Psychotherapy

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Online First Publication, February 23, 2015. http://dx.doi.org/10.1037/a0038733

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0033-3204/15/$12.00 http://dx.doi.org/10.1037/a0038733

The Early Formation of the Working Alliance From the Client's Perspective: A Qualitative Study

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This research used qualitative methods and archival data to examine clients' perceptions of the early formation of the working alliance. Following their first and second sessions of individual psychotherapy, 54 clients responded to structured written assignments that were rooted in Bordin's (1979) model of the alliance. Analysis yielded 884 recording units, which were organized into 4 main clusters: (a) clients' initial misgivings about psychotherapy; (b) organization and meaning-making; (c) psychotherapist supportive activities; and (d) client appreciation of techniques. Clients' perceived contributions to alliance development and their experiences of the initial interactions with their psychotherapists are explored in the context of existing theory and research.

Keywords: alliance, client's perspective, qualitative research

Although the working alliance is among the best predictors of outcome (Baldwin, Wampold, & Imel, 2007), there remains much debate about how to properly define this complex construct. Differences in alliance definitions are not from lack of empirical work, as there have been numerous studies on the components and structure of the alliance (Andrusyna, Tang, DeRubeis, & Luborsky, 2001; Hatcher & Barends, 1996; Hatcher, Barends, Hansell, & Gutfreund, 1995; Hatcher & Gillaspy, 2006; Tracey & Kokotovic, 1989).

Earlier research on the working alliance largely followed a "top-down" strategy, in that much of the definitional work on the alliance emerged from theoreticians and researchers. More recently, research has begun to investigate clients' perceptions of the working alliance using qualitative methodologies (Beck, Friedlander, & Escudero, 2006; Bedi, 2006; Bedi, Davis, & Williams, 2005; Bedi & Duff, 2014; Fitzpatrick, Janzen, Chamodraka, Gamberg, & Blake, 2009; Fitzpatrick, Janzen, Chamodraka, & Park, 2006; Kirsh & Tate, 2006). Such methodologies are thought to be particularly capable of accessing the richness of the clients' experiences in psychotherapy (Morrow, 2005; Ponterotto, 2005; Rennie, 2002). A focus on clients' perspective is important because clients and psychotherapists appear to understand the quality and strength of the alliance differently (Bachelor, 1995; Bedi et al., 2005; Mohr & Woodhouse, 2001), as evidenced by a weak correlation between client and psychotherapist ratings of the alliance (Cecero, Fenton, Frankforter, Nich, & Carroll, 2001).

How might client perspectives yield significantly different information or concepts about the working alliance? While alliance theorists and researchers (Bordin, 1979; Horvath & Bedi, 2002) emphasize the role of collaboration, qualitative interview data imply that collaborative factors may be less integral to alliance development; when interviewed, clients seem to attribute responsibility to the psychotherapist and rarely acknowledge their own contributions to the alliance (Bedi, 2006; Bedi et al., 2005), although this latter finding may be due to insufficient probing during interviews (see Fitzpatrick et al., 2009). Other qualitative research has found that clients value the psychotherapist's supportive behaviors and perceive that this support plays a role in alliance development (Bachelor, 1995; Bedi, 2006; Bedi & Duff, 2009; Bedi & Richards, 2011; Mohr & Woodhouse, 2001). For instance, clients often make references to their psychotherapist's use of encouraging statements, friendliness, respect, validation, and even personalized greetings and farewells (Bedi, 2006; Bedi & Duff, 2014; Bedi & Richards, 2011). One quantitative analysis (Duff & Bedi, 2010), using data from 79 clients, indicated that three particular psychotherapist behaviors (making encouraging statements, making positive comments about the client, and greeting the client with a smile) accounted for 62% of the variance in client ratings of the working alliance. These seemingly simple, yet supportive behaviors were, according to clients, critical to a strong working alliance. Clients also report, when interviewed, that treatment techniques are intimately linked with the alliance and contribute to its development (Bedi, 2006; Bedi et al., 2005; Fitzpatrick et al., 2006).

To elicit clients' perceptions of the working alliance, general terms like *client–therapist relationship*, *working relationship*, and *therapeutic relationship* are typically used because clients are presumably unfamiliar with alliance theory (see Bachelor, 1995; Bedi, 2006; Mohr & Woodhouse, 2001). Although this approach seems to capture the client's phenomenological experience (Rennie, 2002), it also seems to conflate the alliance with the overall therapy relationship (Hatcher & Barends, 2006). As a result, clients' responses often refer to generic relational characteristics (e.g., rapport) that may be disconnected from the alliance construct (Hatcher & Barends, 2006). One solution to this problem is to initiate investigations "above the ground" by using existing theory to guide inquiry of clients' experiences (Stiles, 2009). By rooting prompts in alliance theory, clients

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may be better able to directly comment on the features and components of the alliance construct that are deemed important by researchers and psychotherapists. Such an approach might yield reports that are focused on the working alliance specifically, rather than the therapeutic relationship generally.

In the present study, we analyzed archival data collected in the context of a previous study (Holmberg, 2003), which evaluated the efficacy of a workbook assignment for improving the working alliance and treatment outcome. The prompts and questions in this workbook were rooted in Bordin's (1979) tri-partite model, the most common and influential theory of the alliance. Holmberg (2003) found that the use of the workbook resulted in more frequent discussions of therapy tasks and goals but did not result in higher alliances or better outcomes. Because the workbook data were influenced by Bordin's (1979) conceptualization of the alliance, we conceded, from the outset, that an understanding of the "ground" in the current study would be limited by existing theory.

The current research aimed to bring theory to bear on clients' early experiences of the alliance. The following four specific areas of inquiry were established prior to analysis: (a) level of client contribution to the therapeutic relationship and the establishment of the alliance; (b) the complex interactions of the components of the alliance, including goals, tasks, and bond; (c) elaboration of the alliance components; and (d) psychotherapist activities that either enhance or reduce the strength of alliance.

