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The Efforts of Therapists in the First Session To Establish a Therapeutic Alliance

Gregory H. MacEwan

University of Massachusetts - Amherst, gmacewan@psych.umass.edu

THE EFFORTS OF THERAPISTS IN THE FIRST SESSION

TO ESTABLISH A THERAPEUTIC ALLIANCE

A Thesis Presented

By

GREGORY MACEWAN

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Approved as to style and content by:

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Richard P. Halgin, Chair

_____

Michael J. Constantino, Member

_____

Matthew L. Ouellett, Member

_____

Melinda A. Novak, Department Chair

Department of Psychology

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ABSTRACT

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GREGORY MACEWAN, B.A. UNIVERSITY OF VERMONT

M.S., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor Richard Halgin

Although the therapeutic alliance is known to be a principal therapeutic factor, little attention has focused on therapists' perspectives on the impact of the first session on the development of the therapeutic alliance. The present study is a qualitative exploration of interviews with ten therapists regarding the first session and their efforts to establish a therapeutic alliance with their new clients. The data were analyzed using Clara Hill's *Consensual Qualitative Research* paradigm (CQR). In considering Bordin's (1979) three components of the alliance (tasks, goals, bond), therapists viewed the bond as the most influential contributor to the development of the alliance in the first session. The therapists emphasized being attuned to the client, being honest and open, generating curiosity, gently challenging, and setting the frame and expectations for therapy as important actions to take when working to establish an alliance in the first session. The findings from this study contribute to the literature on the therapeutic alliance, with particular attention to strategies for facilitating alliance development from the outset of therapy.

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CHAPTER I

INTRODUCTION

The ultimate goal of psychotherapy is to help clients address and change the problems that brought them into treatment. For decades researchers and clinicians have engaged in debates about the factors in therapy that facilitate change, with particular attention to the role of the therapist and to the working relationship between the therapist and client (Castonguay, Constantino & Holtforth, 2006). The characteristics and actions of the therapist are essential factors to consider in conducting effective therapy, in light of the fact that these factors facilitate the development and maintenance of a positive relationship with the client (Ackerman & Hilsenroth, 2003) and are central in assisting the client to grow and change. Therapists benefit from being cognizant of their own characteristics, actions, and perceptions, and how these factors affect their ability to establish and maintain a therapeutic relationship with their clients. Moreover, the treatment process begins during the first interactions in the initial session, and therapists should be attuned to the exchanges with their clients the moment treatment commences (Castonguay et al.). The first session is a highly valuable time in therapy, and an area which has not received the necessary empirical and theoretical attention.

The positive relationship between the therapist and client is commonly referred to as the therapeutic alliance. Although the alliance is a principal therapeutic factor, little attention has focused on the therapist's perspective on the impact of early

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interactions on the development of the therapeutic alliance. In this section I will discuss: (1) the historical conceptualizations of the therapeutic alliance; (2) the association between the alliance and outcome; (3) the characteristics of therapists and the techniques they use to foster the therapeutic alliance; (4) the importance of the development of the alliance early in treatment; and (5) the plan for the proposed study.

<div align="center">The History of the Therapeutic Alliance</div>

Interest in the interpersonal aspects of the relationship between the client and the therapist has its roots in early psychoanalytic theory. Nearly a hundred years ago Sigmund Freud (1912) wrote about some characteristics of positive transference that enable the patient to maintain motivation to continue working and collaborating with the analyst. Following Freud's introduction to the dynamics between the therapist and client, other psychotherapists have contributed to the current knowledge of the therapeutic relationship. The therapeutic alliance was a term initially written about by the psychoanalyst, Elizabeth Zetzel (1956), to describe the relationship between an analyst and the healthy part of the patient's ego. She asserted that a "sound therapeutic alliance" is a pre-requisite for effective analysis. Zetzel contended that transferential interpretation, a foundation of psychoanalysis, will only be useful if the interpretations are made at the appropriate time in therapy, at a point in which a positive therapeutic alliance has been established.

Subsequently, Carl Rogers, a prominent humanistic clinician, emphasized the curative ability of the relationship between the therapist and client. Rogers (1957) postulated six essential conditions that need to be present in order for therapeutic

change to occur. The first condition, a relationship between therapist and client, is necessary and *must* be present before any of Rogers's other five conditions can develop. Rogers believed that the other aspects of therapy are important, yet secondary, to the establishment of a relationship. These include: (1) the client is in a state of incongruence; (2) the therapist is integrated into the relationship; (3) the therapist experiences unconditional positive regard and an empathic understanding; and (4) the therapist is able to communicate empathy and understanding to the client. These other 4 aspects of therapy are all characteristics of the relationship between the therapist and client.

Edward Bordin (1979) also believed that the alliance is an essential component to therapy, and in his writings extended the applications of the alliance beyond psychoanalytic theory. Like Rogers, Bordin believed that the alliance is an important agent of change, if not *the* agent of change, and it could be universally applicable to different types of therapy. Bordin presented three elements that he believed to be critical to the development of a positive alliance: an agreement on (1) the *goals* of therapy, (2) the *tasks* of therapy, and (3) the *bond* between therapist and client. According to Bordin, the *goal* component of the alliance relies on a mutual agreement regarding what constitutes the client's stressors, frustrations, and dissatisfactions. The client's problems are, in part, a function of the client's ways of thinking, feeling, and acting. Thus, the aim of therapy is to examine and ameliorate the client's pain. Bordin believed that the way in which the development of the goals is specifically executed in therapy will, inevitably, vary depending upon the therapist and his or her theoretical approach. The *tasks* of therapy are mutually agreed upon means of approaching the

treatment. These include concrete components such as establishing a contract and fee

negotiation as well as the ongoing processes between the client and therapist as they

work together. While the specific tasks assigned to both the client and therapist will

depend upon the type of treatment, according to Bordin, the effectiveness of the tasks

will rely on the therapist's ability to connect the tasks with the client's difficulties. The

bond is the connection between the client and therapist, and represents a level of trust

that must be established between the two participants.

The therapeutic alliance is now widely believed to be a necessary component of

effective treatment across various theories of psychology (Castonguay, 2006;

Constantino, Castonguay, Schut, 2002; Gaston, 1990), and most therapeutic alliance

researchers have adapted a definition of the alliance that encompasses the three

components (tasks, goals, bonds) discussed by Bordin (Horvath, 1991). Furthermore, as

the role of the alliance in therapy has been increasingly discussed as a central factor in

treatment, psychotherapists have increasingly appreciated the impact of the therapeutic

alliance on the process of change in treatment.

<u>The Alliance and Outcome</u>

Several researchers have reported on the association between the therapeutic

alliance and the ability of clients to benefit from treatment. Across various clinical

populations and theoretical orientations the therapeutic alliance has been found to be

strongly related to therapy outcome (Barber, 2000; Castonguay, 2006; Constantino,

2002; Horvath, 2001; Kokotovic & Tracey, 1990; Meier, Barrowclough & Donmall,

2004; Safran & Muan, 2000).

Two meta-analyses (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) reviewed more than three decades of research on the association between alliance and outcome. Adam Horvath and Dianne Symonds (1991) conducted a meta-analysis that examined the quality of the therapeutic alliance and its association to therapy outcome by reviewing 24 studies in which the alliance was studied within the context of individual therapy. Horvath and Symonds determined that there was a moderate but reliable association between good alliance and positive outcome in therapy by finding an effect size of .26. Moreover, they concluded that the association between alliance and outcome was not a function of the type of outcome measure used, the type of therapy, the length of treatment, whether or not the research was published, or the number of participants in the study. They did, however, find small differences in the results when looking at who was reporting on the quality of the therapeutic alliance; the alliance ratings by clients were the strongest predictors of good treatment outcome, followed by the ratings by therapists', and lastly the ratings by observers.

Most clinicians and researchers agree that the therapeutic alliance is a significant contributor to therapy outcome. However, despite reviews of the literature (Horvath & Symonds, 1991) some researchers (eg. Feely, DeRubeis, & Gelfand, 1999) have debated the influence of a third variable, such as client's symptom improvement, in moderating the association between the alliance and outcome. This is an important question to ask as it affects the potential impact and value of the therapeutic alliance. Klein, Schwartz, Santiago, Vivian, and colleagues (2003) specifically addressed this concern as they examined the role of the therapeutic alliance in CBT for depression. These authors found that the early alliance significantly predicted subsequent change in

depressive symptoms even after controlling for other variables such as prior and current levels of depressive symptoms, gender, chronicity, and comorbid psychological disorders.

Martin, Garske, and Davis (2000) conducted a meta-analysis that incorporated previous alliance research and more recent findings on the association between the therapeutic alliance and outcome in psychotherapy. After examining 79 studies, they reported that the association between the therapeutic alliance and outcome is moderate (r =. 22). Consistent with the findings of Horvath and Symonds, (1991) Martin and his colleagues found that the relation between alliance and outcome is not moderated by other variables such as the type of outcome measure used, the type of treatment provided, or whether or not the research was published. Martin and his colleagues concluded that, if a good alliance is established between the client and therapist, the client will experience the relationship as therapeutic, regardless of other treatment interventions. Moreover, the strength of the alliance is predictive of outcome.

