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ABSTRACT

Certain interactional theorists propose that for counseling/psychotherapy to be effective, the therapist must control the definition of the therapy relationship. Although the relationship between patterns of relational dominance/control in counseling and counseling outcome seems reasonably well established, little is known of the relationship between dominance (as a process variable) and measures of relational quality (e.g., evaluations of "therapeutic alliance" and of session depth and smoothness). The purpose of this study was to investigate the nature of relational dominance within and across psychotherapy cases to investigate its relation to relationship quality. Interview transcriptions and therapy process ratings of seven full-length psychotherapy cases served as the basis for this study. Cases ranged from 12 to 20 sessions. The results did not evidence a consistent relationship between relational dominance and any of the relationship quality measures (whether rated by client or therapist). Results suggest that relational dominance/control is not a significant factor in client or therapist evaluations of the quality of the therapeutic relationship. Therapist control of the definition of the therapy relationship appears to neither enhance nor detract from the participants' evaluation of their working alliance or of the depth and smoothness of their sessions together. Includes extensive graphs and charts. Contains 48 references. (Author/JBJ)

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Running head: RELATIONAL CONTROL

**Relational control and relationship quality in psychotherapy**

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## Relational control and relationship quality in psychotherapy

### Abstract

Although the relationship between patterns of relational dominance/control in counseling and counseling outcome seems reasonably well established, little is known of the relationship between dominance (as a process variable) and measures of relational quality (e.g., evaluations of the "therapeutic alliance" and of session depth and smoothness). The purpose of this study was to investigate the nature of relational dominance within and across actual psychotherapy cases in order to investigate its relation to relationship quality. The results did not evidence a consistent relationship between relational dominance and any of the relationship quality measures (whether rated by client or therapist). The results suggest that relational dominance/control is not a significant factor in client or therapist evaluations of the quality of the therapeutic relationship.

## Relational control and relationship quality in psychotherapy

### Introduction

Certain interactional theorists propose that for counseling/psychotherapy to be effective, the therapist must control the definition of the therapy relationship (e.g., Cashdan, 1972; Claiborn & Lichtenberg, 1989; Haley, 1963; Lichtenberg & Barké, 1981; Strong, 1982). For example, Haley (1963) asserted that "(a)lthough psychotherapy involves many factors, such as support, encouragement of self-expression, and so on, it is of crucial importance that the therapist deal successfully with the question of whether he [sic] or the patient is to control what kind of relationship they will have" (p. 19). Haley went on to state that "(i)f the patient gains control [of the relationship], . . . he will perpetuate his difficulties since he will continue to govern by symptomatic means" (p. 19). Strong (1982) has suggested that among the key dynamics of successful therapy is the determination of who changes and how they change (p. 198). Similar views are reflected in Anchin and Kiesler (1982) and Claiborn and Lichtenberg (1989).

The relational dynamic of relational control has been the focus of numerous studies since the early 1980's (Heatherington & Allen, 1984; Lichtenberg & Barké, 1981; Lichtenberg & Knox, 1991; Strong et al., 1988; Tracey, 1985, 1987; Tracey & Ray, 1984; Wampold & Kay-Hyon, 1989). The initial investigation of relational control in therapy failed to confirm Haley's proposition that effective therapists establish a complementary relationship with clients--one in which the therapist is in a "one-up" position relative to the client. Studying only initial counseling interviews and using a relational communication coding system developed by Ericson and Rogers (1973), Lichtenberg and Barké (1981) found no evidence to support the notion that Rogers, Ellis, and Perls, while demonstrating their unique approaches to therapy, exhibited control over the definition of the therapy relationship or achieved a one-up position with respect to the client. Subsequent investigations, however, focusing on relational control across the sessions of therapy

cases generally have supported the notion of therapist control of the definition of the therapy relationship within successful (but not unsuccessful) therapy (Tracey, 1985; Tracey & Ray, 1984) (see, however, Lichtenberg & Kobes, 1992).

Therapist relational control in counseling, however, has not been found to be ubiquitous within successful therapy. Instead, it is moderated by (or at least characteristic of) certain "stages" within the therapy process. Specifically, Tracey (1985), having previously demonstrated a reliable pattern of three stages of in therapist-client interaction (rapport, conflict, resolution) that can distinguish successful from unsuccessful (or less successful) therapy (Tracey & Ray, 1984), found that therapist relational control was characteristic only of the middle stage of successful therapy.

While the relation between patterns of control in counseling and counseling outcome seems reasonably well established, little is known of the relation between control (as a process variable) and measures of relational quality (e.g., evaluations of the "therapeutic alliance" and of session depth and smoothness). Although therapist control/dominance with respect to the therapy relationship may achieve generally positive overall outcomes for the client (at least when it conforms to a certain "stage" pattern), the client and therapist relational experience of its implementation or occurrence is not well understood. Therefore, it was the purpose of this study to investigate the nature of therapist-client interactions within and across actual psychotherapy cases, in order to investigate the relationship between relational control in therapy and the quality of the therapeutic relationship as experienced and evaluated by clients and therapists.

## **Method**

### **Interview/Case Data**

Interview transcriptions and therapy process ratings of seven actual full-length psychotherapy cases served as the basis for this study. Cases ranged in length from 12 to 20 sessions ( $M = 16.42$ ,  $SD = 3.31$ .  $Mdn$  and  $Mode = 17$ ). Transcriptions of the cases were prepared as part of a NIMH-funded study of therapist techniques and client outcomes (Hill, 1989). Process measures of relationship quality (see below) were collected by Hill during this same study.

Both the interview transcriptions and process ratings were made available to these researchers for additional study. The written transcriptions comprised a total of 115 interviews.

### **Participants**

Hill (1989) describes the therapists as "master psychotherapists who believed in and were competent in time-limited therapy" (p. 24). The seven therapists (4 male, 3 female) were all Ph.D. psychologists, who ranged in age from 34 to 78 ( $M = 47.14$ ,  $SD = 14.46$ ) and averaged 18.5 years of postdoctoral experience. Six of the therapists were White; one was Black

Clients all were women; they ranged in age from 32 to 60 ( $M = 43.28$ ,  $SD = 9.62$ ). Five of the clients were White; one was Asian; and one was Arabic. The clients had been recruited through newspaper announcements that offered free individual therapy for women over 25 who had self-esteem and relationship problems. Additionally, to qualify for the study, participants must have had no previous psychotherapy experience and no history of alcohol or drug abuse. Hill (1989) reports receiving 94 appropriate phone inquiries about the study. Of these, 53 completed a battery of psychological screening instruments. Persons selected for inclusion in the study from this pool were identified by Hill as anxious and depressed, based in part on their elevated scores on the MMPI scales 2 (depression) and 7 (psychasthenia). Clients who were not selected for participation in the study were given referrals.