Method

Participants

Clients. We used archival data collected in the context of a previous study (Holmberg, 2003). Participants were clients at a Midwestern university counseling center who participated in a study examining how workbook use affects the alliance between client and psychotherapist (Holmberg, 2003). Holmberg (2003) collected data over a 2-year period from 2000 to 2002; control data were collected during the first year, and the workbook condition data were collected the following year. During this 2-year period, all clients ($N = 2{,}700$) presenting for treatment at the counseling center were invited to participate in the original study, and 179 clients agreed to participate. Of these 179 clients, 85 (47%) were assigned to the control condition, and 94 (52%) were enrolled in the workbook condition. Fifty-four (57%) of these clients completed psychotherapy sessions one and two, as well as the workbook assignments associated with these sessions, and were included in the present study. Dropout from the study was not necessarily indicative of psychotherapy termination. Reasons for study dropout included clerical errors, participants forgetting to return their study forms to the clinic, and participants reporting that completing the workbook was too time consuming.

Clients were full-time undergraduate and graduate students who presented with a range of problems (e.g., adjustment disorders, mood disorders, anxiety disorders, eating disorders, and interpersonal problems). Of the 54 client participants in this study, 52 had valid descriptive information: 45 (86.5%) were female and 48 (92.3%) were Caucasian. Participants had a mean age of 21.5 years ($SD = 3.9$) and were distributed across years in school (9 were freshmen, 7 were sophomores, 16 were juniors, 13 were seniors, and 7 were graduate students). Thirty participants (57.7%) had no previous psychotherapy experience. Forty-six participants (85.2%) completed the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996) before the first session and had a mean score of 78.4 ($SD = 16.8$; range: 41–115). Of the 46 participants who completed the OQ-45 at pretreatment, 36 (78.3%) participants scored above the clinical cutpoint (i.e., 63) on the OQ-45 scale (see Lambert et al., 1996). Although outcome was not included as a variable in this study, results of the OQ-45 are included so that this sample could be compared with other outpatient samples. Fifty-three participants completed the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) after the first session and had a mean total score of 208.15 ($SD = 24.5$; range: 138–251), a mean WAI-Goals score of 68.08 ($SD = 10.1$; range: 41–84), a mean WAI-Tasks score of 71.25 ($SD = 9.1$; range: 45–84), and a mean WAI-Bond score of 68.82 ($SD = 8.3$; range: 46–83).

Psychotherapists. In the original study (Holmberg, 2003), clients saw 19 psychotherapists of which 10 were licensed psychologists and 9 were graduate trainees. Prior to participation, all psychotherapists completed informed consent. The professional psychologists had between 5 and 32 years of experience, while the graduate trainees had from 1 month to 3 years of experience. Five of the doctoral level psychologists provided therapy to 127 (71%) of the participants included in the original study. Theoretical orientations represented by the psychotherapists included cognitive–behavioral, psychodynamic, interpersonal, feminist, and eclectic approaches, and just over half of the psychotherapists ($n = 10$) were male. Prior to the workbook condition phase of the original study (Holmberg, 2003), five of the participating psychotherapists (the same 5 who contributed 71% of the sample) were given a 2-hr training seminar involving: (a) an overview of the working alliance, as well as an introduction to the workbook and its intended use, (b) information about the prevalence of negative process within therapy, (c) a role-induction procedure to help psychotherapists expect negative process in the development of the alliance and to view the workbook as an opportunity to become aware of such problematic alliance developments, (d) case examples of psychotherapist responses to clients' negative reactions within the alliance, and (e) a discussion about how psychotherapists may address negative process in a nondefensive and empathic way. Psychotherapists within the treatment condition conducted therapy as usual and issued the workbooks and forms to their clients. The psychotherapists were given opportunities to review the completed workbooks prior to the subsequent session.

Measures

Outcome Questionnaire-45. The OQ-45 (Lambert et al., 1996) is a self-report instrument designed to assess client outcomes during the course of psychotherapy. The OQ-45 is composed of 45 items that are rated on a 5-point Likert scale (0 = *never* and 4 = *almost always*); high scores reflect poorer psychological functioning. A typical item from the OQ-45 is "I feel blue." This measure has demonstrated good internal consistency and construct validity (Lambert et al., 1996). Alphas for the archival sample used in the current study were not available.

Working Alliance Inventory. The WAI (Horvath & Greenberg, 1989), a self-report measure of the working alliance, contains 36 items that are rated on a 7-point Likert scale (1 = *never* and 7 = *always*). The WAI includes three subscales, each composed of 12

items: WAI-Goals (e.g., "The goals of these sessions are important for me"), WAI-Tasks (e.g., "I am clear about what my responsibilities are in therapy"), and WAI-Bond (e.g., "My therapist and I understand each other"). This measure has been shown to have good internal consistency and construct validity (see Horvath & Greenberg, 1989). Similar to other measures used in this archival study, alphas for the sample were not available.

Alliance workbook. The alliance workbook (see Appendix; Holmberg, 2003) consisted of four sections that directed clients' responses toward Bordin's (1979) conceptualization of the alliance by asking clients to reflect on the goals, tasks, and bond components of the alliance in each session. The questions in the first section focused on the client's presenting problems and the agreement/collaboration between client and psychotherapist on treatment goals. Only one question from section one contributed any responses about client–therapist interactions: "Do you feel you and your therapist have reached an agreement about which problems you should address in treatment? – If no, please explain here . . . ." The second section of the workbook assessed client's positive and negative perceptions of in-session tasks (e.g., "The most difficult aspect of today's session was"; "My therapist made this easier/harder for me by":). One question ("Next session, I might like to focus more on . . . .") did not yield responses with relevant content and was excluded from analysis. The third section of the workbook covered the bond component of the alliance, particularly the client's emotional reactions to the interpersonal process of psychotherapy (e.g., "During today's Session I felt understood/misunderstood by my therapist when"; "I felt hopeful when my therapist"; "I felt frustrated when my therapist":). The fourth and final section of the workbook was a client-written process note. Participants were asked to write about what the session was like and their thoughts/feelings associated with the session. Answers to the fourth section were included in this study.

Procedure

Study measures were administered as part of the Holmberg (2003) study; clients completed the OQ-45 prior to session one and completed the WAI after each session. Following the first session, clients were also given a packet of measures (see Holmberg, 2003) that included an informed consent, a demographics questionnaire (included questions about age, gender, race, and previous therapeutic experience), and the alliance workbook. The alliance workbook was also administered after the second psychotherapy session. Participants were encouraged to complete these materials in a separate, quiet room. Clients were informed that their psychotherapists would have access to their workbook responses.

