form of trauma. In addition, there were several individuals diagnosed with personality disorders and depressive disorders. Overall, the sample was fairly complex in their

processing. They appeared to have some difficulty with ego functioning and stress tolerance, but likely had a somewhat open and non-defensive personality style. Many individuals in the sample appeared to struggle with adequate coping skills; however, they appeared to have at least mildly sufficient coping to manage what may have been minimal distress at the time, which would align with the low OQ-45 scores. With that said, they likely had difficulty effectively coping with stressors had they intensified, which may be at least one reason for attending therapy. It appeared that some participants at the time of their assessment may have been experiencing stressors that would interfere with their ability to reason and be reflective, and to see themselves as the agents of their own experiences. Further, they appeared to have some difficulty modulating their emotions and may have been more reactive in their responses as a result.

Self and other representation. In terms of Self and Other Representation, the sample from the study appears to have mild deficits in understanding themselves, others, and relationships. They may have had difficulty with interpersonal relatedness, which may be a reason for seeking therapy. The sample did not appear to have an overly dependent interpersonal style. Some individuals may have slight difficulty understanding people in different contexts and may have some deficits in interpersonal functioning. They did have a propensity to view interpersonal interactions as supportive, helpful, and collaborative, which may be a reason they chose to attend therapy—seeing therapy as potentially beneficial. The sample also has some potential to form mature and healthy interpersonal relationships overall, although some may demonstrate some splitting tendencies. The sample may have a less adaptive understanding of themselves and others; it may be difficult to manage and maintain close interpersonal relationships. The sample may also demonstrate a bit of guardedness and interpersonal wariness.

Perception and thinking. The sample demonstrated some thinking disturbances and perhaps some difficulty reality testing and impaired object representations. They may have had difficulty in effective communication, and may misinterpret or mistake their perceptions of situations which could lead to poor judgments or poor adaptations in their lives.

Stress and distress. At the time the Rorschach was given, the sample appeared to be experiencing moderate to significant levels of stress. Some may feel helpless in the face of stressors in their lives, while others may feel anxious and perceive the stressor be outside of one's control. The sample may have a tendency to see themselves as injured or damaged or may take an overall pessimistic view to their current situations. Some may be at risk for self-destructive behaviors and may have a tendency to get distracted by inconsistencies or uncertainties in their environments, possibly preventing them from seeing the larger picture or a solution to their problem.

Overall, these data provided a depiction of average individuals who may agree to take a Rorschach for therapeutic purposes and volunteer their data for research purposes. This information may prove useful for the Psychological Services Center at Antioch University New England in order to promote future research.

Limitations and Future Research

The lack of significant findings may stem from several limitations of the study. This may result from sample size issues, participant recruitment, and sample diversity. These limitations are explored in further detail below, in addition to recommendations for future research.

Sample size. The study did not have adequate power to detect statistical significance, likely due to small sample size. The small sample size was potentially due to recruitment issues. It was difficult for the clinicians at the PSC to find individuals willing to take a Rorschach as a

therapeutic assessment. Additionally, it is possible that the clinicians did not have interest or

confidence in conducting the Rorschach, either assuming it would not be useful or having other

impediments (i.e., lack of time to administer the test). These factors contributed to a small data

set. The sample size was also negatively impacted because the inclusion criteria required

individuals to have completed both a Rorschach and a WAI-SR.

Sample homogeneity. The current sample population was diverse in many ways (i.e., the

wide spread on the Rorschach scores), suggesting considerable psychological variability in the

population. While incredibly diverse in their Rorschach scores, the sample was more

homogeneous in the areas of ethnicity and race, which may have limited the sample's variability.

