Factorial validation of a French short-form of the Working Alliance Inventory

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Abstract

Evaluation of the therapeutic alliance is crucial for understanding the therapeutic process and its results. However, few instruments are available in French. This article aims to validate a French short form of the Working Alliance Inventory (WAI). Unlike other questionnaires, the WAI is the most widely used in psychotherapy research as well as in social psychiatry. Confirmatory factor analyses were carried out on a sample of 150 client-case manager dyads in order to determine the validity of this short-form instrument. The results of these confirmatory factor analyses allowed us to answer different authors' questions (Horvath and Greenberg, 1989; Tracey and Kokotovic, 1989) regarding the factorial structure of the WAI. The results also indicated a unidimensional solution as being the most valid for the two samples. We suggest that, in future studies, only one score be considered for the evaluation of the WAI. We also suggest modifying two statements in the English and French versions in order to render a faithful comparison between the therapist and client versions. Copyright © 2006 John Wiley & Sons, Ltd.

Key words: Working Alliance Inventory, validation of questionnaire, confirmatory factor analysis

Introduction

The beneficial role of an alliance between therapists and clients in the psychotherapeutic process is now widely recognized for persons with mood or anxiety disorders (Gaston, 1990; Horvath and Luborsky, 1993; Martin et al., 2000) as well as persons with severe mental illness (Gehrs and Goering, 1994; Neale and Rosenheck, 1995; Svensson and Hansson, 1999; Tyrrell et al., 1999). Over the years, the alliance concept has worn many appellations such as the 'therapeutic alliance', the 'helping alliance' or the 'working alliance'; all defined in a similar fashion: 'These terms refer to the patient's experience of the treatment or the relationship with the therapist as helpful, or potentially helpful, in achieving the patient's goals' (Luborsky et al., 1993: 480). The core of Bordin's alliance theory (Bordin, 1979) lies in its emphasis on the importance

of patient and therapist collaboration prior to initiating therapeutic changes. This alliance process is therefore interactive, with each actor focusing on the treatment while establishing a mutual bond. According to Gaston (1990), the alliance serves three functions in therapy:

- the alliance is therapeutic in and of itself;
- the alliance is an essential prerequisite for therapeutic interventions to be effective;
- the alliance interacts with various types of therapeutic interventions.

Beutler (2000) supports the first function mentioned above as the *sine qua non* of optimal therapeutic treatment. More specifically, he states that: 'therapeutic change is greatest when the therapist is skilful and provides trust, acceptance, acknowledgement, collabo-

ration, and respect for the patient within an environment that both support risk and provides maximal safety' (Beutler, 2001: 1005). The latter two functions described by Gaston are in accordance with results from Horvath and Symond's meta-analysis (1991), which described a significant although moderate effect size linking the alliance to therapeutic outcomes. This effect remained, even when controlling for therapeutic interventions and length. Similarly, with people presenting a serious mental illness such as schizophrenia, Frank and Gunderson (1990) found that those who had established good alliances with their case manager responded better to treatment, had fewer relapses, and had better therapeutic outcomes at 2 years' follow-up than those who had not formed such alliances.

During the past two decades, several instruments have been developed to assess the alliance concept. The most well known are the Working Alliance Inventory (WAI) (Horvath and Greenberg, 1989), the Pennsylvania Scales (Luborsky et al., 1985), the Vanderbilt Scales (Henry and Strupp, 1994) and the California Scales (Marmar et al., 1989; Gaston, 1991). Of these scales, the WAI is one of the most used and recognized in the psychotherapy research literature (Martin et al., 2000). First, the WAI is an easy-to-use self-report questionnaire, available either in long form (36 items) or in short form (12 items). It holds two versions: one for clients and one for therapists. It is consistent with various theoretical orientations and, as suggested by Gehrs and Goering (1994), has the great advantage over the other scales of being applicable to people with severe mental illness. Finally, its internal consistency has been demonstrated for both long-form and short-form versions as well as the three dimensions – bond, task and goal (Horvath and Greenberg, 1989; Kokotovic and Tracey, 1990; Hatcher et al., 1995). However, in spite of all these advantages, its factorial structure still remains to be demonstrated. Furthermore, there is to date no published validation of the French WAI version.