Data Analysis

Researchers. In total, there were four members of the research team, all of whom were male. The principal investigator (first author) was a doctoral student in clinical psychology. He had experience with the working alliance through three years of graduate training, including direct clinical work and didactic, graduate-level courses. The first author's theoretical knowledge of the alliance had been significantly influenced by the writings of Gelso and Carter (1985), Bordin (1979), and Hatcher and Barends (2006), among others. As such, the first author was oriented toward the tri-partite model (Bordin, 1979), as well as the idea that the alliance can be understood as a complex structure of constructs, best thought of as conceptually superordinate to specific methods or procedures (Hatcher & Barends, 2006). The second author was a doctoral-level psychotherapy researcher with a strong affinity for and belief in the efficacy of common factors and was further informed by dynamic and humanistic theories. Two additional graduate student researchers were also part of the team. The third researcher had four years of graduate training and three years of clinical training. He described his theoretical orientation as humanistic. The fourth researcher, a third-year doctoral student with two years of clinical training, also described his orientation as humanistic.

Coding process. This study used a content analysis methodology (Hsieh & Shannon, 2005; Krippendorff, 1989; Weber, 1990), with some features of grounded theory (Rennie, 2002; Strauss & Corbin, 1990). The initial phase of the coding process involved deep engagement with the data by the first author, which was accomplished by reading through the responses to all questions a sufficient number of times, so that a remembered response could instantly be located (Hsieh & Shannon, 2005; Strauss & Corbin, 1990). The first author used note taking and analytic memos to record the coding process (see Morrow, 2005; Stiles, 1993; Strauss & Corbin, 1990), to increase researcher reflexivity (Morrow, 2005), and to analyze the data. The first author organized the responses into recording units (Krippendorff, 1989; Rennie, 2002; Weber, 1990), one workbook question at a time. These recording units were most often established at the level of sentences or several sentences, in which there was an apparent break in meaning of the text being coded. The recording units were categorized based on word use and meaning in context (Weber, 1990) and were given descriptive labels, thereby creating a constellation of categories. Following the grounded coding practice of the constant comparative method (Glaser & Strauss, 1967), all recording units were compared to all established categories, allowing each category to be influenced by all the categories. In this way, each recording unit was compared with all aspects of the meaning hierarchy, allowing for maximization of contact between data and results. During this process, some categories were combined and others separated into subcategories. Finally, all categories were examined and organized until a final level of categorization was achieved.

In addition to the above methods (deep engagement, note taking, creating recording units and categories based on word use and meaning in context, constant comparative method), credibility and confirmability (as parallel to internal validity and objectivity; see Morrow, 2005) were further enhanced through interactions with other researchers during the coding process. The first author had weekly meetings with the second author, and two meetings were held with the entire research team. At these meetings, client transcripts, tables of meaning units, and the coded categories were presented and the reasonableness of the coding process and findings were discussed. During the weekly meetings and team meetings, the other researchers assumed a critical stance to challenge the first author's assumptions, and discussions often occurred that led to recoding and reorganization of the data. In addition to these meetings, the third researcher completed a parallel coding of all the responses to the open-ended process note. This third researcher and the first author examined differences in codes. Disagreements were resolved via discussion. There was substantial overlap of the

higher-order categories, leading to near-identical highest-order categories and the overall structure of meaning. These differences were then further explored with the third researcher before final consensus was achieved. This process of systematically discussing disagreements was used to maintain sensitivity to the data while maximizing objectivity (Strauss & Corbin, 1990).

Results

A total of 884 recording units were identified and grouped into first-level categories within each question. The second through fourth levels of the hierarchy were increasingly more general categories, still within each question. Categories at the highest level were further examined for similarities and organized into meaningful clusters, similar to the format of Levitt, Butler, and Hill (2006). This final level of categorization was performed across questions, and categories were found to be highly redundant at this level. Final clusters were—(a) Clients' initial misgivings about psychotherapy; (b) Organization and meaning-making; (c) Psychotherapist supportive activities; and (d) Client appreciation of techniques. Table 1 provides examples of recording units within each cluster. Overall, clients focused on the concrete activities and tasks of psychotherapy. Clients particularly emphasized the task of communicating with their psychotherapists, and how their communication was helped or hindered by the psychotherapist. Furthermore, clients frequently identified an aspect of communication when asked to describe difficulties in their sessions. The importance attributed to communication, in general, provided a framework for organizing the emergent meaning in the present analysis.

Per convention of reporting results of qualitative research (Levitt et al., 2006), quotes were included in order to illustrate categories and clusters. All identifying information was deleted to protect participants' confidentiality (see American Psychological Association, 2010; Samstag, 2012).

Cluster 1: Clients' Initial Misgivings About Psychotherapy

This cluster captured the difficulty many clients had in actively participating in psychotherapy because they harbored concerns and misgivings early in psychotherapy. Categories making up this cluster included (a) difficulty talking, (b) concern about psychotherapist, (c) going to psychotherapy, (d) apprehension due to novelty of situation, (e) revisiting past events, (f) just being there says something negative about client, (g) crying. Clients' initial apprehensions were often based on not knowing what to expect and not knowing what might be expected of them, possibly suggesting that their psychotherapists did not orient their clients to this novel experience.

The following example demonstrates the clients' lack of understanding of the therapeutic process. The client had no prior psychotherapy experience, and his response exhibited both apprehension and passivity:

> I fear he will ask me about deeper issues than in today's session. I fear that he is a doctor and not a friend. I don't want to be categorized but I want to be understood. I was happy with his restatements about my responses because it made me believe he understood what I said. I am not quite sure where we are going however. I think that one thing he made me realize was that I actually am too busy. I used to believe it was okay, but it really is a problem. I was happy when I left because I got through one session and I am a step closer to answers but I cried a little with confusion.

