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The Effects Of Meta-Communication Training On Therapeutic Process And Outcome At A University Counseling Center

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THE EFFECTS OF META-COMMUNICATION TRAINING ON THERAPEUTIC PROCESS AND OUTCOME AT A UNIVERSITY COUNSELING CENTER

by

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CHAPTER 1

INTRODUCTION

The origin of serious psychotherapy research was stimulated by the early report of Eysenck (1952), who concluded that psychotherapy performs worse than no therapy at all! Since that time, a multitude of controlled studies of psychotherapy outcomes, and many subsequent meta-analyses of these studies, have been conducted, which clearly demonstrate the overall benefits of therapy. Smith, Glass, and Miller (1980) included 475 studies comparing treated and untreated groups. They found an average effect size of .85 standard deviation units, indicating that the average treated person is better off than 80% of those left untreated. The average effect size for general therapy is .82, whereas the average placebo effect size is .42. Several studies examining the broad effects of psychotherapy have been completed which consistently substantiate the benefits of treatment (Lambert & Ogles, 2004).

Empirically-supported treatments (EST) are helping clinicians to gain a better understanding of which treatments work for specific disorders. Outcome research has become more rigorous in recent years. More focused meta-analyses of therapy efficacy look at specific treatments for specific disorders. For example, much of this work has been conducted on unipolar depression. The reviews suggest that treatment for depression surpasses no-treatment and wait-list control conditions (Dobson 1989; Gerson, Belin, Kaufman, Mintz, & Jarvik, 1999; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Lambert, Hatch, Kingston, & Edwards, 1986; Robinson, Berman, and Neimeyer, 1990). However, many other disorders, including anxiety disorders (Abramowitz, 1997; Allen, Hunter, & Donohue, 1989; Clum, 1989; Cox, Swinson,

Morrison, & Lee, 1993; Gould, Otto, Pollack, & Yap, 1997; Sherman, 1998; Trull, Nietzel, & Main, 1988), eating disorders (Fettes & Peters, 1992; Hartmann, Herzog, & Drinkmann, 1992; Lewandowski, Gebing, Anthony, & O'Brien, 1997), and substance dependence (Agosti, 1995; Walters, 2000) have also been studied in randomized, controlled trials, and psychological treatments have routinely been found to be effective for these conditions as well.

In addition to examining the statistical significance of psychological treatments, researchers have increasingly examined the clinical significance of psychotherapy, such as in improving symptoms to a clinically relevant degree, falling to a normal range of functioning, or being indistinguishable from nondeviant peers. Lipsey and Wilson (1993) illustrated the point of clinical significance by comparing psychotherapy outcomes to medical interventions. There are a number of medical interventions that have small effect sizes but substantial ramifications in life and death situations, demonstrating that small effects in critical situations can be very important. For example, meta-analyses have demonstrated that the treatment of obsessive-compulsive disorder and depression produce not only statistically but also clinically significant outcomes (Abramowitz, 1998; Hansen, Lambert, & Forman (2002); Ogles, Lambert, & Sawyer, 1995).

Although many individuals experience clinically significant improvements in adaptive functioning, there are many who do not. Poor treatment outcomes may be due to insufficient or inadequate treatment of clients. For some, treatment ends prematurely before an adequate dose of treatment can be provided. In a meta-analysis conducted by Wierzbicki and Pekarik (1993), it was found that 40-50% of outpatient clients

terminated treatment prematurely. Additional reviews of attrition rates in psychotherapy report that 20-57% of clients failed to return after their first visit to general psychiatric clinics (Baekeland & Lundwall, 1975). Baekeland and Lundwall (1975) also reported that 31% to 56% attended 4 or less therapy sessions. Blackwell (1976) found similar attrition rates and nonadherence to treatment across a variety of clinical populations. The modal number of therapy sessions is one, the median is 3 to 5 sessions, and the mean is 5 to 8 sessions (Phillips, 1985). This finding is consistent in community clinics and among university counseling centers; however, there has been far less empirical research conducted on premature termination among college students (Phillips & DePalma, 1983). One study of a university counseling center, however, found that the "no show" rates immediately following the intake interview range from 20% and 25% (Epperson, Bushway, & Warman, 1983).

Baekeland and Lundwall (1975) identified several client and therapist characteristics associated with premature termination, but these findings have not been systematically explored in the university student population. Client factors that predict early attrition among outpatient clinics include being in a precontemplation or contemplation rather than preparation or action stage of change (Rochlen, Rude, & Baron, 2005), low socioeconomic status and social instability (Baekeland & Lundwall, 1975), lower levels of education, and being an ethnic minority (Garfield, 1994). These client characteristics may lead to premature termination of treatment because they are related to lower levels of client education about the therapeutic process (Garfield, 1994). These factors may also influence premature termination among university counseling center clients. Research on counseling center clients has identified additional variables

associated with premature termination in this population, including there being a long time period between the intake interview and the onset of regular therapy (Rodolfa, Rapaport, & Lee, 1985), the lack of pretherapy training (Mennicke, Lent, & Burgoyne, 1988), “low counseling-ready” clients (Heilbrun, 1972; Cartwright, Lloyd, & Wicklund, 1980), unmet expectations about the therapeutic process (Gunzberger, Henggleler, & Watson, 1985), and dissatisfaction with the counseling center (Greenfield, 1983; Kokotovic & Tracey, 1987; McNeill, May, & Lee, 1987).

Inadequate treatment may also account for poor outcomes among some therapy clients. Although a considerable body of research exists indicating that psychotherapy is effective in relieving psychiatric symptoms, many of these large effect sizes are limited to small to moderate levels of symptomology (Thase et al., 1997). In more severe cases, clinically significant improvement was obtained only through combined treatment that included therapy plus medication. Also, there is a significant portion of clients that may show improvement immediately following treatment, but later experience a relapse (Lambert & Ogles, 2004). Finally, there are some clients who are worse off after receiving treatment than at the onset of therapy (Bergin & Lambert, 1978: Lambert, Bergin, & Collins, 1977). Mohr (1995) examined a large number of studies to determine factors associated with negative outcomes in psychotherapy. He found that clients with interpersonal difficulties and more severe levels of pathology at the beginning of treatment were more likely to be negatively impacted by therapy. Therapist variables that may contribute to poor outcomes included lack of empathy, underestimation of symptom severity, and negative countertransference (Mohr, 1995).

Lambert and Ogles (2004) estimate that 5% to 10% of clients deteriorate while in therapy.

This body of research suggests that there is a need to determine methods to improve outcomes for more clients, including reducing early termination and increasing time in treatment. This dissertation will focus on one such process, which is developing, maintaining, and repairing the therapeutic alliance.

Therapeutic Alliance

Competent therapists of all orientations establish an emotional bond and collaborative relationship with receptive clients. This relationship is the foundation of the work done in psychotherapy. The therapeutic alliance is operationalized as a supportive common factor in psychotherapy research (Lambert & Ogles, 2004), and a substantial amount of research suggests that it is very predictive of outcomes. Gaston (1990) integrated the various constructs of the therapeutic alliance and proposed that it consists of four core components: the client's affective relationship to the therapist; the client's capacity to work in a meaningful way in therapy; the therapist's involvement and empathic understanding of the client; and the client-therapist agreement on tasks and goals of therapy. Bordin's (1979) model of the therapeutic alliance has been most influential and widely studied, however, and consists of three components: agreement on goals, agreement on tasks, and the quality of the affective or relational bond. A sound or adaptive therapeutic alliance occurs when the therapist and client mutually agree on the desired outcomes of the therapeutic process, and they both agree on the tasks by which these goals will be accomplished. The bond refers to mutual trust and acceptance between the therapist and client.

Given the significant theoretical and research interest in the therapeutic alliance, researchers have developed various measures of this construct. There are at least eleven measures of therapeutic alliance, which can be assessed from the perspective of the therapist, client, and independent observer. Measures of therapeutic alliance have two core components; ratings of personal attachments, and the collaboration and willingness to invest in the therapy process (Horvath & Luborsky, 1993). Measures of the alliance might also tap active participation in therapy, acceptance of therapy tasks, agreement of therapy goals, the capacity to form a relationship, and therapist and client positive and negative contributions.

Numerous studies on the predictive validity of the therapeutic alliance have been conducted, and a range of effect sizes has been reported (Gaston, Marmar, Gallagher, & Thompson, 1990; Horvath & Symonds, 1991; Luborsky, 1990). A meta-analysis conducted by Martin, Garske, and Davis (2000), which updated an earlier meta-analysis by Horvath and Symonds (1991), reported that the therapeutic alliance had an effect size predicting treatment outcome of $r = 0.22$ across 79 studies. Horvath and Symonds (1991) initially found an effect size of $r = 0.26$ across 26 studies. They also found that the early alliance was a better predictor of outcome than the alliance measured in the middle of therapy ($r = .3$ compared to $r = .2$). Early ratings of the therapeutic alliance (after the first three sessions) have consistently been shown to be a robust predictor of treatment outcome above and beyond the variance accounted for by symptom severity (Adler, 1988; Horvath, 1981; Moseley, 1983; Plotnicov, 1990; Safran & Wallner, 1991; Wallner & Samstag, 1992). Gaston found that the alliance accounted for 36-57% of the variance in post-therapy outcome beyond short-term improvements (Horvath &

Luborsky, 1991). In contrast, a poor alliance after the first session is a strong predictor of premature, unilateral termination (Kokotovic & Tracey, 1990; Plotnicov, 1990). Studies indicate that the client's perception and contribution to the alliance is a better predictor of outcome than is the therapist's perception.

Some of the client characteristics that contribute to a positive alliance include being ready to engage in therapy and the ability to relate well to others. Clients who are likely to establish a positive alliance tend to be more submissive, isolated, and friendly. Clients are also more likely to develop a positive alliance with the therapist when they perceive similarities in personality and values (Kuentzel, 2001). Conversely, those clients who are more hostile, aggressive and dominant tend to form more negative alliances (Binder & Strupp, 1997). Also, those clients who are very dependent, have negative expectations for therapy, or are extremely sensitive, suspicious or hostile tend to have poorer alliances and outcomes (Binder & Strupp, 1997). Horvath and Luborsky (1993) found that clients who have difficulty maintaining social and family relationships, are defensive and not psychologically minded have poor alliances. The therapeutic alliance is not significantly affected by the type of therapy or the cross-gender combinations between therapist and client (Horvath & Luborsky, 1993, Goren, 1991).

Ruptures in the Therapeutic Alliance

Although several decades of research have demonstrated the predictive validity of the therapeutic alliance and the factors that contribute to it, there has been very little work done on how to develop or maintain the alliance. Recent research, however, has focused on ruptures in the therapeutic alliance, how those ruptures can be repaired, and the impact of this process on treatment outcomes (Safran, Muran, Samstag, & Stevens,

2002). According to Bordin's conceptualization, a rupture in the therapeutic alliance means that there is disagreement between the therapist and client on the goals and/or tasks of therapy or that there is a strain on the bond within the dyad. Some indications that a rupture in the alliance has occurred may include a direct or indirect expression of negative feelings, either non- or overcompliance by the client, avoidance behaviors or non-responsiveness to therapy. Studies have shown that attempts to repair ruptures in the therapeutic alliance may lead to improved treatment outcomes. However, there also are data indicating that therapists and clients often fail to address ruptures in the alliance over the course of treatment.

