THE RELATIONSHIP BEWEEN WORKING ALLIANCE AND THERAPEUTIC GOAL ATTAINMENT IN AN ADOLESCENT INPATIENT, ACUTE CARE BEHAVIORAL HOSPITAL

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

The working alliance continues to be the single most important aspect of counseling outcomes in various settings (Corsini and Wedding, 2011; Hanson et al., 2002; Munder et. al., 2010). Extant research is limited in examining the relationship between working alliance (Blais et al., 2010; Faw et. a., 2005) and therapeutic goal attainment (Balkin, 2013; Balkin & Roland, 2007) with adolescents in inpatient settings. The purpose of this study was to explore working alliance, measured with the Working Alliance Inventory-short (WAI-S), and therapeutic goal attainment, assessed with the Crisis Stabilization Scale (CriSS), with adolescents in an inpatient, acute-care, behavioral hospital in south Texas.

A sample of 75 adolescents admitted into a short-term hospital for crisis reasons was utilized to examine working alliance and therapeutic goal attainment. A canonical correlation analysis was conducted to explore the extent of the relationship between these two variables. Additionally, differences between counselor and client ratings of working alliance were investigated using a repeated measures multivariate analysis of variance.

The results of the canonical correlation analysis indicated that a statistically significant relationship exists between counselor ratings of working alliance and therapeutic goal attainment. Additionally, a statistically significant difference was found on the counselor and client ratings of working alliance. Lastly, no statistically significant relationship was found between client ratings of working alliance and therapeutic goal attainment.

Implications and recommendations for future research are provided. A strong working alliance, specifically collaboration on tasks in counseling, is important for adolescents'

achievement of goals related to stabilization. Additionally, clients may over report progress in counseling. More research is needed with adolescents in crisis inpatient settings to support further findings.

DEDICATION

To any individual struggling with a dark night; may you find light and peace within yourself because you are worth living. To the counselors working with those who struggle; always remember your significance in this field.

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understand the difficultness that is statistics. Your constant support and love helped me to get through tough times. I am forever proud to be by your side. I love you today and always.

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CHAPTER I

Introduction

From 1996 to 2007 there was an increase in the number of adolescents admitted into hospitals for short-term psychiatric care (National Institute of Mental Health [NIMH], 2011). This perhaps may be due to the decrease in the amount of bed days allowed for psychiatric treatment (NIMH, 2011). The United States Department of Health and Human Services and Office of Adolescent Health (n.d.) reported 16% of high school students have contemplated suicide while 8% have pursued suicide. Centers for Disease Control and Prevention (2010) reported suicide being the 10th leading cause of death in the United States of America and accounted for 13% of deaths in people aged 1-24. The American Academy of Child and Adolescent Psychiatry (AACAP, 2009) reported suicide as being the 3rd leading cause of death among adolescents and young adults aged 15-24. Further, suicidal ideations and attempts necessitate the need for psychiatric hospitalization.

Inpatient, acute-care settings are utilized when individuals are in a crisis situation, specifically experiencing harm to self or others. The AACAP (2008) referred to this as crisis residence, defined as a setting with 24 hour a day care for acute crisis hospitalization. Crisis residence consists of less than 15 days (AACAP, 2008) while acute care settings have a typical time frame of 5 to 7 days. Inpatient hospitals have four overall targets for clients including safety, the reduction of harm either to self or others, discharge planning, and resources for outpatient services (Balkin, 2003; Balkin & Roland, 2005). Tubman, Montgomery, and Wagner (2001) discussed goals of crisis intervention as including stabilization, assessment, treatment planning, and resources.

Because clients in an inpatient setting are receiving treatment 24 hours a day, the interaction between clients and staff is fairly high (Balkin & Roland, 2005; Dinger et. al., 2008).

Clients in an inpatient setting may receive a variety of different group experiences as well as individual and family sessions. These groups may include several counseling and nursing topics and activities. Treatment needs to be beneficial for the short amount of time that clients spend in the hospital. Blais, Jacobo, & Smith (2010) utilized a "manualized, brief supportive psychotherapy" with a sample of 20 clients in an inpatient, acute-care setting (p. 388). The focus of their study was on clients' addressing and coping with symptoms and unhealthy relational patterns. The researchers found a positive working alliance to be related to high functional stages as well as a negative relationship between outcome and working alliance in an inpatient hospital (Blais et. al., 2010).

Adolescents are admitted into an inpatient hospital as the result of two specific incidents involving harm to self or harm to others. Because of safety reasons, inpatient, acute-care facilities seem to be imperative for stabilization (Balkin & Roland, 2007). Adolescence, according to Sigelman and Rider (2006), is defined as "the transitional period between childhood and adulthood that begins with puberty and ends when the individual has acquired adult competencies and responsibilities" (p. 6). This period is a notable time in an individual's life that can be marked with developing an identity. In summary, this is a time for change (Sigelman & Rider, 2006).

Therapeutic alliance, also known as the therapeutic relationship and working alliance in counseling, highlighted by Carl Rogers (therapeutic alliance; 1961) and Edward Bordin (working alliance; 1979), was researched and found to be a positive factor in predicting counseling outcomes (Blais et al., 2010; Dinger, et. al., 2008; Hanson, Curry, & Bandalos, 2002; Munder et. al., 2010). The working alliance can be defined as collaboration in counseling in which the counselor is helpful to the client and has an emotional connection (Corsini and Wedding, 2011;

Hanson et al., 2002; Munder et. al., 2010). Bordin (1979) developed a model of working alliance and found that the working alliance includes the following: agreement on tasks, agreement on goals, and a bond between counselor and client. According to Faw, Hogue, Johnson, Diamond, and Liddle (2005) there has been a minimal amount of research with adolescents that focuses on the working alliance. Most of the research studying this phenomenon has taken place with adults (Faw et. a., 2005). The working alliance has been studied extensively in outpatient counseling settings but not extensively in inpatient settings (Blais et al., 2010). Additional factors affecting a positive outcome and the working alliance include a strong partnership as well as a treatment commitment (Dinger, et. al., 2008). Colson et al. (1991) reported that working alliance was difficult with clients who were defiant and oppositional (Bettmann & Jasperson, 2009). The core conditions of genuineness, unconditional positive regard, and empathy are the main components of a relationship that leads to a strong working alliance (Overholser, 2002). However, working alliance may incorporate different components particularly when in short-term inpatient settings where goals related to stabilization are necessary for discharge.

Therapeutic goal attainment is the achievement of the client's goals related to stabilization and includes coping and commitment to follow-up (Balkin, 2013). This model of goal attainment, proposed by Balkin (2004), incorporated the identification of problems, commitment to safety, processing coping skills, and commitment to follow-up. Further, therapeutic goal attainment was related to counseling outcomes (Balkin & Roland, 2007; Balkin, Leicht, Sartor, & Powell, 2011).

Statement of the Problem

The average length of stay at an acute care, behavioral hospital is approximately 5 to 7 days. Adolescents in crisis enter an acute care setting and generally leave within the allotted

time frame when safety is reached and harm is no longer a factor. Therapeutic goal attainment, which includes coping and commitment to follow-up, was connected to stabilization in adolescents within an acute care hospital (Balkin & Roland, 2007). Extant research is limited regarding working alliance when it comes to inpatient settings (Blais, Jacobo, & Smith, 2010). As a result of managed care systems, behavioral hospitals have moved away from treatment and more towards rapid crisis stabilization. As a result, recidivism is more likely to happen, therefore increasing costs for insurance companies (Balkin, 2006). Individuals admitted into inpatient behavioral hospitals stay for a short period of time. Counselors' interactions with clients in these short days can be crucial to treatment outcomes. There is a gap in the literature regarding the relationship between working alliance and therapeutic goal attainment.

Purpose of the Study

The purpose of this quantitative study was to examine the relationship between working alliance and therapeutic goal attainment with adolescent clients in an inpatient, acute care hospital setting. The limited amount of research in regard to working alliance with adolescents in inpatient behavioral health settings will be addressed. Working alliance, measured by the Working Alliance Inventory-short (WAI-S), incorporates goals, tasks, and bonds (Hanson, Curry, & Bandalos, 2002). Therapeutic goal attainment, measured by the Crisis Stabilization Scale (CriSS), incorporates coping (commitment to safety, problem identification, and processing coping skills) and commitment to follow up (Balkin & Roland, 2007). Gender differences and diagnosis differences could possibly have an interaction on the relationship between working alliance and therapeutic goal attainment.

Results of this study can benefit inpatient settings by determining the significance of the working alliance as related to therapeutic goal attainment. Because the findings of many studies

have reported that working alliance is the most important factor in outcomes, this would seem true when assessing therapeutic progress in goal attainment as well. Clinicians in inpatient settings are responsible for several duties (individual, group, and family sessions; paperwork; case management; psychiatrist consultation; etc.) and often have heavy case loads. This may influence the development of the working alliance. Results of this study may help to bring information to counselors, counselor educators, and employees of inpatient hospitals on how working alliance effects therapeutic goal attainment in clients. Additionally, this study can perhaps aid in the training of counselors to be able to be beneficial with clients who are in danger of harming themselves or others and therefore are admitted into an inpatient facility.

Significance of the Study

A study on therapeutic goal attainment and the working alliance in an acute-care, inpatient setting will add to the limited amount of current literature on this topic. This study can be beneficial for several reasons. This study can be useful in finding the extent of the working alliance between clients and clinicians in an inpatient facility and to what extent it relates to goal attainment. A number of researchers have found that the working alliance is significantly related to counseling outcomes (Blais et. al., 2010; Dinger, et. al., 2008; Hanson, Curry, & Bandalos, 2002; Munder et. al., 2010). Hospitals, which tend to follow a medical model, can benefit from research that demonstrates the importance of the relationship.

Results of this investigation can provide insight into the components that predict goal attainment with adolescents in an acute-care, inpatient facility. Balkin and Roland (2007) found that "stabilization of adolescent clients treated in an acute care psychiatric unit likely was linked to achievement of therapeutic goals" (p. 69). The findings of this study could strengthen an awareness and knowledge of predictors of goal attainment.

Inpatient hospitalization is not a natural habitat for humans and being in a structured environment can feel chaotic for adolescents (Bettmann & Jasperson, 2009). The longer clients stay in a 24/7 care hospital; perhaps the more "normal" or "better" clients would feel. This is due to the lack of extraneous stressors that could be contributing to the need for inpatient psychiatric care. Long-term hospitalization for clients might cause a plateau in growth since there are little effects of environmental stimuli. Therefore, it would possibly be in the client's best interest for behavioral hospitals to implement methods to increase rapid stabilization.

