DISCUSSION 3

Prior to beginning work on this discussion forum, be certain to have read all the required resources for this week. The use of mandated, or legally coerced, treatment is widespread. Yet research demonstrating the efficacy of this type of treatment is limited, and mandating mental health treatment is one of the most contested issues in the field of psychology. To justify the continued use of mandated treatment, policymakers, practitioners, and researchers are obligated to demonstrate the effectiveness and limitations of such treatment programs.

You have been called in to consult on cases that may require mandated treatment. After reviewing the PSY699 The ethics of mandated treatment scenarios (Links to an external site.), choose two to discuss in your initial post. Begin your research with the required resources for this week. Using the specific situations presented in each of the scenarios you have chosen, conduct further research to help inform your recommendations for each individual. A minimum of one resource per scenario, beyond those already required for the assignment, must be included in your initial post.

attached

In your post, construct clear and concise arguments using evidence-based psychological concepts and theories to present your recommendations as to whether or not treatment should be mandated for the individuals in each of the scenarios. As you write your recommendations, be certain to provide insights into the following questions.

- What are the ethical principles and implications raised by legally mandating clients into treatment?
- What evidence exists regarding the effectiveness of treatment with and without coercion for this type of situation?
- What would be the challenges in evaluating the effectiveness of mandated treatment?
- How might mandated treatment impact your clinical decision making as the mental health professional assigned to these cases?
- What client factors might limit or augment the potential benefits of treatment if it were mandated?

Integrating concepts from your research and the required readings, offer insights across different content domains as to why you have reached these conclusions. Explain how you used the APA Ethical Code of Conduct to guide your decisions. Evaluate the generalizability of your specific research findings to the situations presented and provide a rationale as to why this research supports your recommendations.

PSY699: Master of Arts in Psychology Capstone

The Ethics of Mandated Treatment Scenarios

Scenario 1:

A client with a well-established history of repeated dangerous behavior and inpatient commitment has been treated, stabilized, and discharged into the community. The treating psychiatrist believes that the client's success in the community is far more likely if treatment is continued. However, the client wishes to terminate treatment. A request for mandated treatment is filed by the psychiatrist with the court. During the hearing, the psychiatrist testifies that while the client is not imminently dangerous, he potentially could become dangerous again without treatment.

Scenario 2:

A long-term client appeared quite excited during a recent session with her therapist. Speaking rapidly, she told the therapist that she was planning a gambling trip that would win her millions of dollars. After some probing, the therapist learned the client had recently stopped taking the medication prescribed for her bipolar disorder because she had been feeling so happy. The client also indicated that she no longer saw a need for therapy and was planning to stop treatment.

Scenario 3:

An older, debilitated adult is living within two miles of her adult daughter. The daughter currently has control of her mother's finances and is aware that her mother is unable to leave home to purchase basic necessities. The mother wishes to be in psychotherapy, but the daughter claims that she can care for her mother on her own.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

American Psychological Association (2010). Ethical principles of Psychologists and Code of Conduct: Including 2010 Amendments.

Section 1: Resolving Ethical Issues

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable

steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations
When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority (#102) , and 1.03, Conflicts Between Ethics and Organizational Demands (#103) .)

1.05 Reporting Ethical Violations
If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations (#104) , or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority (#102) .)

1.06 Cooperating with Ethics Committees
Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints
Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

Section 2: Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies (#202) .

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

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AN EXAMINATION OF MANDATED VERSUS VOLUNTARY REFERRAL AS A DETERMINANT OF CLINICAL OUTCOME

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Abstract

A literature review was undertaken to examine evidence for the effectiveness of psychotherapy with mandated clients. The primary question addressed was whether or not clients mandated to therapy, whether by court order or by order of their employers, show poorer outcomes than clients who enter therapy voluntarily. To this end, research on client resistance and motivational readiness to change was reviewed. This was followed by an examination of research on the effectiveness of mandated treatment. The question of the potential influence of relationship factors such as the therapeutic alliance was also addressed. The literature review was followed by suggestions for future research on the effectiveness of treatment for clients with mandated or voluntary referral status. [PUBLICATION ABSTRACT]

Full Text

Headnote

A literature review was undertaken to examine evidence for the effectiveness of psychotherapy with mandated clients. The primary question addressed was whether or not clients mandated to therapy, whether by court order or by order of their employers, show poorer outcomes than clients who enter therapy voluntarily. To this end, research on client resistance and motivational readiness to change was reviewed. This was followed by an examination of research on the effectiveness of mandated treatment. The question of the potential influence of relationship factors such as the therapeutic alliance was also addressed. The literature review was followed by suggestions for future research on the effectiveness of treatment for clients with mandated or voluntary referral status.

Psychotherapy encompasses a vast array of psychotherapeutic and systemic schools of thought, each with their corresponding styles and techniques. Although models may differ, one widespread assumption is that clients enter therapy voluntarily and are at least somewhat motivated to be there (Cingolani, 1984; Haley, 1992; Harris & Watkins, 1987; Rooney, 1992). Unfortunately, this assumption fails to account for clients who enter therapy under duress. Some of these clients are legally required by the courts to attend therapy for a variety of offenses involving child abuse and neglect, domestic violence, incest, or substance abuse. Others are referred to therapy by their employers for a variety of mental health problems (often substance abuse) under threat of losing their jobs.

The question of whether traditional therapy techniques, which are generally based on working with voluntary clients, can be effective when applied to clients who do not attend treatment voluntarily has received limited attention in the field of psychotherapy and even less in the field of marriage and family therapy. Harris and Watkins (1987) noted, for instance, that "little has been written about the problems of adapting psychological theories to clients who are involuntary and reluctant to participate in a change process" (pp. 6-7). The involuntary client is likely to resist treatment in all the ways that the voluntary client might, but the coerced entry into counseling can compound the resistance and add new complications to the beginning of the therapy process. Most authors who

have addressed this subject agree that mandated clients generally enter treatment with greater resistance to therapy and less motivation to change than those who begin treatment voluntarily (Begun et al., 2003; Chamberlain, Patterson, Reid, Kavanaugh, & Forgatch, 1984; Lehmer, 1986; Miller & Rollnick, 1991; Rooney, 1992; Taft, Murphy, Elliott, & Morrei, 2001). The greater the resistance, the less likely clients will change (Miller & Sovereign, 1989) or remain in therapy (Chamberlain et al., 1984).

It would seem that mandated versus voluntary referral status, and the accompanying issues of client resistance and motivation to change, constitute key determinants to psychotherapy outcome. The purpose of this article is to examine this issue by reviewing research on client resistance and motivational readiness to change. This is followed by an examination of research on the effectiveness of mandated treatment. The potential influence of relationship factors such as the therapeutic alliance is also discussed. The article concludes with suggestions for future research on the effectiveness of treatment for clients with mandated versus voluntary referral status.

CLIENT RESISTANCE

The literature is relatively uniform in suggesting that mandated clients are more resistant to treatment than voluntary clients (Chamberlain et al., 1984; Haley, 1992; Lehmer, 1986; Miller & Rollnick, 1991; Rooney, 1992; Taft et al., 2001). DiClemente (1991) suggested that this resistance is the result of "the four R's": client reluctance, rebellion, resignation, and rationalization. A broader view is that this phenomenon is a normal reaction to compulsory treatment, as people are likely to resist their loss of freedom and independence (Weakland & Jordan, 1990; Woody & Grinstead, 1992). They also might reasonably be expected to revolt against being labeled by an outside party as having a mental problem, having a course of therapy imposed on them, or perceiving their therapist as an agent of the state (Ackerman, Colapinto, Scharf, Weinshel, & Winawer, 1991; Adams, 1992; Haley, 1992; Weakland & Jordan, 1990; Woody & Grinstead, 1992).

Another often-overlooked contributing factor to the concept of resistance is that minority groups appear to be disproportionately represented among court-mandated clients (O'Hare, 1996; Rooney, 1992). Cultural factors inherent in this clientele are often not well understood by their predominantly White therapists, and this may cause strain in the therapist-client relationship. Moreover, perceived client "resistance" may actually be, within certain cultural subgroups, a normative reaction to mandated therapy with a therapist who represents the majority establishment. Waldman's (1999) study of involuntary therapy with minority groups found that clients perceived the therapy and the therapist as being part of the punishment imposed by an oppressive, White, European American system. Cultural factors inherent in this clientele are often not well understood by their therapists, such as the following: (a) the importance of maintaining family secrets, keeping up appearances with outsiders, and a heightened suspicion of White institutions, among African Americans (Boyd-Franklin, 1989); (b) the importance to certain Hispanic groups of loyalty to family, women's obligation (through the concept of marianismo) to revere, protect, and never criticize their husbands, and the strong, macho self-concept in the men (Boyd-Franklin & Garcia-Preto, 1994); and (c) the possible conflict between the cultural importance of not "losing face," maintaining emotional restraint, and the confessional character of psychotherapy, for Asian American clients (Zane, Nagayama-Hall, Sue, Young, & Nunez, 2004).

The concern is that therapists who lack adequate cultural training may not view their clients' problems through the appropriate "cultural lens" (Abu Baker, 1999; Falikov, 1988), and thus fail to normalize diverse clients' negative perceptions about therapy and/or their White therapists. This may then begin an unfruitful therapeutic interaction whereby therapists (a) add to the already-existing client resistance, beyond that which is already normative for mandated clients, and (b) trigger their own feelings of defensiveness when their clients present as unreceptive or unmotivated.

Some have hypothesized that failure to expect and normalize clients' resistance has historically resulted in therapists internalizing their clients' reluctance as rejection, and becoming defensive as a result (Vriend & Dyer, 1973). Therapists, like most people, are not good at handling hostility and rejection, and more importantly are not properly trained to anticipate and deal with it (Strupp, 1980). Others have suggested that negative client responses may in fact be the result of a lack of fit between the mind-set of mandated clients and the voluntary therapy concepts which are applied by their therapists. Frustration over negative reactions can cause practitioners to project

their frustration onto their clients, essentially blaming their clients for their "resistance," and reacting with anger when clients are hostile or unmotivated, rather than understanding that their clients' negative reaction is a normal part of involuntary therapy (Cingolani, 1984; Rooney, 1992).

Despite these constraints, resistance is increasingly being viewed as amenable to therapeutic intervention (Donovan & Rosengren, 1999; Miller & Rollnick, 1991). Some have suggested that resistance can be purposely utilized in the service of therapeutic change (Watzlawick, Weakland, & Fisch, 1974). Others have gone so far as to suggest that resistance is therapy (Anderson & Stewart, 1983). Most agree that the goal is to transform the therapy as quickly as possible from an involuntary process to a voluntary one by establishing a strong therapeutic alliance with the client system and thereby facilitating change, without increasing the client's resistance or the therapist's defensiveness. Many have suggested specific techniques for doing so. Although a discussion of the specific therapeutic interventions that have been proposed for working with mandated clients is beyond the scope of this article, readers may be interested in some of the most frequently cited resources (Abu Baker, 1999; Bastien & Adelman, 1984; Caesar & Friday-Roberts, 1991; Colapinto, 1995; Haley, 1987; Miller & Rollnick, 1991; Rooney, 1992; Schottenfeld, 1989; Watzlawick et al., 1974; Weakland & Jordan, 1990).