Table 1 summarizes the therapist and client demographic information for each of the seven cases.

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Insert Table 1 about here

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### **Response Coding**

The transcribed verbal responses of the therapists and clients were coded using Stiles' (1986) taxonomy of verbal response modes (VRM) for coding interpersonal communication. The taxonomy classifies verbal responses into eight response modes (Disclosure, Advisement, Edification, Confirmation, Question, Interpretation, Acknowledgment, Reflection) based on a

well-articulated conceptual system of classification principles (see Stiles, 1986) which consider (a) the source of the experience being reported in the utterance, (b) the frame of reference or viewpoint using in making the utterance, and (c) the focus of the utterance or whether the speaker, in making the utterance implicitly presumes to know the other's experience or frame of reference. Each of these three classification principles can have a value of "speaker" or "other" -- thereby yielding a 2x2x2 classification scheme (see Figure 1). Coding is done for both the form and the intent of the communication. Previous research (see Stiles, 1987) supports that coding using the VRM can be done reliably ( $k=.56-96$  for form;  $k=.36-89$  for intent). For purposes of this study, only ratings of communication intent were considered. Rater reliability for the study was good (all kappa's  $>.70$ ). Stiles' VRM system has been used extensively and productively in numerous research studies of therapist/client verbal interaction (e.g., Stiles, 1987; Stiles & Sultan, 1979).

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Insert Table 2 about here

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Following Stiles' recommendation (Stiles, 1986, 1987), response codes were collapsed across "role dimensions" in order to reduce the number of response utterances needed to achieve stable response transition probabilities and to facilitate data analysis (see Table 3). Collapsing the eight response modes yielded three distinctive role dimension response categories: (a) utterances concerning the other's experience--attentiveness (Question, Interpretation, Acknowledgment, Reflection) vs. informativeness (Disclosure, Edification, Advisement, Confirmation), (b) utterances using the other's frame of reference--acquiescence (Edification, Confirmation, Acknowledgment, Reflection) vs. directiveness (Disclosure, Advisement, Question, Interpretation), and (c) utterances focused on the other--presumptuousness (Advisement, Confirmation, Interpretation, Reflection) vs. unassumingness (Disclosure, Edification, Question, Acknowledgment) (Stiles, 1986, p. 178). Previous research on these derived role dimension response categories has supported their construct validity (e.g., Cansler & Stiles, 1981; Stiles, 1979; Stiles, Waszak & Barton, 1979).

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Insert Table 3 about here

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### **Instruments**

Relational quality was measured using two different rating instruments: (a) the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986), and (b) the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984). The WAI and SEQ were completed independently by both the client and therapist following each therapy session. Data on both measures were collected as part of an earlier research study (Hill, 1989).

Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). The WAI was developed by Horvath and Greenberg (1986) as a measure of three specific process variables that Bordin (1979) has proposed as central to an effective working relationship between a therapist and a client: (a) agreement and mutual valuing of the aims and purpose of the therapeutic intervention (goals), (b) agreement and mutual acceptance of the relevant tasks to be carried out during therapy (tasks), and (c) a positive personal attachment between the therapist and client--one based on mutual acceptance, trust and confidence (bonds). Various studies have suggested the working alliance (as measured by the WAI) to be predictive of therapy outcome (e.g., Horvath & Greenberg, 1986, 1994; Tichenor & Hill, 1989), although Kokotovick and Tracey (1990) did not find the WAI to be predictive of premature termination from counseling.

The WAI consists of three subscales (bond, task, goal), each with 12 items rated on a 7-point Likert scale, and each measuring one of Bordin's (1979) three theoretically important aspects of the therapeutic relationship. Horvath and Greenberg (1986) report overall internal consistency coefficients (Cronbach's alpha) of .93 and .87 respectively for the client and therapist versions of the instrument. Hoyt internal consistency estimates for the individual subscales of the client version of the WAI are .88 (goal), .88 (task) and .85 (bond); and for the therapist version of the instrument, these estimates are .37 (goal), .82 (task) and .68 (bond). With the exception of the therapist WAI-bond subscale (which may be influenced by a possible "ceiling effect" resulting



from therapists being asked to rate themselves; Horvath & Greenberg, 1986), these reliability coefficients are quite acceptable for a self-report instrument. Horvath and Greenberg (1986) report correlations between client WAI ratings and PTQ (Client Posttherapy Questionnaire; Strupp, Wallach & Wogan, 1964) ratings of satisfaction and change as: task/satisfaction = .65, bond/satisfaction = .32, goal/satisfaction = .40, overall/satisfaction = .50, task/change = .45, bond/change = .23, goal/change = .24, overall/change = .33. Similar correlations for therapist ratings are reported as: task/satisfaction = .68, bond/satisfaction = .48, goal/satisfaction = .60, overall/satisfaction = .66, task/change = .37, bond/change = .47, goal/change = .22, overall/change = .38. The results of these correlations suggest that the client task ratings are the most effective in predicting client-reported satisfaction and change. They also suggest that while therapist task ratings are most effective in predicting therapist-reported client satisfaction, therapist bond ratings are more effective in predicting therapist reports of client change.

Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984a). The SEQ was developed as a measure of the impact of psychotherapy sessions. The full instrument consists of 24 items comprising four scales: two scales which reflect session evaluation (depth, which reflects the session's felt power and value; smoothness, which reflects the session's comfort and pleasantness) and two scales that assess postsession mood (positivity, arousal). Factor analyses have shown the scales to be distinct orthogonal qualitative aspects of the therapy relationship (Stiles & Snow, 1984b).