This client reported discomfort and distrust ("I fear that he is a doctor and not a friend"), and through this, the client also expressed feeling understood ("I was happy with his restatements about my responses because it made me believe he understood what I said") and even gained new insight ("I think that one thing he made me realize was that I actually am too busy"). The client also reported a lack of comprehension around the process of psychotherapy ("I am not quite sure where we are going however"), which led to confusion and lack of direction. This client also appeared to have a perception of being a passive recipient of psychotherapy ("He made me realize . . . ").

The following client, having had prior psychotherapy experience, had a markedly different experience and illustrated well the importance of clients' orientation to psychotherapy:

> I knew how my previous sessions were with my other therapist, so I knew the format could not be much different. The first meeting was for me to talk to the therapist about what is troubling me. I felt like I had so much to say. It is extremely difficult for me to express my feelings in words. I was a little apprehensive about coming.

This client was aware of the initial task of self-disclosure (" . . . the first meeting was for me to talk to the therapist about what is troubling me"), due to his previous experience in psychotherapy. This client's apprehension was reportedly related to the ability to perform the task ("It is extremely difficult for me to express my feelings in words."). The client went on to suggest that this initial apprehension was overcome through the psychotherapist's ability to understand the client's feelings, and that this process led the client to feel hopeful about psychotherapy and to anticipate the next session. However, the client simply acquiesced to the format decided upon by others ("The first meeting was for me to talk . . ."). Much like the previous example, the client seemed to sense that what happened in psychotherapy was already decided upon, and not a process of collaboration.

In the following example, the client transitioned from being fearful that the psychotherapist would be judgmental to sensing the utility of opening up in a safe environment:

> I was very nervous about coming to therapy today . . . . I was nervous that I would be facing someone judgmental who would think like a parent. I was very pleased with the way the session turned out. I was a little awkward at the beginning of the session but by the end I found it was very easy to open up . . . . I felt it was a safe place to express my feelings and it felt good to actually be heard and validated . . . . I think that beginning to open up and express myself in this safe environment will be really helpful.

Despite the client's trepidations, the psychotherapist assisted the client in feeling moderately comfortable, which in turn facilitated in-session activities and helped the client feel the session was useful. This client's perception of psychotherapy appeared to have evolved through this experience. Furthermore, the client described a process of having shifted from being passive and frightened to becoming more expressive and actively involved within psychotherapy sessions.

Table 1
Response Examples by Category and Cluster

Category	Response example
Cluster 1: Clients' initial misgivings about psychotherapy	
(a) difficulty talking	(The most difficult aspect of today's session was:) really opening up and not being able to fully express myself yet.
(b) concern about psychotherapist	(I wish my therapist would have:) had more time to listen and prompted me more and I don't know where to start.
(c) going to psychotherapy	Going into the session I was a nervous wreck. I actually tried to talk my boyfriend out of going in. I didn't want to get analyzed and have my therapist pick things out that were bad about me . . . .
(d) apprehension due to novelty of situation	It did feel good to talk about things that have been swirling in my head, but I didn't feel I came up with any answers or even any questions. I think I might need more of a structure, more prodding and more challenging of my answers because I may not be being honest with myself all of the time.
(e) revisiting past events	(The most difficult aspect of today's session was:) recounting a lifetime history of unpleasant/shameful situations.
(f) just being there says something negative about client	I can't help but feel that to admit that I need help means that I have utterly failed . . .
(g) crying	(The most difficult aspect of today's session was:) I cried more than I wanted.
Cluster 2: Organization and meaning-making	
(a) psychotherapist responding to make clarifications	(My therapist communicated a sense of respect for me by:) making sure that we were communicating well and establishing rooms of discussion for our sessions.
(b) psychotherapist asking for clarifications	. . . At first I did not have much to talk about and I felt bad because I thought that I was wasting time but with a few questions from my counselor I ended up talking for the whole session.
(c) giving client understanding	(During today's session, I felt understood by my therapist when:) he clarified some of the things that I was having trouble saying.
(d) psychotherapist clarifying client	(During today's session, I felt understood by my therapist when:) he helped me see the way that I think about myself.
(e) psychotherapist reiterating	. . . It felt very easy talking to my therapist because he gave a sense that he was understanding my feelings. . . .
Cluster 3: Psychotherapist supportive activities	
(a) psychotherapist reassuring the client	(Some things my therapist said or did today that I feel good about or feel were helpful were:) I do have opinions! He convinced me of this.
(b) psychotherapist empowering the client	(Some things my therapist said or did today that I feel good about or feel were helpful were:) identifying my own resources—thinking skills that can or cannot help my problem.
(c) psychotherapist normalizing client's situation	(Some things my therapist said or did today that I feel good about or feel were helpful were:) she told me it was common and that she would help me get better.
(d) psychotherapist being calm when the client was not	I was nervous until I got into the office because I didn't know exactly what to expect. The therapist was relaxed, the office was nice. I relaxed.
(e) psychotherapist instilling hope	(Some things my therapist said or did today that I feel good about or feel were helpful were:) Pointed out how (specific behavior) may be hurting me. Gave overall sense that I can eventually overcome this.
(f) psychotherapist offering praise	(Some things my therapist said or did today that I feel good about or feel were helpful were:) "It took courage" to seek help.
Cluster 4: Client appreciation of techniques	
(a) promising to help or helping	(I felt hopeful when my therapist:) talked about how she was seeing not only the different issues, but a variety of ways to begin working through them.
(b) exercises, homework, and other concrete tools	(I felt hopeful when my therapist:) gave me things to work on outside of therapy.
(c) psychotherapist offering suggestions	(I felt hopeful when my therapist:) gave me suggestions on what to do that might help.
(d) specifically discussed goals	(I felt hopeful when my therapist:) talked about goals.
(e) psycho-education	(I felt hopeful when my therapist:) explained more about inner dialogue.
(f) offering assessment	(I felt hopeful when my therapist:) said I could try to be tested for learning disabilities.
(g) client sense of progress	(Some things my therapist said or did today that I feel good about or feel were helpful were:) I feel we made progress, less talking about relationship and more about my problems as a person.
(h) showing client options	(Some things my therapist said or did today that I feel good about or feel were helpful were:) suggesting ways in which I might approach my (relative) to try and resolve issues.