MOTIVATION TO CHANGE

Internal motivation to change has often been presumed to be a prerequisite to successful treatment (Orlinsky & Howard, 1986; Schottenfeld, 1989). Yet, surprisingly little research has addressed the differences in treatment outcomes between clients with an intrinsic motivation to change versus those who have been influenced externally, such as by court referral (Rotgers, 1992).

Mandated clients generally have been found to have lower levels of motivation and initial readiness for change than voluntary clients (Begun et al., 2003). As intrinsic motivation appears to predict better treatment outcomes (Orlinsky & Howard, 1986; Schottenfeld, 1989), logic would argue that mandated clients should have poorer outcomes than their voluntary counterparts. Interestingly, research has not shown a strong correlation between initial motivation and successful outcome (Bastien & Adelman, 1984; Lehmer, 1986; Satel, 2000). As a result, the presumption that intrinsic motivation must be present at the outset of therapy in order for it to succeed has not been supported (Rounsaville & Kleber, 1985).

A notable contribution toward clarifying this issue is the "transtheoretical" model of motivational readiness to change, developed by Prochaska, DiClemente, and Norcross (1992). The model proposes that individuals pass through a series of five stages of change in their attempt to address problem behaviors. Thus, motivational readiness to change is viewed as a progressive continuum rather than a "yes" or "no" (present or absent) phenomenon. Clients move from (a) precontemplation (no acknowledgment of a problem, and no intention to change), to (b) contemplation (awareness of the existence of the problem, thinking about changing in the next 6 months, but ambivalent, with no commitment to changing the problematic behavior), to (c) preparation to change (seriously thinking about changing in the next month, and perhaps completing small, preparatory changes), to (d) taking action (specific changes to address the problem behavior have been initiated within the past 6 months), and finally, to (e) maintenance (consolidating changes and taking steps to prevent relapse; Prochaska et al., 1992).

Most research on the model has involved verifying clients' internal characteristics at each stage (Prochaska et al., 1994) and confirming that the individual's stage of change can predict treatment outcome (DiClemente et al., 1991; Edens & Willoghby, 2000). Precontemplators and contemplators have been shown to be less motivated to change than those in the action or maintenance stages (DiClemente & Hughes, 1990), and less likely to develop a strong therapeutic alliance (Connors et al., 2000). McConnaughy, Prochaska, and Velicer (1983) further concluded that clients who were high on Precontemplation and very low on Action were most likely to enter therapy because of family, legal, or employer pressures rather than an internal motivation to change, and to terminate therapy prematurely. Other studies have confirmed the relationships between clients who remain in the precontemplation stage of change and weak therapeutic alliance, premature termination, and poor improvement in therapy (Satterfield, Buelow, Lyddon, & Johnson, 1995; Smith, Subich, & Kalodner, 1995).

The "transtheoretical" stage of change model appears to have considerable relevance to many of the client populations that are mandated by outside referral sources such as the courts, the state, or employers. For instance, domestic violence perpetrators have generally been found to enter counseling at the precontemplation or contemplation stages of change (Taft et al., 2001), as have substance abusers (DiClemente, 1991) and sex offenders (Garland & Dougher, 1991; Serran, Fernandez, Marshall, & Mann, 2003).

Court-referred clients have generally been found to be less motivated to change than voluntary clients (Begun et al., 2003; Chamberlain et al., 1984; Lehmer, 1986; Miller & Rollnick, 1991; Rooney, 1992; Taft et al., 2001; Woody & Grinstead, 1992). Poor motivation may be an entirely expected reaction if these clients are precontemplators or contemplators, and thus not cognitively ready to undertake a course of therapy aimed at changing their behavior. Behaviorally focused interventions would be more appropriate for voluntary clients who would be more likely to enter therapy in the action stage of change (Prochaska et al., 1992). These findings suggest that a critical consideration for therapy with mandated clients is to match interventions to the client's level of motivational readiness to change.

This conclusion dovetails with Cingolani's (1984) and Rooney's (1992) hypotheses that negative client responses to mandated therapy may be the result of the lack of fit between the mindset of involuntary clients and the interventions that are applied by therapists who have been trained in treatment models based solely on work with voluntary clients. Outcome research with the stages of change model has consistently found that tailoring interventions on the basis of a client's motivational readiness to change positively affects treatment outcomes (Prochaska, DiClemente, Velicer, & Rossi, 1993; Prochaska & Velicer, 1997; Velicer & Prochaska, 1999; Velicer et al., 1993).

Although there do not yet appear to be any marital and family therapy applications to the Prochaska et al. (1992) model of change, some marriage and family therapy treatment models, such as functional family therapy, have focused on the importance of client and family motivation, by making the enhancement of motivation the first stage of treatment (Sexton & Alexander, 2003).

EFFECTIVENESS OF MANDATED TREATMENT

Several authors have expressed doubt that mandated treatment can be effective due to resistance factors and the apparent lack of internal motivation to change in mandated clients (Rosenfeld, 1992). However, the view that intrinsic motivation to change must be present at the outset of treatment in order for it to be successful has been largely dispelled in light of the undeniable treatment successes in so many areas of mandated therapy, including domestic violence, child abuse, incest perpetrator therapy, and, most particularly, substance abuse.

A comprehensive review of all literature related to mandated treatment for each of these presenting problems is beyond the scope of the present review. However, selected findings are discussed in the following sections to offer the reader an appreciation of the extent to which mandated treatment has been found to be effective.

Domestic Violence

The vast majority of domestic violence perpetrators enter therapy against their will, whether by court order or under pressure from their partners (Taft et al., 2001). As in other instances of mandated treatment, some have questioned whether treatment under these conditions can be effective. For instance, Rosenfeld (1992) found that most treatment studies of domestic abusers reported only minimal decreases in violent incidents posttreatment compared with men who received no treatment. This led Rosenfeld (1992) to question whether it was realistic to expect court mandates to foster motivation to change or even regular attendance in treatment. This view was supported by other findings that indicated voluntary referrals exhibited higher levels of motivation to change than mandated referrals (Bowen & Gilchrist, 2004).

On the other hand, batterers who were ordered to treatment and completed it were significantly less likely to commit further domestic violence offenses than those who did not complete the treatment. Batterers who completed treatment were more likely to be first-time offenders, be employed, have a higher income, and be more educated than dropouts, suggesting that perhaps their compliance was the result of having more to lose (Sherman,

Smith, Schmidt, & Rogan, 1992). In another study, batterers who did not complete treatment were more likely to be unemployed and have more extensive criminal records than those who completed treatment. The authors suggested that dropouts represented a more socially disenfranchised group, less subject to normal social controls and incentives (Babcock & Steiner, 1999).

The issue of attending and remaining in treatment is an important one in the area of domestic violence treatment because studies have shown that the more sessions batterers attend, the better the treatment outcomes, and the lower the rates of violence recidivism (Babcock & Steiner, 1999; Chen, Bersani, Myers, & Denton, 1989; Taft et al., 2001). And yet, dropout rates are generally exceedingly high (40-60% within the first 3 months of treatment; Cadsky, Hanson, Crawford, & Lalonde, 1996) and many batterers (up to 90% by some estimates) never show up for treatment (Gondolf & Foster, 1991). Many of the above authors have advocated utilizing the court's power to require batterers to attend a full course of treatment. In one recent study, 14% of the batterers who completed treatment did so only after bench warrants were ordered for their arrests. This suggests that court-mandated treatment, backed up by active court intervention in the event of breaches of probation, can increase compliance with domestic violence treatment (Babcock & Steiner, 1999).

However, forcing clients to remain in treatment is not the same as achieving the goal of reducing or eliminating violence. One promising approach involves applying Prochaska's transtheoretical model of change (Prochaska et al., 1992) to frame batterers' resistance as an incongruence between intervention techniques and the client's stage of motivational readiness to change (Daniels & Murphy, 1997; Miller & Rollnick, 1991). Most batterers' programs are behaviorally oriented and emphasize skills training strategies (e.g., anger management, taking timeouts) that presuppose clients have motivation to change. Clients in the precontemplation stage often resist treatment, either actively (arguing with the therapist about the usefulness of various skills) or passively (sidetracking with frequent crises, failing to complete homework assignments, or remaining disengaged in sessions; Daniels & Murphy, 1997). Treatment goals for such clients would be more focused on increasing their motivation to change (Bowen & Gilchrist, 2004).

Child Abuse

Court intervention and control have been found to be key therapeutic tools in both enhancing motivation to change in perpetrators, and protecting potential victims, in cases of child abuse (Landau, Salus, Stiffarm, & Kalb, 1980). Abusive and neglectful parents rarely seek help voluntarily and are often in denial about their actions (Azar, 1984). Mandated therapy for child abuse perpetrators has nevertheless been found to be successful in several reported cases. In one of the few published empirical studies, mandated participants in a treatment program for child abusers performed as well as nonmandated clients in terms of attendance, participation levels, and improvements in communication with their children Mandated parents were found to be substantially (50%) less verbally critical with their children than they had been prior to treatment (Irueste-Montes & Montes, 1988). In another study, court-mandated parents were found to be five times more likely than voluntary parents to successfully complete the treatment program (Wolfe, Aragona, Kaufman, & Sandler, 1980). Perhaps the fear of losing their children to state authorities, and ongoing supervision by such authorities, provided sufficient motivation for mandated parents to comply with treatment program objectives. Finally, a third study of only three court-mandated families examined a treatment that offered parenting and affective skills training. The treatment was found to be successful with all three families, notwithstanding the fact that they were coerced into treatment (Dawson, De Armas, McGrath, & Kelly, 1986).

Incest Perpetrators

The vast majority of treatment of incest perpetrators is conducted under court order, and the number of offenders who enter treatment voluntarily is extraordinarily small (Horton, 1992). Incest perpetrators generally present as unmotivated for treatment, and frequently deny and rationalize their behavior (Garland & Dougher, 1991). More particularly, the lack of motivation and rigid defense mechanisms employed by sex offenders are associated with high treatment dropout rates (Knopp, 1984) and high (60%) rates of recidivism (Krauth & Smith, 1988).

Motivational interventions and treatment successes are nevertheless said to be possible with this treatment population. Client motivation for change is considered to be the most important determinant of outcome in sex offender treatment, meaning that motivational enhancement techniques are critical in working with this population (Garland & Dougher, 1991). What is said to be important is recognizing where the sex offender is on the continuum of readiness to change, and meeting the client with interventions that are appropriate to that stage. Creating and enhancing motivation for change can be enhanced through such strategies as increasing the offender's empathy for the victim and emphasizing the costs (e.g., loss of family and friends, social stigma, and incarceration) of continuing with sexually deviant behavior (Garland & Dougher, 1991).

In the interim, the threat of court intervention is often needed to keep that person in treatment (Horton, 1992; Ryan, 1986). The threat of what might be termed the "legal ax" seems to be essential to successful treatment outcomes. Encouraging offenders to visualize this ax waiting to fall (e.g., revocation of probation and subsequent incarceration) has been shown to enhance the potential for offenders to address their inappropriate behaviors (Horton, Johnson, Roundy, & Williams, 1990).