For the present study, only the session evaluation scales (depth, smoothness) were used. Each scale has five bipolar adjectives arranged in a 7-point semantic differential format. Consistent with previous use of the instrument (Nocita & Stiles, 1986), each scale was scored from 1 to 7, with higher scores indicating greater depth or greater smoothness. The depth index was the mean rating on deep-shallow, valuable-worthless, full-empty, powerful-weak, and special-ordinary; the smoothness index was the mean rating on smooth-rough, comfortable-uncomfortable, easy-difficult, pleasant-unpleasant, and relaxed-tense. Stiles and Snow (1984a) report alpha coefficients of .91 and .87 respectively for therapists and clients on the depth scale, and alpha coefficients of

.89 and .93 respectively for therapist and clients on the smoothness scale. They comment that their findings of large session-to-session variability in SEQ ratings is consistent with previous findings of instability in therapist-offered conditions and variation in client verbal behavior across sessions. Stiles and Snow also note that overall, clients tend to rate their sessions as deeper and slightly smoother than do therapists.

### **Analyses**

Each psychotherapy case was analyzed individually. For each session of each case, indices of relational control/dominance were calculated separately for the VRM role dimensions of (a) attentiveness (vs. informativeness), (b) directiveness (vs. acquiescence), and (c) presumptuousness (vs. unassumingness) for each session. Relational control was indexed using a measure of "response ambiguity" (Attneave, 1959; Lichtenberg & Paolo, 1986)--an index of the decrease in the randomness of a speaker's response, given knowledge of the response of the immediately preceding response of the other speaker (see Attneave, 1959, for computational formulae). This index, which has previously been used to study relational control in group therapy (Lichtenberg & Knox, 1991), was used to provide an index of the relative influence (relational control) the therapist and client had on the responding of the other, thereby allowing determination of who "influences" whose relational responding the most and thereby controls the definition of their relationship. "To the extent that one speaker's responses are more predictable (less random) than the preceding speaker's responses...the antecedent speaker evidences a greater constraint over the occurrence of the other's response. That is to say, the second speaker has less 'freedom of choice' ... than the first in 'selecting' a next response (Lichtenberg & Paolo, 1986, p. 40). Differences in the degree of predictability of speakers' responses therefore allow determination of who "controls the definition of the relationship" which is defined by their interaction (Castellan, 1979; Gottman, 1979; Lichtenberg & Heck, 1986; Wampold, 1984). For purposes of analyses in this study, the response ambiguity index for the client's responding (given the therapist as the antecedent speaker) was subtracted from the ambiguity index for the therapist's responding (given the client as the antecedent speaker). In light of the logic previously presented

for the use of these ambiguity indices (see Lichtenberg & Paolo, 1986), if the resulting difference score were positive, it suggested that the therapist's responding was less predictable than that of the client and that the therapist had more influence over the definition of the relationship than did the client. The reverse was true if the resulting difference score were negative.

These indices of relational control were correlated with client and therapist ratings of (a) the Working Alliance (bonds, tasks, goals), (b) session depth, and (c) session smoothness--also made for each session. No theoretically derived hypotheses were made with regard to therapist control/dominance and its relation to WAI or SEQ ratings; this study was intended to be exploratory and discovery-oriented. However, in light of the previous findings of stages of therapist control (Tracey, 1985, 1987, 1993; Tracey & Ray, 1984), it was suspected that WAI and SEQ ratings might reflect a similar "stage" pattern. Overlay plots of relational control (one each for attentiveness, directiveness and presumptuousness), WAI and SEQ ratings across the sessions of each case were prepared in order to investigate this possibility.

### Results

Table 4 summarizes for each case the correlations between (a) the individual session scores for the WAI (client and therapist ratings), SEQ (client and therapist ratings), and relational control for each of the cases studied. No pattern was found among the correlations that would support a conclusion of a consistent relationship between relational control (on any of the verbal response mode dimensions) and any of the relationship quality measures (whether rated by the client or the therapist). Significant correlations that were found, whether positive or negative, were not consistent across cases and could not be explained in terms of any unique characteristics of the cases.

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Insert Table 4 about here

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Examination of the overlay plots failed to reveal any obvious "stage pattern" in any of the relational control or relationship quality indices across therapy sessions. Although each case evidenced its own unique pattern of control and relationship quality dynamics, there was some

suggestion of a gradual enhancement of the therapeutic working alliance across sessions within each case--most notably as rated by the therapist. No such pattern was noted, however, for either the client or therapist SEQ ratings of session depth or smoothness. Nor was there any obvious pattern of change on the relational control indices for the various VRM role dimensions.

Figures 1 through 5 (representing only one of therapy cases) respectively present the across-session overlay plots for (a) client ratings of the working alliance (bond, task, goal), (b) therapist ratings of the working alliance (bond, task, goal), (c) client ratings of session depth and smoothness (SEQ ratings), (d) therapist ratings of session depth and smoothness (SEQ ratings), and (e) relational control. With regard to the last figure, positive relational control values suggest therapist control over the interaction while negative values suggest client control. Overall, the results of this study suggest that relational dominance/control may not be a significant factor in client or therapist evaluations of the quality of the therapeutic relationship.

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Insert Figures 1-5 about here

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### Discussion

Haley (1963) has suggested that when individuals communicate with one another, each by her/his acts, is maneuvering to define their relationship with one another. That is, by what they say and the way they say it, they are indicating to the other, "This is the sort of relationship I want to have with you." Therapists and clients are no different from others in this regard; and like others, they are posed with the mutual problems of (a) what kinds of behavior are to take place in their therapy relationship and (b) "who is to control what is to take place in the relationship and thereby control the definition of the relationship" (Haley, 1963, p. 9). As those writing in the field have noted, individuals cannot avoid being involved in a struggle over the definition of their relationships with others, and they are constantly involved in defining their relationships or countering the relationship definitions offered by others (Claiborn & Lichtenberg, 1989; Haley, 1963; Strong, 1982; Strong & Claiborn, 1982).

In this regard, Strong and Claiborn (1982) have commented that interpersonal behavior, by definition, seeks to control another. But they are also careful to note that "because each person is independent, self-generating and willful" (p. 32), it is wrong to say that one person "controls" another if control is viewed as direct, mechanical or inevitable. Instead, relational control is a function of people creating circumstances that "invite others to act one way rather than another" (p. 32) and making certain interpersonal responses more attractive and others less attractive. Relational control is achieved when the other is enticed into behaving as desired by giving the impression that such behavior will generate the relationship he or she desires. It was anticipated that therapist and client maneuvering for control in therapy would have an effect on and be correlated with therapist and client evaluations of the quality of their therapy relationship--although the nature of that relationship was not specified. That this was not the case was surprising and is not easily explained.