Failing to address ruptures in the alliance generally leads to unilateral termination of treatment on the part of the client or to a stalled therapy that makes little gains. Premature termination may occur because the client becomes overwhelmed by the therapeutic process or feels unsatisfied with the process. Many clients feel obligated to show the therapist deference in the therapeutic relationship. This deference may prevent the client from discussing their concerns about therapy with the clinician. Therefore, the therapist does not have an opportunity to address these concerns. Rennie (1994) conducted qualitative research demonstrating that clients' deference to therapists played a significant role in therapeutic interactions. Some of the factors associated with client deference include a fear of criticizing the therapist, a need to meet the therapist's perceived expectations, acceptance of the limitations of the therapist, fear of threatening the clinician's self-esteem, and a sense of indebtedness to the therapist.

There is also research that suggests that when therapists are aware of the clients' negative feelings toward them, that it may be detrimental to outcome (Lambert & Ogles, 2004; Safran et al., 2002). Patterns of therapist responding include increasing adherence to the treatment orientation in an inflexible way, or responding to the clients' negative feelings by expressing their own in a defensive manner. Castonguay, Goldfried, Wiser, and Raue (1996) looked at the outcome of cognitive therapy for depression and found that focusing on intrapersonal consequences was inversely related to improvement.

Given that the modal number of therapy sessions is one (Philips, 1985), it is important to address the alliance and orient the client to the alliance as early in the process as possible. It appears important for the therapist to intervene to address ruptures in the alliance (Horvath & Luborsky, 1993). Safran et al. (2002) proposed a model of meta-communication in session that specifically outlines a process by which alliance ruptures can be addressed and repaired, thereby improving the therapeutic alliance and subsequent treatment outcomes. Meta-communication means that a therapist talks non-defensively with a client about the communication process that the two of them are engaging in. Their model focuses on addressing ruptures in the alliance either directly or indirectly at the surface level or by examining underlying factors. Within this model, ruptures in the therapeutic alliance are addressed once the therapist detects an alliance strain or rupture. Yet, there is a substantial need to study how meta-communication regarding the alliance might affect the change process or influence treatment outcomes by preventing ruptures in the therapeutic alliance. Introducing the client to the importance of meta-communication early in therapy might

be considered a “psychotherapy orientation” technique, and there is a literature on such therapy orientations, or pretherapy training.

Orienting clients to psychotherapy

Orienting clients to the therapy process provides them with a better understanding of the roles of the client and therapist, how therapy can be helpful, and familiarizes them with information on what psychotherapy is and what to expect. Three broad categories of psychotherapy preparatory techniques include role induction, vicarious therapy pretraining, and experiential pretraining (Walitzer, Dermen, & Connors, 1999). There are various techniques used to orient clients to the psychotherapy process including one-on-one preparatory interviews by the therapist, lecture-discussion formats, and multimedia (video taped, audio taped and slide) presentations. These techniques have been utilized with individual clients and with therapy groups across theoretical orientations. They have been effective in reducing attrition rates and increasing utilization and treatment efficacy (Strupp, 1980).

Role induction (RI) techniques seek to clarify client and staff roles and address misunderstandings about the treatment process. Orientation programs are conducted in substance abuse treatment centers where retention is generally poor (Stark & Kane, 1985). Client misperceptions about the treatment process may negatively impact motivation for treatment as well as retention. Role induction techniques are shown to enhance treatment compliance and improve retention rates. Katz et al. (2004) found that clients participating in a drug-free outpatient program who were given a RI orientation were retained for more days, more likely to attend post-orientation sessions and more satisfied with treatment than those not provided with RI orientation. Ilardi and

Craighead (1994) argue that providing a client with a rationale for treatment acts as a common factor in cognitive behavioral therapy and may influence positive change before an adequate dose of CBT interventions can be administered to the client.

Vicarious therapy pretraining provides examples of actual therapy sessions for clients through the use of audio/visual, lecture, interview and written material. This technique gives the client an idea of how therapy sessions may be conducted and gives the therapist an opportunity to provide the client with models of ideal client behavior. These behaviors might include self-disclosure, confrontation, interpretation and support (Connell & Ryback, 1978). France and Dugo (1985) found that vicarious therapy pretraining resulted in improved attendance and lower drop out rates. Several studies on this technique indicate that it has the potential to positively influence attendance, process, and outcome (Walitzer et al., 1999).

Experiential pretraining allows the client to actually attempt and practice various behaviors that may occur during therapy. The client is engaged in exercises that allow him or her to role-play model behaviors such as self-disclosure and emotional processing. This technique is usually used in group therapy but may be applied to individual therapy as well. Studies indicate that this technique may positively influence attendance, but has not been shown to have a significant impact on process or outcome (Walitzer et al., 1999).

Pretraining on meta-communication regarding the therapeutic alliance

Given the impact that the therapeutic alliance has on therapy outcome, it is important for clinicians to do whatever possible to form a positive alliance as early in the process as possible. Helping clients acquire accurate expectations of the therapeutic

process will likely facilitate the development of a positive alliance and prevent later ruptures that could impair treatment. Orientation programs have been found particularly helpful for low-income and minority clients (Acosta, Evans, Yamamoto & Wilcox, 1980; Acosta, Yamamoto & Evans, 1992; Acosta, Yamamoto, Evans & Skilbeck, 1983). This research indicated that orientation programs might lead to favorable attitudes toward the therapeutic process for clients (Jones & Matsumoto, 1982).

Preparatory techniques may provide a positive prognosis expectancy leading to increased treatment attendance and outcome. Clients may be shown how to assertively express themselves during therapy and communicate their needs to the therapist. The therapist and the client can align their expectations for therapy, the amount of work to be conducted outside of the therapy session, and the frequency and length of therapy sessions. Clarifying these expectations may lead to greater treatment adherence and satisfaction on the part of the client. Therapy pretraining may also be used to demonstrate positive client behaviors and proactively address potential negative reactions to therapy (Walitzer et al., 1999).

It would be worthwhile to examine the impact of addressing meta-communication in the therapy relationship prior to ruptures occurring. Meta-communication during the therapy session regarding alliance ruptures is an issue worth examining, but there is little empirical evidence available to assist in the development of specific recommendations for addressing this important process factor. To date, there has not been research conducted on the effects of orienting clients to meta-communication about the therapeutic alliance early in therapy. Safran and Muran (2002) have investigated the potential benefit of using meta-communication to repair ruptures in the

therapeutic alliance. However, this is very different than utilizing client orientation techniques regarding meta-communication as a preventive measure.

For instance, role induction and experiential pretraining regarding the therapeutic alliance could be combined to introduce the client to the concept of the alliance and allow them to practice meta-communicating with the therapist at the onset of treatment. In a meta-communication orientation intervention, the client would be provided psychoeducation on the three components of the therapeutic alliance (agreement on goals, agreement on tasks, and the bond) and information regarding the predictive validity of the alliance. They could then be provided with an opportunity to role-play meta-communication with the therapist. During this exercise, the client would receive feedback designed to foster assertive, non-defensive meta-communication. It is possible that introducing meta-communication early in treatment will reduce the rates of premature termination and set the stage for helping clients to deal with issues normally not disclosed.

The changing demographics of university students warrant further exploration of pretraining procedures with this population. University counseling centers are a significant source of mental health services in this country. Approximately 9% of enrolled students seek counseling each year (Minami et al., 2009). University students are presenting with issues similar to those found in community clinics such as depression, substance abuse, eating disorders, sexual assault and personality disorders (Rudd, 2004). Many counselors perceive an increase in the severity of presenting issues over the past ten years (Benton, Robertson, Tseng, Newton, & Benton, 2003). It is unclear at this time if the perceived changes in college student

mental health reflect actual increases in pathology or if the observation is a consequence of the changing population on college campuses. Between 1988 to 2000, the percentage of 18- to 24-year olds that attended college increased from 30% to 37%. Also, the number of university students who come from disadvantaged backgrounds or lower socioeconomic status is increasing as the importance of higher education in this society is made clear and a range of cost options for students become available (Rudd, 2004). As noted previously, lower SES is predictive of premature termination of therapy, which further warrants the development of pretraining procedures for the college student population. Given the high drop out rates among counseling center clients and follow-up data showing that only 29% of those that terminate prematurely report that their issues were resolved (Mennicke, Lent, & Burgoyne, 1988), the effectiveness of therapy with this population could be improved substantially.

The goal of this study was to test the effects of a novel meta-communication orientation technique utilized in the first session of therapy with clients in a University counseling center. This study consisted of an experimental design with random assignment of whether or not a client received the meta-communication orientation intervention. The meta-communication orientation technique introduced participants to the concept of the therapeutic alliance, emphasized the importance of addressing alliance ruptures or strains as they occur, and then engaged them in a short exercise to demonstrate how to discuss alliance concerns in session.

It was hypothesized that, compared with student clients who were in the control condition and who received no additional meta-communication orientation, those clients who received the meta-communication orientation would:

1) show higher positive mood and control and reduced arousal after the orientation session and after subsequent sessions;
2) rate the therapeutic alliance more positively;
3) show greater symptom improvement at sessions 3 and 6;
4) attend more sessions of therapy; and
5) be rated by counselors as having more overall improvement from therapy.

CHAPTER 2

METHODS

Participants

Participants were 44 University of Michigan – Flint (UMF) students who voluntarily requested psychological services at the UMF Counseling Services (CS). Counseling Services provides free counseling and assessment services to University of Michigan – Flint students (both undergraduate and graduate), the majority of whom participate in short-term counseling for psychological problems (i.e., anxiety, depression, stress, academic problems). Included students were specifically seeking services for counseling or psychotherapy rather than evaluations, workshops, or crisis counseling, which CS also provides.

Potential participants were excluded if, during the intake process, it was determined that the client's presenting concerns are beyond the scope of the counseling center requiring that s/he be referred to a community provider (i.e., the presenting issue required more than twelve sessions to be adequately addressed). Clients who were suicidal or actively psychotic were excluded from the study. Clients were also excluded if the presenting issue typically warranted a disposition evaluation, such as learning disability or test anxiety. Of 46 students who consented to participate, two were excluded due to serious mental illness or active suicidality.

This study analyzed data from 44 participants. The 44 participants included in the data analysis were aged 18 to 52, with a mean age of 25.89. The sample was 79.5% female, and the ethnic composition was: 77.3% Caucasian, 11.4% African American, 4.5% Latina/o, and 6.8% mixed ethnicity. Approximately 43% of the sample

had been in counseling previously, and 23% were currently taking psychotropic medications.

Four counselors participated in the study as team members. One of the therapists (Therapist B) was male and had a doctoral level degree, two therapists (Therapists A and D) were female and had master's degrees, and one therapist (Therapist C) was female and had a bachelor degree. Factors that influenced how participating clients were assigned to each therapist included the age of the participant and severity of clinical symptoms at intake. Therapist B was limited to seeing clients aged 21 and under. Therapist C, a graduate intern, was assigned clients appropriate for her skill level, following a developmental model in which the level of impairment increased over the course of the internship.

Procedure

Recruitment. Potential participants (clients) were identified through the intake process at CS. At the end of the intake process, any client who did not need immediate (crisis) services or meet exclusion criteria was given the research study Consent Form. In the research study Consent Form, clients were asked to participate in a study designed to assist CS staff members in finding ways to improve services to CS clients. All clients were informed that there were forms that they needed to complete either before and/or after the therapy session. If the client declined participation, standard therapy was given as usual. If the client agreed and signed the written informed consent to participate (which was approved by the Institutional Review Board; Appendix A), then they were enrolled in the study. A procedural flowchart, which outlines each step completed in the study, can be found in Appendix B.