<u>The Role of the Therapist</u>

Although several researchers have investigated the importance of the alliance in therapy (Bachelor, 1995; Horvath et al., 1991; Safran et al., 2000), Constantino and colleagues (2002) contend that there has been insufficient research focusing on the role of the therapist. Questions remain regarding what therapists actually do in their efforts to establish a therapeutic alliance. Ackerman and Hilsenroth (2003) also believe that attention to the therapist's contributions in the development of the therapeutic alliance is an area of research that has been less developed; they emphasize the significance of

investigating the therapist's personal attributes and technical interventions which affect the development of an alliance. In their reviews of numerous studies on the alliance, Ackerman and Hilsenroth (2001, 2003) reported on therapist characteristics and techniques, across a range of theoretical orientations, which either negatively or positively impact the therapeutic alliance.

In analyzing therapist variables that negatively impact the alliance, Ackerman and Hilsenroth (2001) concurred with the previously held belief that negative characteristics of the therapist can decrease the quality of a previously established alliance with an existing client as well as inhibit the establishment of an alliance with a new client. The personal attributes of therapists that have a negative influence on the alliance include instances in which a therapist is rigid, uncertain, exploitive, critical, distant, tense, aloof, or distracted. Ackerman and Hilsenroth also found that certain therapeutic techniques can have a negative impact on the alliance such as over-structuring the therapy, failing to structure the therapy, inappropriate self-disclosure, managing, unyielding transference interpretation, inappropriate use of silence, belittling, and the use of superficial interventions. The authors found little variation among different theoretical orientations regarding the personal attributes and techniques that negatively impact the alliance.

In their examination of therapists personal attributes and in-session activities that positively influence the alliance, Ackerman and Hilsenroth (2003) also reviewed the research on therapy from a range of theoretical orientations. The personal attributes of therapists that aid in establishing positive therapeutic alliances with their clients

include flexibility, experience, honesty, respect, trustworthiness, confidence, interest, alertness, friendliness, warmth, and openness. The therapeutic techniques that positively contribute to the alliance are exploration, reflection, being supportive, noting past therapy success, providing accurate interpretation, facilitating the expression of affect, active affirming, understanding, and attending to the experience of the client. In this review, as well, Ackerman and Hilsenroth found little variation as the result of theoretical orientations on the personal attributes or techniques of the therapist that positively impact the alliance.

Psychotherapy researchers and clinicians have increasingly recognized the ways in which the use of technique and the therapeutic alliance work together to facilitate change (Goldfried & Davila, 2005). Ackerman and Hilsenroth (2001, 2003) reviewed the association between therapeutic techniques and the therapeutic alliance; other researchers such as Goldfried and Davila (2005) have urged the field to move away from exploring which of these is more important, and consider the alliance and technique as mutual ongoing processes that work together.

In writing about the relationship between therapists' technique and the therapeutic alliance, Clara Hill (2005) categorized therapy into four stages: initial impression, beginning therapy, tasks of therapy, and termination. She addressed the use of technique and the alliance as an ongoing back-and-forth process throughout these four stages. During the initial impression stage, supportive and engaging techniques allow the client to become involved in the therapeutic process, and the therapeutic relationship evolves as a result. During the beginning therapy stage, the establishment

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of an early therapeutic alliance allows for exploratory techniques that can then deepen the client's involvement in the therapeutic process. Hill asserts that as the latter stages of treatment continue to develop, so does the connected and mutually facilitating relationship of technique and alliance.

<div align="center">Early Establishment of the Therapeutic Alliance</div>

The early establishment of a therapeutic alliance is believed to be important for two reasons: the alliance is a particularly good predictor of outcome when established and measured early in treatment (Castonguay et al., 2006; Constantino et al., 2002; Horvath 2001), and poor early alliance has been empirically connected with clients' premature termination of treatment (Constantino, 2002). Luborsky (1976, 2000) discussed the alliance as comprised of two parts that work at different points, specifically earlier in treatment (Type I alliance) and later in treatment (Type II alliance). In establishing of a Type I alliance, Luborsky emphasized therapist's efforts to be helpful, supportive, and effective in instilling hope in the client towards therapeutic change. The early therapy sessions are important in many ways as the client and therapist meet, assess each other, and decide if they can work together. Constantino (2002) addresses the multifaceted aspects of early treatment and highlights that, if a client is not able to feel engaged in the therapy process or feel a developing bond with the therapist, the client is less likely to continue with treatment.

Sexton, Littauer, Sexton, and Tommeras (2005) studied the process of therapy and its influence on the development of the therapeutic alliance early in treatment. They examined the psychotherapy process during the first session, ratings of the

therapeutic alliance, and the connection between the client and therapist. The goal of these researchers was to examine the early session alliance-building processes in efforts to expand upon the previous empirical findings that have shown the association between early alliance and outcome. These researchers had external raters evaluate many aspects of the therapist and client connection during the first session. The therapist aspects that were rated for connection were: emotion (ranging from warm to disapproving); therapist tension (ranging from comfortable to anxious); therapist listening, quality or engagement (focused, not focused); therapist action (interpretation, positive feedback; Socratic questioning, information-advice, information gathering, miscellaneous, silent) and therapist verbal content (primarily emotional, mixed cognitive/emotion, cognitive, silence). Sexton and his colleagues concluded that the initial session appears to be influential in developing a positive alliance, and the depth of the client-therapist connection that was largely established during the first session accounted for more than 20% of the variance in the second session alliance ratings. Specifically, the therapists who demonstrated a mix of cognitive and emotional speech content, who conveyed warmth, and who were seen as more actively listening to their clients had a better overall connection with their clients.

Hilsenroth and Cromer (2007) conducted a research review of the therapeutic alliance during the earliest parts of treatment, in which they looked at therapist interventions and characteristics that have been found to positively influence the alliance during pre-therapy assessment, the initial interview, and the initial session of therapy. According to Hilsenroth and Cromer, the initial assessment and the initial therapy session are opportunities to for the therapists to develop the foundations of the

alliance. The initial assessment meeting and initial session of therapy are also times for the client to experience the empathic and collaborative aspects of therapy while working with the therapist to develop treatment goals and tasks. They contend that the effects of the alliance developed at this point in treatment persist throughout the course of therapy. In reviewing the literature specifically pertaining to the initial therapy session, Hilsenroth and Cromer concluded that therapists who use techniques to convey a sense of trust, appreciation, warmth, and understanding are more likely to establish a stronger alliance with their clients during the initial session. Also, therapists develop stronger alliances if they speak with both emotional and cognitive content, conduct a longer, more involved and in-depth initial session, sustain an active concentration on topics pertinent to treatment, explore the therapeutic process in session, are attuned to the affect of the client while being non-defensive or judgmental, and pinpoint new issues for the client which enable deeper levels of understanding and insight.

Clinical training literature has also focused on the importance of the first session of therapy and the therapeutic relationship. In her seminal book on psychotherapist development, Hilde Bruch (1974) fittingly titled the chapter on the initial session of therapy, "When Strangers Meet." In this chapter she addressed the importance of the first session, stating that it all begins with this initial encounter, and what is experienced during that time may well determine the course of therapy. As has been evident in several decades of research on the early phase of therapy, Bruch addresses the important role of therapist factors in the initial meeting. These factors include open-mindedness, awareness of oneself and one's own reactions and feelings, confidence, a sensitivity and ability to understand the client's needs, and efforts to establish a mutual trust.

Furthermore, she believes that a therapist's capacity to establish an early alliance depends greatly upon his or her ability to relay to the client the emotional experience of having made contact, and to convey a sense that the therapist is a sympathetic and understanding listener. According to Bruch, the formal aspects of therapy, which are requisite in the initial session, are not something to be hurried through during the last few minutes of the meeting. Rather, she suggests scheduling the first meeting longer in order to discuss the practical arrangements such as frequency and length of the sessions and the fee negotiation, all of which are important aspects of the treatment.

Nancy McWilliams (1999) also articulated the importance of the initial meeting and the value of the actions by the therapist during this first encounter when establishing a working relationship with a client. McWilliams discusses her perspective of the prototypical first session as a time in which the therapist tries to learn about the client and allow the client to speak openly while the clinician works to reduce the client's anxiety. By the end of the initial session, McWilliams aims to show her client that she has been listening and has a sense of her client's suffering, has assessed the client's reactions to how McWilliams has initially understood the presenting issues, has relayed a sense of hope, has made a contract regarding the logistical aspects of therapy, and has invited the client to ask questions of the therapist or about the therapeutic process.

