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2000, *SASB/ INTREX: Instructions for administering questionnaires, interpreting reports, and giving raters feedback* (Unpublished manual).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,

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).
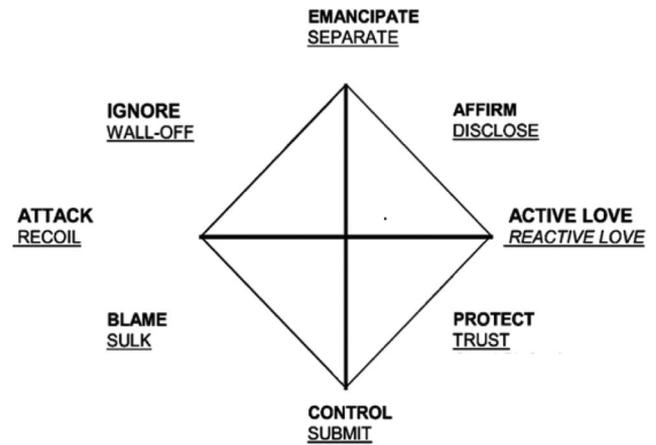

Figure 1. Simplified One-Word Cluster Model (Benjamin, 1996) with Corresponding Angular Displacement Added. Therapist transitive scores in **bold**; client intransitive scores *underlined*.

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 Enrolled ($n = 61$)	Court 1 Court ($n = 168$)	Court 2 Enrolled ($n = 28$)	Court 2 Court ($n = 70$)	Court 3 Enrolled ($n = 9$)	Court 3 Court ($n = 33$)	Court 4 Enrolled ($n = 27$)	Court 4 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 ($\alpha = .82$) and test–retest ($\alpha = .84$; Benjamin, Rothweiler, & Critchfield, 2006) reliability and good (Cronbach, 1951) internal consistency in the present sample ($\alpha = .85$). 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

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.

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.

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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