Substance Abuse

While there has been some research and scholarly writings on the subject of mandated clients in other treatment groups, the vast majority of research has been conducted in the area of substance abuse. It is a commonly held presumption that substance abusers, like other mandated clients, are resistant to treatment, unmotivated to change, noncompliant with treatment recommendations, likely to terminate treatment prematurely, and unlikely to achieve positive outcomes (Donovan & Rosengren, 1999). This is due in part to the conventional wisdom that substance abusers have to "hit bottom" and be intrinsically motivated to change before they can change (Donovan & Rosengren, 1999).

One of the primary distinctions between mandatory and voluntary substance abuse treatment clients has been shown to be intrinsic motivation to change (Farabee, Nelson, & Spence, 1993; Farabee, Prendergast, & Anglin, 1998). Lack of motivation to change in substance abuse treatment has been associated with lower treatment retention rates (De Leon & Jainchill, 1986) and poorer outcomes (Simpson, Joe, & Rowan-Szal, 1997). Conversely, high pretreatment motivation to change has been associated with twice the likelihood of a positive outcome in substance abuse treatment (Simpson et al., 1997). As Leukefeld and Tims (1988) noted, "A stable recovery cannot be maintained by external (legal) pressure only; motivation and commitment must come from internal pressure. The role of external pressure from this point of view is to influence the person to enter treatment" (p. 243).

While some outcome research reports that mandated clients did better than voluntary clients (Chopra, Preston, & Gerson, 1979; Dunham & Mauss, 1982), others (Smart, 1974) report that voluntary clients fared better. The majority, however, have found similarly beneficial outcomes for both groups (Anglin, Brecht, & Maddahian, 1989; Brecht, Anglin, & Wang, 1993; De Leon, 1988; Flores, 1983; Freedberg & Johnston, 1978; Hubbard et al., 1989; McGlothlin, 1979; Watson, Brown, Tilleskjor, Jacobs, & Pucel, 1988). Illustrative of these findings was a study by Anglin et al. (1989), who found that outcomes (length of stay in treatment, posttreatment gains) did not differ for addicts with legally coerced versus voluntary treatment entry. They suggested that given these findings, it made little sense to promote a social policy that allowed drug-dependent individuals to choose when to enter treatment and when to leave. Instead, a less costly and more efficient process would be to implement a more externally constraining system that does not rely on the individual's fluctuating motivational state. In a literature review covering up to the year 2000, Miller and Flaherty (2000) concluded that the preponderance of the literature confirms the efficacy of mandated addiction treatment and that coercion helped motivate clients to comply with treatment.

The inconsistent findings that have emerged in this literature may be due to the fact that outcome research in the area of substance abuse treatment has suffered from various methodological shortcomings (Howard & McCaughrin, 1996; Rotgers, 1992; Shearer, 2000). These include differences in outcome measures (e.g., measuring recidivism rates rather than client drinking levels, measuring employee job performance rather than level of substance use) and differences in comparison groups (e.g., comparing young, mandated, relatively healthy individuals with voluntary, older, chronic addicts). Differences may also be due to definitional inconsistencies as to what constitutes

a mandated client (De Leon, 1988; Rotgers, 1992), addicts' personal characteristics that affect response to treatment (such as the existence of personality disorders), or variations in treatment plans (Anglin et al., 1989). Others point to the inevitable problem of lack of control groups and random assignments (Howard & McCaughrin, 1996) and selection or recruitment bias (Dunham & Mauss, 1982). As it is virtually impossible to secure random assignment to treatment conditions, any quasi-experimental design which is implemented will be unable to definitively determine which effects on the outcome variable are due to treatment effects, rather than preexisting differences in the groups such as severity of the drinking problem, age, education, or social class. Finally, others point out that treatment programs vary widely and thus program sources of variance obscure the measurement of treatment effectiveness for legally referred clients (Inciardi, 1994).

In what has been described as one of the only research studies that has tried to address many of these methodological problems, and "probably the best designed and executed study of coercion and treatment outcome to date" (Rotgers, 1992), Walsh et al. (1991) compared results of three treatment options for employees referred by their employee assistance plan for alcohol problems (compulsory inpatient; mandatory Alcoholics Anonymous [AA] meetings only; or voluntary option to do either). The employees were randomly assigned to these treatment programs and followed for 2 years. All three groups were found to have improved in terms of job functioning and reduced drinking, with the inpatient clients faring the best. As the employer could back up the referral to treatment with firing if drinking continued, the researchers opined that clients' motivation for succeeding in the more intensive inpatient condition might have been confounded with employer coercion.

Research shows that length of time in treatment affects outcome, and mandated clients do appear to remain in treatment longer than voluntary clients (De Leon, Melnick, & Tims, 2001; Goldsmith & Latessa, 2001; Leukefeld & Tims, 1988; Satel, 2000). In an interesting study, Dunham and Mauss (1982) compared the differential rates of alcoholism treatment success rates for courtmandated and voluntary clients in a community alcoholism treatment center, statistically controlling for pretreatment differences. Clients were divided into four groups: self-referrals, informal agency (AA, physician) referrals, driving while impaired (DWI; court) referrals, and other legal/court referrals. While it was found that certain socioeconomic traits had a powerful impact on outcome (i.e., no prior treatment experience, active employment, education, not dependent on social assistance, stable marriage and family life), type of referral was a stronger predictor of outcome. The more coercion that was applied, the better the outcome. Treatment success was greater for those referred from the justice system than those attending voluntarily. The success rate for DWI clients was almost double that of voluntary clients (43% vs. 22%). The authors concluded that the certainty of the consequences for noncompliance with treatment for the DWI clients, and their having the most to lose (as they had the best occupations, highest education, etc.), was an important factor. Dehmel, Klett, and Buhringer (1986) also found that more socially integrated clients (e.g., employed, stable home, and family life) had a greater likelihood of completing treatment.

Although it may appear daunting to be able to establish a positive therapeutic alliance with mandated clients, and successfully treat them when they are there against their will, the evidence to the contrary is surprising. Granted, voluntary clients tend to exhibit much more motivation and willingness to engage in the treatment process (O'Hare, 1996), and intrinsic motivation appears to predict better treatment outcomes (Joe, Simpson, & Broome, 1998; Orlinsky & Howard, 1986; Schottenfeld, 1989). However, mandated clients can be motivated to change, or become so after therapy has begun. Perhaps this is because outcomes are less dependent on legal status than on the quality of the interaction between client and therapist (Rooney, 1992), or the therapist's ability to help raise a client's level of motivation (Donovan & Rosengren, 1999; Miller & Rollnick, 1991).

It appears that under the right therapeutic conditions, clients mandated to attend therapy can be helped to change their initial perceptions and become engaged in the therapy process (Leukefeld & Tims, 1988; Satel, 2000). By "meeting the clients where they are," taking into account any cultural issues, assessing initial levels of motivational readiness to change (or lack thereof), and using appropriately timed interventions, therapists can assuage resistance and transform the mandated process into an essentially voluntary and productive one. As stated by Howard and McCaughrin (1996), "A possible way to reduce treatment failure among court-mandated clients is to not treat them and voluntary clients in a homogenous manner. Positive attitudes and treatment practices specific to court-mandated clients work best in producing successful treatment outcomes" (p. 919). Finally, the research literature suggests that what mandated clients may lack in terms of initial motivation may be more than

compensated for by their tendency to stay in treatment longer than their voluntary counterparts, allowing time for intrinsic motivation to develop and therapeutic techniques to take effect. Length of time in treatment affects outcome, and mandated clients appear to remain in treatment longer than their voluntary counterparts.

THERAPEUTIC ALLIANCE

Bordin (1979) defined the "therapeutic" or "working" alliance as the therapeutic bond between the client and therapist, based on their agreement on the goals and tasks of therapy. He hypothesized that the strength of that alliance was a significant mediator, if not the most important mediator, of therapeutic outcome. Family therapists expanded on this by adding that the therapeutic alliance is developed by building a bond and joining not only with the individual client but also with each family member (Fennel & Weinhold, 1997; Minuchin, 1974). Sprenkle and Blow (2004) referred to the "expanded therapeutic alliance" as a common factor that is unique to marriage and family therapy. The therapist must form an alliance with the family as a whole, each subsystem, and each family member.

While it is beyond the scope of this article to discuss the therapeutic alliance literature in more detail, what is clear is that the therapeutic alliance has been shown to be an essential element of the treatment process regardless of the type of therapy approach being used, the type of client population being targeted, or the type of client referral (mandated or voluntary; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Sprenkle & Blow, 2004). While it may take longer to develop a therapeutic alliance with a mandated client (Honea-Boles & Griffin, 2001), the literature discussed above clearly shows that it is possible to do so. How the therapist responds to the client's resistance, some say, will determine outcome (Miller & Rollnick, 1991). What appears to be key in developing a therapeutic alliance with any client system, mandated or not, is (a) getting off to a good start early in the therapeutic process, (b) intervening with motivationally enhancing techniques with those clients who exhibit a low level of motivational readiness to change, (c) being sensitive to the cultural background of the individual client or client system, and (d) achieving an empathic emotional bond, consensus on the goals of therapy, and a mutual understanding of the tasks to be implemented (Horvath & Symonds, 1991; Pinsoff, 1994).

While we do not know with specificity what makes a therapeutic encounter successful (or not), we do know that positive outcomes are consistently associated with a strong therapeutic alliance. We have found no research to date that has examined whether the strength of the alliance or the mandated versus voluntary referral status is more predictive of outcome. This would seem to be a topic worthy of investigation.

CONCLUSIONS

As we have seen in the research described above, mandated therapy can in many cases be as successful as voluntary therapy, across diverse problem types. While mandated clientele are more likely to exhibit resistance and lack intrinsic motivation to change at the outset of treatment, the above-described treatment outcome successes indicate that these factors are not, in and of themselves, determinative of outcome. Instead, it appears that the resistance and lack of motivation found in the mandated client population can be subject to therapeutic intervention and improvement.

Why outcomes among the two treatment populations are often reported to be similar has yet to be fully explained. However, we offer here several possible explanations:

Perhaps there are not many differences between mandated and voluntary clients after all, because most clients are coerced, whether it be legally or informally (through their families or employers), to be in therapy (Bowen & Gilchrist, 2004; Haley, 1963). Informal psychosocial pressures coming from spouses, family, and employers may have substantially more influence over decisions to enter treatment than legal pressures (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001; Marlowe et al., 1996).

Another possibility is that mandated clients who enter therapy unwilling or unmotivated to change may become as engaged as voluntary clients as therapy progresses. Perhaps this is because outcomes are less dependent on legal status than on the quality of the therapeutic alliance between client and therapist (Rooney, 1992), and/or the therapist's ability to help raise a client's level of motivation (Donovan & Rosengren, 1999; Miller & Rollnick, 1991).

Finally, what mandated clients may lack in terms of initial intrinsic motivation, they may make up for with more consistent and longer attendance in treatment than their voluntary counterparts, with intrinsic motivation developing along the way.