The initial phase of therapy, particularly the first session, is a vital time in treatment. The empirical findings and the clinical literature suggest that the actions of the therapist in the initial session have a powerful impact on the establishment of a

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therapeutic alliance and the engagement of new clients in treatment. As Martin (2000) asserts, therapists must be effective at establishing a positive alliance with their clients early in treatment. Research that explores the characteristics and actions of psychotherapists will contribute to an improved understanding of the processes that facilitate the development of therapeutic alliance early in treatment.

The Present Study

In light of the fact that the early establishment of the therapeutic alliance is particularly predictive of outcome (Constantino, 2002, Horvath, 1994), research is needed that studies the first session of therapy and explores the therapist's perspective regarding factors that influence the early establishment of the therapeutic alliance. Sprenkle and Blow (2007) are amazed by the dearth of attention given to therapist variables in psychotherapy research, stating that too frequently researchers regard the skills, personality, and experience of therapists as "side issues". Considering that 30% to 60% of clients prematurely terminate from treatment (Reis, 1999), the early phase of therapy, in particular the initial session, is an important area to study. Furthermore, the therapist and client are meeting for the first time during the initial session and the therapist has yet to develop a working hypothesis of the problems that brought the client into treatment. As a result, the first session of therapy can be especially difficult to negotiate (Feldman, 2002).

Given the high percentage of premature terminations and the number of factors inherent in the first session, the present study explored what therapists do in the first session to establish a therapeutic alliance with their new clients. The study examined

therapist characteristics, perceptions, actions, and how, within the context of the first session, these factors influence the establishment of the therapeutic alliance. In particular, the goals of this study were to address the following questions:

1) What is the perception held by seasoned therapists of the therapeutic alliance?

2) What phenomena in the first session do seasoned therapists regard as the most influential contributors to the establishment of an alliance?

3) What do seasoned therapists do in the first session to facilitate the establishment of a therapeutic alliance?

4) During the first session of psychotherapy, how is the development of a therapeutic alliance influenced by the therapist's characteristics and variables?

5) During the first session of psychotherapy, how are the efforts of the therapist to develop a therapeutic alliance influenced by the therapist's perception of the client factors and presenting problems?

By investigating the work of seasoned therapists we were able to gain a better understanding of influential factors in the natural clinical setting during the first session. A qualitative inquiry following Clara Hill's (1997) paradigm was used to gather data. This topic is best studied via a qualitative approach because of the little empirical attention that has been paid to the alliance in the first session, thus far. This "bottom-up" approach provides rich, detailed reports from seasoned psychotherapists regarding the factors involved in developing the earliest phase of a therapeutic alliance.

The narrative accounts about therapists' efforts in the first session help to generate hypotheses for future research on this topic as well as provides a foundation of data to develop clinical measurements which can assess the alliance-developing variables present in the first session of therapy.

CHAPTER II

METHOD

In this project, interviews were conducted with 10 therapists to gain greater understanding of therapists' views regarding efforts in the first session to begin developing a therapeutic alliance. The therapists were interviewed using a semi-structured format in which they were asked to discuss their attitudes about the importance of focusing on the establishment of the therapeutic alliance in the first session and the actions they take to facilitate this alliance.

A qualitative inquiry following Clara Hill's (1997) Consensual Qualitative Research (CQR) paradigm was used to gather the data in this study. Following the approach articulated in Hill's CQR model, this author: (1) gathered data from a small number of seasoned therapists by means of an interview using open-ended questions; (2) used an approach that relied on words to describe the therapeutic alliance rather than numbers; (3) analyzed the responses of these therapists; (4) relied on the context of the entire interview in an effort to understand the specific parts of the experience; (5) used an inductive process in which conclusions emerged from the data; (6) collaborated with a small team of researchers who analyzed and coded the interview content, arriving at conceptual consensus; (7) relied on an auditor to check the consensus judgments of the coders, who ensured that the primary team did not overlook important data; and (8) incorporated a procedure in which the research team reviewed the raw data to ensure reliability.

<u>Participants</u>

<u>Therapists</u>

Therapists were invited to participate in this study after they were identified as seasoned clinicians and who also have an expressed interest in the therapeutic alliance. The therapists in this study were recruited through a psychotherapy organization and a psychiatric hospital, both in the northeastern part of the United States. The inclusion criterion for therapists in this study was as follows: (1) have a doctorate in psychology, (2) are seasoned clinicians, (3) are clinically active, (4) incorporate psychodynamic theory into their clinical practice, and (5) treat clients for interpersonal issues. A "seasoned" clinician was defined as someone who is a licensed psychologist, and has been practicing psychotherapy between five years and eighteen years since earning their degree. To be considered "clinically active," participants must provide mental health services at least ten hours of direct individual, psychodynamically-informed psychotherapy per week. To meet the criterion pertaining to the "incorporation of psychodynamic theory," clinicians must have received psychodynamic training at the graduate or post-graduate level. Furthermore, they should define their therapeutic approach as either "psychodynamic" or "integrative, but incorporating psychodynamic theory." The definition of interpersonal issues was loosely based on the characterizations of Klerman, Weissman et al. (1984) to include clinical concerns pertaining to: (a) grief, (b) role transition, (c) interpersonal disputes, or (d) interpersonal deficits. Participants were not excluded based on gender, age, or ethnicity. The criterion-based sampling approach permits the recruitment of a fairly homogeneous

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sample (Hill et al. 1997). The therapists did not receive any compensation for their participation in the study. The sample characteristics of the ten therapists interviewed for this study are shown in Table 1.

Interviewer

All the interviews were conducted by the principal investigator, a graduate student who conducted the present study for his Master's thesis.

Judges

A team of graduate and undergraduate research assistants coded the interviews for thematic analysis in accordance with the CQR components previously outlined. An experienced clinician, who is a professor of clinical psychology, supervised the project and a graduate student in clinical psychology served as an auditor during the data analysis process.

Bracketing biases

Each coder recorded his or her expectations and biases at the start of the study in an effort to minimize any influence on the data analysis. According to Hill (1997), *Expectations* are the beliefs that the researchers have which emerge from their previous reading of the literature and their previous experiences with the development of the therapeutic alliance. The researchers in this project recorded their expectations by responding to the interview questions according to what they believed would be the typical response. *Biases* are defined as personal issues that may make it difficult for researchers to objectively examine the data. By recording expectations and biases

before the project commences, the researchers worked to ensure that their interpretations are reflective of the data. The procedure of bracketing biases is used in qualitative research and recommended by several psychotherapy researchers (Hill, 1997; Hayes, McCracken, McClanahan, Hill, Harp & Carozzoni, 1998).

The main themes of the reported biases and expectations of the coders are reported. All coders believed that the therapeutic alliance plays a critical role in the therapeutic process, and that the early establishment of an alliance most likely is a significant contributing factor in the course of successful therapy. Four coders believed that their experiences in therapy (as a therapist and client) is important to maintain an awareness of as they code the interviews; three coders highlighted their belief that starting the first session with empathy and understanding is important for alliance development. Two coders believed that the context/environment will be discussed as an important factor in alliance development; however, one reported that the settings where therapists do not have to handle the logistics (i.e., clinic/hospital) will be easier to establish an alliance while the other coder reported that the private practice setting will be more conducive to alliance development. One coder believed that the therapists would be reluctant to share information about him or herself, in particular when asked about what characteristics about them impede alliance development. All coders were interested in the topic and discussed being open to exploring the data.

Table 1.   Therapist Characteristics   **# Cases**

Age Range			
	30-35		2
	36-40		2
	41-45		5
	46-50		1
Years of post-doctoral Clinical Experience			
	5-8		3
	9-12		5
	13-16		2
Gender			
	Males		4
	Females		6
Location for Clinical Practice			
	Private Practice		5
	Hospital/Clinic		1
	Private Practice + Hospital Clinic		4

Table 1. (continued) Therapist Characteristics   **# Cases & Frequency**

Definition of Theoretical Orientation			
	Integrative		8 (Typical)
		Combination of psychodynamic & behavioral	5 (Variant)
		Predominantly psychodynamic	2 (Variant)
		Combination of psychodynamic & cultural	1*
	Psychodynamic		2 (Variant)

Procedure

Pilot Interviews

During the preparation of the project proposal in August of 2007, two pilot interviews were conducted with experienced therapists who are also members of the clinical faculty at the University of Massachusetts, Amherst. The purpose of the pilot interviews was to gather initial data in order to refine the interview questions, obtain feedback from the participating therapists regarding the structure and content of the interview questions and the interview process, and determine the viability of the proposed project. After completing the pilot interviews and receiving feedback from the pilot-interviewees, the order in which the interview questions were administered was rearranged for greater clarification; two interview questions were deleted because of redundancy and in efforts to ensure a time efficient interview protocol. The data

obtained via the pilot interviews was not included in the analysis of the project; the two interviewees served as consultants in the development of the study.