One might argue that the findings of this study, which suggest the absence of a relationship between relational control and the therapy quality ratings of either the client or therapist, are a function the subtlety with which relational control is exerted. That is, the working alliance and session evaluation ratings were uncorrelated with relational control because neither the client nor therapist was aware of or sensitive to the control maneuvers of the other. Tyndall (1989), however, found that observers of therapy interaction could reliably and accurately perceive the relational control dynamics occurring in therapy--at least as defined in terms of Tracey's topic determination coding system (Tracey, Heck, & Lichtenberg, 1981; also see Lichtenberg & Kobes, 1992).

Numerous interactional theorists have suggested "stage models" of the therapy process (e.g., Cashdan, 1973; Claiborn & Lichtenberg, 1989; Strong & Claiborn, 1982; Strong, 1982; Tracey, 1987; Tracey, 1993; Tracey & Ray, 1984); and Tracey has been quite consistent in empirically demonstrating "stages" using his process coding system for determining speaker control of the topical focus within therapy (e.g., Tracey, 1987; Tracey, 1993; Tracey & Ray, 1984). It should be noted, however, that it is possible that Tracey's topic determination coding

system (which captures who controls what topics are discussed in counseling), may uniquely yield the undulating pattern of relational control stages that Tracey has identified. That is, this system, although reflective of aspects of the mutual relational control issues faced by clients and therapists (Haley, 1963) and clearly a useful index of relational control, may be responsible for creating this particular "stage phenomenon." Another response coding system such as the one used in the present study, which taps who controls how matters are discussed in therapy (e.g., the role dimensions produced by Stiles' [1987] verbal response modes; or see Ericson & Rogers, 1973 and Penman, 1980), may not produce or reveal the same patterning (stages) of control. In this regard, Tracey (1991) has shown that the various methods generally used for operationalizing control in counseling are far from isomorphic.

Relatedly, the notion of stage patterning in therapy--at least as proposed by Tracey (1993; Tracey & Ray, 1984)--rather specifically addresses the dynamics of successful (or effective) therapy--as defined in terms of self-reported symptom reduction (using the SCL-90-R; Derogatis, 1977). In this regard, that no stage patterning was found on the relational control indices and no consistent or reliable relation was found between session quality (as assessed by client and therapist ratings on WAI and SEQ) and relational control may be indicative of the quality of the therapeutic outcomes in these seven cases. Referring back to Hill (1989; also see Wettersten & Lichtenberg, 1995), outcome data from her study show that not all of the cases showed a decrease in the number and severity client-reported of psychological symptoms when the SCL-90-R was administered (a) immediately following treatment or (b) at 6 months following treatment. Specifically, case 4 showed a moderate increase in symptomology at immediate follow-up, and cases 4 and 6 show slight increases at the 6-month follow-up. With the possible exception of case 1, which showed the greatest decrease in symptoms, in none of the cases did there appear to be a significant decrease or increase in symptomology across therapy. It is possible that a relationship between relational control and relationship quality would have presented itself in cases in which client change had been more dramatic.

Nevertheless, while such outcome findings may offer a possible explanation for the lack of a stage pattern in the relational control indices, and the very modest change (improvement) in WAI and SEQ ratings across sessions, such an interpretation must be made cautiously. It is not clear how little or how much change in SCL-90-R ratings (i.e., client symptomology) warrants or justifies an evaluation of "successful therapy." In this regard, although the SCL-90-R has been shown to be sensitive to client improvement and useful as a outcome/change measure for evaluating therapy (Rhoads, 1983; Speer & Swindle, 1982), it may not reveal whether a client's focal symptom(s)--the *raison d'être* for entering therapy--was addressed. Indeed, although a number of symptoms may have abated, the "real" problems that brought the client in for treatment may not have been alleviated. Conversely, although the pre-post change in the overall number of client symptoms may show an increase in symptomology, the client's presenting complaint(s) may have abated.

It has been and continues to be a basic tenet of interactional counseling that successful counseling is characterized by the therapist (rather than the client) controlling the definition of the therapy relationship (Claiborn & Lichtenberg, 1989; Haley, 1963; Strong, 1982). While the impact of the therapist relational control on therapy outcome was not addressed in this study, concerns over the possible negative impact of therapist control of the definition of therapist-client relationship (e.g., Dowd & Milne, 1986; Johnson, 1986; Schmidt, 1986) on the therapy relationships and processes may be unwarranted. The present study suggests that therapist (or client) control of the definition of the therapy relationship appears to neither enhance nor detract from the participants' evaluation of their working alliance or of the depth and smoothness of their sessions together.

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Table 1

Summary of Therapist and Client Demographic and Case Information<sup>1</sup>


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<u>Case #</u>	<u>Sex</u>	<u>Age</u>	<u>#Sessions in case</u>	<u>Race/ ethnicity</u>
<b><u>Case 1</u></b>				
Therapist	M	47	20	White
Client	F	35		Arabic
<b><u>Case 2</u></b>				
Therapist	F	47	17	White
Client	F	51		White
<b><u>Case 3</u></b>				
Therapist	M	43	17	White
Client	F	60		White
<b><u>Case 4</u></b>				
Therapist	F	37	12	Black
Client	F	44		Asian
<b><u>Case 5</u></b>				
Therapist	M	34	17	White
Client	F	42		White
<b><u>Case 6</u></b>				
Therapist	M	44	20	White
Client	F	32		White
<b><u>Case 7</u></b>				
Therapist	F	78	12	White
Client	F	39		White

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<sup>1</sup> See Hill (1989) for complete case information

Table 2

Taxonomy of Verbal Response Modes (Stiles, 1987)

Source of Experience	Frame of Reference	Focus	
		Speaker	Other
Speaker	Speaker	Disclosure	Advisement
Speaker	Other	Edification	Confirmation
Other	Speaker	Question	Interpretation
Other	Other	Acknowledgment	Reflection

Table 3

Role dimension response categories (from Stiles, 1986, p. 178)

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(a) Utterances concerning the other's experience:

Attentiveness (Question, Interpretation, Acknowledgment, Reflection) vs.