Clearly, there is a great deal yet to be understood as to what makes therapy work (or not) in mandated client populations.

DIRECTIONS FOR FUTURE RESEARCH

It will be important to address the following methodological issues to advance research on the effectiveness of therapy with mandated versus voluntary referral clients.

Mandated Versus Voluntary Referral Categorization

Future research should properly assess, on a continuum, to what extent a client is voluntarily entering the therapeutic relationship. While mandated clients are clearly mandated to be in therapy, we must question whether the so-called "voluntary" clients are really there entirely of their own volition. As we have noted earlier, the purely voluntary client may be relatively rare, as there is usually some form of third-party pressure, or at least something to lose, if the client does not proceed with treatment. In one study, substance-abusing clients reported family pressure to be the primary motivator for entering treatment (Marlowe et al., 2001). In another study, male batterers who entered treatment "voluntarily" reported that they were there not due to an intrinsic desire to change, but as a strategy to avoid losing their partner (Burton, Regan, & Kelly, 1998).

Typically, clients have been categorized in the research as either "mandated" by virtue of court or agency referral, or "voluntary." The resulting comparison groups may not actually be independent for statistical purposes. Furthermore, dichotomizing a variable which may in fact be considered a continuous variable reduces statistical power in data analyses. As noted by Marlowe et al. (2001), statistical power is substantially reduced (by up to a third) when a continuous variable is dichotomized. It seems more reasonable to assume that coercion is a continuous variable, with patients experiencing varying degrees and types of coercive pressures. This would allow for the use of more sensitive statistical techniques.

Another suggestion is to measure the subjective perception of clients in terms of the impact of external coercion on their level of internal motivation (Farabee et al., 1998). Being legally coerced into therapy does not equate with the amount of pressure clients feel or their initial level of motivation to change. Such measurements could take into account less formal motivators to enter treatment (e.g., spouse, family, and employer pressure) that have been shown to be as important if not more important than legal pressure (Marlowe et al., 1996, 2001). Finally, follow-up interviews with clients would be another way to retrospectively record their actual motivations to enter treatment.

Differences in Outcome Measures and Comparison Groups

Future research should address the problem which has arisen in the past when researchers utilized different outcome measures (e.g., recidivism rates rather than client drinking levels, employee job performance rather than level of substance use) and unequal (nonrandomized) comparison groups (e.g., young, mandated, relatively healthy individuals versus older, voluntary, chronic addicts). What is needed is greater methodological or statistical control of pretreatment differences in problem severity, as well as differences in age, gender, and social class, among others.

Client and Therapist Factors

While no study can measure all variables potentially influencing outcome, ideally future research would control for the existence of certain client factors such as personality disorders, and therapist factors such as therapist cultural training or preconceptions about treating "mandated" clients. Future research might also benefit from attending to clients' motivational readiness to change, the potential impact of therapist interventions to raise levels of client motivational readiness to change, and the quality of the therapeutic alliance.

Client Motivational Readiness to Change

Given the implications of the Prochaska et al. (1992) transtheoretical model of the stages of change, it would appear that the treatment outcome of any client will depend at least in part on the client's level of motivational readiness to change, and whether or not the therapist utilized techniques appropriate to that client's stage of change. Virtually all studies of mandated clients which discuss motivation suggest that motivationally enhancing techniques should be used with clients displaying low motivation to change. However, relatively few outcome studies have considered the fit between clients' motivational stage and the techniques applied by their therapists, or investigated whether their therapists tried to match their interventions to the clients' level of motivation.

Therapeutic alliance. As noted earlier, some evidence indicates that clients in the precontemplation or contemplation stages of readiness to change (who are also often mandated) are less likely to develop a strong therapeutic alliance than clients at other levels of motivation to change (Connors et al., 2000). This has been found to be the case in studies involving adolescents as well as those involving adults (Simpson, Joe, Rowan-Szal, & Greener, 1997). Thus, simply assessing the quality of the therapeutic alliance without understanding the client's motivational readiness to change seems insufficient.

In concluding, we would like to emphasize that the issue of mandated versus voluntary referral status has implications for most, if not all, practicing therapists. The majority of therapists will encounter clients who have been mandated to attend therapy by the courts or other state agencies. Even if one does not work regularly with clients mandated to attend therapy by such entities, most therapists will regularly encounter clients who have been effectively pressured by family members, employers, or others to enter therapy and who initially exhibit resistance and low motivation to change. Notwithstanding this, it appears that the vast majority of therapists have not been trained to work with mandated clientele (Cingolani, 1984; Larrabee, 1982; Rooney, 1992). Their training and education appear to be based on voluntary client principles, as most models of individual and family therapy do not address this matter directly (for example, by incorporating readiness to change assessments or motivational intervention strategies into their approaches).

As we have noted, there is a body of research that suggests mandated treatment with a variety of clients with various presenting problems can be effective. However, additional work is necessary in several areas. Future research will need to attend to the above-described methodological issues. The quality of the therapeutic alliance between client and therapist and clients' level of motivational readiness for change should be studied together to determine which of these constructs is most influential in determining treatment outcomes. Only in this way can future research establish which specific techniques work best to influence positive outcomes within the mandated client population. Finally, therapists would need to be provided with appropriate training to work with this clientele. That training would include an understanding that the majority of their clientele could very well be in the room under some form of duress. As a result, client resistance and/or hostility should be anticipated as a normal part of the therapeutic process. Such a stance would then help therapists to avoid internalizing such a client reaction as rejection. Cultural training would be incorporated so as to not trigger or compound client resistance due to unexamined cultural factors. When a high degree of resistance is encountered or if a positive therapeutic alliance cannot be achieved, therapists would be trained to examine the "fit" or "lack of fit" between their interventions and their clients' level of motivational readiness to change.

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Care, Control, or Both? Characterizing Major Dimensions of the Mandated Treatment Relationship

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Current conceptualizations of the therapeutic alliance may not capture key features of therapeutic relationships in mandated treatment, which may extend beyond care (i.e., bond and affiliation) to include control (i.e., behavioral monitoring and influence). This study is designed to determine whether mandated treatment relationships involve greater control than traditional treatment relationships, and if so, whether this control covaries with reduced affiliation. In this study, 125 mental health court participants described the nature of their mandated treatment relationships using the INTREX (Benjamin, L., 2000, *SASB/INTREX: Instructions for administering questionnaires, interpreting reports, and giving raters feedback* (Unpublished manual). Salt Lake City, UT: University of Utah, Department of Psychology), a measure based on the interpersonal circumplex theory and assesses eight interpersonal clusters organized by orthogonal axes of affiliation and control. INTREX cluster scores were statistically compared to existing data from three separate voluntary treatment samples, and structural summary analyses were applied to distill the predominant theme of mandated treatment relationships. Compared with voluntary treatment relationships, mandated treatment relationships demonstrate greater therapist control and corresponding client submission. Nonetheless, the predominant theme of these relationships is affiliative and autonomy-granting. Although mandated treatment relationships involve significantly greater therapist control than traditional relationships, they remain largely affiliative and consistent with the principles of healthy adult attachment.

Keywords: mandated treatment, therapeutic alliance, treatment alliance, interpersonal circumplex, SASB, INTREX

The quality of the therapist–client relationship is the strongest controllable predictor of outcome in psychotherapy (Horvath, Del Re, Flueckiger, & Symonds, 2011; Klinkenberg, Calsyn, & Morse, 1998; Krupnick et al., 1996; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Martin, Garske, & Davis, 2000). This relationship reflects an accumulation of interpersonal interactions over time that vary in their degree of (a) affiliation or connectedness (ranging from hostile to friendly) and (b) control or influence (ranging from controlling to autonomy-granting on the part of the therapist or from submissive to autonomy-taking on the part of the client; see Benjamin, Rothweiler, & Critchfield, 2006; Henry, Schact, & Strupp, 1990; Kiesler, 1983).

Conceptualizations of high-quality therapeutic relationships tend to focus almost exclusively on strong affiliation between therapist and client (see Bordin, 1979; Horvath & Luborsky, 1993). For example, the most widely used measure of the therapeutic alliance (Horvath & Symonds, 1991; Martin et al., 2000; Tryon, Blackwell, & Hammel, 2007), the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), emphasizes an interpersonal bond between the therapist and client and collaboration in working toward shared goals. In contrast, the role of control in these relationships tends to be neglected or explicitly minimized (see Curtis & Hirsch, 2003; Rogers, 1957).

Therapist Control and Assertive or Involuntary Treatment

In contemporary service contexts for clients with serious mental illnesses (e.g., schizophrenia, bipolar disorder, major depression), control may play a prominent role in treatment relationships, because services are often assertively delivered, leveraged, or even mandated by the court. This may be because individuals with serious mental illness often have co-occurring substance abuse problems and difficulty following treatment recommendations (see American Psychiatric Association, 1994; Cramer & Rosenheck,

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1998; Fenton, Blyler, & Heinssen, 1997; Karberg & James, 2005; Kessler et al., 1996; Regier et al., 1990).

There are clear signs that therapist control plays a role in treatment services for this population. For example, Assertive Community Treatment (ACT; see Dixon, 2000; Drake et al., 1998; McCabe & Priebe, 2004) is one of the best-known evidence-based treatment programs for clients with serious mental illness. Studies of ACT teams have revealed that therapists often try to increase their clients' medication adherence by applying pressure, withholding assistance, and occasionally threatening to pursue involuntary hospitalization (see Angell, 2006; Neale & Rosenheck, 2000).

There may be a similar "pull" toward therapist control when clients are informally or formally mandated to take part in treatment. Informally, services in the community can be "leveraged," or made contingent upon treatment compliance. In a study of more than 1,000 patients, Monahan et al. (2005) found that patients were often required to participate in therapy and/or take medication to obtain discretionary money (7%–19%) or maintain housing (23%–40%; see Monahan et al., 2005). Treatment may also be formally mandated by a court, in both civil (i.e., inpatient or outpatient commitment) and criminal contexts. In fact, Monahan et al. (2005) found that among patients who had ever been arrested, up to half were told that they would be incarcerated unless they complied with treatment. When patients are required to participate in treatment, control may become an important component of the relationship.

Does Therapist Control Necessarily Reduce Affiliation?

Does increased control in a therapeutic relationship come at the expense of affiliation? Data relevant to this question are available from studies of voluntary psychotherapy (K. Critchfield, personal communication, June, 2011; Coady & Marziali, 1994; Critchfield, Henry, Castonguay, & Borkovec, 2007; Harrist, Quntana, Strupp, & Henry, 1994; Henry et al., 1990; Najavits & Strupp, 1994; Shearin & Linehan, 1992) that apply the interpersonal circumplex model of relationships (Freedman, Leary, Ossorio, & Coffey, 1951; Gurtman, 1992; Kiesler, 1983; Leary, 1957). We provide a brief introduction to the model here, using Benjamin's (1996) operationalization.

