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Development and Validation of the Working Alliance Inventory

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Present stages of development and preliminary validation of a self-report instrument for measuring the quality of alliance, the Working Alliance Inventory (WAI). The measure is based on Bordin's (1980) pantheoretical, tripartite (bonds, goals, and tasks) conceptualization of the alliance. Results from three studies were used to investigate the instrument's reliability and validity and the relations among the WAI scales. The data suggest that the WAI has adequate reliability. The instrument is reliably correlated with a variety of counselor and client self-reported outcome measures. Nontrivial relations were also observed between the WAI and other relationship indicators. These results are interpreted as preliminary support for the validity of the instrument. Although the results obtained in the reviewed studies are encouraging, the high correlations between the three subscales of the inventory bring into question the distinctness of the alliance components.

In this article we describe the development of a paper-and-pencil instrument designed to measure some of the generic (nonspecific to a theory or technique) variables affecting the degree of success in counseling. After summarizing the issues that gave rise to the development of the instrument, we present a brief review of previous attempts to measure these variables and a discussion of the theory on which the Working Alliance Inventory (WAI) is based. The next section deals with the development and initial construct validation of the instrument. We then describe three studies that used the WAI to predict various indexes of counseling outcome. The evidence gathered in these studies is synthesized to answer questions about the instrument's validity and reliability and the relations among the alliance components. Finally, this information is related to the applicability and further development of the instrument.

Theoretical Approaches

The hope for a rapid and decisive resolution of the questions surrounding differential treatment efficacy among the different theoretical approaches to counseling has been fading in light of the emerging evidence of the complexity of variables involved in the determination of successful outcome. A growing number of investigations (Greenberg & Pinsof, 1987; Shapiro & Shapiro, 1983; Smith & Glass, 1977) comparing the efficacy of a variety of different therapies suggest that in general all treatments have some beneficial effects but there is relatively little reliable difference in efficacy among treatments. These results may be interpreted to support the idea that a great deal of the salutary beneficial effects of counseling may lie in variables common to many forms of interventions (Frank, 1961; Strupp & Hadley, 1979).

One of the steps necessary to clarify the important issues concerning the relation of the theory/technique specific and the generic variables is the development of a more precise measurement of the latter (Gelso & Carter, 1985). Over the last 3 decades, there have been continued attempts to define and explore the generic counseling variable or variables that appear to account for the large proportion of outcome variance common to different forms of counseling (Horvath, 1981). Four major theoretical formulations have provided the bases of empirical investigation of these variables: Rogers's (1951) client-centered theory, Strong's (1968) social influence theory, the psychodynamic perspective on the working relationship (Greenson, 1967), and Bordin's (1975) integrationist formulation of the working alliance. The first three of these positions are reviewed briefly next, and the last (Bordin's position) is presented in more detail.

Among the different theoretical approaches brought to bear on this important problem, historically the most influential one has been Rogers's (1951, 1957) pioneering effort to define the active components of the therapeutic relationship (empathy, unconditional positive regard, and congruence). Rogers's theoretical approach generated a great deal of research and much early hope that the Rosetta stone of all therapies might be found. However, more recent reviewers (Gelso & Carter, 1985; Mitchell, Bozarth, & Krauft, 1977; Parloff, Waskow, & Wolfe, 1978) of the literature on the therapist-offered conditions have suggested that the effects of these variables, although they appear to play a significant role for client-centered therapists, do not generalize across therapies as well as it was originally hoped.

Strong's (1968) theory of interpersonal influence was another attempt to conceptualize the therapeutic general variable that might span the broad spectrum of different counseling approaches. This formulation suggested that the degree to which a client believes that the counselor is trustworthy,

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expert, and attractive is proportional to the likelihood of successful counseling outcome. This paradigm may be contrasted with Rogers's formulation insofar as the former attributed the locus of the generic variable in the client's perception, whereas the latter defines the locus as the counselor's ability to offer specific conditions salient to the outcome of counseling.

Another approach to delineating the non-technique-specific component of therapist-induced healing can be traced to some of the early writings of Freud. Freud (1913/1958) drew some distinctions between the "neurotic" and the "friendly" feelings of the analysand toward the analyst. Later psychodynamic writers such as Sterba (1934), Zetzel (1956), and Gitleson (1962) further explored the client's realistic attachment to the therapist and the forces that are instrumental in creating a strong therapeutic partnership. Greenson in 1967 described the concept of the working alliance as one of the essential components of the therapeutic process.

Bordin's Theory of the Working Alliance

Bordin, in a series of seminal works (1975, 1976, 1980), reconceptualized the psychoanalytic notion of the working alliance to encompass all change-inducing relationships. His concept of the alliance built on Greenson's (1967) earlier work but broke away from the idea of a working alliance that exists in partnership with or as complement to the transference neurosis. He clearly delineated the differences between the unconscious projections of the client (i.e., transference) and the positive joining of counselor and client against the common foe of the client's pain and self-defeating behavior. The working alliance, from Bordin's point of view, is what "makes it possible for the patient to accept and follow treatment faithfully" (Bordin, 1980, p. 2). He believed that in any helping relationship the task of participating collaboratively in the counseling process taps directly into aspects of the client's self-defeating behavior. He went on to assert that

> to the degree that the therapeutic task or tasks succeeds in tapping into these self defeating habits of feeling, thought and action, breaks in the working alliance that are representative of other ways in which the person's habits function in self defeat will inevitably occur during therapeutic collaboration. The overcoming of these obstacles will then provide the person with those new ways of thinking feeling or acting with, under the right circumstances will generalize to other areas of his or her life. (Bordin, 1980, p. 3)

Although Bordin (1976) perceived the working alliance as an integrated relationship, he clearly defined three constituent components (tasks, bonds, and goals) that in combination define the quality and strength of all alliances. Over a period of 5 years (1975–1980), these components were refined and clarified. The meaning of these terms may be briefly summarized thus: *Tasks* refers to the in-counseling behaviors and cognitions that form the substance of the counseling process. In a well-functioning relationship, both persons must perceive these tasks as relevant and efficacious; furthermore, each must accept the responsibility to perform these acts. A strong working alliance is characterized by the counselor's and the client's mutually endorsing and valuing the *goals* (outcomes) that are the target of the intervention. The concept of *bonds* embraces the complex network of positive personal attachments between the client and the counselor that includes issues such as mutual trust, acceptance, and confidence (Bordin, 1975, 1976, 1980).