In addition, the sample was also more homogenous in WAI-SR scores. The majority of

individuals began treatment with moderate to relatively high WAI-SR scores, which created a

lack of variability in the sample. This limitation may have affected the generalizability of the

results. The relatively high initial WAI-SR scores could be due to the nature of the center; given

that the PSC is an outpatient setting, the average individual seeking services and consenting to

take a Rorschach is fairly high-functioning, likely indicating their ability to adequately form a

therapeutic relationship. Another factor that may have created high WAI-SR scores was that the

WAI-SR is not administered anonymously at the PSC. This is particularly true for the Bonds

dimension of the WAI-SR, which asks questions pertaining to the relationship such as "I believe

___ likes me," which could impact how individuals respond, possibly making it difficult for

individuals to comment negatively about their therapists. No individual rated the Bonds

dimension below a score of 10.

Future Directions for the Psychological Services Center

　　Given the small sample size of the present study, future research requires a higher sample size in hopes of identifying more generalizable results. A greater sample size would potentially provide more variability in the sample as well. It may also be beneficial to examine other measures of the patient–therapist alliance, as it was unclear in the present study whether the WAI-SR was sufficiently sensitive to detect noteworthy differences in the sample.

　　Trainings. Specifically for the PSC, it may help to target ways in which clinicians can incorporate the Rorschach into their treatment planning or as a therapeutic assessment. Offering Rorschach trainings to provide greater understanding of its utility in treatment may increase the likelihood of PSC clinicians offering the Rorschach to their patients.

　　Rorschach Interest Group. It may be helpful to provide a space in which clinicians can have time to code or interpret tests. A Rorschach Interest Group (RIG), similar to the PSC's Family Interest Group (FIG), in which clinicians could have designated time to go over protocols, coding questions, or cases, could serve as one way to achieve this, which may foster greater understanding of the usefulness of the Rorschach and eliminate the issue of not having enough time to code or interpret the results.

　　Recommendations template. In addition, creating a template of useful recommendations for therapy related to certain profiles in the Rorschach could help clinicians better implement the information gathered from the Rorschach in therapeutic practice. For example, if someone tended to be more emotionally reactive or have difficulty managing their emotional experience, it may be beneficial to teach the patient grounding techniques first before exploring the problems for which they are coming to therapy more deeply. This would potentially allow the therapist to be more successful completing the tasks within the working alliance. Additionally, if an

individual's Rorschach identified them as being more vigilant, the therapist may wish to take

extra care in building trust and rapport in the first few sessions, increasing the therapist–patient

bond.

Consent script. It may be useful for the creator of the consent script to speak with the

clinicians who have had success with patients agreeing to taking a Rorschach to ensure the utility

and importance of completing a Rorschach and the benefits of allowing the results to be used for

research purposes are explained in a uniform manner. This may allow for the illumination of

similarities in how they are presenting the process. A script could be created from that

information that would be read to patients or used as a starting part for clinical discussions. It

may be helpful to include information such as: "A Rorschach can provide information about an

individual's cognitive, affective, and relational patterns and can provide your clinician with

information that could help inform their approach to treatment." An example of a useful

statements describing the importance of research may include: "Research helps student clinicians

improve at their job, which helps them provide better therapy to people seeking help. " If the

clinician shares the importance of the Rorschach and its benefits for research, then individuals

may be more likely to agree to take a Rorschach and allow their information to be used for

research, if they see that it is mutually beneficial.

Keep talking. If clinicians at the PSC believe that the Rorschach is important, and they

share these thoughts and feelings with collogues, it may help to keep the topic relevant and at the

forefront of clinicians' minds. The more a topic is discussed, the more it becomes part of the

organization's culture. If clinicians understand that providing a Rorschach is always an option,

they may be more likely to offer the test.