As shown in Figure 1, the circumplex is defined by a horizontal axis of affiliation ("Attack" to "Love") and a vertical axis of control ("Autonomy Granting" to "Control"). Each point in circumplex space reflects a weighted combination of these two dimensions and can be used to map the therapeutic relationship (see Freedman et al., 1951; Gurtman, 1992; Kiesler, 1983; Leary, 1957). For example, prototypic therapist behaviors that combine moderate affiliation with moderate control are mapped as "Protect," whereas those that combine moderate affiliation with moderate autonomy granting are mapped as "Affirm." Beyond describing relationships, the circumplex model also allows for prediction. Specifically, according to the principle of complementarity, one person's behavior evokes a class of behavior from the other person that is similar on the affiliation axis (e.g., therapist hostility invites client hostility) and reciprocal on the control axis (e.g., therapist control invites either client submission or client autonomy taking; Benjamin, 2000).

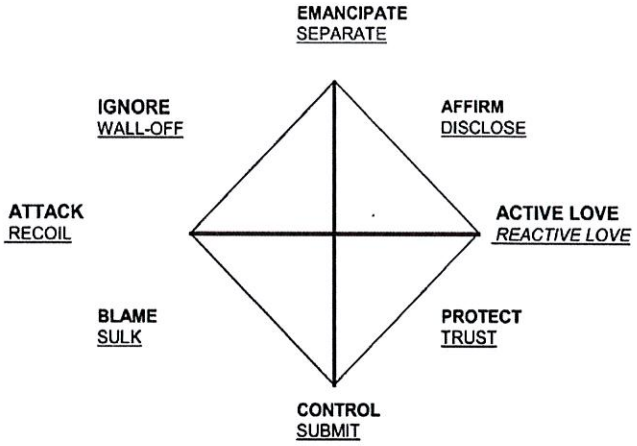

Figure 1. Simplified One-Word Cluster Model (Benjamin, 1996) with Corresponding Angular Displacement Added. Therapist transitive scores in **bold**; client intransitive scores *underlined*.

According to both the structure of the interpersonal circumplex (see Figure 1) and the principle of complementarity, therapist control alone will not influence the degree of affiliation in the therapeutic relationship. Given that the control axis is orthogonal to the affiliation axis, therapist behavior can be purely controlling (and neutral in affiliation). Theoretically, control will come at the expense of affiliation only if control tends to be combined with hostility. Specifically, hostile control from a therapist (i.e., "Blame," Figure 1) would elicit hostile submission ("Sulk") or hostile autonomy taking ("Wall Off") from a client.

Two relevant findings have emerged from studies of voluntary psychotherapy that apply Benjamin's circumplex measures: the observer-rated Structural Analysis of Social Behavior (SASB: Benjamin, 1996), or the self-report INTREX (Benjamin, 2000). First, therapists rarely exercise pure control or hostile control and (perhaps for that reason) clients rarely respond in a manner that is disaffiliative or distancing. Instead, voluntary treatment relationships are predominantly characterized by therapist "Affirm" and "Protect" (i.e., affiliative autonomy-granting and control) and corresponding client "Disclose" and "Trust" (i.e., affiliative autonomy-taking and submission; Critchfield et al., 2007). Even among patients with poor outcomes, therapist pure control (M = 5.3) and patient pure submission (M = 4.2) are quite low, relative to therapist "Affirm" (M = 35) and "Protect" (M = 20) and patient "Trust" (M = 17) and "Disclose" (M = 101; Henry et al., 1990; see also Harrist et al., 1994; Shearin & Linehan, 1992; K. Critchfield, personal communication, June, 2011; Tables 1 and 2).

Second, when therapists do exercise pure or hostile control, patients tend to behave in a manner that is disaffiliative and often experience poor clinical outcomes. INTREX ratings of high therapist control are associated with disaffiliative responses from the client (e.g., "Sulk" and "Wall off"; see K. Critchfield, personal communication, June, 2011; Harrist et al., 1994; Table 2). Similarly, therapist "Watch/Control" early in therapy is associated with poorer overall therapist-rated alliance (Coady & Marziali, 1994). Moreover, having a therapist with low "Affirm" and high "Control" is predictive of longer hos-

Table 1
Therapist Transitive INTREX Cluster Score Predictions and Preexisting Voluntary Data Findings

Cluster	Prediction[a]	Critchfield[b]	Shearin & Linehan (1992)	Harrist et al. (1994)	Grand *M* (used as distilled data)
Affiliation clusters					
Affirm/Understand[***1]	Highest	95.4 (6.8)	85.0 (14.5)	74.4 (15.9)	78.4 (14.3)
Love/Approach[c***2,3]	High	75.0 (33.4)	82.1 (12.0)	40.5 (18.0)	65.9 (21.1)
Nurture/Protect[c***4]	Highest	83.0 (25.3)	89.1 (11.4)	57.3 (17.5)	76.5 (18.0)
Attack clusters					
Belittle/Blame	Lowest	0.3 (1.3)	5.4 (6.6)	3.1 (6.9)	2.7 (5.9)
Attack/Reject	Lowest	0.0 (0.0)	5.8 (10.5)	2.5 (5.6)	2.2 (4.9)
Ignore/Neglect	Lowest	0.3 (1.3)	9.8 (14.5)	4.5 (9.3)	4.0 (8.2)
Control dimension					
Free/Forget	Moderate	43.0 (40.1)	44.6 (28.4)	44.2 (17.3)	44.0 (21.6)
Watch/Control	Low	18.3 (21.2)	34.1 (32.1)	12.9 (12.8)	14.8 (15.1)

Note. Values are means with standard deviation in parentheses. A Bonferroni correction was applied to the Attachment and Attack Clusters and Control Dimension. Any flagged significant effects in these clusters are $\alpha < .02$.
[a] High = $M > 75$; moderate = M 26–74; low = $M < 25$. [b] K. Critchfield, personal communication, June, 2011. [c] Unweighted grand M was used.
*** $p < .001$, F test for comparing sample means; [1] Critchfield vs. Harrist $t_{(df = 83)} = 5.0$, $p < .001$; Cohen's $d = 1.1$; [2] Critchfield vs. Harrist $t_{(df = 83)} = 5.7$, $p < .001$; Cohen's $d = 1.3$; [3] Shearin & Linehan vs. Harrist $t_{(df = 72)} = 4.6$, $p < .001$; Cohen's $d = 1.1$; [4] Critchfield vs. Harrist $t_{(df = 83)} = 4.7$, $p < .001$; Cohen's $d = 1.0$.

pital stays and less symptom improvement for clients (Najavits & Strupp, 1994).

In summary, research on voluntary treatment relationships suggests that therapists rarely express "pure" or hostile control, but when they do, it tends to promote disaffiliation, distancing, and poor outcomes. The extent to which these findings generalize from voluntary to involuntary treatment contexts is unknown. In involuntary contexts, therapists may be pulled toward more controlling behavior, and clients may feel coerced to take part in treatment. Patients who feel coerced may respond with (a) anger and resistance to treatment goals or (b) a sense of helplessness and decreased therapeutic engagement (see Monahan et al., 1995).

There is indirect evidence for such propositions. Specifically, patients in mandated civil psychiatric treatment perceive greater coercion to take part in treatment than voluntary patients (Sheehan & Burns, 2011; Swartz, Wager, Swanson, Hiday, & Burns, 2002). In turn, perceived coercion is inversely associated with patient ratings of the therapeutic alliance (Sheehan & Burns, 2011), which emphasize affiliation. Similarly, in correctional treatment, rehabilitative probation officers' use of hostile control (i.e., "toughness") is associated with decreased caring, fairness, and trust in the officer–probationer relationship (Skeem, Eno Louden, Polaschek, & Camp, 2007).

The extent to which mandated treatment relationships involve greater amounts of therapist control than voluntary treatment relationship is unknown. Even more, it is unclear whether pronounced control (which is rare in voluntary relationships, but may be common in mandated relationships) comes at the expense of affiliation. Because the quality of the client-provider relationship may play a crucial role in behavior change, it is necessary to properly operationalize the construct to study its effects on client outcomes. Ratings of the therapeutic alliance (i.e., affiliation) may not fully capture therapist–client relationship quality in mandated treatment, where control may play a prominent role. It is necessary to first empirically test whether it is the case that mandated treatment relationships are higher in control and explore how control and affiliation are related in mandated treatment.

Table 2
Client Intransitive INTREX Cluster Score Predictions and Preexisting Voluntary Data Findings

Cluster	Prediction[a]	Critchfield[b]	Shearin & Linehan (1992)	Harrist et al. (1994)	Grand *M* (used as distilled data)
Affiliation clusters					
Disclose/Express	Highest	75.0 (23.7)	N/A	78.6 (13.9)	78.0 (15.6)
Joyfully Connect[c***1]	High	65.7 (34.5)	N/A	47.5 (15.4)	56.6 (25.0)
Trust/Rely[c***2]	Highest	82.0 (19.7)	N/A	65.2 (14.7)	73.6 (17.2)
Attack clusters					
Sulk/Scurry	Lowest	16.0 (28.8)	N/A	9.6 (11.3)	10.7 (14.4)
Protest/Recoil	Lowest	7.0 (16.2)	N/A	4.9 (8.3)	5.3 (9.7)
Wall-off/Distance[***3]	Lowest	24.3 (23.3)	N/A	9.8 (12.3)	12.4 (14.2)
Control dimension					
Assert/Separate[***4]	Moderate	32.0 (34.2)	N/A	62.3 (11.9)	57.0 (15.8)
Defer/Submit	Low	18.7 (29.6)	N/A	12.4 (12.4)	13.5 (15.4)

Note. Values are means with standard deviation in parentheses. N/A = not available. A Bonferroni correction was applied to the Attachment and Attack Clusters and Control Dimension. Any flagged significant effects in these clusters are $\alpha < .02$.
[a] High = $M > 75$; moderate = M 26–74; low = $M < 25$. [b] K. Critchfield, personal communication, June, 2011. [c] Unweighted grand M was used.
*** $p < .001$; t test for comparing sample means; [1] $t_{(df = 83)} = 3.6$, $p < .001$; Cohen's $d = .79$; [2] $t_{(df = 83)} = 3.8$, $p < .001$; Cohen's $d = .83$; [3] $t_{(df = 83)} = 3.5$, $p < .001$; Cohen's $d = .77$; [4] $t_{(df = 83)} = -6.0$, $p < .001$; Cohen's $d = 1.3$.

Present Study

Based on a sample of individuals with serious mental illness mandated to mental health treatment through the criminal justice system, we addressed two aims in this study. First, we seek to determine how more frequent control is present in mandated treatment relationships than voluntary treatment relationships. Second, we determine whether increased therapist control in mandated treatment is associated with decreased client–therapist affiliation. We articulate our hypotheses and the procedures to test these hypotheses below.

To address our first aim, we provide not only a descriptive summary of our mandated sample, but we also seek to place our findings in context. To do so, we compare ratings of control and affiliation from our mandated sample to those found in prior studies of voluntary clients. We use this approach for two primary reasons. First, it is difficult—perhaps infeasible—to randomly assign offenders to voluntary versus mandated treatment. As noted by Parhar, Wormith, Derkzen, and Beauregard (2008, p. 1111), "[t]rue voluntary participation [in correctional treatment] does not exist in the criminal justice system because there is always some degree of external pressure." A judge is unlikely to mandate treatment arbitrarily for some people with serious mental illness but not others. Second, absent any comparison or context, it is often difficult to interpret purely descriptive findings. Having a group against which to compare new data can place research findings in context.