Bordin's working alliance model can be most clearly distinguished from both Rogers's (1951, 1957) concept of the essential counseling relationship and Strong's interpersonal influence conceptualization (LaCrosse, 1980; Strong, 1968) along the dimension of mutuality. Bordin's concepts of bond, goal, and task involve collaboration and hinge on the degree of concordance and joint purpose between the counselor and client. This stance may be contrasted with the alternative hypotheses that rely either on the client's perception of the counselor's qualities or on the attitude and behavior of the counselor without taking into account the degree of agreement, willingness to collaborate, or mutuality that is present between the counselor and client. Bordin's position was a significant departure. No previous conceptualization had emphasized client–counselor interdependence to this extent. Bordin (1980) explicitly stated that the quality of mutuality in the working alliance is a primary ingredient in its effectiveness. This notion provides a framework within which the relationship variables can be examined at a different and, it seems to us, more logical level than the more traditional perspective of examining the counselor–client relationship features independently.

Another difference between Bordin's (1980) working alliance model and the notion of therapist-offered conditions (Rogers, 1957) is that Bordin did not see the working alliance itself as a counseling intervention, much less a sufficient condition; rather, he perceived it as a vehicle that enables and facilitates the specific counseling techniques (Bordin, 1980). That is, the working alliance provides the context that promotes and interacts with specific counseling strategies. This conceptualization apparently provides a framework for viewing both relationship variables and specific intervention techniques in an integrated format. Lastly, this formulation of the working alliance not only broadens the scope of the concept but makes it pantheoretical. If the concept can be successfully measured, it may prove to be an aid in predicting counseling outcome and provide further insight into the process of counseling.

Bordin (1980) also predicted that helping interventions based on different theoretical premises would place different degrees of emphasis on the bond, task, and goal components of the working alliance. He further claimed that these different aspects of the alliance were not equally important in all phases of counseling (Bordin, 1976). This position implies that although a working alliance requires a high degree of cooperation and mutuality in all of these dimensions, the ideal or strong working alliance has different critical values with respect to each of the dimensions, depending on the theoretical framework of the counselor. Within each of these ideal alliance configurations, the relative importance a particular alliance component may depend on the phase of counseling.

Although this perspective appears to be a refinement of the previous, more global notions of the alliance, Bordin's (1980) theoretical statements did not elucidate the alliance parame-

ters specific to different theories and different stages of counseling. This created a potential measurement problem because part of the evidence supporting the validity of an alliance measure must be based on the relation of the alliance components to outcome. Because the theory lacked such specificity, it was assumed on the basis of empirical evidence (Orlinsky & Howard, 1975; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976) that during the early phases of intervention (i.e., between the second and fourth session), the demands on all aspects of a relationship variable such as the working alliance would be reasonably high. By this logic it appeared reasonable that documenting the relation between counseling outcome and the working alliance, if one existed, would be optimal during the early phase of the counseling process.

Measurement Issues

There has been a growing interest in the measurement of the working alliance (Hadley & Strupp, 1976; Marmar, Horowitz, Weiss, & Marziali, 1987; Morgan, Luborsky, Crits-Cristoph, Curtis, & Solomon, 1982). These efforts have met with considerable initial success in a variety of measurement approaches and across a variety of counseling orientations. Most of the designers of the measuring systems tended to be guided by empirical considerations in developing a measure that captures the maximum proportion of outcome variance (Frieswyk et al., 1986). Theoretically, these measuring instruments are based on some form or derivative of Greenson's (1967) nonneurotic transference model (Luborsky, 1976; Marmar et al., 1987; Morgan et al., 1982).

The focus of our own approach is to develop a measure that not only captures outcome variance but has a clearly articulated relation with a specified body of theory, which in turn clearly explicates the relation of the theoretical constructs to the counseling process. We feel that an assessment of the working alliance, if it is to have some clinical as well as research utility, must be independent of the counselor's theoretical orientation, yet it must be based on a clear statement of the working alliance's constituents and the alliance's function within the helping process. Without a clear statement of these relations, the working alliance measure cannot be properly interpreted—in individual instances—and will not contribute to the explication of the counseling process in research applications. For instance, a measurement based on a conceptualization that uses positive transference as the basis of the working alliance, if it were applied to behaviorally based counseling would, even if it proved to have predictive efficacy, has limited clinical value and fails to explicate the counseling process. Similarly, a measurement technique that is not based on explicit notions regarding the nature and function of the working alliance fails to generate knowledge to techniques that may improve the development of a strong alliance. On the basis of these arguments, we decided to develop an instrument based on Bordin's (1975, 1976, 1980) pantheoretical conceptualization of the working alliance.

The material presented later is part of a programmatic study to explore the concept of the working alliance within Bordin's (1980) theoretical framework. The portion of the project reported next describes the development and initial efforts at validation of a self-report instrument that captures the client's and counselor's perception of the working alliance during counseling. Some of the procedures used to generate the working alliance scales are described first, and the description of the procedures and results of the initial test construction and pilot testing phases follows. We then present the methods and results of three studies that produced data relevant to the Working Alliance Inventory's (WAI) reliability and validity. The last section synthesizes data from these studies under the headings of *Scale Interdependence*, *Reliability*, and *Validity*.

Instrument Development

Item Generation

The instrument was generated through a series of sequential ratings and evaluations of the prospective items. An initial pool of 91 items was generated (35 bond, 33 goal, and 23 task items) on the basis of a content analysis of Bordin's (1976, 1980) descriptions of each of these dimensions. Each item in the pool was designed to capture a feeling, sensation, or attitude in the client's field of awareness that may be present or absent depending on the strength of one of the components of Bordin's concept of the working alliance. These item stems were evaluated by three psychologists with different theoretical perspectives to reduce conceptual and linguistic bias.

Rating by Experts

The randomized item pool was rated for construct fidelity by seven experts in the field of working alliance. These experts were identified by a review of the published literature on the alliance. Two questions were asked of the raters with respect to each item: (a) Is this item relevant to the working alliance? and (b) which of the three dimensions of the working alliance does this item refer to?