The WAI was based on Bordin's theory of Working Alliance (Bordin, 1979), which, rather than focusing on unconscious transference processes, aims at the real joining of the therapist and the client for the purpose of reducing the client's distress (Gehrs and Goering, 1994). Initially, the WAI was conceived as a measure comprising three subscales – bond, task, and goal – and its authors recommended that four scores be consid-

ered, one from each of the three subscales, and one overall score (Horvath and Greenberg, 1989). The *bond* subscale reflects the positive relation between the therapist and the client. The *task* subscale concerns the behaviours and cognitions that support the agreement between the therapist and the client on the tasks to be accomplished. The *goal* subscale concerns the collaboration between the therapist and the client regarding the goals to be attained. The global scale simply represents the sum of all items. These suggestions were followed in most studies (Gehrs and Goering, 1994; Hatcher et al., 1995; Neale and Rosenheck, 1995; Tyrrell et al., 1999; Kivlighan and Shaughnessy, 2000). Yet, it is worth noting that some authors, including the very authors of the scale (Horvath and Greenberg, 1989; Horvath and Luborsky, 1993) have questioned the validity of a three-factor model since their own results showed very high correlation coefficients between the three subscales (r from 0.69 to 0.92).

This issue of validity has been more fully examined by Tracey and Kokotovic (1989) who have tested with confirmatory factor analyses three models based on Bordin's theory of the working alliance (1979) and Horvath and Greenberg's (1989) results. Their first model comprised three correlated factors (bond, task, and goal subscales were correlated), while their second model contained a single general factor comprising all items of the WAI. The third model was a bi-level hierarchical factor model in which the three WAI subscales (first order) were subsumed under a larger dimension, the latent concept of working alliance (second order factor). These three models were tested using all 36 items of the scale as well as a shorter form comprising 12 items (Tracey and Kokotovic, 1989). Their results revealed that the only well adjusted model was the hierarchical bi-level model with the short-form. The authors concluded that the WAI measures the three distinct dimensions of *bond*, *task* and *goal*, as well as the general dimension of working alliance. They suggested considering the three subscales simultaneously in multivariate analyses in order to account and control for the strong correlations between the scales. If univariate tests were required, then the one overall alliance score should be used. Although appropriate at the statistical level, these suggestions did not quite solve the issue of validity of the WAI on practical grounds. Indeed, since the publication of this latter paper, few studies have reported using it in the recommended way. Various

versions of the WAI were used interchangeably, that of 12 or 36 items, with one or three dimensions, and with no considerations for the strong correlations among the subscales as warned by Tracey and Kokotovic (1989) or even by the author of the WAI (Horvath and Greenberg, 1989). Moreover, the results of Tracey and Kokotovic (1989) did not quite resolve the lack of significant conceptual distinction between WAI subscales as evidenced by three highly correlated subscales.

These issues are addressed in this paper, which presents the validation process applied to a French short-form of the scale (WAI-F), with an emphasis on the confirmatory factor analyses conducted to specify the best factorial model.

Method

The data used for the present paper come from an evaluation study on the implementation, functioning and effects of an intensive community programme for psychiatric patients in Montreal, Canada (Ricard et al., 2000). This study is based on a sample of 150 client-case manager dyads. The sample comes from another sample of 252 dyads used in a larger longitudinal study, which examined mental health users receiving intensive case-management services for severe mental health problems. The 150 dyads were selected on the basis of having complete response to the WAI scale from both the client and the case manager at the one-year follow-up. This choice was based on the premise that a working alliance takes time to establish, and an assessment of the validity of a measuring scale would not have been as valid when it occurs at the beginning of the relationships. No significant difference has been observed between the 252 respondents and the 150 respondents regarding their gender, age, psychiatric diagnosis, and length and number of hospitalizations.

Clients

The 150 psychiatric clients comprised 111 women and 39 men suffering from a severe mental illness, aged from 22 to 83 years ($M = 51.7$, $SD = 14$). Among them, 76 (50.7%) had a diagnosis of schizophrenia or another form of psychosis, 54 (36%) had an affective disorder, 9 (6%) had anxious disorders, 5 (3.3%) had a personality disorder, and 6 (4%) other. All clients were diagnosed by certified psychiatrists and diagnoses were based on criteria in the *Diagnosis and Statistical Manual of Mental Disorders (DSM-IV)*. These clients were followed by 30 case managers.