A final benefit relates to the preparation of counselors. Experiences in an inpatient facility can be very different than working with clients in outpatient settings. Research findings can assist in the educational training of student counselors who will work in inpatient settings, and might enhance training methods used when working with this population (Blais et. al., 2010; Mellin, 2009).

Research Questions

The goal of this study was to examine the relationship between therapeutic goal attainment and working alliance in adolescent clients admitted to an acute care, behavioral hospital. Additionally, another goal of this study was to determine if clinicians and adolescent clients rated working alliance differently. Therapeutic goal attainment was measured using the Crisis Scale of Stabilization (CriSS) and working alliance was measured using the Working Alliance Inventory-short (WAI-S). Gender and diagnosis was also examined. The following research questions were examined:

1. What is the extent of the relationship between working alliance as rated by clinicians and therapeutic goal attainment?

2. What is the extent of the relationship between working alliance as rated by clients and therapeutic goal attainment?
3. What is the extent of the difference between clinician and client ratings on the Working Alliance Inventory-short?

Assumptions

The adolescent participants of this study were admitted into an inpatient, acute care behavioral hospital. In order to be admitted into such a hospital, clients must be a danger to self or others (i.e. in crisis). For clients to be discharged they must no longer be a danger to self or others therefore no longer in crisis.

Delimitations

Participants of this study were admitted into an acute-care behavioral hospital in crisis and had a variety of diagnoses including depression, bipolar disorders, psychotic disorders, and posttraumatic stress disorder. This study focused on measuring therapeutic goal attainment and working alliance. Treatment efficacy and improvement after discharge was not measured.

This study included adolescent participants aged 12 through 17. Clinicians completing the scales had a master's degree in counseling and were licensed (LPC or LPC-intern) individuals. All participants were voluntary; parental consent was obtained, participant assent was received, and clinician consent was obtained. The factors that were addressed included therapeutic goal attainment and working alliance.

Limitations

One limitation of this study pertains to the training background of clinicians. The clinicians utilized in this study do not have the same background training and therefore may lack consistency with how they respond to the WAI-S items. Additionally, some clinicians may hold

the importance of working alliance to a higher degree when examining the achievement of goals. For example, a clinician may have been trained to value agreement of goals for counseling while another clinician may not have been trained to view the importance of this.

Definition of Terms

Acute care, which is also identified as crisis residence, can be defined as a brief, 24-hour treatment (i.e., less than 15 days; American Academy of Child and Adolescent Psychiatry, 2008).

Adolescence is a time period between being a child and an adult. This time frame is saturated with change in the physical, cognitive, and social self (Sigelman & Rider, 2006, p. 514).

Bond, a component of working alliance, is defined as the relationship between counselor and client that includes trust, confidence, and liking (Bordin, 1979; Horvath & Greenberg, 1989).

Commitment to follow-up, an element of therapeutic goal attainment, includes the client's pledge to attend follow-up services upon discharge from an inpatient hospital (Balkin, 2014).

Coping is a factor of therapeutic goal attainment and contains the client's ability to commit to safety, identify problems, and process coping skills (Balkin, 2014).

Diagnosis is the application of the Diagnostic and Statistical Manual of Mental Disorders 4th edition, text revision (DSM-IV-TR) in the identification of a mental disorder for a client (American Psychiatric Association, 2000). Because the site where the study was conducted utilizes the DSM-IV-TR for diagnosis, this edition was be used.

Goal, an element of working alliance, is an objective for the purpose of achievement in counseling (Bordin, 1979; Horvath & Greenberg, 1989).

Inpatient hospitalization includes receiving psychiatric care in a hospital setting. Treatment is tailored to fit the needs of adolescents (American Academy of Child and Adolescent Psychiatry, 2008).

Task, a component of working alliance, includes specific assignments or duties the client accomplishes in a counseling session (Bordin, 1979; Horvath & Greenberg, 1989).

Therapeutic goal attainment can be defined as "the degree to which the adolescent is able to commit to safety, identify problems, process coping skills, and commit to follow-up" (Balkin, Flores, and Casillas, 2011, p. 2).

Working alliance is defined as a professional, collaborative relationship between counselor and client that includes an agreement on goals and tasks as well as the formation of a bond (Bordin, 1979; Muran and Barber, 2010).

Remaining Chapters

Chapter Two presents a review of the literature. The literature review focuses on the working alliance, acute-care hospitalization with adolescents, and therapeutic goal attainment. Chapter Three includes the methodology used in this investigation, which consists of the sample, design, data collection, and data analysis. Chapter Four provides the findings of the study. Research questions are addressed in chapter four. Chapter Five focuses on the discussion of findings, implications and conclusions. Recommendations for further research are also explored in chapter five.

CHAPTER II

Literature Review

Adolescent Development

Adolescence is a time for change in which the individual goes through many different transitions including physical, mental, and emotional that are influenced by biological and environmental factors. During this time, a significant amount of exploration and identity development occurs, and throughout this process individuals face formidable responsibility and also vulnerability and heartache (American Psychological Association [APA], 2002). Relationships are better viewed as transitory and confounded with an abundance of emotional stress (Baskin, Quintana, & Slaten, 2014) and excessive anxiety (Hazler & Mellin, 2004). However, the adolescent experience is unique with different views on adolescent development and the need for research with adolescents.

Many researchers and theorists studied adolescent development and identity, such as G. Stanley Hall, Margaret Mead, Havighurst, Freud, Erikson, James Marcia, Piaget, and Kohlberg (Santrock, 1993). In his book *Adolescence,* G. Stanley Hall (1904), a pioneer in adolescent development, was one of the first to describe and attempt to understand the changes that occurred within this time frame. For example, adolescents have heightened awareness of sex and personal sexuality during this stage of development. Hall (1904) believed that adolescent development is influenced by genetics and environment and is full of discord in which he referred to as "storm and stress" throughout his book. In contrast, Mead (1928), although her work was controversial, believed in the sociocultural perspective and studied the period of adolescence in the Samoan culture and found that when this period was centered around knowledge, awareness of otherwise adult experiences (e.g. sex, birth, and death), and calmness, adolescence was not overwhelmed

with stress. On the other hand, adolescence in United States culture tends to not involve the aforementioned and therefore is plagued with hardship.

Robert Havighurst (1960), on the other hand, did not agree with the storm and stress model of adolescence and proposed a developmental theory that consisted of tasks at various life stages. Havighurst believed that this time was a period that incorporated a consistent biological component (puberty) and a cultural component universal to adolescence. This time of puberty is when the adolescent is going through biological changes into adulthood. The cultural component is distinct to different people and the move to adulthood happens when independence and security is achieved.

Sigmund Freud, the father of psychoanalysis, developed the theory of psychosexual development, which includes the oral, anal, phallic, latency, and genital stages (Freud, 1930, 2001). The stages of latency and genital are most closely related to adolescence. In the latency stage, ages 6-11, children and adolescents engage in social activities, such as sports and academic interests. Sexuality issues will be latent at this phase and adolescents are more likely to possess serenity. Further, in the genital stage (i.e., puberty), adolescents seek independence from others, which is confounded with confusion and defenses (Crain, 2000). Moreover, Freud (1920) described his beliefs of personality, the unconscious, dream work, and how sexuality drives humans, among many other things. Freud described, what he called the three structures of personality (a) the id, which manages pleasure; (b) the ego, which controls reality; (c) and the superego, which governs morale (Santrock, 1993).

Additionally, Erik Erikson (1968), who was influenced by Freud, hypothesized that individuals develop, in what he called psychosocial stages. He postulated that individuals developed in 8 prearranged stages in which each advances upon the last. In the adolescent stage,

Identity versus identity confusion, individuals focus on their identity (who they are), which can be affected by their environment (Erikson, 1968). Further, Erikson and Erikson (1957) stated that "delinquents are made, not born—and they are made slowly and gradually" (p. 16). This statement demonstrates Erikson's believe in the environmental aspect of development. During the period of adolescence, individuals' character and personality is more established and influenced by parental expectations, for example (Erikson & Erikson, 1957). Considering this, there is no surprise that this time period may be stressful and confusing to adolescents.

James Marcia, who followed and was influenced by Erikson, conducted research on adolescent psychosocial development. Marcia (1966) developed identity statuses for ego identity, a term influenced by Erikson, which describes a time when older adolescents form adult-like identities. These statuses include identity achievement, moratorium, foreclosure, and identity diffusion. Marcia (1980) described the extent of crisis and commitment in occupation and beliefs as being central to adolescent identity development.

Jean Piaget, known for cognitive developmental theory, believed that development incorporated four stages. In the formal operational stage (i.e., ages 11-15), individuals focused on abstract thought and the future (Santrock, 1993). Piaget (1997) posited that adolescence is a time where the individual becomes less involved with family and more interested in social aspects of life (i.e. friends and peers). In other words, the child develops into an adolescent and becomes more independent. Further, Piaget and Inhelder (2000) believed in the social aspects of development and that adolescence, the ages of 15 to 18, was a debut into adulthood. At this stage, individuals are beginning to think about future careers and how they might fit into a social society.

Lastly, Lawrence Kohlberg, known for his theory of moral development, believed that moral development was the progress of growth in a person's values and occurred in six stages (Kohlberg & Hersh, 1977). The moral stages include a preconventional level, stage one and two, a conventional level, stage three and four, and a postconventional level, stage five and six. Further, Kohlberg discussed the importance of viewing schools' influence on children's and adolescents' moral development as well as the family and church (Kohlberg, 1966; Kohlberg & Hersh, 1977).

Colby, Kohlberg, Gibbs, and Lieberman (1983) completed a 20-year study on the development of moral judgment. This study examined Kohlberg's theory of moral development. Results indicated that stages were sequential and have a ranked order, a result that Kohlberg and Hersh (1977) discussed as well. Additionally, results suggested that moral judgment had a positive correlation with factors such as age, socioeconomic status, education, and intelligence quotient. For example, the older an individual is the more likely his or her moral judgment would be stronger and vice versa.

Although each theorist has a unique perspective and attributes certain developmental characteristic to adolescence, all present continuity in development. In other words, the individuals face the challenges presented in each stage in order to successfully move into the latter stages. To date, there is no agreed upon theory that accounts for every facet of adolescent development, yet using multiple theories in order to full conceptualize the complexity of adolescence is surely warranted.

Mental Health in Adolescence

Mental illness in adolescence has become more prevalent, yet only a few studies have examined this phenomenon. The National Alliance on Mental Illness (2013) reported on

adolescent mental illness information, which is outlined below. Mental health issues are developmental and there is an interaction effect between biology and the environment. For example, parental issues, unsupportive environments, and poor social environments may affect mental illness in adolescents and further into adulthood (i.e. developmental).