Some participants complained about a lack of structure and direction from the psychotherapist. In one case, the client responded that the psychotherapist simply agreed with the client about the issues underlying the problems but provided no direction for further exploration. Similarly, another client complained that the psychotherapist did not facilitate self-examination, and that the psychotherapist did not respond " . . . directly to what I was saying." Others said the psychotherapist did not respond much or

seemed apathetic. For instance, one client said that the psychotherapist had done little more than nod and therefore "felt [the psychotherapist] wasn't interested."

For some clients, their psychotherapists' questions conveyed an understanding of what the client had said and helped the client to engage in further self-expression. Other clients reported feeling confused about their psychotherapists' communications. One client indicated that the psychotherapist guided the discussion toward a topic the client perceived as tangential. Following session two, this same client again reported confusion because the client did not understand "how therapy is supposed to work or what roads you take so it will be helpful." Another client, following session one, felt confused by the questions the psychotherapist repeatedly asked of him. Following session two, the same client remained confused when the psychotherapist asked the same questions to "dig deeper." The client's negative reaction seemed to be due to a lack of orienting efforts by the psychotherapist.

In summary, clients generally did not view themselves as collaborating in the process of psychotherapy with their psychotherapists. Early in psychotherapy, clients seldom saw themselves as sharing responsibility with their psychotherapists in a collaborative effort toward agreement about goals and how to reach them. This may result because of clients' concerns and misgivings about psychotherapy. Apparently, some clients felt frustrated when negotiating roles, goals, and tasks of psychotherapy. Furthermore, the links between tasks and goals on the one hand, and the development of a therapeutic bond on the other, are highlighted in the above examples. In at least some situations, the bond seemed to develop alongside the goal/task agreement.

Cluster 2: Organization and Meaning-Making

The organization and meaning-making cluster consisted of psychotherapist activities: (a) psychotherapist responding to make clarifications; (b) psychotherapist asking for clarifications; (c) giving client understanding; (d) psychotherapist clarifying client; and (e) psychotherapist reiterating. Although clients emphasized the role of organization and meaning-making early in psychotherapy, some reported difficulties in this area. These difficulties are illustrated in the following examples:

> (. . .) I think I might need more structure, prodding and challenging of my answers. I may not be being completely honest all of the time during the session.

When having trouble communicating clearly, one client was left feeling overwhelmed:

> The first session was hopefully the most uncomfortable one because I have a hard time venting or expressing my feelings to people I don't know yet. (My psychotherapist) did make me feel welcome to say anything, but at times I felt stuck and as if a lot of loose ends were scattered throughout the session. It's a bit overwhelming to come in and talk about my situation because most of my problems have been going on for a long time . . . .

This client was looking for help in expressing her story. Clients often suggested that they were unable to express themselves well and had trouble articulating their thoughts and feelings. When psychotherapists were attuned to these difficulties and could assist the client, some relief was experienced.

Psychotherapists' activities that might have been construed as clarifying were not always welcomed, however. Clients' responses included concerns about their psychotherapists probing beyond clients' comfort level or asking specific questions about client's psychotherapy goals when the client was still unclear about what to work on.

> I want to run out when he begins to overload me with questions about why do you . . . I DON′T KNOW WHY! I just know that I want to be analyzed, more variety will be necessary though. I feel like we talk about too general issues. I need to know why things in the past happened. Specific things. I feel nervous the whole time I am in there, I feel like he is collecting data for his own personal research. I do feel like he opens my eyes though . . . .

In addition to concerns about the psychotherapists' questioning, clients also focused on the psychotherapists' level of involvement in the clients' experiences (text in parenthesis is the question stem from the workbook):

> (I wish my therapist would have:) learned/asked a little more about my life to get a better understanding of where I am coming from and who I am.

To conclude, clients in the initial sessions of psychotherapy appeared to use the process of communication to further their understanding of themselves. Structuring and meaning-making seemed to be very important to clients, and impediments to these processes may produce discomfort for clients. Moreover, clients perceived that psychotherapists play an integral role in the client's self-expression. Generally, clients inferred that their psychotherapists' involvement helped provide organization and meaning to their stories. These activities, during the first two sessions of therapy, can be seen as foundational to developing goal consensus.

Cluster 3: Psychotherapist Supportive Activities

Supportive activities performed by the psychotherapist included (a) psychotherapist reassuring the client; (b) psychotherapist empowering the client; (c) psychotherapist normalizing client's situation; (d) psychotherapist being calm when the client was not; (e) psychotherapist instilling hope; (f) psychotherapist offering praise; and (g) psychotherapist being sympathetic. Examples of the importance of the clients' feeling comfortable, safe, and supported by the psychotherapist can be seen in excerpts from the following clients:

> Client example A: I have been to see a few counselors in the past, but this was the first time I truly felt comfortable talking to the other person. That really makes me feel good about personal progress thus far and it reassures me that (my psychotherapist) and I will be able to establish a relationship in which I can work through my feelings. Her reassurance that I've been doing the right steps to this point reminded me that I am in control of what I do and that I am capable of getting through this. I'm extremely optimistic about the rest of my sessions, whether I use all 13 or not.

> Client example B: Today went very well again. (My psychotherapist) is a great therapist. I really feel respected and accepted in his company. Today we talked about my progress with (eating disorder) and how the things we discussed last session have helped me advance in my struggle—I feel more in control of the situation than I ever have before. This time too, we also brought up my anxiety. He was understanding and helpful here too. I always feel better when I talk out

> loud about it. It helps me listen to myself and it relieves the pressure of it all. Today was successful. Thank you (psychotherapist)!

Clients responded to these supportive activities by reportedly feeling optimistic, in control, safe, and respected. As noted in the first cluster, some clients were concerned about the psychotherapy process. Nevertheless, these initial worries were overcome through psychotherapists' reassurance, understanding, and support. One client, who initially had misgivings about psychotherapy, found it helpful when the psychotherapist praised the client's courage for seeking treatment.

In total, several supportive actions were suggested focusing on the psychotherapist's use of emotional support, hope, and empathy. Clients perceived that these supportive activities attenuated their concerns and misgivings about psychotherapy. Not only did supportive activities seem to alleviate clients' initial concerns, but they also laid the foundation for further therapeutic work.