Case managers

All 30 case managers participated in the study and were included in the sample. The work of case managers consists of responding to the various needs of their clients regarding mental and physical health, social integration and psychosocial readaptation, and the management of their daily living. Case managers are part of a multidisciplinary team and can refer their clients to other professionals when needed. However, they remain the major contact for the client – the primary person in the health system on whom the client can rely to meet his or her various needs. On average, case managers see each of their clients 1.5 times a week for about an hour-and-a-half.

Each case manager responded to the therapist version of the WAI in regards to his or her own clients. These included 15 nurses and 15 specialized educators aged from 25 to 62 years ($M = 44.5$, $SD = 6.17$). Among them, 24 had a college degree and six had a university degree. On average, case managers had 18 years of experience in psychiatry ($SD: 6.31$), including experience in short- and long-stay ambulatory clinics, and intensive care programmes in the community. There were 22 women and eight men, and on average each took care of nine patients.

Instrument

Definition

The Working Alliance Inventory (WAI) (Horvath and Greenberg, 1989) is a self-administered questionnaire rated on a seven-point Likert-type scale, and reflects the quality of the client and clinician's therapeutic relationship. The authors initially built the scale comprised of 36 items, holding three 12-item subscale scores – bond, task and goal – as well as one overall score. Then, Tracey and Kokotovic (1989) proposed a short-form scale containing 12 items drawn in equal proportion from the three initial subscales. They mentioned very high alpha coefficients for each scale, varying from 0.83 to 0.98. The WAI questionnaire used for this study is the short-form of the WAI. It was administered to case managers and their clients one year after their first entry into the programme.

Translation

A first French translation of the short-form WAI was submitted to a group of case managers working in mental health in order to assess understanding and

wording of each item and the potential problems with administration of the scale in a community setting. After assessing the instrument individually case managers were invited to a group discussion about difficulties encountered with the questionnaire. A consensus was reached regarding the best and most appropriate formulation for each item. This resulted in some minor modifications of the first translation. The same procedure was followed with the client version of the WAI. Finally, a few more modifications were made to obtain comparable versions for case managers and clients.

Data analyses

Following the lead traced by Tracey and Kokotovic (1989), two models were first examined: the one-factor model and the three-factor model, on both the client and the therapist versions. Confirmatory factor analyses and internal consistency tests were conducted in order to specify and validate the best structure of the French short-form WAI, both on conceptual and empirical grounds.

Analyses essentially consisted of confirmatory factor analyses (CFA) using the EQS software (Bentler, 1995). The CFA consisted of assessing the fit for each model, using various standard statistical indices of fit such as the χ^2_{DF} ratio (Bacher, 1987), the Non-normed Fit Index (NNFI), the Comparative Fit Index (CFI), the robust CFI (calculated starting from the Satorra-Bentler chi square), and the root mean standard error of approximation (RMSEA). Generally agreed upon standards were followed for judging a model as well as fitting the data. For instance, for a model to have an

adequate fit to the data, the χ^2_{DF} ratio must be equal or below 2 (Byrne, 1989; Hofmann, 1995), the NNFI, CFI, and robust CFI must be higher than 0.90 and the RMSEA must not be much greater than 0.08 (Jöreskog and Sörbom, 1993; Mueller, 1996). All models were assessed using the Maximum Likelihood-Robust estimation method. Then, adjustments were made to the models on the basis of the Lagrange multiplier modification index in order to improve fit (Bacher, 1987). The internal consistency of each scale or subscale was then assessed using Cronbach's alpha, and correlations were calculated between the subscales within and across samples.

Results

The results of the confirmatory factor analyses (CFA) with respect to the therapist version and the client version of the WAI are shown respectively in Tables 1 and 2. As evidenced by the fit indices obtained with the case managers sample, both the one-factor model (M1) and the three-factor model (M2) appear to approximate the data reasonably well (Table 1). For both models, the χ^2 ratio is near 2, the NNFI, CFI and CFI robust are well above the acceptability threshold, and the NFI falls short only by a fraction. Yet, the RMSEA index is slightly high, indicating a lack of fit in some part of the model. Adjustments were then made to both models on the basis of the Lagrange multiplier modification index, specifically by adding two correlations between error terms (r_{e21e12} and r_{e21e27}). With these adjustments, all fit indices, including the χ^2 ratio, the NFI and the RMSEA were within the acceptance criteria.