Statistics. Suicide in adolescents and young adults is the third leading cause of death and can be due to many issues including an influx in stress and chaos (AACAP, 2013). According to Murphy, Xu, and Kochanek (2013), suicide was the 10th leading cause of death in 2010, which was an increase from 2009. Males were four times more likely to die from suicide than females, who are more likely to disclose a suicide attempt. The types of suicide discussed included poisoning, drug/alcohol induced, cutting, drowning, falling, transportation, suffocation, and firearms, which again increased from 2009.

The Department of Health and Human Services and Office of Adolescent Health (n.d.) reported data on symptoms of depression and suicide in adolescents. In the United States approximately 30% of students in high school experienced sadness or hopelessness (Centers for Disease Control and Prevention [CDC], 2013). According to CDC (2013), females (39%) were more likely to experience these symptoms than males (21%). Seventeen percent of high school students considered suicide (22% female; 12% male); approximately fourteen percent created a suicide plan (17% female; 10% male); eight percent tried suicide (11% female; 5% male); and three percent who attempted suicide needed professional medical attention (4% female; 2% male).

Common disorders/diagnoses in adolescents. Given the alarming rate of suicide and suicide attempts, a review of common disorders and diagnoses in adolescence is important to consider, especially when examining what contributes to psychiatric hospitalization. Common

disorders diagnosed that correlate with suicidality include depressive disorders, bipolar disorders, psychotic disorders, and suicidal and homicidal ideations. Further, these disorders, for the most part, are diagnosed with the same criteria in all age groups (children-adults) and both depression and bipolar usually include psychotic features in adolescence (McCarthy & Dobroshi, 2014). Having an aforementioned diagnosis solely does not warrant the need for hospitalization; rather, these diagnoses are prevalent among patients seen in a psychiatric inpatient setting.

Depression in adolescence. An adolescent with a major depression diagnosis may have symptoms such as depressed mood, loss of interest, and irritability (American Psychiatric Association [APA], 2013). Further, adolescents might exhibit weight gain or weight loss, which is different in this age group when compared to children, as well as too much sleep or lack of sleep (McCarthy & Dobroshi, 2014).

Depression among adolescents negatively influences most aspects of their lives including academic, social, and psychological. Baskin, Quintana, and Slaten (2014) discussed emotional distress among adolescents and how this may lead to depression, which can affect aspects like family relationships and friendships, gang involvement, and academic achievement. Further, depression can sometimes lead to suicidal ideation and suicidal attempts (Hazler & Mellin, 2004; McCarthy & Dobroshi, 2014). This warrants the necessity of psychiatric hospitalization for adolescents with suicidality.

Depression may be expressed differently in adolescence than in adulthood, specifically for academic performance and social connection (Hazler & Mellin, 2004). Weisz, McCarty, and Valeri (2006) produced a meta-analysis on children and adolescents with depression and counseling results, which included 35 studies. Findings indicated that treatments for depression have similar effects no matter the approach. However, treatment effects of other issues in youth

seem to exceed treatment effects for depression. Furthermore, findings indicated that counseling is effective for depression treatment; cognitive as well as non-cognitive approaches were effective for the treatment of children and adolescents with depression, and depression treatment may be effective for anxiety (Weisz et al., 2006). In a similar study, Erford et al. (2011) presented a meta-analysis on counseling outcomes for youth with depression. This study utilized 42 investigations of counseling in school settings as well as outpatient settings. Results of this meta-analysis suggested three general findings: counseling is effective for depression with youth; counseling has a long-term affect for treatment of depression; and counseling in school settings and outpatient settings are equally effective (Erford et al., 2011).

Bipolar disorders in adolescence. Bipolar disorders include periods of depression with either mania or hypomania. Further, bipolar disorder may be exhibited with psychotic features (APA, 2013), which is more common among adolescents (McCarthy & Dobroshi, 2014). Adolescents with this diagnosis have auditory hallucinations and delusions more often than those in childhood.

Diagnosing bipolar disorder in youth has been disputed among mental health professionals. There are differences in the literature when it comes to reporting bipolar symptoms and how they manifest in children and adolescents due to developmental issues. Perhaps because of this, bipolar disorder has high comorbidity with disorders such as substance use and attention deficient hyperactivity disorder (ADHD; Birmaher, 2013; McCarthy & Dobroshi, 2014). Additionally, Birmaher (2013) reported controversies with diagnosing bipolar disorder in youth such as the possibility of overdiagnosis in the United States.

Schizophrenia and psychosis in adolescence. Schizophrenia is considered a severe mental disorder with low prognosis rates due to the intense symptoms and lack of connection

with reality, which may make those who experience this diagnosis dependent on others for care. For example, symptoms commonly seen with those who experience psychosis include delusions, hallucinations, and disorganized speech (APA, 2013). Adolescence and young adulthood are the most common time for the onset of psychotic disorders, which can be confusing and traumatic to those experiencing this diagnosis. As a result, some individuals may need admission into a psychiatric hospital for further evaluation and safety needs.

Bratlien et al. (2014) studied social factors and psychotic disorders among adolescents (i.e., 15-16 years old). They compared those who had psychotic disorders to a control group. Findings from this study indicated those adolescents who had more economic issues, smaller social support systems, and reduced academic aspirations were the individuals who developed psychotic symptoms. More on the genetic side of the spectrum, Trotman et al. (2013) considered hormone changes in adolescents' brain development for those experiencing psychosis. Hormonal changes in puberty may relate to the risk of psychosis.

Suicidal and homicidal ideation. Being that safety issues are the reasons for admission, suicidal ideation would seem to be the leading cause of psychiatric hospitalization. Additional rationales may include homicidal ideation, psychotic symptoms, substance use, and behavioral issues. Despite these other reasons, an individual who is a danger to self or a danger to others requires inpatient treatment. Having knowledge and awareness surrounding suicide is crucial for counselors to provide effective prevention and treatment. Sheperis and Sheperis (2015) discussed theories about suicide. Some factors included in these theories were social dynamics, psychological suffering, lethality, hopelessness, trauma, emotional dysregulation, and emotional, biological, and psychological needs not being met. Further, factors surrounding suicide are important to be aware of in order to provide future assessment and intervention.

Inpatient Hospitalization

Inpatient hospitalization ranges from acute to subacute, depending on symptom severity; clients are under 24-hour supervision from hospital staff when receiving treatment in an inpatient setting. Hospitalization in acute-care settings, which is usually around 5 to 7 days, has little research in counseling literature. Recent research on this topic was completed primarily by Balkin and collegues (Balkin, 2013; Balkin, Casillas, Flores, & Leicht, 2011; Balkin, Flores, & Casillas, 2011; Balkin, Leicht, Sartor, & Powell, 2011; Balkin & Roland, 2007; Balkin & Roland, 2005). These studies examine goal attainment with adolescents in acute-care hospital settings. Individuals being admitted into these settings are a danger to self or others. In other words, these individuals are in a crisis situation, therefore needing hospitalization in order to prevent further harm towards self or others.

There are certain indications warranting the need for hospitalization in children. For instance, those in which outpatient treatment is not appropriate due to suicidal issues or psychotic symptoms (Green, 1992) as well as youth who have not been successful with outpatient counseling (AACAP, 2011) may necessitate the need for further services in an inpatient setting. These clients would certainly necessitate the need for inpatient treatment due to the dire need of supervision, diagnosis, medication management, and safety. Additionally, hospitalization may be needed for further evaluation or medication stabilization.

Ponterotto (1987) addressed procedures and information regarding hospitalization, and although dated, the information remains substantial. Individuals admitted to hospitals, whether voluntary or involuntary, experience a mental status exam, a psychosocial assessment, medication evaluation, and treatment groups. More importantly, counseling was found to be

effective in inpatient settings as a whole, while separate elements of determining effectiveness in this environment may be challenging (Dinger et al., 2008). Challenges to consider when examining treatment in inpatient settings include various treatment providers, diverse client issues and comorbidities, and short time frames. Lastly, counselors should be aware of current trends in hospitalization in order to provide the best treatment possible.

Balkin (2006) provided the direction of acute-care psychiatric hospitalization for adolescents, specifically in terms of ethnicity, insurance, and duration of stay. The three major results of this study may imply the need for a multicultural lens when treating adolescents in this setting. Findings revealed that minority adolescents and those with Medicaid insurance had a longer duration of stay than their Caucasian counterparts and those with private insurance. Additionally, different diagnoses did not impact the duration of stay for adolescents (Balkin, 2006). Trends such as these are important to recognize as they are factors that influence client care and client safety.

Heflinger, Simpkins, and Foster (2002) examined predictors of youth foster care admissions into a psychiatric hospital and developed a model to investigate these factors. Results of this study showed that males, older adolescents, those in custody, and those who had a previous hospitalization had a higher chance of hospitalization. Another interesting finding from this study was community services decreased number of hospitalizations (Heflinger et al., 2002). In other words, community services such as outpatient mental health centers may be beneficial for on-going treatment after discharge. Additionally, outpatient treatment in the community provides services for individuals that need help; therefore, one could conclude that the more services offered in a community, the less number of psychiatric hospitalizations necessary.

Balkin, Flores, and Casillas (2011) investigated differences in goal attainment with dual diagnosis adolescents either in a general psychiatric inpatient program or a dual diagnosis inpatient program. Findings indicated that adolescents who participated in the general psychiatric inpatient program had higher goal attainment, specifically with higher coping skills. Therefore, adolescents with dual diagnoses may benefit more from a general psychiatric modality than a dual diagnosis program, which includes substance abuse matters. These results are useful due to the high rate of adolescents' comorbidity when being admitted into psychiatric hospitals.

There has been a progression of the view of youth mental health and the need for hospitalization. Before the 1960s hospitalization for children and adolescents was scarce; therefore, so is the research on this population in comparison to hospitalization and mental health for adults. For the purpose of the current study, the focus is on acute-care, behavioral settings for adolescents in crisis.

Adolescent care in hospitalization. Because of the difficult age frame, adolescents are now being admitted more and more into inpatient settings for treatment (Bettmann & Jasperson, 2009). There are several opposing views as to the benefits and limitations to admitting adolescents into this environment. Ward (2004) posited that the structured environment of inpatient care could possibly cause harm for clients. Further, minors admitted into this setting may have more extreme issues than the general public, including trauma and abuse, as well as being brought up in chaotic environments. Hence, adolescents possess psychiatric and behavioral disorders that may warrant hospitalization. Though inpatient treatment might be justified, the structured environment of an inpatient setting could seem uncomfortable and abnormal to clients.