Informativeness (Disclosure, Edification, Advisement, Confirmation)

(b) Utterances using the other's frame of reference

Acquiescence (Edification, Confirmation, Acknowledgment, Reflection) vs.

Directiveness (Disclosure, Advisement, Question, Interpretation)

(c) Utterances focused on the other

Presumptuousness (Advisement, Confirmation, Interpretation, Reflection)

Unassumingness (Disclosure, Edification, Question, Acknowledgment)

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**Table 4 Legend:**

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**Ctask** = Client rating of WAI (task)

**Cgoal** = Client rating of WAI (goal)

**Cbond** = Client rating of WAI (bond)

**Cdepth** = Client rating of SEQ (depth)

**Csmooth** = Client rating of SEQ (smoothness)

**Ttask** = Therapist rating of WAI (task)

**Tgoal** = Therapist rating of WAI (goal)

**Tbond** = Therapist rating of WAI (bond)

**Tdepth** = Therapist rating of SEQ (depth)

**Tsmooth** = Therapist rating of SEQ (smoothness)

**Attentiveness** = Relational control on verbal dimension of attentiveness vs. informativeness

**Directiveness** = Relational control on verbal dimension of directiveness vs. acquiescence

**Presumptuous** = Relational control on verbal dimension of presumptuousness vs. unassumingness

---

Table 4 Correlations between Relationship Quality and Dominance (Attentiveness, Directiveness and Presumptuousness)

Case	Dominance	Client	Working	Alliance	Therapist	Working	Alliance	Tgoal	Tbond	Cdepth	Csmooth	Tdepth	Tsmooth
		Ctask	Cgoal	Cbond	Ttask	Tgoal	Tbond						
1	Attentiveness	-.433	-.349	-.431	-.210	-.402	-.498	-.201	.059	.055	-.387		
	Directiveness	.096	-.111	-.017	.085	-.222	.420	.301	-.111	.327	.216		
	Presumptuous	-.182	-.161	-.607	-.313	-.158	-.127	.146	-.081	-.283	.309		
2	Attentiveness	-.181	.079	.070	.653	.360	-.022	-.100	.122	-.045	.230		
	Directiveness	-.296	-.114	.070	.327	.227	.131	.056	.079	.032	.259		
	Presumptuous	.328	.288	-.021	.203	.252	.283	-.109	.020	.117	-.344		
3	Attentiveness	.323	-.111	.027	-.406	-.326	-.354	.224	-.219	-.449	-.058		
	Directiveness	-.351	-.331	-.126	.462	.574	.657	-.003	.170	.103	.034		
	Presumptuous	-.120	-.166	.010	.068	.009	.195	-.064	-.021	-.166	-.420		
4	Attentiveness	-.188	-.278	-.391	-.489	-.381	-.250	-.465	.035	-.433	-.141		
	Directiveness	-.301	-.257	.097	.202	.120	.459	-.327	-.668	.727	-.242		
	Presumptuous	-.067	.120	.117	.404	.553	.382	-.464	-.488	.323	-.163		
5	Attentiveness	.043	.198	-.042	.336	.336	.489	.332	-.355	-.067	.004		
	Directiveness	.058	-.040	-.154	.215	.052	-.127	.162	-.589	-.046	.077		
	Presumptuous	.202	-.037	.114	-.128	-.192	-.242	.346	-.646	-.156	-.249		
6	Attentiveness	-.646	-.769	-.107	-.488	.402	-.512	-.415	-.017	-.207	-.202		
	Directiveness	.142	.282	-.198	.202	-.431	.263	.253	.013	.184	-.053		
	Presumptuous	-.125	.099	-.369	.265	.164	.453	-.040	-.121	-.162	-.120		
7	Attentiveness	.300	.163	.011	.312	.304	.104	-.161	-.087	-.363	-.284		
	Directiveness	.623	.210	.277	.237	.461	.307	.555	.210	.355	-.222		
	Presumptuous	.363	.076	-.224	.017	.110	.094	-.114	-.049	-.232	-.675		