Intake Process. The intake process was completed using Titanium Schedule, which is software specifically designed for scheduling, clinical documentation, and reporting in counseling centers. The client completed the Standardized Data Set (SDS) and the Counseling Center Assessment of Psychological Symptoms (CCAPS). The CCAPS is an intake measure that provides information on current functioning across several domains. Through this process, clients provided demographic information, information regarding the presenting problem, and basic psychological, social, suicidal, and medical histories. Clients also completed additional data forms that obtained information on emergency contacts and health insurance. The Confidentiality Statement and Informed Consent form was completed in hard copy. After clients completed the intake process, they were scheduled for a first appointment.

Data Collection. Data collection extended through the 6th counseling session; however no data were collected during sessions 4 or 5. All participants completed the same measures at the same time point regardless of experimental condition. Baseline measures included the Standard Data Set (SDS) and the Counseling Center Assessment of Psychological Symptoms (CCAPS). Clients and therapists were blind to their experimental group when baseline measures were completed. Following sessions 1, 2, 3, and 6, participants completed the Working Alliance Inventory (WAI), the Self Assessment Manikin (SAM), and the Post-session questions. Participants were asked to complete the CCAPS at intake and prior to sessions 3 and 6.

Therapists completed the WAI and Post-session measures following sessions 1, 2, 3, and 6. The post treatment data consisted of a Treatment Summary Form and

Global Rating of Improvement. Therapists also reported the number of sessions attended through termination or session 12, whichever was later.

Experimental Conditions

After completing baseline measures, clients were randomly assigned to an experimental group via pre-randomized packets; blocking in sets of 2 was done prior to randomization so that equal numbers of clients end up in the two experimental groups. In addition, randomization was stratified by therapist; that is, separate randomization schemes were used for each therapist so that each therapist would treat an equal number of clients in each experimental condition.

Of the 44 clients enrolled in the study, 20 participants were randomized to the meta-communication orientation group, and 24 participants to the control group. Those participants in the control group received the standard introduction to therapy at the beginning of the first session. The intake session then proceeded as normal. The standard introduction to therapy consisted of the following:

Standard Counseling Introduction

All clients in the study received the standard counseling introduction. This included the therapist's name, discipline, a description of credentials and disclosure of the supervisor's name. The therapist then reviewed confidentiality with the clients and informed them of limitations to confidentiality, which included imminent risk of harm to self or others, the reported abuse or neglect of a child, the elderly, or a disabled person abuse, or the issuance of a court order for treatment records. The clients were also advised that other staff members in the Student Development Center (SDC) may be aware of their identity due to the interactions involved in checking in clients for a

session; contacting clients to cancel or reschedule appointments for counselors that may be ill or out of the office for some other reason; and when clients engage in disruptive behaviors within the SDC. The clients were then provided with basic information regarding the frequency of sessions (weekly appointments), the brief treatment model of care utilized by CS, and the limitations of services (i.e., 12 session limit). Control group clients received only this information, but did not receive any discussion about meta-communication or the relationship with the therapist.

Meta-communication Orientation

Those participants randomized to the experimental condition received the standard introduction to therapy as outlined above, and the first session proceeded as usual until the last 5 to 10 minutes of the session, at which point, they received the following meta-communication orientation. They were provided with information regarding the therapeutic alliance (TA) and meta-communication about the TA, and then engaged in a brief demonstration of engaging in meta-communication about the TA. The meta-communication orientation training proceeded as follows:

1. The client was provided with an introduction to the three components of the therapeutic alliance based on Bordin's (1979) model. A simple diagram was utilized to help the client understand this concept (See Appendix C).

"I'd like to take a few moments to discuss an important part of therapy, our work together, something called the therapeutic alliance, or how we work together. The therapeutic alliance has three main components to it: our agreement on the goals of therapy, our agreement on the way that we reach the goals of therapy, and the bond or connection between you and me."

2. The client was informed of the predictive validity of the therapeutic alliance.

"Studies have shown that how well we work together is a good predictor of how well counseling will turn out. If you and I agree on the goals and tasks of counseling as well as feel connected and in support of one another, then counseling goes very well, and you will probably have a good outcome. If one or more of these three parts isn't working so well, then counseling sometimes doesn't go as well. Throughout the time that we work together, it's really important that we're working towards the same things. It's also very important that our work together feels comfortable and safe for you. We'll discuss goals for your counseling and things to do to reach those goals."

3. Strains in the alliance were described and the importance of meta-communicating was discussed.

"There likely will be times when we might misunderstand each other or that we will not agree on our goals or what we should do to reach those goals. We also might be struggling to feel connected to each other. These difficult times may put a strain on our relationship, at least temporarily. It's very important that we can talk openly about these situations."

4. The client was invited to provide input on how s/he would like to address any disagreements or disconnection during the counseling process.

"How would you like to discuss these struggles if they occur? (Pause and wait for response from the client.)"

5. The client engaged in a role-playing activity to practice discussing how s/he would handle a disagreement of "tasks". When necessary, the client's responses

were shaped until s/he generated direct statements without manifesting much anxiety or defensiveness.

“What would be a way that you could tell me that you disagree with or don’t understand something that I’ve said or suggested?” (Pause and wait for response from the client. The therapist might need to provide a specific phrase for the client to use, such as “Tamara, I don’t like your suggestion…” Have client repeat until it seems genuine (non-defensive).

6. Once the client engaged in genuine, assertive communication, s/he was reinforced for his or her efforts.

“That’s a great job, talking to me directly about something that you don’t like or you disagree with.” Now, when this actually happens in our work together—when you are feeling like we are disagreeing or feeling bothered by something I do or say, please make sure that you let me know, just like you did right now. Please don’t worry about hurting my feelings or worry that I’ll be mad at you. It is very important that you let me know what you are thinking and feeling about how we are working together. OK?”

7. The client was asked to provide advice on how s/he would like the therapist to discuss any concerns that the therapist has regarding the therapeutic alliance.

“It also is possible that I might have some concerns about how we are working together. What should I do if I have concerns or disagreements with you? (Pause and wait for response from the client. If they do not suggest it, then bring up therapist meta-communicating.) If it’s OK with you, I would like your

permission to be up front with you and let you know my thoughts or concerns. Is that OK?"

8. The discussion of meta-communication during the counseling process closed by asking the client to address any concerns as we move forward.

"Great! Let's make sure that as we move forward, we both bring up any concerns that we have. Are you up for that? Did this discussion help you, or did I scare you or upset by bringing it up?"

Once the first session was completed, all clients (in both conditions) were scheduled for the next session and asked to complete the post-session measures. The client was provided instructions on completing these measures, and instructed to place them in a drop box before leaving. The clients were reminded that their responses would remain confidential and that the therapist did not have access to that information over the course of therapy. The client was asked to return to the waiting area to complete the forms. This concluded the first session. The therapists completed the forms in their office and dropped them into the box in the main office. All forms had a unique client code on them, but not client or therapist names. A separate file linking codes to names was maintained on the PI's password-protected computer. Throughout the study, the therapist reminded the client of the measures to be completed before and/or after each session.

Measures

Outcome Measures

CCAPS. The participants completed the Counseling Center Assessment of Psychological Symptoms (CCAPS) at intake and before sessions 3 and 6. The CCAPS

is an instrument that was designed to be a quick, yet effective means of assessing college student mental health. It is a 62-item instrument with eight subscales that measure: depression, generalized anxiety, social anxiety, academic distress, eating/body image issues, family issues, hostility, and substance use. The items are scored on a five-point likert scale from "0 – not at all" to "4 – extremely well". Clients are asked to indicate how well each item describes them over the past two weeks. All reliability coefficients for each of the eight subscales were calculated using Cronbach's alpha and were greater than .80, with the highest being .93. The CCAPS was also found to be a valid measure able to distinguish between clinical and non-clinical populations (Soet & Sevig, 2006).

Working Alliance Inventory (WAI). Both clients and therapists independently completed the Working Alliance Inventory – Short Form (Tracey & Kokotovic, 1989; Appendices D and E) to assess therapeutic alliance at the end of each of sessions 1, 2, 3, and 6. This 12-item self-report questionnaire was taken from the Working Alliance Inventory (Horvath, 1981) and has four subscales: Total, Task, Goal, and Bond. Tracey and Kokotovic (1989) found the internal consistency, Cronbach's α, of the WAI-S client version was 0.98 and the therapist version was 0.95 (n= 124).

Self-Assessment Manikin (SAM). Clients completed the Self-Assessment Manikin (Hodes et al., 1985; Appendix F) after sessions 1, 2, 3, and 6. The SAM is a valid measure allowing participants to rate three dimensions of underlying emotion; valence (displeasure/pleasure), activation (arousal/calmness), and control (in control/controlled). The SAM was presented to the participants in a paper format in which they will circle the figure corresponding to their current emotional state with a

scale of “1” to ‘5”. The valence dimension allows the participant to indicate if s/he is feeling completely unhappy (annoyed, unsatisfied, melancholic, despairing or bored) through a range to feeling completely happy (pleased, satisfied, contented and/or hopeful). The activation dimension allows the participant to indicate if s/he is excited (stimulated, frenzied, jittery, wide-awake, and/or aroused) through a range to calmness (relaxed, sluggish, dull, sleepy, and/or unaroused). The final dimension, controlled/in-control allows the participant to indicate that s/he feels controlled (influenced, cared-for, awed, submissive, and/or guided) or in-control (influential, important, dominant, and/or autonomous). For the valence and activation scales, lower scores (closer to 1.0) indicate greater positive valence and arousal. For the control scale, higher scores (closer to 5.0) indicate greater control.

Experiencing Scale. Following sessions 1, 2, 3, and 6 therapists rated their client’s level of experiencing from that session. The experiencing scale is a one-item scale and developed by Greenberg and Safran (1989; Appendix G) and rates the clients' ability and willingness to process issues in a meaningful way and be actively involved in the therapeutic process. This scale reflects the client’s level of productive engagement in the therapeutic process and integrates the cognitive and affective components of an experience into a meaningful entity.

Post Session Questions. Following sessions 1, 2, 3, and 6, clients and therapists answered questions pertaining to that specific session (Appendices H and I). There are seven items (client version) or eight items (counselor version) that utilize a 7-point likert scale to assess the similarity between the client and therapist and the degree of meta-

communication taking place. The measure also records the number of issues/topics discussed during the session.

Attendance. The therapists reported the total number of sessions attended by each participant. The total number of sessions attended by the client, through session 12, was utilized in the data analysis.

Therapist Rating of Global Improvement. At the end of the counseling (or after 12 sessions if therapy was continuing), counselors reported an overall impression of the client's improvement on a simple scale ranging from "worsening," "no change," "a little improvement," "moderate improvement," and "much improvement" (Appendix J).

CHAPTER 3

RESULTS

Comparison of Experimental Groups at Baseline

There were 44 clients who consented to participate and were randomized to the two experimental groups. An initial analysis of the CCAPS and demographic data collected at baseline was conducted to determine if the randomization process created equivalent groups. Independent samples t-tests were conducted on the age, grade point average, and CCAPS data. Chi-square tests of equivalence were conducted on the gender and race variables.