Table 1. Results from the CFA of the WAI-Case managers (N = 150)

Models	Adjustment fit indices							
	DF	χ^2	χ^2/df	NFI	NNFI	CFI	CFI robust	RMSEA
M1. One-factor	54	130.1	2.4	0.89	0.91	0.93	0.95	0.10
M2. Three-factors	51	123.6	2.4	0.89	0.91	0.93	0.96	0.10
M1b. One-factor, adjusted	52	106.2	2.0	0.91	0.94	0.95	0.98	0.08
M2b. Three-factors, adjusted	49	99.4	2.0	0.91	0.94	0.95	0.98	0.08

CFA = confirmatory factor analysis; NFI = normed fit index; NNFI = non-normed fit index; CFI = comparative fit index; RMSEA = root mean square error of approximation.

In contrast, neither the one-factor model nor the three-factor model initially tested appear to fit the data obtained from the clients sample (Table 2). Indeed, all fit indices are below the acceptance threshold. Here again, adjustments were made in order to find a better fit while keeping the same one-factor and three-factor structures. As seen in Figure 1, four correlations between error terms were added to achieve this goal as recommended by Hull and collaborators (Hull et al., 1991). With these adjustments, both models reached an acceptable level of fit.

As the *post hoc* addition of a correlation between error terms means either that the initial model underpredicts the covariance between a given pair of indicators (positive correlation), or that it overpredicts the covariance (negative correlation), the correlation matrices were examined more closely. In all cases, the observed correlations for the pairs of items for which error terms were correlated was in the expected direction: either larger than average in case of positive error correlation (for example, $r = 0.76$; $p < 0.01$, items 23 and 24 of the client version), or smaller in case of negative error correlation (for example, $r = 0.27$; $p < 0.01$; items 21 and 27 of the therapist version).

As the adjusted one-factor and three-factor models were adequately adjusted to data while preserving the core of the original model (all items loading on their same respective factor), coefficients of internal consistency (Cronbach's alpha) were calculated for the general alliance dimension as well as for the three subscales of *bond*, *task* and *goal*. For the general alliance scale, the alphas are respectively 0.88 and 0.93 for the clients' and

the case managers' samples (Table 3). For the three subscales, the alpha ranged from 0.64 to 0.93. Summed scores were then calculated for each general scale and subscale and the correlations between them within and across samples were calculated (Table 3). The correlation between the three subscales vary from 0.71 to 0.76 ($p < 0.01$) in the clients' sample, and from 0.78 to 0.86 ($p < 0.01$) for case managers. The correlations between the subscales and the general scale are all above 0.90 in both samples. It can also be seen that the correlations between the same subscale across samples, which range between 0.29 and 0.46 ($p < 0.01$), are rather weak compared to correlations across the different subscales within each sample.

All of these results raise a firm doubt as to the significant conceptual distinction between all three subscales (the three-factor solution). Using the results of the CFA, a formal test was made of the hypothesis that the three factors are in fact measuring one and the same dimension. To test such a hypothesis, one generally adds the constraint in the model that the correlation between the factors is 1, and tests whether this constraint significantly reduces the fit of the model using a chi-square difference test (Hayduk, 1987). Alternatively, because the one-factor model is hierarchically included within the three-factor model (adding the constraint that all correlations between factors are 1 would be exactly the same as testing the one-factor model) (Hayduk, 1987), the test of the hypothesis of all subscales being the same can readily be made using the chi-square difference test with the one-factor model versus the three-factor model. For both the Clients

Table 2. Results from the CFA of the WAI-Clients (N = 150)

Models	Adjustment fit indices							
	DF	χ^2	χ^2/df	NFI	NNFI	CFI	CFI robust	RMSEA
M1. One-factor	54	198.2	3.7	0.78	0.79	0.83	0.93	0.13
M2. Three-factors	51	193.5	3.8	0.79	0.78	0.83	0.92	0.14
M1b. One-factor, adjusted	50	106.3	2.1	0.88	0.91	0.93	0.98	0.09
M2b. Three-factors, adjusted	47	101.3	2.2	0.89	0.91	0.94	0.98	0.09

CFA = confirmatory factor analysis; NFI = normed fit index; NNFI = non-normed fit index; CFI = comparative fit index; RMSEA = root mean square error of approximation.

Figure 1. Confirmatory factor analyses for a French short-form of the WAI questionnaire (clients' and case managers' samples).