The relevance of each potential item to the concept of the working alliance, according to definitions of constructs that we supplied, was rated on a 5-point Likert scale. A rating of 1 indicated that the item was *not related* to the alliance and a rating of 5 meant that the items was *very relevant* to the working alliance. Items with a mean relevance rating of less than 4.0 were eliminated from the item pool. In addition, raters classified each item as referencing one of Bordin's three alliance components: bonds, goals, and task. A percentage of agreement (PA) index was calculated for each item. Items with a PA index of less than 70% were rejected. Twenty-one items were eliminated from the item pool, and 11 items were edited as a result of the expert rating procedure.

Rating by Professionals

The remaining items were rated by 21 randomly selected registered psychologists from the roster of the local psychological association. The procedures and criteria for rating of the items used with the second group of raters were identical to the previous one. Of the 70 items forwarded to this second group, 15 failed to meet the cutoff criteria and were eliminated. The 55 remaining items were first separated into the three working alliance dimensions they were referencing; second, these dimension clusters were further subdivided into "meaning clusters" on the basis of similarity of item content by an open ended sorting procedure. From within each meaning cluster the highest rated items were chosen for inclusion in the inventory until the desired number of items (12) were obtained for each dimen-

Table 1
Item Rating Summary

Domain	No. of items	Rating		% of agreement
		M	*SD*	
Goal	12	4.38	0.19	85.3
Bond	12	4.43	0.14	94.8
Task	12	4.23	0.16	86.2
Total	36	4.35	0.18	88.7

Note. Twenty-one raters.

sion. Mean relevance ratings and percentages of agreement assigned by the second group of raters for the 36 items retained for use in the WAI are shown in Table 1.

From this item pool two versions (client and counselor) of the WAI were developed. The instruments each had 36 items (12 for each of the alliance dimensions). The instructions on the face sheet of the WAI directed the respondent to rate each item on a 5-point descriptively anchored Likert scale.

Pilot Testing

The WAI was pilot tested by using as subjects 29 graduate students in a counseling psychology program engaged in a peer counseling task. The instrument was administered after the third interview and the resultant data were item analyzed (Horvath, 1981). Minor adjustments were made both in content and presentation as a result of the piloting procedure.

Reliability estimates based on an item homogeneity index (Hoyt, 1941) in the pilot sample ranged from .85 to .88 for the subscales for the client's version of the instrument and from .68 to .87 for the counselor's version. Reliability estimates for the complete instrument were estimated to be .93 for the client's and .87 for the counselor's version by Cronbach's (1951) procedure.

As a result of experience accumulated in two subsequent projects (Studies 1 and 2 described later), the WAI has undergone a minor editorial revision. The revision consisted of (a) clarifying the wording of three items in the client's form and four items in the counselor's form of the WAI and (b) extending the Likert scale of each item from the original 5-point scale, which was anchored at three points, to a fully anchored 7-point scale. In the last study discussed in this report, the revised instrument was used. Differences between the two versions were deemed sufficiently minor to pool the results of the three studies in the discussion section. The 36 items of the revised client's version of the WAI are presented in Table 2.

Clinical Trials

Study 1

Method

In the first study the WAI was administered to 29 counselor-client dyads engaged in short-term (less than 15 sessions) counseling (Horvath, 1981). The counselors involved in these sessions were all experienced professionals who identified themselves as adherents of various theoretical frameworks (client-centered, analytic, Jungian, behavioral, or cognitive). The clients were adults (age range, 19–65) who either were part of the normal case load of these counselors or had sought service from one of the counselors on a fee for service basis. The working alliance was assessed after the third counseling session. In addition to the WAI, the clients and the counselors in this study completed the Empathy scale of the Relationship Inventory (RI; Barrett-Lennard, 1962), and the clients responded to the Counselor Rating Form (CRF; LaCrosse & Barak, 1976).

The RI measures the three therapist-offered facilitative conditions (empathy, congruence, and positive regard) identified by Rogers (1957) as the essential ingredients for positive client change. This instrument has proven reliability (Gurman, 1977), and it is considered to be a valid measure of the client-centered constructs (Mitchell et al., 1977). The three RI scales are fairly strongly correlated, and the client's Empathy scale is the most reliably associated with counseling outcome (Mitchell et al., 1977). The Empathy scale was included in this study for two reasons: moderate correlations between this scale and the WAI would support the notion that the WAI is measuring a

Table 2
Item Stems of the Working Alliance Inventory (Client Form)

	Item
1.	I feel uncomfortable with _____.
2.	_____ and I agree about the things I will need to do in therapy to help improve my situation.
3.	I am worried about the outcome of these sessions.
4.	What I am doing in therapy gives me new ways of looking at my problem.
5.	_____ and I understand each other.
6.	_____ perceives accurately what my goals are.
7.	I find what I am doing in therapy confusing.
8.	I believe _____ likes me.
9.	I wish _____ and I could clarify the purpose of our sessions.
10.	I disagree with _____ about what I ought to get out of therapy.
11.	I believe the time _____ and I are spending together is not spent efficiently.
12.	_____ does not understand what I am trying to accomplish in therapy.
13.	I am clear on what my responsibilities are in therapy.
14.	The goals of these sessions are important to me.
15.	I find what _____ and I are doing in therapy are unrelated to my concerns.
16.	I feel that the things I do in therapy will help me to accomplish the changes that I want.
17.	I believe _____ is genuinely concerned for my welfare.
18.	I am clear as to what _____ wants me to do in these sessions.
19.	_____ and I respect each other.
20.	I feel that _____ is not totally honest about his/her feelings toward me.
21.	I am confident in _____'s ability to help me.
22.	_____ and I are working towards mutually agreed upon goals.
23.	I feel that _____ appreciates me.
24.	We agree on what is important for me to work on.
25.	As a result of these sessions I am clearer as to how I might be able to change.
26.	_____ and I trust one another.
27.	_____ and I have different ideas on what my problems are.
28.	My relationship with _____ is very important to me.
29.	I have the feeling that if I say or do the wrong things, _____ will stop working with me.
30.	_____ and I collaborate on setting goals for my therapy.
31.	I am frustrated by the things I am doing in therapy.
32.	We have established a good understanding of the kind of changes that would be good for me.
33.	The things that _____ is asking me to do don't make sense.
34.	I don't know what to expect as the result of my therapy.
35.	I believe the way we are working with my problem is correct.
36.	I feel _____ cares about me even when I do things that he/she does not approve of.

similar but not identical construct; a comparison between the relations of the Empathy scale, WAI, and outcome, would help to answer the question of whether the construct of the working alliance captures a larger proportion of outcome variance than rival conceptualizations.