<u>Interviews</u>

Ten therapists were interviewed about their perceptions of therapists' efforts to establish a therapeutic alliance within the first session. The therapists were asked to discuss their attitudes on issues that relate to the first therapy session and what they do to foster the establishment of a therapeutic alliance with their clients. The semi-structured interview (Appendix A) was a revised version of the interviews used during the pilot interviews, and was conducted in-person; each interview lasted approximately one hour. The therapists had the choice to meet in their own offices or in the Psychological Services Center at the University of Massachusetts, Amherst. Eight therapists chose to meet in their office and two chose to meet in their home. All interviews were audio recorded and transcribed verbatim by a team of research assistants. Directly prior to the interview, therapists were asked to fill out a therapist characteristic sheet (Appendix B), which asks them to provide their age, years of clinical experience, and location(s) of clinical practice (shown in Table 1). All therapists were asked to sign a consent form (Appendix C).

Data Analysis

Stage I: Transcription

The ten interviews in the study were transcribed verbatim in order to analyze each therapist's discussion about their efforts in the first session to establish a therapeutic alliance. Another research assistant reviewed the transcription for any errors, and deleted proper names, places, or other material which could identify the participants in any way.

Stage II: Generating Themes & Determining Domains

Once the interviews were transcribed, two members of the research team independently reviewed each transcript to generate domains that encompass the major themes pertaining to the establishment of the therapeutic alliance in the first session. The research team then discussed the domains and came to an agreement about the number of domains that should be included for each interview. The domains were used to code and categorize the data gathered for each of the 10 interviews. At times, the specific domains changed over the course of the transcription review and coding process as new data emerged (i.e., new domains were created as needed, or two domains were fold into one domain if the research team found that the information was overlapping too much between the two domains). Thus, the final domains differed from

the initial domains because they were based upon the data rather than on theory or the initial interview questions.

Stage III: Coding

After the domains were created, two members of the research team independently read each interview and coded all of the information in the transcript into one of the designated domains according to the domain definition and criteria. Each block of data (ranging from a single phrase to several sentences) from each interview was assigned to a domain which best described the theme of the data. The two team members (for each transcribed interview) independently wrote down the domain title on the transcript next to the pertinent section of information relevant to that domain. Once each member of the research team independently coded all of the data for his or her specific transcript, the two coders reading the same transcript met to come to a consensus as to which domain(s) the coded information should be included. If there were any questions among the two coders they discussed the issues with the entire research team. These last two steps in the coding stage were designed to help the team arrive at a consensus regarding the most appropriate domain for the data.

Stage IV: Constructing Core Ideas

After all of the content from the interviews has been coded into domains, members of the research team independently read the coded data from each domain and developed a few sentences that best described the core ideas that were illustrated for the specific domain for all of the interviews. The work in this stage enabled the research

team, in a style that is clear and concise, to capture the essence of what each interviewee said relevant to the respective domains. In the final phase of Stage IV, an auditor provided an external perspective by reviewing the accuracy of the match between core ideas and the domain to which they had been assigned.

Interpreting the Data

Stage I: Cross Analysis

The research team took the core ideas that described each domain from the ten interviews and examined these core ideas across the ten interviews to determine how they could be grouped into categories. Specifically, in this initial phase of interpretation, instead of looking at the individual interviewee responses separately, the researchers looked at the domains and core idea themes across all of the interviews in order to thematically categorize the data within each domain. The researchers examined the information together as a team to brainstorm about the creation of categories. By doing this, similarities and differences emerged from the interviews which provided various perspective regarding efforts in the first session to establish the therapeutic alliance. After the research team came to a consensus on the categorization of the core ideas, the auditor reviewed the cross analysis to ensure that each core idea fit the designated category. Following the feedback from the auditor, the research team met again to discuss any appropriate changes.

<u>Stage II: Representativeness to the Sample</u>

In order to determine how frequently the categories (defined in the previous stage of data interpretation) appear in this sample of therapists, and to see to what extent generalizations could be made about the therapists interviewed in this study, the following descriptions were used: (1) "general" was used to describe a category that applied to nine or ten of the therapists in this sample; (2) "typical" was used to describe a category that applied to six, seven, or eight of the therapists in this sample; and (3) "variant" will describe a category that applies to a range from two therapists to five of the therapists. If a category is found to apply to only one of the therapists, it was not used to imply representativeness of the sample.

<u>Stage III: Charting the Results and Narrative Write-Up</u>

The interviewees' responses were charted to view the frequencies of the responses. The charted results are shown in Tables 2-5. Brief narratives are also presented to describe the categories and examples of therapists' responses that were provided within each domain.

CHAPTER III

RESULTS

For this project, the Consensual Qualitative Research (Hill et al., 1997; 2005) was used to collect, code, and analyze interview data. A total of 12 domains organized by four overarching research questions were identified. Within each of the 12 domains, categories were created to capture the core ideas from the interviews. In this system, the following characterizations are used for categorizing responses of the ten interviewees in this study: (1) *general* applies to nine or ten interviewees; (2) *typical* applies to six, seven, or eight interviewees; and (3) *variant* applies to two, three, four, or five interviewees. To provide an understanding for the range of responses, all categories are included in the tables; however, categories including only *one* response are not included in the narrative write-up unless specifically noted for the purpose of clarification. Consistent with Hill et al. (1997, 2005) the categories including one response do not have an accompanying adjective to describe the frequency of occurrence, and are thus indicated in the table with an asterisk (*).

Within the text, the title of the category is italicized for readability. One core idea is used as an example of the information therapists provided within each category. In certain domains (e.g., Therapist Actions) multiple responses were recorded from each therapist, and thus therapists' responses could be organized into more than one category within a given domain. For example, a therapist may have reported that there are several things that he or she does (Therapist Actions) in the first session to facilitate the alliance, and each of the responses may be coded into a different category.

How Do Therapists View the Therapeutic Alliance?

Theoretical Orientation

Therapists were first asked to define their theoretical orientation, and their responses fell into two main categories, with *integrative* being the typical theoretical orientation. Eight therapists reported that they use a combination of theoretical approaches depending on the client, situation, and presenting problems. Although these therapists all identified their work as *integrative,* they did not all describe their theoretical approach in the same manner, and thus the category was conceptualized in three subcategories: (1) Half of the integrative therapists stated that they use a *combination of psychodynamic and behavioral theories.* For instance, one therapist stated that she often uses a developmental and psychodynamic understanding of people, but also uses concepts that are cognitive behavioral, particularly mindfulness and the dialectics of DBT. (2) Two therapists stated that they focus on using an integrative approach with *predominantly psychodynamic underpinnings.* One of the therapists in this subcategory stated that her training has been mostly psychodynamic, and stated that she has a dynamic focus with many clients, but integrates behavioral approaches and strategies *when* she feels it is helpful. (3) Lastly, one therapist described herself as *non-traditional* in that she uses a combination of relational, cultural/sociopolitical, and psychodynamic theory.

In two cases, therapists described their work as exclusively *psychodynamic.* Therapists in this category reported using object relations, ego psychology, and self-psychology theories; and describing their approach as taking a less direct path to the

goals of treatment. One therapist stated that it is the "client's reactions" to the therapist and the therapy that are most important (see Table 1).

Definition of the Therapeutic Alliance

Therapists' descriptions of the therapeutic alliance varied, yielding four categories: (1) Three therapists described the alliance as a *relationship* between the therapist and client, with one therapist in this category characterizing the alliance as a "mutual sense between the therapist and client that can be either implicit or explicit." (2) Three therapists defined the alliance as a *collaboration*. In this description, one therapist said that the therapist and client can share, trust, and work together in therapy. (3) Three therapists defined the alliance as a *progressive process*. One therapist commented, "There are different levels to the alliance, in particular, earlier and later in treatment that allow you to do different kinds of work, whereby the therapist creates an environment in which the patient feels validated, genuinely heard, and connected to the therapist." (4) Lastly, one therapist described the alliance as an *openness*, indicating that she feels that she establishes an alliance by allowing the client to feel safe and free to speak (see Table 2).

Association Between Theoretical Orientation & Therapeutic Alliance

All therapists expressed the general view that their theoretical orientation informs their perspective of the therapeutic alliance, and they view the establishment of an alliance as an important aspect early in treatment; however, they varied in their perspectives regarding the best ways for facilitating an alliance. As a result, three

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categories emerged within this domain: (1) Three therapists placed an emphasis on an *active, verbal, overt facilitation* of the alliance, with one therapist stating that she shares her own thoughts and feelings in an effort to facilitate the alliance. (2) By contrast, the second category consisted of four therapists who emphasize *providing space and respect* when establishing an alliance, with one therapist stating, "If they are not in a place to take direct action, behaviorally, then I will spend several sessions offering a space for a person to just feel what they need to feel." (3) Lastly, three therapists acknowledged the importance of the alliance, but did not indicate specifically how their theoretical orientation informs their perspective on the alliance. One therapist in this category reported that her theoretical orientation *encourages a focus on the relationship* between the therapist and client (see Table 2).