\* p < .05

\*\* p < .01

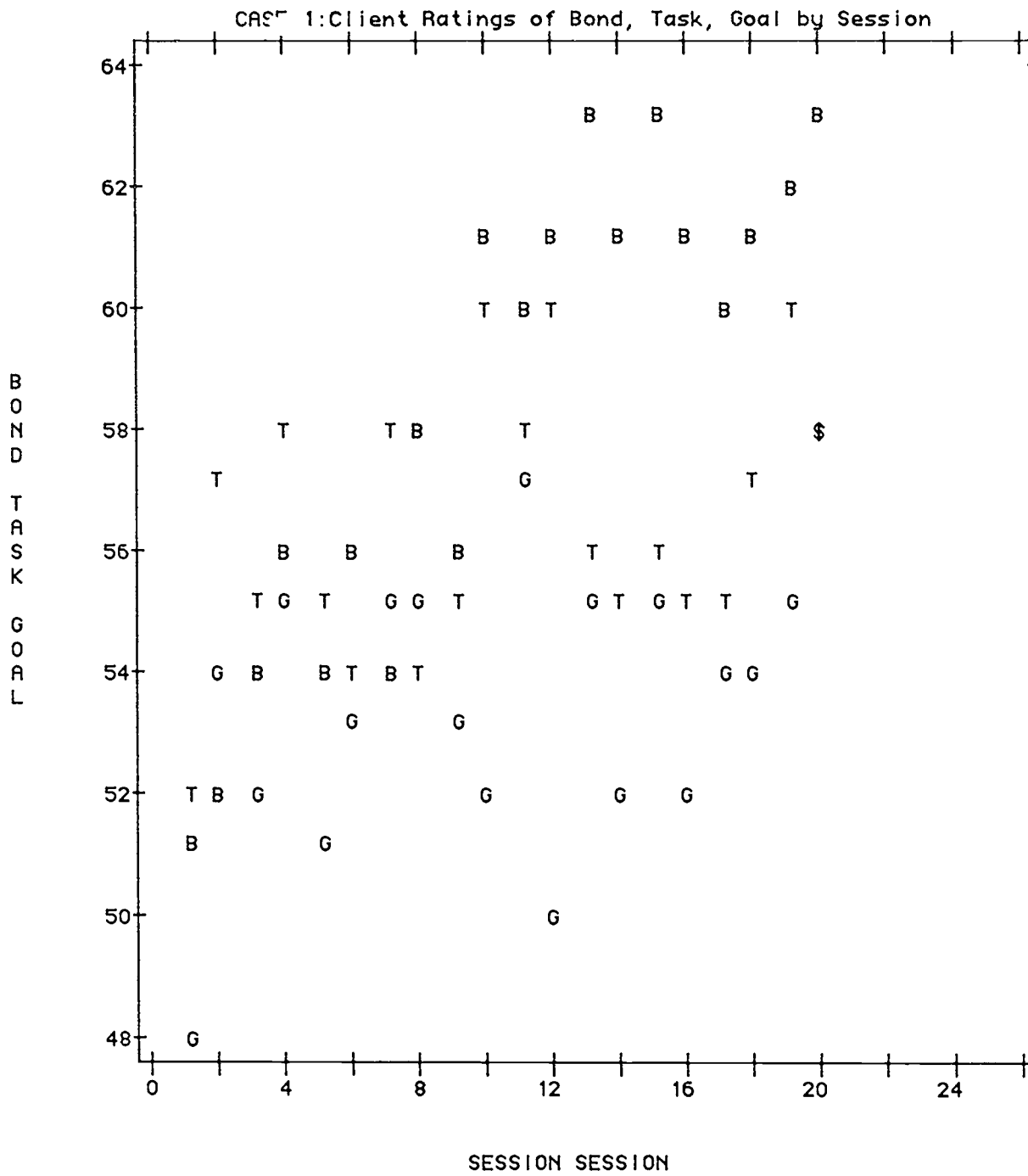


**Figure Captions (Figures 1-5)**

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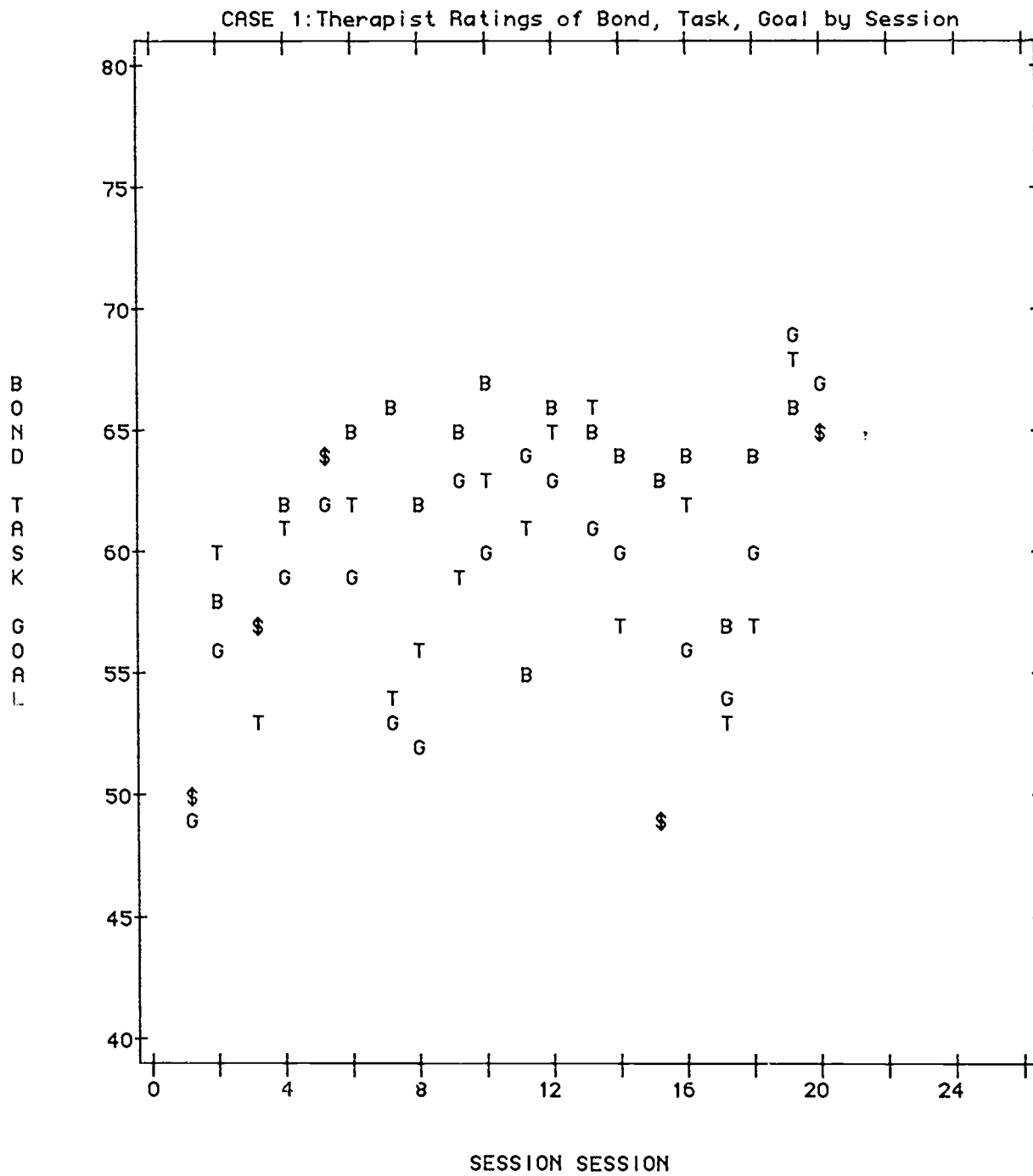
- Figure 1 Case 1: Client Ratings of Bond (B), Task (T), and Goal (G) by Session
- Figure 2 Case 1: Therapist Ratings of Bond (B), Task (T), and Goal (G) by Session
- Figure 3 Case 1: Client Ratings of Depth (D) and Smoothness (S) by Session
- Figure 4 Case 1: Therapist Ratings of Depth (D) and Smoothness (S) by Session
- Figure 5 Case 1: Relational Control by Role Dimension Across Sessions (A = Attentiveness vs. Informativeness; D = Directiveness vs. Acquiescence; P = Presumptuousness vs. Unassumingness)