The CRF was designed to measure Strong's (1968) social influence theory conceptualization of the relationship constructs. This instrument appears to be the most reliable and thoroughly validated measure of the social influence relationship variables of *attractiveness*, *trustworthiness*, and *expertness* (LaCrosse, 1980; LaCrosse & Barak, 1976).

Outcome was measured after the 10th session by an adaptation of the Client Posttherapy Questionnaire (CPQ; Strupp, Wallach & Wogan, 1964). The CPQ is highly recommended (Waskow & Parloff, 1975) as a broad range retrospective therapy outcome measure. This instrument was originally developed to measure changes in severely disturbed clients receiving long-term psychodynamically oriented therapy. The original instrument has 23 items; 11 of these solicit information appropriate to limited-term counseling interventions; these items were retained for use in this study. The version of the CPQ used references three areas of client progress: satisfaction, perceived change, and perceived adjustment (Horvath, 1981). The therapists' version of this outcome instrument (Therapist Posttherapy Questionnaire; TPQ) was also administered to the counselors to gauge the relations between the counselor's perception of the working alliance and the counselor's view of outcome.

The reliabilities of the instruments measuring the predictor variables were generally adequate. Reliability estimates based on item homogeneity (Hoyt, 1941) for the CRF ranged from .84 to .87; for the RI the values were .88 for the client's and .89 for the counselor's version. The WAI's reliability estimates for the client's version of the instrument ranged from .85 to .88, whereas the figures for the therapist's version were .87 for the Goal scale, .82 for the Task scale, and .68 for the Bond scale. The outcome scales' reliabilities generally ranged from .88 (client's Change scale) to .75 (counselor's Change scale), however the counselor's satisfaction scale had a coefficient of reliability of .37. The low estimate obtained for the counselor's satisfaction is probably related to the fact that this scale has only two items.

Results

The findings of this study suggest that statistically reliable relations exist between early (third session) working alliance measurements and two out of three client-reported outcome indicators (satisfaction and change). No reliable relations were found, however, between the WAI and the adjustment component of the CPQ. This finding may be because the outcome survey was administered after the 10th counseling session: The adjustment component of client change may be unresponsive to the effects of counseling within such a short time. The composite WAI score appeared to be reliably correlated to the composite outcome measurement. The relations found in this study between the client-reported working alliance dimensions and client-reported outcome as measured by the CPQ are detailed in Table 3.

Although we agree with Mitchell et al. (1977) and Waskow and Parloff (1975) that counselor-based data are not as clinically valuable as that based on the client's perspective, the correlations between counselor's WAI data and the PTQ (reported in Table 4) do provide a supplementary point of view. The results suggest that the correlations found between the client's alliance and outcome data hold generally consistently through counselor-based data.

Table 3
Zero-Order Correlation Coefficients Between Client-Reported Relationship Variables and Client-Reported Outcome

Scale	Satisfaction	Change	Adjustment	Composite
Task	.65*	.45*	.31	.57*
Bond	.32	.23	.21	.31
Goal	.40*	.24	.09	.30
WAI composite	.50*	.33*	.22	.42*
Attractiveness	−.07	−.06	.03	−.05
Trustworthiness	.02	−.10	.16	.01
Expertness	.15	.09	.14	.15
Empathy	.11	.05	.26	.15

Note. $n = 29$. WAI = Working Alliance Inventory.
* $p < .05$.

The correlations shown in Table 4 tend to be marginally higher than corresponding values for the clients displayed in Table 3. This finding may be explained by the fact that the counselors might be more apt to have a well-articulated frame of reference with respect to the desirable features of the relationship as well as to the outcome. This frame of reference would often include ideas regarding the quality of the client-counselor relationship that were consistent with Bordin's (1976, 1980) concepts. Therefore, in situations where the qualities that produced high WAI ratings were perceived, the counselor might experience a degree of satisfaction regarding the helping process in general, have expectations of more positive results, and consequently view the outcome favorably. Conversely, a negative evaluation of the alliance features might be more likely to predispose counselors to rate outcome negatively than to bias the more naive client evaluations.

Study 2

Method

In the second study (Greenberg & Webster, 1982), 31 adult subjects participated in time-limited counseling based on the Gestalt two-chair technique. The clients were selected by Malan's (1976) criteria for brief therapy from respondents to an advertisement offering counseling services to persons experiencing personal conflict in return for participation in the research. Thirty-one women and 5 men began participation in this study. The six counselors had 2 to 7 years of experience with the Gestalt method. The assignment of counselors to clients was random.

Table 4
Zero-Order Correlation Coefficients Between Counselor-Reported Working Alliance Inventory (WAI) Dimensions and Counselor-Reported Outcome

Scale	Satisfaction	Change	Adjustment	Composite
Task	.68*	.37*	.32	.54*
Bond	.48*	.47*	.16	.48*
Goal	.60*	.22	.25	.39*
WAI composite	.66*	.38*	.27	.52*

Note. $n = 29$.
* $p < .05$.

The goal of the intervention was to resolve decisional conflicts. Clients remained in treatment until their conflict was resolved or the program terminated. Five of the clients terminated early; 31 clients provided usable data. To predict treatment outcome, the clients were assessed on the level of client-perceived counselor empathy with the RI (Barrett-Lennard, 1962). The social influence variables of trustworthiness, expertness, and attractiveness were assessed with the CRF (LaCrosse & Barak, 1976), and an estimate of the working alliance was obtained with the Task scale of the WAI. The predictor scales were administered after the second interview.