Conclusion

Wide consensus exists among psychotherapists of the importance of the therapeutic

alliance in psychotherapy treatment outcome (Horvath et al., 2011; Safran et al., 2014). Thus, it

is important for therapists to have knowledge about what may predict the formation of the

alliance. While many variables have been studied, comparatively little research has investigated

the predictive ability of the Rorschach (R-PAS) on this important therapeutic variable. My

doctoral research explored whether specific Rorschach variables can predict the working alliance

in therapy. While there were some relationships that trended toward significance, no meaningful

statistically significant results were detected—perhaps due to the limited power of a small

sample size. Given the unique opportunity of having a collective Rorschach sample, I chose to

interpret the results from an angle that provides a greater understanding of the personality factors

that may contribute to individuals agreeing to a Rorschach and allowing their data used for

research purposes. This approach will hopefully aid future research at the PSC.

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Table 1

Multiple Linear Regression Analysis for Rorschach Variables Predicting WAI Scores

_____

	Bonds			Goals			Tasks		
Variable	B	SEB	ß	B	SEB	ß	B	SEB	ß
V-Comp	0.18	0.11	0.56	-	-	-	-	-	-
COP	-0.33	0.11	-1.14	-	-	-	-	-	-
MAH	0.15	0.09	0.56	-	-	-	-	-	-
ODL	0.17	0.09	0.51	-	-	-	-	-	-
H	0.03	0.07	0.11	-	-	-	-	-	-
Complexity	-	-	-	0.02	0.10	0.06	-	-	-
MMC	-	-	-	-0.22	0.08	-0.67	-	-	-
MCPPD	-	-	-	-	-	-	0.12	0.14	0.31
M	-	-	-	-	-	-	-0.70	0.07	-0.32
EII	-	-	-	-	-	-	-0.10	0.07	-0.05
R^2		0.60			0.44			0.16	
R		0.78			0.66			0.40	
F		2.10			3.53			0.58	

Table 2

Descriptive Statistics

	N	Minimum	Maximum	Mean	Standard Deviation
OQ Initial	13	21.0	100.0	58.31	25.58
OQ Final	13	5.0	83.0	43.69	30.16
WAI Initial	13	18.0	55.0	41.39	11.57
WAI Final	13	32.0	60.0	50.23	8.11
WAI Bonds Initial	13	6.0	20.0	14.85	4.20
WAI Bonds Final	13	13.0	20.0	18.0	2.45
WAI Tasks Initial	13	4.0	18.0	12.92	3.73
WAI Tasks Final	13	11.0	20.0	15.77	2.68
WAI Goals Initial	13	4.0	19.0	13.46	4.48
WAI Goals Final	13	5.0	20.0	15.77	4.19
Complexity	13	89.0	137.0	107.15	12.92
R	13	83.0	146.0	106.15	15.45
MCPPD	13	87.0	121.0	97.85	9.65
M	13	71.0	135.0	99.39	16.86
MMC	12	86.0	135.0	103.5	14.34
EII	13	78.0	143.0	111.23	17.71
ODL	13	74.0	112.0	90.54	12.96
H	13	75.0	139.0	99.15	15.64
COP	13	88.0	134.0	110.69	14.41

Table 2 (continued)

MAH	13	90.0	134.0	102.15	15.38
PHR	13	87.0	115.0	103.77	8.95
Vcomp	13	85.0	132.0	104.15	13.28
TPcomp	13	85.0	142.0	112.94	15.59
SevCog	13	94.0	138.0	104.50	14.56
WsumCog	13	79.0	139.0	103.78	18.56
FQ-	13	85.0	143.0	115.72	17.72
WD-	13	82.0	143.0	113.89	17.35
FQo	13	74.0	122.0	93.94	11.57
P	13	72.0	132.0	96.00	15.84
YTVC'	13	82.0	115.0	100.78	10.93
m	13	84.0	150.0	103.83	14.97
Y	13	85.0	111.0	99.28	9.58
MOR	13	86.0	130.0	102.28	13.62
SCComp	13	65.0	122.0	101.81	17.15