Demographic data for both experimental conditions is presented in Table 1. The two experimental groups did not significantly differ on key demographic variables including age ($t(42) = 0.39$, $p=.70$), grade point average ($t(34) = 0.20$, $p=.85$), gender ($\chi^2(N = 44) = 0.47$, $p =.50$), or race ($\chi^2(N = 44) = 3.15$, $p =.08$). (Race was dichotomized to Non-white and White participants.) However, there was a marginal imbalance of race between the experimental conditions with slightly higher proportion of non-whites than whites in the meta-communication condition than in the control condition. There were no significant differences between the experimental groups in the proportion of participants who had a history of previous treatment ($\chi^2(N=44) = 0.70$, $p = .41$) or those currently taking psychotropic medication ($\chi^2(N=43) = 1.06$, $p=.30$).

Table 1: Demographics of study participants

	Meta-Comm	Control	p-value
	n = 20	n = 24	
Gender			
Female	15 (34.1%)	20 (45.5%)	.50
Male	5 (11.4%)	4 (9.1%)	
Race			
Non-white	7 (15.9%)	3 (6.8%)	.08
White	13 (29.5%)	21 (47.7%)	
Previous Treatment			
No	10 (22.7%)	9 (20.5%)	.41
Yes	10 (22.7%)	15 (34.1%)	
Medication			
No	16 (37.2%)	17 (39.5%)	.30
Yes	3 (7.0%)	7 (16.3%)	

An ANOVA was conducted on the CCAPS data (symptoms) to determine if there were significant differences between the experimental groups at baseline. There were no significant differences between the two groups on depression ($t(41) = -0.82$, $p = .42$), generalized anxiety ($t(41) = 0.33$, $p = .74$), social anxiety ($t(41) = 0.19$, $p = .85$), academic distress ($t(41) = 0.17$, $p = .86$), eating/body image issues ($t(41) = 0.69$, $p = .49$), hostility ($t(41) = 1.57$, $p = .12$), or substance use ($t(41) = 0.85$, $p = .40$). A significant difference was found on the family distress scale ($t(41) = 2.19$, $p = .03$), with control group participants reporting higher levels of family distress than their counterparts in the meta-communication condition. These data are presented in Table 2.

Table 2: Clinical Data at Baseline (CCAPS), T-scores

Scale	Meta-Comm n=19	Control n=24	p-value
	Mean (SD)	Mean (SD)	
Depression	56.58 (9.25)	54.29 (8.89)	.42
Generalized Anxiety	53.58 (10.55)	54.63 (10.23)	.74
Social Anxiety	51.89 (11.99)	52.54 (10.38)	.85
Academic Distress	53.68 (8.96)	54.13 (7.67)	.86
Eating/Body Image	52.89 (11.91)	55.25 (10.41)	.49
Family Problems	54.68 (11.42)	61.67 (9.52)	.03
Hostility	51.47 (10.14)	56.71 (11.36)	.12
Substance Use	47.00 (8.79)	49.83 (12.14)	.40

Randomization of Participants Across Therapists

A chi-square test of equivalence was conducted to determine if the randomization process was successful in assigning participants equally to counselors. As expected, given the stratification process, there were no significant differences between conditions as a function of counselor (x^2(n=44) = 0.10, p = .99). This data is presented in Table 3.

Table 3: Counselor Caseload, n=44

Counselor	Meta-Comm	Control	p-value
	n=20	n=24	
A	6 (13.6%)	8 (18.2%)	.99
B	4 (9.1%)	5 (11.4%)	
C	3 (6.8%)	3 (6.8%)	
D	7 (15.9%)	8 (18.2%	

Primary Analyses of Process Measures

Independent samples t-tests were conducted on the Self Assessment Manikin (SAM), Working Alliance Inventory-Client and Counselor (WAI-Client, WAI-Counselor), Experiencing Scale (EXP), Post Session Questionnaires, and Treatment Outcome data. Also, t-tests were conducted on the CCAPS change scores, which compared baseline data to session 3 and session 6 data, respectively. The analyses were conducted on

sessions 1, 2, 3, and 6 separately because of differences in sample size at each data point—due primarily to the fact that there was expected attrition across sessions, as clients terminated or dropped from counseling. The sample sizes for each experimental condition by research measure and data point are organized in Table 4.

Table 4: Sample Sizes for Data Collection for each Experimental Condition, Research Measure, and Data Point

Measure/Session	Meta-comm	Control
Self Assessment Manikin (SAM)		
Session 1	19	24
Session 2	16	20
Session 3	14	17
Session 6	9	13
Working Alliance Inventory – Client		
Session 1	20	24
Session 2	17	20
Session 3	16	17
Session 6	9	13
Working Alliance Inventory – Counselor		
Session 1	20	23
Session 2	18	21
Session 3	16	18
Session 6	9	13
Experiencing Scale		
Session 1	20	24
Session 2	18	21
Session 3	15	18
Session 6	9	13
Post Session Questions – Client		
Session 1	20	23
Session 2	17	20
Session 3	16	17
Session 6	8	13
Post Session Questions – Counselor		
Session 1	14	17
Session 2	18	21
Session 3	16	18
Session 6	9	13
CCAPS		
Session 1	19	24
Session 3	14	15
Session 6	7	13
Treatment Outcome – Counselor	14	17
Number of Sessions	14	19

Mood Ratings – Self Assessment Manikin:

Table 5 shows the data for the three SAM measures of mood or affect during each session.

Valence. The valence scale of the SAM measures the degree of pleasure or displeasure that the participant feels. Lower scores on this scale reflect higher levels of pleasure or positive valence. There were no significant differences between the experimental conditions on valence during session 1 ($t(41) = -0.44$, $p = .66$), session 2 ($t(34) = -0.49$, $p = .63$), session 3 ($t(29) = 0.88$, $p = .37$) or session 6 ($t(20) = 0.00$, $p = 1.00$).

Arousal / Activation. The activation scale of the SAM reflects the level of arousal experienced by the participant. Lower scores on this scale indicate that the participant is feeling more aroused. There were no significant group differences during session 1 ($t(41) = -1.13$, $p = .27$). During session 2, there was a marginally significant group difference in level of arousal ($t(34) = -1.91$, $p = .06$). There was a significant difference between the meta-communication and controls groups during session 3 ($t(29) = -2.43$, $p = .02$) and session 6 ($t(20) = -2.33$, $p = .03$. In these sessions, the meta-communication group experienced less activation / arousal than the controls.

Control. The control scale of the SAM allows the participant to indicate the level of control that they are experiencing. Higher scores on this scale reflect feelings of being in control, or dominant. There were no significant group differences on level of control during session 1 ($t(41) = 1.28$, $p = .21$), session 2 ($t(34) = -0.05$, $p = .97$), session 3 ($t(29) = -1.93$, $p = .06$), or session 6 ($t(20)= 0.00$, $p = 1.00$).

Table 5: Mood Ratings for Experimental Conditions (SAM, Self Assessment Manikin)

Scale	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Valence			
Session 1	2.63 (0.96)	2.50 (0.98)	.66
Session 2	2.50 (1.03)	2.35 (0.81)	.63
Session 3	2.07 (0.83)	2.35 (0.93)	.39
Session 6	2.00 (0.71)	2.00 (0.91)	1.00
Activation			
Session 1	3.47 (0.91)	3.13 (1.08)	.27
Session 2	3.44 (0.89)	2.85 (0.93)	.06
Session 3	3.57 (0.94)	2.76 (0.90)	.02
Session 6	3.56 (1.01)	2.62 (0.87)	.03
Control			
Session 1	2.58 (0.90)	2.92 (0.83)	.21
Session 2	2.81 (0.83)	2.80 (0.83)	.97
Session 3	3.00 (0.56)	2.59 (0.62)	.06
Session 6	3.00 (0.71)	3.00 (0.82)	1.00

Working Alliance

The working alliance was assessed on both clients and therapists. Higher scores reflect a stronger alliance between the client and therapist. The means and standard deviations for the client ratings of working alliance are shown in Table 6. No significant group differences were found on client-reported working alliance for session 1, ($t(42) = -0.58$, $p = .56$), session 2, ($t(35) = 0.41$, $p = .68$), session 3, ($t(31) = 0.72$, $p = .48$), or session 6 ($t(20) = .88$, $p = .39$). The data for therapist ratings of working alliance are shown in Table 7. In session 1, therapists rated the meta-communication condition has having a marginally stronger working alliance than did the control condition ($t(42) = -1.91$), $p = .06$). However, there were no significant group differences found in therapist-rated working alliance in session 2, ($t(35) = -0.77$, $p = .45$), session 3, ($t(31) = 0.47$, $p = .64$), or session 6 ($t(20) = -0.31$, $p = .76$).

Table 6: Working Alliance, Participant Ratings (Total Score)

Session	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Session 1	6.28 (0.59)	6.15 (0.80)	.56
Session 2	6.40 (0.53)	6.47 (0.55)	.68
Session 3	6.47 (0.42)	6.58 (0.49)	.48
Session 6	6.51 (0.46)	6.68 (0.43)	.39

Table 7: Working Alliance, Therapist Ratings (Total Score)

Session	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Session 1	5.65 (0.55)	5.29 (0.66)	.06
Session 2	6.02 (0.61)	5.84 (0.86)	.45
Session 3	6.00 (0.71)	6.11 (0.62)	.64
Session 6	6.37 (0.48)	6.29 (0.62)	.76

Experiencing

The experiencing scale rates the participants' ability and willingness to process issues in a meaningful way and actively engage in the therapeutic process. With the exception of session 2, when the control group unexpectedly had a marginally higher mean experiencing rating than the meta-communication group, ($t(37) = 1.95$, $p = .06$), the two conditions were very similar in experiencing in session 1, ($t(42) = 0.23$, $p = .82$), session 3, ($t(31) = 0.00$, $p = 1.00$), and session 6, ($t(20) = 0.85$, $p = .41$). These data are presented in Table 8.

Table 8: Experiencing Scale

Session	Meta-Comm	Control	p-value
Session 1	3.90 (0.85)	3.96 (0.86)	.82
Session 2	4.28 (0.67)	4.67 (0.58)	.06
Session 3	4.67 (0.72)	4.67 (0.84)	1.00
Session 6	5.11 (0.93)	5.46 (0.97)	.41

Post Session Questionnaire

The post session questionnaire assessed meta-communication and various other processes taking place during sessions. Table 9 shows the client data. It is interesting

to note that, after session 1, control group clients reported that they shared their personal, private thoughts during the session more than did the meta-communication group clients, ($t(41) = 3.31$, $p = .002$). However, there were no other group differences on client post-session ratings.