*WAI item numbers

sample ($\chi^2 = 5$, $DF = 3$, $p = 0.17$), and the case managers sample ($\chi^2 = 6.8$, $df = 3$, $p = 0.08$), the χ^2 is non-significant, which indicates that the three subscales of bond, task and goal could not be reasonably said to measure different concepts, with regards to both client and therapist versions.

Discussion

The goal of this paper was to test the factorial structure of a French short-form of the WAI, with a sample case managers working in the context of an intensive community treatment programme and their clients suffer-

ing from severe mental illness. The results show that the two tested models, the one-factor and the three-factor models for the short-form of the WAI, mainly inspired by the work of Tracey and Kokotovic (1989), were reasonably accurate to fit the data, with some minor adjustments, with respect to both client and therapist versions.

However, and still for both of these versions, much evidence suggests the inadequacy of the three-factor model. First, with correlations between the subscales ranging from 0.71 to 0.86, there are reasonable doubts as to the significant conceptual distinction of the three

Table 3. Correlations among the WAI scales within and across samples

Scales	Clients				Case managers			
	Alliance	Bond	Task	Goal	Alliance	Bond	Task	Goal
Clients								
Single general factor	0.88							
Bond	(5.98; 0.76) 0.91	0.77 (6.19; 0.79) 0.74						
Task	0.90		0.64 (5.79; 0.83)					
Goal	0.91	0.76	0.71	0.67 (5.95; 0.92)				
Case managers								
Single general factor	0.44	0.32	0.45	0.43	0.93 (5.91; 0.77) 0.90			
Bond	0.35	0.29	0.35	0.31		0.78 (6.24; 0.65) 0.78		
Task	0.44	0.30	0.46	0.42	0.95		0.86 (5.79; 0.90) 0.86	
Goal	0.44	0.31	0.44	0.43	0.95	0.78		0.81 (5.71; 0.94)

All correlation coefficients are significant at $p < 0.01$.

Bold numbers on the diagonal are alpha coefficients and the bracket includes mean and SD (M; SD) for each scale.

Coefficients in italics are correlations between the same scales across samples.

subscales. Such levels of correlation between the three subscales were also obtained in most studies examining the validity of the WAI, including those of Tracey and Kokotovic (1989) and that of Horvath and Greenberg (1989). The correlations between each of these subscales and the single general factor were also shown to be extremely high, that is above 0.90. Finally, a formal test of the three-factor model, using the results of the CFA, has shown that the three WAI subscales – bond, task and goal – were not significantly distinct. There are several ways of interpreting these last results. For one, it is difficult to distinguish between the items of the goal scale and those of the task scale. Nearly all the items of these scales refer to approximately the same concept, in that the tasks are often accomplished in order to attain goals. Furthermore, the affective dimension of the alliance, represented by the bond scale, is of crucial importance in the development of a working alliance. It cements the mutual understanding between client and case manager with regard to the tasks needed in order to meet the targeted goals. Without this affective dimension, a mutual understanding and confidence between client and case manager would be impossible to build. As a consequence, the working alliance can only be conceived as the result of a mutual investment, of both client and case manager, that is rebuilt at each meeting around affective (bond) and rational dimensions (task and goal). Thus, even though the bond, tasks and goals scales, as distinct components of the alliance, are conceptually interesting, they remain strongly intercorrelated at an empirical and statistical level.

Other evidence and reasons support the acceptance and further use of the one-factor model (a single general factor). The model was shown to fit the data accurately, both for the client and the therapist versions. It corresponds to the general concept of working alliance, which has been of interest in most clinical and research settings using the WAI and other similar scales. In addition, the calculation and use of the scale is simple and easily applied: only a single score can be calculated and interpreted, instead of three highly correlated scores used simultaneously in multivariate analyses, as proposed by Tracey and Kokotovic (1989). Another advantage is that the model proves to fit the client and the therapist forms well. This makes a valid comparison of clients' and therapists' perceptions possible, and the calculation of proximity or deviance scores that could be used for research or clinical purposes.

This study has some limits. A first limit concerns the generalization of the findings, particularly with respect to the French short-form of the WAI as used here and the particular sample of respondents from which the results were obtained. Although it appears that many of the results obtained in this study are indeed quite similar to those of other studies mentioned previously (Horvath and Greenberg, 1989; Tracey and Kokotovic, 1989).