Effectiveness of the counseling intervention was assessed at the conclusion of the sessions and again 1 month after termination. The outcome measures used to gauge client-reported success were residual gain scores on the following measures: the Scale of Indecision (SI; Osipow, Carney, & Barak, 1976); State–Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970); and the Target Complaint (TC; Battle et al., 1966). The counselor's estimates of client improvements were measured with an adaptation of the TC questionnaire, the Therapist's Target Complaint questionnaire (TTC; Greenberg & Webster, 1982).

The SI was selected because this scale bears directly on the expected outcome of the intervention, whereas it was believed that the STAI State scale would be a useful general indicator of decreased levels of anxiety usually associated with successful counseling (Waskow & Parloff, 1975). TC measures were chosen to track improvements with respect to the specific issues that each client identified as the focus of their concern. Each of these dependent measures were administered pre- and posttreatment to gauge the impact of the interventions. The differences between these two scores were in turn residualized to remove statistically the differential effects due to the scores' regression toward the mean as a matter of measurement artifact (Glass & Stanley, 1970).

Results

The zero-order correlations of the independent variables and the 1-month follow-up outcome indexes (dependent variables) are reported in Table 5. The results suggest that there is a statistically reliable relation between the client WAI Task scale and conflict resolution outcome accounting for approximately 30%–46% of the client-based and 35% of the counselor-based outcome variance. In this study the Task scale captured a larger proportion of the outcome variance than the scales that reflected alternative conceptualizations of the facilitative relationship.

Table 5
Correlations Between Relationship Variables and Outcome Measures in Conflict Resolution Counseling Using the Gestalt Two-Chair Technique

Scale	Indecision	STAI	TC	TTC
WAI Task	.68**	.55*	.65**	.59**
Expertness	.28	−.08	.26	.08
Trustworthiness	−.17	−.11	.19	.00
Attractiveness	−.08	−.08	−.02	−.18
Empathy	−.45	−.29	.34	.24

Note. $n = 31$. STAI = State–Trait Anxiety Inventory. TC = Target Complaints. TTC = Therapist's Target Complaints. WAI = Working Alliance Inventory.
* $p < .01$. ** $p < .001$.

Study 3

Method

The third study (Moseley, 1983) was a replication and extension of the first study with 25 client–counselor dyads representing a broad range of theoretical orientations (client-centered, gestalt, psychodynamic, behavioral, cognitive-behavioral, and rational–emotive). Clients were recruited through an appeal to counselors in various settings (government agencies, university clinics, or private practice). Each counselor was asked to solicit the voluntary participation of their new clients. The participants were told that the study was designed to understand better the nature of the therapeutic relationship. The dyad had to have a minimum of seven sessions to be included in the study.

In addition to the CPQ used in the first study, the STAI and the TC questionnaire were also used as postcounseling outcome measures. The Tennessee Self Concept Scale (TSCS; Fitts, 1965) was used as a pre–post-treatment measure. The TSCS is a measure of a person's image of self. Fitts reported adequate reliability for the TSCS and claimed that the instrument strongly correlated with the appropriate subscales of the Minnesota Multiphasic Personality Inventory. Persons with high scores on this instrument tend to be satisfied with themselves, feel confident, and have positive self-worth. It was expected that, in general, successful counseling would positively impact on the client's self-concept.

Predictor variables used were the same as in the first study (WAI, CRF, and RI Empathy scale), and these were obtained after the third counseling interview. The outcome information was gathered immediately after the termination of counseling or after the 14th session, whichever came first.

Results

In this study Moseley (1983) used the revised version (Horvath, 1982) of the WAI. Reliability estimates based on item homogeneity indexes (Hoyt, 1941) were .89 for the Goal and .92 for the Task and Bond scales. A composite alpha value for the 32 items was .93 (Cronbach, 1951).

Gain scores of the TSCS were residualized to statistically control for the differences in pretreatment scores. Parts of the results of this study are shown in Table 6. These findings generally confirm earlier investigations suggesting a significant positive relation between the alliance as measured by the WAI and outcome.

On the other hand, the working alliance dimensions failed to explain significant portions of the variance in residual gain in state anxiety (STAI) and self-esteem (TSCS). Moseley (1983) pointed out that these results may be partially explained by the fact that 4 of the 25 clients appeared to increase in anxiety and decrease in self-esteem over the course of the counseling sessions, whereas the remaining subjects showed the opposite pattern. These discrepant data came from 4 clients working with two of the counselors. He speculated that these anomalous protocols were the result of counselor-induced deterioration. In such cases the alliance measures taken early in the counseling process are unable to detect difficulties resulting from technique-specific counseling error occurring in a later session. When the data were reanalyzed without the deteriorating subjects, the WAI Task scale correlated reliably ($p < .05$) with both the TSCS and the STAI residual gain

Table 6
Relationship Between the Working Alliance Inventory (WAI) and Client-Based Counseling Outcome Measures

Scale	*n*	WAI		
		Bond	Task	Goal
State Anxiety	25	−.16	−.13	−.04
Self Concept	25	.11	.21	−.02
Target Complaint	19	.51*	.53**	.33
CPQ Composite	22	.46*	.50**	.37*
CPO Adjustment	22	.21	.35	.32
CPQ Satisfaction	24	.71***	.63***	.50**
CPQ Change	22	.25	.30	.16

Note. CPQ = Client Posttherapy Questionnaire.
* $p < .05$. ** $p < .01$. *** $p < .001$.

scores. One cannot, however, discard the possibility that the WAI measurements, particularly if taken early in the counseling process, are not predictive in the cases where actual client deterioration will occur.

Scale Interdependence, Reliability, and Validity of the Working Alliance Inventory

Scale Interdependence

Bordin's (1975, 1976, 1980) theoretical exposition of the various components of the working alliance did not directly address the question of the relative independence or interdependence of the alliance dimensions. From a psychometric point of view, orthogonal components offer the best chance of both the prediction of outcome and the explication of counseling process. Because of the desirability of demonstrating the unique contribution each of the three dimensions, the fact that Bordin defined each dimension partially in terms of the others poses a potential problem. During the instrument-development phase, an attempt was made to maximize the differences between the subscales by selecting items that appeared to be least ambiguous and most distinct with respect to the alliance dimension they represented. Subsequent empirical investigations revealed, however, that these efforts were only partially successful. Table 7 contains the subscale intercorrelation matrix of data based on the two studies (Horvath, 1981; Moseley, 1983).