Table 3

Bonds Correlations

		COP	H	ODL	MAH	VComp
COP	Pearson Correlation	1	-0.009	-0.012	0.615*	0.498
	Sig. (2-tailed)	-	0.976	0.970	0.025	0.083
	N	13	13	13	13	13
H	Pearson Correlation	-0.009	1	0.238	-0.058	-0.356
	Sig. (2-tailed)	0.976	-	0.434	0.850	0.233
	N	13	13	13	13	13
ODL	Pearson Correlation	-0.012	0.238	1	-0.157	-0.367
	Sig. (2-tailed)	0.970	0.434	-	0.609	0.217
	N	13	13	13	13	13
MAH	Pearson Correlation	0.615*	-0.058	-0.157	1	0.211
	Sig. (2-tailed)	0.025	0.850	0.609	-	0.490
	N	13	13	13	13	13
VComp	Pearson Correlation	0.498	-0.356	-0.367	0.211	1
	Sig. (2-tailed)	0.083	0.233	0.217	0.490	-
	N	13	13	13	13	13
WAI Bonds Initial	Pearson Correlation	-0.520	0.009	0.259	-0.108	-0.115
	Sig. (2-tailed)	0.069	0.976	0.393	0.726	0.709
	N	13	13	13	13	13
WAI Bonds Final	Pearson Correlation	-0.444	0.039	-0.239	-0.310	0.197
	Sig. (2-tailed)	0.129	0.899	0.432	0.303	0.518
	N	13	13	13	13	13

Note. * denotes correlation is significant at the 0.05 level, ** denotes correlation is significant at the 0.01 level.

Table 4

Goals Correlations

		WAI Goals Initial	WAI Goals Final	Complexity	MMC
WAI Goals Initial	Pearson Correlation	1	0.845**	-0.011	-0.660*
	Sig. (2-tailed)	-	0.000	0.971	0.019
	N	13	13	13	13
WAI Goals Final	Pearson Correlation	0.845**	1	-0.126	-0.517
	Sig. (2-tailed)	0.000	-	0.683	0.085
	N	13	13	13	12
Complexity	Pearson Correlation	-0.011	-0.126	1	0.175
	Sig. (2-tailed)	0.971	0.683	-	0.568
	N	13	13	13	12
MMC	Pearson Correlation	-0.660*	-0.517	0.175	1
	Sig. (2-tailed)	0.019	0.085	0.586	-
	N	12	12	12	12

Note. * denotes correlation is significant at the 0.05 level, ** denotes correlation is significant at the 0.01 level.

Table 5

Tasks Correlations

		WAI Tasks Initial	WAI Tasks Final	MCPPD	M	EII
WAI Tasks Initial	Pearson Correlation	1	0.665*	0.250	-0.239	-0.210
	Sig. (2-tailed)	-	0.013	0.411	0.431	0.490
	N	13	13	13	13	13
WAI Tasks Final	Pearson Correlation	0.665*	1	0.417	-0.219	-0.106
	Sig. (2-tailed)	0.013	-	0.156	0.472	0.731
	N	13	13	13	13	13
MCPPD	Pearson Correlation	0.250	0.417	1	0.256	-0.453
	Sig. (2-tailed)	0.411	0.156	-	0.398	0.120
	N	13	13	13	13	13
M	Pearson Correlation	-0.239	-0.219	0.256	1	0.078
	Sig. (2-tailed)	0.431	0.472	0.398	-	0.799
	N	13	13	13	13	13
EII	Pearson Correlation	-0.210	-0.106	-0.453	0.078	1
	Sig. (2-tailed)	0.490	0.731	0.120	0.799	-
	N	13	13	13	13	13

Note. * denotes correlation is significant at the 0.05 level, ** denotes correlation is significant at the 0.01 level.