Another limit concerns the cross-sectional administration of the WAI, which can only reflect a one-time appreciation of the therapeutic process, in this case one year after client entry into the programme. Kivlighan and Shaughnessy (2000) also underline the inability of most studies to take into account the over time development of the working alliance. However, although this study comprised a single administration of the WAI, it had the advantage over other studies (Tracey and Kokotovic, 1989; Kivlighan and Shaughnessy, 2000) to have measured the alliance later in the therapeutic process, suggesting a possible consolidation of the alliance, and simultaneously with the client and the therapist.

Another limitation relates to the possibility of shared individual case-manager characteristics that underlie case managers' WAI assessment. As 30 case managers each assessed nine clients on average, it was possible to find a potential correlation between a case manager's evaluations regarding his or her clients. However, the WAI factor structure of the case-manager responses presented a good fit of adjustments.

Another limitation of the proposed models does not pertain to the study itself but rather to the wording of certain items. Most sentences in the client version correspond to those of the therapist version but there are a few exceptions. For instance, items #4 and #12 show some discrepancy, where the person to whom the action applies differs from one version to the other. This is true for both the English and the French versions. Item #4 in the client version is worded as 'What I am doing in therapy gives me new ways of looking at my problems.' In the therapist version it is worded as, '____ and I both feel confident about the usefulness of our current activity in therapy.' Consequently, item #4 has a very weak loading on the general factor in the client version (0.24) though it has a sizeable loading in the therapist version (0.80). This seems to reflect the fact that the two versions of the item have indeed different meanings. Yet, having parallel client and thera-

pist versions of the WAI is an essential quality of the instrument, allowing comparisons and in some case deriving proximity scores. In order to keep the same correspondence between the two versions of the items, the client version of the item could be reworded as 'My therapist and I both feel confident about the usefulness of our current activity in therapy.' Similarly, item #12 of the client version could be reworded as 'I have doubts about what we are trying to accomplish.' The English version of the suggested wording is shown in the appendices.

Regarding all of these considerations, the next step in the validation process would be to evaluate the predictive validity of the WAI questionnaire, client and therapist versions. Additional research is warranted with larger samples and/or inter-cultural comparisons in order to further explore the validation of the WAI.

Conclusion

In this paper, we presented evidence for the factorial structure of a French short-form of the WAI questionnaire administered to case managers working in an intensive community treatment programme and to their clients with severe mental illness. Consequently, this study enables us to answer the question asked by many authors: does the WAI present a one-factor model or a three-factor model (Horvath and Greenberg, 1989; Tracey and Kokotovic, 1989)? Among the tested models, it appears that the single general model proposed by Tracey and Kokotovic (1989) fits the data more accurately with some minor adjustments. It is believed that these adjustments reflect the particularity of the chosen sample and that they do not invalidate the model itself. The WAI is an easy to administrate scale due to its short length and its administration. As a result, this measuring instrument should have real potential in both research and clinical settings.

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Appendices

Appendix 1: short version of the WAI – case managers

Items
2. ___ and I agree about the steps to be taken to improve his/her situation.
4. ___ and I both feel confident about the usefulness of our current activity.
8. I believe ___ likes me.
12. I have doubts about what we are trying to accomplish.
21. I am confident in my ability to help ___.
22. ___ and I are working towards mutually agreed upon goals.
23. I appreciate ___ as a person.
24. We agree on what is important to work on.
26. ___ and I have built a mutual trust.

27. ___ and I have different ideas on what his/her real problems are.
32. We have established a good understanding of the kind of changes that would be good for ___.
35. ___ believes the way we are working with his/her problem is correct.

The original bond subscale comprises the items 8, 21, 23 and 26, the task subscale, items 2, 4, 24, and 35, and the goal subscale, the items 12, 22, 27 and 32.

Appendix 2: short version of the WAI – clients

Items
2. ___ and I agree about the steps to be taken to improve my situation.
4* ___ and I both feel confident about the usefulness of our current activity.
8. I believe ___ likes me.
12* I have doubts about what we are trying to accomplish.
21. I am confident in ___'s ability to help me.
22. ___ and I are working towards mutually agreed upon goals.
23. I feel that ___ appreciates me.
24. We agree on what is important for me to work on.
26. ___ and I trust one another.
27. ___ and I have different ideas on what my problems are.
32. We have established a good understanding of the kind of changes that would be good for me.
35. I believe the way we are working with my problem is correct.

*These items were revised in order to have a corresponding meaning for both the client-version and the therapist-version.

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