Outcome Research with Adolescent Hospitalization

Pratt and Moreland (2013) reported findings on counseling with youth and adolescents. As expected, those who receive counseling services have better outcomes. For example, two groups of adolescents were compared in which one group received brief counseling in a school setting and the other did not. Results indicated that those who received the counseling services had higher self-efficacy and beneficial results with their behavior (Rakauskiene & Dumciene, 2013). Additionally, Pratt and Moreland (2013) found that family support and commitment to outpatient services also lead to better outcomes but there are challenges to this. For example, according to Spirito et al. (2011), the average number of individual counseling sessions that adolescents attended after 6-month discharge from a psychiatric hospital was 13; follow-up can be affected by parental barriers and parent-therapist alliance. While there are barriers for commitment to services, including family support, individuals who follow-up after hospitalization would seem to reduce the likelihood of readmission. Thus, one can speculate that there is a need for family therapy and commitment as well as follow-up to services upon discharge in order for optimum effectiveness.

Working Alliance

Alliance is a broad term and used to define the working relationship established between the client and counselor. Authors, theorists, and researchers have different terms for this alliance, which includes the therapeutic alliance, therapeutic relationship, helping alliance, and working alliance. The alliance in counseling research has been examined and recognized extensively as being the most significant factor in counseling outcomes (Hanson, Curry, & Bandalos, 2002; Munder et al., 2010).

Counseling researchers expressed the importance of working alliance in the literature, yet limited research actually focuses on the therapeutic alliance with adolescents (Faw, Hogue, Johnson, Diamond, & Liddle, 2005), particularly in inpatient psychiatric care settings (Blais, Jacobo, & Smith, 2010; Johansson & Eklund, 2004). Faw et al. (2005) found only three studies on measuring this concept with minors and two studies examining alliance and treatment outcomes.

Collaboration is an important aspect of working alliance and was highlighted by both Carl Rogers and Edward Bordin. Although Bordin and Rogers strongly believed in the counseling relationship, there were differences in what they viewed as the counseling process (Bordin, 1948). For example, Bordin did not hold a non-directive approach as the ultimate form of counseling (Bordin, 1950). Rogers's and Bordin's efforts are reviewed below.

Carl Rogers and the counseling relationship. Carl Rogers developed client-centered, now known as person-centered, counseling and stressed the importance of the relationship between counselor and client and how to develop this relationship. Rogers (1961) declared, "If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur" (p. 33). This notion from Roger's seminal work was central to the counseling profession and important in outcome research.

Rogers also believed in the importance of the counselor as a person and less in techniques and knowledge. He had a relational view of counseling and valued people in general. Overholser (2007) reviewed an interview he had with Rogers in which Rogers expressed the short nature that could accompany the development of an alliance. This is important to note due to the short nature of inpatient hospitalization as declared above.

Rogers declared the core conditions of empathy, unconditional positive regard, and congruence as being the contributor to change within clients. These are characteristics needed of the counselor in order to create growth. While Roger's notion was critical, Muran and Barber (2010) explained the core conditions as helping the client and counselor to purposely work together to produce change. Together these core conditions can help towards empowerment of the client, which is a main goal of counseling. Description of the three core conditions are as follows below.

Unconditional positive regard. Unconditional positive regard, according to Rogers, means accepting the client without restrictions (Overholser, 2007). This signifies that the counselor values the client as a person including thoughts, behaviors, and emotions without judgment. The without judgment portion can be especially valuable for those who have experienced much criticism (Muran & Barber, 2010) and stigma that clients with mental health issues experience, especially those requiring hospitalization.

Clients experiencing this core condition from their counselor may begin to amalgamate a strong sense of self worth (Muran & Barber, 2010). This is needed for optimal health and can be helpful for those who are lacking support and experience judgment in everyday life. Unconditional positive regard can be especially meaningful while working with adolescents because, like stated above, this is a time of crucial change with high vulnerability.

Congruence. Congruence or genuineness is being authentic in the counseling environment and also sharing that authenticity with the client (Overholser, 2007). In order for counselors to do this, they must become aware of personal thoughts, emotions, and values.

Empathy. Empathy, the most valuable variable in counseling, is experiencing the client's world as the counselor's own, while knowing it is not (Overholser, 2007). Therefore, empathy is

more then listening in the moment, although this is an important aspect of counseling. Empathy is also revealing meaning to clients' content for clients to have rich experiences in counseling (Muran & Barber, 2010).

Experiencing validation, empowerment, and components of empathy (Muran & Barber, 2010) in short-term settings such as inpatient hospitals can be influential in the client's overall experience and may in turn influence whether the client follows up with services in outpatient settings. For example, outpatient settings mimic certain aspects of the interaction experience during inpatient care. Further, clients may be able to maintain some of the central relationships experienced. Lastly, the ability to follow-up with treatment after discharge from inpatient hospitalization is crucial for continuity. Therefore, the ability of the counselor to experience and demonstrate empathy may affect the overall treatment of mental health for clients.

Bordin's model of the working alliance. Bordin (1948) discussed the tenets of the counseling process, which included responsibility, regard for client feelings, and response to client attitudes. He believed that these terms described to counselors the methods of what they do in a more sensitive manner than the description of Rogers's work, which Bordin thought lacked restriction of labeling. For example, by describing counseling as non-directive (client-centered) or directive Bordin (1948) asserted that this could label the directive counselor as not having respect for his or her client and; therefore, being less client-centered.

The focus for the current study is on Bordin's model of working alliance in counseling. Muran and Barber (2010) discussed how Bordin's global model of working alliance accounted for the professional relationship in which client and counselor worked collectively in promoting change within the client. Three hypotheses for the success of a strong alliance included in Bordin's theory consisted of the following: counseling efforts are discussed and agreed upon by

the client and counselor; counseling outcomes improve with a stronger working alliance; and the essence of the counselor and client as well as relationship outcome beliefs are an appropriate fit (Muran and Barber, 2010).

Working alliance, according to Bordin (1979), includes three essential components for what he calls negotiation: agreement on tasks, establishment of a bond, and agreement on goals. Along with the three components above, Bordin also posited that a strong alliance is always collaborative and deliberate in counseling efforts. Bordin (1979) believed that no matter the theoretical orientation, the alliance between client and counselor needed to be strong for counseling to be effective. In addition, the strength of this alliance arises with collaboration between client and counselor in regards to the beliefs of the utilized theoretical orientation.

Munder et al. (2010) reported that Bordin's model of working alliance was suitable for both an outpatient and inpatient setting. In their study on working alliance in an outpatient and inpatient setting with German clients, Munder et al. (2010) found that there was more of a distinction between the bond, tasks, and goals in the outpatient setting then in the inpatient setting. Additionally, they found the alliance to be stronger with clients and their counselors in an outpatient setting. This could be due to distinct factors related to inpatient settings such as time frame, multiple treatment providers, and abnormal supervision.

Working alliance is important to consider when counseling with individuals and groups. Further, the importance of the working alliance was shown to be effective in counseling outcomes, yielding evidence behind the working alliance and the significance of its effects on counseling outcomes.

Factors that influence working alliance in an inpatient setting. Different factors may influence the working alliance in an inpatient setting due to the environment. Munder et al.

(2010) discussed these components and how they could possibly affect the working alliance in this environment. In an inpatient hospitalization there are several different elements and people associated with client care; therefore, the alliance may not be as determined and precise as necessary. For example, Munder et al. (2010) and Dinger, Strack, Leichsenring, Wilmers, and Schauenburg (2008) discussed the team nature of inpatient hospitals and how this is not necessarily essential in outpatient environments. The various team members (e.g., psychiatrists, other physicians, registered nurses, licensed professional counselors, chemical dependency counselors, social workers, activity therapists, mental health technicians, and discharge planners) and various treatment types (e. g., therapy groups, nursing groups, individual sessions, family sessions, and activity therapy) can affect alliance outcome (Blais et al., 2010). Further, severity of clients' symptoms and issues may also affect alliance (Munder et al., 2010). Considering all these factors together directly impact working alliance in inpatient settings.

Working alliance with adolescents. Research on working alliance with adolescents has been lacking when compared to adults. This could be due to many factors including the fact that minors are a protected population and therefore more difficult to investigate with different constructs.

Fitzpatrick and Irannejad (2008) investigated the working alliance and high school students' readiness for change. Findings indicated that those adolescents who were more action oriented toward change had a stronger working alliance with their counselor. Counselors in inpatient settings should be aware of these implications due to the involuntary nature of admissions and the unlikelihood of adolescents being in this stage after such a short timeframe.

Working alliance in an inpatient setting. Blais et al. (2010) examined alliance in a brief, inpatient psychotherapy setting and found several useful results. When comparing clients

scoring and counselor scoring on alliance ratings, clients rated the alliance higher than counselors. They also found that clients with higher levels of functioning were able to develop a stronger alliance (Blais et al., 2010). Considering these findings, counselors should be aware of the environment that they provide for clients and may perhaps need to alter in order to build a strong working alliance.

Johansson and Eklund (2004) discussed the atmosphere surrounding inpatient hospitalization and found that the alliance is important when considering a supportive environment. The environment in a fast-paced psychiatric hospital can perhaps affect the working alliance and therefore training in this specific area may be warranted. In addition, the alliance was demonstrated as important specifically for an inpatient setting due to safety issues of the client and the counselor being able to attain the client's well-being (Ponterotto, 1987). Counselors are trained to build a strong alliance and although difficult in a short, crisis setting, strong alliance can be beneficial for safety and support.

Goal Attainment Scaling

Goal attainment scaling was proposed by Kiresuk and Sherman (1968) for measuring goal development in which the goals are chosen previous to counseling and attainment is measured after treatment. The scaling portion of goal attainment scaling is measured from a -2 to 2 range, in which -2 is evidence to "much worse than expected outcome" and 2 designates "much better than expected outcome" and 0 denotes "expected outcome" (Paritzky & Magoon, 1982, p. 382).

Goal attainment scaling may be appropriate for application in many different environments that incorporate goals as a factor of care (Krasny-Pacini, Hiebel, Pauly, Godon, &

Chevignard, 2013). The medical field, rehabilitation, and the counseling field, to name a few, can benefit from employing goal attainment scaling for achievement of treatment goals.

A Therapeutic Goal Attainment Model in Inpatient Hospitalization

Balkin (2013) produced a goal attainment model for adolescents in psychiatric care, which included coping skills and a commitment to follow-up. Coping skills contained "commitment to safety, identification of problems, and coping strategies" (p. 262). From this model, an instrument, the Goal Attainment Scale of Stabilization (GASS), now called the Crisis Stabilization Scale (CriSS; Balkin, 2014), was created to measure therapeutic goal attainment. Balkin (2013) examined 435 adolescent participants in an acute-care setting and found that the CriSS (then called the GASS) was beneficial in these settings in order to ensure that clients meet their goals related to stabilization.