Appendix A: Consent Form for Antioch Psychological Services Center

CONSENT FORM

Welcome to Antioch's Center for Psychological Services. This form will provide information about our services and about your rights and responsibilities as a patient. Please be sure to discuss any questions with your clinician or the Director, Dr. Vincent Pignatiello. Your signature at the bottom indicates that you understand the information and freely consent to treatment. This is a training clinic for doctoral students in clinical psychology. Our students are under the supervision of our doctoral program faculty, licensed psychologists with expertise in many specialties, such as children, families, trauma and addictions. In order to ensure the best possible service, your clinician will be discussing your treatment with her/his supervisor(s). If you are seeing a student-clinician, you will be informed of the name of this supervisor during your first session. The name of my supervisor is _____. It is the nature of a training clinic to closely train and supervise clinicians. Therefore, in keeping with common practice nationally, we tape record all counseling sessions. Clinicians and their supervisors review tapes to refine their clinical skills. The tapes are not a part of your record and are erased regularly after use.

TREATMENT:

There are a number of different forms of treatment available including individual psychotherapy, relationship and family counseling, group therapy, psychological assessments, and various educational activities. It is important to realize that although there are many potential benefits from these treatment activities, there are also some risks. In psychotherapy, for example, it is not uncommon to experience feelings of sadness, anger, anxiety, or guilt. These feelings may be natural and normal, and an important part of the therapy process, but they may also be unexpected and confusing. Although there are no guarantees, when therapy is effective there is a reduction in feelings of distress and a positive experience of problems being improved or resolved. You are encouraged to discuss with your clinician any feelings or concerns that arise during your treatment.

By initialing in the box, I understand the benefits and risks to treatment. ☐

CONFIDENTIALITY:

What you talk about with your clinician is confidential and will not be revealed outside this clinic without your permission. Before any information is shared with other professionals or agencies, we would request a written release from you. *This release is available in our office or may be completed with any individual whom you wish to give such access, and then provided to us.* The only exceptions to this policy are rare situations in which we are required by law to release information with or without your permission. These are: 1) if there is evidence of physical and/or sexual abuse of children, or abuse of the elderly; 2) if we judge that you are in danger of harming yourself or another individual; and 3) if your records are subpoenaed/ordered by the court. In the rare event of any of these situations, we would attempt to discuss our intentions with you before an action is taken, and we would limit disclosure of confidential information to the minimum necessary to insure safety.

This is a training clinic attached to a university department of clinical psychology that is also part of a larger group of departments housed in the same building. As such, it is a facility that serves various segments of the population such as first year assessment students' accessing testing materials in our storage closet. In addition, predictable traffic for bathrooms and cleaning personnel, for example, is present. It is therefore impossible to guarantee anonymity in our waiting area, for example. Our staff, faculty, and clinical psychology students are all sensitive and tuned to the respect and demands of confidentiality and proceed with decorum and professional attunement to privacy. It is important to realize, however, that sterilized insulation from persons as described here is not possible.

In order to provide the best clinical service to you and your family, different family members may be seen by various clinicians on our staff. We feel that it is appropriate for our staff to consult with one another and

discuss the meetings held with different family members in order to facilitate the overall therapeutic work. Information shared with staff will be done with discretion, discussing only what each clinician feels would be relevant. Part of training involves peer review and supervision as monitored by the Director and faculty supervisors. Once or twice a year, the student clinicians review the entire folder of a peer clinician for completeness, accuracy, and clarity. As for all clinical endeavors, the same demands for confidentiality exist. In other words, a reviewer is bound to the same level of confidentiality as the clinician.   If you have any questions or concerns about this, please feel free to discuss these concerns with your clinician.

Regarding electronic communications. No therapeutic conversations will be conducted via email or other social media, except in the case where a brief email may be used to schedule or change appointments.

Regarding use of the elevator. At the Psychological Services Center, all confidentiality is secured. However, due to the necessity to use elevator services, it will be required that you enter other parts of the building outside the Psychological Services Center. When traveling to and from the elevator, we cannot assure that confidentiality will take place.

By initialing in the box, I understand the role of confidentiality and limitations to confidentiality.