Table 9: Post Session Questions, Client

Item / Session	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Item #1 – I discussed my personal feelings about the counselor.			
Session 1	4.65 (2.13)	4.96 (2.46)	.67
Session 2	4.82 (2.40)	5.25 (2.29)	.59
Session 3	4.94 (2.18)	6.18 (1.91)	.09
Session 6	4.88 (2.10)	5.15 (2.61)	.80
Item #2 – I shared my private, personal thoughts.			
Session 1	5.85 (0.93)	6.65 (0.65)	.002
Session 2	6.24 (0.83)	6.70 (0.80)	.09
Session 3	6.38 (0.96)	6.71 (0.85)	.30
Session 6	6.67 (0.71)	6.77 (0.60)	.72
Item #3 – I expressed myself openly and honestly.			
Session 1	6.45 (0.83)	6.78 (0.52)	.12
Session 2	6.53 (0.51)	6.85 (0.67)	.12
Session 3	6.69 (0.60)	6.76 (0.75)	.75
Session 6	6.67 (0.50)	6.69 (0.63)	.92
Item #4 – I discussed my goals for counseling.			
Session 1	5.80 (1.44)	5.83 (1.85)	.96
Session 2	5.82 (1.13)	6.15 (1.46)	.46
Session 3	5.88 (1.20)	6.41 (1.23)	.22
Session 6	6.22 (0.67)	5.92 (1.85)	.65
Item #5 – I discussed how to reach the goals of counseling.			
Session 1	5.30 (1.46)	5.26 (1.60)	.93
Session 2	5.94 (1.20)	5.70 (1.66)	.62
Session 3	6.06 (1.18)	6.18 (1.85)	.84
Session 6	6.00 (0.87)	5.85 (1.95)	.83
Item #6 – I believe that this session was helpful in reaching my counseling goals.			
Session 1	6.00 (0.92)	6.00 (1.38)	1.00
Session 2	6.24 (0.83)	6.25 (1.29)	.97
Session 3	6.44 (0.51)	6.53 (1.01)	.75
Session 6	6.44 (0.73)	6.69 (0.48)	.35
Item #7 – I feel that I'm reaching my counseling goals.			
Session 1	5.15 (1.53)	5.35 (1.56)	.68
Session 2	5.82 (1.33)	6.00 (1.03)	.65
Session 3	6.00 (0.89)	6.06 (1.09)	.87
Session 6	6.22 (0.83)	6.62 (0.51)	.18

The therapists' post session questionnaire consisted of eight items. As was the case with the participant ratings, the only significant group differences occurred with Item #2. The session 3 scores indicate that the therapists rated control group participants as sharing their personal, private thoughts significantly higher than the meta-communication group ($t(32) = 2.14$, $p = .04$). Table 10 shows the therapist data.

Table 10: Post Session Questions, Therapist

Item #/Session	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Item #1 – The client shared his/her personal feelings about you.			
Session 1	2.30 (1.56)	2.08 (1.50)	.64
Session 2	1.56 (1.04)	2.29 (1.42)	.08
Session 3	1.69 (1.08)	2.33 (1.68)	.20
Session 6	1.67 (0.87)	2.00 (1.35)	.52
Item #2 – The client shared his/her private, personal thoughts.			
Session 1	5.60 (0.94)	5.92 (1.02)	.29
Session 2	5.67 (1.19)	6.05 (1.02)	.29
Session 3	6.13 (0.72)	6.61 (0.61)	.04
Session 6	6.11 (0.60)	6.23 (0.93)	.74
Item #3 – The client expressed him/herself openly and honestly.			
Session 1	6.15 (0.93)	5.96 (0.91)	.50
Session 2	5.94 (0.80)	6.33 (0.80)	.14
Session 3	6.25 (0.78)	6.67 (0.59)	.09
Session 6	6.33 (0.71)	6.62 (0.51)	.29
Item #4 – We discussed goals for counseling.			
Session 1	5.15 (1.57)	5.29 (1.16)	.73
Session 2	5.83 (0.92)	5.52 (1.08)	.35
Session 3	5.44 (1.15)	5.11 (1.41)	.47
Session 6	5.11 (1.54)	5.15 (1.54)	.95
Item #5 – We discussed how to reach the goals of counseling.			
Session 1	4.65 (1.50)	4.04 (1.57)	.20
Session 2	5.50 (1.10)	5.38 (1.16)	.75
Session 3	5.44 (1.21)	5.33 (1.24)	.81
Session 6	5.11 (1.69)	5.15 (1.68)	.95
Item #6 – I believe that this session was helpful in reaching my counseling goals.			
Session 1	5.45 (0.83)	4.92 (0.97)	.06
Session 2	6.00 (0.84)	5.67 (1.07)	.29
Session 3	5.88 (1.03)	5.72 (0.90)	.65
Session 6	6.22 (0.83)	5.69 (0.86)	.16
Item #7 – I discussed my personal feelings about the client with him or her.			
Session 1	3.00 (1.84)	2.79 (1.69)	.70
Session 2	3.39 (1.58)	3.57 (1.66)	.73
Session 3	3.13 (1.67)	3.17 (2.04)	.95
Session 6	3.00 (1.41)	2.77 (1.30)	.70

Item #8 – I feel that the client is reaching the counseling goals.			
Session 1	3.80 (1.67)	3.08 (1.59)	.15
Session 2	4.78 (1.06)	4.48 (1.33)	.44
Session 3	5.25 (1.24)	5.06 (0.87)	.60
Session 6	5.44 (0.73)	5.46 (0.97)	.97

Primary Analyses of Counseling Outcomes

Improvement in mental health was assessed by examining changes on the CCAPS between the baseline scores sessions 3 and 6. Change scores were calculated by subtracting the baseline scores on the CCAPS subscales from measures taken at session 3 and session 6. Table 11 shows the data for session 3. At session 3, the meta-communication group demonstrated significantly greater improvement than the control group on generalized anxiety, ($t(27) = 2.58$, $p = .02$), and marginally greater improvement in depression, ($t(27) = 1.89$, $p = .07$), and hostility ($t(27) = 1.79$, $p = .09$). There were no significant group differences in social anxiety ($t(27) = -0.41$, $p = .67$), academic distress ($t(27) = -0.66$, $p = .51$), eating/body image ($t(27) = 0.64$, $p = .53$), family distress ($t(27) = -.17$, $p = .87$), or substance use ($t(27) = 0.63$, $p = .53$).

Table 11: Clinical Outcome, CCAPS Change Scores at Session 3

Scale	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Depression	-0.65 (0.39)	-0.33 (0.50)	.07
Generalized Anxiety	-0.55 (0.52)	-0.02 (0.59)	.02
Social Anxiety	-0.01 (0.52)	-0.10 (0.74)	.67
Academic Distress	-0.21 (0.69)	-0.39 (0.71)	.51
Eating/Body Image	-0.07 (0.56)	0.07 (0.64)	.53
Family Problems	-0.25 (0.62)	-0.29 (0.62)	.87
Hostility	-0.24 (0.46)	0.05 (0.42)	.09
Substance Use	0.10 (0.36)	0.23 (0.74)	.53
Total	-0.24 (0.34)	-0.10 (0.25)	.22

As shown in Table 12, at session 6, the meta-communication group continued to tend to have higher levels of improvement on the same scales (generalized anxiety, depression, hostility), then the control group, but the smaller sample sizes at session 6

resulted in these differences being non-significant. Overall, groups did not differ significantly at session 6 on any of the CCAPS measures: depression (t(18) = 0.65, p = .53), generalized anxiety (t(18) = 0.87, p = .40), academic distress (t(18) = 0.59, p = .56), hostility (t(18) = 1.56, p = .13), substance use (t(18) = 0.99, p = .33), social anxiety (t(18) = -.025, p = .81), eating/body image (t(18) = -0.60, p = .55), family distress (t(18) = -0.10, p = .99), and CCAPS Total (t(18) = 0.77, p = .45).

Table 12: Clinical Outcome, CCAPS Change Scores, Session 6 and Baseline

Scale	Meta-Comm	Control	p-value
	M (SD)	M (SD)	
Depression	-1.04 (0.88)	-0.83 (0.61)	.53
Generalized Anxiety	-0.78 (0.82)	-0.47 (0.73)	.40
Social Anxiety	-0.18 (0.41)	-0.24 (0.62)	.81
Academic Distress	-0.80 (0.69)	-0.57 (0.89)	.56
Eating/Body Image	-0.15 (0.46)	-0.34 (0.76)	.55
Family Problems	-0.55 (0.61)	-0.55 (0.83)	.99
Hostility	-0.82 (0.56)	-0.31 (0.74)	.13
Substance Use	-0.14 (0.26)	0.06 (0.51)	.33
Total	-0.56 (0.35)	-0.41 (0.45)	.45

Sessions Attended and Therapist-Rated Change

These variables were assessed by determining the number of sessions that participants attended, the manner in which treatment ended, the extent to which the presenting issues were successfully resolved, and the impact that treatment had on other problems or issues. There were no significant differences in the number of sessions attended (through session 12) between the meta-communication group (Mean = 7.00, SD = 3.98) and the control group (Mean = 7.74, SD = 3.94) (t(31) = 0.53, p = .60).

Therapists were asked to indicate the manner in which treatment ended. Although the sample sizes in given cells are too small to permit a valid chi-square test,

as shown in Table 13, there are no obvious differences in reasons for termination between the two groups.

Table 13: Treatment Outcome, Therapist

	Meta-Comm	Control
Value		
Terminated	3 (9.7%)	6 (19.4%)
Premature termination	6 (19.4%)	5 (16.1%)
Continued to end of semester	5 (16.1%)	5 (16.1%)
Transferred	0 (0%)	1 (3.2%)

The therapists also rated how much clients had improved at the end of treatment. This data was available only for those clients who completed therapy. There were no significant group differences between the two experimental conditions on rate of improvement for the presenting issue ($t(29) = 0.12$, $p = .91$). The meta-communication group showed somewhat higher rates of improvement on other problems or issues as compared to the control group, but this finding was non-significant ($t(29) = -1.11$, $p = .28$). This data is depicted in Table 14.

Table 14: Rating of Improvement, Therapist

	Meta-Comm n=14	Control n=17	
	M (SD)	M (SD)	p-value
Presenting Issue	3.71 (0.99)	3.76 (1.30)	.91
Other Issues	3.36 (1.01)	3.00 (0.79)	.28

CHAPTER 4

DISCUSSION

There is a considerable body of research related to both the therapeutic alliance and orienting clients to the psychotherapy process. However, this study is the first to examine the impact of a meta-communication orientation exercise regarding the therapeutic alliance on therapy process variables and outcome variables. Participants were randomly assigned to either a control or meta-communication condition to determine if engaging in the orientation exercise would improve mood, ratings of the therapeutic alliance, level of experiencing, symptoms, attendance, and therapists' ratings of overall improvement from therapy. Participants in the experimental condition were engaged in an orientation exercise that combined elements of role induction and experiential pretraining regarding Bordin's (1979) model of the therapeutic alliance. Analyses indicate that some of the initial hypotheses were supported, but that the effects were mixed. Generally, the meta-communication exercise achieved only a few of its goals.

Process Variables

On ratings of mood during the session, the meta-communication orientation led to decreased activation or arousal during later sessions, but did not affect mood valence or feelings of control. It appears that engaging in the exercise helped clients feel more calm and relaxed while working with therapists, perhaps because of the acceptance conveyed to the participant by the therapists. It is also possible that discussing the therapeutic process helped to allay concerns that the clients may have had.

Although the meta-communication clients rated themselves as less aroused than controls, they did not view the therapeutic alliance any differently. Interestingly, therapists rated the alliance of the meta-communication condition stronger than the controls, but only in session 1, and not subsequent sessions. It is likely that the therapist ratings for session 1 are a simple reaction to the fact that they had just engaged in an exercise designed specifically to highlight the alliance. Thus, the therapist ratings of improved alliance in session 1 probably are just an artifact, or should be considered a manipulation check. Overall, however, this intervention, which was designed to improve the therapeutic alliance, did not do so. There are several potential reasons for this, including several discussed below, but it is worth noting here that alliance ratings in this study—as in most studies—were quite high on average, suggesting that it may be difficult to improve on it. Alternatively, the Working Alliance Inventory may not be sufficiently sensitive to variations in the alliance, or participants may not be sensitive to ways that the alliance might be even stronger than currently experienced.

The level of psychological and emotional experiencing also generally did not differ between the two conditions. However, there was a marginal difference during the second session, with control group participants reporting greater experiencing than clients in the meta-communication group. This could be a result of clients in the meta-communication group focusing more on the therapeutic relationship than on their own psychological issues. This effect completely disappeared by the third session. There are some questions regarding the use of the Experiencing Scale in this study. The Experiencing Scale may have been an inappropriate measure to use because this study

was not designed to attempt to deepen experiencing, but rather to try and facilitate the alliance.