Cluster 4: Client Appreciation of Techniques

Specific techniques and help offered to clients included (a) promising to help or helping; (b) exercises, homework, and other concrete tools; (c) promise of ways to work on problems; (d) psychotherapist offering suggestions; (e) specifically discussed goals; (f) psychoeducation; (g) offering assessment; (h) clarifying for client; (i) client sense of progress; (j) showing client options; and (k) providing constructive feedback. These concrete activities were important to clients, in part because they indicated to the client that something was being done to help them with their problems. The following client excerpts illustrate this cluster.

> Client example C: Today's session was helpful. I was pleased to be able to tell (my psychotherapist) that I feel better. His methods have helped me and I employ them regularly. I am still fighting the sour feelings of my break up, but noticed that instead of focusing on that, I wanted to focus on me which is a sign to me that I am on the right track. I am looking forward to my next visit.

Client example D: . . . My session went extremely well. I was given sound advice and felt like I could tell her anything. She made me realize I'm creating this problem in my head and also doing so by continuing to have such a pessimistic attitude . . . . I think these sessions will help me realize a lot about myself and my character.

Clients reported feeling hopeful, feeling good about the session, and feeling helped by the psychotherapist when they could put a finger on something concrete or useful they had received from the psychotherapist. These concrete indicators of help and change (e.g., psychoeducation, suggestions and advice from the psychotherapist, assessments, homework, new perspective on a problem) allowed clients to perceive psychotherapy as a useful and productive activity early in therapy. These activities, in addition to their direct utility, also appeared to play an important role in the developing relationship between client and psychotherapist. Similar to Bordin's (1979) discussion of agreement on tasks, these were therapeutic activities the client could agree upon, either explicitly or implicitly, and appeared to lead to an improvement in the bond.

In summary, clients made use of therapeutic tasks, which they saw as connected to their goals. These techniques seemed to buttress the client's belief that the psychotherapist met their needs and will continue to be useful to them. These techniques also appeared to facilitate the development of the therapeutic relationship.

Discussion

Client participants were provided with theory-driven questions about the alliance in order to "scaffold" their open-ended responses. Clients' responses were then organized into four main clusters: (a) clients' initial misgivings about psychotherapy; (b) organization and meaning-making; (c) psychotherapist supportive activities; and (d) client appreciation of techniques. These clusters were in many ways consistent with existing literature that used different methods. For instance, cluster three (psychotherapist supportive activities) of the present study was comparable with Bachelor's (1995) largest category, nurturant alliance. Evidently, clients recognize and appreciate when psychotherapists are respectful, attentive, empathic, and understanding. Our results extend previous qualitative findings in that these supportive behaviors seem to alleviate clients' initial misgivings about psychotherapy (cluster one). Given that many clients enter therapy with misgivings and concerns, it may be especially important that psychotherapists use supportive gestures in the initial sessions to guide the client through these difficulties.

Cluster four (client appreciation of techniques) in the current study was comparable with Bedi and colleagues' (2005) most frequent category, technical activity, lending further evidence that clients react in a positive way to the psychotherapists' use of techniques (e.g., exercises, psychoeducation, homework). Moreover, mirroring the finding by Bedi and colleagues (2005), clients seemed to view these techniques as directly contributing to alliance development, including the bond component. A number of other researchers have highlighted this relationship between technique and alliance (Ilardi & Craighead, 1994; Tang & Derubeis, 1999; Hatcher & Barends, 2006), and our results buttress Norcross's (2002) assertion that virtually all techniques have a relational impact.

Clients seemed to focus on the process of communication in their initial sessions. Communication between client and psychotherapist was a theme in clusters one, two, and three. Cluster one (clients' initial misgivings about psychotherapy) centered mostly on the difficulties clients experienced when attempting to communicate early in therapy, while clusters two and three pertained to how well the psychotherapist helped the client to communicate. Increased communication between client and psychotherapist appeared to facilitate the process of psychotherapy: they were then able to develop goals, work together on the tasks, and cultivate a relationship that was both necessary for the activity to take place and sprang from that activity. As consistent with findings from the alliance literature (Ackerman & Hilsenroth, 2003; Pinto et al., 2012), effective communication between client and psychotherapist seemed to be critical and instrumental in the establishment of the alliance.

Although clients in this study reported active engagement in session (e.g., communicating even when it was difficult or painful), they seemed to view the psychotherapist as primarily responsible for the process of psychotherapy. That is, clients in the current research appeared to have little awareness of their own contributions to alliance development. This seems discordant with the collaborative factors emphasized in alliance theory (e.g., see Horvath & Bedi, 2002). Bedi and colleagues (2005) suggest that clients are in a preoccupied or vulnerable state when first seeking psychotherapy and therefore do not consider themselves as active contributors toward building a therapeutic relationship and instead assign that responsibility to their psychotherapists.

It should be noted that just because clients do not recognize their contributions to the therapeutic relationship does not mean that they play no part in its development. In other words, clients may be active participants in the alliance process and yet may be unaware of these important contributions. Safran and Muran (2000) described how many aspects of alliance communication are expressions of the client's internal awareness that are often subtle enough to escape detection by both the psychotherapist and client. This study suggests that indeed clients may be participating in the alliance process well before they are capable of verbally discussing it. Even when clients were directly asked, through numerous open-ended prompts, about the alliance and its theoretical components, they did not discuss the alliance in a similar manner as psychotherapists and researchers. According to the clients in this study, it is through the work of therapy that the alliance is developed, and clients engage in this work, even when difficult. Further qualitative research in this area should more thoroughly assess clients' perceptions about their contributions to alliance development (see Fitzpatrick et al., 2009).

This study has several limitations related to the homogeneity of our sample and the use of archival data. Because all participants were college students, this sample may not represent psychotherapy clients as a whole and participants' responses may be idiosyncratic to college students. In addition, most participants identified as female and Caucasian, and caution should be taken when heuristically applying this research to other populations. Of note, relative to the large number of clients who used the counseling center, a very small percentage of clients agreed to participate in the original study (Holmberg, 2003). However, the total WAI score of the present sample (session one WAI total = 208.15) did not differ substantially from scores reported in the literature (Horvath & Greenberg, 1989; WAI total = 205.5).