Literature on goal attainment with adolescents in inpatient settings is limited. Balkin (2013) discussed the importance of this concept for adolescents in crisis settings particularly, when it comes to the four factors: "commit to safety, identify problems, process coping skills, and commit to follow up" (p. 261). Effective outcomes were shown when clients were able to achieve the above goals (Balkin & Roland, 2007). Further, these goals are deemed important for client stabilization. That is, clients should be able to commit to safety before being discharged due to the dire nature of being admitted in an inpatient hospital in the first place; clients who are able to identify the specific problem tend to develop greater stability (Balkin & Roland, 2007); clients who are able to process coping skills will seem less likely to enter into the same setting; and clients' ability to commit to follow up is important due to the short-term nature of acute-care behavioral settings (Balkin, 2013).

Balkin and Roland (2007) found that two constructs, problem identification and processing coping skills assessed related phenomenon; therefore, they decided on a slightly different model including problem identification and commitment to follow-up. Additionally, they discussed problem identification as a necessary component for processing coping skills and as a result concluded with a model containing 2 overall constructs: "coping skills – consisting of commitment to safety, identification of problems, and coping strategies – and commitment to follow-up" (Balkin, 2013, p. 262). To illustrate this, problem identification, coping skills and problem solving, and commitment to follow- up will be discussed further below.

Problem identification. Problem identification is important step for clients and deemed essential in order to process coping skills (Balkin & Roland, 2007). Because problem identification is deemed necessary for problem solving and therefore effective coping, individuals who are unable to resolve issues adequately run the risk of further stress and maladaptation (Sahin, Sahin, & Heppner, 1993).

Coping and problem solving. According to Lazarus (2006), coping is a fairly complex construct and "is concerned with our efforts to manage adaptational demands and the emotions they generate" (p. 10). Lazarus discussed the importance of coping with stress in one's life, which may be hard to measure due to relational and situational components of the individual person. Coping is necessary in order to effectively deal with life stress while inefficient coping can be detrimental to well-being. Further, Lazarus (2006) discussed effective coping as important in crisis situations, and additionally, he stated that this can change an individual's life and contribute to better life fulfillment.

Essential aspects of coping with issues include effective problem solving, which Heppner (2008) defined as "highly complex, often intermittent, goal-directed sequences of

cognitive, affective, and behavioral operations for adapting to what are often stressful internal and external demands" (p. 806) and emotion regulation (Monat & Lazarus, 1991). The type of coping needed and used is determined by the nature of the stressor. For example, the loss of a job may need a more emotion regulation coping strategy, while a problem solving effort may work better for those experiencing everyday stressors with job duties. Additionally, an important aspect of coping includes support systems. Individuals with social support have better outcomes then those that do not when it comes to coping to stressful situations (Monat & Lazarus, 1991).

Heppner, Cooper, Mulholland, & Wei (2001) examined clients' problem solving and resolution with counseling outcomes. Results indicated that effective counseling includes problem resolution of clients' issues. Therefore, things indicative of effective counseling, such as a positive working alliance and positive counseling outcomes are related to efficient problem resolution. Additionally, having a strong action plan with concrete goals, knowledge and skills, and work on impairment is important to solve problems.

Commitment to follow-up. Commitment to follow-up is an important step before discharge due to the short time frame of acute-care hospitalization and focus on stabilization outcomes. This may include the responsibility of the adolescent and parent/guardian to follow up with needed outpatient treatment (Ponterotto, 1987). Continuing with services can be beneficial for stabilization, medication compliance if needed, and overall health. In addition, there are consequences of not following up including risk of being readmitted into the hospital.

Research on Therapeutic Goal Attainment

As stated above, research in this area is lacking and more is needed in order to fully understand therapeutic goal attainment in short-term psychiatric hospitalization. Previous research includes therapeutic goal attainment with adolescents in acute-care psychiatric hospitals

and includes constructs such as stabilization (Balkin & Roland, 2007), predictors of goal attainment (Balkin, Casillas, Flores, & Leicht, 2011), psychosocial characteristics (Balkin, Leicht, Sartor, & Powell, 2011), and the development of a therapeutic goal attainment model (Balkin, 2004).

In his dissertation, Balkin (2004) examined goal attainment and stabilization with adolescents in an acute care psychiatric program. He developed a model including identification of the problem, coping skills, and commitment to follow-up (Balkin, 2004), which later was altered to two factors, coping and commitment to follow-up (Balkin, 2013). Balkin (2004) and Balkin and Roland (2007) concluded that stabilization in a crisis hospital was related to attainment of goals. Further, Balkin, Casillas, Flores, and Leicht (2011) investigated predictors of goal attainment and found certain issues that thwart goal attainment such as behavioral (e.g., aggression, substance use, runaway, legal issues, and family problems) and psychotic issues. Additionally, Balkin, Leicht, Sartor, and Powell (2011) examined the relationship between goal attainment and psychosocial characteristics with adolescents. Findings indicated that clients with emotional issues demonstrated higher levels of goal attainment while clients with behavioral issues presented with lower levels of goal attainment. In conclusion, the aforementioned studies yielded strong results for counselors in the utilization of a therapeutic goal attainment model with adolescents in acute care, psychiatric hospitals.

Summary

Psychiatric hospitalization for adolescents may be deemed necessary in certain situations such as suicidal ideations and exhibiting psychotic symptoms insomuch as they are in danger of hurting self or others. Counselors in these settings can be valuable in order to help ensure that clients meet goals for stabilization.

The current study examines working alliance and therapeutic goal attainment with adolescents in an inpatient behavioral hospital. This study adds to the body of literature by increasing knowledge regarding working alliance with adolescents in an inpatient acute-care setting and how this may influence therapeutic goal attainment.

CHAPTER III

Methods

The purpose of this study was to examine the extent of the relationship between goal attainment and working alliance. This chapter describes research questions, research design, participants, measures, data collection, and data analysis.

Research Questions

1. What is the extent of the relationship between working alliance as rated by clinicians and therapeutic goal attainment?
2. What is the extent of the relationship between working alliance as rated by clients and therapeutic goal attainment?
3. What is the extent of the difference between clinician and client ratings on the Working Alliance Inventory-short?

Research Design

Research Question 1: What is the extent of the relationship between working alliance as rated by clinicians and therapeutic goal attainment? and Research Question 2: What is the extent of the relationship between working alliance as rated by clients and therapeutic goal attainment? The research design utilized for research questions 1 and 2 was a correlational design, which examined the relationship between variables (Dimitrov, 2010). A correlational design was chosen to examine the extent of the relationship between two sets of variables, therapeutic goal attainment and working alliance. The criterion variable in this study was therapeutic goal attainment. The predictor variable for this study was working alliance. Random assignment and random selection were not applicable. As in any correlational design, results do not provide causality (Heppner, Wampold, & Kivlighan, 2008).

Research Question 3: What is the extent of the difference between clinician and client ratings on the Working Alliance Inventory-Short? The research design utilized for research question 3 was a quasi-experimental design. Clinician and client ratings on the WAI-S were compared to identify any differences. Random assignment and random selection were not possible due to the nature of the study. The participants could not be randomly assigned to different treatments due to the ethical concerns such as the crisis nature of the setting and treatment not being altered in this study (Heppner et. al., 2008).

Participants

Data were collected from adolescents admitted to an inpatient, acute care behavioral hospital in the southern region of the United States. The hospital utilized in this study is accredited by The Joint Commission. The Joint Commission strives for quality care and standards. All hospitals accredited by The Joint Commission carry the same standards, therefore acute-care, behavioral hospitals have the same admission requirements and the same types of client issues. For this reason, the results of this study can be generalizable to other areas that house acute-care, behavioral hospitals (The Joint Commission, 2014).

Adolescents, aged 12 to 17, participating in this study met the requirements for admission in the hospital, which consisted of being a danger to themselves or others. The adolescent participants and clinicians completed the WAI-S. Licensed master's level clinicians employed at the hospital also completed the CriSS as well as a demographic survey on the adolescents. The 16-bed adolescent unit is housed in the behavioral health hospital and included both males and females.

Measures

Measures for the current study include the Crisis Stabilization Scale (CriSS; Balkin, 2014), Working Alliance Inventory-Short (WAI-S; Horvath & Greenberg, 1986; 1989), and a client demographic form.

Crisis Stabilization Scale. The Crisis Stabilization Scale (CriSS) (Balkin, 2014), formally known as the Goal Attainment Scale of Stabilization (GASS), was initiated from the goal attainment model of stabilization. The CriSS was validated on adolescents in crisis and researched in relationship to clients' levels of therapeutic goal satisfaction. The CriSS is a 25-item instrument used by clinicians to rate clients at discharge from -2 to +2. The ratings are indicated by the following: *"-2 denotes the least favorable outcome, -1 outcome is less than desired or expected, 0 attained desired or expected outcome, +1 outcome is more than desired or expected, +2 denotes the most favorable outcome"* (Balkin, 2013). The CriSS has two subscales that measure therapeutic goal attainment: coping and commitment to follow-up. The coping subscale includes commitment to safety, problem identification, and processing coping skills. Reliability scores as well as convergent and discriminant evidence were found to be high for the CriSS. Cronbach's alphas ranged from .97 to .98 scores on the coping subscale. Cronbach's alphas ranged from .89 to .96 for scores on the commitment to follow-up subscale. A total reliability coefficient of .96 was found for scores on the CriSS (Balkin, 2013; Balkin et. al., 2011; Balkin & Roland, 2005). Utilizing an exploratory factor analysis (EFA) to examine structure of the CriSS, two factors were retained and had eigen values of 16.29 and 1.95, which accounted for 72.97% of the total variance. Factor loadings ranged from .75 to .91 on factors one and two. The first subscale, *coping*, had 18 items that were found with positive loadings. The second subscale, *commitment to follow-up,* had 7 items that were found with positive

loadings. The two subscales had a strong correlation, $r = .68$. A confirmatory factor analysis (CFA) was utilized to identify a sufficient model which included the two variables *coping* and *commitment to follow-up***.** Balkin (2013) concluded that results from the EFA and CFA reinforced a two-factor model.

Working Alliance Inventory-short. The Working Alliance Inventory-Short (WAI-S; Tracey & Kokotovic, 1989), a short form of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), is a self-report scale of working alliance. The WAI-S is a 12-item instrument with a clinician rating form as well as a client rating form. The WAI-S consists of a 7-point scale. The scale meanings are indicated by the following: *1-never, 2-rarely, 3-occasionally, 4-sometimes, 5-often, 6-very often, 7-always*. Included in the WAI are three subscales; agreement on goals, agreement on tasks, and establishment of a bond (Hanson, Curry, & Bandalos, 2002). Hanson et. al. (2002) reported that subscale scores as well as total scores can be calculated and high scores on the WAI-S denoted a higher rating of the working alliance. High internal consistency scores were found, ranging from .83 to .92 on subscale scores and .95 to .98 on total scores (Hanson et. al., 2002).