The post-session questions were created to further assess aspects of the therapeutic alliance. Interestingly, during the first session, control group participants reported that they shared their private, personal thoughts with the therapists more than those in the meta-communication condition. There was also a marginal difference in the same direction during the second session. These client ratings were also supported by the therapists' ratings, which also indicated that the control group participants shared private, personal thoughts more than those in the meta-communication condition during session 3. These findings, of course, are opposite of what was hypothesized. It is likely that the intervention had an unexpected "sensitizing" effect. The orientation exercise likely made clients more aware of the fact that there were thoughts and feelings that they were not sharing, whereas control participants simply remained unaware of this. It is possible, of course, that the exercise actually inhibited clients from expressing their thoughts and feelings, although this is doubtful, given the explicit encouragement and support to do so. Differentiating these two possibilities would require detailed analysis of session content, which is not possible in this study.

Overall, then, it seems that the meta-communication exercise had mixed results on process variables. Participants who received the exercise were less aroused during their interactions with therapists, but also more aware that they had might not be open in their sharing of feelings. Also, there were no effects on the therapeutic alliance. This discussion will now turn to an examination of group differences in the impact of treatment on mental health and therapy outcomes.

Therapy Outcome Measures

The effect of treatment was assessed primarily by examining changes in mental health symptoms from baseline to sessions 3 and 6, as reported on the CCAPS. Changes in symptoms after session 3 show that the meta-communication group was less symptomatic than the control group on generalized anxiety. Also, clients in the meta-communication group were marginally less symptomatic on both depression and hostility. The group differences in symptom improvement were similar in magnitude at session 6, but did not reach significance, primarily because there were fewer participants at session 6 and, therefore, less statistical power.

Previous literature indicates that repairing ruptures in the therapeutic alliance can reduce the rates of premature termination (Safran et al., 2002). In the present study, however, there were no differences in the number of sessions attended between the two experimental conditions. Similarly, there were no group differences in the manner in which therapy ended between the two conditions, nor differences in the therapists' ratings of improvement at the end of treatment.

Overall, then, it appears that the meta-communication exercise had positive yet rather weak benefits on treatment outcomes, but mixed effects on therapy process. How can this be explained? It must be considered that this brief exercise was relatively weak when compared with the more powerful therapeutic factors operating in individual therapy. A substantial body of literature has shown that broader factors such as expectation for improvement, warmth and attention, understanding and insight, encouragement, engaging in new behaviors and relationships are central to psychological interventions and play key roles in client improvement that cross

therapeutic modalities (Lambert & Ogles, 2003). In fact, most therapist and client variables do not have a clear effect on outcome (Lambert & Ogles, 2003). Importantly, in component analyses, Ahn and Wampold (2001) found that adding or removing components of treatment did not change the effects of the core treatment. The current study, which attempted to improve on therapy process and outcome by adding an single, 5-10 minute element, is consistent with the general statement that it is difficult to improve on the core aspects of therapy.

A consideration related to a lack of significant group differences is the design of the study itself. The only difference between the two groups was the implementation of the meta-communication orientation exercise at the end of session 1. All other aspects of the first session were identical so that the control group participants received a standard intake session. It is clinically and ethically necessary to discuss the presenting issues with the clients during the first session in order to develop an appropriate treatment plan. Also, Counseling Services utilizes a brief treatment model in which therapeutic interventions are employed during the first session, when feasible. Therefore, although there would not have been an explicit discussion of the therapeutic alliance with control group participants, they would have been engaged in a discussion of treatment goals and likely provided with specific means of obtaining those goals. Given this, the only difference between the two groups may have been a focus on the therapeutic relationship—rather than goals and tasks—and this focus appears to have had mixed effects on process, including increasing awareness of what is not being shared or discussed in therapy.

Limitations

As with any project, various factors limit how the study was conducted and what conclusions can be made. These issues include small sample sizes, failure to monitor the fidelity of the meta-communication exercise, a lack of direct information about how participants and therapists were influenced by the meta-communication orientation exercise, and use of self-report measures. These will be discussed in turn.

Perhaps the greatest limitation to finding significant effects in this study is the small sample size. There were a maximum of 44 clients for some analyses of session 1 data, and analyses of subsequent sessions and outcomes had even fewer. Such small sample sizes reduce statistical power, rendering it difficult to identify significant group differences. Sixty participants would have allowed 30 to be randomized to each of the two experimental conditions, which is the minimum number recommended by the APA Division 12 Task Force on Empirically Supported Treatments to have sufficient power to detect meaningful differences. A power analysis showed that 29 participants per group would yield .80 power to detect a moderate to large effect size, using an independent-groups t-test. Also, recruiting efforts were more difficult than expected. This study will be extended to reach the necessary sample size to meet the above criteria, and it should be noted that there are at least 10 additional participants currently enrolled in the study but whose data were not available at the time of analysis for this dissertation.

This study would be improved by monitoring the fidelity of the meta-communication orientation exercise. There was no evaluation of how well, or poorly, it was delivered to clients in the meta-communication condition. If presented poorly, then it would be expected to have a weak or even paradoxical effect on process.

Furthermore, it is not known if therapists responded appropriately when relational discussions and meta-communication were raised in subsequent sessions. In particular, therapists in this study were not trained to deal with any subsequent relational or alliance issues that developed, and it is possible that some therapists were not able to deal successfully with the increased interpersonal communication. Also, it is not known whether therapists of the control participants might have increasingly addressed relational issues because they were simultaneously engaging in meta-communication with clients assigned to the experimental group. Such lack of condition fidelity is more likely to happen when therapists are crossed with conditions, as in this study, rather than nested solely within treatment conditions.

There has been some previous discussion regarding the possible unintended consequences of the meta-communication exercise on research participants. It is possible that those in the meta-communication group, and possibly their therapists, were sensitized to the therapeutic alliance after engaging in the orientation exercise. This consideration is speculative and the information necessary to reach a more objective conclusion is unavailable because there is no direct data on how the participants in the meta-communication condition or therapists were influenced by that exercise. In future research, it would be helpful to include quantitative and qualitative data that looks at how participants interpreted and responded to the meta-communication orientation exercise. Participants could also be asked to inform the researcher on how they believe this exercise impacted their work with the therapists. It is possible that this information could be obtained by having independent observers rate videos of session content.

There are longstanding concerns about the use of self-report measures in psychological research. Even the CCAPS, which is a widely adopted symptom measure, fails to include validity indices that could assist clinicians in assessing over- or underreporting of symptoms. As noted above, the Working Alliance Inventory tends to have a positive response bias. More stringent operationalization of research measures would improve the data obtained in future studies; that is, the number of statements directly addressing therapeutic goals and tasks associated with reaching treatment goals, and references to the client-therapist relationship would be more closely tied to ratings on the scales used in the research.

Future Directions

As suggested above, there are several ways that this study could be improved. An increased sample size would increase the statistical power necessary to find significant effects of the intervention. It would be helpful to collect data directly from participants on the influence of the meta-communication orientation exercise and there needs to be increased focus on the operationalization of self-report measures. Future studies could audio or videotape sessions and have independent raters evaluate how the exercise influenced therapy and provide an outside rater's evaluation of alliance. Also, inter-rater agreement would significantly improve the reliably of ratings on the therapeutic alliance scales. Independent raters could also be used to evaluate the fidelity of the meta-communication orientation exercise completed in session 1.

Also, it would be helpful to target this intervention on populations in most need of improving the therapeutic alliance. In future studies, measures should be incorporated which help to assess personality pathology. It will be necessary to carefully review the

measures available for assessing personality functioning given the substantive changes being made in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition in the classification of personality disorders. Participants with significant characterological difficulties would be randomly assigned to either a control or meta-communication condition to determine if this exercise might improve the alliance within this population of clients. Of course, it seems wise to actually train the therapists to successfully handle the increased focus on the relationship and meta-communication that would likely follow such an exercise.

Finally, some attention should be given to examining therapists' characteristics. The therapists included in this study are at various stages of licensing and from different disciplines, including psychology and personal counseling. Future research would need to consider how these factors influence process and outcome variables. It would also be helpful to examine if theoretical orientation plays a role in treatment outcomes. For instance, those therapists with backgrounds in cognitive-behavioral therapy may interact with clients very differently than those with a humanistic or psychodynamic orientation. Other therapist characteristics of interest include level of empathy and familiarity or proficiency in working within a brief treatment model, particularly as it involves the treatment of personality disorders.

Implications of this Research

This study was helpful in shedding light on the impact of discussing the therapeutic alliance with clients and incorporating rigorous clinical trials into the routine practices of University counseling centers. The meta-communication orientation exercise was found to be effective in reducing the arousal that clients experienced in

working with their therapists. It also resulted in more rapid symptom improvement. This suggests that there is clear benefit to engaging in this exercise.

There seems to be evidence that the exercise increased awareness of what clients discussed—or did not discuss—with their therapists. There was the surprising consequence that clients who received the meta-communication exercise engaged in less interpersonal disclosure during several sessions. This certainly shows that the orientation exercise is effective in influencing the dynamics of the therapy process, but that such interventions are complex. We do not know whether such increased awareness of what is not being shared is helpful or harmful. Clearly, more work is needed in this area.

Research on alliance repairs, conducted by Muran, Eubanks-Carter, and Safran (2000), has placed emphasis on working with clients who have chronic difficulties in developing and maintaining a positive working alliance with their therapists. In contrast, in this study, the intervention was tested on students, many or most of whom do not necessarily have substantial interpersonal pathology. Perhaps the current intervention, therefore, would be more effective if it were targeted to those people with substantial relational difficulties, such as personality disordered clients.

This provides an interesting challenge for counseling centers because typically, the clients presenting in these settings are less impaired and counseling centers are more likely to utilize a brief treatment model. Many brief models exclude clients with characterological difficulties because these problems generally are not amenable to short term treatment (Mann, 1973; Sifneos, 1972). Other models attempt to ignore the personality pathology (Klerman, Rounsaville, Chevron, & Weissman, 1984) or appeal to

the client's healthier attributes (Beck, Rush, Shaw, & Emery, 1979) while maintaining focus on the presenting issues. There are some brief models, however, that focus on personality pathology as the primary presenting issue (Luborsky, 1984; Strupp & Binder, 1987; Muran, Safran, Samstag, & Winston, 2005). Budman and Gurman (1988) have completed a review of this literature that sheds some important light on an issue with which counseling centers continue to struggle.

This study also demonstrated the feasibility of conducting a randomized clinical trial in a university counseling center setting. A number of counseling centers consider research to be a foundational activity along with clinical services, outreach activities, and training, and there have been deliberate efforts to increase research activities in these settings. This is an important step in improving the services provided by counseling centers, given the increased enrollment in higher education and the changing characteristics of college and university students. Counseling centers provide services to approximately 9% of enrolled students who are presenting with more serious levels of impairment. Also, more students are beginning their college experience with prior diagnoses and prescriptions for psychotropic medications. Having a research base for clinical work in these settings is crucial, and the current study suggests that even randomized trials are feasible in these settings.

APPENDIX A - INFORMED CONSENT

1. Title of the Research Project Factors that Influence the Process of Therapy

2. Names of the Researchers

Tamara L. McKay, M.A.
Lead Campus Counselor, University of Michigan-Flint
Psychology Doctoral student, Wayne State University.