EMERGENCIES:

Our office is usually open Monday through Friday from 9:00 until 5:00. When we are unavailable, your call will be answered by an answering machine, and we will return your call as soon as possible during working hours. **The clinic does not have a way to respond to crisis situations that occur at times when the office is closed**. For this reason, it is important to be aware of the general support services that are available to you in your community; your clinician will discuss these services with you during your intake interview. If you or your clinician believes that your well-being might be at risk due to these limitations in after-hours crisis coverage, we will help you find a more appropriate setting for your treatment. It is the PSC's policy to contact your emergency contact(s), the police, or both in the event of a medical or psychiatric emergency.

By initialing the box, I understand the PSC's emergency procedures.

NO WEAPON POLICY:

For many reasons, the PSC cannot allow weapons in the facility. If you have things like a Leatherman, pepper spray, for example, or anything else that could be used as a weapon, you must not bring it into the building.

By initialing the box, I understand that weapons are not allowed in the facility.

FEE AND PAYMENT POLICY:

The standard hourly fee for psychotherapy services is $60 when seeing a student-clinician, and $140 when seeing a New Hampshire Licensed Psychologist. This fee may be adjusted depending upon your financial circumstances. The fee for group treatment and educational activities will vary according to the nature of the activity.   Your clinician will discuss your fee with you, and will record any adjustments below. Patient's Fee: _____

You will be expected to pay for each session at the time it is held, unless you have made another arrangement with your clinician.

We will be happy to provide you with a statement that you may submit to your insurance company for possible reimbursement. Please be aware that you are responsible for any unpaid portion of your bill. You should also be aware that many insurance companies do not pay for psychotherapy services provided by students in training.

By initialing the box, I understand the payment policy.

CANCELLATION AND ATTENDANCE POLICY:

If you cannot attend a scheduled appointment, we ask that you call to cancel the appointment at least 24 hours in advance. Missed appointments for reasons other than emergencies will be billed at your normal hourly fee. You will be expected to pay this fee prior to your next scheduled session.

It is very important that you attend your scheduled sessions. Due to high levels of incoming referrals we cannot offer immediate services to everyone. This means you are receiving services that are not provided to someone else who may have sought therapy elsewhere or may be on our waiting list. Also, since our clinicians are in training, the hours they accumulate in providing therapy are crucial to advancement in their doctoral program. Therefore, missed sessions present obvious problems for a number of people. I agree to attend all scheduled sessions except for illness and other circumstances reasonable people would see as an emergency. I understand all missed sessions will need to be discussed with your therapist, as your therapist is required to consider ending services for absences with their supervisor and the clinic Director.

By initialing the box, I understand the cancellation and attendance policy.

FAMILY, COUPLES AND CHILD THERAPY ONLY:

The clinic does not perform child custody or visitation evaluations. If, based on information provided, there is a reasonable expectation or potential for these matters to be contested in a way that could involve clinician testimony or records; we are not the service for you. But we would be willing to provide referrals to services that would be more in line with those needs. To obtain records from couple's therapy sessions the clinic requires a release signed by both individuals who attended the sessions.

I have read and understand the above clinic policy.

I as parent or guardian give my consent for _____ **to** (*initial boxes for which you provide consent*)

leave the clinic without an adult present [ ] and/or **receive transportation from** _____

MONITORING TREATMENT PROGRESS AND OUTCOME:

The clinic, along with the clinical psychology field in general, is committed to monitoring the effectiveness of our treatment and educational activities. Therefore, we will routinely collect questionnaire data from you during the course of your treatment. These data is used for a variety of clinical purposes, such as assessing your progress during treatment, training our student clinicians, and tracking our service utilization rates. This information becomes a permanent part of your record and will therefore be treated with the same respect for confidentiality as other information in your file. Your clinician may discuss the information obtained from these questionnaires with you, and many patients find this a useful way to reflect upon their own treatment progress and goals.