Clearly, there appears to be a substantial overlap among all of the alliance scales. Although the 1982 revision of the original instrument may have succeeded to a limited degree in separating the Goal and Bond scales, the Task and Goal dimensions continue to share a high degree of covariance. All of these correlations are obviously significant in the clinical as well as in the statistical sense.

Table 7
Working Alliance Inventory Scale Intercorrelations Based on Horvath (1981) and Moseley (1983)

Scale	Bond	Goal	Task
Bond	—	.69	.78
Goal	.84	—	.92
Task	.79	.88	—

Note. Correlations below the diagonal are from Horvath (1981; $n = 29$); correlations above the diagonal are from Moseley (1983; $n = 25$).

Although the strong connection between the Task and Bond scales may be the natural consequence of the former being developed in the context of the latter, the magnitude of all these correlations poses a question that needs to be carefully explored: Are there conceptually distinct alliance components sampled by these scales within the overall domain of working alliance, or do the high scale intercorrelations imply the unidimensionality of the working alliance? Empirically this question was formulated thus: Are there significant proportions of outcome variance that are systemically correlated with either the Goal or the Bond scales after the outcome variance explained by the Task scale has been statistically removed? To answer this question a series of stepwise multiple-regression equations were generated with the outcome measures as the dependent variables and the WAI subscales as predictors. Initially, the scale with the highest zero-order correlation was entered into the equation, and subsequently, the predictor variables with the highest partial correlation with the remaining unexplained portion of variance in the dependent variable were introduced. The probability to enter a value was set to .05, and tolerance was set at 1.0. Table 8 contains the partial results of these analyses.

It seems that, notwithstanding the high correlations between the WAI dimensions, both the Bond and the Goal scales can under certain circumstances predict a significant added portion of the outcome beyond that accounted for by the dominating Task scale. This phenomenon was observed with respect to two out of the three successfully predicted outcome measures in the first study and in one of the two predictable outcome measures in the third investigation. At this stage of the exploration, the evidence appears to suggest that we might be dealing with some highly related but functionally distinguishable components. However, given the limited evidence and the early stage of the exploration, the dimensionality of Bordin's working alliance cannot assume to have been confirmed. More empirical research, perhaps specifically designed to assess the factorial structure of the working alliance as measured by the WAI is needed.

On the basis of the recent theoretical expositions on this subject (Frieswyk et al., 1986; Gelso & Carter, 1985), it is tempting to hypothesize that the various components of the working alliance gain predictive significance at different points of the counseling process. For example, it seems that the agreement on and acceptance of counseling tasks, and perhaps to some extent goals, are very important in the early phases of the work. The strength of the bond component may be more crucial in the later phases of treatment when the client is faced with difficult and painful choices and needs the human understanding, support, and trust of the counselor to maintain therapeutic momentum. If such is the case, longitudinal monitoring of the alliance ought to be able to test the hypothesis.

Reliability

The data from the studies reviewed suggests that the reliability of the WAI is adequate. Based on item homogeneity

Table 8
Stepwise Regression Analyses of Dependent Variables: Counseling Outcome Measures

Dependent variable and variable entered	Increase in R^2	F probability
CPQ composite[a]		
Task	.33	.000
Goal	.15	.000
CPQ Satisfaction[a]		
Task	.43	.000
Bond	.10	.000
Target Complaint[b]		
Task	.28	.000
Goal	.17	.007

Note. p to enter = .05. CPQ = Client Posttherapy Questionnaire. [a] Based on Horvath's (1981) study; n = 29. [b] Based on Moseley's (1983) study; n = 19.

indexes, the client's version of the instrument had an estimated alpha of .93 (Cronbach, 1951) in both Studies 1 and 3. There was only one clinical trial of the counselor's version of the WAI (Study 1), and it yielded a composite reliability estimate of .87.

The individual scales also appear to be reasonably stable. Reliability estimates based on Hoyt's (1941) algorithm range from .85 for the Bond scale in Study 1 to .92 for the Bond and Task scales in Study 2 for the client's version of the instrument (see Table 9). The counselor's version of the Goal and Task scales appear to be satisfactory (Hoyt's index of .82 to .87); however, the Bond scale's reliability needs further support (initial reliability estimate in Study 1 was .68).

Validity

Convergent and discriminant validity. The results of the studies presented can be used to examine the convergent and discriminant validity of the WAI. Strong associations between the WAI and other inventories designed to measure similar traits, combined with evidence of lesser associations between the WAI and other sources of information that share only methodological features with the inventory, can be interpreted as evidence that some of the unique concepts associated with the working alliance are captured (Campbell & Fiske, 1959).

In Table 9 the three WAI dimensions and the Empathy scale from Study 1 are treated as *traits* and the sources of evaluation (i.e., counselors and clients) are used as the *method* to construct a multimethod–multitrait matrix. This matrix can be subdivided into four conceptually meaningful components: the reliability diagonal (figures in bold), the heterotrait monomethod triangles, the heteromethod–heterotrait triangles and the validity diagonal (values in italics). Campbell and Fiske (1959) specified four conditions that bear on the question of the instrument's validity: (a) The values on the validity diagonal should be different from zero and "sufficiently large to encourage further examination of validity" (p. 82); (b) the values on the validity diagonal should be greater than the values lying on its column and row in the heterotrait–heteromethod triangle; (c) the values representing efforts to measure the same construct with different methods (validity diagonal) should be greater than those that simply represent the same method measuring different constructs (off-diagonal elements); and (d) the same pattern of trait interrelationship should be evident in all the heterotrait triangles of both the heteromethod and monomethod blocks.

Analysis of the values in Table 9 suggests that all of the WAI scales have met the first and fourth conditions, none of the scales have conformed to the third requirement because of the high intercorrelations among the subscales, and the Task and the Goal scales met the second requirement. Note however that although the Task scale's validity coefficient was higher than the correlation between the client's Task and counselor's Goal scale, the difference between these correlations was trivial.