Thomas Wrobel, Ph.D.
Professor, Psychology Department, University of Michigan-Flint

3. Description of the Research

The purpose of the study is to learn about factors that influence the process and outcomes of counseling to improve our services to students who are clients at the Counseling Services. These factors include the relationship between the therapist and the client, the amount of time spent in counseling, and other characteristics of therapist and client. All people who come to Counseling Services for therapy are being asked to participate in this research, and this study will continue until about 60 students have participated.

4. Description of Human Subject Involvement

Before counseling begins, you will complete several brief questionnaires about your health, background, and personality. The first counseling session will focus on your problems and needs. Your counselor may or may not discuss with you details of how you might work together. Whether or not this topic is discussed will be determined randomly (like by the flip of a coin).

During the course of your counseling, you and your therapist will occasionally report how you are doing. Before sessions 3, 6, and 9, you will complete the same health measure that you completed at the start of counseling (which will take about 5-10 minutes), and immediately following sessions 1, 2, 3, 6, and 9, you will complete a questionnaire about your thoughts and feelings about the session; this will take only 5 minutes each time. Your reports will not be shared with the therapist.

5. Length of Human Subject Participation

Your participation will last through session 9 of your counseling experience at CS, or until counseling is terminated, whichever comes first. Participation in the research will require about 5 to 10 minutes before each of 4 sessions and about 5 minutes after each of 5 sessions.

6. Risks and Discomforts of Participation

This project is deemed as no more than minimal risk. The study team does not foresee or anticipate any direct risk to the subjects.

7. Expected Benefits to Subjects or Others

Your health and functioning may benefit from participation in this study, but it may not. Participation may result in your counseling making better progress. Although you may not receive direct benefit from your participation, others may ultimately benefit from the knowledge obtained in this study.

8. Costs to Subject Resulting from Participation in the Study

You will not incur any costs for participating in this study.

9. Incentives to Subject for Participation in the Study

You will not be paid for taking part in this study.

10.Confidentiality of Records / Data

You will not be identified in any reports on this study. Records will be kept confidential to the extent provided by federal, state, and local law. However, the institution review board, the sponsor of this study, or university and government officials responsible for monitoring this study may inspect these records. All information collected will be stored on a secure server at the University of Michigan-Flint, and will be identified only by a unique code number, not your name. All data and information collected as part of this research project will be destroyed after the research is completed.

11. Contact Information

If you have any questions now or in the future, you may contact Ms. Tamara McKay at 810-762-3456, or Dr. Thomas Wrobel at 810-762-3424.

12. Required IRB Contact Information

Should you have questions regarding your rights as a research participant, please contact John Callewaert in the Institutional Review Board, 530 French Hall, Flint, MI., 48502, 810-762-3383, email: jcallew@umflint.edu.

13. Voluntary Nature of Participation

Your participation in this project is voluntary. Even after you sign the informed consent document, you may decide to leave the study at any time without penalty or loss of benefits to which you may otherwise be entitled. The alternative to participating in this

study is not to participate. You will receive standard care from Counseling Services regardless of your participation.

14. Documentation of Consent

One copy of this document will be kept together with the research records of this study. Also, you will be given a copy to keep.

15. Consent of the Subject

I have read (or been informed) of the information given above. Tamara McKay has offered to answer any question that I have concerning the study. I hereby consent to participate in the study.

Adult Subject of Research

_____

Printed Name Signature

Legal Representative

_____

Printed Name Signature

Relationship to Subject: _____

Date: _____

16. Audiorecording of Subjects

The first counseling session will be audiotaped and later reviewed by the research team to better understand how you and the counselor worked together. (This audiotape will destroyed after data have been analyzed.)

Please sign below if you are willing to have session 1 audiorecorded.

_____

Signature Date

I do not wish to have session 1 audiorecorded, however, I wish to participate in the research project.

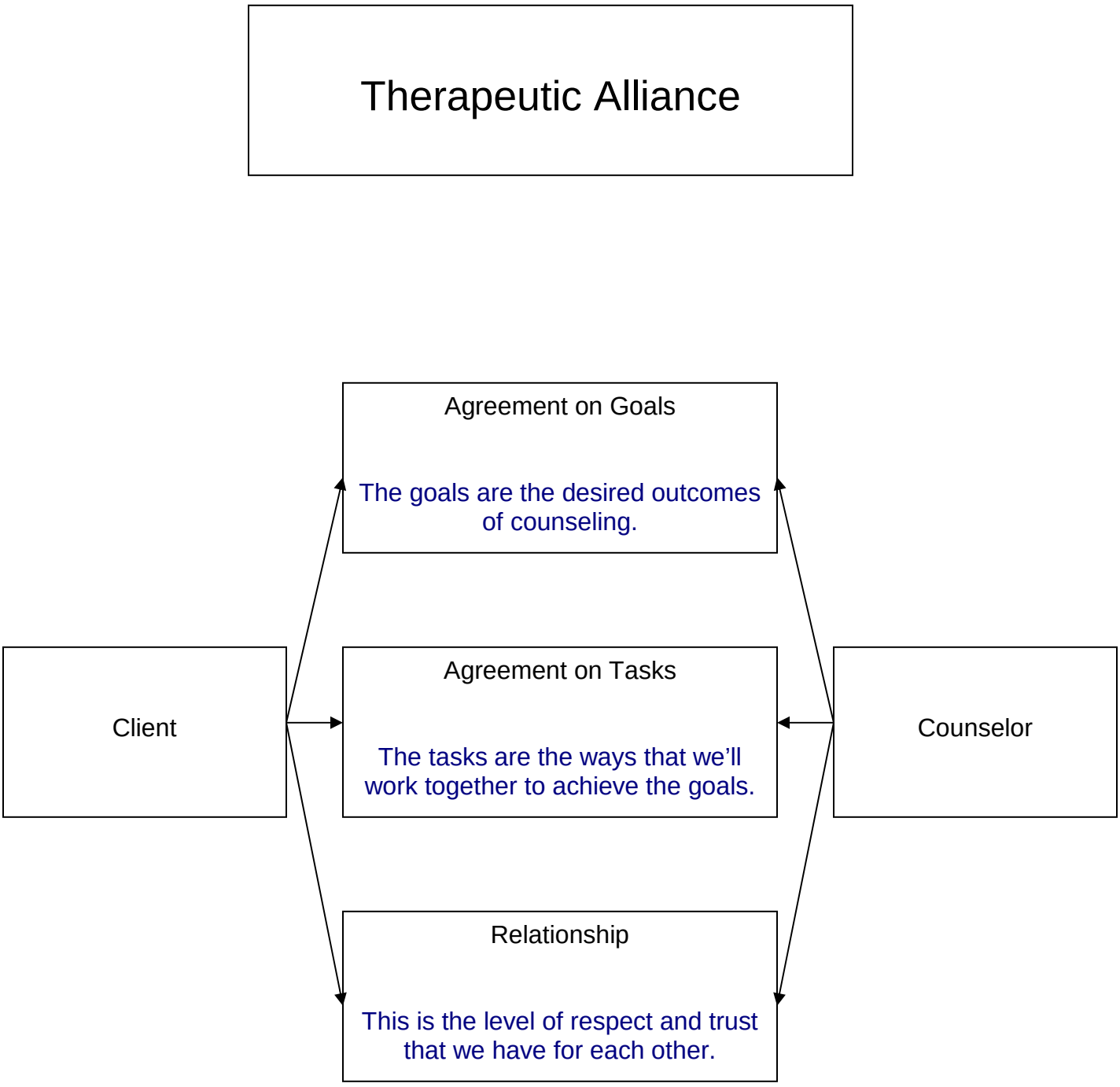
_____

Signature Date

APPENDIX B
Procedural Flowchart

Time Point	Counselor	Control Condition Participants	Intervention Condition Participants
Intake/Random Assignment	Identify participant assignment	Complete Intake Material and group assignment: SDS, CCAPS, Data Forms, Relationship Questionnaire, Consent Forms	
	Scheduled for First Appointment		
Session One	Complete the Manipulation Check; Complete WAI and Post-session measures	1. Standard Intro at beginning of session 2. Complete WAI, SAM, Post-Session Questions	1. Standard Intro at beginning of session 2. Meta-Communication training at end of session 3. Complete WAI, SAM, Post-Session Questions
Session Two	1. Remind Client to complete CCAPS at beginning of session three 2. Complete WAI and Post-session measures	End of session: WAI, SAM, Post-session measures	
Session Three	Complete WAI and Post-session measures	Before Session: Complete CCAPS End of Session: WAI, SAM, Post-session measures	
Session Four	No measures to complete		
Session Five	Remind Client to complete CCAPS at beginning of session six. No measures to complete.	No measures to complete	
Session Six	Complete WAI and Post-session measures	Before Session: Complete CCAPS End of Session: WAI, SAM, Post-session measures	
Session Nine	Complete WAI and Post-session measures	Before Session: Complete CCAPS End of Session: WAI, SAM, Post-session measures	
Post Treatment	Calculate Attendance; Complete Global Rating of Improvement		

APPENDIX C
Bordin's Model of the Therapeutic Alliance



WORKING ALLIANCE INVENTORY – Client

The following sentences describe some of the different ways that you might feel toward your therapist working with you in the session. If the statement describes the way you **always** feel or think, circle the number 7. If it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL** -- your therapist will not see your answers.

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.	1 2 3 4 5 6 7
2. What I am doing in therapy gives me new ways of looking at my problem.	1 2 3 4 5 6 7
3. I believe my therapist likes me.	1 2 3 4 5 6 7
4. My therapist does not understand what I am trying to accomplish in therapy.	1 2 3 4 5 6 7
5. I am confident in my therapist's ability to help me.	1 2 3 4 5 6 7
6. My therapist and I are working towards mutually agreed upon goals.	1 2 3 4 5 6 7
7. I feel that my therapist appreciates me.	1 2 3 4 5 6 7
8. We agree on what is important for me to work on.	1 2 3 4 5 6 7
9. My therapist and I trust one another.	1 2 3 4 5 6 7
10. My therapist and I have different ideas on what my problems are.	1 2 3 4 5 6 7
11. We have established a good understanding of the kind of changes that would be good for me.	1 2 3 4 5 6 7
12. I believe the way we are working with my problem is correct.	1 2 3 4 5 6 7

APPENDIX E
WORKING ALLIANCE INVENTORY – Therapist

The following sentences describe some of the different ways that you might feel toward your client working with you in the session. If the statement describes the way you **always** feel or think, circle the number 7. If it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