Such practices are used both in the interpersonal circumplex (Excel Circumplex Calculator, **A.** Pincus, personal communication, April 25, 2011; Wright, Pincus, Conroy, & Hilsenroth, 2009) and the psychological assessment literatures. For example Morgan, Fisher, Duan, Mandracchia, and Murray (2010) examined the criminal thinking styles of prison inmates with serious mental illness in light of scores obtained from nonoffender psychiatric patients and nonmentally ill offenders. More formally, Bornstein, Gottdiener, and Winarick (2009) used existing validation data on interpersonal dependency from nonclinical college samples as a benchmark against which to statistically compare their newly obtained data from a clinical substance-abusing sample.

Given the precedent to use existing data as a point of comparison when providing descriptive information about a sample for which there is not direct comparison group, we use published and nonpublished patient-rated, self-report INTREX data to which we compare our mandated sample data (K. Critchfield, personal communication, June, 2011; Harrist et al., 1994; Shearin & Linehan, 1992). Based on previous research (Angell, 2006; Monahan et al., 2005; Neale & Rosenheck, 2000) and consistent with the principles of complementarity in interpersonal theory (i.e., behavior toward a person will elicit a complementary response; e.g., control and submission; see Benjamin, 2000), we hypothesize that mandated treatment relationships involve greater therapist control and corresponding greater client submission than voluntary treatment relationships.

To address our second aim—to examine the relationship between affiliation and control, we focus exclusively on the mandated treatment sample and use several different indices commonly used in interpersonal research in general (e.g., structural summary analyses to characterize the predominant interpersonal pattern in the client–therapist relationship) and with SASB/INTREX technology, specifically (e.g., use of cluster score correlations and pattern coefficients, described below). Given that observer-rated and self-report studies of voluntary treatment relationships suggest that when control is present, it may adversely affect the relationship, we hypothesize that higher levels of control in mandated treatment will be associated with reduced client–therapist affiliation.

Method

We interviewed 125 mental health court participants about their relationship with their primary treatment provider and rated this relationship on the INTREX (Benjamin, 2000). We then compared data from this sample to published and unpublished data on patients in voluntary treatment and used several interpersonal circumplex- specific statistical techniques and indices to examine the quality of mandated treatment relationships.

Procedure

Participants were recruited either at a courthouse or mandated treatment facility. Research assistants (RAs) made brief announcements to groups of prospective participants to describe the study (e.g., eligibility requirements, interview nature, confidentiality protections, and compensation of $30) and invited them to participate. RAs screened interested participants for eligibility and scheduled an interview for eligible persons at a time and location of their convenience. At the scheduled time, RAs completed the informed consent process and a 2-hr interview with participants, which included verbal administration of the INTREX and several other measures not central to the present study aims. The study protocol was approved by relevant Institutional Review Boards.

Participants

Participants were English-speaking adults who (1) were current participants in one of four mental health courts, (2) had completed at least one mandated treatment session with a therapist, case manager, or counselor, and (3) had a remaining mental health court term of approximately 4 months. Participants' average age was 37 years (SD = 11.4); 54% were women, and 67.2% were White (16% Hispanic, 10.4% African American, 3.2% Native American, 3.2% Asian). Although 87% were currently unemployed, 70% of participants had received high school diploma/GED or greater education. Participants' self-reported (and chart-verified) primary diagnosis was for a mood disorder (bipolar disorder = 54%; major depression = 19%; mood NOS = 2%); 23% had a diagnosis of schizophrenia, schizoaffective disorder, or other psychotic disorder; and 2% had another Axis I mental disorder (e.g., anxiety, ADHD). Participants' index offense was for drug (50%), property (32%), minor (11%), and person (6%) crimes (as defined by Monahan et al., 2001).

The average participation rate across the four courts, defined as the total number of people enrolled in the study divided by the total number of people enrolled in the mental health court during the year in which the study was conducted, was 32% (range = 25%–40%). As shown in Table 3, enrolled participants did not differ from the court populations from which they were drawn in terms of gender, ethnicity, and age, which helps mitigate concern about selection bias.

Table 3
Demographic Characteristics of Enrolled Samples vs. Court Populations

Demographics	Total enrolled	Court 1		Court 2		Court 3		Court 4	
		Enrolled (n = 61)	Court (n = 168)	Enrolled (n = 28)	Court (n = 70)	Enrolled (n = 9)	Court (n = 33)	Enrolled (n = 27)	Court (n = 110)
Age *M* (*SD*)	37 (11)	38 (11)		36 (12)		28 (8)		40 (12)	
Age grouping (%)									
18–21	12.0	9.8	8.3	14.3	10.0	33.3	18.2	7.4	5.0
22–30	18.4	13.1	25.0	21.4	25.7	44.3	30.3	18.5	32.0
31–40	28.0	36.1	29.8	21.4	32.9	11.1	21.2	22.2	24.0
41–50	30.4	29.5	23.8	32.1	21.4	11.1	30.3	37.0	27.0
51+	11.2	11.5	13.1	10.7	10.0	0.0	0.0	14.8	12.0
Race (%)									
Caucasian	67.2	63.9	73.2	78.6	75.7	66.7	85.0	63.0	49.0
African American	10.4	9.8	5.3	3.6	4.3	11.1	3.0	18.5	22.0
Asian	3.2	3.3	1.8	7.1	4.3	0.0	0.0	0.0	1.0
Hispanic	16.0	19.7	15.5	7.1	12.9	22.2	9.0	14.8	22.0
Other	3.2	3.3	4.2	3.6	2.9	0.0	3.0	3.7	6.0
Gender (% women)	54	57	54	61	59	78	61	33	43

Note. For Court 4, the age distribution provided was 18–20, 21–30; all other categories were the same; Group 3 vs. Group 1: $t_{(df = 13)} = 3.3$, $p < .05$; Group 3 vs. Group 2: $t_{(df = 21)} = 2.3$, $p < .05$; Group 3 vs. Group 4: $t_{(df = 20)} = 3.4$, $p < .05$.

Data on participants were pooled across the four courts. There were no court-related differences between participants in gender or race/ethnicity. Although participants in Court 3 were younger than those in the other three courts ($F_{(df = 3)} = 3.3$, $p < .05$; see Table 3), age generally does not predict client–therapist relationship quality (see Constantino, Arnow, Blasey, & Agras, 2005; cf. Schiff & Levit, 2010), and participants from this court did not differ from those in the other courts on INTREX ratings. For these reasons, participants were pooled for analyses.

Measure

Because many (56%) of the enrolled mandated clients were involved in day treatment programs where clients worked with several mental health providers at once (e.g., case worker, therapist, substance abuse counselor), participants were asked to rate the INTREX (Benjamin, 2000) on the provider who was considered to be "the mental health professional you are most likely to turn to when you need advice or assurance, who helps you the most, and/or with whom you have the most significant discussions." This professional could be a mental health therapist, a case worker, or a substance abuse counselor whom the participant saw individually on a regular basis.

The INTREX is a self-report version of the SASB (Benjamin, 1996).The 64-item medium form of the INTREX, which was used in the present study, provides for an "octant" model. The INTREX has three foci: (1) how an individual acts transitively toward another, (2) how an individual responds or reacts intransitively to another, and (3) how an individual relates to him/herself (not shown because this domain is not used in the present study). The horizontal axis is the "Love–Hate" (i.e., "affiliation") axis, and the vertical axis is the "Differentiation–Enmeshment" (i.e., "control") axis.

Participants rated how well each item described their relationship with their primary provider on a scale that ranged from 0 (*never describes*) to 100 (*describes perfectly all of the time*). Because the focus of the present study is largely on how the therapist transitively acts toward the client and how the client intransitively reacts toward the therapist, our analyses focused on 32 of the original 64 items. Sixteen items assessed how the provider treated or acted toward the client (therapist focus, "transitive surface"—two items × eight clusters, e.g., "My therapist helps, guides, and shows me how to do things"). The other 16 items described how the client reacted or responded to the therapist ("intransitive" surface, client focus—two items × eight clusters, e.g., "I defer to my therapist and conform to his or her wishes"). As shown in Figure 1, provider transitive cluster scores are shown in bold font, the client intransitive cluster scores are shown with an underline. Across both foci, the eight clusters can be simplified as (a) three "Affiliation Clusters" on the right side of the circumplex (provider "Affirm," "Active love," and "Protect"; client "Disclose," "Reactive love," and "Trust"), (b) three "Attack Clusters" on the left side (provider "Ignore," "Attack," and "Blame"; client "Wall-off," "Recoil," and "Sulk"), and (c) two clusters at the poles of the vertical axis that reflect Pure Autonomy (provider "Autonomy granting" and client "Autonomy-taking") and Pure Control (provider neutral "Control" and client neural "Submission").

The INTREX is written at a seventh grade reading level (Benjamin, 2000). For the purposes of this study, we made minimal changes to the wording of a few INTREX items to fit the therapeutic relationship, but maintained emphasis on reading ease (e.g., "lovingly" was changed to "caringly"). The INTREX demonstrates good split half (α = .82) and test–retest (α = .84; Benjamin, Rothweiler, & Critchfield, 2006) reliability and good (Cronbach, 1951) internal consistency in the present sample (α = .85). With respect to validity, the INTREX has been shown to predict both patient satisfaction (Schedin, 2005) and clinical improvement (i.e., reduced parasuicidal behavior; Shearin & Linehan, 1992).

Distilling Voluntary Comparison Data

Three steps were taken to identify, analyze, and distill a comparison data set from previous studies of voluntary treatment relationships. First, we conducted a two-pronged search strategy to

identify relevant INTREX data sets. One prong involved using a variety of search terms in PsychInfo (i.e., combinations of "therap*," "client," "patient," "relation*," "alliance," and "INTREX") to identify research teams who had used the medium version client-rated INTREX to assess client–therapist relationships (to match the data and clusters examined in the present study). Three teams were identified and contacted to request descriptive data (i.e., means and standard deviations for eight therapist transitive clusters and eight client intransitive clusters). Data were obtained from two teams; the third declined our request. The second prong of the search strategy involved contacting researchers who were known to routinely use the INTREX in clinical research and/or practice. This method yielded one additional set of data, for a total of three data sets: (1) Shearin and Linehan's (1992) study of four borderline women in manualized Dialectical Behavioral Therapy across 31 weeks, (2) Harrist et al.'s (1994) "Vanderbilt II-based" study of 70 patients with primarily anxiety and depression in manualized time-limited dynamic psychotherapy (≤25 sessions), and (3) Critchfield's study (K. Critchfield, personal communication, June, 2011) of 15 patients with predominantly co-occurring Axis I (largely anxiety and depression) and II disorders in Interpersonal Reconstructive Therapy (Benjamin, 2003).