Because we used archival data collected more than 12 years ago, we were unable to seek feedback from participants about the emergent coding, a useful procedure that would add to the trustworthiness of the findings (Bedi, 2006). Expanding the data collection to include responses from the psychotherapists could have added to the findings of this study, potentially allowing us to explore not only differences in experience, but also how each party assumes responsibility in the development of the therapeutic relationship. Also, due to the use of archival data, it was not possible to fully describe the samples of clients and therapists (e.g., the race of non-Caucasian participants, the demographics of the specific psychotherapists who saw clients included in the present study) or to include the internal consistency estimates of the OQ-45 and WAI. Future research should examine links between standardized alliance measures and client qualitative descriptions of alliance such as the ones gathered through our workbooks. Such an examination might look at contribution to the alliance of different types of alliances based on client report.

As none of the research questions directly asked about the clients' feelings for their psychotherapists, the exploration of the bond component of the alliance was limited. Similarly, some of the questions about the tasks and goals of therapy were not included in the current analyses because they were closed ended and did not elicit meaningful information. The remaining questions were informative and could be incorporated into client monitoring programs (see Lambert, 2007) to enhance psychotherapy outcomes. A final limitation is that because clients knew their psychotherapists had access to their responses, some clients may have been less honest and candid in their responses.

Conclusion

Clients may be unaware of the role they play in alliance development, although this does not necessarily negate their contributions to its development. Indeed, clients' efforts to communicate their troubles early in therapy, along with the psychotherapists' assistance in this task, may often be the foundation for alliance development. As such, these early interactions are critical for the process of psychotherapy and warrant further empirical study. Such research might explore clients' interpretation of psychotherapists' helping activities as they develop across several sessions of psychotherapy. This would more firmly establish the importance of the clients' interpretations of psychotherapist activities, as well as their own contributions to the process of psychotherapy and the therapeutic relationship. Future qualitative research should explore clients' perceptions of the therapeutic bond, broader types of the alliance as suggested by Horvath (2006), and the possibility of a bond taxonomy as suggested by Hatcher and Barends (2006). It might also be fruitful to investigate a taxonomy of tasks (Bordin, 1994) and the process of reaching task and goal consensus. However, such taxonomies should be flexible enough to capture the experience of the alliance as implied by these findings, and not be based on the overly literal interpretation of Bordin's model that has been so predominant in the literature (Hatcher & Barends, 2006). These empirical efforts will likely cast new light on the structure of the alliance.

The present study provides evidence that communication, supportive behaviors, and technical activities facilitate alliance development. Moreover, the present study underscores the importance of studying clients' perceptions of the alliance, which evidently diverge from researchers' and psychotherapists' perceptions of the alliance.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1–33. http://dx.doi.org/10.1016/S0272-7358(02)00146-0

American Psychological Association. (2010). *American Psychological Association ethical principles of psychologists and code of conduct*. Retrieved from http://www.apa.org/ethics/code/principles.pdf

Andrusyna, T. P., Tang, T. Z., DeRubeis, R. J., & Luborsky, L. (2001). The factor structure of the working alliance inventory in cognitive-behavioral therapy. *Journal of Psychotherapy Practice and Research, 10,* 173–178.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance. *Journal of Counseling Psychology, 42,* 323–337. http://dx.doi.org/10.1037/0022-0167.42.3.323

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75,* 842–852. http://dx.doi.org/10.1037/0022-006X.75.6.842

Beck, M., Friedlander, M. L., & Escudero, V. (2006). Three perspectives on clients' experiences of the therapeutic alliance: A discovery-oriented investigation. *Journal of Marital and Family Therapy, 32,* 355–368. http://dx.doi.org/10.1111/j.1752-0606.2006.tb01612.x

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology, 53,* 26–35. http://dx.doi.org/10.1037/0022-0167.53.1.26

Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical incidents in the formation of the therapeutic alliance from the client's perspective. *Psychotherapy: Theory, Research, Practice, Training, 42,* 311–323. http://dx.doi.org/10.1037/0033-3204.42.3.311

Bedi, R., & Duff, C. (2009). Prevalence of counseling alliance type preferences across two samples. *Canadian Journal of Counselling, 43,* 151–164.

Bedi, R., & Duff, C. (2014). Client as expert: A Delphi poll of clients' subjective experience of therapeutic alliance formation variables. *Counselling Psychology Quarterly, 27,* 1–18. http://dx.doi.org/10.1080/09515070.2013.857295

Bedi, R. P., & Richards, M. (2011). What a man wants: The male perspective on therapeutic alliance formation. *Psychotherapy: Theory, Research, & Practice, 48,* 381–390. http://dx.doi.org/10.1037/a0022424

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice, 16,* 252–260. http://dx.doi.org/10.1037/h0085885

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 13–37). New York, NY: Wiley.

Cecero, J. J., Fenton, L. R., Frankforter, T. L., Nich, C., & Carroll, K. M. (2001). Focus on therapeutic alliance: The psychometric properties of six measures across three instruments. *Psychotherapy: Theory, Research, Practice, Training, 38,* 1–11. http://dx.doi.org/10.1037/0033-3204.38.1.1

Duff, C. T., & Bedi, R. P. (2010). Counsellor behaviors that predict therapeutic alliance: From the client's perspective. *Counselling Psychology Quarterly, 23,* 91–110. http://dx.doi.org/10.1080/09515071003688165

Fitzpatrick, M. R., Janzen, J., Chamodraka, M., Gamberg, S., & Blake, E. (2009). Client relationship incidents in early therapy: Doorways to collaborative engagement. *Psychotherapy Research, 19,* 654–665. http://dx.doi.org/10.1080/10503300902878235

Fitzpatrick, M., Janzen, J., Chamodraka, M., & Park, J. (2006). Client critical incidents in the process of early alliance development: A positive emotion–exploration spiral. *Psychotherapy Research, 16,* 486–498. http://dx.doi.org/10.1080/10503300500485391

Gelso, C., & Carter, J. (1985). The relationship in counseling and psychotherapy: Components, consequences and theoretical antecedents. *The Counseling Psychologist, 13,* 155–243. http://dx.doi.org/10.1177/0011000085132001

Glaser, B. G., & Strauss, A. (1967). *The Discovery of Grounded Theory*. New York: Aldine de Gruyter.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance of psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64,* 1326–1336. http://dx.doi.org/10.1037/0022-006X.64.6.1326

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy, 43,* 292–299. http://dx.doi.org/10.1037/0033-3204.43.3.292

Hatcher, R. L., Barends, A., Hansell, J., & Gutfreund, M. J. (1995). Patients' and therapists' shared and unique views of the therapeutic alliance: An investigation using confirmatory factor analysis in a nested design. *Journal of Consulting and Clinical Psychology, 63,* 636–643. http://dx.doi.org/10.1037/0022-006X.63.4.636

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16,* 12–25. http://dx.doi.org/10.1080/10503300500352500

Holmberg, J. K. (2003). *Development and evaluation of an alliance workbook*. (Unpublished doctoral dissertation). OH University, Athens, OH.