Alliance in First Session & Outcome

Therapists were evenly divided in their views regarding their first-session efforts to establish an alliance and clients' outcome in therapy. Five therapists said that there is a relation between first session alliance and outcome; however, these five therapists varied in how strongly they feel about the association: (1) Two therapists believe that there is *likely a relationship*, and stated that addressing the alliance is important for both the therapist and the client to feel safe. One therapist stated that the first session can set the tone for therapy, which *may* affect the outcome and/or duration of treatment. (2) Three other therapists believe that their effort to consciously attend to establishing a strong alliance in the first session is *highly related* to the likelihood of successful treatment.

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In contrast, the second category that emerged within this domain includes therapists who believe that a first-session alliance is *not strongly related* to treatment outcome. These therapists also varied to some degree in their beliefs about the association: (1) Four therapists said that it is *unclear in the first session*, with one stating that she is, "uncertain about whether positive feelings that may be present in the first session are actually an alliance; rather, the alliance takes time to develop through positive and negative exchanges." (2) The second subcategory, *alliance is not necessary*, was generated by the reports of four therapists. One therapist spoke to how she and her clients do not need to have a conflict-free alliance at the end of the first session to have a successful therapy (see Table 2).

Table 2. How Therapists View the Alliance

Domain	Category	Subcategory	# Cases & Frequency
Definition of the Alliance			
	Relationship		3 (Variant)
	Collaboration		3 (Variant)
	Progressive process		3 (Variant)
	An establishment of openness		1*
Therapists' Views on the Association Between Theoretical Orientation & Therapeutic Alliance			
	Orientation informs the alliance		10 (General)
		Through active, verbal & overt facilitation	3 (Variant)
		By providing space & respect	4 (Variant)
		By a natural focus on the relationship	3 (Variant)

Table 2. (continued) How Therapists View the Alliance

Domain	Category	Subcategory	# Cases & Frequency
Therapist's Views on the Association Between 1st Session Alliance Development & Outcome			
	Positively related to outcome		5 (Variant)
		Likely related	2 (Variant)
		Highly related	3 (Variant)
	Not clearly related		5 (Variant)
		Unclear impact	4 (Variant)
		Not strongly related	1*

<u>What Phenomena in the First Session Do Therapists Regard As the Most Influential
Contributors to the Establishment of an Alliance?</u>

<u>Concerns About Establishing an Alliance</u>

All ten therapists in this study expressed the general belief that their concern about establishing a strong therapeutic alliance is their *primary focus* during their interactions in the first session. One therapist said, "It is absolutely the main thing on my mind; it shapes nearly everything I do in the first session." Four therapists expanded upon this belief with statements comprising two subcategories: (1) Two therapists addressed the nature of a *mutual evaluation* during the first session, indicating that the first meeting can help to give the therapist and client a sense of whether they will be able to work together. (2) Two therapists discussed the notion that the way in which they work to establish an alliance *depends on the client*. One of these therapists said, "Some clients come in and are talking right off the bat, and don't, initially, need much from me, whereas others are more hesitant around something, and I may have to reach out with questions or empathic comments to help build the alliance" (see Table 3).

<u>Contextual and Environmental Factors</u>

All the therapists in this study see clients in private practice, but several also see clients in a hospital or clinic. Thus, therapists spoke to their experiences in both environments. Three categories emerged from therapists' reports of the *negative effects of a hospital/clinic setting* on their efforts to establish an alliance in the first session. (1) The typical response was that the *institution's policies and inability to personalize the*

treatment or environment negatively affect their work. For instance, one therapist spoke about how her clients have to go through a long process with a lot of "red tape", which can frustrate the clients and affect the initial interactions with the therapist. Responses varied in the two other categories: (2) Three therapists noted that the hospital/clinic setting is *less intimate*, with one saying that she may have to do a more formal evaluation, and the physical environment can affect how she feels when sitting with new clients. (3) One therapist indicated that there is a *potential for a negative interaction with administrative persons,* which can negatively affect the client and her efforts to establish an alliance.

Conversely, two variant responses emerged regarding the hospital/clinic setting, with two therapists noting a *positive effect* of this environment in which the *institution provides support* for both the client and therapist. One therapist said that her clients may enter treatment, identify with a hospital, and feel supported; furthermore, she feels especially supported if she is starting with a challenging client.

In the *private practice setting*, three categories emerged from the therapists' reports: (1) The general belief is that the private-practice setting allows the therapists to *personalize their office and treatment approach*. For example, one therapist said, "My office is not too personal to be threatening, and not too professional to be distancing, which helps facilitate the alliance." (2) Therapists also typically said that their private practice enables greater *intimacy and provides a holding environment*. These therapists mentioned how their office provides a secluded, intimate atmosphere which clients can perceive as warm, welcoming, and comfortable. (3) Lastly, two therapists mentioned

the fact that their ability to *select their own clientele*, such as higher functioning clients, positively affects how they work to establish an alliance (see Table 3).

Pre-1st Session Contact

Not surprisingly, all therapists reported that they have phone contact with their clients prior to the first session. The general practice of these therapists is to *address logistical issues* and insurance questions. Many of these therapists address these concerns over the phone to reduce the client's anxiety by providing information (e.g., detailed directions and insurance coverage clarification), so that their clients are not taken off guard in the first session, an experience that would threaten the early establishment of the alliance. Half the therapists indicated that they also allow time on the phone to *address clients' concerns* or therapy-related issues. One therapist stated that she listens to the clients' concerns and validates the client in an effort to help establish the alliance in the first session (see Table 3).

Logistical Aspects

The therapists' responses varied in regard to how and when the logistical aspects of therapy are addressed. (1) Half the therapists reported that they try to *limit the logistical aspects* as much as possible in the first session. One therapist explained how she tries to keep the administrative pieces to a minimum; however, she does not view attention to these issues as a problem, because understanding how the client handles the logistics can be informative for the relationship. (2) Although the other half of the therapists detailed how they address the logistics at the *end of the first session*, one

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stated that doing so allows her to start with empathy and first see what the client is looking for in therapy.

The therapists also spoke to how addressing logistics affects their efforts to establish an alliance. Again, their responses varied. (1) Half the therapists highlighted how their efforts to build an early alliance usually include addressing the logistical aspects of treatment. Specifically, how the therapist and client handle the logistics can either foster or diminish the development of the alliance. (2) Two therapists believe that logistics should be kept separate, and they try not to allow the "business-like nature of the logistics to interfere and negatively affect the alliance." (3) Lastly, three therapists said that they feel it depends on the client. One therapist elaborated by noting that, if the client is in a crisis, she will "stay with the action and discuss as little logistical information as possible" (see Table 3).

Table 3.   Influential Alliance Building Phenomena in 1st Session

Domain	Subdomain	Category	Subcategory	# Cases & Frequency
Concerns About Alliance Establishment				
		Establishing an alliance is primary focus in 1st session		10 (General)
			Process of establishing an alliance involves a mutual evaluation between client & therapist	2 (Variant)
			Process of establishing an alliance depends on the client	2 (Variant)
			Process of establishing an alliance is an overall, general emphasis in 1st session	6 (Typical)

Table 3. (continued) Influential Alliance Building Phenomena in 1st Session

Domain	Subdomain	Category	Subcategory	# Cases & Frequency
Effects of Contextual & Environmental Factors				
	Hospital/clinic setting			
		Negative effects		
			Less intimacy	3 (Variant)
			Restrictions due to institutional policies & inability to personalize treatment	6 (Typical)
			Potential negative interactions with administrative staff	1*
		Positive effects		
			Support of institution for clients & therapists	2 (Variant)
	Private practice			
		Positive effects		
			Ability to personalize office & treatment	8 (Typical)
			Ability to establish intimacy & holding environment	6 (Typical)
			Ability to select clientele	2 (Variant)

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Table 3. (continued) Influential Alliance Building Phenomena in 1st Session

Domain	Subdomain	Category	Subcategory	# Cases & Frequency
Tasks of Pre-1st Session Phone Contact				
		Address logistical issues		10 (General)
			Also address client's concerns	5 (Variant)
Addressing Logistical Aspects				
		How & when logistical aspects are addressed		
			Minimal discussion in 1st session	5 (Variant)
			Discussion at end of 1st session	5 (Variant)
		How discussion affects alliance establishment		
			Building alliance includes discussion of logistics	5 (Variant)
			Discussion of logistics is separate from alliance building	2 (Variant)
			Depends on situation	3 (Variant)

<u>What Do Therapists Do in the First Session to Facilitate the Establishment of a
Therapeutic Alliance?</u>

<u>Bordin's Components of the Alliance</u>

The therapists addressed how they attend to the three components of the alliance
(i.e., Tasks, Goals, Bond) as proposed by Bordin (1979), and they discussed which
component(s) they view as most influential in establishing an alliance in the first
session. Typically, the *bond* was viewed as the most important aspect of the alliance to
address in the first session, as one therapist said that it is necessary in order to have
clients stay in treatment. Three therapists had a variant response in which they discussed
how they believe that the three components are *all interrelated*. For example, one
therapist said, "The discussion of tasks and goals often overlaps, and the more precise
the client and therapist get with these components, the more intense the bond."