Although we were unable to directly compare our mandated sample with these voluntary samples on several sample demographic characteristics, we were able to determine that our sample was not statistically different in age ($M = 37$, $SD = 11$) from the Harrist et al. (1994; $M = 41$, range = 24–64) and Critchfield's ($M = 36$, $SD = 11$) samples (K. Critchfield, personal communication, June, 2011). Our mandated sample (54% women) was also comparable to the Harrist et al. (1994) and Critchfield samples on gender composition (77% and 65% women, respectively). Additionally, our mandated sample was comparable to the Critchfield sample on education level (70% vs. 64% had high school degree or higher, respectively), but the Harrist et al. (1994) sample was slightly more educated (79% had some college). The mandated sample has some overlap with the Harrist et al. (1994) and Critchfield samples, in terms of Axis I mood—but not psychotic—disorders, and the voluntary samples appear to have higher rates of Axis II personality disorders. Finally, our mandated sample appears to be somewhat more racially diverse (67% Caucasian) than the Harrist et al. (1994) and Critchfield samples (95% Caucasian for both). We were unable to obtain this information on the Shearin and Linehan (1992) sample.

Next, we analyzed these three data sets to assess the degree of consistency in INTREX scores across studies. Specifically, we tested whether the studies yielded significantly different average client-rated INTREX cluster scores, using ANOVA and *t* tests, and calculated effect sizes for significant differences using Cohen's *d* (1988), where effects of .2, .5, and .8 can be considered small, medium, and large, respectively. A Bonferroni correction (requiring $\alpha < .02$) was applied to maintain a family-wise error rate of $\alpha < .05$ for the "Affiliation" family (three clusters), "Attack" family (three clusters), and "Control" family (two clusters). The results are shown in Table 1 (for transitive or therapist clusters) and Table 2 (for intransitive or client clusters). In discerning patterns, we placed emphasis on transitive (therapist) ratings described in Table 1, because (a) the study aims emphasize therapist control (or lack thereof), and (b) only two data sets were available for intransitive (client) ratings, which limits pattern detection. As shown in Table 1, despite differences in therapy types, there were few significant differences among the preexisting studies' transitive INTREX scores; the consistencies across the studies far outweigh the discrepancies.

Third, we distilled a comparison voluntary treatment data set by calculating the grand mean for each cluster. For most clusters (12 of 16), we weighted the grand mean by sample size, because (a) larger sample sizes tend to yield more stable estimates and (b) the study with the largest sample (Harrist et al., 1994) yielded transitive scores similar to one or both of the smaller samples. For a minority of clusters (4 of 16), we did not weight the grand mean, because the study with the largest sample (Harrist et al., 1994) strongly differed from both the smaller samples on the transitive surface ("Active Love," sometimes also referred to as "Love/Approach," and "Watch/Protect" for therapists) and intransitive surface ("Reactive Love," sometimes referred to as "Joyfully connect," and "Trust/Rely" for clients) and from theory that suggests that high quality relationships are characterized by high affiliation (e.g., operationalized in this study as $M = 75$–100), low attack ($M < 25$), and moderate ($M = 50$–75) autonomy (Florsheim, Henry, & Benjamin, 1996). The distilled data set is shown in the last column of Tables 1 and 2.

Results

Are Mandated Treatment Relationships Characterized by Greater Control Than Voluntary Treatment Relationships?

We used independent *t* tests of cluster means to examine whether mandated treatment relationships are characterized by greater therapist control and corresponding client submission than voluntary treatment relationships. We applied a Bonferroni correction to maintain a family wise error rate of .05 for the affiliation family, attack family, and control dimension (for details, see Method above) and calculated Cohen's *d* to reflect the magnitude of any group differences.

The results are shown in Tables 4 and 5. The six clusters relevant to the present aim involve therapist control and client submission. The results indicate that mandated treatment relationships involve *much* greater therapist *neutral* control (Watch/Control) than voluntary treatment relationships, even though there are no significant differences between the two types of treatment in therapists' *affiliative* control (Nurture/Protect, which is uniformly high) or *hostile* control (Belittle/Blame, which is uniformly low). In addition, mandated treatment relationships involve greater client *neutral* submission (Defer/Submit) and *affiliative* submission (Trust/Rely) than voluntary treatment relationships, but not greater client *hostile* submission (Sulk/Scurry, which is uniformly low). The effect size for therapists' neutral control and clients' neutral submission were large.

Is Greater Control Associated With Less Affiliation?

Given that mandated treatment is associated with particularly high therapist control, are mandated treatment relationships less affiliative (and/or more hostile) than voluntary treatment relationships? The results that address question are shown in Tables 4 and 5. The 12 relevant clusters are those in the therapist and client

"affiliation" and "attack" families. The results indicate that, if anything, mandated treatment relationships are slightly more affiliative than voluntary ones. Specifically, compared to voluntary treatment, mandated relationships were minimally greater in therapist pure affiliation ("Love/Approach") and affiliative autonomy-granting ("Affirm/Understand"), and moderately greater in client pure affiliation ("Joyfully connect") and affiliative submission ("Trust/Rely").

Even if mandated relationships are no less affiliative, on average, than voluntary ones, it is still possible that greater control is associated with less affiliation within mandated treatment. To directly test this possibility, we calculated bivariate correlations between "attack" and "control" pattern coefficients. These coefficients are computed from the SASB/INTREX software and reflect the degree to which the eight clusters are oriented around the two axes—specifically how the patterning of the current data relates to an ideal patterning of scores within the circumplex framework (see Benjamin, 2000). These coefficients can be viewed as summary indices of the degree of hostility (or nonaffiliation) and control (for the transitive focus) or submission (for the intransitive focus) present in the relationship, respectively. Therapist control was inversely associated with therapist attack ($r = -.39$, $p < .01$) and was not significantly related to client attack ($r = -.16$). In keeping with the results above, these results suggest that control does not come at the expense of affiliation.

As a third method of analyzing the association between control and affiliation, we completed a "structural summary" analysis of INTREX cluster scores to describe the dominant process or "theme" of mandated relationships (see Gurtman, 1992; Gurtman & Pincus, 2003; Wright et al., 2009). Specifically, this analysis was completed to yield an "angular displacement" statistic, or angle on the circumplex (see Figure 1). Because voluntary treatment data were used as the metric against which the mandated data were compared, conceptually, the voluntary data may be viewed as the "predicted" cluster scores and the angular displacement is where the INTREX profile for the mandated sample "achieves its highest predicted correlation" (Gurtman & Pincus, 2003, p. 421). The results indicate that mandated relationships are best characterized as affiliative and autonomous. Specifically, therapist transitive angular displacement is 72°, which corresponds to the clusters of "Free/Forget" and "Affirm/Understand." The client intransitive angular displacement is 61°, which corresponds to the clusters of "Assert/Separate" and "Disclose/Express." Across this set of three analyses, results indicate that increased control does not come at the expense of decreased affiliation in mandated treatment relationships.

Table 4
Therapist Transitive Cluster Scores for Voluntary and Mandated Samples

Cluster	Distilled voluntary data ($N = 89$)[a]	Mandated sample ($n = 125$)[a]	Cohen's d	[95% CI]
Affiliation clusters				
Affirm/Understand**	78.4 (14.3)	85.8 (20.2)	−0.41	[−2.8, 2.0]
Love/Approach**	65.9 (21.1)	75.7 (29.0)	−0.38	[−3.9, 3.1]
Nurture/Protect	76.5 (18.9)	82.5 (24.1)	−0.27	[−3.2, 2.7]
Attack clusters				
Belittle/Blame	2.7 (5.9)	3.9 (12.6)	−0.12	[−1.5, 1.3]
Attack/Reject	2.2 (4.9)	1.7 (9.9)	0.06	[−1.0, 1.2]
Ignore/Neglect	4.0 (8.2)	5.0 (14.4)	−0.08	[−1.7, 1.6]
Control dimension				
Free/Forget***	44.0 (21.6)	56.9 (30.3)	−0.48	[−4.1, 3.1]
Watch/Control***	14.8 (15.1)	66.5 (29.7)	−2.10	[−5.4, 1.2]

Note. A Bonferroni correction was applied to the Attachment and Attack Clusters and Control Dimension. Any flagged significant effects in these clusters are $\alpha < .02$.
[a] Values are means with standard deviation in parentheses.
** $p < .01$; *** $p < .001$; t test for comparing sample means.

Table 5
Client Intransitive Cluster Scores for Voluntary and Mandated Samples

Cluster	Distilled voluntary data ($N = 85$)[a]	Mandated sample ($n = 125$)[a]	Cohen's d	[95% CI]
Affiliation clusters				
Disclose/Express	78.0 (15.6)	83.6 (23.4)	−0.27	[−3.1, 2.5]
Joyfully Connect***	56.6 (25.0)	75.4 (30.1)	−0.67	[−4.5, 3.1]
Trust/Rely***	73.6 (17.2)	83.6 (21.7)	−0.50	[−3.2, 2.2]
Attack clusters				
Sulk/Scurry	10.7 (14.4)	12.4 (21.6)	−0.09	[−2.7, 2.5]
Protest/Recoil	5.3 (9.7)	4.8 (15.4)	0.04	[−1.7, 1.8]
Wall-Off/Distance	12.4 (14.2)	18.6 (27.7)	−0.27	[−3.4, 2.9]
Control dimension				
Assert/Separate	57.0 (15.8)	45.7 (33.4)	0.41	[−3.3, 4.1]
Defer/Submit***	13.5 (15.4)	33.1 (31.2)	−0.76	[−4.3, 2.7]

Note. A Bonferroni correction was applied to the Attachment and Attack Clusters and Control Dimension. Any flagged significant effects in these clusters are $\alpha < .02$.
[a] Values are means with standard deviation in parentheses.
*** $p < .001$; t test for comparing sample means.

Discussion

This study is among the first to explore whether and how treatment mandates alter the form of the therapeutic relationship. The results indicate that mandated treatment relationships involve substantially more therapist control and client submission than observed in extant studies of voluntary treatment relationships. Nevertheless, mandated treatment relationships remain largely affiliative, that is, control does not come at the expense of warmth. As a group, mandated therapists seem to treat—and mandated clients seem to respond—in a manner that is consistent with healthy affiliation and good relationship quality.

Finding 1: Therapist Control and Client Submission Are Much Stronger in Mandated Than Voluntary Treatment Relationships

This study is the first to demonstrate that therapist control and client submission are present to a significantly greater degree in mandated versus voluntary treatment relationships. This finding is particularly remarkable, because the voluntary comparison data were obtained from patients predominantly with co-occurring mood and personality disorders in manualized treatment. This treatment context may be associated with increased therapist directiveness, and thus greater control, than in typical voluntary

outpatient treatment. The fact that the effects for control were large and much higher in mandated than manualized voluntary treatment strongly suggests that control is central to, and should be included in, operationalizations and measurement of mandated treatment relationships. The large effects observed for therapist control in the mandated sample may be attributable to the roles (e.g., behavior monitoring), goals (e.g., improving treatment adherence), and accountabilities (e.g., to the court) that treatment mandates add to traditional provider–client relationships (see Ross, Polaschek, & Ward, 2008; Trotter, 1999). The present findings are consistent with the literature on treatment for people with serious mental illness in that, as providers are called upon to manage multiple domains of clients' lives and to target outcomes that extend beyond symptoms and functioning, their use of control increases (Angell, 2006; Monahan et al., 2005; Neale & Rosenheck, 2000).