Client Demographic Form. The client demographic form for the current study was utilized to obtain demographic information about client participants. The form included client information such as gender, age, ethnicity, and diagnosis. Additionally, the form contained information on admission and discharge date as well as reason for admission, which included danger to self, danger to others, psychotic symptoms, substance use, and other. Clinicians completed the demographic form regarding the adolescents' background.

Data Collection

Participants in this study were admitted to the adolescent unit at a behavioral hospital. There were no differences in typical treatment of the clients. At discharge, the clinicians on the adolescent unit completed the CriSS. The clinician and client completed the WAI-S. The clinicians also completed a demographics survey on each participant, which included age, gender, ethnicity, diagnosis, number of days in the hospital, and reason(s) for admission.

Research was approved by the institutional review board of Texas A&M University Corpus Christi as well as the behavioral hospital. Consent and assent was obtained from guardians and adolescents in order to gain voluntary participation. The forms explained the purpose and description of the study. Parents and adolescents were able to ask questions and voice concerns.

Data Analysis

Research Question 1: What is the extent of the relationship between working alliance as rated by clinicians and therapeutic goal attainment? and Research Question 2: What is the extent of the relationship between working alliance as rated by clients and therapeutic goal attainment? To examine research questions 1 and 2, a canonical correlation analysis was utilized to look at the relationship between subscale scores on the CriSS and subscale scores on the WAI-S. The purpose of using a canonical correlation was to examine the extent of the relationship between goal attainment and working alliance. A canonical correlation utilizes two correlated sets of multivariate measures. A canonical function is the relationship between the predictor and criterion variables. The criterion variable in this study included the two subscales on the CriSS (coping and commitment to follow-up). The predictor variable for this study included the three subscales on the WAI-S (goals, tasks, and bond). To determine the

maximum quantity of canonical functions, the least amount of variables on either the predictor (working alliance) or criterion (goal attainment) was calculated (Meyers, Gamst, & Guarino, 2013). For this study the maximum quantity of canonical functions was two. The first canonical function will always be the most meaningful, accounting for the largest percentage of variance, therefore, having the largest eigenvalue. Because each canonical function is independent from the others, the amount of variance accounted for can always be added to the previous until all canonical functions are obtained (Meyers et. al., 2013).

A canonical correlation was conducted to first establish if the model was significant. If statistically significant, then at least some of the variance on the criterion variables was accounted for by the predictor variables. Each canonical variate was examined for significance and only significant variates were interpreted. Eigenvalues were utilized to interpret the amount of variance accounted for by each canonical function (Meyers et. al., 2013). An alpha level of .05 was utilized. Descriptive statistics were examined. Normality, linearity, and homoscedascity were analyzed using box plots and scatter plots. Factor loadings and beta weights were interpreted to consider correlation. A limitation of canonical correlation can be it's exploratory nature (Meyers et. al., 2013).

Research question 3: What is the extent of the difference between clinician and client ratings on the Working Alliance Inventory-Short? To examine research question 3, a repeated measures multivariate analysis of variance (MANOVA) was utilized to determine whether there were statistically significant differences between the therapist's scores and client's scores on the Working Alliance Inventory-Short. A repeated measures MANOVA examines the same subject multiple times on two or more dependent variables. The dependent variables for

this were the subscales on the Working Alliance Inventory-Short, which included goals, tasks, and bond. The clinician rated the working alliance as well as the client.

Normality and independence of the observations were examined using box plots and scatter plots. An alpha level of .05 was utilized. A repeated measures MANOVA was conducted to determine if there was a statistically significant difference between clinicians' ratings on the WAI-S and clients' ratings on the WAI-S. A statistically significant difference means that measure differences were found on the WAI-S subscale scores. If statistical significance is found in repeated measures MANOVA, then a post hoc analysis is examined. The post hoc analysis examines where the differences lie (Meyers et. al., 2013).

CHAPTER IV

Results

The purpose of the current study was to examine the relationship between therapeutic goal attainment and working alliance with adolescents in an inpatient behavioral health hospital. The Crisis Stabilization Scale (CriSS) measured therapeutic goal attainment. The Working Alliance Inventory Short (WAI-S) measured the working alliance between counselor and client. The clients completed a version of the WAI-S (client version). The counselors completed the CriSS and the WAI-S (therapist version) as well as a demographic portion.

This study utilized two sets of variables: working alliance and therapeutic goal attainment. Working alliance consisted of agreement on tasks, establishment of a bond, and agreement on goals, each served as predictor variables. Therapeutic goal attainment included coping and commitment to follow-up, each served as criterion variables.

Results of this study included demographics of the clients. Model assumptions were evaluated for a canonical correlation and repeated measures MANOVA utilizing box plots and scatter plots. Canonical correlation analysis and repeated measures MANOVA were utilized to address research questions. All analyses were completed using the Statistical Package for Social Sciences (SPSS). There was no missing data in this study.

Demographics of Participants

The six female clinicians for this study were licensed at the master's level and included Licensed Professional Counselors and Licensed Professional Counselor-Interns. The participants for this study included 75 adolescent clients admitted into a behavioral hospital over a 6-month period. Demographic information, which included age, gender, ethnicity, diagnosis, admission date, discharge date, and reason for admission were collected. The age of clients ranged from 12

to 17 with an average of 14.67. The majority of clients were female (81.3%). Participants were primarily Hispanic (53.3%), with the remainder self-identifying as Caucasian (41.3%), African American (4%), and Asian (1.3%). The predominant diagnosis of participants was Major Depressive Disorder (69.3%). Other diagnoses included Depressive Disorder NOS (17.3%), Bipolar Disorder (6.7%), Posttraumatic Stress Disorder (4%), Psychotic Disorder (1.3%), and Adjustment Disorder with depressed mood (1.3%). 30.7% of adolescents were diagnosed with co-morbid disorders. The average number of days in the hospital was 6.61. The majority of participants were admitted for danger to self (57%) with other reasons including danger to others (5%), psychotic symptoms (1%) and combined reasons (36%). Combined reasons for admission into the hospital included a mixture of the above mentioned reasons. For example, a client may be admitted for danger to self with psychotic symptoms or danger to others with substance use. Table 1 provides demographic information of clients who participated in this study.

Table 1

Demographic Information of Participants

Demographic Variables	N	Percentage
Age (M = 14.67; SD = 1.46)		
12	6	8
13	12	16
14	15	20
15	19	25.3
16	14	18.7
17	9	12
Gender		
Male	61	81.3
Female	14	18.7
Ethnicity		
Hispanic	40	53.3
Caucasian	31	41.3
African American	3	4
Asian	1	1.3
Diagnosis		
MDD	52	69.3
Depressive D/O NOS	13	17.3
Bipolar D/O	5	6.7
Psychotic D/O	1	1.3
Other-PTSD	3	4
Other-Adjustment D/O w/ depressed mood	1	1.3
Reason for Admission		
Danger to self	43	57.3
Danger to others	4	5.3
Psychotic Symptoms	1	1.3
Combined	27	36

Research Questions

The following research questions were examined in this study:

1. What is the extent of the relationship between working alliance as rated by clinicians and therapeutic goal attainment?
2. What is the extent of the relationship between working alliance as rated by clients and therapeutic goal attainment?
3. What is the extent of the difference between clinician and client ratings on the Working Alliance Inventory-short?

Instrument Scores

The subscales of the Crisis Stabilization Scale (CriSS; Balkin, 2014) and the Working Alliance Inventory Short (WAI-S; Horvath, 1981; Horvath & Greenberg, 1986, 1989) were used as variables in the current study. Descriptive statistics for both versions of WAI-S and CriSS are provided in Table 2.

Correlations between subscales were computed and are presented in Table 3 and 4. In regards to the clinician version of the WAI-S and the CriSS, all subscales formed statistically significant correlations at the .001 level ($p < .001$). Further, high intercorrelations among subscales were found. Statistically significant correlations found on the client version of the WAI-S and CriSS included coping and follow-up (.706), bond and task (.697), goal and task (.655), and goal and bond (.663).

Table 2

Descriptive Statistics for the WAI-S and CriSS

Scale	Mean	SD	N
WAI-S			
TTask	21.07	3.29	75
TBond	23.27	2.75	75
TGoal	22.45	3.02	75
CTask	22.84	4.86	75
CBond	22.71	4.57	75
CGoal	22.33	4.24	75
CriSS			
Coping	10.01	10.65	75
Follow-up	4.41	4.26	75

* $p < .05$

Table 3

Correlations between Subscales (WAI-S Therapist and CriSS)

	Coping	FollowUp	TTask	TBond	TGoal
Coping	1	.706*	.654*	.535*	.582*
FollowUp	.706*	1	.570*	.379*	.517*
TTask	.654*	.570*	1	.771*	.857*
TBond	.535*	.379*	.771*	1	.763*
TGoal	.582*	.517*	.857*	.763*	1

n = 75, * correlations significant at p < .001 level (2-tailed).

Table 4

Correlations between Subscales (WAI-S Client and CriSS)

	Coping	FollowUp	CTask	CBond	CGoal
Coping	1	.706*	.043	.091	.067
FollowUp	.706*	1	.011	-.010	-.018
CTask	.043	.011	1	.697*	.655*
CBond	.091	-.010	.697*	1	.663*
CGoal	.067	-.018	.655*	.663*	1

n = 75, * correlations significant at p < .001 level (2-tailed).

Canonical Correlation

A canonical correlation analysis was conducted between two sets of variables, working alliance and therapeutic goal attainment. Three subscales from the WAI-S and two subscales from the CriSS were used in this study. Working alliance included agreement on goals, agreement on tasks, and establishment of a bond. Therapeutic goal attainment included coping and commitment to follow-up. An alpha level of .05 was utilized.

The WAI-S (Horvath, 1981; Horvath & Greenberg, 1986, 1989) measures the working alliance between clinicians and clients. This working alliance includes the clinician and client agreement on tasks, establishment of a bond, and agreement on goals. The task subscale measures the agreement of specific therapeutic tasks to accomplish in counseling. The bond subscale measures establishing a trust, liking, appreciation, and confidence between counselor and client. The goal subscale measures an agreement on specific goals necessary for the client. Higher scores on the working alliance scales are indicative of a stronger working alliance between the counselor and the client. For example, larger scores for the agreement on goals subscale are indicative of a strong agreement between client and counselor on the client's goals.

The CriSS (Balkin, 2014) measures therapeutic goal attainment for stabilization. This includes processing coping skills, problem identification, commitment to safety, and commitment to follow-up. Two subscales from the CriSS are coping and commitment to follow-up. Higher scores on the therapeutic goal attainment subscales indicated stronger attainment of goals related to stabilization. For example, larger scores on the on the coping subscale are indicative of achievement of goals related to coping.