Therapists' opinions varied as to how they address the *tasks* of therapy within
the first session. Three categories emerged from the responses: (1) Half of the
therapists said that they feel that it *depends on the client*. One therapist elucidated on
this by saying that there is not a particular agenda in the first session because it depends
on what the client is coming in with; if asked how the therapist would treat a certain
disorder, the therapist talks about the tasks of the treatment.

(2) Three therapists indicated that they *address the tasks* of treatment within the first session, but they tend to save that discussion until the end of the session. (3) Conversely, two therapists reported that the tasks are *not a main focus* in the initial meeting, saying "it is almost premature to establish tasks and goals in the first session."

The therapists also varied in how they address the goals of treatment in the first session. (1) Four therapists explained how they initially develop goals with clients, but believe this work may change and extend *beyond the first session*, with one therapist pointing out that the goals shift in meaning, and are re-contextualized over the course of therapy. (2) Four other therapists spoke to allowing the goals to be *generated from the clients' concerns;* they ask about goals to get a sense of what brings the client into treatment. (3) Two therapists reported that they do not talk about goals in the first session.

Regarding efforts to enhance the *bond* in the first session: (1) The typical response involved therapists' efforts to use *empathy, honesty, and self-awareness*. (2) Four therapists spoke to the value in establishing therapy as a *mutual endeavor*. One therapist reported trying to convey that "we are both here and this will be a journey together." (3) Two therapists discussed being *aware of the clients' presentation* and reactions; specifically, they try to give the client a sense of what it is like to be in therapy and to sit with the therapist, while the therapist responds in ways aimed at facilitating the alliance (see Table 4).

Therapist Actions

       The therapists enumerated various ways they work to facilitate an alliance with new clients. The categories that include half or more of the therapists' responses are elaborated in this section, but all the categories are presented in Table 4. (1) Typically, therapists reported using *active listening* and maintaining close *attention to their client's story*. As such, one therapist talked about spending much of the first session just listening to the client and helping the client to feel that he or she has been heard and understood. (2) Another typical response pertains to efforts to be *honest and open* during these initial interactions. For instance, one therapist believes, "The clients need to know that you are human; I will try to give my clients a sense that I am a real person. Being real is a certain kind of disclosure." (3) Half of the therapists try to *generate curiosity* in their new clients and may *gently challenge* a client by inviting the client to reflect on an issue or using a trial interpretation to see how the client responds. (4) Half of the therapists also emphasized the use of *empathy, validation, and trust* in the first session to facilitate an alliance. For instance, one therapist described asking questions of the client and then reflecting back an understanding in her efforts to validate clients' responses and make them feel comfortable. (5) Lastly, half of the therapists spoke to the value of *setting the frame, expectations, and process of therapy*. Therapists discussed asking questions to engage the client, directing client where to sit, ending on time, providing psychoeducation if needed, and giving the overall message that the relationship is important (see Table 4).

Table 4. What Therapists Do in the 1st Session to Facilitate the Establishment of an Alliance

Domain	Subdomain	Category	Subcategory	# Cases & Frequency
Bordin's Components of the Alliance				
	Extent to which **tasks** of therapy are addressed in 1st session			
		Depends on the client		5 (Variant)
		Are addressed in 1st session		3 (Variant)
		Not a main focus		2 (Variant)
	Extent to which **goals** of therapy are addressed in the 1st session			
		Initially developed but extended beyond 1st session		4 (Variant)
		Addressed in 1st session, but are generated from client concerns		4 (Variant)
		Not addressed in 1st session		2 (Variant)

Table 4. (continued) What Therapists Do in the 1st Session to Facilitate the Establishment of an Alliance

Domain	Subdomain	Category	Subcategory	# Cases & Frequency
Bordin's Components of the Alliance				
	Extent to which efforts are made to enhance a **bond** in 1st session			
		Addressed in 1st session		10 (General)
			Use of empathy, honesty, & self-awareness	7 (Typical)
			Therapy is established as a mutual endeavor	4 (Variant)
			Being aware of client's presentation & reactions	2 (Variant)
	Views about most important component			
		Establishment of a bond		7 (Typical)
		All components are interrelated		3 (Typical)

Table 4. (continued) What Therapists Do in the 1st Session to Facilitate the Establishment of an Alliance

Domain	Subdomain	Category	Subcategory	# Cases & Frequency
Therapist Actions to Facilitate the Alliance				
		Use of active listening & close attention to client's story		8 (Typical)
		Being honest & open		7 (Typical)
		Attempts to generate curiosity or gentle challenging		5 (Variant)
		Use of empathy, validation, & trust		5 (Variant)
		Setting of the frame, expectations, & process of therapy		5 (Variant)
		Self-Awareness		2 (Variant)
		Facilitation of client to choose topic + direction		4 (Variant)
		Instillation of hope		2 (Variant)
		Attention to use of language		2 (Variant)

Therapist Factors

Two sub-domains emerged from the therapists' responses: therapist factors *facilitating* the alliance and Therapist Factors *impeding* the alliance. Interestingly, the therapists' responses varied considerably, such that five categories were generated pertaining to therapist factors that *facilitate* the alliance in the first session: (1) Half of the therapists said that they can communicate their *own humanness*, with one therapist describing the ability to access his own emotions, thus enabling the client to do the same. (2) Half of the therapists also spoke to being *emotionally accessible, warm, and non-judgmental*. These therapists spoke about making the client feel at ease and comfortable, rather than simply staying neutral, as well as being understanding and good listeners. (3) Four therapists reported that their *clinical experience or confidence* enables them to facilitate the alliance. One therapist in this category discussed feeling prepared, confident, and comfortable as a therapist. (4) Half of the therapists emphasized being *aware of themselves* and their feelings in being able to *recognize their own limitations*. These facilitating factors were discussed in regard to knowing how late in the day one can hold a session before the therapist feels it is intruding on her personal time and boundaries as well as being able to admit "I have no idea" when addressing a novel clinical issue. (5) Lastly, half of the therapists said that they are *attentive, empathic, and good listeners*. For instance, one therapist in this category said, "Empathy, compassion, and implicit acceptance come naturally, perhaps as a part of loving my job."

The responses also varied regarding the therapists' reports of their own

behaviors, characteristics, and issues that may *impede* the establishment of an alliance.

(1) Four therapists spoke about their *anxiety* regarding their own limitations or in

certain clinical situations. One therapist elaborated by stating that she can get anxious if

she does not understand the presentation of a client or if she does not quickly have

theories about how she will proceed in therapy with a new client; as a result, she may

have a more challenging time staying connected to the client. (2) Three therapists

indicated that they can become *too active or verbal*, thus becoming too didactic or

chiming in too frequently and inhibiting the flow of the session. (3) Three other

therapists explained that, at times, their *less structured approach* may hinder the

establishment of the alliance. For instance, one therapist said that her method of

developing a treatment plan may feel too vague for some clients. Another therapist said

that when she does not take a particular stance on an issue it may feel uncomfortable for

new clients. (4) Two therapists discussed how their own *personal distractions/issues*

may interfere with their ability to foster a new alliance (see Table 5).

Client Factors

Two sub-domains emerged from the therapists' responses regarding client

factors that influence the alliance in the first session: Client factors *facilitating* the

alliance and client factors *impeding* the alliance. Therapists' responses varied regarding

client factors that *facilitate* the establishment of an alliance: (1) Half of the therapists

stressed the value of clients being able to *open-up or reflect*. One therapist said,

"Clients are best when they are interested in self-reflection and have an openness to

exploring themselves and their relationships." (2) On a slightly different note, four therapists discussed the positive quality that some clients have their *capacity to build relationships,* such as those who are "invested in human interactions" or are less defensive and able to engage with the therapist. (3) Three therapists spoke about clients' *motivation and readiness for change* as being a facilitating factor. One therapist said, "Clients who are motivated start the hard work of treatment even though it can get painful at points."

Two typical responses emerged about client factors that *impede* the establishment of an alliance in the first session: (1) Clients who are *overly-defensive or resistant to treatment* can impede the establishment of an alliance. These therapists spoke about clients who lack motivation to be in treatment or do the work of therapy, who are extremely guarded or quiet, or who do not have a sense of what they want out of therapy. (2) Also impeding the establishment of an alliance are clients who present with certain *characterlogical or diagnostic barriers* such as extreme depression, paranoia, psychosis, as well as personality disorders such as borderline, narcissistic, and antisocial. As a variant response, two therapists discussed the role that clients' *negative expectations*, or expectations that are *different* from those of the therapist, can play in impeding the establishment of the alliance (see Table 5).