By initialing the box, I understand the PSC's policy on monitoring treatment and outcome.

SERVICE ANIMALS:

As you may have noticed from the signage, you may encounter a service animal while you are here at the PSC. We take the health, safety, and comfort of our clinicians and patients seriously. While we ask that you be mindful around these animals (i.e., do not approach or pet a service animal while it is working on site), we also ask that you please inform your clinician, the administrative personnel, or the Director of any potential concerns that you may have. These concerns may include but not be limited to allergies, phobias, or other adverse experiences associated with the service animal. We are happy to make reasonable accommodations to ensure your health, safety, and comfort while you are receiving services here at the PSC.

By initialing the box, I understand the policy regarding the presence of service animals.

RESEARCH ACTIVITIES:

We are also committed to enhancing our body of scientific knowledge about psychological treatment through faculty and student research projects. As such, your treatment data (e.g., the questionnaires mentioned above that

all patients respond to during treatment), in combination with treatment data from other patients, can help us improve treatment effectiveness in the future. We take every precaution to ensure that your confidentiality and anonymity will be protected in all of our research. First, any such research projects using data must be reviewed and approved by the Antioch University New England Institutional Review Board to ensure that your rights are protected. Second, we require that all information that would identify you, such as name, date of birth, address, and job, be removed and replaced with a code before the data are used for scientific purposes.

Please initial the box below that indicates whether you consent to making your anonymously coded data available for research purposes. Your permission is entirely voluntary and you will not be penalized in any way should you choose to withhold your consent.

I consent to making my treatment data available for research purposes.

OR

I do not consent to making my treatment data available for research purposes.

FOR ANTIOCH STUDENTS <u>ONLY</u>:

Because our clinic is a training center for students in the clinical psychology doctoral program and services many Antioch students, we try to make your coming to therapy here as comfortable as possible. Of course we cannot guarantee invisibility in light of these circumstances, but we do our best to eliminate or minimize any encounters with your peers or faculty that could be awkward for you. Nevertheless, there may be elements of discomfort reasonably attached to the traffic areas in reception.

There exists a possibility that two students from the one program may see the same clinician. We do our best to avoid such conflicts; however, we may not always be able to do so. We invite you to let your desires about visibility be known to us as soon as you make your first contact within the intake interview process. We also ask for your help in alerting us to any existing or reasonably predictable potential conflict.

Recently Antioch University made a push for all new students to "friend" each other on Facebook or connect via other social media sites. Although you may not directly know one of our clinicians, it is clinic policy to "unfriend" patients and prohibit the use of social media as well as email contact with clinicians here at the Psychological Services Center.

By initialing the box, I understand the PSC's policy for Antioch students.

AGREEMENT:

I have read the information contained in the **Consent Form** and I fully understand my rights and obligations as a patient at the Antioch Psychological Services Center. I freely agree to treatment.

If patient is under 18 years of age please add names of other people who have <u>your permission</u> to be picking up your child after therapy.
_____

_____

_____   _____
Printed Name of Patient/Child/Couple   Printed Name of Parent (if patient under 18 years old)

_____   _____
Signature of Parent (if patient under 18 years old)/Patient/Couple   Date

_____   _____
Signature of Clinician   Date

Appendix B: Working Alliance Inventory—Short Revised (WAI-SR)

Working Alliance Inventory – Short Revised (WAI-SR)
Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

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

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe____likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ____and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ____and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. ____and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that____appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

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

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

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

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

Note: Items copyright © Adam Horvath. Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12; Bond

Items: 3, 5, 7, 9

March 31, 2019

Jordan Stewart, M.S.

███████████████
████████████████████████████
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Dear Ms. Stewart,

You have our permission to use the Working Alliance Inventory-Short Form (WAI-SR) in your dissertation study using archival data. Please be aware that we require publishing the following note at the end of the measure:

Reprinted by permission of the Society for Psychotherapy Research © 2016.

We wish you the best in your work. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

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