Model assumptions for canonical correlation client and clinician version. Model assumptions for a canonical correlation including normality, linearity, and homoscedascity; each were analyzed through boxplots and scatterplots. Regarding the canonical correlation analysis examining clinician's rating of working alliance and therapeutic goal attainment, normality, linearity, and homoscedacity assumptions were met.

Model assumptions were evaluated regarding client ratings of working alliance and therapeutic goal attainment. The normality assumption was not met for working alliance and data was negatively skewed. Tabachnick and Fidell (2007) indicated that multivariate normality testing is exceedingly sensitive. Further, they suggested transformation of data as the most dependable method if normality is not met. Therefore, data were transformed utilizing a logarithmic transformation with a constant (log10[k-x]), which is supported when data differs substantially from normal rather than moderately or severely. However, Tabachnick and Fidell (2007) recommended that when data are negatively skewed, a reflection is necessary. A reflection relies specifically on the value of the constant, which shifts the data in its opposite direction. For example, with negatively skewed data, K would represent the highest score possible for a subscale, plus one (i.e., 28 + 1 = 29). The reason your constant (K) needs to have one significant value great than your highest subscale score is because the lowest score you

could possibly have is one (i.e, 29 – 28 = 1). Furthermore, your transformed variable [i.e, log(29 – 28) would equal to zero, resulting in data that are normally distributed. Lastly, results were run and the normality assumption was then met. Further, when normality was met, results, as shown below, did not change significantly. This is because, as noted by Dimitrov (2010), the effects of non-normality are rather negligible. When interpreting transformed data, it is important to note that scores' meaning will be opposite. For example, higher scores (closer to 28) on the task subscale of the WAI-S are indicative of a higher working alliance. After transformation, lower scores (closer to 0) are indicative of a higher working alliance. It is important to make descriptive statistics interpretable in relation to scores on the subscales. Transformed and nontransformed descriptive statistics for the client version of the WAI-S are provided in table 5. Transformed variables were transformed back by using the following equation: $x = 10^{T} - k$, where t is the transformed mean or transformed standard deviation and k is the constant (29).

Two significant multivariate outliers were identified utilizing Mahalanobis distance. Analyses were run with and without the outliers. The cases were not deleted due to few differences being detected. The total sample size for this study concluded with $n = 75$.

Table 5

Descriptive Statistics for the WAI-S client version-Transformed vs. Untransformed

Subscale	TMean	NTMean	TSD	NTSD	N
CTask	.646	24.57	.378	26.61	75
CBond	.665	24.38	.372	26.64	75
CGoal	.718	23.78	.333	26.85	75

TMean = transformed mean; NTMean = nontransformed mean; TSD = transformed standard deviation; NTSD = nontransformed standard deviation

Findings for canonical correlation clinician version. A statistically significant relationship was found between the clinician version of the WAI-S subscales and CriSS subscales, $F(6, 140) = 8.94$, $p < .001$, accounting for 48% of the variance. The first canonical

root was significant, λ = .52, F (6,140) = 8.94, $p < 0.01$, accounting for 45% (r_c = .67) of the variance. The second canonical root was not significant, λ = .96, F (2, 71) = 1.59, p = .211, accounting for 4% (r_c = .21) of the variance. Therefore, only the first canonical root was interpreted. See table 6 for statistics related to canonical roots.

The first canonical variate included scores on the three subscales of the WAI-S, Task (-.99), Bond (-.77), and Goal (-.89) and the subscales on the CriSS, Coping (-. 97) and Commitment to Follow-up (-.85). Adolescent clients with high working alliance scores suggests higher coping ability and higher commitment to follow-up.

Table 6

Dimension Reduction Analysis CCA with WAI-S (clinician version) and CriSS

Roots	Wilks' λ	*F*	Hypoth DF	Error DF	Sig of *F*
1	.52	8.94	6	140	< .001
2	.96	1.59	2	71	.211

Findings for canonical correlation client version. There was no statistically significant relationship found between the client version of the WAI-S subscales and CriSS subscales, F (6, 140) = .335, p = .918, accounting for 3% of the variance. Further, after transformed, results displayed similar findings. No statistically significant relationship was found, F (6, 140) = .500, p = .807, accounting for 4% of the variance. This indicates that there was no pattern of response found between working alliance as rated by clients and therapeutic goal attainment. See table 7 and table 8 for statistics related to canonical roots in both an untransformed version and transformed version.

Table 7

Dimension Reduction Analysis CCA with WAI-S (client version) and CriSS- Untransformed

Roots	Wilks' λ	*F*	Hypoth DF	Error DF	Sig of *F*
1	.972	.335	6	140	.918
2	.999	.023	2	71	.977

Table 8

Dimension Reduction Analysis CCA with WAI-S (client version) and CriSS- Transformed

Roots	Wilks' λ	*F*	Hypoth DF	Error DF	Sig of *F*
1	.958	.500	6	140	.807
2	.994	.228	2	71	.797

Repeated Measures Multivariate Analysis of Variance (MANOVA)

A repeated measures MANOVA was conducted to examine differences on working alliance between client and counselor. An alpha level of .05 was utilized. Descriptive statistics are in Table 1 above.

Model assumptions for repeated measures MANOVA. Model assumptions for a repeated measures MANOVA, including normality and independence were analyzed. In other words scores should be normally distributed and scores should be independent of each other. Due to having a balanced design, the analysis was robust to non-normality (Dimitrov, 2010).

Findings for repeated measures MANOVA. A statistically significant difference was found between client and clinician ratings on the WAI-S, F (2, 73) = 12.88, $p < .001$, partial η^2 =

.261, indicating a large effect size. Post hoc analyses were conducted to analyze significant differences between each of the subscales on the WAI-S. A Bonferroni adjustment yielded an alpha level of .017 for statistical significance. A statistically significant difference was found between client version of the task subscale and clinician version of the task subscale, F (1, 74) = 7.73, p = .007, partial η^2 = .095, indicating a moderate, approaching large effect size. No statistically significant difference was found between the client version of the bond subscale and the clinician version of the bond subscale, F (1, 74) = .901, p = .346, partial η^2 = .012, indicating a small effect size. No statistically significant difference was found between the client version of the goal subscale and the clinician version of the goal subscale, F (1, 74) = .540, p = .840, partial η^2 = .001, indicating a very small effect size.

Summary

One finding of the current research was the strong relationship between working alliance and achievement of goals related to stabilization. Further, agreement on therapeutic tasks was indicative of higher coping skills in adolescent clients. Additionally, counselors and clients may view working alliance differently specifically relating to therapeutic tasks.

CHAPTER V

Discussion

The relationship between working alliance and therapeutic goal attainment was examined. Data were used to determine if working alliance could predict therapeutic goal attainment with adolescents in an inpatient, acute-care, behavioral health hospital. Further, WAI-S subscales, CriSS subscales, and demographic information were evaluated. All subscales were included in this study: three for WAI-S (task, bond, goal) and two for CriSS (coping, follow-up).

This chapter offers information on the rationale for this study and a discussion of the results. Additionally, implications for counselors and counselor educators and limitations are considered. Lastly, directions for future research on the topics presented are acknowledged in order to further enrich the counseling field.

Rationale for the Current Study

Findings from the current study were indicative of the importance of developing a strong working alliance in order to attain stabilization goals for adolescents in an inpatient setting. Past research findings suggested the significance of alliance mostly with outpatient settings (Hanson, Curry, & Bandalos, 2002; Munder et al., 2010), while the research in inpatient settings remained inadequate (Blais, Jacobo, & Smith, 2010; Johansson & Eklund, 2004). Further, much of the research in this area was conducted with adults; whereas adolescents remain a more difficult population to research (Faw, Hogue, Johnson, Diamond, & Liddle, 2005). In addition, much of the research done in the area of therapeutic goal attainment with inpatient settings remains fairly limited (Balkin 2004; Balkin, 2006; Balkin, 2013; Balkin, Casillas, Flores, & Leight, 2011;

Balkin, Flores, & Casillas, 2011; Balkin, Leicht, Sartor, & Powell, 2011; Balkin, & Roland, 2005; & Balkin, & Roland, 2007).

Discussion of Results

Canonical correlation analyses were utilized to examine the relationship between working alliance and therapeutic goal attainment. Five total variables were examined. Working alliance included agreement on goals, agreement on tasks, and establishment of a bond. Therapeutic goal attainment included coping skills and commitment to follow-up. Further, a repeated measures multivariate analysis of variance analysis was conducted to examine whether any statistically significant differences existed between the clinicians ratings and clients ratings on the Working Alliance Inventory-Short.

A strong relationship was evidence between clinician's rating of working alliance and therapeutic goal attainment. In a study on alliance in a brief inpatient setting, Blais et al. (2010) found that alliance had an inverse relationship with progress outcomes. For example, as alliance increases improvement decreases. This is in contrast to the current findings, which suggest as working alliance increases so does therapeutic goal attainment. Factor loadings are highly correlated and negative, but going in the same direction. In other words, as working alliance decreases so does therapeutic goal attainment. Conversely, as working alliance increases, therapeutic goal attainment also increases indicating the importance of building a strong working alliance in order to achieve goals related to stabilization.

As working alliance increases, coping is the factor mostly affected. The commitment to follow-up subscale is not highly affected. Additionally, within working alliance, the task subscale has the most effect on goal attainment. There is little change in regards to the establishment of a bond. Reasons for this might include the brief nature of acute care

hospitalization. Clients and clinicians may in fact need a longer period of time to form a bond and have this affect achievement of goals. Further, in these settings clients have several different interactions with many staff members including counselors, mental health technicians, social workers, registered nurses, psychiatrists, medical doctors, activity therapists, and discharge planners. Perhaps, there is confusion to clients on staff members differing duties.

Lastly, the items on the CriSS are more aligned with therapeutic tasks than therapeutic goals or bond, indicating that what clients are specifically doing in counseling is important in order to accomplish their goals related to stabilization. For example, clients and counselors who focus on specific client behaviors and thoughts (Horvath & Greenberg, 1989) related to admission into the hospital may be related to achieving stabilization goals such as processing coping skills. Other researchers found that therapeutic tasks lead to positive counseling outcomes especially related to effective tasks and parental involvement in the counseling setting (Bowlby, 1988; Karver, Handelsman, Fields, & Bickman, 2006). Further, perhaps therapeutic tasks held more importance due to the structured, task-oriented environment that is often incorporated in inpatient settings in order to meet goals. For example, in order to meet goals related to stabilization clients must integrate tasks that have "demonstrated stable behaviors" and "worked toward identifying personal strengths to encourage coping and decrease stress" (Balkin, 2014). Similarly Bowlby (1988) described five therapeutic tasks important for positive outcomes. For instance, counselors may help clients to become aware of maladaptive thoughts and behaviors; thus, developing healthier coping skills.