Figure 1



B: BOND WITH SESSION 20 cases    T: TASK WITH SESSION 20 cases    G: GOAL WITH SESSION 20 cases  
 \$: Multiple occurrence

Figure 2



B:TBOND WITH SESSION 20 cases    T:TTASK WITH SESSION 20 cases    G:TGOAL WITH SESSION 20 cases  
 \$:Multiple occurrence

Figure 3

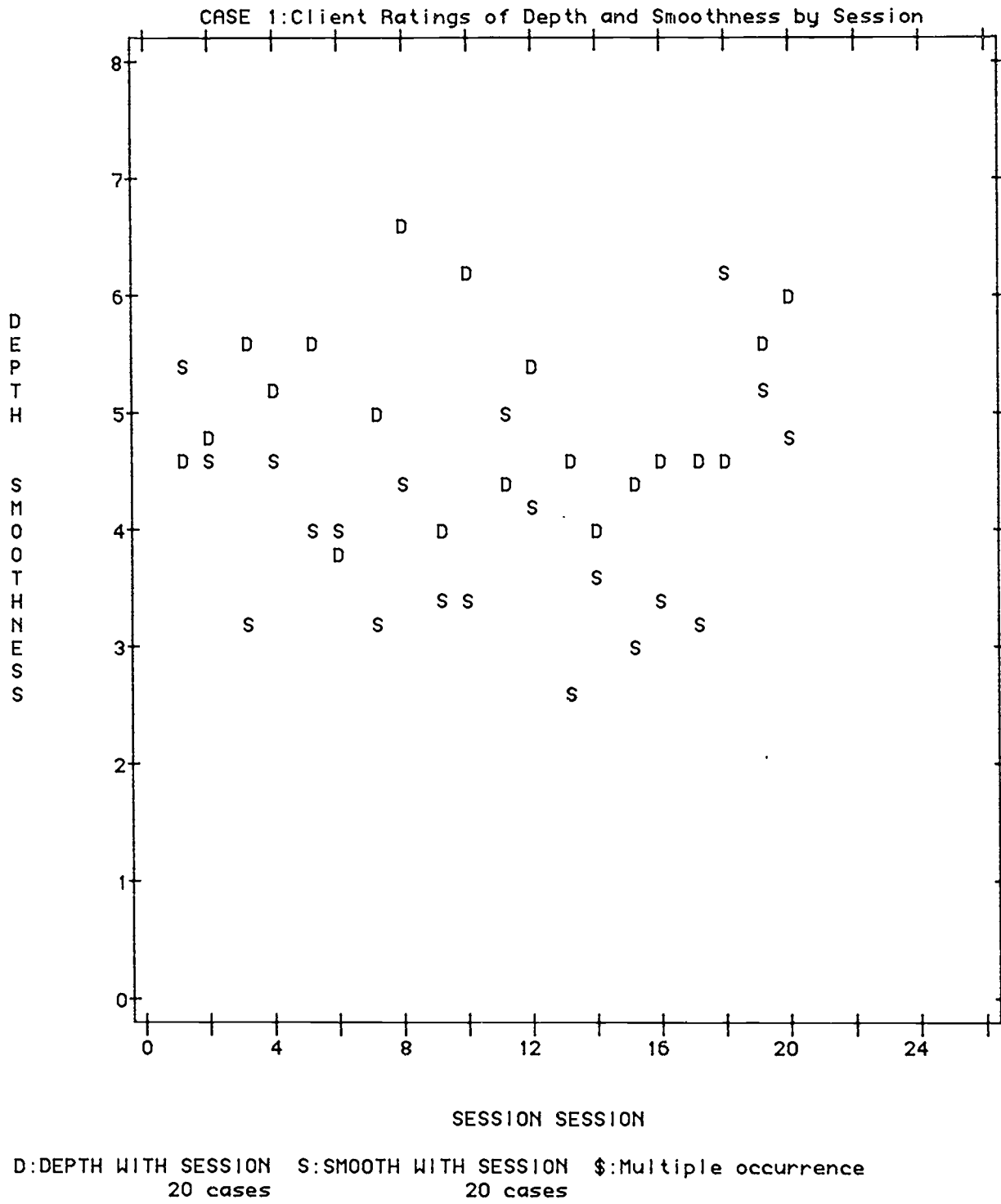


Figure 4

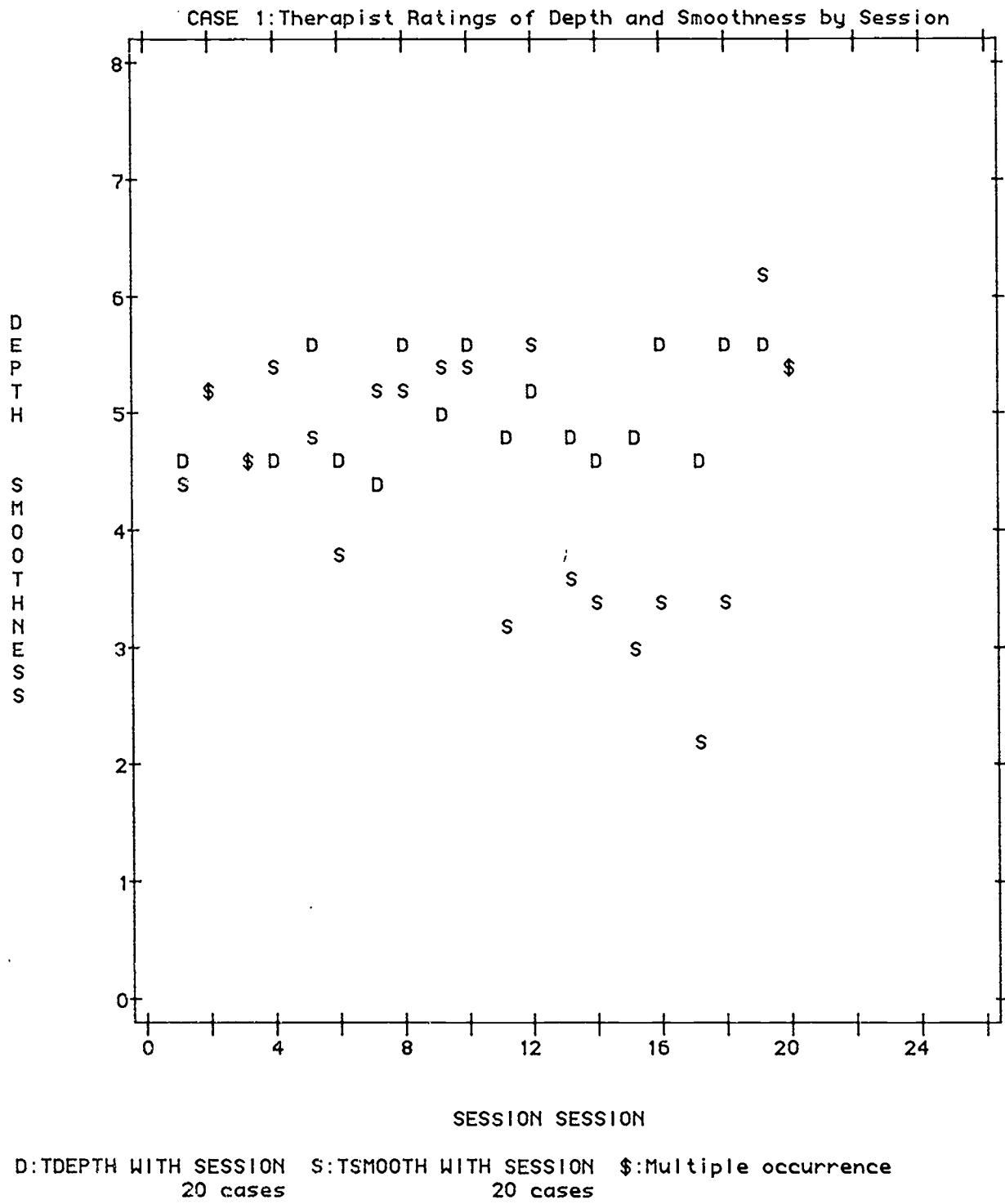
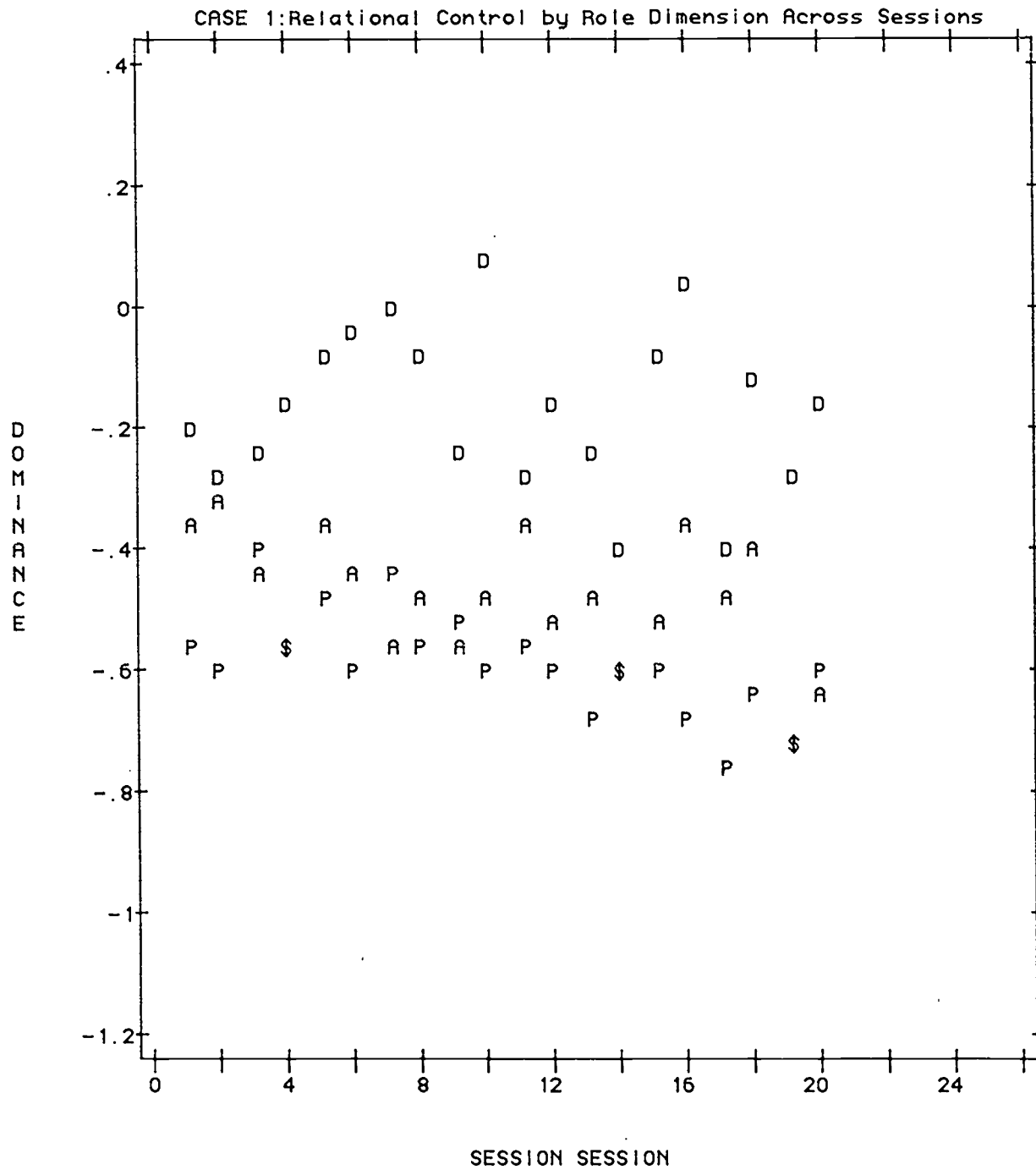


Figure 5



A: A\_DOMIN WITH SESSION 20 cases    D: D\_DOMIN WITH SESSION 20 cases    P: P\_DOMIN WITH SESSION 20 cases  
 \$: Multiple occurrence