Table 5. Factors Affecting the Development of the Alliance in the 1st Session

Domain	Subdomain	Category	# Cases & Frequency
Therapist Factors			
	Facilitate Development of Alliance		
		Communication of one's own humanness	5 (Variant)
		Emotional accessibility, warmth, non-judgmental stance	5 (Variant)
		Clinical experience or confidence	4 (Variant)
		Awareness of self &/or own limitations	5 (Variant)
		Attention, empathy, & good listening	5 (Variant)
	Impede Development of Alliance		
		Anxiety about one's own limitations or clinical situation	4 (Variant)
		Excessive activity or talking	3 (Variant)
		Less structured style (at times)	3 (Variant)
		Interference of personal distractions + issues	2 (Variant)

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Table 5. (continued)   Factors Affecting the Development of the Alliance in the 1st Session

Domain	Subdomain	Category	# Cases & Frequency
Client Factors			
	Facilitate Development of Alliance		
		Ability to open up or reflect	5 (Variant)
		Ability & willingness to build relationships	4 (Variant)
		Motivation or readiness for treatment	3 (Variant)
		Positive expectations	2 (Variant)
		Ability to express emotions	2 (Variant)
	Impede Development of Alliance		
		Excessive defensiveness or resistance to treatment	7 (Typical)
		Characterological or diagnostic barriers	6 (Typical)
		Negative expectations	2 (Variant)
		Disparity in Age or Gender role	1*

CHAPTER IV

DISCUSSION

The results of this study speak to the pivotal role of the first psychotherapy session in setting the stage for the establishment of a therapeutic alliance. The therapists interviewed for the project discussed several first-session factors that influence the course of therapy. The typical theoretical orientation for therapists in this study is integrative, and all therapists discussed incorporating psychodynamic theory into their clinical work. Consistent with the literature (e.g., Constantino & Schut, 2002), the therapists varied in their definition of the alliance; however, all the therapists emphasized that the therapeutic alliance incorporates a strong relational component. Although previous researchers have demonstrated that the alliance is a moderate but reliable predictor of outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), little empirical research has been published on the impact on treatment outcome of therapists' efforts to establish an alliance in the first session. All the therapists in the study discussed the essential role of their early efforts to foster the relationship, and enduring impact of these efforts on both short-term and long-term therapeutic work. However, they varied in their responses regarding the extent to which first-session alliance development is associated with the outcome of treatment. Half the therapists view their first-session efforts as influencing the outcome of therapy, and the other half acknowledged that early efforts to establish the alliance are important, but believe that such efforts extend beyond just the very first session.

Influential Contributors to the Establishment of an Alliance in the First Session

From the perspective of the therapists in this study, a focus on the alliance should take precedence over all other aspects in the first session, suggesting that it is important for therapists to maintain an active focus on the relationship in the initial clinical encounter, a notion consistent with the research of Castonguay, Constantino, and Holtforth (2006) who attest that therapists should be attuned to their interactions with their clients "the moment treatment commences." By making early efforts to foster the relationship, therapists are working to build a solid foundation for future therapeutic work.

The setting in which the psychotherapy takes place greatly influences the facility with which therapists begin establishing an alliance in the first session. All of the therapists but one in this study work in private practice, and not surprisingly, they discussed the fact that they experience greater autonomy, and therefore more flexibility in determining how they interact with clients from the outset of treatment. When therapists can personalize the decor, location, and layout of their office they are able to communicate their efforts to establish an environment of warmth, privacy, and trust. When therapists can provide a professional *and* personal atmosphere for their clients, they are able to augment their actions to develop the alliance in the initial encounter. By contrast, several of the therapists who also work in hospitals and clinics discussed the ways in which they approach institutional obstacles which may impede their efforts to initiate an alliance in those settings. Although these therapists contend with institutional procedures and environmental limitations, they realize that they must make

special efforts in the first session to moderate the contextual factors that might cause a new client to feel distanced or de-individuated.

Therapists generally have some initial pre-therapy interaction with new clients, which is usually a conversation on the phone. Not surprisingly, the therapists in this study view this preliminary contact as an important context for sowing the seeds of alliance development. All the therapists address questions about insurance, directions, and other logistical matters; however, half the therapists in this study also speak with their new clients on the phone about presenting problems or questions regarding therapy. Although this initial contact is of considerable importance, therapists find that they are walking a fine line between attending to the task of discussing logistical concerns and engaging in a clinical dialogue which "starts therapy" prior to the first meeting. Because little research has focused on the role that the preliminary phone conversation may play in setting the stage for alliance development, this interaction certainly warrants further empirical study. Of note, with the ever increasing use of computers, clients are also making their first inquiry about therapy via email. The ways in which prospective clients contact therapists, and what they say or ask, can provide important clinical information that predicts some of the issues that the therapist will face in his or her efforts to establish the alliance when treatment commences. Regardless of the mode of contact, therapists should be attentive to the realization that preliminary contacts with prospective clients will have impact on what happens when therapist and client come face to face for the first time.

Therapists face the challenge of attending to a myriad of tasks in the first session, which often include gathering insurance information, obtaining informed consent, and discussing scheduling. Such necessary procedures can be distracting to the client and to the clinician, leaving some clients feeling distanced and impersonally treated. For ethical and legal reasons, logistical information must be covered at the beginning of therapy (Fisher, 2003); however, therapists may be frustrated by feeling pressured to address the business aspects of therapy, when their greatest wish is to listen to the clients' concerns while conveying empathy and understanding. In the present study, several therapists discussed this dual pressure of attending to business while also trying to be therapeutic. Some therapists judiciously leave discussion of logistics for the end of the first session, so that they can begin the session by listening to the client and providing empathy. Therapists in this study also discussed how they try to use clients' reactions to the discussion of logistics as a way of developing the alliance. For instance, therapists can pay attention to how a client reacts to the conversation about the fee or limits of confidentiality, and respond to the client's reaction in a manner that is attuned to the development of the relationship. Corroborating with the writings of Hilde Bruch (1974) , therapists who pay particular attention to logistical aspects in their effort to develop an alliance may be addressing the logistical information in a different fashion. The manner in which these therapists discuss the logistical concerns, and the attention they dedicate to the role of logistics, may have an impact on the alliance.

First-Session Efforts to Facilitate the Establishment of a Therapeutic Alliance

Most alliance researchers use a definition of the therapeutic alliance that contains the three components (tasks, goals, and bond) proposed by Bordin in 1979. Although the role of the tasks, goals, and bond has been studied in the therapeutic process (Horvath, 2001; Horvath & Symonds, 1991), the present study is the first to examine the role of these three components in the development of the alliance in the first session of therapy. The therapists in this study emphasize the bond as the most important component on which to focus within the first session. Although discussion of the client's presenting problems, and the process by which a client's issues are addressed, are important features of the first session, experienced therapists are attuned to the establishment of an emotional, affective attachment which they view as an essential goal at the start of therapy. Some of the tasks and goals of therapy cannot be addressed without the interpersonal foundation upon which therapists will build a sound alliance. Supporting this notion, all the therapists reported that they address the affective and relational bond-based component within the first session, but less than half address the tasks and goals of therapy. Many therapists also discussed how the three components of alliance (tasks, goals, and bond) become more interrelated when therapy extends beyond the first session. A half-century ago, Carl Rogers (1957) emphasized a similar notion, that the establishment of the relationship between the client and therapist is the first condition of therapy and the prerequisite for subsequent work. Clients benefit from feeling that they are being listened to and understood, experiences that facilitate the establishment of safety and trust which are crucial first-session predictors of strong alliance development.

Although the therapists in this study were asked to discuss what techniques they use to facilitate an alliance in the first session, the majority of the therapists objected to the use of the word "technique," a term they view as too impersonal or suggestive of something being imposed on the client. Considering this, all the therapists discussed their active efforts in the first session to establish an alliance with a new client. Interestingly, the therapists' preference to discuss their facilitating behaviors as *therapist actions,* as opposed to techniques, is reflected in the personal nature of their responses. The therapists in this study corroborated and elaborated upon the findings of Sexton, Littauer, Sexton, and Tommeras (2005) as they addressed alliance-facilitating aspects of the first session. The therapists in this study spoke of the importance of being mindful and paying exceptionally close attention to the moment-to-moment process in the first session. This involves attending to the client and his or her experience in the room, seeing how the client reacts to questions, and assessing what the client chooses to talk about or chooses to not to talk about in the initial meeting. While all this is going on, experienced therapists realize that they should try to be mindful of their presence during the initial encounter, possibly by using themselves as a clinical tool and monitoring *their own* thoughts and feelings, their use of language, or the timing of their comments and questions. Several interviewees discussed the *human* side of themselves as therapists and the need to be honest and open about their therapeutic interactions. The therapeutic use of honesty and openness is not synonymous with unwieldy self-disclosure; rather, clients value and appreciate being helped by a candid therapist who can speak about his or her uncertainty around an issue, who is genuine and not overly reassuring, or who can even share a laugh. Goldfried and Davila (2005),

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and Hill (2005) discuss the ongoing process that therapists' actions have on developing the therapeutic alliance, and as a result, the value that the alliance has in setting a safe context for the use of subsequent techniques. Effective therapists appreciate the importance of their actions in the first session, understanding that "a goal of the first session is the second session." If therapists cannot help their clients feel safe, listened to, and understood, then they risk the likelihood that their clients may not return for further treatment. In the present study, the spotlight focused on the "initial impressions" phase as conceptualized by Hill (2005). In this phase, effective therapists use supportive and engaging techniques in their efforts to stay attuned to the client's experience. In this process, they generate curiosity in clients; they are open and honest; and they provide empathy, validation, and assistance in establishing trust.