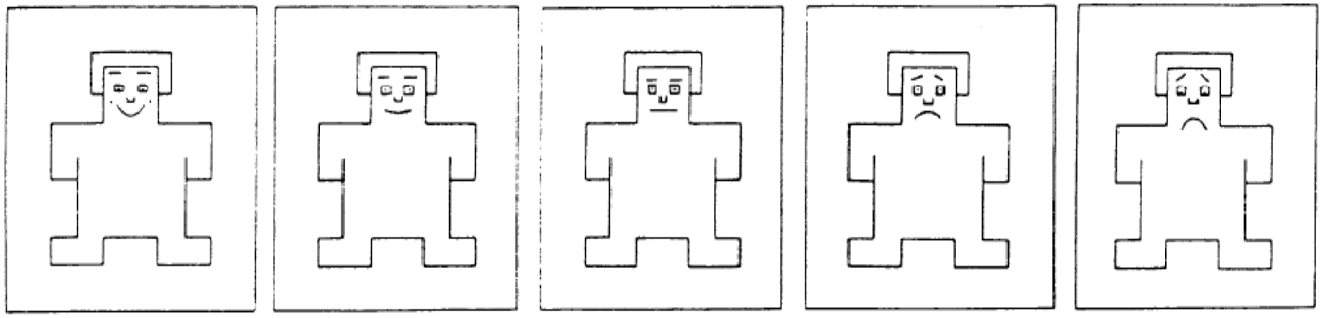
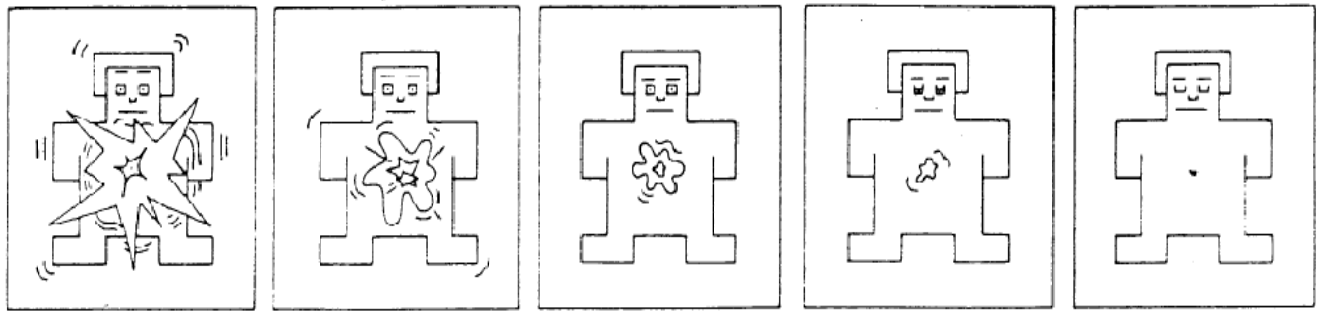
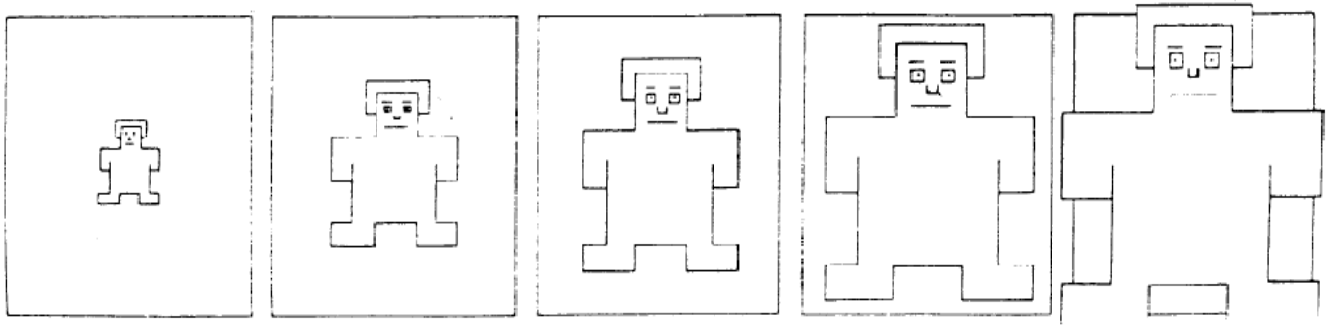
This questionnaire is **CONFIDENTIAL** -- your client will not see your answers.

1. My client and I agree about the steps to be taken to improve his/her situation.	1 2 3 4 5 6 7
2. My client and I both feel confident about the usefulness of our current activity in therapy.	1 2 3 4 5 6 7
3. I believe my client likes me.	1 2 3 4 5 6 7
4. I have doubts about what we are trying to accomplish in therapy.	1 2 3 4 5 6 7
5. I am confident in my ability to help my client.	1 2 3 4 5 6 7
6. We are working toward mutually agreed upon goals.	1 2 3 4 5 6 7
7. I appreciate my client as a person.	1 2 3 4 5 6 7
8. We agree on what is important for my client to work on.	1 2 3 4 5 6 7
9. My client and I trust one another.	1 2 3 4 5 6 7
10. My client and I have different ideas on what his/her problems are.	1 2 3 4 5 6 7
11. We have established a good understanding between us of the kind of changes that would be good for my client.	1 2 3 4 5 6 7
12. My client believes the way we are working with his/her problems is correct.	1 2 3 4 5 6 7

Study ID #: _____
Session #: _____
Date: _____

Self -Assessment Manikin

Instructions: In each row, circle the picture that best represents how you feel

On this side of the scale you feel:		On this side of the scale you feel:
Completely: Pleasant Happy Pleased Satisfied Contented		**Completely:** Unpleasant Unhappy Annoyed Unsatisfied Despairing
Completely: Stimulated Excited Frenzied Jittery Wide-awake		**Completely:** Calm Sluggish Dull Sleepy Unaroused
Completely: Controlled Influenced Cared For Awed Submissive Guided		**Completely:** Controlling Influential In Control Important Dominant

APPENDIX F
SELF ASSESSMENT MANIKIN

APPENDIX G
Experiencing Scale

Throughout initial stages of involvement, emotional dialogue or references are absent.

Stage 1: Involvement is limited and is characterized by superficial and detached dialogue. Clients refer to aspects of the event without directly discussing the events

Stage 2: Others' reactions to the events are disclosed, without any reference to personal thoughts or feelings about the experience.

Stage 3: A discussion of the external events, including behavioral or factual details about the event is the focus.

As clients move further along the scale, more internal references are made.

Stage 4: Represents the shift from an external to an internal focus on the experience and individuals begin to discuss the personal impact of the event by acknowledging and discussing their emotional reactions. For example, they are able to communicate the anger or sadness they feel.

Stage 5: Individuals begin to explore the problems they are experiencing as a result of the experience, as well as possible ways to solve these problems. This stage may include conflictual emotional experiences, for example, an adult caregiver may feel sadness and relief over the death of a parent, but also may feel guilty for their sense of relief. It is in this stage where individuals begin to process these conflicting states and explore their hypothetical solutions.

Stage 6: Clients have resolved their emotional conflicts and other problems related to the events, and they are able to describe their emotions in vivid detail.

Stage 7: Individuals begin to communicate new perspectives on the experience s a result of its resolution and integration.

APPENDIX H
POST SESSION QUESTIONS – Client

Please answer the following statements based on this past therapy session. If the statement describes how you feel or think **VERY MUCH**, circle the number 7. If **NOT AT ALL**, circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL** -- your therapist will not see your answers.

	Not at all Very much
1. I discussed my personal feelings about the client.	1 2 3 4 5 6 7
2. I shared my private, personal thoughts.	1 2 3 4 5 6 7
3. I expressed myself openly and honestly.	1 2 3 4 5 6 7
4. I discussed the goals for counseling.	1 2 3 4 5 6 7
5. I discussed how to reach the goals of counseling.	1 2 3 4 5 6 7
6. I believe that this session was helpful in helping the client reach counseling goals.	1 2 3 4 5 6 7
7. I feel that the client is reaching the counseling goals.	1 2 3 4 5 6 7

APPENDIX I
POST SESSION QUESTIONS – Therapist

Please answer the following statements based on this past therapy session. If the statement describes how you feel or think **VERY MUCH**, circle the number 7. If **NOT AT ALL**, circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL** -- your client will not see your answers.

	Not at all Very much
1. The client shared his/her personal feelings about you.	1 2 3 4 5 6 7
2. The client shared his/her private, personal thoughts.	1 2 3 4 5 6 7
3. The client expressed him/herself openly and honestly.	1 2 3 4 5 6 7
4. We discussed goals for counseling.	1 2 3 4 5 6 7
5. We discussed how to reach the goals of counseling.	1 2 3 4 5 6 7
6. I believe that this session was helpful in reaching my counseling goals.	1 2 3 4 5 6 7
7. I discussed my personal feelings about the client with him or her.	1 2 3 4 5 6 7
8. I feel that the client is reaching the counseling goals.	1 2 3 4 5 6 7
9. Please provide your rating of the client's level of "experiencing" using the Experiencing Scale.	1 2 3 4 5 6 7

APPENDIX J
Treatment Summary Form and Global Rating of Improvement - Therapist

1. How many sessions did the client attend? ___

2. How did counseling end? Pick all that apply:

___ Dropped out of counseling prematurely
___ Counseling goals were met and was terminated
___ Continued in counseling until end of semester / maximum number of sessions
___ Transferred elsewhere

3. Please provide your best estimate of how much or little the client changed with respect to the central problem or complaint that that he/she presented?

___ Somewhat worse
___ No change
___ A little improvement
___ Moderate improvement
___ Much improvement

4. Please provide your best estimate of how the client changed with respect to other issues or problems that were not the original complaint (e.g., relationships, mood, physical symptoms, daily functioning, general personality)?

___ Somewhat worse
___ No change
___ A little improvement
___ Moderate improvement
___ Much improvement

5. If this client did the therapeutic alliance exercise at the start of counseling, how do you think that this exercise affected the course of counseling?

___ Interfered with or slowed the process of counseling
___ Had no effect on counseling
___ Helped or aided counseling a little
___ Helped or aided counseling moderately
___ Helped or aided counseling much

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ABSTRACT

THE EFFECTS OF META-COMMUNICATION TRAINING ON THERAPEUTIC PROCESS AND OUTCOME AT A UNIVERSITY COUNSELING CENTER

by

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Advisor: Mark A. Lumley, Ph.D.

Major: Psychology (Clinical)

Degree: Doctor of Philosophy

There is a considerable body of research related to both the therapeutic alliance and orienting clients to the psychotherapy process. This study is the first to examine the impact of a meta-communication orientation exercise regarding the therapeutic alliance on process variables and treatment outcomes. Participants (N=44) were randomly assigned to either a control condition or a meta-communication condition, in which they engaged in an orientation exercise in their first session that combined elements of role induction and experiential pretraining regarding Bordin's (1979) model of the therapeutic alliance. Independent samples t-tests were used to determine if engaging in the orientation exercise improved mood, ratings of the therapeutic alliance, level of experiencing, mental health symptoms, attendance, and therapists' ratings of overall improvement from therapy.

Findings show that the meta-communication exercise was influential in reducing the level of arousal that client's experienced and led to more rapid symptom improvement, including generalized anxiety at session 3. The orientation exercise also had the unintended effect of sensitizing clients to the level of disclosure taking place in

the therapeutic relationship. Future studies should place more focus on addressing alliance issues in populations with substantial relational difficulties, such as those with diagnosed personality disorders. Subsequent research should also examine the impact of addressing alliance issues with this population in counseling centers that utilize brief treatment models.

AUTOBIOGRAPHICAL STATEMENT

TAMARA LYNN MCKAY

Tamara McKay attended the University of Michigan – Flint, where she completed a Bachelor of Arts in the Honors Program in the field of Public Administration in 1993 and a Bachelor of Science in Research Psychology in 1999. She earned a Master of Arts in Psychology from Wayne State University and is currently fulfilling the requirements for a doctorate in Psychology from this same institution. Tamara is currently employed in Counseling Services at the University of Michigan – Flint as the Senior Campus Counselor. This rewarding position provides the opportunity to work with a diverse student population and to develop skills as a generalist practitioner while developing competence in the treatment of PTSD.

Tamara also participates on the Board of Directors of two non-profit organizations. She is the Secretary for the Families of Murdered Children Support Group, and the Chair of the Diversity Committee for the Michigan Psychological Association. When not engaged in professional activities, she enjoys spending time with her son, family, and friends.