Similar to Horvath (1981), intercorrelations found between subscales on the clinician version of WAI-S subscales were fairly high. This perhaps indicates that the WAI-S subscales are measuring similar constructs rather than distinct components as in Bordin's (1979) model of

working alliance, which is what the WAI-S was based. Also similar to Horvath (1981), the scores on the task and goal subscales had the highest intercorrelation coefficient, likely due to the relationship between tasks that are necessary to achieve a goal. For example, clients in an inpatient hospital may work on exploring thoughts of worthlessness in order to accomplish a goal of decreasing suicidal thoughts and behaviors.

The findings from this study contribute evidence of the importance of building a strong alliance in order to achieve goals related to stabilization. Similar to these findings were Hanson, Curry, & Bandalos (2002), who examined both client and clinician versions of alliance and Munder et al. (2010), who investigated client ratings of alliance, all of whom reported that a strong alliance between client and counselor attributed to positive outcomes in counseling.

In contrast, the client's rating of working alliance was not a significant predictor of therapeutic goal attainment. No consistent pattern was found between the way clients rated working alliance and how that related to therapeutic goal attainment. There may be multiple reasons behind this result. Perhaps, adolescents did not fully understand or interpret items on the WAI-S accurately. Additionally, individuals are admitted into an inpatient hospital due to being in crisis, such as suicidal ideations. Adolescents in crisis may not have the best insight on themselves (Bettmann & Jasperson, 2009; Munder et al., 2010). Further, adolescents may have over or under reported elements of the WAI-S for evaluation reasons. Due to this, a self-report may not be an accurate representation of clients' true accounts. Lastly, perhaps the diverse large number of staff interactions may be contributing to a confusion of specific counselor-client working alliance. Munder et al. (2010) agreed with this element of inpatient hospitalization and stated that this confusion may be attributing to the several factors including the client's relationships to other staff members in the setting as well as the counselor's alliance with other

clients whom the current client may have formed a collaboration. One solution to this might be the development of a working alliance inventory that takes into account the diverse relationships (Blais, 2004) and components of inpatient hospitalization.

Client perceptions of treatment and their counselors may influence ratings of working alliance. Additionally, satisfaction with services contributes to positive outcomes (Swift and Callahan, 2009) and perhaps the likelihood that a client will continue with outpatient services. Smith, Norton, and McLean (2013) explored perspectives and satisfaction of counseling with clients experiencing anxiety. Clients reported that the most helpful aspect of counseling was having a supportive counselor. Similarly, Swift and Callahan (2010) reported that individuals care most about an empathic counselor. In other words, according to clients, counselor characteristics that are necessary in building a strong alliance are important factors to consider. Further, these counselor characteristics and clients' perceptions of them may not be realistic given the fast-paced, short-term setting, which may account for the findings in this study.

There was a statistically significant difference between the clinician and client ratings on the WAI-S. Clinicians and clients may view working alliance differently. Specifically, the difference was found on the task subscale. Perhaps, adolescent clients report their progress more positively than what it really is. Similar to this finding is Bordin's (1979) work on client and clinician perspectives of working alliance, which Bordin stated could be different. Additionally, Arnkoff and Glass (1993) reported that counselors working with stable clients are more likely to have a stronger agreement on therapeutic tasks. Clients admitted into acute care inpatient settings are perhaps not in the most stable situation, and the age group of the current sample may have difficulties when conceptualizing tasks and how these tasks relate to goals in counseling (Shirk & Karver, 2010).

Further there were no differences found between counselor and client ratings on the bond and goal subscale. This indicates that clients and clinicians are in agreement of trusting and liking one another. Additionally, clinicians and clients are in agreement of goals that clients need to work towards.

Conclusions from the current study will aid in the lack of research in this area of counseling in adolescent inpatient settings. More specifically the current study examined if working alliance is a predictor of therapeutic goal attainment. There are no other studies known to this date that report data on these two variables with adolescents in an inpatient hospital.

Implications

Counselors can benefit from the results of this study through awareness of what contributes to client goals related to stabilization. Findings indicated that counselor and client ability to form a strong working alliance contributed to clients' ability to form coping skills and commit to follow-up services upon discharge. This is important due to the high relation of goal attainment to client stabilization (Balkin & Roland, 2007). In other words, clients who are able to develop coping skills, identify problems, commit to safety, and commit to follow-up are more likely to reach stabilization.

Findings indicated that counselors should be mindful of what contributes to working alliance. Bordin's (1979) model of working alliance includes three domains: agreement on tasks, establishment of a bond, and agreement on goals. Because there was a statistical significant difference found between client and clinician ratings of working alliance, clients and clinicians may view the working alliance differently. Specifically, differences were found on the ratings of the task subscale demonstrating that perhaps clients and counselors disagree with specific assignments needed to work on in counseling. For example, in an inpatient setting an adolescent

might develop a safety plan for future stressful situations. Perhaps the counselor views this task as more necessary than the client and therefore, rates the task items higher. Further, the bond and goal scales were not rated differently indicating that counselors and clients rated these similarly. Particularly, counselors and clients both rated bond comparably, which included liking, having confidence, trusting, and appreciating one another. In addition, counselors and clients rated goals similarly signifying agreement on specific goals to work on. These findings are important for counselors to be aware of what is important when working with adolescents in inpatient, crises settings.

Knowing these findings can also aid counselors in developing treatment plans, advocacy strategies, and client care. For example, knowing that working alliance is related to clients meeting goals for stabilization (i.e. therapeutic goal attainment), counselors could emphasize developing a strong alliance with their clients. Thus, specific goals, objectives, and interventions on the client's personal treatment plan may be more easily developed For example, a client who presents with depression may have a goal of learning effective coping strategies in order to decrease depressive symptoms, which will be measured by verbalization and demonstration during counseling sessions. An intervention might include components of working alliance such as collaboratively developing specific steps in order to reach that goal in an individual counseling session with the client. Additionally, findings can aid counselors with the importance of client care as it relates to working alliance in inpatient settings. Traditionally, these settings are built on a medical model. Perhaps findings will support the need of counselors in these specific settings, as well as the need to highlight counselors' ability to form a working alliance.

In addition to counselors benefiting from the results of the current study, counselor educators and counselor education programs may benefit as well by highlighting the ability to

form an alliance quickly and in hospital settings. Current findings provide support for the preparation of counselors in graduate programs. Knowledge of what may influence goal attainment for adolescents in an inpatient hospital can provide better training for those seeking employment in these settings.

Lastly, findings could potentially shed light on policy and procedures of inpatient settings. As said above, these settings run on a medical model background while traditional counseling settings run more on a developmental model. Therefore, working alliance may not be accentuated as imperative for client care. The medical model emphasizes disease and treatment of symptoms (Anderson, 1995); a developmental model highlights health holistically. Perhaps, staff procedures emphasizing working alliance while treating crises issues will benefit hospitals as well as clients in achieving their goals. Trainings would be valuable in this area in order to meet optimal client care and safety.

Limitations

The current study contributes to counseling research on working alliance, therapeutic goal attainment, and adolescents in inpatient settings in a meaningful way; however, there are limitations of the findings. Limitations include information regarding demographic sample, training level of clinicians, and potential multicollinearity issues.

The majority of participants for this study were of Hispanic ethnicity due to the area. Results may not be generalizable to all populations. Additionally, there was a limited amount of clinicians available for this study. Data were collected at only one facility with seventy-five adolescents between the ages of 12 and 17 and six clinicians and neither were randomly selected.

Another limitation may be different level of trainings for clinicians in building an alliance with their clients. Program standards differ in regards to training specifically in differences

between CACREP and non-CACREP accredited programs. In addition, training standards evolve through years and may perhaps affect findings due to differences in years of practice.

Lastly, there were high intercorrelations between the scores on the WAI-S subscales (clinician version), particularly with the task and goal subscale. Despite the potential similarities, however agreement on tasks provided a stronger relationship to therapeutic goal attainment. It is possible that working alliance would be better suited as a singular concept. Faw et al. (2005) declared that the alliance between counselors and youth clients might be understood better as a unitary concept.

Future Research

Future research in the area of inpatient hospitalization would be beneficial for counselors, counselor educators, and the general public. This could focus on what contributes to positive outcomes (i.e. goal attainment and stabilization) with clients of all ages. The current study included adolescents ages 12-17. Potential studies could focus on other age groups including young children and adults. More research is needed in regards to goal attainment and stabilization in inpatient settings.

Further research could include other factors that contribute to predictors of therapeutic goal attainment. Considerations include parental involvement (parent/guardian vs. CPS) to determine if this contributes to whether youth are able to achieve goals related to stabilization or not. Further, diagnosis may be useful, particularly the influence between more severe diagnosis (i.e. Schizophrenia) versus a more common diagnosis (i.e. Depression) and how it affects goal attainment. Due to the majority of participants being of Hispanic heritage, perhaps future studies on factors of hospitalization with Hispanic populations would be advantageous.

Additionally, it would be beneficial to examine recidivism in inpatient settings and what factors contribute to this. Perhaps clients who experience a strong working alliance and therefore achieve goals related to stabilization are less likely to be readmitted into these settings. This research would be helpful to determine the best method for client care in order to have the least restrictive environment.

Future research with goal attainment and other populations and/or settings would be beneficial in order to assess what supports achieving goals. Inpatient hospitals may include child, adolescent, adult, geriatric, and chemical dependency units. These particular units could benefit from further research. Although chemical dependency units may have different needs then psychiatric units, goal attainment research is needed in order to determine what helps these clients reach goals specific for their needs. In addition, research with clients in outpatient programs (i.e. intensive outpatient; partial hospitalization program) would be valuable.

Finally, this research study was conducted with participants admitted into an acute care, inpatient hospital. Long-term care and follow-up was not assessed but would be helpful to determine long-term treatment outcomes.

Conclusion

The purpose of this study was to examine the relationship between working alliance and therapeutic goal attainment with adolescents in an acute care, inpatient hospital. Additionally, the difference between how clients and clinicians rated working alliance was investigated.

Findings from the current study indicated the necessity of building a strong working alliance in order to achieve goals related to stabilization. Further, therapeutic tasks had the most effect on therapeutic goal attainment demonstrating the importance of what a counselor and client specifically does in counseling. Additionally, counselors and clients may view therapeutic

tasks differently. Implications for this study include the importance of advocating for working alliance in inpatient settings for client care and preparation of counselors who may work with these clients in the future. The results of this study are meaningful for counselors, counselor educators, counselor education programs, and individuals working in inpatient settings.

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