The therapists in this study highlighted various characteristics they see in themselves that facilitate and impede alliance development, observations that are consistent with research findings of Ackerman and Hilsenroth (2001; 2003), who examined therapist characteristics that positively and negatively impact the alliance. Therapists in this study reported that the following characteristics facilitate alliance development: being warm and non-judgmental, paying attention to the experience of the client, having confidence, having clinical experience, being honest, and maintaining openness or awareness of their own experiences. Ackerman and Hilsenroth (2003) urged future researchers to integrate quantitative and qualitative data to examine interactions between the client and therapist; the present study provides descriptive insight into the role the therapist plays in developing the therapeutic relationship. Mindful awareness of oneself as a therapist *and* the experience of one's client are so

valuable in building the alliance. Consistent with the writings of Hilsenroth and Cromer (2007) on the alliance in the initial encounter, the therapists in this study discussed the actions and characteristics which they regard as most important in facilitating an early alliance. Therapists feel that they are most effective when they act genuine, feel comfortable with themselves, are aware of the client's experience in the therapy room, and are attuned to the process of alliance development.

The therapists in this study varied in their responses about the characteristics of themselves that may impede their ability to develop an alliance in the first session, although several discussed the role that a therapist's anxiety plays in interactions affecting alliance development. Therapists may be anxious in the first session for various reasons such as the presentation of a new or challenging clinical issue, their lack of relevant experience, or the recognition of their own limitations. Regardless of the basis for anxiety, it can hinder a therapist's ability to think clearly or interact spontaneously with a new client. Therapists should strive to be aware of their anxiety and the fashion in which inner tension is manifested, so that they can make efforts to positively moderate such distracting personal emotions. For instance, therapists who become loquacious when anxious can strive to restrain their talkativeness in an effort to allow more space for a client to speak.

<div align="center">Client Factors</div>

For years psychotherapists have discussed various phenomena that characterize "difficult clients" (Beitz & Rasmussen Hall, 2006; Benjamin, 2003; Davidtz, 2008). These include characteristics, which are challenging to therapy in general, also

specifically impede therapist efforts in the first session to establish an alliance. As

discussed by the therapists in this study, several client factors present a challenge in the

initial encounter, such as the following: clients who are overly defensive or resistant to

treatment; clients who have certain characterological presentations or diagnoses such as

paranoia and psychosis; or clients who present with borderline, narcissistic, and

antisocial personality disorders. Therapists who are prepared for such challenges are

better equipped to deal with clients presenting with especially difficult clinical issues.

Therapists should be alert to the possibility that preliminary expectations may unduly

have a negative influence on their actions; however, therapists may find it tremendously

helpful when entering a first session in which the establishment of an alliance may be

more challenging given the client's presentation.

Limitations and Directions for Future Research

This study was based on a thorough analysis of data culled from interviews with

ten seasoned integrative therapists who primarily treat clients in private practice settings

in a metropolitan area. Recruitment of participants for this study was not random;

rather, it was criterion-based and done through networking within a psychotherapy

organization and a psychiatric hospital in the northeastern part of the United States.

The findings from this study provide a rich, detailed examination of ten therapists'

perceptions and experiences, but cannot be assumed to extend to all therapists. This

study can help generate hypotheses about how therapists value the role of the alliance

and how they work to establish an alliance in the first session; however, other therapists

may view these issues differently. As such, future researchers will benefit from

studying therapists with different theoretical orientations, varying years of clinical experience, or who treat different clinical populations. Furthermore, this study was limited to an exploration of therapists' perceptions and actions pertaining to their efforts to establish an alliance in the first session. It would be valuable to conduct a similar CQR study in which clients are interviewed about their experiences in the first session, how their first-session experiences influenced their views of the therapeutic relationship, and how the first-session experiences affected their perceptions of treatment. In addition, a longitudinal study should be formulated which compares first-session alliance variables with outcome.

Every therapy has a first session, but many therapists probably proceed through the routine of their initial encounters without consciously attending to the myriad of influential first-session factors that influence the development of an alliance and the establishment of a foundation for future therapeutic work. The therapists in this study examined their perceptions about the features of the first session that have bearing on the developing alliance. The contributions of these thoughtful clinicians will hopefully help therapists and researchers evaluate what takes place in the first session, and what therapists might change as they strive to develop more effective strategies for getting to the second session, and for attaining successful treatment outcome.

APPENDIX A

Interview Question

1. How do seasoned therapists view the therapeutic alliance?

    a. How do you define the therapeutic alliance?

    b. [What is your theoretical orientation?] How does your theoretical

       orientation inform your perspective on the alliance?

2. What phenomena in the first session do seasoned therapists regards as the most

   influential contributors to the establishment of an alliance?

    a. To what extent does your concern about establishing a strong alliance

       influence your interactions with clients in the first session?

    b. In your view, what is the relationship between the establishment of a

       strong therapeutic alliance early in therapy and the outcome of therapy?

    c. Bordin defines three aspects of the therapeutic alliance: Tasks, Goals,

       Bonds (I will briefly define each). Explain how you attend to each of

       these three aspects and which you regard as most influential in

       establishing an alliance in the first session.

3. What do seasoned therapists do in the first session to facilitate the establishment of a therapeutic alliance?

   a. What specific techniques do you use in the first session to facilitate establishment of the therapeutic alliance?

   b. In what ways does the context in which you work (i.e., private practice, hospital, outpatient clinic) affect your efforts to establish an alliance?

   c. How and when do you handle the logistical aspects (i.e.; fee negotiation, insurance, informed consent)? How does discussion of these pragmatic concerns affect your efforts to establish an alliance?

4. During the first session of psychotherapy, how is the development of a therapeutic alliance influenced by the following [therapeutic] factors: (a) the therapist's personality, and (b) the client's personality and presenting problem?

   a. What personal aspects and characteristics of yourself do you see as facilitating your ability to establish an alliance in the first session?

   b. What personal aspects and characteristics of yourself do you see as impeding your ability to establish an alliance in the first session?

   c. Which client characteristics facilitate the establishment of an alliance?

   d. Which client characteristics impede the establishment of an alliance?

APPENDIX B

THRAPIST CHARACTERISTICS SHEET

Age:

Gender:

Years of clinical experience:

Setting of clinical practice:

APPENDIX C

INTERVIEW CONSENT FORM

This study explores the efforts of therapists in the first session of therapy to begin the process of establishing a therapeutic alliance.

My participation in this study will consist of taking part in a one-hour interview with the investigator, Greg MacEwan, a graduate student in the Clinical Psychology program at the University of Massachusetts, Amherst. I understand that I will be asked to describe my experiences as a psychotherapist, including my perceptions about the therapeutic alliance and my efforts to establish a therapeutic alliance with new clients. This process may involve examining and talking about my professional experiences as a therapist as well as personal reactions and beliefs about the first session of therapy. Possible benefits of participation include an increased understanding of the impact of my own experiences on my work with clients, and the opportunity to make a valuable contribution to the psychotherapy research literature.

I understand that I may ask questions of the investigator, Greg MacEwan, at any point during the interview and that I may refuse to answer any question. I also may withdraw from the study at any time.

I understand that the interview will be audiotaped, and that verbatim transcripts and summaries will be made from the tapes. All of the information I provide during my participation in this study will be kept confidential. In the reporting of results (and any resulting publication), my name and all other identifying information will be altered. If complete anonymity is not possible for any reason, I will be consulted for further consent. Only the investigator, his appointed research associates, and his faculty supervisor, Dr. Richard P. Halgin, will have access to the data in its raw form (verbatim transcripts). If, for any reason, I do not want the verbatim transcripts of this interview to be shared with Dr. Halgin and/or research associates, I may request that. If at any time I wish to know the names of research associates involved with the project, I may ask the investigator.

I have read the above and understand the nature of this project and what is required of me. I am willing to participate in this research study.

_____   _____

Signature   Date

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