Horvath, A. O. (2006). The alliance in context: Accomplishments, challenges, and future directions. *Psychotherapy: Theory, Research, Practice, Training, 43,* 258–263. http://dx.doi.org/10.1037/0033-3204.43.3.258

Horvath, A. O., & Bedi, R. P. (2002). The therapeutic alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist relational contributions to effective psychotherapy*. New York, NY: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223–233. http://dx.doi.org/10.1037/0022-0167.36.2.223

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15,* 1277–1288. http://dx.doi.org/10.1177/1049732305276687

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive–behavior therapy for depression. *Clinical Psychology: Science and Practice, 1,* 138–156. http://dx.doi.org/10.1111/j.1468-2850.1994.tb00016.x

Kirsh, B., & Tate, E. (2006). Developing a comprehensive understanding of the working alliance in community mental health. *Qualitative Health Research, 16,* 1054–1074. http://dx.doi.org/10.1177/1049732306292100

Krippendorff, K. (1989). Content analysis. In E. Barnouw, G. Gerbner, W. Schramm, T. L. Worth, & L. Gross (Eds.), *International encyclopedia of communication*. New York, NY: Oxford University Press.

Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research, 17,* 1–14. http://dx.doi.org/10.1080/10503300601032506

Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., . . . Reisinger, C. W. (1996). *Administration and scoring manual for the Outcome Questionnaire (OQ45.2)*. Wilmington, DE: American Professional Credentialing Services.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology, 53,* 314–324. http://dx.doi.org/10.1037/0022-0167.53.3.314

Mohr, J. J., & Woodhouse, S. S. (2001). Looking inside the therapeutic alliance: Assessing clients' visions of helpful and harmful psychotherapy. *Psychotherapy Bulletin, 36,* 15–16.

Morrow, S. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250–260. http://dx.doi.org/10.1037/0022-0167.52.2.250

Norcross, J. C. (Ed.), (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York, NY: Oxford University Press.

Pinto, R. Z., Ferreira, M. L., Oliveira, V. C., Franco, M. R., Adams, R., Maher, C. G., & Ferreira, P. H. (2012). Patient-centred communication is associated with positive therapeutic alliance: A systematic review. *Journal of Physiotherapy, 58,* 77–87. http://dx.doi.org/10.1016/S1836-9553(12)70087-5

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52,* 126–136. http://dx.doi.org/10.1037/0022-0167.52.2.126

Rennie, D. L. (2002). Experiencing psychotherapy: Grounded theory studies. In D. J., Cain (Ed.), *Humanistic psychotherapies: Handbook of research and practice.*Washington, DC: American Psychological Association.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Samstag, L. (2012). Introduction to the special section on ethical issues in clinical writing. *Psychotherapy, 49,* 1–2. http://dx.doi.org/10.1037/a0027037

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13,* 593–618. http://dx.doi.org/10.1016/0272-7358(93)90048-Q

Stiles, W. B. (2009). When is a case study scientific research? *PCSP: Pragmatic Case Studies in Psychotherapy, 5,* 6–11.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.

Tang, T. Z., & DeRubeis, R. J. (1999). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology, 67,* 894–904. http://dx.doi.org/10.1037/0022-006X.67.6.894

Tracey, T. J., & Kokotovic, A. M. (1989). Factors structure of the working alliance inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1,* 207–210. http://dx.doi.org/10.1037/1040-3590.1.3.207

Weber, R. P. (1990). *Basic Content Analysis*. Newbury Park, CA: Sage Publications.

Appendix

Questionnaire

Section 1: Session Goals

1. The problem I most want to work on in therapy is: (e.g., I feel depressed):
2. How much was I bothered by this problem in the last week? (circle one):

Not at all, Slightly, Moderately, Severely, Very Severely

3. What are some *possible* ways other people or circumstances are contributing to this problem?
4. What are some *possible* ways that I am contributing to the problem?
5. What can I do to change this problem right now?
6. Do you feel like you and your therapist have reached an agreement about which problems you should address in treatment? (Please circle yes or no)

Section 2: Session Reactions (Part A)

1. The most difficult aspect of today's session was:
2. My therapist made this easier for me by:
3. My therapist made this more difficult for me by:
4. Some things my therapist said or did today that I feel good about or feel were helpful were:
5. Some things my therapist said or did today that I feel were unhelpful were:
6. I wish my therapist would have:
7. Next session, I might like to focus more on:

Section 3: Session Reactions (Part B)

1. During today's session, I felt understood by my therapist when:
2. During today's session, I felt misunderstood by my therapist when:
3. I felt hopeful when my therapist:
4. My feelings were little hurt when my therapist:
5. I felt relieved when:
6. I felt frustrated when my therapist:
7. I felt confused when my therapist:
8. I felt somewhat criticized when my therapist:
9. During today's session I felt cared for and supported when my therapist:
10. My therapist communicated a sense of respect for me by:

Section 4: Process/Progress Note

Instructions: Your task is to write about your very deepest thoughts and feelings about coming to therapy today and what this experience was like for you. In your writing, try to let yourself go and write continuously about your emotions and thoughts about your session, including feelings you had within the presence of your therapist, feelings about what was said and done in your session, and what you are taking from your session today. The primary task is for you to reflect on your most basic thoughts and emotions about your session today.

Received April 15, 2014
Revision received December 8, 2014
Accepted December 14, 2014 ■