Finding 2: Despite Pronounced Control Dynamics, Mandated Relationships Are Predominantly Affiliative

Our hypothesis that increased therapist control would be offset by decreased affiliation was clearly rejected by findings that (a) mandated participants perceived their treatment relationships as slightly more affiliative than voluntary clients did, (b) within the mandated sample, therapist control was moderately *inversely* associated with therapist attack (indicating a positive association between control and affiliation), and (c) the predominant theme of mandated relationships (i.e., the theme that best fit predictions from voluntary relationships) was affiliative and autonomy-granting.

Although it is possible that these findings reflect a positive response bias wherein either (a) mandated clients "bumped up" their affiliation ratings of their therapist to compensate for high control ratings or (b) the criteria for nominating a provider to rate (e.g., "the provider you are most likely to turn to for advice or assurance") potentially affected clients' ratings, there is evidence that this was not the case. For example, there is considerable variance in scores across clusters, suggesting that participants were willing to report negative aspects of the relationship, when present. Instead, we believe that relatively high affiliation ratings in mandated relationships reflect the fact that (a) social networks of offenders in mandated criminal justice treatment are very small and (b) service providers (controlling or not) are often one of the only "positive" individuals in that network (see Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2009). It is plausible, then, that mandated clients perceive their provider as more affiliative than voluntary clients in part because they feel closer to their provider and/or their provider is more important to them. Higher affiliation ratings in the mandated sample could also be attributable to attenuated expression of affiliation that may accompany manualized therapy (see Henry, Strupp, Butler, Schacht, & Binder, 1993). Future research should explore differences between mandated and more common, "real world" voluntary treatment relationships that are often not manualized and instead reflect an eclectic blend of techniques (see Norcross, Hedges, & Prochaska, 2002).

The high affiliation we found in mandated treatment relationships—despite high therapist control—is consistent not only with circumplex theory (which views dimensions of affiliation and control as orthogonal), but also with principles of procedural justice. Procedural justice is present when an individual believes that an authority figure provides her with an opportunity to voice her opinions (including disagreements) and participate in decision making, treats her with respect (e.g., explaining the reasons for decisions and courses of action), and acts partially out of concern for her welfare (see Tyler, 1989). When procedural justice characterizes a decision process, individuals tend to perceive the authority figure as fair and legitimate and are relatively likely to abide by his or her decision (Lind & Tyler, 1988; Tyler, 1989, 1994; Watson & Angell, 2007).

More directly, our finding that high affiliation can coexist with high control in mandated treatment relationships is consistent with past research on "dual role relationship quality" between probation/parole officers and their supervisees (see Kennealy, Skeem, Manchak, & Eno Louden, 2012; Klockars, 1972; Paparozzi & Gendreau, 2005; Skeem et al., 2007). For example, a relatively well-validated measure of dual role relationship quality assesses not only affiliation (i.e., "caring"), but also dimensions related to control (i.e., "fairness" and "trust"; Skeem et al., 2007). Strong dual role relationship quality has been shown to protect against recidivism, both for offenders with and without serious mental illness (Kennealy et al., 2012; Skeem et al., 2007). This characterization of strong dual role relationships as fundamentally authoritative (not authoritarian, not permissive) seems to mirror this study's description of mandated treatment relationships as both affiliative and controlling.

Although control does not seem to harm relationship quality for the group as a whole, there may be a subgroup for whom control comes at the expense of affiliation. There is one suggestion that this may be the case—as shown in Table 2, mandated clients obtained modestly higher hostile withdrawal ("Wall off/Distance") scores than voluntary clients ($d = -.27$). Although this hostile withdrawal lies downstream from therapist control and related contextual factors (e.g., providers' responsibility to report to the court), it is impossible to test this possibility with the current, cross-sectional data. Future process-based research is needed to determine whether therapist neutral or affiliative control predicts hostile withdrawal for some clients, which would be inconsistent with the principles of complementarity in interpersonal circumplex theory (see Tyler, 1989; Benjamin, 2000), or whether clients respond only when therapist exhibit hostile control ("blame") or under specific circumstances (e.g., differing of opinion, client receipt of criminal justice sanction for treatment noncompliance).

Limitations

The findings of the present study need to be interpreted with consideration for two primary limitations. First, the extent to which differences in ratings of affiliation and control can be attributed to factors that could not be directly assessed in the present design is unknown. Although the comparison data represent INTREX consistencies across various types of voluntary clients, symptom severity, Axis I and II comorbidity, therapists, and treatment, we could not measure and statistically compare the current mandated sample with the voluntary comparison samples on these factors. The comparability of the voluntary samples to our mandated sample on age, education, and gender is perhaps undermined by our inability to say with certainly that the observed differences in mandated and voluntary treatment relationships are

not due to differences in clients' clinical characteristics. In theory, client and therapist factors can influence relationship quality (for a review, see Horvath, 2000). It is also possible that therapeutic approach (e.g., psychotherapy vs. case management) and structure (e.g., manualized vs. not) may provide an alternative explanation for the differences seen between mandated and voluntary treatment relationships (see Critchfield et al., 2007; Henry et al., 1993). Even so, there is a clear signal here that mandated treatment is higher in control, and such findings are likely to be upheld in a more rigorous test of the differences between voluntary and involuntary treatment.

Second, the way in which participants were asked to choose a provider to rate, when they had more than one provider (i.e., "the mental health professional you are most likely to turn to when you need advice or assurance, who helps you the most, and/or with whom you have the most significant discussions") could have biased the findings for Aim 2 in favor of a more affiliative relationship. The Aim 2 finding that mandated relationships are largely affiliative and autonomy-granting, despite high levels of therapist control, may be considered a "best-case scenario." As such, it is quite feasible that the relationship between control and affiliation may differ in a more rigorous test of mandated relationship quality (e.g., spontaneously assessing relationship quality of particular mandated providers), rather than having the participant rate his or her favorite.

Despite these limitations, parallels between our findings and relevant past research lend confidence that our results are not merely a function of methodology. For example, given that past studies of nonoffenders enrolled in ACT reveal a substantial amount of control (Angell, 2006; Monahan et al., 2005; Neale & Rosenheck, 2000), our finding of greater control in mandated than voluntary treatment does not appear solely attributable to our use of a comparison group derived from the literature. Nevertheless, to build confidence in the present findings, they must be replicated in a future controlled trial of mandated versus voluntary treatment and in more ethnically diverse samples.

Implications

Given that mandated treatment relationships involve much greater therapist control and client submission than voluntary treatment relationships, it seems important to assess this dimension as part of relationship quality in mandated treatment. This could be accomplished by adapting existing measures of the therapeutic alliance (to emphasize control), adapting existing measures of dual role relationship quality (to fit mandated treatment relationships), or developing a new measure. Pursuing one of these paths may allow researchers to tease apart the differential effects of care and control on various outcomes. It may be that control not only does *no* harm to relationship quality, but also improves the therapists' ability to change behavior. In keeping with this possibility, dual role relationship quality—but not "working alliance"—has been shown to predict improved criminal justice outcomes (Skeem et al., 2007). Thus, the dimension of control in mandated treatment may be integral to both process and outcome.

Providers of mandated treatment may find our findings relatively reassuring, given that they directly challenge clinical impressions that control is necessarily antitherapeutic (e.g., see Curtis & Hirsch, 2003). Combined with past research, these findings suggest that when providers express control in a caring, respectful, nonauthoritarian manner, relationship quality can remain positive. The potential utility in combining care with control for affecting outcomes beyond symptoms and functioning is yet to be explored but holds much promise. The first step toward examining this is to accurately assess and measure what treatment relationships look like across a variety of voluntary, asserted, leveraged, and mandated (civil vs. criminal) contexts.

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DISCUSSION 3

Effective clinical innovations and the dissemination of research findings are key elements in the growth and development of the psychology profession. There are numerous avenues that enable authors to publish and present their work. Poster presentations at conferences are effective methods for communicating research findings and providing opportunities to meet with other researchers and clinicians to discuss the research being presented. Thus, these types of conference presentations play a key role in the proliferation of research.

In this week's discussion, you will be submitting your proposal for the Week Five Virtual Conference. You may utilize relevant assignments from previous courses in this program or suitable projects from your professional life. See the PSY699 Call for Student Poster (Links to an external site.) Presentations document for specific parameters and instructions on how to create your proposal. Following the guidelines presented in the document, create your proposal and attach it to your initial post in the discussion forum. Evaluate the impact participating in conference presentations may have on potential work settings and/or doctoral programs and comment on the following questions in your initial post.

- How are conference presentations professionally relevant?
- What elements of the proposal process were most difficult for you, and why?
- What positive outcomes do you anticipate will come from this process, which may be applied to potential work settings and/or doctoral programs?

PSY699: Master of Arts in Psychology Capstone

Call for Student Poster Presentations

We invite you to submit a proposal for the Virtual Conference that will occur in Week Five of this course. The Virtual Conference is designed to bring the class together to review and evaluate poster presentations of technical, professional, and/or scientific interest to psychology professionals.

To submit your poster proposal, include the following information in a document attached to your initial post.

- Poster Title
- Author Information
- Abstract (300 to 500 words maximum)
- List of References

The abstract should concisely explain the purpose and content of the poster. Abstracts for empirical studies, literature reviews, and meta-analyses should include the following sections: Objectives, Method, Results, Conclusions, and Implications. Abstracts for case studies, theoretical and methodological studies, and other projects should include the following sections: Purpose, Description, Assessment, and Conclusions.

The poster proposal must represent your original work. Work already published in another conference or journal will not be accepted. Please see the instructions for the Week Five Virtual Poster Conference Discussion for the Poster Submission Guidelines in order to prepare your poster for presentation.

Assignment 3

Writing a personal mission statement offers the opportunity to establish what's important in your professional life. A personal mission statement is often an integral part of a job or graduate-level application as it provides reviewers with insights into an applicant's strengths in, and philosophies regarding, the discipline.

The personal mission statement includes a description of your focus and goals, which can serve to provide direction for the next one to five years of your career. It can be used not only as a guide, but also as a tool of conscious reflection encouraging you to accomplish your professional objectives. In the course of this assignment, you will evaluate potential career direction and satisfaction by reflecting on the following questions:

- What do you hope to accomplish in the profession?
- What positive and unique qualities do you bring to the profession?
- How do you see your role in the profession evolving through time?
- Why is the work you hope to do important?

Your Personal Mission Statement should be a minimum of 500 words, but it should not exceed 1000 words. Therefore, it is important that your writing be clear and concise and that your thoughts and philosophies are effectively communicated to your reader.

The Personal Mission Statement

- Must be 500 words to 1000 words in length and formatted according to APA style as outlined in the Ashford Writing Center.
- Must include a header on each page with the following:
  - Personal Mission Statement
  - Student's name
  - Student's contact email
  - Date submitted
- Must address the topic of the mission statement with critical thought.
- Must document all sources in APA style as outlined in the Ashford Writing Center.