In summary, there is evidence supporting the convergent validity of the WAI scales. The results also offer some support for the discriminant validity of the Goal scale, and there is limited support for the Task scale. The status of the Bond scale is equivocal; although the elevated correlation between Bond and Empathy was explicable on the basis of the similarity of the underlying constructs, the strong relationship between the client's Bond and the counselor's Goal scales suggests a conceptual similarity between these constructs during the early phase of counseling.

Concurrent validity. In Studies 1 and 3, the WAI was used along with two other measures of counselor–client relationship, the CRF and the Empathy scale of the RI. The data may be examined to discover to what extent the WAI is

Table 9
Multitrait-Multimethod Matrix Based on the Relationship Variables in Study 1

	Client				Counselor			
Scale	Bond	Task	Goal	Empathy	Bond	Task	Goal	Empathy
Client								
Bond	**.85**							
Task	.79	**.88**						
Goal	.84	.88	**.88**					
Empathy	.83	.63	.62	**.89**				
Counselor								
Bond	*.53*	.43	.50	.55	**.68**			
Task	.46	*.76*	.66	.33	.59	**.82**		
Goal	.55	.75	*.80*	.48	.69	.83	**.78**	
Empathy	.53	.32	.48	*.50*	.74	.49	.60	**.88**

isomorphic with other instruments looking at the generic relationship variable. The correlation coefficients shown in Table 10 suggests that the average common variance or overlap among the CRF scales and the WAI dimensions range from 6% in Study 1 to 40% in Study 3. The common variance between the alliance dimensions and Empathy is somewhat greater, in the range of 48%–52%. (Generally the relations are higher in Study 3 than in Study 1; this might be due to the greater variability of the later sample.)

These results are in accord with expectations based on the conceptual relation between these constructs; Empathy is more closely related to the concept of the working alliance, particularly the Bond scale, than the Social Influence dimensions. These figures also appear to indicate that all of these measures are to some degree responsive to components of the "good relationship," although not all components of the "good relationships" are necessarily equally conducive to positive treatment outcome.

Predictive validity. The studies reviewed provide an opportunity to compare the WAI's and other relationship measures' efficacy of predicting counseling outcomes. In the first study (Horvath, 1981), all of the subjects completed the WAI, the CRF, and the Empathy scale after the third counseling session; only the WAI composite score, the WAI Task subscale, and the WAI Goal subscale correlated significantly ($p < .05$) with client-reported outcome as measured by the CPQ. In the second study (Greenberg & Webster, 1982), the predictor variables investigated were the CRF, the RI Empathy scale and the Task scale of the WAI. Three client-based (SI, STAI, and TC) and one counselor-based (TTC) outcome measures were administered (see Table 5). The WAI Task scale was a significantly better predictor of client-based outcome measures than the three CRF scales or Empathy.

There are some tentative indications that, across a variety of treatment orientations, the WAI might perform at least as well as some of the currently used relationship measuring instruments. Taken together, these results seem to support the predictive validity of the instrument.

Table 10
Intercorrelations of Working Alliance Inventory (WAI) and Counselor Rating Form (CRF) Scales From Study 1 and Study 3

CRF scale	WAI scale			
	Goal	Task	Bond	Empathy
	Study 1			
Attractiveness	.22	.33	.38	.38
Expertness	.29	.39	.28	.29
Trustworthiness	.08	.23	.05	.09
Empathy	.63	.63	.83	—
	Study 3			
Attractiveness	.59	.65	.73	.78
Expertness	.69	.69	.66	.63
Trustworthiness	.41	.53	.72	.75
Empathy	.70	.70	.76	—

Conclusions

Recent articles discussing the future direction of counseling research have emphasized the need for researchers to pay more attention to the fine-grained detail of the change process (Greenberg, 1986; Martin, 1987; Rice & Greenberg, 1984). There also appears to be an increasing attempt to isolate small pantheoretical events in the client change process (Hill & O'Grady, 1985; Mahrer & Nadler, 1986). Increasingly the concept of working alliance is identified as one of the possible variables that, coupled with specific client–counselor interactions, might provide a framework for a metatheory of the change process (Gelso & Carter, 1985). Whereas this challenge might prove daunting in the short term, it appears that this particular direction of inquiry is likely to advance both the generation of theories and the impact of research on clinical practice (Greenberg, 1986; Horvath, 1986; Horvath & Greenberg, 1987).

One of the issues that will have to be addressed in this new research framework is the importance of developing and testing research instruments that are capable of isolating and quantifying the relationship variables that fit into this integrationist research context. In this article an argument is presented that such measuring instruments must be solidly based in a clearly articulated theoretical framework. The WAI was designed with the aim to fit into such a paradigm.

The WAI is showing some promise of being an efficacious early predictor of successful counseling outcome; however, it is obviously at an early stage of development insofar as evidence of its validity, reliability, and utility is concerned. There are also a number of issues awaiting clarification with respect to the dimensionality of the working alliance: First, the multidimensional nature of the Bordin (1980) model needs further empirical support. Second, the relative importance and impact of the goal, task, and bond dimensions of the alliance in the beginning, middle, and end phases of counseling needs to be assessed. Finally, the differences among good working alliances developed by counselors of different orientations must be compared and contrasted in light of the answers to the first two questions.

References

Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs, 76*(42, Whole No. 562).

Battle, C. C., Imber, S. D., Hohen-Saric, R., Stone, A. R., Nash, E. R., & Frank, J. D. (1966). Target complaints as a criterion of improvement. *American Journal of Psychotherapy, 20* 184–192.

Bordin, E. S. (1975, August). *The working alliance: Basis for a general theory of psychotherapy.* Paper presented at a symposium of the American Psychological Association, Washington, DC.

Bordin, E. S. (1976). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Bordin, E. S. (1980, June). *Of human bonds that bind or free.* Presidential address delivered at the meeting of the Society for Psychotherapy Research, Pacific Grove, CA.

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin, 56*, 81–105.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*, 297–234.

Fitts, W. H. (1965). *Manual for the Tennessee Self Concept Scale.* Nashville, TN: Counselor Recordings and Tests.

Frank, J. D. (1961). *Persuasion and healing.* New York: Johns Hopkins University Press.

Freud, S. (1958). On the beginning of treatment: Further recommendations on the technique of psychanalysis. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 122–144). London: Hogarth Press. (Original work published 1913)

Frieswyk, S. H., Allen, J. G., Colson, D. B., Coyne, L., Gabbard, G. O., Horwitz, L. & Newsom, G. (1986). Therapeutic alliance: Its place as a process and outcome variable in dynamic psychotherapy research. *Journal of Consulting and Clinical Psychology, 54*, 32–38.

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 13*, 155–243.

Gitleson, M. (1962). The curative functions in psychotherapy. *International Journal of Psychoanalysis, 43*, 194–205.

Glass, G. V, & Stanley, J. C. (1970). *Statistical methods in education and psychology.* Englewood Cliffs, NJ: Prentice-Hall.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4–9.

Greenberg, L. S., & Pinsof, W. M. (Eds.). (1987). *The psychotherapeutic process: A research handbook.* New York: Guilford Press.

Greenberg, L. S., & Webster, M. C. (1982). Resolving decisional conflict by Gestalt two-chair dialogue: Relating process to outcome. *Journal of Counseling Psychology, 29*, 468–477.

Greenson, R. R. (1967). *Technique and practice of psychoanalysis.* New York: International Universities Press.

Gurman, A. L. (1977). The patient's perception of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy* (pp. 503–544). New York: Pergamon Press.

Hadley, S. W., & Strupp, H. H. (1976). Contemporary views of negative effects of psychotherapy. *Archives of General Psychiatry, 33*, 1291–1302.

Hill, C. E., & O'Grady, K. E. (1985). List of therapist intentions illustrated in a case study and with therapists of varying theoretical orientations. *Journal of Counseling Psychology, 32*, 3–22.

Horvath, A. O. (1981). *An exploratory study of the concept of therapeutic alliance and its measurement.* Unpublished doctoral dissertation, University of British Columbia, Vancouver, Canada.

Horvath, A. O. (1982). *Working alliance* (Rev. ed.). Unpublished manuscript, Simon Fraser University, Vancouver, British Columbia, Canada.

Horvath, A. O. (1986). *Another approach to assess the counseling relationship: The working alliance.* Paper presented at the annual conference of the American Educational Research Association, San Francisco.

Horvath, A. O., & Greenberg, L. S. (1987). The development of the working alliance inventory. In L. S. Greenberg & W. M. Pinsof (Eds.)., *The psychotherapeutic research process: A research handbook* (pp. 529–556). New York: Guilford Press.

Hoyt, C. L. (1941). Test reliability measured by analysis of variance. *Psychometrika, 5*, 153–160.

LaCrosse, M. B. (1980). Perceived counselor social influence and counseling outcomes: Validity of the Counselor Rating Form. *Journal of Counseling Psychology, 27*, 320–327.

LaCrosse, M. B., & Barak, A. (1976). Differen ial perception of counselor behavior. *Journal of Counseling Psychology, 23*, 170–172.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92–118). New York: Brunner/Mazel.

Mahrer, A. R., & Nadler, W. P. (1986). Good moments in psychotherapy: A preliminary review, a list, and some promising research avenues. *Journal of Consulting and Clinical Psychology, 54*, 10–15.

Malan, H. D. (1976). *Toward the validation of dynamic psychotherapy: A replication.* New York: Plenum Press.

Marmar, C. R., Horowitz, M. J., Weiss, D. S., & Marziali, E. (1987). The development of the therapeutic alliance rating system. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 367–390). New York: Guilford Press.

Martin, J. (1987). Cognitive change in clients: Cognitive mediational models. *Counselor Education and Supervision, 26*, 192–203.

Mitchell, K. M., Bozarth, J. D. & Krauft, C. C. (1977). A reappraisal of the therapeutic effectiveness of accurate empathy, non-possessive warmth and genuineness. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 482–503). New York: Pergamon Press.

Morgan, R., Luborsky, L., Crits-Cristoph, P., Curtis, H., & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry, 39*, 397–402.

Moseley, D. C. (1983). *The therapeutic relationship and its association with outcome.* Unpublished master's thesis, University of British Columbia, Vancouver, Canada.

Orlinsky, D. E., & Howard, K. I. (1975). *Varieties of psychotherapeutic experience.* New York: Teachers College Press.

Osipow, S. H., Carney, C. G., & Barak, A. A. (1976). A scale of educational vocational indecisiveness: A typological approach. *Journal of Vocational Behavior, 9*, 233–343.

Parloff, M. B., Waskow, I. E., & Wolfe, B. E. (1978). Research on therapist variables in relation to process and outcome. In S. L. Garfield & A. R. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 233–282). New York: Wiley.

Rice, L. N., & Greenberg, L. S. (Eds.). (1984). *Patterns of change: Intensive analysis of psychotherapy process.* New York: Guilford Press.

Rogers, C. R. (1951). *Client-centered therapy.* Cambridge, MA: Riverside Press.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 22*, 95–1103.

Saltzman, C., Luetgert, M. J., Roth, C. H., Creaser, J., & Howard, L. (1976). Formation of a therapeutic relationship: Experiences during the initial phase of psychotherapy as predictors of treatment duration and outcome. *Journal of Consulting and Clinical Psychology, 44*, 546–555.

Shapiro, D., & Shapiro, D. (1983). Comparative therapy outcome research: Methological implications of meta-analysis. *Journal of Consulting and Clinical Psychology, 51*, 42–53.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*, 752–760.

Spielberger, C. D., Gorsuch, R. L., & Lushene, E. R. (1970). *Manual for the State-Trait Anxiety Inventory.* Palo Alto, CA: Consulting Psychologist Press.

Sterba, R. F. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis, 115*, 117–126.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*, 215–224.

Strupp, H. H., & Hadley, S. W. (1979). Specific versus nonspecific

factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry, 36*, 1125–1136.

Strupp, H. H., Wallach, M. S., & Wogan, M. (1964). Psychotherapy experience in retrospect: Questionnaire survey of former patients and their therapists. *Psychological Monographs, 78*(11, Whole No. 588).

Waskow, I. E., & Parloff, M. B. (Eds.). (1975). *Psychotherapy change measures*. Rockville, MD: National Institute of Mental Health.

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37*, 369–376.

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